Challenges facing Healthcare Professionals (HCPs) in their roles of identifying and responding to victims of Child Sexual Abuse (CSA) in Nigeria

By:

Moninuola Ifayomi

A thesis submitted in partial fulfilment of the requirements for the degree

of

Doctor of Philosophy

The University of Sheffield Faculty of Medicine, Dentistry and Health

School of Nursing and Midwifery

February 2023

ABSTRACT

Child sexual abuse is a global social and public health issue, the effects of which create long-lasting impacts on victims, their families, and wider society. Healthcare professionals possess a wealth of knowledge, skills, and experience and are strategically placed to identify and provide care to victims of child sexual abuse. Little is known about the challenges facing healthcare professionals performing their role in a Nigerian context. This study aimed to explore the challenges of supporting victims of child sexual abuse in Nigeria as well as the implications of those challenges for healthcare professionals and service users.

Methods: This qualitative study used a constructivist grounded theory approach and used purposive and theoretical sampling techniques to identify twenty-six healthcare professionals who specialise in supporting victims of child sexual abuse. Participants were recruited from hospitals and Sexual Assault Referral Centres to participate in online semi-structured interviews. Data were analysed using a constant comparison method.

Findings: Healthcare professionals play a vital role in ensuring victims receive medico-legal care, psychosocial support, access to justice, and protection from re-victimisation. Identifying and responding to sexually abused children presented inherent challenges and was described as a complex, sensitive, and traumatic process for healthcare professionals. There are key areas of conceptual disagreement among healthcare professionals' regarding their understanding of the construct of child sexual abuse, which hinders an effective multi-professional approach to victim care. Socio-cultural norms, including traditional practices, increased the child's vulnerability to sexual abuse, isolated them, and prevented them from disclosing the abuse. Using a

grounded theory approach, a ‘practice challenges theory’ was developed, which proposes that challenges faced by healthcare professionals are inherent in the dimensions and context of practice. The theory provides an encompassing framework indicating these challenges resulted from the complex interplay of individual and socio-ecological contextual factors.

Conclusion: The main conclusion of this study is that it is important to use approaches that systematically target change mechanisms at each level of influence, with a focus on the context and dimensions of practice.

Acknowledgements

In the first place, I am filled with awe and reverence at His divine and tremendous grace God has bestowed on me in completing my PhD and making the journey so much easier.

My sincere gratitude and heartfelt respect to my supervisors; Professor Parveen Ali and Dr Katie Ellis. I will be forever grateful to both of you for your unrelenting support and guidance. You advised, encouraged, and supported me, and provided many opportunities to triumph during and beyond my PhD journey. Your level of confidence in me right from the start is beyond my understanding, it fuelled my dreams.

As well, I would like to thank everyone who participated in this study for sharing their invaluable perspectives and experiences with me. I would like to thank my colleagues for providing me with invaluable assistance at times and for exchanging edifying views that have been vital to my development.

My heartiest thanks to my highly respected and selfless husband, Mr Abiola Ifayomi, for his perseverance and endurance through it all. Without his unwavering love, support, and inspiration—especially during trying times—the entire process of writing my thesis would not have been successful. Thank you for holding my hands and praying with me when I was scared of uncertainties. To my lovely mother, my gratitude knows no bounds. I am grateful for your support in helping me pursue my dreams and achieve them in the best way. To my adorable daughters: Mirabelle, I will never forget your tiny voice saying ‘mum, breathe in and breathe out;’ it always brightens me up. To Bisola, I doff my hat for you. To my lovely brother, thank you for everything. To my friends, thank you all for your lovely support and understanding.

Declaration

I declare that the content of this dissertation is entirely my own work, and has not been submitted, in whole or in part, to any previous degree or professional qualification application. References have been provided for all supporting literature, and resources have been acknowledged.

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List of abbreviations

Abbreviations	Definition
CAMHS	Child and Adolescent Mental Health Services
CASP	Critical Appraisal Skill Programme
CSA	Child Sexual Abuse
FMOH	Federal Ministry of Health
GMP	General Medical Practitioner
GT	Grounded Theory
HCPs	Health Care Professionals
NHIS	National Health Insurance Scheme
OSCC	One Stop Crisis Centre
PEO	Population Exposure Outcome
SARC	Sexual Assault Referral Centre
SSPS	Statistical Package for the Social Science
UNCRC	United Nation Convention on Right of Child
UNICEF	United Nations International Children's Emergency Funds
WHO	World Health Organisation

Preface: Structure of the study

This thesis has ten chapters and an overview of each is presented below. Chapter one sets out the background of this study and outlines the aims and research questions. It explains the concept of child sexual abuse (CSA) and identifies discrepancies and variances across different contexts and their implications, especially in the study setting. It further explains the roles of healthcare professionals (HCP) and their importance, as well as the researcher's impetus and background. It outlines the current challenges to outline the significance of this study.

Chapter two contextualises the study within relevant global literature, policy, and practice. The chapter starts with an examination of the global existing evidence-based relating to HCPs' perceptions of their roles of identifying and responding to sexually abused children. This chapter reviews, analyses, summarises, and discusses relevant literature, and identifies research gaps. It closes with a critical appraisal of all the systematic reviews of literature from both international and national articles, justifying the current study.

Chapter three presents theories of CSA with an emphasis on theoretical explanations of sexual offending behaviour and ecosystem factors as related to CSA. It provides an overview of the socio-cultural and healthcare systems in Nigeria and the services available for sexually abused children in Nigeria, highlighting the roles of HCPs. The chapter concludes by providing the comprehensive process and findings from a systematic review of literature on CSA in Nigeria.

Chapter four presents a comprehensive explanation of the methodological framework and research paradigm for this study. It focuses on the methodological characteristics

of the chosen approaches, followed by an overview and rationale for the use of a qualitative research strategy and a constructivist grounded theory approach.

Chapter five offers a detailed description of the qualitative research design and situates the study within the social constructionism and constructivist grounded theory approach. I explain the rationale for selecting in-depth semi structured interviews as the core research method for this study and present an overview of the practical aspects of research study which include gatekeeping, accessing research settings, recruitment and selection of samples, and safeguarding. It includes reflections on the research process and the nature of the claims made in qualitative research, as well as data management, analysis, and rigour of the study . A major aspect of the discussion is the research setting and ethical considerations.

Chapters six and seven present the research findings in substantial detail. Each chapter combines verbatim data from each participant's transcripts with analysis and reflection. The two chapters present findings from the 26 participants sequentially, enabling a cumulative and contrasted argument that highlights HCPs' understanding of CSA and perception of their roles, as well as the multi-level and interconnected systems and factors challenging and undermining their practice.

Chapter eight discusses the emergent core category and its relationship to other categories, as well as its contribution to theory. It presents and explains the study-generated grounded theory of challenges facing HCPs in their professional roles of identifying and responding to sexually abused children. This chapter also relates this theory to other pertinent existing theories explaining CSA and considers how the current study is similar or different to other theories and their significance.

Chapter nine discusses the findings of the current study in the context of relevant existing literature, highlights the project's contribution to knowledge, and discusses the strengths and limitations of the study, along with potential areas for future research. This chapter concludes with recommendations to improve the performance of HCPs in identifying and responding to sexually abused children in Nigeria.

Chapter 10 is the concluding chapter of this thesis. It presents my reflections on the research process, the strengths and limitations of the study, and the recommendations and conclusions of the study.

CHAPTER ONE: BACKGROUND

This chapter provides the background of the study by introducing the thesis, the aims and research question, and the impetus and justification for this research. It discusses the concept of Child Sexual Abuse (CSA), its risk factors and consequences, and the roles of healthcare professionals (HCPs). This chapter also discusses discrepancies in definitions of CSA across three main domains relevant to sexually abused children and HCPs' roles, and their implications for practice.

1.1. Child sexual abuse

CSA is a major social and public health problem affecting thousands of children and adolescents globally, with long-lasting impacts on the victims, their families and society. It refers to:

> 'The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society.' (WHO, 2006, p. 10).

The definition focuses on developmental age, the child's maturity, the use of coercion or violence and the social context. The definition of CSA has become more encompassing over the years. In its most simplistic form, it is defined as inciting a child to engage in, or involvement of a child in, any form of sexual activity. However, to understand the context in which HCPs operate and its implication for practice, a clear exploration and understanding of variations and discrepancies between existing definitions and how different relevant domains have conceptualised this phenomenon is important.

CSA can be contact or non-contact, penetrative or non-penetrative or an exploitative act. Contact CSA occurs when a perpetrator makes physical contact with a child, including but not limited to inappropriate touching, using objects, coercion, making a child undress, kissing, performing oral and anal sex (Manyike *et al.*, 2015). Non-contact CSA occurs when a perpetrator achieves sexual pleasure without physical contact and by exposing children to pornography, sexual images, sexual acts, asking them to masturbate, viewing, sharing or creating child abuse images or forcing a child to participate in either penetrative or non-penetrative sexual activities (Manyike *et al.*, 2015; Sanderson, 2006).

According to WHO, one in four children globally experiences some form of sexual abuse, while the prevalence of CSA in Nigeria ranges from 2.1 to 77.7% (Audu, Geidam and Jarma, 2009; Obisesan and Adeyemo, 2002). More than 31.4% of girls' first sexual experience in Nigeria was reported to be rape or forced sex (United Nations International Children's Emergency Funds, 2015). The actual magnitude of CSA remains unknown, with disparities in published statistics across the world (Audu *et al.*, 2009; Pereda, Guilera, Forns and Gómez-Benito, 2009) as it is highly underreported and underestimated. For example, in the UK only 10% of sexually abused children reported to officials and 7% reported to the police (UK Home Office, 2017).

1.2. Contributing factors

The causes of CSA are multifaceted, comprising individual, contextual and ecosystem factors that increase a child's vulnerability (Stephen, William and Richard, 2013). Young children, for example, are particularly vulnerable to CSA due to their higher level of dependency, inability to protect themselves, and difficulty articulating their experiences or seeking help (Martin *et al.*, 2004; Martinello, 2020; Sodipo *et al.*,

2018). In addition, they are unable to see sexual exploitation as socially unacceptable or/and may be willing to tolerate such abuse in exchange for what might be offered – love, protection, privileges, friendship, treats, or money (Stephen *et al.*, 2013). In addition, a child with a learning or physical disability, interrupted care histories or children living in secure or residential homes (Brown *et al.*, 2016) are more at risk of experiencing CSA. Other common factors include family characteristics and structure. These factors and a more robust theoretical explanation of sexual offending behaviour and influence of ecosystem factors will be outlined in chapter 3.

1.2.1. Consequence of CSA

CSA entails short-term and lifelong sequela for the individual, family and society, especially if left unrecognised or untreated (Hornor, 2010; Mullers and Dowling, 2008; Warrington *et al.,* 2016). Early trauma suffered by sexually abused children has been linked to multiple behavioural, psychiatric and mental problems, including substance abuse, anxiety and depression, post-traumatic stress disorder, and suicide attempts (Martin *et al,* 2004; Mullers and Dowling, 2008; Okeafor, Okeafor and Tobin-West, 2018). As a result of CSA, victims experience both physical (genital trauma, unplanned pregnancy, and sexually transmitted diseases), psychological (suicide attempts, depression, post-traumatic stress disorder, flashbacks, sleep disorders, guilt, self-blame, emotional numbness, powerlessness, distrust, and anger), emotional (fear and anxiety), and behavioural difficulties (mistrust of others and missing from home) (Aborisade and Vaughan 2014; Okeafor *et al.*, 2018; Oteh, Ogbuke and Iheriohanma, 2009). Such experiences often leave the victims traumatised with unsavoury memories which tend to truncate psychosocial development and impede their educational careers.

1.3. CSA definition: Dimensions, variations in different contexts, and implications for practice

The definition of CSA has changed over time. While this study does not focus on variations in the definition of CSA, a clear exploration of how different relevant domains have conceptualised this phenomenon is important to understand the context wherein HCPs operate. The necessity for a common definition of CSA was acknowledged in the late 1970s by practitioners, researchers, agencies, and politicians (Haugaard, 2000; Mathews and Collin-Vézina, 2019). A review of existing literature on CSA identified three areas of variation across all domains: the definition of the CSA construct, the acts that comprise it, and the concept of consent (Mathews and Collin-Vézina, 2019). This section examines the definition of CSA in three different contexts, including research and theory, legal frameworks and policy responses and documents, and the effects of variations.

1.3.1. Research domain: Definition of CSA

Despite persistent efforts to find common ground, variations in the terminology used by individual researchers are frequently observed in research studies. Each researcher has a unique understanding of what constitutes CSA (Macdonald *et al.*, 2016; Manly, 2005), resulting in the development of individual definitions (Murray, Nguyen and Cohen, 2014; Pereda *et al.*, 2009). Interpretations of CSA vary on factors such as the age at which a child is defined, the characteristics of the abuse, such as whether it was contact or non-contact and the level of intrusiveness, or the age difference between the abuser and the victim (Carr, 2006; Pereda *et al.*, 2009). Additionally, there are

differences between contact and non-contact sexual abuse (National Society for the Prevention of Cruelty to Children, 2015), and intra-familial and extra-familial sexual abuse (Carr, 2006). Other definitions of CSA vary regarding the nature of the incidence, pattern, and frequency of the abuse, as well as the duration of the abuse, the age at which the abuse began, the presence or absence of force, perpetrator characteristics, the level of intrusiveness and frequency, as well as social norms and practice (Collin-Vézina, Daigneault and Héber, 2013; Mathews and Collin-Vézina, 2019). The level of intrusiveness can range from exposure to or watching sexual content to actual penetration, and frequency can range from a single episode to recurrent and continuous abuse. The definition of incest is difficult to pin down, particularly in situations in which siblings who have not yet reached the age of sexual consent engage in sexual behaviours with one another (Tener and Silberstein, 2019). In situations like this, it is impossible for professionals to identify one of the siblings as the 'perpetrator' or 'victim.' Variations in CSA research tools, especially survey questions, are also an important aspect. Some studies have used just one or two questions (Dinwiddie *et al.*, 2000; Fanslow *et al.*, 2007), while others have used four or five questions (David *et al.*, 2018; Sodipo *et al.*, 2018) or as many as 21 questions (Koss *et al.*, 2006; Mcgee, Garavan and Byrne, 2002). Additionally, research instruments/tools are also affected by the varied definitions (Finkelhor *et al.*, 2014; Koss *et al.*, 2006; Mcgee *et al.*, 2002; Zolotor *et al.*, 2009;).

A major problem is defining the construct of the CSA. Most studies adopted a definition limited to contact abuse, kissing, fondling, touching, and penetration (either oral, penile, vaginal, or anal) (David *et al.*, 2018; Fanslow *et al.*, 2007; Singh, Parsekar and Nair, 2014; Sodipo *et al.*, 2018). Only a few studies have provided a list of CSA behaviours, which can range from short lists of specific sexual behaviours that are

frequently only allowed in contact sexual acts to longer lists of specific non-contact sexual abuse acts (Audu *et al.,* 2009). Studies that included both contact and non-contact sexual activities showed a higher prevalence of CSA than studies examining contact experiences only. For example, in Nigeria, Obisesan and Adeyemo (2002) reported the lowest prevalence (2.1%) of CSA in a community study, with the definition being limited to penetrative sex, while another community study that considered wider constructs (Audu *et al.,* 2009) reported the highest prevalence (77.7%). Sexual involvement of a person under a statutorily designated age is considered CSA. However, expectations around 'appropriate' childhood and the age of sexual consent vary across countries and cultures, starting from a younger age of 12 to an older age of 18. Such variation makes it difficult for professionals to determine whether sexual activities are consensual or sexual offences in various socio-legal contexts. This uncertainty impacts HCPs' skills, competence, and professional judgement and curiosity to effectively identify and respond to sexually abused children. Due to this, estimating prevalence and incidence can be challenging (Pereda *et al.,* 2009), and developing and implementing policies, legislation, and services for victims/survivors (Murray *et al.,* 2014). This variation poses problems for research and knowledge formation. The fact that different definitions of CSA exist in research on prevalence, aetiology, and sequelae means that something as fundamental as shared knowledge of prevalence is difficult to determine.

1.3.2. Legal domain: Definition of CSA

A country's legal system is vital for dealing with CSA cases, ensuring victims receive justice, upholding criminal laws, safeguarding children, enforcing social norms, and establishing the legal age of consent (Bowman, 2016; Mathews and Collin-Vézina,

2019). In cases involving very young children, prosecuting CSA presents challenges for the justice system. For this reason, domestic legal systems require a comprehensive conceptual approach to CSA. Children's rights are explicitly stated in the legal framework, and it is recommended that they should not decide when to engage in sexual activities since they are not capable (UNCRC, 2005; 2016). There is no consensus on how to address CSA, as different branches of law serve differing purposes (Bowman, 2016). Various areas of the law prohibit certain acts and provide remedies for violations, thereby setting standards of conduct (Bowman, 2016; Mathews and Collin-Vézina, 2019). As an example, civil law provides compensation for injuries sustained, criminal law apprehends perpetrators and facilitators and prosecutes crimes, and child protection law focuses on identifying and preventing CSA. Constitutional law prohibits CSA materials, and professional licensure prevents offenders from accessing children to address re-victimisation. Conceptual ambiguity or a lack of definition is a problem in each of these fields. The unjustified exclusion of acts from the CSA concept may bar civil remedies and criminal prosecutions.

The United Nations Convention on the Rights of the Child (UNCRC), which Nigeria and the UK ratified in 1991, defines a child as 'person under the age of 18, unless national laws recognise the age of majority earlier' (Office of the High Commissioner for Human Rights, 1989, Article 1). Like the UK, Nigeria considers anyone under the age of 18 to be a child (NSPCC, 2015). Across all legal disciplines, consent is highly regarded, and is required at the legal age for all sexual activities. Consent must be freely and voluntarily given, and cannot be obtained through threats, intimidation, or abuse of power. It is therefore impossible for an adult or child to claim that their sexual activity was consensual when they engage in it with someone younger than the age of consent, and such activity is considered CSA, although in some relevant areas of law,

such as civil law and child protection law, this clarification is not explicitly stated (Mathews and Collin-Vézina, 2019). In terms of the identity or relational position of the perpetrator (Mathews and Collin-Vézina, 2019), CSA may be perpetrated by parents, caregivers, family members, or anyone with power or care over the child (Collin-Vézina *et al.,* 2013; Mathews and Collin-Vézina, 2019).

There is no clear definition and national legislation of CSA in Nigeria, and professionals merely rely on the adopted Child Rights Act (CRA) (2003) and the 1999 constitution of the Republic of Nigeria. Section 34 of the 1999 Constitution prohibits all forms of torture, inhuman or degrading treatment, and slavery, forced, or compulsory labour and ensures the child's right to dignity (Federal Republic of Nigeria, 1999). Meanwhile, the legal documents available to practitioners state that cases of CSA can only be confirmed in the presence of the essential elements of the crime, namely force, lack of consent, penetration or broken hymen, and ejaculation (Ekhator, 2015). To be considered a 'victim' by law, children are expected to put up a physical resistance at some point, otherwise, it will not be considered a violation and the perpetrator cannot be convicted. These requirements make it difficult for HCPs and victims to clearly label forms of sexual activity without these elements as non-consensual sexual abuse in Nigeria, particularly as there is little to no policy or law that helps protect the victims, and instead victims can be held accountable and stigmatised by society if their stories are made public.

1.3.3. Policy domain: Definition of CSA

International organisations like the WHO (2006) and the Committee on the Rights of the Child (2011) can significantly influence the direction of policy and practical outcomes on CSA. Unfortunately, some of these bodies that have called for improved

definitions and consensus have used different definitions themselves (WHO, 2006). For example, different definitions have been used by the WHO (2006, p.10) and the Committee on the Rights of the Child (Committee on the Rights of the Child, 2011, p.10).

The identities or relational positions of the perpetrators are also diversely defined. In some policies, it is explicitly stated that both children and adults can be abused, as long as the perpetrator is in a position or relationship of 'responsibility, trust, or power' over the victim. Regarding the acts that constitute CSA, some policies simply employ a broad reference to 'sexual activity,' with the added alternative of 'taboo violation' (Mathews and Collin-Vézina, 2019). In other policies, sexual activity is further elucidated as including the inducement or coercion of a child to engage in any 'unlawful sexual activity,' and the exploitative use of a child in prostitution, other unlawful sexual practices, or pornographic performances or materials (UNCRC, 2011, p.10). Others refer to acts that the child does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared (WHO, 2006, p. 10).

Overall, the CSA definition analysis reveals three main areas of variance and conceptual dispute within each domain of epidemiological studies, policy instruments, and legal frameworks (See Mathews and Collin-Vézina, 2019). Many countries have adopted varied definitions of CSA in their national policies. However, lacking national guidelines of its own on CSA, Nigeria adopted the WHO consultation on child abuse prevention definition, as stated in section 1.2. The definition states that CSA may include but is not limited to 'the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of a child in prostitution or other unlawful sexual practices; and the exploitative use of children in pornographic performance and

materials' (WHO, 2006, p. 10). International policy definitions demonstrate that while minor cultural variations may pose difficulties, the fundamental principles of CSA are universal (Mathews and Collin-Vézina, 2019). This definition has been employed in this study to fit into the existing research paradigm.

1.4. The role of healthcare professionals

This study adopts the WHO definition of HCP, a term which refers to a person, stakeholder or organisation, who is qualified, registered and authorised by a regulatory body to provide healthcare and social services to the population through the application of principles and procedures of evidence-based medicine and caring (adapted from International Labour Organisation 2008; WHO, 2010). By virtue of their role, HCPs are in a powerful position to identify and respond to CSA victims. As their relationship with the patient is based on trust, empathy, and the creation of a safe space, it provides opportunities to facilitate the disclosure of CSA (Stavrianopoulos and Gourvelou, 2012). HCPs can decode the messages underlying children's behaviours and can play a key role in child protection (Todres and Clayton, 2014) and signposting children to necessary specialist care (Gadda and Taylor, 2016; Royal Commission of Australia, 2017). HCPs also assist in the collection of forensic evidence such as clothing, specimens, and images, which are essential for criminal prosecution and improve the chances of a positive legal outcome (Stavrianopoulos and Gourvelou, 2012).

While HCPs possess a wealth of knowledge, skills, and experience to identify and manage CSA victims (Royal Commission of Australia, 2017; WHO, 2006), little is known about the challenges they face when supporting CSA victims (Ajema *et al.*, 2018; Sekhar *et al.*, 2018). A closer insight into HCPs' roles- from their point of view- adds a new dimension to academic knowledge of CSA. Additionally, the study offers

a comprehensive explanation of the barriers and challenges facing HCPs supporting sexually abused children, and the implications for their practice and for victims and society. The roles of HCPs in Nigeria and the pathway of care for sexually abused children will be explored in chapter 3 while discussing available services to victims of CSA in Nigeria. Addressing CSA requires multidisciplinary collaboration and necessitates a common conceptual and operational definition to enable case identification and management (Barth, Bermetz, Heim, Trelle and Tonia, 2013; Veenema, Thornton and Corley, 2015).

1.5. Social, economic, cultural and political context of Nigeria and CSA

Nigeria is a highly enriched multicultural patriarchal society (Udebunu, 2011; Ifechelobi, 2014), where a male child is preferred (Aderinto, 2011) and girls are viewed as having limited opportunities to carry on the family name and providing less economic contribution to the family. Over the years, Nigerian society has intentionally discriminated against sponsoring education for female children, due to the belief that when the girl gets married, the family are deprived of their investment. Consequently, female children end up with limited career and employment opportunities (Audu *et al.*, 2009). Nigeria consists of multicultural groups that are blessed with varied natural resources that could have been used to establish economic stability (Udebunu, 2011). Unfortunately, the opposite is the case, as multiculturalism is exploited by a particular tribe, who monopolise the resources and govern the country politically (Udebunu, 2011). Consequently, there is an increased level of economic instability and security chaos in the country. Children, particularly girls, are also subjected to extreme hardships and unhealthy conditions that jeopardise their safety and security (Innocent,

2014). This situation has been seen in the case of young children employed as house girls or nannies in the houses of well-to-do families in Nigeria. Girls under 12 years old, without formal education, work for more than 8 hours per day or took two or more jobs to provide for their family (Audu *et al.,* 2009). The family's poverty subjects many children to different forms of abuse, especially sexual abuse (UNICEF, 2007).

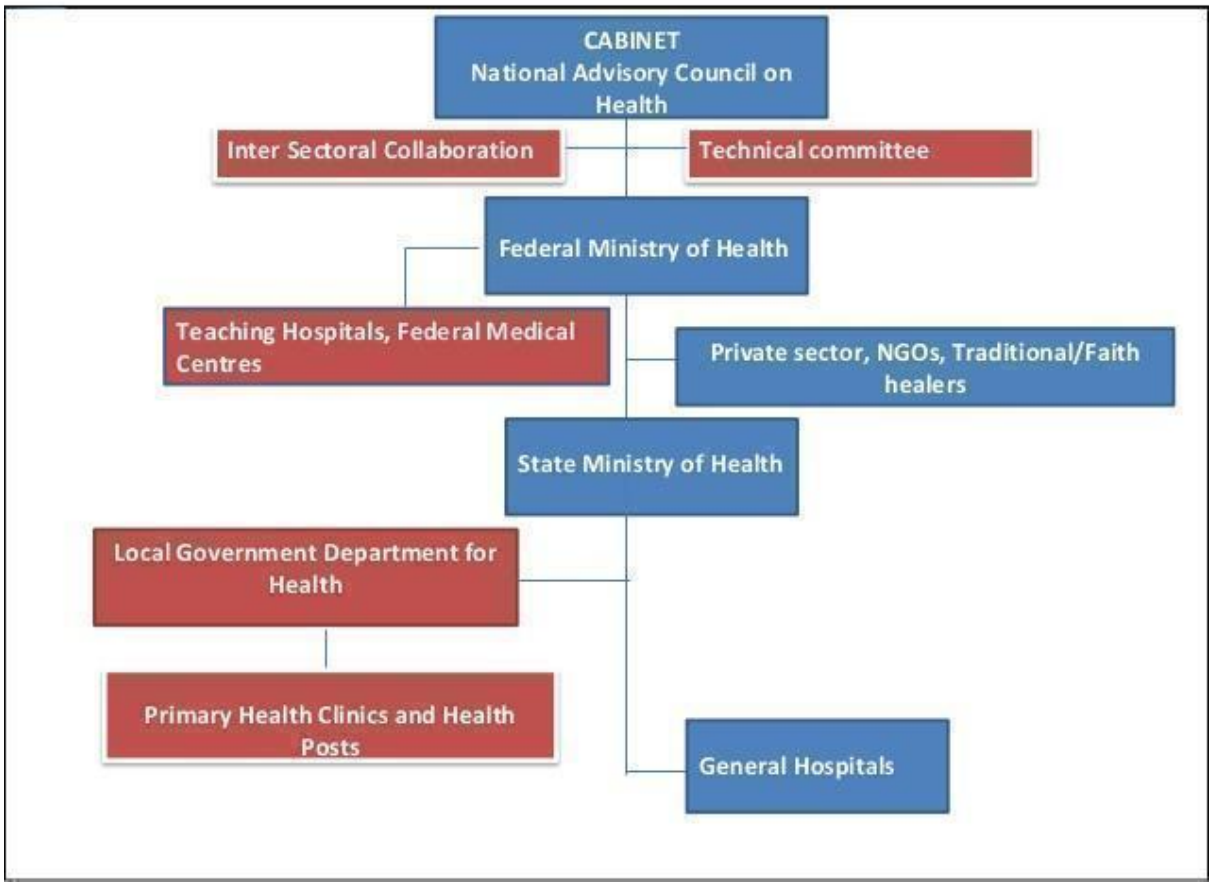
The Nigerian legal system is multifaceted, containing elements of common English law, Sharia law and cultural customs (Okeafor *et al.,* 2018), leading to discrepancies that compromise the implementation and interpretation of the Child Rights Act. For instance, in Northern Nigeria, CSA is perceived as contrary to local customs, culture and religion, which prescribes that girls should be married as soon as they attain puberty. The non-existence and non-implementation of a law against CSA has made early disclosure, recognition and response to CSA difficult (Nwanna and Ogunniran, 2019; Okeafor *et al.,* 2018).

1.6. The Nigerian healthcare system and structure

The Nigerian healthcare system is pluralistic in nature. It includes orthodox (modern medicine), alternative (complementary) and traditional healthcare delivery systems functioning alongside each other, often interdependently. The Government recognises and regulates these three systems. The administration of the healthcare system is organised into three tiers of Government: Federal; State; and Local. As regards the organisational pyramid, the federal government regulates, controls and oversees the tertiary healthcare level through the federal ministry of health. The state government oversees secondary healthcare services through the state ministry of health, headed by the commissioner of health, while the primary level consists of healthcare services provided by the local government and private providers (FRN/FMOH, 2005). There

are varied contributions, interferences, collaborations and interplay at different levels of the Nigerian healthcare system by the private health sector, NGOs and traditional medicine. By developing guidelines and frameworks, the National Advisory Council on Health governs the health system. This framework from cabinet is passed to the federal ministry of health, down to the state ministry, then to the local governments and the political wards. Figure 1 shows the diagrammatic structure of the Nigerian healthcare structure.

Figure 1: Structure of the Nigerian health system



Source: Federal Ministry of Health 2004. Healthcare in Nigeria. Annual Bulletin of the Federal Ministry of Health. Abuja, Nigeria.

In Nigeria, healthcare is financed through a combination of sources, namely taxes from federal revenue of oil and gas, out-of-pocket payments from patients, international and national donor funding, and the National Health Insurance Scheme (NHIS). The NHIS was initially conceptualised in Nigeria in 1960 to address health issues, though it faces numerous factors that make implementation challenging. It utilises the services of Health Maintenance Organisations (HMOs) as health managers, collecting revenues and distributing health services to formal sector employees by collecting premiums and purchasing health services (NHIS, 2001). The scheme is undermined by legislation and political instability (Omoruan, Bamidele and Phillips, 2009). According to Ichocku (2005), the scheme only covers 40% of formal sector employees, excluding over 60% of informal sector workers, particularly in rural areas. Even with the introduction of the NHIS, over 90% of health care in Nigeria is still paid for directly by service users (Ichocku 2005).

The Nigerian health system is collapsing, and several health workforce predicaments have surfaced in recent times due to long-standing unpaid wages, poor welfare, lack of suitable health facilities, and emerging factions among HCPs (Innocent, Uche and Uche 2014). For instance, in Nigeria, the government pays special attention and allocates resources and remunerations to doctors compared to other professionals like nurses, pharmacists and social workers, resulting in internal conflicts. A WHO report on the healthcare system ranked Nigeria 187th out of 191 countries sampled, on its attainment of health goals, responsiveness to healthcare and overall performance (WHO, 2000). Currently, the doctor-patient ratio is 1:5000, compared to the 1:600, specified by the WHO. Poor administration and lack of staff have contributed to further internal crises among HCPs as various factions engaged in a protracted supremacy

challenge (Innocent *et al.,* 2014). These crises have impeded the delivery of optimal healthcare to the Nigerian population, including sexually abused children and families.

1.7. The current challenges

Even though the detrimental impact of CSA on victims is getting more attention around the world, professionals in Nigeria struggle to develop effective practices, services, and policies (Akin-Odanye, 2014; Duru, Ederiane and Akinbami, 2014). The limited available research evidence describes substandard practices regarding the management of CSA and prevention of associated complications among CSA victims (Duru *et al.,* 2014, Ige and Fawole 2012; Olatunya *et al.,* 2013). This substandard care is potentially due to the ambiguous and monolithic nature of this crime, given that indicators for CSA are non-definite, making self-disclosure essential. Disclosure of CSA is critical for victims to access and for HCPs to initiate medical, psychosocial, and legal interventions and to receive social welfare and support (Duru *et al.,* 2014, Ige and Fawole 2012; Olatunya *et al.,* 2013). However, disclosure can be a complex and painful process (Alaggia and Kirshenbaum, 2005), though it remains a hallmark of addressing CSA. Self-disclosure of CSA can lead to an early end to the abuse and help the abused children receive necessary therapeutic interventions (Alaggia and Kirshenbaum, 2005). Long delays in disclosure unfortunately common in Nigeria (Ige and Fawole 2012; Olatunya *et al.,* 2013) and may result in further abuse, re-victimisation, and other children being at risk. In Nigeria, as in any other Sub-Saharan African country, information on CSA is still shrouded in secrecy by victims and their caregivers, out of fear of ostracism by society or of losing family integrity. This circumstance makes it difficult for HCPs to identify CSA victims and provide quality care.

Globally, many programmes developed to respond to the needs of sexually abused children are based in healthcare settings, including emergency departments, gynaecological clinics, and Sexual Assault Referral Centres (SARC) (Edinburgh, Saewyc and Levitt, 2008). The healthcare system and HCPs play a critical role in providing resources and in the identification, treatment, and prevention of sexual violence. These roles emphasise the criticality of HCPs' roles in ensuring victims receive medical-legal care and psychosocial support, have access to justice, and are protected from re-victimisation (Home Office Government 2017; Royal Commission of Australia, 2017). In developed countries, studies showed that hospital-based services for sexually abused children were effective for assessments of abuse-related risk factors, experience, and management of the immediate sexual health needs of victims/ survivors (Edinburgh *et al.,* 2008; UK Home Office, 2021). Radical services and approaches are in place for the protection and social welfare of children and the prevention of CSA (Nelson, 2016).

This approaches is contrary to the current situation in Nigeria, where the quality of medical and psychosocial care provided to survivors of CSA remains poorly studied and has proved to be substandard compared to the required care for victims (Akin-Odanye, 2018). There is still a substantial gap between the medical services provided to victims of CSA and their healthcare needs (Aborisade *et al.,* 2017; Akin-Odanye, 2018; Ige and Fawole, 2012), and HCPs expressed their frustration as their efforts remained unproductive. Data from the CSA literature in Nigeria showed that important routine investigations were not requested for sexual abuse cases presented across all Nigerian hospitals (Akinlusi *et al.,* 2014; Bugaje, Ogunrinde and Faruk, 2012; Duru *et al.,* 2014). Among those few hospitals where investigations were requested, only a few victims actually received the requested investigations. For example, only 18 of the

29 HIV screening tests that were requested in one of the reviewed studies were actually carried out, and only five of the 20 vaginal swabs that were requested were actually performed (Duru *et al.,* 2014). The most common treatments offered to victims of CSA were basic and emergency contraceptives, HIV post-exposure prophylaxis (PEP), antibiotics, and psychosocial support are not commonly provided (Akin-Odanye, 2018; Duru *et al.,* 2014). A five-year retrospective review shows no referrals for psychotherapy were made, nor were forensic specimens collected, nor were any records of post-assault conceptions or HIV infections found (Akinlusi *et al.,* 2014; Akin-Odanye, 2018).

A significant number of studies found that written protocols for CSA evaluation, management, and follow-up were not available in most medical facilities in Nigeria (Abdulkadir *et al.*, 2011; Akinlusi *et al.*, 2014; Bugaje *et al.*, 2012). The few available protocols are international, which may be difficult to follow or domesticate as the content differs from the typical representation of the healthcare, social care, and socio-cultural systems in Nigeria. Regarding the prosecution of CSA cases in Nigeria, although a good number of assailants were known, only a few arrests were made, no forensic investigation was carried out, and no offenders were prosecuted (Badejoko *et al.*, 2014; Duru *et al.*, 2014; Bugaje *et al.,* 2012; Olatunya *et al.*, 2013).

Globally, only a handful of studies claim that HCPs hold a wealth of knowledge, skills, and experience and are strategically placed to identify and provide care to victims of CSA (Alsaleem *et al.,* 2019; Franklin and Smeaton, 2016). On the contrary, empirical evidence shows that HCPs perceive themselves as incompetent and inexperienced in these roles and are unable to address the complexity of CSA (Ajema *et al.,* 2018; Alsaleem *et al.,* 2019; Franklin and Smeaton, 2016). The survivors are subjected to delays when seeking care, receiving substandard medical care, no psychosocial

support, uncertainty and re-victimisation (Aborisade *et al.*, 2017; Ige and Fawole, 2012; Wangamati, Thorsen, Gele and Sundby, 2016). Similarly, studies on CSA in Nigeria are scarce and to date, no empirical work has been conducted to explore how HCPs can help prevent CSA, raise awareness, and help victims emotionally and socially.

HCPs play an integral role in facilitating the disclosure process and identifying and responding to victims of CSA. While it is clear that the available healthcare services for sexually abused children in Nigeria are substandard and ineffective compared to the comprehensive care required by these victims, little is known about the way HCPs perceive and understand their roles and the challenges they experience. Several reports in Nigeria (Aborisade *et al.*, 2017; Ige and Fawole, 2012) say that sexual abuse of children is one of the most troubling issues of our time, a problem that little is known about and from which much can be learned. Based on practice reports and literature, there is low awareness and a limited understanding of CSA among professionals who work with children and young people. Inefficiency in medical care and psychosocial intervention has been considered as merely professional incompetence in these areas (Ige and Fawole, 2012), a perspective that denies opportunities to identify and acknowledge all-encompassing challenges and to implement effective approaches. A comprehensive exploration of this phenomenon is critical and a closer insight into the HCPs' role and the associated issues and challenges undermining their effort from their own point of view is necessary.

1.8. Why Am I interested in this topic

I am a Nigerian nurse. As a mental and public health nurse, I have worked with children and families with psychosocial and behavioural problems. I have an MSc in

Child and Adolescent Mental Health Services (CAMHS) and my master's project focused on promoting young people's social and mental well-being. I am interested in exploring social and public issues that victimise children and violate their rights according to the United Nations Convention on the Rights of the Child (UNCRC). The impetus for this research came from my personal and professional experience. I grew up in an extremist culture of male supremacy, gender inequality, and patriarchy. I felt the need to conduct this research during my clinical practice as a mental health nurse in Nigeria. I participated in the routine care of children and adolescents and was responsible for safeguarding children. I observed that children and their families were unwilling to disclose abuse and violence, even in obvious cases, to prevent bringing shame and stigma to the family. My experience of supporting children and young people experiencing psychological and mental problems caused by CSA made me question the responsibilities and capacities of HCPs such as myself in tackling CSA. As part of a multi-professional team, I have observed colleagues doubting their professional competence when confronted with suspected or identified cases of CSA, and most professionals avoid taking up CSA cases. Sometimes it is difficult to completely attribute the HCP's reluctance to the complexity and sensitivity of CSA cases, or the numerous associated challenges of addressing one. It is possible that HCPs had a similar experience without receiving better support or are afraid of raising the child's hopes and end up inappropriately managing the case. I have sometimes felt that the system has been ineffective to the point where not only the victim but also the HCPs themselves have lost trust in it.

Through reflection, I could identify the chance to improve my practice. Findings from my master's thesis that explored the roles of client-therapist relationships on the outcome of therapy from the perspective of young people highlighted that most of the

participants who had experienced CSA found it extremely difficult to develop a therapeutic relationship with their therapist (when they had one) and suffered dire consequences as a result.

Following the completion of my master's, I began my quest for knowledge with a focus on challenges faced by HCPs and found that there was little literature available on the topic. Although the prevalence of CSA in Nigeria is extremely high, there are no guidelines for HCPs to respond to and identify victims in Nigeria. Most of the research identified a deficiency in the practice of HCPs in terms of identifying and responding to victims. The few available studies are quantitative in nature and lack contextual and in-depth exploration of the human experience of CSA. Some researchers have examined the challenges in practice in other countries, but researchers have not considered HCP practices of working with CSA victims in a Nigerian context. I am interested in exploring the issues and challenges undermining the provision of healthcare services to CSA victims in a Nigerian context and the implications for present and future practice. Identification of such issues will help develop practice strategies and the implementation of laws and policies that will benefit victims, HCPs and society in reducing the impact of CSA. I believe that an understanding of the social construction of childhood and sexuality, as well as the way CSA is conceptualised in Nigeria's health, legal and socio-cultural domains, is crucial to the significance attached and the quality of care the victims get. Therefore, CSA is a complex issue permeated by broader system issues – personal, social, and professional.

1.9. Research aims and questions

This study aimed to explore the perspectives of HCPs involved in identifying, responding to, referring, and working with children and young people who experienced CSA and their families. It explores how HCPs make sense of CSA, their

own professional practice, and their perspectives on challenges they encounter while working with CSA victims. I used a grounded theory approach to explore the following research questions:

1. How do HCPs perceive and understand the construct of CSA, their role and practice of recognising and responding to victims of CSA in the context of Nigeria?
2. What are the real-life challenges faced by HCPs when identifying and responding to victims of CSA? How do they make sense of these challenges?
3. What are the implications of the identified challenges on present and future practices of HCPs, victims and families, and society?
4. What strategies can help to mitigate these challenges, promote victims' experience of available services, and develop effective child safeguarding laws and policies?

1.10. Summary

This chapter presented the concept, causes, and consequences of CSA, and the roles of HCPs in identifying and supporting sexually abused children. The existing definition variances in relevant three contexts (epidemiology research domain, legal and policy domains) were discussed, and the implications were highlighted. Finally, this chapter presented a statement of the problem by looking at current challenges, the rationale for conducting this thesis, and the researcher's background, the aims and purpose of this study and the significance of conducting this research. The next chapter will present findings from a systematic review of global literature on the issues and challenges facing HCPs in their roles of identifying and responding to sexually abused children.

CHAPTER TWO: LITERATURE REVIEW

This chapter presents a systematic review of the literature on the challenges experienced by HCPs relating to identifying, reporting, responding and referring victims of CSA. In this review, the term 'healthcare professional or practitioner' was used to refer to nurses, doctors, gynaecologists, family social workers, school counsellors, teachers and administrators, professional stakeholders, child protection/safeguarding organisations, therapists, paramedics, psychologists, and community health workers.

2.1. Healthcare professionals' perceptions regarding recognising and responding to victims of CSA

In the last few decades, awareness of CSA has increased for both practitioners and researchers. HCPs are confronted with the complexity of CSA with inherent multi-systemic challenges undermining their work. While it is clear they possess a wealth of knowledge, skills and experience and are strategically well-placed to identify and provide care to victims of CSA, little is known about the challenges they experience performing their role. This subject remains a complex, social and public menace, however limited attempts have been made to aggregate the available evidence from the perspective of HCPs. The main purpose of this review is to aggregate empirical articles and critically appraise the quality of the included articles with the following aims:

- Identify and systematically review existing literature on HCPs' perceptions of challenges relating to their role in providing services to CSA victims.

- Aggregate the relevant body of knowledge on the challenges associated with recognising and responding to victims of CSA.

To minimise bias and avoid inclusion of low-quality studies, the following steps are followed in all reviews: (i) creating a clinical question to answer (PEO framework), (ii) developing a protocol stating the inclusion and exclusion criteria, (iii) conducting a thorough and extensive literature search, and (iv) screening the abstracts of the studies found in the search and following a thorough selection process using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA). The review question was developed using the Population Exposure Outcome (PEO) framework that is commonly used in healthcare research (Bettany-Saltikov, 2012; Linares-Espinos *et al.*, 2018).

Table 1: Formulating evidence-based practice questions using the PEO framework

Question: What challenges are faced by healthcare professionals when identifying and responding to victims of CSA?	
PEO framework	
Population (P)	Healthcare professionals (nurses, doctors, psychologists and social workers)
Exposure (E)	Child sexual abuse
Outcome (O)	Perception of issues and challenges Experiences

2.1.1. Method of review

A systematic review approach was used to identify and review the available relevant literature. This approach is considered suitable for synthesising and accumulating research evidence to identify key concepts and theories, as well as to understand the nature of existing literature on the issues and challenges faced by HCPs in recognising, responding, reporting and referring victims of CSA (Grant and Booth, 2009; Linares-

Espinos *et al.,* 2018). A systematic review approach is also popularly used to understand sparsely researched fields, as is the case for this topic, to develop an idea or concept, to produce best evidence synthesis, to identify gaps in the literature, and to outline recommendations for practice and future research (Grant and Booth, 2009).

2.1.2. Eligibility criteria

Studies were considered eligible for review if they explored issues, constraints, problems, difficulties and challenges relating to any aspect of identifying and responding to sexually abused children from the HCPs' perspective. Studies had to be peer-reviewed and published in English in the last 22 years (between January 1999 to May 2022) to synthesise recent relevant literature. Table 2 mentions the inclusion and exclusion criteria for this review.

Table 2: Inclusion and exclusion criteria

Inclusion Criteria	**Exclusion Criteria**
Studies that focus on issues, constraints, difficulties and challenges in identifying and responding to CSA victims	Studies that did not focus on CSA
Explored healthcare professionals' perspectives	
Used either quantitative, qualitative or mixed methods research designs	Literature reviews including either narratives or systematic or meta-analysis reviews and commentaries
Published in peer-reviewed journals	PhD theses
Published in English	Not published in English
Published between 1st January 1999 to 31st May 2022	Studies conducted before 1st January 1999

2.1.3. Search strategy for literature review

The following six databases were searched: PubMed, PsycINFO, CINAHL, ASSIA, AJOL and PILOTS. Search terms used included ‘healthcare professional’, ‘primary health worker’, ‘healthcare workers’, ‘doctors’, ‘nurses’, ‘dentists’, ‘social workers’, ‘midwives’, ‘obstetricians’, ‘gynaecologist’, ‘psychologist’, ‘physicians’, ‘child sexual abuse’, ‘sexual abuse’, ‘child molestation’, ‘child abuse’, ‘adolescents sexual abuse’, ‘barriers’, ‘hindrance’, ‘challenges’, ‘opposition’, ‘constraints’, ‘difficulties’, and ‘problems’. To conduct an effective search, Boolean operators (AND and OR) and truncation (*) were used alongside the search terms mentioned above. Appendix 1.1 provides an extensive list of search terms and appendix 1.2 shows the search result.

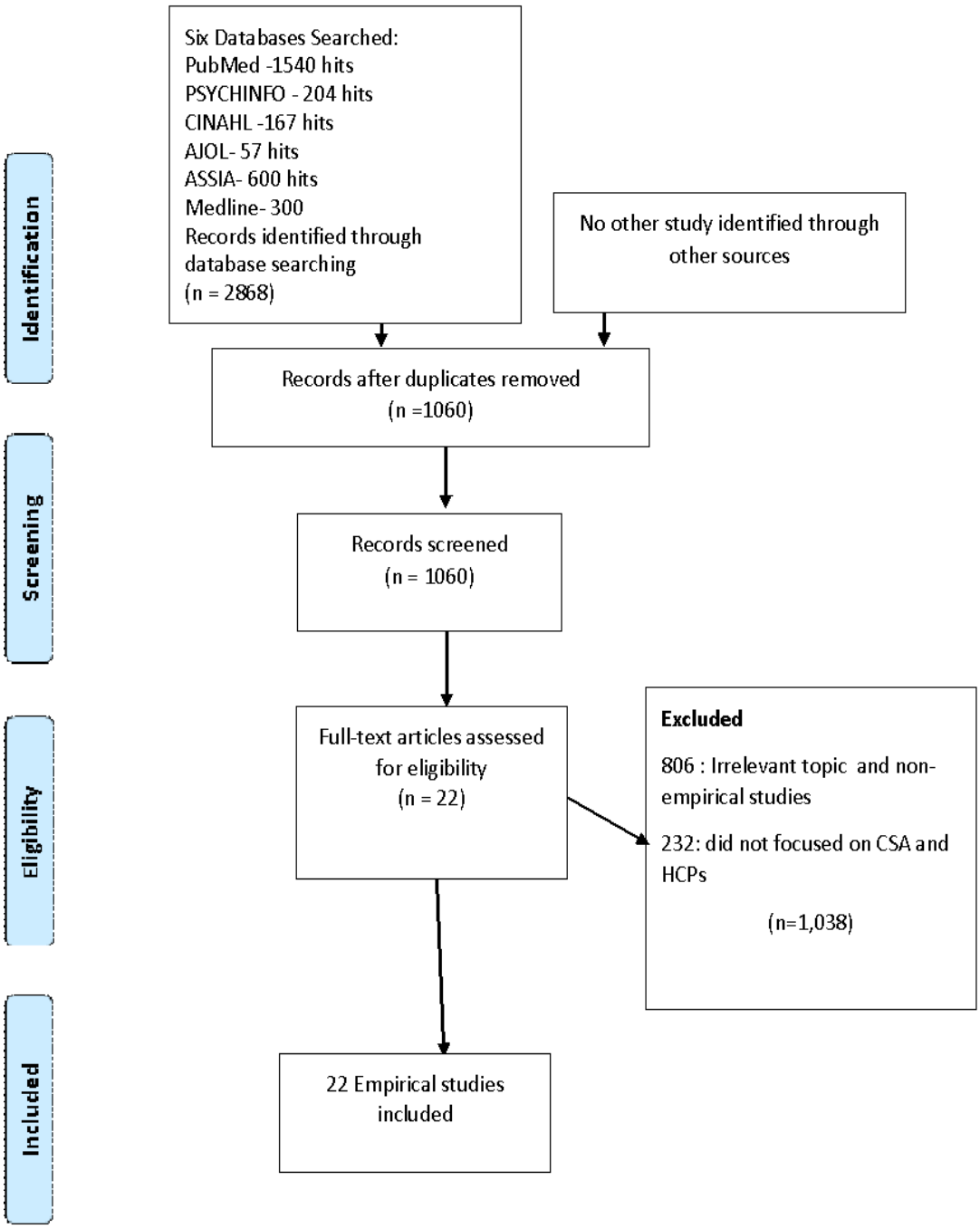
2.1.4. Study selection

Following a comprehensive search of databases, a total of 2848 studies were selected. After excluding duplicate, irrelevant and articles not meeting the eligibility criteria, a total of 22 articles are included in this review. Figure 2 shows the PRISMA flowchart from studies identification to the inclusion process.

2.1.5. Data extraction and critical review

A data extraction template was developed to extract important information about the author names, years of study, aims, design, settings, methodology, sample size and results. Findings from this review have been reported by clustering similar concepts together and developing themes. Each included study was quality assessed using a critical appraisal skill programme (CASP) qualitative checklist (Appendix 1.3) and quantitative checklist (Appendix 1.4). For mixed method studies, the mixed methods

Figure 2: PRISMA flowchart of study selection[1]



[1] Based on Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed1000097

appraisal tool (MMAT)-Version 2011 was employed (Appendix 1.5), while the CASP case-control study checklist was used for the single case-control studies.

2.2. Results: Characteristics of Included Studies

The results from the reviewed literature are presented below and structured into two main divisions: a description of the included studies, followed by a discussion on HCPs' perception of the issues and challenges in recognising and responding to CSA victims. Appendix 1.6 presents the purpose of the included studies, while appendix 1.7 shows the summary of geographical settings, sampling methods, design of data collection, participants' information and results.

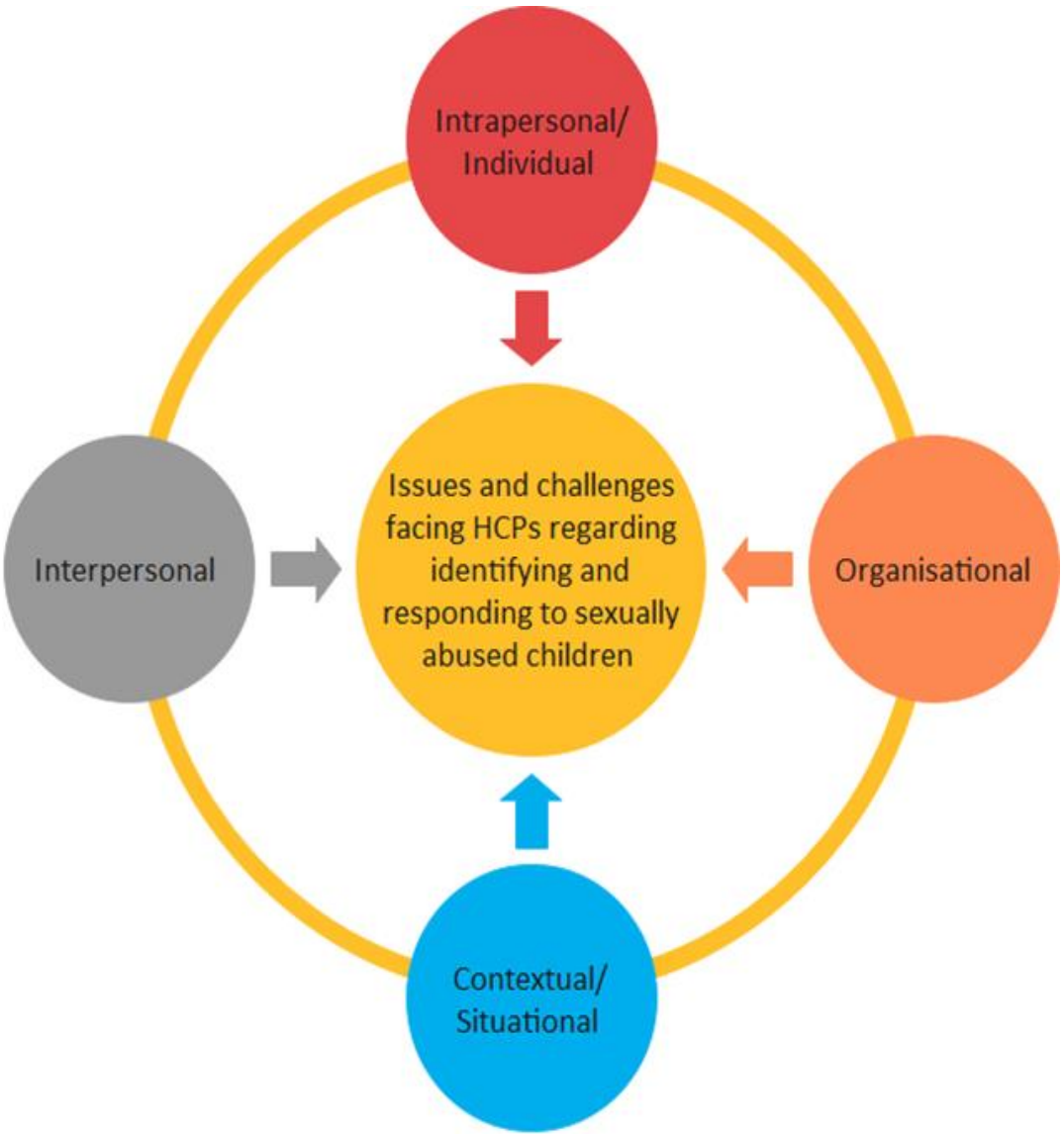
Studies were conducted in the UK (Kwhali, Martin, Brady and Brown, 2016; Saltiel, 2016), the United States (Bryant and Milsom, 2015; Sekhar *et al.,* 2018; Wanlass, Moreno and Thomson, 2006), and Europe including Southern Norway, Cyprus, Germany, Italy, Sweden and Ireland (Crisma *et al.*, 2004; Kennedy *et al.*, 2021; Kraft, Rahm and Eriksson 2017; Panayiotopoulos, 2011; Søftestad and Toverud, 2013). Studies were also conducted in South Africa (Schiller, 2017), Kenya (Ajema *et al.*, 2018; Wangamati *et al.*, 2019), Zimbabwe (Muridzo, Chikadzi and Kaseke, 2018), Middle East (Jerusalem and Saudi Arabia) (Alsaleem *et al.*, 2019; Tener and Silberstein, 2019) and Canada (Alaggia and Kirshenbaum, 2005; Martin, 2016; Sivagurunathan *et al.*, 2019).

Most studies used a qualitative approach (n=17), though some used a quantitative (n=4) or mixed method approach (n=3). Data in the study were collected via interview (n=9), focus group discussion (n=3), and questionnaire (n=4). Two studies used both questionnaires and interviews, and two used both focus group discussions and individual interviews (Kwhali *et al.,* 2016). One study combined focus group

discussion, interviews and observation methods (Panayiotopoulos, 2011) and another study used case studies (Wanlass *et al.,* 2006). Sample size ranged from five to 1617 participants across all the studies. As most studies included in the literature review used self-developed questionnaires, their psychometric properties are absent. One study by Feng and Levine (2005) used standardised questionnaires: the Child Abuse Report Intention Scale (CARIS) with Cronbach's alphas for the subscales ranging from 0.62 to 0.91.

Participants in the reported studies ranged from frontline HCPs such as nurses, doctors, policymakers and stakeholders, with varied years of experience (from 1 to 45 years). Participants were also recruited from schools, child health providers' organisations, specialised CSA organisations, hospitals and through online surveys. The number of participants widely varied from two to 300 participants. The sampling method most commonly employed was purposive and/or theoretical, though it was not clearly stated in some studies (Bryant and Milsom 2005; Farrow *et al.*, 2018; Feng and Levine, 2005). This approach was followed by snowball sampling, a mix of convenience and purposive sampling, or snowball with purposive sampling. Common data analysis methods reported included thematic analysis (Saltiel, 2016; Wangamati *et al.,* 2019) grounded theory (Søftestad and Toverud, 2013), framework and content analysis (Sekhar *et al.*, 2018). However, quantitative studies used descriptive and inferential analysis using Statistical Package for the Social Sciences (SPSS) software for quantitative data (Ajema *et al.,* 2018; Alsaleem *et al.*, 2019).

Figure 3: Diagrammatic representation of the results



2.3. Healthcare professionals' perspectives on challenges regarding recognising and responding to victims of CSA

HCPs' perceptions of this topic were categorised into four themes: intrapersonal or individual, interpersonal, organisational/institutional and contextual/situational and these are presented below.

2.3.1. Intrapersonal or individual and challenges

This theme reflects the inherent or personal issues that undermine HCPs' ability to identify and respond to victims of CSA. It describes their reflections on their inefficient knowledge and awareness of CSA and how it poses a threat and undermines their confidence.

Confidence and Competence: HCPs have a moral, ethical and legal responsibility to recognise, respond to and report CSA. However, many studies identified insufficient or lack of specialised training, knowledge, experience and confidence among HCPs when it comes to recognising and responding to CSA victims (Ajema *et al.,* 2018; Alsaleem *et al.,* 2019; Franklin and Smeaton, 2016). In a study (Ajema *et al.,* 2018, p. 479), one participant said:

'Right now, I do not have the knowledge. Sometimes you even fear to ask them [child survivors] because you do not have the skills; you may not know how to respond. But if I am trained, I can be able to help her even better to cope with the situation.'

(Male laboratory technologist)

Another participant in this study (Ajema *et al.*, 2018, p. 479) said, *'I do not know anything about Antiretroviral drugs…[post-exposure prophylaxis for HIV], ... counselling a child may be tricky and tough because they need to understand. However, many of them keep on asking, but why [did this happen to me]?'*

(Male clinical officer)

Controversies in terms of the definition of CSA, and its complex and sensitive nature (Ajema *et al.*, 2018; Schiller, 2017) make HCPs' task further complicated. Included studies suggest that HCPs feel that there is uncertainty surrounding the non-physical

signs and behaviours, the lack of strong evidence, and the potential aberrant nature and permanency of CSA images online (CSAIO) (Bryant and Milsom, 2005; Franklin and Smeaton, 2016; Martin, 2016). HCPs felt that handling such cases is challenging as victims are preoccupied with thoughts of 'who might view the shared image' instead of focusing on therapy and are being re-victimised each time the online image is viewed (Martin, 2016).

Bryant and Milsom (2005) investigated child abuse reporting behaviours of school counsellors, and perceived obstacles to reporting. HCPs felt more confident in their ability to recognise physical abuse compared to sexual abuse. Challenges reported include the uncertainties about how to identify and when to report allegations of CSA, and incompetency in dealing with cases (Schiller, 2017). Further, the decision to report is complex due to HCPs' insufficient understanding to recognise the symptoms, especially in children with learning disabilities (Franklin and Smeaton, 2016; Kwhali *et al.*, 2016; Schiller, 2017). Another issue reported by HCPs is the decision to report when the 'best interests' of the child are at stake (Kwhali *et al.*, 2016; Schiller, 2017). This uncertainty is a common situation seen in reported cases of CSA, where the law enforcement agencies and court prosecution focus on apprehending the perpetrator without considering safety, confidentiality and privacy for the child and the possible stigma the child might suffer. HCPs believed this trend further compromised the child's best interests.

Evoking Strong Emotions: This sub-theme reported under intrapersonal issues and challenges relates to the affinitive nature of CSA to evoke strong emotions in HCPs (Kwhali *et al.*, 2016). Significantly, some HCPs reported that becoming involved in families' sensitive private spheres aroused inner ambivalent feelings (Kraft *et al.*, 2017). This was prevalent in cases of incest involving intra-familial perpetrators such

as parents, siblings, other blood relatives, and stepparents or major benefactors to the victims. Another study in North England explored how social workers make decisions to safeguard children in complex and uncertain situations (Saltiel, 2016). Participants considered the unpredictable nature of their work, the constant concern that challenging events will necessitate a stressful investigation, and the dilemmas that come with each case (Saltiel, 2016). Overall, respondents believed that while management of CSA cases is stressful and complex, it is a core component of HCPs' safeguarding responsibilities (Saltiel, 2016). Therefore, the pragmatic occurrence of not detecting CSA is distressing, frustrating and provocative for most HCPs (Kwhali *et al.,* 2016; Søftestad and Toverud, 2013)

2.3.2. Interpersonal issues and challenges

This theme explained the challenges that HCPs experienced in an attempt to develop a working relationship with victims, their families and child social support systems.

Establishing therapeutic relationships

Several studies demonstrated various challenges in developing therapeutic relationships with CSA victims (Sekhar *et al.,* 2018; Sivagurunathan *et al.,* 2019; Wanlass *et al.,* 2006). One study, by Wanlass *et al.* (2006), found that participants experienced difficulty in establishing cohesive and healthy norms, and encouraging interaction. A difficulty in developing therapeutic relationship with sexually abuse children may be because such children have experienced abuse from people designated as their protectors and therefore may have developed emotional difficulties. For example, in a study (Wanlass *et al.,* 2006, p. 315) that observed HCPs conducting group therapy, a victim aged 13 said *'Who am I now? I'm not the same, but I am. I am still Lisa (Pseudonym), I guess. Is my grandpa still my grandpa? I know he hurt me,*

but so what?... All I know is ever since that stupid caseworker came into the picture, my life is horrible.'

Another participant from this same study (Wanlass *et al.*, 2006, p. 319) stated *'I do not know why I come to this group. You cannot really help me, no one can. No matter what you say, it does not change what happened. You cannot make me normal. I am like a dress with a permanent stain. Who wants that? ...There is nothing you can do.'*

Some reported that they found it hard to trust therapists and see them as potential perpetrators. Some victims perceived HCPs as persecutory, intrusive, opportunistic, and as an example of a powerful adult exploiting them. Another participant, aged 11, in Wanlass and colleagues' study, said to the therapist '*What is wrong with you? Do you get off on people's pain or something? You keep asking her about every detail. Don't you get what happened to her? (Sarcastically, she mimics the therapist) 'How do you feel? Then what happened? What did he say?' Geez, enough! You are hurting her. Don't you get it?'* (Wanlass *et al.*, 2006, p. 320*)*

Consequently, participants found decoding and responding to messages underlying children's behaviours, which is a core component of therapeutic healing, a challenge. Findings suggest that the major problem for identifying and reporting abuse is earning the confidence of the child to disclose what has happened (Bryant and Milsom, 2005).

Strong reluctance to disclose

Three studies in this review described that HCPs believe disclosing abuse is a complicated process for children (Saltiel, 2016; Sekhar *et al.*, 2018; Wanlass *et al.*, 2006). This is due to limited understanding of professional protocols of privacy and confidentiality and children's unwillingness to disclose. Further, HCPs reported that older children sometimes exhibit strong reluctance to disclose because of the fear that

the school nurse will inform their parents (Sekhar *et al.*, 2018). Other research reported younger children were more ready to disclose but were often not competent to or found it difficult to put their experiences into words (Saltiel, 2016).

2.3.3. Organisational/institutional barriers

Out of 22 studies, ten identified institutional barriers affecting HCPs' ability to identify and respond to CSA victims, assert their suspicions and provide adequate referral services to CSA victims.

Lack of resources

The most frequently cited institutional barrier was the lack of human and financial resources (Ajema *et al.*, 2018; Kwhali *et al.*, 2016; Muridzo *et al.*, 2018; Saltiel, 2016; Schiller, 2017)**.** Respondents in these studies claimed their overall confidence and performance were reduced by staff shortages and high caseloads. In Wangamati *et al.* (2019, p. 17), one participant stated *'there is a problem with staffing . . . what they say about this station (is that) we are supposed to be 108. But we are only 38!'* HCPs claimed they experienced time pressures, heavy workloads and limited consultation time for necessary inquiry, preparation and reflection to ascertain suspicion (Kwhali *et al.*, 2016; Søftestad and Toverud, 2013), and poor infrastructure, which refers to a lack of temporary shelters for victims, as well as withdrawal of funding and logistical constraints that consequently restrain service delivery (Muridzo, *et al.,* 2018). Kwhali's study (2016) reported a high reliance on the voluntary sectors for providing therapeutic support to sexually abused children.

Procedural and protocol challenges

The second most-reported issue within organisations are procedural and protocol challenges such as the lack of specific procedures, and complex protocols for collecting and reporting evidence and connecting victims to available support (Kwhali *et al.,* 2016; Panayiotopoulos, 2011; Saltiel, 2016; Wanlass, *et al.,* 2006). HCPs reflected and reported issues related to the referral process. Most participants in these studies claimed referral processes were written by administrative staff. Therefore, there were complaints of incomplete information and cases with risk of further devastating harm were not 'flagged up,' thereby putting the victim in more danger.

Participants also identified prolonged waiting times to secure assessments and evaluation from the child welfare system (Panayiotopoulos, 2011; Sekhar *et al.*, 2018) and securing access to mental health and psychosocial support as a challenge (Ajema *et al.,* 2018). Respondents in Bryant and Milsom (2005) mentioned the habitual non-investigatory culture in child safeguarding organisations meant that cases were not investigated, and the child and family rarely received justice, leading to a negative impact on the child, family as well as HCPs. Participants felt a sense of powerlessness when faced with the bureaucracy and complexity of the child welfare system (Wanlass *et al.,* 2006). Significantly, HCPs claimed that they experienced avoidable adjournment of cases by magistrates, and corruption of some officials that compromised the justice system. This occurrence dampened the morale of victims and their families (Wangamati *et al.*, 2019).

Ensuring the child's best interests

Social workers in Schiller's study (2017) claimed they experienced challenges in ensuring the 'best interest of the child' as stipulated by UNCRC after making mandatory reports to authorities. The respondents claimed the judiciary procedure often disregards the child's socio-emotional needs, a situation HCPs felt they have little control over (Schiller, 2017). Beyond this incapacity, HCPs claimed they experienced obstacles in ensuring further contact with the child making assessing re-victimisation risk difficult during CSA investigations and proceedings (Søftestad and Toverud, 2013). Despite HCPs' awareness of their responsibilities in reporting CSA to authorities, they were reluctant to do so.

2.3.4. Contextual Challenges

Only three studies extensively identified issues related to the contexts in which participants suspected CSA (Alsaleem *et al.*, 2019; Tener and Silberstein, 2019).

The 'grey area' of CSA: The term 'grey area' is used to explain the frustration in dealing with situations where CSA victims do not perceive themselves as victims (Tener and Silberstein, 2019) and/or sexual abuse is within usual social norms. This study further suggested there are discrepancies in their stories and the victim's psychological perception of the abuse, creating a gap between survivors' and professionals' understanding. This discrepancies could be because some children are too young to understand the illegality of the acts (Tener and Silberstein, 2019). Another point reported was that sexual relations between siblings may be normalised, without necessarily being perceived as being abusive. This situation raises difficult questions for HCPs concerning how ethical and therapeutic it would be to make the child accept he/she is a victim.

The case of incest is another challenge, especially when siblings below the age of sexual consent mutually involve themselves in sexual activities (Tener and Silberstein, 2019). In such cases, professionals cannot clearly label one of the siblings as the 'perpetrator or victim' – which is mandatory in legal and welfare systems for initiating and presenting cases. Sometimes, victims are reported to conceptualise the sexual act as sources of comfort, protection, and intimacy (Tener and Silberstein, 2019), and there are situations where HCPs had to stand by their patient's internal perceptions or perceive both siblings as survivors of the family's circumstances rather than victims of each other. Wangamati *et al. (* 2019) revealed that in certain cases when CSA victims have a close relationship or when their life is dependent on and intertwined with that of their perpetrators, they are likely to be re-victimised or return to their abuser, a reality that the HCPs claimed is hard to live with.

Cultural Practices and Traditions: Community's patriarchal traditions and cultural practices were mentioned as part of the challenges facing HCPs (Alsaleem *et al.*, 2019; Tener and Silberstein, 2019; Wangamati *et al.*, 2019). Respondents realised that CSA is intertwined with certain cultural practices such as female genital mutilation, child marriage, and victim blaming, which hinder the disclosure of CSA, resulting in most cases going unidentified with long-lasting impacts on victims (Kwhali *et al.*, 2016; Sekhar *et al.*, 2018). Participants considered the uncooperative behaviour of witnesses and the decision of some families to marry their child to the perpetrator as serious issues (Alsaleem *et al.*, 2019; Wangamati *et al.*, 2019). For example, in Wangamati *et al.* (2019, p.18) study, a participant said *'You rescue a child from early marriage and take the case to the court. This person is given a bond and then you hear they are reunited'.* The common occurrence of victim married out to their perpetrator is

peculiar in cases of sexual abuse resulting in pregnancy to save families from the associated shame and stigma (Wangamati *et al.*, 2019).

Overall, despite variances in statutory roles, the HCPs in the reviewed studies provided insight into the intrapersonal, interpersonal, organisational and contextual challenges they encountered in their roles of identifying and responding to sexually abused children.

2.4. Appraisal of reviewed studies on HCPs' perspectives

This section aims to critically appraise the 22 studies included in this review and justify the proposed study. As seen in Appendix 2.7, the majority (n = 17) of the 22 included studies employed a qualitative approach. 15 studies produced a rich and in-depth understanding of the challenges faced by HCPs concerning recognising and responding to victims of CSA as well as their perceptions, meanings and constructs of this phenomenon. Each of the studies intentionally employed purposive sampling solely or partly with other forms of sampling such as snowball and convenient sampling, which is considered a good strategy to gather highly relevant data to answer research questions (Sivagurunathan *et al.*, 2019; Wangamati *et al.*, 2019). The included studies not only recruited from a diverse field of HCPs with a wealth of knowledge and experience on CSA but also considered the perspectives of frontline professionals in child protection and safeguarding services.

Overall, participants' years of practice and experience ranged from one to 45 years. In terms of analytical processes, eight studies used flexible, transparent thematic analysis, grounded theory, framework approach. Quantitative studies used descriptive and inferential analysis using Statistical Package for the Social Sciences (SPSS). Credibility, in most studies, was established through site triangulation, member

checking, rechecking and active involvement of participants in the research process (Sivagurunathan *et al.,* 2019). Some studies were sensitive to the legal and cultural context of research samples; for example, a study conducted by Bryant and Milsom (2005) explored the existing local laws on CSA.

The sample sizes used in the included studies appeared to be appropriate, and most studies reached saturation (Martin, 2016; Søftestad and Toverud, 2013). The three mixed-method studies detailed the components of their data collected using quantitative and qualitative methods (Franklin and Smeaton, 2016).

One of the main weaknesses was that some study's reports lacked clarity and detail (Alsaleem *et al.,* 2019; Kwhali *et al.,* 2016; Saltiel, 2016; Wanlass *et al.,* 2006). This observation raised the question of whether the researchers followed a rigorous process or not. The collection of data and recruitment processes were also not clearly stated in some studies (Wanlass *et al.,* 2006). One study did not mention the number of participants (Saltiel, 2016). The interview guide and questionnaires' validity, reliability, applicability and comprehensiveness were tested through pilot studies (Alsaleem *et al.,* 2019; Franklin and Smeaton, 2016; Schiller, 2017). Some studies used focus groups to generate evidence from participants' experiences and views, though discussing sensitive issues like CSA in a focus group may prevent the participants from providing in-depth information (Wangamati *et al.,* 2019). In this way, participants may provide a biased response and findings from these studies might not be the true reality of the participant.

While HCPs accepted that they hold a moral, ethical and legal responsibility for supporting sexually abused children, recognising and responding to them remains a challenge. HCPs encountered difficulties identifying victims due to the probable nature of CSA, developing and sustaining therapeutic relationships with victims and

preventing re-victimisation. Also, identifying and understanding factors that discourage CSA disclosures has the potential to facilitate earlier disclosures, assist survivors to receive services without delay, and potentially prevent further sexual victimisation.

2.5. Summary

This chapter describes a literature review on issues and challenges facing HCPs in their roles of identifying and responding sexually abused children. Through the process of aggregating this evidence, the gap in the current knowledge is filled, promoting a better understanding from HCPs point of view of HCPs. Additionally, this chapter provides an assessment of the included studies including the strengths and weaknesses and justifies the current study. The next chapter will present the findings and theories of the aetiology of CSA and a brief description of Nigeria, introducing the research setting and discussing the systematic process of aggregating empirical evidence from all peer review journals on CSA in Nigeria.

CHAPTER THREE: EXISTING THEORIES AND CHILD SEXUAL ABUSE IN NIGERIA

This chapter is divided into two. The first part presents a brief overview of theoretical explanations of sexual offending behaviour, to provide better understanding and to set a standard by which to appraise and critique the theory constructed in this thesis. The second part presents a detailed explanation of the research settings and context. It shares an overview of Nigeria, its geographical location and the pathway of care, highlighting the existing available services to sexually abused children in Nigeria. It aims to explain the process and findings of the literature review on CSA in Nigeria, which included the available healthcare services for sexually abused children in Nigeria.

3.1. Theories of CSA

This section examines single- and multiple-factor theories that contribute to our understanding of CSA. I present the supporting and opposing views for each theoretical argument. Many theories have been developed to understand the complexity of CSA, vulnerabilities, and its impact on victims (Barnardo, 2011; Franklin *et al.,* 2012). There have been a few theories that explain adult sexual offending, including pathways that are associated with the onset, development, and maintenance of sexually abusive behaviour (Agnew and Brezina, 2019; Cooney and Rogowski, 2017; Franklin *et al.,* 2012; Martinello 2020).

3.1.1. Single-factor theories

Single-factor theories explain CSA by a narrow set of factors or by a single underlying cause. While they are numerous, a few with high relevance to the concept of CSA are discussed below. These include biological, attachment, psychological, psychodynamic, and cognitive-behavioural theories.

Biological perspective of CSA

Biological theories focus on physiological factors, genetic makeup, congenital, and organic explanations of human behaviour. It conceptualise sexual offending in terms of brain structure, hormonal levels, genetic and chromosomal makeup, and cognitive deficits (Faupel, 2015; Stinson, Sales and Becker, 2008). This section discusses genetic defects, brain injuries, neuropathology, as well as structural and functional changes in the brain after trauma (De Bellis, Spratt and Hooper, 2011; Faupel, 2015; Rosler and Witztum, 2000; Wiss, Brewerton and Tomiyama, 2021).

Genetics. While biological theory has failed to prove the existence of any 'sex offending gene,' a constellation of genes linked to impulse control, intelligence, and sexual appetite are considered to influence individual's risk of committing sexual violence and crime. Langström *et al*. (2015) found genetic factors contributed 40% of the variability in any sexual crime, compared with 2% by the shared family environment, which they defined as parental attitudes and the neighbourhood. Research measurement tools' errors, perinatal challenges, and social events and processes that did not happen to both siblings account for 58% of the difference. These findings may also help improve the assessment of sexual violence risk through familial factors by including family history risk items, developing a person-centred approach to care and stipulating preventive measures for genetically linked individuals. Even

though it is believed to be unlikely that the offender's first-degree family members were responsible for his or her sexual aggression, it is possible that they could benefit from interventions that raise their awareness of risks and sexual boundaries as well as help them communicate and resolve conflicts more effectively (Långström *et al.,* 2015).

Hormonal imbalance. Research has indicated that some sex offenders have abnormal hormones and glands, making them more aggressive or attracted to children (Aromäki, Lindman and Eriksson, 2002; Jordan, Fromberger, Stolpmann and Müller, 2011; Langström *et al.,* 2015). A few studies have examined the endocrinology and pathophysiology of paedophilic individuals and other sex offenders, focusing on androgen, testosterone, and monoamines (Aromäki *et al.,* 2002; Giotakos, Markianos, Vaidakis and Christodoulou, 2003). Androgens cause male physical changes and regulate sexuality, aggression, cognition, emotion, and personality, while testosterone causes aggression (Langström *et al.,* 2015; Marques *et al.,* 2002). Testosterone modulates autonomic sexual functions like erection and ejaculation, and motivational, cognitive, and emotional aspects like sexual interest, thoughts, and fantasies (Jordan *et al.,* 2011; Langström *et al.,* 2015; Marques *et al.,* 2002;). Findings from these studies show that hormone abnormalities cause medical conditions (paraphilias) and deviant sexual behaviours such as sexual abuse and victimisation of children. Using biological theory, some studies investigated the effects of sexual abuse on a person's development and psychology (for further reading, see De Bellis *et al.,* 2011; Wiss *et al.,* 2021). Relying on the underpinning constructs of biological theory, antiandrogens have been developed and appear to have reduced symptoms of paraphilic disorder and sex offender sexual motivation, intensity, and frequency of deviant sexual fantasies, as well as masturbation rate. Hence, biological theories make important contributions

to the field of CSA, in terms of its aetiology, vulnerabilities, criminology, and treatment.

Psychological perspectives

Psychology theories have been used to establish causal relationships for many psychological conditions, including offending/deviant sexual behaviour involved in CSA. The psychological perspective focuses on psychopathology, personality disorders, attachment needs, anger/hostility, substance and alcohol abuse, and other unresolved conflicts experienced during various developmental stages (Ensink *et al.*, 2020; Nisha, 2014; Perring, 2014). This section focuses on four early but significant, influential theories that have been used to understand CSA: attachment theory, personality theory, psychodynamic theory, and cognitive-behavioural theory.

Attachment Theory of CSA: Attachment theory focuses on the child's family context, dynamics, and relationships to understand vulnerabilities, victimology, familial antecedents, and long-term impacts of sexual abuse (Ensink *et al.,* 2020; Fitzgerald, 2020; Perring, 2014). Attachment theory examines the interpersonal and intrapersonal causes of sexism. Certain familial features predict CSA, including the absence of a biological parent, the mother's unavailability, role reversal/parentification, parental conflict, paternal dominance, poor parent–child relationships, and the presence of a stepfather (Burk and Burkhart, 2003; Ensink *et al.*, 2020; Olafson, 2002; Perring, 2014; Staufenberg, 2010). Having a secure-base attachment with a significant person in childhood and adolescence is considered to promote emotional regulation and control, cognitive development, self-reliance and interpersonal skills; thus, individuals with such an attachment display high levels of emotional competence, ego resilience, resourcefulness, and empathy. Children with attachment problems, such as avoidant or neurotic attachment, are more likely to show

emotional indifference, a lack of empathy, anger or antisocial behaviour, and attention-seeking behaviour (Burk and Burkhart, 2003; Ensink *et al.,* 2020). Those who lack self-regulation may use sexual offences to control others (Burk and Burkhart, 2003; Ensink *et al.,* 2020). Individuals with disorganised attachment experiences may not develop or internalise self-regulatory abilities, relying instead on external sources (Burk and Burkhart, 2003; Olafson, 2002; Staufenberg, 2010). Such impairments may influence the aetiology of sexual offending behaviours in perpetrators, and children who lack secure attachment are more susceptible to sexual abuse as a result of their attempts to form a secure attachment (Olafson, 2002; Perring, 2014; Staufenberg, 2010). Knowledge of attachment theory has played a crucial role in the reform of psychosocial interventions for neglected and abused children, as well as adoption and fostering (Perring, 2014; Woodhouse, 2018).

This theory has been criticised for its use of ambiguous and vague terms that lack distinct, defined or consensus meaning for the diagnosis of attachment disorder (examples are ‘attachment difficulties,’ and ‘attachment therapy’) (Chaffin *et al.,* 2006; Perrings 2014). Also, this perspective only considers the immediate context of the child and completely neglects the wider system. For example, in most African cultures, the idea of a child being deeply bonded to a caregiver is uncommon, as child-rearing responsibilities are more equitably spread among immediate and extended family members (Evans 2010; Mohamed, 2010).

Personality Theories: From Aristotle to Sigmund Freud and Abraham Maslow, many have offered theories on personality and addressed the question of what aspects of an individual contribute to their unique personality. A person’s thoughts, feelings, and actions form their personality and affect the way in which an individual interacts with their environment (Izdebska, 2021; James and Prout, 2018). These recent studies have

focused more precisely on the impact that traumatic experiences or mistreatment in childhood play in the development of personality disorders that facilitate sexually inappropriate behaviour (Izdebska, 2021; James and Prout, 2018; Leguizamo, 2002). Although every personality disorder can be described in terms of ego strength, defences, and introjects, it is the complex interplay among these variables that determines the underlying dynamics and surface manifestations of different syndromes. Those with borderline personality disorder lack a cohesive sense of self, so they describe themselves and others as 'all good' or 'all bad' (Izdebska, 2021; James and Sprout, 2018; Leguizamo, 2002). The self-destructive behaviours seen in individuals with borderline personality are in part a product of their poor impulse control and inability to manage negative affect through internal means, and they have little insight into the underlying motives that drive these actions (Bornstein, 2005; Izdebska, 2021; James and Prout, 2018; Leguizamo, 2002). When parents do not respond positively to their child's early displays of competency and initiative, the child protects himself or herself from overwhelming feelings of rejection and worthlessness by constructing an exaggerated sense of self-importance, as seen in narcissistic personality (Izdebska, 2021; James and Prout, 2018; Leguizamo, 2002). There is a conscious perception of self as special and unique, along with a view of other people as inferior, thus acting in a demeanour manner to others.

Research has shown that children who have personality disorders are more likely to have experienced CSA and to be vulnerable to it, especially children with dependent personalities (Izdebska, 2021; James and Sprout, 2018). There is a mental representation of the self as vulnerable, weak, and ineffectual; this 'helpless' self-concept results from a sustained pattern of overprotective and/or authoritarian parenting early in life (Bornstein, 2005; Leguizamo, 2002). Consequently, causing the

child to hold tenaciously onto a belief that the way to survive is to accede to others' expectations and demands, and to form a mental representation of other people as powerful and potent. This can then alter how the child views sex and his or her role in sexual relationships (Bornstein, 2005; Izdebska, 2021; Leguizamo, 2002). This perspective further supports the argument of sexual abuse or victimisation even in consensual intimate relationships among peers and provides a basis for an approach to CSA that should address both the personality structure and the specificity of the impact of CSA.

Psychodynamic theory

Psychodynamic theory is an extension of Freud's personality theory and seeks to explain how our unconscious mental life affects our worldview. This theory suggests that humans are often driven by unconscious motivations and that adult personalities and relationships are shaped by childhood experiences (Barber and Solomonov, 2016; Bornstein, Denckla and Chung, 2013; McDonough, 2020; Nisha, 2014). Personality development was thought by Freud to focus on different body parts, and if a child passes through the stages without incident, they are well-developed; otherwise, infatuation occurs later in life, as seen in people with sexually deviant behaviours, including aggressive behaviour (Bornstein, 2005; McDonough, 2020; Nisha, 2014). Sexual deviance has been explained as the product of unresolved developmental problems and psychological conflict, causing fixations or hindrances that distort sexual preferences and desires (McDonough, 2020; Nisha, 2014). More importantly, Freud divided the personality structure into three: id, ego, and superego. A person's id controls innate drives, their ego moderates their id and superego, and their superego develops their morality. This idea further emphasises that sexual aggressors lack a strong superego and are ruled by their primitive id (McDonough, 2020; Nisha, 2014).

Sexual abuse survivors treated with psychodynamic therapy showed improvements in symptomatic emotional distress, functioning, and dynamic personality characteristics (McDonough, 2020; Price *et al.*, 2004;). During and after treatment, they developed a positive sense of self, and maintained therapeutic relationships with their therapist and other significant individuals (Price *et al.,* 2004), suggesting that psychodynamic psychotherapy is effective in treating sexual abuse survivors' depression and interpersonal problems. Although this theory significantly contributes to our understanding of CSA and its impact, the idea lacks empirical support and is underappreciated by psychologists (Price *et al.,* 2004).

Cognitive behavioural theory (CBT)

CBT focuses on how certain thoughts lead to certain feelings, which, in turn, lead to certain behavioural responses. The theory has been used to explore how sex offenders rationalised their actions to reduce their sense of guilt and shame (Nisha, 2014; Stinson *et al.,* 2008). These studies show that offenders can escape responsibility, shame, or guilt for their actions by using cognitive distortions such as minimisation of harm, claiming entitlement to behaviour, or blaming the victims for the abuse perpetrated against them (Nisha, 2014; Stinson *et al.,* 2008; Merdian *et al.,* 2014). Researchers have identified sexual entitlement as a narcissistic and desire-driven cognitive distortion (Boillat *et al.,* 2017; Nisha, 2014; Stinson *et al.,* 2008). According to this theory, sexual offenders may misinterpret social cues and struggle to recognise anger or fear in their victims, thus seeing their victims' behaviour as provocative (Lim *et al.,* 2022; Stinson *et al.,* 2008). For example, perpetrators may misunderstand children's natural affectionate behaviours, like sitting on an adult's lap, for sexual contact or curiosity to experience sexual activities (Boillat *et al.,* 2017; Keenan and Ward, 2000; Nisha, 2014).

Cognitive behavioural therapeutic approaches are concerned with understanding how events and experiences are interpreted, and with identifying and changing the distortions or deficits that occur in cognitive processing (Early and Grady 2017; Nisha, 2014; Stallard 2002). It offers an integrated approach to assessing risks, developing therapeutic interventions that consider individual factors and social contexts of learning (Lim *et al.,* 2021; Stinson *et al.,* 2008). Additionally, by focusing on the role of cognitions in understanding and changing emotions and behaviours, it is an effective therapeutic model for treating CSA victims and their families. Cognitive-behavioural approaches to treating sexually abused children focus on how the child and the non-offending parent perceive events (Lim *et al.,* 2021). It helps the practitioners to identify the victim's misinterpretation of the experience, such as poor self-perceptions and internalisation of self-blame, which results in feelings of guilt and low self-esteem.

Feminist theory

Feminist theory offers causal explanations for the sexually deviant behaviour of males. Through this perspective, assumptions, analytic lenses, topic focus, and viewpoints are shifted towards women's perspectives and experiences (Purvis and Ward, 2006; Ward, Polaschek and Beech; 2008). Thus, the feminist theory illuminates social problems, trends, and issues that historically predominant male perspectives would have missed or misidentified. Feminism provides a gender-based analysis of the patriarchal social order that gives men power and privilege over women. Feminist theory illuminates social problems, trends, and issues that the historically dominant male perspective in social theory overlooks or misidentifies (Azzopardi, Alaggia and Fallon, 2018; Harnois, 2012). There are a variety of issues being addressed, including those relating to inequalities, gender discrimination, and objectification, as well as stereotypes in the

field of gender. This section considers radical, post-modern feminism in addressing the issue of CSA.

Radical Feminism: According to radical feminism, CSA is the result of patriarchy and masculinity, with the state playing an important role in supporting patriarchal family relationships. Patriarchy is a system of male supremacy that attempts to control and dominate women (Azzopardi *et al.,* 2018; Harnois, 2012; Purvis and Ward, 2006). This perspective emphasises men's possession of power: the power that all men have and exercise over all women, explicitly or implicitly, resulting in the sexual abuse of women and girls (Mann and Beech, 2003; Purvis and Ward, 2006). According to radical feminists, all men are socialised to have sexually offensive attitudes and behaviours. Additionally, in problematising and reframing mother-blaming narratives in CSA, feminist theory conceptualises the sexual abuse of children and the idealising and blaming of mothers within the broader milieu of male-perpetrated violence against women and children. As a result of deeply entrenched patriarchal social structures, which require male entitlement and female vulnerability, sexual violence, or the threat of sexual violence, by men against women and children becomes a means of exerting and maintaining power (Azzopardi *et al.,* 2018; Harnois, 2012; Mann and Beech, 2003; Purvis and Ward, 2006). The aetiology of CSA is founded on uneven gender-based power relations in the service of patriarchy, not individual pathological deviance, sexual desire, familial dysfunction, or maternal incompetence. In other words, the authors who support radical feminism believe that men are permitted by society to commit sexual offences because they are men (Harnois, 2012; Purvis and Ward, 2006).

Despite providing an explanation for the origins of CSA and addressing the gendered nature of state responses to sexual abuse, this view is considered by others to lack nuance. The idea that all members of one group have complete power over another

group is simplistic, with many authors arguing that power is relational, complicated, and unstable (Harnois, 2012; Hook, 2014; Mann and Beech, 2003; Purvis and Ward, 2006). Radical feminist ideology does not allow for the possibility of criminals who sexually molest children for reasons other than power, such as seeking connection and affection and perceiving themselves in a caring relationship with their victim. Due to its reductionist view of men and patriarchy, the radical notion that the state upholds abusive patriarchal relationships is viewed as conspiratorial and unsupportable. Other critics of radical feminism claim theories fail to consider offender agency, arguing that the concept that sex offenders have beliefs that are supportive of abuse suggests that these have been socially learned, implying that most men have the potential to be abusive and lack direct control over their behaviour (Purvis and Ward, 2006).

Post-Modern Feminism Theory: Post-modern feminists oppose the radical feminist perspective as a simplistic way of understanding male dominance and child molestation. Post-modern feminists are warier of universal explanations and insufficiently self-critical ideas of radicals (Azzopardi *et al.*, 2018; Harnois, 2012; Mann and Beech, 2003). Instead, they focus on the results of oppression rather than its universal roots and reject the idea that gender and power are immutable and inevitable. This post-modern perspective's emphasis on causal explanations has led to ideas that exclude, marginalise, and control outliers. Post-modernists consider gender as relational, rather than discrete and oppositional, in contrast to radicals. Purvis and Ward (2006) state that generalisations in theory about abusive and powerful men, passive and virtuous women, and powerless children are both empirically incorrect and unhelpful in practice. They agree that sexual aggression cannot be explained as part of a man's character (Purvis and Ward, 2006).

Post-modern feminists argue that power, like gender, is relational and question radical ideas of power that place power in the hands of males or the State (Purvis and Ward, 2006). Many reject the idea that men abuse children to show their power over women and children. Post-modern thinkers do not directly define their position on child sexual offences, which may be due to their emphasis on understanding experience over explaining causal factors of CSA (Hook, 2014; Mann and Beech, 2003; Ward *et al.,* 2005).

Sociological feminist theory: Cossins' power/powerless theory: Cossins (2000) agrees that radical feminism has offered a strong intellectual context for perspectives and theories, but she distances herself from radicalism's notion that patriarchy and masculinity cause CSA. Cossins writes from a sociological feminist perspective, arguing that radical feminists' view of patriarchy and masculinity is simplistic and deterministic (Pollock and Brunet 2018; Purvis and Ward, 2006). It is Cossins' view that child sexual assault is a male's way of demonstrating masculinity, and overcoming weakness. She says there is no inclination or predisposition to engage in CSA because sexuality is socially formed (Purvis and Ward, 2006). She contends that sexually exploitative behaviour is a socially constructed representation of normal masculine sexuality, and that child sexual offending is likewise linked to conventional masculine sexual practises structured on power relations (Purvis and Ward, 2006). Cossins links child sexual offences to men's helplessness, perceived threats to authority and masculinity, and real or perceived personal faults (Mann and Beech, 2003; Pollock and Brunnet, 2018; Purvis and Ward, 2006). This feminist perspective shows a strong readiness to move beyond radical feminists' reductionist viewpoint, as seen in Cossin's ability to locate sexual misconduct within a societal context, without blaming patriarchy or the state. Cossin explained feminist perspective by claiming that men

display sexually offending behaviour to demonstrate their masculinity to overcome their weaknesses.

The power/powerlessness paradigm has conceptual flaws. First, linking child sexual misconduct to normal masculine sexuality is contradictory. CSA reflects conventional masculine sexuality, Cossins claims, because it permits men to be self-focused, domineering, and distant (Cossins 2000; Lay and Daley, 2018; Purvis and Ward, 2006). On the other hand, she says, choosing a child as a sexual partner may also reflect a lack of conformity to the masculine sexual ideal. The argument seems paradoxical and may only apply to specific sorts of child sexual predators, notably those seeking empowerment through child abuse.

3.1.2. Multi-factorial theories

This section discusses multifactorial theories that explain CSA by concentrating on the individual, social, and cultural aspects that enhance a child's vulnerability/risk, prevent or delay disclosure, and consider the implications for practice and preventive strategies. Ecological theory will be discussed because it is pertinent to the current study and has been used to comprehensively explain the causes, risk factors, and effects of CSA. It has also been used to explain the implications of the child's sociocultural context for practice and policies on CSA and recommendations for practice (Hirsch and Keller, 2015; Martinello, 2020).

An ecological theory of child sexual abuse

In 1977, Urie Bronfenbrenner developed the ecological systems theory, which provides a holistic, context-based, multifactorial view of CSA (Dietrich *et al.,* 2013; Harper *et al.,* 2014; Martinello, 2020). According to Bronfenbrenner's theory, each person's ecology is influenced by a range of elements, situations, and events across

their lifetime (Bronfenbrenner, 1977). This refers to the developing individual's larger (formal and informal) social milieu. The idea divides a person's world/existence into six social interaction systems: the individual, microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Aucamp *et al.,* 2014; Martinelo 2014; Pack, 2013). This theory organises a person's interactions with his environment into nested structures, and due to the system's flexible and overlapping borders, modifications to one component influence the others (Martinelo, 2019). This section presents the ecological system theory's domains, showing their influences on a child's vulnerability to sexual abuse, decision to disclose or withhold, re-victimisation, and seeking professional support. The goal is to highlight how a child's sociocultural background can affect HCPs' professional practice and involvement with sexually abused children.

Individual system

Few studies have examined CSA risk variables by implicating certain personal attributes. Age and developmental level, ethnicity and culture, sexual orientation, gender, aptitude, and current knowledge are important to CSA (Chinawa *et al.,* 2014; Envudale *et al.,* 2013; Martinello, 2020; UNICEF, 2015).

Age and cognitive developmental stage. Age and developmental level determine if a child will disclose and seek treatment. Children who are aged between 14 and 18 are most likely to report CSA when it occurs (Chinawa *et al.,* 2014; Envudale *et al.,* 2013; Manyike *et al.,* 2015). Younger children are particularly vulnerable due to their dependency, inability to protect themselves, and inability to disclose or seek professional help (Martin *et al.,* 2004; Sodipo *et al.,* 2018). Children are unable to recognise evil intent or comprehend abstract concepts as a result of egocentrism (Chen, Fortson, and Tseng, 2012; Kenny *et al.,* 2008). Their desire for love, protection,

privileges, and attachment at this developmental age may also be a factor (Stephen *et al.,* 2013). Younger children are more likely to disclose their abuse compared to older children, which may be due to a sense of responsibility or guilt felt by older children. Age and developmental level affect children's vulnerability, understanding, and ability to report CSA. An understanding of this model may help practitioners to prioritise a child's age while developing CSA preventive measures and supportive programmes.

Race/culture. Most sexual abuse is contextual and situational, so cultures, races, or communities may influence incidence and victim experiences (Alsaleem *et al.,* 2019; Kraft *et al.,* 2017; Martinello, 2020). Cultural factors are relevant to CSA in three major ways: they contribute to family situations that subtly tolerate CSA; they prohibit or hinder disclosure or reporting, and they play a role in a child's decision to seek professional help or accept prevention programmes. Due to differences in definition, child-rearing practices, age of consent, and cultural and social norms and practices, it is impossible to get accurate statistics on CSA across ethnic and racial groups. Despite these differences, most ethnic groups agree on what constitutes sexual abuse and disapprove of such acts, but it is society's response to such occurrences which is more crucial. Sexual abuse occurs globally, but some social and cultural practices or norms may increase the risk for children in certain ethnic groups and patriarchal societies, especially in non-western countries that practise child marriage, and female genital mutilation (Okeke, Anyaehie and Ezenyeaku, 2012; Schaffnit, Urassa and Lawson, 2019).

In African countries, for example Nigeria, there is a cultural belief that girls are to blame for arousing men's sexual urges. It is also believed that sleeping with girls who are virgins acts to cleanse the blood, cures diseases, and is a good way to seek wealth (Jewkes, Martin and Penn-Kekana, 2002; Jewkes, Penn-Kekana and Rose-Junius,

2005; Petersen, Bhana and McKay, 2005). Early girl-child marriage is culturally acceptable, and health education on sexuality and sexual abuse is thought to expose children to unsuitable topics and promote promiscuity, hence, cases of CSA are kept secret (Aderinto, 2011). In some cultures, children are considered the property of their parents. Extended family living is acceptable, and it is normally expected that children should obey and respect all adults, even in arranged marriages (Jewkes *et al.,* 2005; Shafe and Hutchinson, 2014). Most western countries are individualistic and members value their personal needs above the connection they share with others. People in such cultures are more open about their sexual experiences compared with victims in a society that values community bonding over individual needs. Bottoms *et al.* (2004) observed that, due to racial stereotypes and prejudices, Black children's reports of sexual abuse may not be taken seriously, affecting their support and legal decisions. As a result of their culture of silence around sex, sexuality, and sexual abuse, and their reluctance to access mental health and public health services, Asians and Africans may be underrepresented in the statistics (Martinello, 2020). So, a child's race and/or culture may affect abuse risk, victim impact, and support received.

Gender and sexual orientation. Gender differences play a role in experiencing sexual violence, as statistics show that females are more vulnerable to sexual victimisation than males and are at high risk of stranger-perpetrated sexual abuse (Canada and Statistics Canada, 2009; Manyike *et al.,* 2015; McNeish and Scott, 2018). Girls are more likely to disclose their sexual abuse compared to boys (Crisma *et al.,* 2004; Royal Commission of Australia, 2017). It is thought that boys tend to withhold disclosure due to the belief that boys are rarely victimised and fear of being tagged as potential abusers in the future (Alaggia, 2005; Münzer *et al.,* 2016). Males who report abuse may not be considered 'real men' and their masculinity may be questioned in

patriarchal societies such as Nigeria. As a result, a child's gender and role expectations affect their likelihood of experiencing sexual abuse, deciding to report, and seeking support.

Sexual orientation is a risk factor for sexual abuse. Research by Friedman *et al.* (2011) and Andersen and Blosnich (2013) found that 5% of heterosexual males, 21% of homosexual and 24% of bisexual males reported experience of CSA, meaning that the risk for non-straight boys of being sexually abused is nearly four times higher than that of their peers.

The child's ability and knowledge. Knowledge is another often-overlooked factor that may increase a child's risk of sexual abuse. Regardless of their knowledge level, children are unlikely to be able to prevent or stop abuse, but they are better at safely reporting if they know what happened to them was abuse and that their rights were violated (Martinello, 2020). As children are not responsible for their abuse, learning about sexuality and sexual abuse can help them report abuse safely and prevent or stop their own abuse (Martinello, 2020; Shafe and Hutchinson, 2014). Since we can separate child knowledge and ability from CSA, prevention programmes should teach children skills to identify, avoid, or reduce abuse, such as self-defence, rights and consent, escaping from situations, disclosure and reporting of abuse, following self-feelings and intuitions, supporting body awareness, and understanding who is responsible (Ko and Cosden, 2001; Martinello, 2020; Shafe and Hutchinson, 2014). Such programmes help children identify and report abuse, reducing CSA rates (Barron and Topping 2013; Kenny *et al.*, 2008; Leclerc *et al.*, 2011).

Research suggests that individuals with disabilities are more likely to experience long-term sexual abuse by a single or multiple perpetrators and may suffer more as a result and be less likely to disclose or seek professional support (Franklin and Smeaton,

2016; Kwhali *et al.,* 2016; Martinello, 2020). Due to isolation, dependence on others, and limited social participation, disabled children are vulnerable to sexual abuse. Perpetrators may take advantage of, enforce control over, and sexually abuse disabled children. (Smith and Harrell, 2013).

Microsystem

Microsystems, the first and immediate ecological level of a child's development, are the foundational/elementary level for learning about the world (Martinello, 2020). This microsystem level of interaction highlights how and what children and young people learn and understand about CSA, its predisposing and precipitating factors, and the actual experience of sexual abuse. Family is a key component of a child's microsystem since they influence learning, vulnerability, and engagement with society; therefore, family dynamics are important. In a functional family, where a child receives care, support, and emotional connections, intra and extrafamilial sexual abuse is less likely, as opposed to dysfunctional families that have rigid gender roles and patriarchal dominance, domestic violence, aggressive behaviours, and social isolation (Ajuwon *et al.,* 2001; Manyike *et al.,* 2009; Olatosi *et al.,* 2018). Children from such families may be willing to tolerate sexual exploitation in exchange for love, protection, privileges, friendships, treats, or money (Stephen *et al.,* 2013). Although CSA occurs across social status and class, in some contexts parental socio-economic status determines the vulnerability of a child, as often sexual abuse is rooted in poverty. For example, a study in Nigeria found that due to financial difficulties, a parent may ask a child to engage in transactional sex to meet basic needs, or the child may be exposed early to labour/financial income, exposing them to sexual abuse (Oteh, Ogbuke and Iheriohanma, 2009; Oyekola and Agunbiade, 2018). Blaming mothers for their child's sexual abuse merely reinforces male privilege (McLaren 2013), as mothers may not

be aware of the ongoing sexual abuse. McLaren (2013) notes that fathers who sexually abuse their child(ren) 'premeditated, planned, and purposely undermined the mother-child relationship,' encouraging trust and secrecy and limiting the child's relationship with the mother, thereby impairing disclosure. Even when mothers are aware of the abuse, fear of the stigma of having an abusive partner reinforces the heteronormative idea that women should be able to 'protect their children and manage their adult relationships' (McLaren 2013, p. 445). Shaming and judging mothers may reduce their willingness to report abuse. This misplaced blame is similar to blaming children for not preventing sexual abuse, in that it diverts attention from the perpetrator. Additionally, while many educators see orienting children on sexual relationships and sex education as a progressive policy, parents, social groups, and children's agencies critique this idea of over-sensitising children (Department of Education, UK, 2019; Kenny *et al.*, 2008). Although families may have difficulty recognising and reporting CSA, they play a critical role in preventing, identifying, and intervening.

Professionals as Sexuality Educators: According to Paranal *et al.* (2012), educational staff, law enforcement officers, social services staff, medical and mental health practitioners, childcare workers, and foster care providers most often reported CSA. It is true, however, that how one person (e.g., a family member) supports a child can have a profound impact and can also be impacted by another person (e.g., their teacher). For these reasons, family resource centres and schools may be well-positioned to support CSA prevention, recognise signs and symptoms of abuse, respond to allegations, report abuse to the proper authorities, and provide information on community resources and supports (Kenny *et al.,* 2008; Martinello, 2020). Families interact with professionals who play a role in their child's sex education, as the formal educator's role is to engage in family communication.

Perpetrators of CSA: Healthcare professionals must understand that perpetrators are also part of a child's microsystem, therefore they must pay attention to the perpetrators' characteristics and behaviours. As a potential victim, the child's ecological system is important, but so is the perpetrator's, and living in the same microsystem may affect their victimisation and support-seeking (Martinello, 2019). More studies have examined perpetrators' traits to understand their roles in the child's microsystem. Sexual offenders often 'deny, minimise, and/or rationalise [their] behaviour' (Burn and Brown 2006, p.227). Recognising the mesosystem, a system of interacting elements within the microsystem, it is clear that often the perpetrators of CSA have a relationship with the child's family. Approximately 88% of abuse incidents involved children who knew their abuser, while 70–90% involved family members (Chen *et al.*, 2012; Statistics Canada 2011). Martinello *et al.* (2019) highlight that children may not recognise desensitisation/grooming process and may feel like they have a consensual relationship.

Mesosystem

The mesosystem is influenced by the exosystem and includes participatory relationships linking two or more systems or social relations among the main settings that contain the developing individual at a particular point in life (Swick and Williams, 2006). Meso-systems are one aspect of the microsystem, which represents that there is interaction between elements within the microsystem (e.g., families interact with teachers, perpetrators often interact with families). Media and popular culture influence how CSA is portrayed and understood. Rheingold *et al.* (2012) found that the media is a primary source of information about CSA for families, indicating that the mesosystem can impact how families understand CSA. Recent media coverage has indicated that CSA may be perpetrated by trusted individuals known to the children

and/or family (e.g., clergy, care providers, family members), a stark contrast to the concept of 'stranger danger.' As the media shifts their narratives of CSA, families, risk factors, and intervention strategies are better understood. Intervention in the exosystem may include ensuring responsible, accurate media portrayals that help people understand CSA and perpetration.

Macrosystem

The child's macrosystem includes beliefs, cultures, laws, customs, resources, and knowledge (Dietrich *et al.,* 2013). Laws can set the age of protection and mandate sexual abuse reporting (Department of Justice 2016) and can also determine if sexual behaviour is exploitative, criminal, or acceptable (Department of Justice, 2016). Mandatory counselling, registration, and movement and residence restrictions reduce recidivism among perpetrators (Martinello, 2020). Cultural perceptions may influence how society perceives CSA in the macrosystem. If victims turn to legal, medical, or mental health systems, they may face disbelief, blame, and refusals of help. The trauma of rape extends beyond the assault, and society's response can affect women's well-being (Campbell *et al.,* 2009; Martinello, 2020). This cultural perception is also responsible for victim blaming and mother blaming and is felt at both the individual and microsystem levels. Its internalisation may impact an individual's likelihood of reporting and their own beliefs about themselves, affecting their recovery (Campbell *et al.,* 2009). Race and ethnicity may affect CSA across tiers of the ecological theory, including the macrosystem. Gender impacts CSA across multiple tiers of the ecological theory; according to Ratlif and Watson (2014), perpetrators of sexually abusive behaviours are male (88%), which may reflect a culture where males are socialised to believe sexuality and power are masculine traits.

Chronosystem

The chronosystem describes how each system is affected by time. Growing up may provide children with a greater opportunity to reject and report abuse as they become more knowledgeable and skilled. According to Campbell *et al.* (2009), each experience of sexual abuse can be viewed as a 'historical lifespan factor that shapes how the other levels in the model affect a recent victimisation' (p. 229). The ecosystem of a child may change if he or she is sexually abused, and time may affect system interactions as relationships change (Neal and Neal, 2013). The chronosystem reflects changes in knowledge, programmes, and societal values over time. As cultures become more invested in their children and their rights, how they respond to CSA changes, protecting and supporting children through powerful and influential narratives about sexual abuse of children.

3.2. Discussion and critical analysis

Biological theories of crime causation assume a person's biological characteristics predetermine crime. This theory has provided clear observable and measurable evidence of some correlation between individual genetic and hormonal factors and offending sexual behaviours, which increases its scientific credibility. Despite these virtues, several common problems exist in the fundamental principles of biological perspective that limit their use as an etiological theory of CSA. According to this theory, environmental factors have no influence on human behaviour, feelings, or thoughts (Faupel, 2015; Stinson *et al.*, 2008). Furthermore, biological explanations are reductionistic, deterministic, and ethically problematic because they rely too heavily on biological factors and ignore contextual factors. Therefore, it becomes difficult to

fully apply this simplistic explanation to explore the sensitive contextual-interactive social phenomenon under study.

Psychological theories of CSA focus on causes at the individual level, but instead of associating crime with observable phenomena like brain abnormalities, they associate crime with abstractions such as cognitive processes and psychological development, attachments, intelligence, or personality traits and psychopathologies. Psychological theories extensively provide explanations for the aetiology and vulnerabilities of CSA as well as psychosocial therapeutic approaches. This theory lacks strong research backing and tends to integrate other arguments and ideas envisioned in other theories. The core concepts are vague, meaning that they can be used to explain everything but predict little. It is very difficult to verify the arguments that are considered the basic tenets of feminist theories scientifically (Burk and Burkhart, 2003; Ensink *et al.*, 2020).

Feminist theories beliefs are based on the idea that the main causes of women's oppression and gender based violence, including sexual abuse and victimisation, originate from social roles and institutional structures being constructed by male supremacy and patriarchy (Harnois, 2012; Hook, 2014; Mann and Beech, 2003; Purvis and Ward, 2006). Based on its underpinning principles, it has no doubt improved women's empowerment. However, in spite of the seeming contributions of feminism to the development of society, it is not without criticism. Instead of concentrating on equalising the distribution of power, they focused their efforts on completely eliminating patriarchy by transforming the entire structure of society, specifically by getting rid of traditional gender roles, a demand that may be considered too extravagant and unrealistic (Harnois, 2012; Hook, 2014). Feminism does not have a sound basis; yet they demand equal economic, political, and social opportunities of the male and female sexes. The central tenet on which feminism builds its argument is that both the

male and female genders are equal by nature, they share the same rights and privileges (Hook, 2014; Mann and Beech, 2003; Purvis and Ward, 2006). But the question is; what the basis for the postulation is that the male and female genders are equal. Additionally, the demand for equal opportunities in itself is an admission of inequality: An equal does not beg to be equal; his equality would shine for all to see. Additionally, it corrodes family systems and avenues to inculcate informal education and value in children (Bisong and Ekanem, 2014).

The ecological theory moves the explanation from reductionist to holistic approaches by providing a theoretical and research framework through which the influence of the environment as a whole (holistic) can be factored into human development. This approach encourages researchers to look more broadly and inclusively at the forces acting on children. The theory integrates multiple influences on child development and provides a holistic framework from which to understand child development and experience. All factors then become mutually and systematically influential, even the smallest factor, which makes the theory very difficult to implement in practice.

3.3. The relevance of existing theories to current study and practice

Critical analysis of the above discussed theories shows that biological and psychological theories are less relevant to providing explanations and understanding the contextual-interactive based phenomenon under study due to its uni-directional nature. Existing theories are quite important in the medical field to explain the aetiology of CSA and offending sexual behaviour and contribute to advancements in the provision of medical and psychosocial treatment for sexually abused children and perpetrators. However, ignoring the contextual and environmental factors of the child

means these theories are unable to provide an insight into the context that forms the child's experience and that the practitioner operates in. Relying on an individualistic and decontextualising biological and psychological perspective will result in missing an important aspect of HCPs' experiences of identifying and responding to sexually abused children. On the other hand, feminist theory considers the social and cultural context of the child but focuses merely on the cultural and social differences in gender construction, which makes it reductionist in nature. By doing this, the individual, familial, and interactive factors are neglected, consequently providing a myopic view of the influence of context on child experience and the practice of HCPs as related to issues of CSA.

Ecological theory offers a systemic thinking approach, which means that even the smallest factors of influence need to be considered and understood as part of a multifaceted system of influence. Although ecological theory has been criticised for this idea, it integrates multiple influences on child development and provides a holistic framework from which to understand the child's context, child-professional interaction, and experience. Using its integrated approach, it has been used to discuss the aetiology of CSA and child's vulnerabilities (which has been explored in detail in the section 'An ecological theory of child sexual abuse'), barriers to disclosure and decision to seek support, and the influence of the ecological system on a child's experience.

In practice, ecological theory highlights the importance of individual differences and experience and influences how we view and assist a child who experiences CSA, making CSA practice no longer a 'one size fits all' approach. Its ability to complement and support individualist accounts of psychosocial development when used in conjunction with other theories means that it can be used to develop a holistic

supportive system guided by overarching theory that shows appreciation for a child's and HCP's unique circumstances. This contextual based approach is highly relevant and important as it may provide a significant insight into child-professional interactive space as well as an understanding of the associated issues and challenges.

3.4. Brief overview of Nigeria

Situated at the heart of the Western coast of Africa, Nigeria is the seventh most populous country in the world and the most highly populated African country. It has a surface area of 923,768 sq. km, with over 200 million inhabitants, making the population density around 212.04 individuals per sq. km. In 2019, the population was 200.96 million, as compared to 43 million in 1960 when Nigeria obtained independence (Nigeria National Bureau of Statistics, 2019).

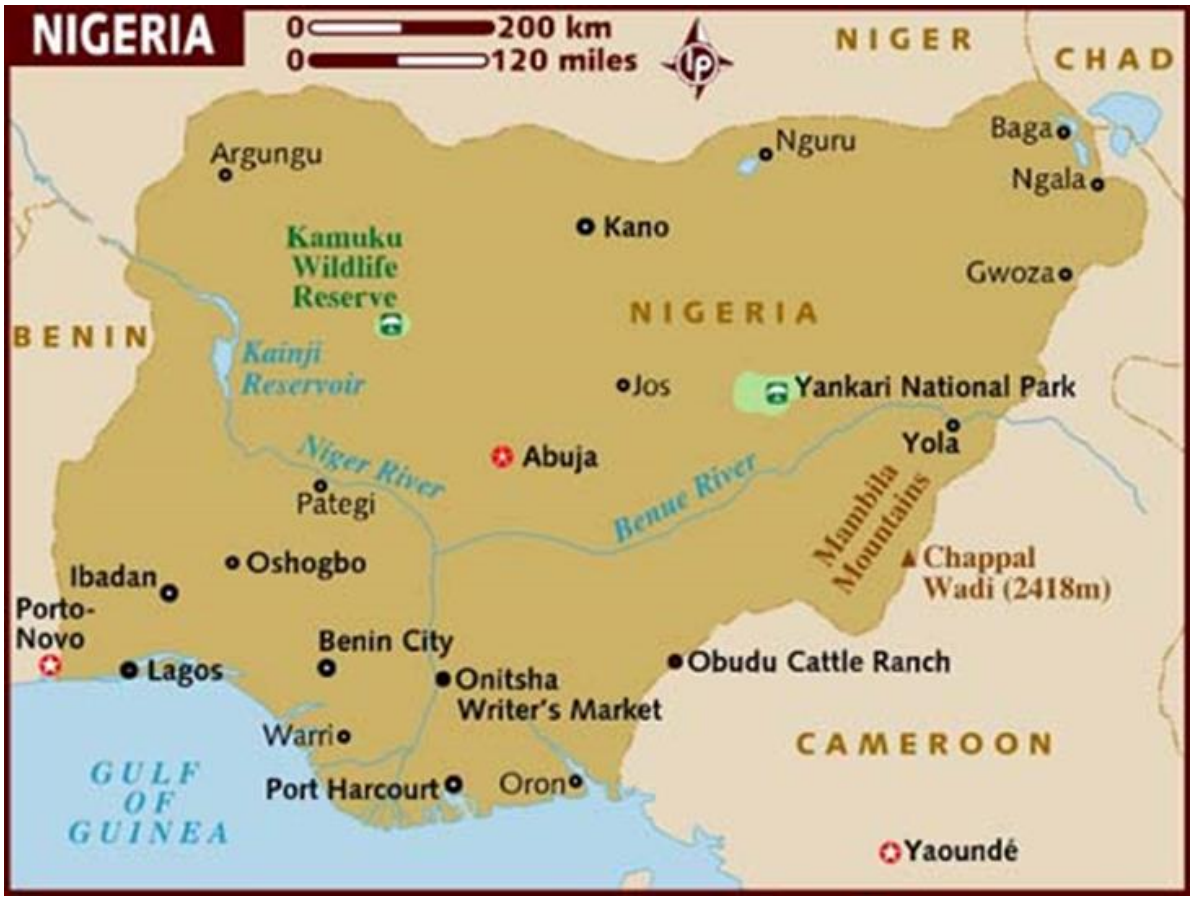
Nigeria shares its border with five African countries, as seen in figure 4. To the west of Nigeria is the Republic of Benin, to the east is Chad and Cameroon, the Gulf of Guinea is to the south, while to the north it is bordered by Lake Chad. The country consists of 36 states that are divided into six geopolitical zones, namely the North Centre (NC), North-East (NE), South-South (SS), South-West (SW), North-West (NW), and South-East (SE). These zones are the major modern divisions based on geographical locations, and ethnic and political history.

Nigeria is a multi-cultural, multi-ethnic, and multi-religious country, containing over 250 ethnic groups speaking over 400 languages (Ayeni 2020; Ezema, 2012), which makes it a richly diverse country. However, the three largest ethnic groups are the Hausa/Fulani, Yoruba, and Igbo, making up 29%, 21%, and 19% of the population, respectively. Although English is the second language of Nigerians, it remains the

official national language because it was a British colony. The most commonly practised religions are Christianity, Islam, and traditional religions.

Life expectancy, according to the World Health Organisation (2018), is around 55.2 years, which is the sixth lowest in the world and may be attributed to numerous factors including health issues and is a strong indicator for economic underdevelopment. While a national health insurance scheme was introduced by the government, a mere 5% of Nigerians are insured (Ilesanmi *et al.,* 2014; NHIS 2011). The Nigeria healthcare system and structure will be discussed shortly.

Figure 4: Map of Nigeria showing bordering countries



3.5. Pathways of care for sexually abused children in Nigeria

In Nigeria HCPs respond to victims of CSA following two main pathways of care. Interventions are classified into either emergency or non-emergency care pathways. The emergency pathway entails immediate interventions for critically ill victims or those with life-threatening conditions resulting from abuse. The following discussion is based on the pathways of care that were observed while conducting this study.

3.5.1. Emergency care pathway

In emergency situations, two teams are immediately mobilised. The medical emergency rescue team provides immediate medical care, surgical repairs of trauma and other injuries, as well as preventative services. Second, the police team to apprehend the suspected perpetrator. Once the victim is stabilised, HCPs offer immediate holistic referral and transport the victim to hospital for further care. This service also provides emergency preventative services such as post-exposure prophylaxis (PEP) and emergency contraceptives. This describes a range of emergency care and services HCPs provided to CSA victims.

3.5.2. Non-emergency care pathway

Non-emergency provides patients with routine care in the absence of immediate risks to life. The first step in this pathway is the introductory phase, where HCPs familiarise the victim with the support team and key professionals. The next step is to obtain permission from a parent or guardian, which is required unless one or both of the

parents were involved in or caused the abuse. Other processes of providing care for sexually abused children are outlined below.

Giving psychological support: Throughout the care process, it is important to give victims psychological and emotional support and help them understand that their feelings are normal. This normalization of emotional difficulties is to let victims know that those emotional and psychological difficulties experienced following such adverse childhood experiences are not abnormal, and that such emotional reactions exist among people with similar experiences. The next step is an interview with the victim or a family member to get more information about the sexual abuse.

Investigative Interviews: Conducting investigative interviews is another important role played by HCPs in responding to victims of CSA. Through questioning techniques, professionals gather information and evidence to identify and prioritise victims' immediate needs and care; therefore, they consider interviews important for obtaining essential information and collecting evidence to guide the intervention or plan victims' subsequent care. Other information that can be collected includes the time and source of abuse, the perpetrator's identity, the type of CSA, whether penetrative or not, onset of abuse, and what signs or symptoms the victim exhibits, such as pain or trauma.

Medical History, Physical Examination, and Documentation: HCPs are responsible for doing full clinical examinations, which include a physical evaluation, a medical examination, a laboratory investigation, and the collection of forensic specimens. The child is examined from head to toe to look for signs of sexual abuse, broken hymens, bruises, injuries, and any other evidence that may be present. HCPs also collect forensic specimens from the genital areas of victims, and suspects if possible, as soon as it is practical to do so, in a manner that adheres precisely to the

criteria for the collection and labelling of evidence. In order to confirm the occurrence of sexual assault in accordance with the legal definition of the term, to develop a care plan that is centred on the individual, and to make certain that laboratory investigations are carried out in a timely manner, a comprehensive examination is also considered an essential diagnostic tool.

Medical Care, Including Prophylaxis and Preventive Services: After mandatory comprehensive investigations, HCPs provide medical and preventive interventions, which is crucial for survival, future normality and seeking justice. Patients are treated symptomatically, meaning medical care is provided based on the victim's clinical presentation. In other words, medical care is provided to the victims based on a need-directed approach, such as administering analgesics to relieve pain and dressing wounds with antiseptics. HCPs said children or adolescents who experience penetrative sexual abuse are at risk of contracting HIV and other sexually transmitted infections. Likewise, children who have attained reproductive age and have experienced sexual abuse may be at risk of unplanned pregnancy. The hospital provides victims with medical preventive care such as antibiotics, post-exposure prophylaxis (PEP) and emergency contraceptives to address any physiological conditions that could result from the abuse.

Psychosocial Intervention: A comparative analysis of the data gathered in this study shows that HCPs' statutory roles in supporting victims of CSA vary. While nurses and doctors heavily focused on medical and physical examinations and providing surgery to the victims, the social workers, psychologists and counsellors said that their main responsibility was providing psychological support and counselling. As previously discussed, sexual abuse of children and young people have both short- and long-term psychological and mental health consequences; therefore, HCPs provide immediate

and ongoing psychotherapies and counselling to emotionally stabilise victims and support them in developing positive strategies to manage the possible repercussions of their experiences.

Legal Support and Referral: Nigeria's National Agency for Prohibition of Trafficking in Persons (NAPTIP) has a mandate to investigate and prosecute cases of gender-based violence in Nigeria. HCPs help victims navigate the Nigerian legal and judicial system, advising and supporting the victim through the litigation process; seeking and obtaining justice remain important aspects of victim care. Most cases have already been reported to the police and are only referred to hospitals by security agencies that are actively involved.

Follow-up: Follow-up is an essential aspect of HCP support for victims to ensure compliance with medication and therapies, check clients' emotional well-being and monitor the prosecution processes. Apart from medical care, physical assessment and identification of victims' needs, another major HCP role that emerged was providing psychosocial support and counselling and deciding for litigation and prosecution processes.

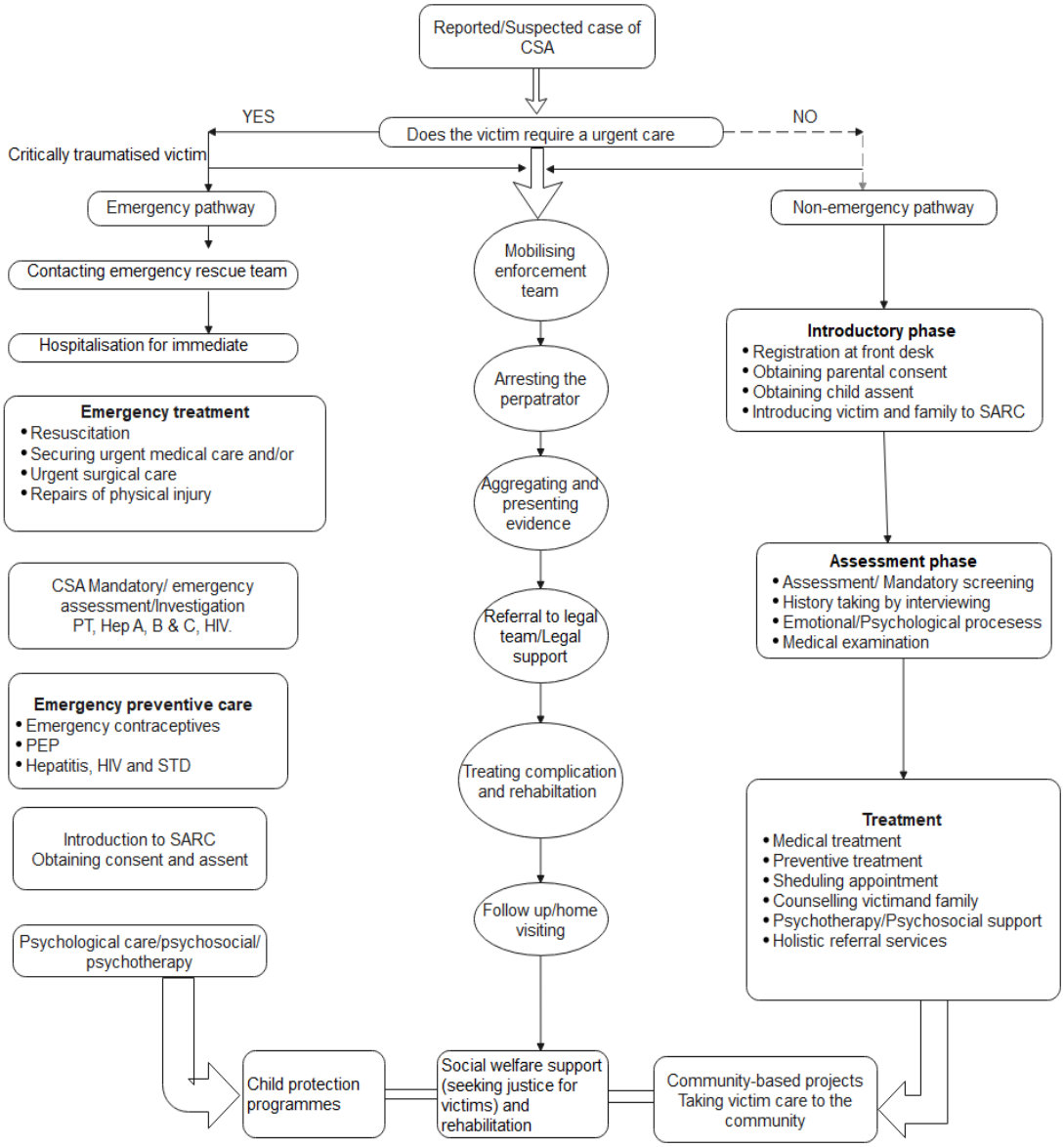
Two other extended services or programmes focus on rehabilitating victims and empowering them to minimise or eliminate their chance of re-victimisation.

Social Welfare Support and Rehabilitation: The Child Protection Programme (CPP) aims to ensure the child's best interests, provide financial support and essential needs, empower them, keep them informed and protect them from re-victimisation. HCPs act as advocates for victims to benefit from empowerment finances or grant-related programmes, as well as secure funded education programmes for survivors and integrate them into the educational system. These programmes extend to arranging

temporary and permanent shelter, including alternative kinship care, offering fostering and adoption for victims, and providing training to raise awareness amongst young people and their families.

Community-Based Projects Involving the Wider System: HCPs used their platforms to establish various community-based projects, such as supportive, educational and preventive projects. There are awareness programmes and empowering services for individual victims, groups of survivors, schools, social groups, religious groups and communities to empower individuals and communities to identify victims early and present the appropriate response. HCPs stated that these programmes also address unhealthy cultural norms. Moreover, there are preventive workshops for parents to help them understand their roles in preventing CSA, as part of an attempt to focus on preventing CSA and increasing societal awareness. Figure 5 show a diagrammatic representation of the pathway of care in Nigeria. The next section briefly discusses CSA in Nigeria based on the systematic literature review conducted on this topic.

Figure 5: A diagrammatic illustration of the pathway of care for sexually abused children



3.6. Systematic review: A brief report of child sexual abuse in Nigeria

The true burden of the CSA phenomenon in Nigeria remains unknown and difficult to determine, as most available data are collected through social media and cases presented at hospitals, rather than community-based surveys. The culture of silence around CSA, non-disclosure of the victims, particularly among young victims, the fear

of being blamed, fear of further harm from the perpetrator/s or resources deprivation, and culture inhibitions have prevailed in masking the extent of CSA. In addition, limited research has been conducted to aggregate the existing evidence around CSA in Nigeria. The few existing peer-reviewed articles from Nigeria are from clinical cases, and do not account for the many cases that never reach a clinic. This leaves out evidence that may be present among children in and out of school, and adolescents from both secondary and tertiary institutions. Therefore, it is important to systematically appraise the few empirical studies available in Nigeria to aggregate the available evidence and to understand the nature and extent of CSA in Nigeria. More importantly, this information will provide the context in which the HCPs who participated in the study operate.

3.6.1. Aims and objectives

The main purpose of this review is to aggregate empirical articles and critically appraise the quality of the included articles for the following reasons:

- To systematically review existing body of knowledge on CSA in Nigeria; the prevalence and pattern of CSA, causes, determinant/predictor, impact on victims, society awareness, perception and HCPs practices and available services for sexually abuse children and highlight gaps in literature
- To identify what was known about CSA in Nigeria and highlight any gaps in the existing research literature
- Develop a theoretical framework to underpin and design the present study

The review question was developed using the Population Exposure Outcome (PEO) framework that is commonly used in healthcare research (Bettany-Saltikov, 2012).

Table 3: Formulating evidence-based practice questions using the PEO framework

Question: What is the prevalence, patterns, causes and perceptions of CSA and available services for its victims in the Nigerian context?	
PEO Framework	
Population (P)	Nigerian context
Exposure (E)	Child sexual abuse
Outcome (O)	The prevalence and pattern of CSA Causes and determinants/predictors Impact on victims Society's awareness HCPs' perceptions and practices and available services Identifying issues and challenges

3.6.2. Method of review

A systematic review approach was used to conduct exhaustive searches to identify and review available relevant literature on CSA in Nigeria (Grant and Booth, 2009). A systematic review approach is used to understand sparsely researched fields, such as this topic, to develop an idea or concept, produce best evidence synthesis to identify gaps in the literature, and outline recommendations for practice and future research (Grant and Booth, 2009). To achieve a comprehensive search, I conducted a systematic review of all peer reviewed literature on CSA in Nigeria published in English in the last 22 years (between January 1999 and May 2022).

3.6.3. Eligibility criteria

Studies were considered eligible for review if they were empirical in nature, explored any topics on CSA in Nigeria, and published in English language in scholarly journals between 1st January 1999 and May 2022. Literature from this period was included as

the period signifies significant milestones in the literature review on CSA and professional attention to victims of CSA in Nigeria. Table 4 highlights the inclusion and exclusion criteria for this review.

Table 4: Inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
Focused on CSA prevalence, pattern and impacts	Studies that did not focus on CSA
Focused on society perception of CSA	Studies conducted before 1st Jan 1999
Focused on healthcare workers' knowledge, attitudes, or awareness of CSA	Literature reviews including either narratives or systematic or meta-analysis reviews and commentaries
Focused on the present CSA intervention in Nigeria, issues and challenges facing HCPs	PhD thesis
Only studies published in the English Language	Not published in English
Between the years 1st January 1999 to May 2022	Studies conducted before 1st January 1999
Published in peer reviewed journal	

3.6.4. Search strategy for literature review

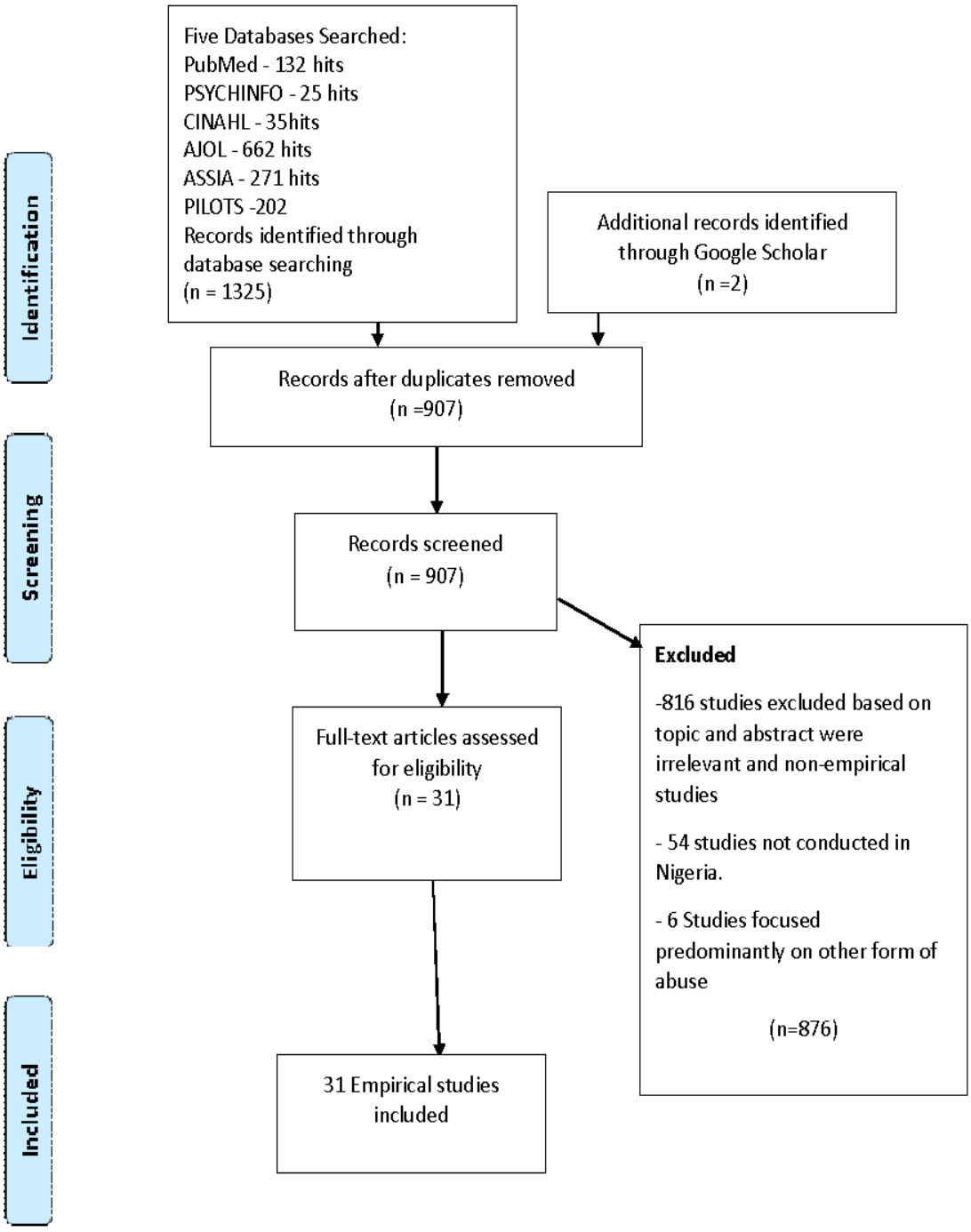
The following six databases were systematically searched: PubMed, PSYCINFO, CINAHL, ASSIA, PILOTS and African Journals Online (AJOL), the world's largest, African-published scholarly journals. Google Scholar was also used in order not to miss out any studies not indexed. Boolean operators (AND and OR) and truncation (*) was used, alongside some of these keywords: 'Child sexual abuse and pattern', 'Prevalence and child sexual abuse' 'Child sexual abuse and causes' 'Child abuse AND Nigeria', 'healthcare professionals AND child sexual abuse', 'Nigeria AND girls AND abuse', 'Nigeria AND sexual child abuse OR sexual exploitation', 'Doctors OR Nurse AND child sexual abuse OR child molestation', 'Nigeria AND issues and

challenges AND healthcare providers', 'Barriers AND detecting Child abuse in Nigeria'. Appendix 2.1 presents the extensive list and appendix 2.2 presents the search result.

3.6.5. Study selection

Following a comprehensive search, a total of 1325 studies were identified. Following exclusion of 418 duplicates, 876 irrelevant studies (did not meet the inclusion criteria, were not empirical, not conducted in Nigeria, or do not focus on CSA) were excluded. Only 31 empirical studies that met the inclusion criteria were included. Figure 6 shows the PRISMA flowchart from identification of studies to the inclusion process.

Figure 6: PRISMA flowchart of study selection[2]



[2] Based on Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed1000097

3.6.6. Data extraction and quality appraisal

A data extraction form was used to collate data on the author names, year of study, aims of the study, design, settings, methodology, sample size, and the study's results. Similar concepts were clustered together to present findings. Each study that met the inclusion criteria was quality assessed using the critical appraisal skill programme (CASP) checklists, including the qualitative checklist (for qualitative studies – see Appendix 2.3), cohort study checklist (for quantitative studies – see Appendix 2.4), and case-control study checklist. The mixed methods appraisal tool (MMAT) Version 2011 was employed for quality evaluation of mixed methods studies (Appendix 2.5).

3.7. Results: Description of studies setting, population, design and methodology

Appendix 2.6 presents the purpose and appendix 2.7 summarises each of the 31 included studies. The majority of these studies were quantitative (n=20) and cross sectional. Only nine studies were qualitative (Aderinto 2010; Olatunya *et al.,* 2013; Oteh *et al.,* 2009; Sodipo *et al.,* 2018), and the remaining two were mixed methods (Ogunyemi 2000; Oyekola and Agunbiade 2018). The majority of the studies were conducted the Southwest (n=19), and only five were carried out in the Southeast. One was conducted in each remaining geographical zone except Northwest, where research on CSA was unavailable.

Setting

A significant number of the studies were community-based (n=12). Nine studies were conducted in clinical settings, five in school settings, and only one study explored child sex offenders in prison (Aborisade *et al.,* 2017). Most of the studies collected data

from children and adolescents, particularly girls. Very few explored the experiences of parents, community leaders, religious leaders, healthcare professionals, teachers and offenders, and none included policy makers.

Sampling

Purposive and convenience sampling techniques were commonly used. Sample sizes ranged from 23 to 4000 participants (Obisesan, Adeyemo and Onifade, 1999; Ashimi, Amole and Ugwa, 2015).

Data collection

Data were collected using questionnaires (n=18). Most of these questionnaires were self-developed and they considered the social lifestyle and factors that could predispose their participants to being sexually abused in childhood. Also, the age of onset was commonly elicited across the questionnaires, as was the relationship between the victims and the perpetrators. Some studies used only 6-item questionnaires (Adeleke *et al.*, 2012), while others used as many as 30 (Ajuwon *et al.*, 2001). Other methods of data collection include in-depth qualitative interviews (n=5), and three studies used a mixed approach to data collection, which included questionnaires, in depth individual interviews and focus groups (Ogunyemi 2000; Oyekola and Agunbiade 2018).

3.7.1. The prevalence and patterns of CSA

A wide variation in the prevalence of CSA in Nigeria was reported, with 2.1% (Obisesan *et al.,* 1999) being the lowest and 77.7% being the highest (Audu *et al.,* 2009). Of the 31 included studies, 12 reported a higher prevalence of CSA in females (Obisesan *et al.,* 1999). Only one study, however, showed that more boys than girls

experienced sexual abuse as children. This discrepancy could be attributed to the difference in the number of females and males that participated, which was not clearly stated in this study. A variation in prevalence was observed depending on the group, for example the prevalence of CSA was reported to be 70% among apprentices (Ajuwon *et al.,* 2001), 69.9% among girls selling goods on the street (Ikechebelu *et al.,* 2008), 10% to 68% among teenagers attending secondary schools (Envuladu *et al.,* 2013; Manyike *et al.,* 2015), and 35% in out-of-school children (Kunnuji and Esiet, 2015). Only one study identified the overall prevalence and one-time prevalence rate among secondary school students 40% and 11.5%, respectively, and almost half participants in this study had lost count of the number of times that they had been abused (Manyike *et al.,* 2015).

The most common age of first exposure was reported to be 12, and those under the age of 18 years were most likely to be victimised again within the next year (Kunnuji and Esiet, 2015). Common forms of CSA reported were unwanted kissing, hugging, inappropriate touch to breasts and genitals, verbal threats, abuse and rape (Abdulkadir *et al.,* 2011; Ajuwon *et al.,* 2001; Ikechebelu *et al.,* 2008; Nwolisa *et al.,* 2016). In addition, teenagers were forced to look at pornographic pictures, films, videotapes or magazines, to watch perpetrators exposing genitals and masturbating, coerced into full sexual intercourse, or experienced rape and vaginal or anal penetration (David et al., 2018; Manyinke *et al.,* 2015; Okeafor *et al.,* 2018; Oyekola and Agunbiade, 2018). All the studies found that perpetrators were usually men, mostly known to the victims (Adeleke *et al.,* 2012) either as relatives, friends or neighbours. Only a few respondents were victims of stranger or gang rape.

A few studies found that perpetrators used different forms of enticement such as money, gifts or food, alluring promises, shelter or accommodation to lure adolescents

in Nigeria (Ajuwon *et al.,* 2001). Common places reported for CSA by perpetrators known or related to the child were during times of being home alone with the child, watching TV with the child, or when they sent the child on an errand after gaining the parent's trust. The most common places for unknown assailants to coerce the child into sexual activity were friend's homes, familiar neighbourhoods, and during organised activities, such as parties (Aborisade, Adeleke and Shontan, 2018).

One particular study, by Ikechebelu *et al.* (2008), considered children respondents' awareness of the risks associated with unprotected sex. 56.9% and 45.7% were unaware that such coercion could lead to unwanted pregnancy and sexually transmitted infections, respectively. However, a significant percentage (31.5%) of girls that participated in this study claimed they bought self-prescribed medication at a pharmacy, after experiencing abuse. Most of the victims preferred to keep the experience to themselves, and few victims discussed their experience with friends and family members.

3.7.2. Determinants/causes of CSA in Nigeria

Twelve studies explored determinant/causes of CSA (Aderinto 2010; Fawole *et al.,* 2002; Nlewem and Amodu, 2017). One study, by Nlewem and Amodu (2017), found that female adolescents living with their parents were less likely to be sexually abused than female adolescents with separated or divorced parents. Other factors include basic deprivation and living arrangements (Kunnuji and Esiet 2015), younger age (child aged 10 to 15 years), alcohol consumption, disability, and child labour and exploitation practices, such as hawking (Aderinto 2010; Envuladu *et al.,* 2013; Fawole *et al.,* 2002; Ikechebelu *et al.,* 2008). One study identified no significant relationships between the incidence of adolescent sexual abuse and socioeconomic class or age (Ikechebelu *et*

al., 2008). In contrast, Envuladu *et al.* (2013) found significant relationships between age, hawking, alcohol consumption and living separately from parents.

3.7.3. Causes of CSA from the perspective of Nigerian children

Research exploring teenagers' perspectives has shown that the most common causes of CSA are poverty (52%), and cultural and religious practices (28%). Most children that participated in these studies in Nigeria think their parents' low socioeconomic status and inability to meet their financial needs has subjected them to exploitative practices such as hawking, street begging, and seeking employment as house maids, which appeared to be an immediate solution to their financial predicament, but indirectly exposed them to CSA (Oteh *et al.,* 2009; Oyekola and Agunbiade, 2018). Beyond the exploitative practice, gender discrimination and the relative social invisibility of young females alongside prevailing societal norms that are supportive of sexual violence were identified as other causes of CSA in Nigeria (Ajuwon *et al.,* 2001; Manyike *et al.,* 2009; Olatosi *et al.,* 2018). The least-reported factors were physical appearance and lack of sex education (Oyekola and Agunbiade, 2018). Two studies identified protective factors, such as the active involvement of parents and teachers in terms of early sexual education and orientation of girls on CSA (Manyike 2015; Oyekola and Agunbiade, 2018).

3.7.4. Nigerian parents' and victims' knowledge, perceptions and attitudes regarding CSA

Six studies explored participants' knowledge, perceptions and attitudes, with emphasis on their sociocultural perspective and how this frames their standpoint regarding CSA. Ige and Fawole (2011) revealed that the majority (78.3%) of respondents (parents) had

previous knowledge, as well as having heard about an incident involving their child or another child. Of these, merely 18.8% defined CSA as sexual intercourse with a child, either forcefully or consensually. Unfortunately, this study did not report how the remaining 80% of respondents defined CSA. The majority (84.2%) of the respondents agreed that CSA is common in their community; however, only (34.6%) agreed that CSA could have a serious health impact on victims. This study further revealed that merely 2.1% of parents disclosed their children had experienced CSA and more than 90% of respondents claimed they discussed the stranger-danger (all forms of danger experienced by children caused by strangers) element with their children. Despite the parental awareness, almost half of the respondents claimed their children could not be sexually abused; hence, Ige and Fawole stated that over a quarter of them leave their children unsupervised. A majority of the respondents condemned CSA acts such as rape, date rape, gang rape, child prostitution, and incest; however, evidence of gender-role stereotyping exists, which endangers the reproductive health of girls and predisposes them to sexual rights violation (Ogunyemi, 2000). Beyond these unhealthy practices, female gender rights are seen as an appendage to males, due to boy-child preferences in Nigeria.

Ige and Fawole (2011) explored parents' perspectives and practices that could contribute to CSA, finding that respondents agreed they should sell their children to whoever can feed or properly educate them, especially in instances of extreme financial poverty; an opinion the researchers perceived could mortgage the child's future. Aderinto (2010) stated that victims of sexual abuse are forced to marry their perpetrators, especially when the sexual abuse results in unplanned pregnancy. Unfortunately, participants were less aware of the possible impact of such acts on a child. Sexually abused children who participated in this study claimed they did not

disclose to parents, and 75% preferred to discuss it with their friend, whereas some studies found that some children still reported their experience of CSA with family members and friends (Oyekola and Agunbiade, 2018). The number of parents who disclosed their child's experience to the police, community leaders, or a healthcare professional was negligible. This attitude may be due to the current trend in Nigeria, where victims are subjected to secondary victimisation by their parents, medical personnel, families, neighbours, and others (Aborisade and Vaughan, 2014; Ebuenyi, Chikezie and Dariah, 2018). The reviewed studies found that more efforts are required within the school system and at household and societal levels to curb, manage and reduce CSA. Victims must be referred for counselling and perpetrators must be severely punished. These studies identified the strengths and gaps in parents' knowledge, perceptions, and practices of CSA in Nigeria

3.7.5. Recognising victims and reported preventive practices in Nigeria

Research by Oyekola and Agunbiade (2018) explored teachers' opinions and reported complexities surrounding the recognition of CSA. Respondents identified psychological symptoms such as emotional changes, withdrawal from others, sadness or moodiness, anxiety and pains or difficulty in carrying out daily activities, which usually made them suspicious of CSA. Studies suggest that primary prevention in contemporary Nigeria is based on parental supervision, child-parent communication about sexual activity and danger from strangers and familiar people, while secondary preventive practices include reporting to the police station and hospital for medical examination. Unfortunately, the authors reflect that discussions around sexual abuse seldom occur and parental supervision is neglected (Ige and Fawole, 2011). Also, this

study revealed that although Nigerian parents can readily identify the immediate physical signs of CSA, they are unable to recognise behavioural changes as indicators. Such unawareness about the range of symptoms associated with CSA may delay the needed response to protect the child from further abuse and seek treatment. In cases where abuse is identified, they are rarely reported as respondents believe disclosing such acts will only bring social stigma and more trauma for their child and family, rather than justice (Ogunyemi, 2000). This non-disclosure is particularly challenging, as the parental response to CSA determines the child's interactions with legal and health professionals, when seeking help following abuse.

3.7.6. CSA from the perspective of child sexual offenders

Aborisade *et al*. (2018) employed a qualitative approach to explore CSA from the experiences and perspectives of CSA perpetrators and focused on their reasoning and remorse status. A majority (58.62%) of offenders attributed their act to a variety of factors including the inability to control themself, not being conscious of their acts, being under the influence of heavy alcohol consumption and psychoactive substances, ignorant of the law regarding child sexual consent age, spiritual manipulation, and as a revenge on the mother (where the perpetrator is the mother's boyfriend). Most of them stated that they subsequently felt remorse for the psychological trauma and social stigma their action may have inflicted on their victims, while a significant number felt bad only because of their current undesired condition of being in prison. Two offenders were completely unremorseful. A note of caution is due here since these participants were already caught and either awaiting judgement or had received verdicts, so they might be providing a socially acceptable response.

The perpetrator in this study described their victims as sex objects, who can be ascribed the status of a woman to satisfy their sexual interest, and a vessel to channel their revenge. The authors highlighted the need for policy makers to urgently address the issue of sexual nature of the objectification of girls and create awareness campaigns as a part of the primary prevention of CSA in Nigeria.

3.7.7. The impact of sexual abuse among adolescents in Nigeria

Among the 31 included studies, only two predominantly focused on the immediate and long-term sequelae of abuse on adolescents, society, and the nation at large. These studies identified psychological consequences such as flashbacks, sleep disorders, sense of guilt and self-blame, emotional numbness, feeling of personal powerlessness, sense of distrust, and anger. Participants claimed these experiences left them traumatised with unsavoury memories which tend to truncate psychosocial development. Regarding the impact on the nation, the respondents (children) affirmed that such traumatic experiences damaged their educational career, reduce the country's future workforce, and impair their future contribution to economic development (Oteh, *et al.,* 2009).

3.7.8. Healthcare professionals' knowledge, perceptions, and attitudes regarding CSA

Three studies focused on HCPs and assessed their knowledge, perceptions, and attitudes about CSA. Olatosi and colleagues (2018) assessed the knowledge of 175 Nigerian dentists on the clinical signs as relatively poor and respondents reported a lack of a clear structure for referring victims to essential services. 46.5% of the respondents reported that they do not evaluate children for abuse or neglect. When the

respondents were asked about their response to suspected cases of abuse, 56.5% said they took no action, only 25.9% documented signs of suspected cases in patients' records, and 14.1% contacted social welfare. Almost all the dentists (98.9%) agreed that knowledge of child protection protocol is vital, but only 57% felt confident to recognise abuse in children and 95% claimed that they needed more clinical training. In terms of barriers to non-enquiry and non-reporting suspected cases, 65.4% of the respondents reported a lack of knowledge about referral procedures, 59.2% had concerns about confidentiality and 57.5% were afraid of the consequences for the child. Findings from this study are consistent with research by Opekitan, Fetuga, Ogunsemi and Adeleye (2019), which assessed HCPs' levels of awareness of the social and legal supports available for victims. Disturbingly, an overwhelming proportion of respondents in this study agreed they are unaware of the available social resources for victims. Additionally, the study shows that a majority of HCPs lack adequate knowledge of referral procedures and were concerned about confidentiality issues, a predominant barrier to reporting suspicious cases of child abuse (Olatosi *et al.*, 2018). Despite theoretical knowledge, clinical inefficiency exists, which demonstrated knowledge gaps among the healthcare professional in recognising and responding to victims of sexual abuse, culminating in professional non-enquiry attitudes. On the other hand, a particular study by Aborisade and Vaughan (2014) explored rape victims' post-assault experiences and adjustment patterns, interviewed two medical doctors and two psychologists and collected experts' opinions on the victimology of rape. Respondents from this study stated that victims' reactions and recovery largely depend on a complex combination of individual characteristics (such as personality) and external factors (such as the victim's social support network, victim-assailant

relationship and severity of the assault), because such factors have a great impact on a victim's psychological functioning and adjustment process.

3.7.9. Management of CSA in Nigeria

Of the 31 included studies, two focused on management of CSA (Olatunya *et al.,* 2013; Ige and Fawole 2012). Only 50% of victims from cases reviewed were subjected to routine High Vaginal Swabbing and retroviral screening, including for hepatitis B and C, and none received HIV and viral hepatitis post-exposure prophylaxis (PEP). Out of the 60.7% cases reported to the police, none led to prosecution (Ige and Fawole 2012; Olatunya *et al.,* 2013). Another clinical prospective study indicated that about 40% of victims presented within 24 hours of sexual abuse, but none had PEP (Adeleke *et al.,* 2012). Antibiotics were only prescribed to 34% of the victims, with fewer prescriptions for analgesics, vitamins, counselling, and contraceptives; only three quarters of the victims were checked for sexually transmitted infections and a negligible number of victims were referred to post exposure prophylaxis, while none received the hepatitis B vaccine (Ige and Fawole, 2012). These studies reported that cases were reported between one hour and thirty days after occurrence of the abuse, generically managed, and not reported to the police.

HCPs only come in contact with children when they are presented by the parent, guardian or teacher, and there are no structural systems in place to report abuse; most cases go unnoticed as there is no routine screening for child abuse among young girls in the Nigerian healthcare system. Previous studies have clearly identified that parents are less likely to report the sexual abuse of their child because of the social stigma and future consequences for the child.

3.8. Critical analysis and evaluation of the reviewed studies

This review highlights that limited research has been conducted on CSA in Nigeria. A majority of the studies predominantly focused on the prevalence and patterns of CSA. Only a few focused directly on the factors responsible and little effort had been made to examine the current clinical patterns of management. Only two focused on the knowledge and awareness of HCPs, and none focused on the challenges faced in identifying and responding to a victim of CSA. None of these studies directly explored young people's and adults' perceptions about children's status in society and the association with CSA.

The majority of the studies purposely recruited participants from the secondary school settings, although the reasons for this pattern were often not clearly stated. Generally, approaching young people in school to explore complex and sensitive experiences such as CSA will provide the participants with a sense of privacy and freedom to respond without the parent interference and minimise response bias. In some studies teachers were asked to leave the room (Nlewem and Amodu 2017). Many of the researchers also considered the sensitive nature of the research in terms of power dynamics and avoiding oversensitivity of the participants. For example, Ajuwon *et al.* (2001) extensively trained eight male and female adolescents as interviewers to minimise power imbalances and excluded schools where the researchers had previously completed a narrative workshop on sexual coercion, in order not to oversensitise participants, which could influence the research findings.

The majority of the reviewed studies were carried out using quantitative approaches, to explore the prevalence and experiences of the CSA victims (Ajuwon *et al.,* 2001; Badejoko *et al.,* 2014). Most of the studies explored the experiences of victims and

HCPs using a quantitative study (Adeleke *et al.,* 2012; Badejoko *et al.,* 2014; Manyike *et al.,* 2015; Olatosi *et al.,* 2018). CSA experiences are not only complex and sensitive but subjective in nature, and using a quantitative approach decontextualises the complexity of that experience. Some of the researchers that used clinical case studies seem not to be sensitive to the context, and the possible influences of this approach on the reliability and generalisation of these studies were not mentioned (Abdulkadir *et al.,* 2011; Ige and Fawole, 2012; Nwolisa *et al.,* 2016; Olatunya *et al.,* 2013; Sodipo *et al.,* 2018). Although only five studies used qualitative designs, qualitative research produces important in-depth insights around complex issues and contextualises data within the sample. For instance, these studies provide idiographic meaning attached by the victims to the experience of CSA (Aborisade and Vaughan, 2014), which adds richness to the available data, and also uncover the excuses, accounts and perspectives of CSA offenders (Aborisade *et al.,* 2018). One obvious limitation of this study is that the researchers did not discuss whether the child sexual offenders interviewed were pre-informed that their participation and responses could not overturn their sentence or in any way alter the charges against them. It is important to consider that respondents (inmates) may not provide genuine accounts of the experience, especially among those who are still awaiting trial and have not yet been convicted.

It is noteworthy to mention that the four studies exploring healthcare workers' knowledge and experiences of child abuse did not involve professionals that specialised in children and reproductive health (Olatosi *et al.,* 2018). Similarly, Opekitan *et al.* (2019) modelled their study sample on the previously-studied sample size, so the researchers recruited 86 instead of the 120 participants previously specified, and healthcare centres were also included based on convenience (ease of road access and the geographical region served). This raises questions regarding

sample representativeness, which may lead to under-estimation of healthcare professionals' knowledge and experience of CSA in Nigeria. Similarly, convenience and randomly-selected sampling methods were employed by most studies (Abdulkadir *et al.,* 2011; Ige and Fawole, 2012; Olatunya *et al.,* 2013). Most studies from Nigeria are undertaken by examining reported clinical cases and merely depend on victims' care notes or medical files, leaving out the many situations that never got to the clinic and occurred in the community (Ashimi, Amole and Ugwa, 2015).

Another important limitation is that most questionnaires were self-developed, which means that there is lack of reliability and validity of these tools. This affects their robustness (Abdulkadir *et al.,* 2011; David *et al.,* 2018; Envuladu *et al.,* 2013; Nwolisa *et al.,* 2016). In addition, some of the studies are retrospective and case study-based; this patently increases the chances of introducing memory bias, particularly with case studies which depend heavily on second hand data (Abdulkadir *et al.,* 2011; Ige and Fawole, 2012; Nwolisa *et al.,* 2016; Olatunya *et al.,* 2013). Finally, most studies did not clearly explain the methodology used and the limitations of the research (Aderinto, 2010; Chinawa *et al.,* 2014), which means such studies are not transparent enough, and raises the issue of replication.

However, these studies provide an insight into the magnitude of the CSA problem in Nigeria, with a prevalence rate ranging from 2.1% to 77%. As discussed, the wide disparity could be multifactorial: the demographic characteristic of the respondents, methodology, sample size, and focus of research, to mention a few. For instance, a study by Chinawa *et al.* (2014) states that among the 77.2% of participants who belong to the upper social classes, the prevalence of CSA is only 10.2%, compared to the 77.7% rate seen in Audu *et al.* (2009) study, where the participants were experiencing economic hardships. Having justified the wide disparity in prevalence, however, a

caution must be sounded on available studies, which might have underestimated or overestimated the burden of CSA in Nigeria. As it stands, these findings from reviewed studies on Nigerian healthcare professionals proved that they lacked the sufficient knowledge and competence in recognising this problem, compounded by a culture of non-disclosure. There is a wide gap between the available structures of CSA management and the care the victims require. Only three studies had directly explored CSA from the perspective of healthcare workers, and none of the previous studies had ever looked at the issues and challenges undermining professional intervention and service for victims of CSA.

A systematic review was used to identify gaps in CSA knowledge in Nigeria and set priorities for proposed studies. As a result of these findings, the main purpose of this study is to identify the challenges and issues faced by healthcare professionals when recognising children and young people at risk of CSA. There is a need to understand the actual practice of different disciplines who provide CSA-specific and nonspecific services to children and adolescents in Nigeria. The high prevalence of CSA in Nigeria, its impact on victims and families, the importance of early identification and intervention, and the expressed frustration from HCPs regarding their relevant roles, as well as the dearth of empirical studies and information on the professional practice of supporting sexually abused children, were considered extremely significant and timely. Having identified gaps in the literature, it became clear there was an urgent need to explore, uncover and conceptualise those issues and challenges encountered by HCPs that undermine their efforts. I also wanted this research to have practical implications and to inform practice and policy, which was deemed by HCPs and child protection organisations as extremely relevant. Hence, this study was designed to develop a relevant, socio-culturally theoretical model of the issues and challenges

facing HCPs working with sexually abused children, and to recommend a way forward based on the research findings.

3.9. A critical appraisal of the two systematic reviews: The justification for the current study in the Nigerian context

This section presents the critical appraisal of all the two systematic reviews, and how it informed researchers' understanding of the concepts under study, helped to identify gaps and became the basis for justifying the current study in Nigeria. The two systematic reviews conducted were the systematic review of literature on the issues and challenges of supporting sexually abused children from a professional perspective (section 2.2), and CSA in Nigeria (section 3.7). These reviews followed a systematic literature search, included all methodology, and considered the global perspective of professionals, as well as the narratives and practices about CSA in Nigeria. The global systematic literature review on HCPs' perspectives provided an insight into day-to-day experiences or aspects of their practice that they considered as challenges undermining their practice, and those barriers that prevent disclosure and management of CSA cases, as well as how these constraints are framed. Without doubt, conducting this systematic and comprehensive literature review improved the researcher's awareness of the context of the social phenomenon under study, and identified relevant conceptual frameworks which informed the methodological approach for this study.

The findings from these reviews suggested that the challenges undermining HCPs' practice from the individual to interpersonal level and from organisational to

contextual. This indicates that the context in which each study was conducted had a great impact on what constitutes the challenges, how they are framed, their impact on practice, and the possible pragmatic approaches in each geographical region. These findings further indicate that CSA is a highly sensitive and socio-cultural concept, meaning that the context in which it is being explored heavily influences the outcome, and the assumption that challenges faced by HCPs in other countries are in alignment with Nigeria HCPs may not be true because of the social and cultural differences. The importance of context in understanding the issues and challenges faced by professionals in their related mandatory roles, the victims' responses to the abuse, and barriers to disclosure and seeking professional support became apparent in these systematic reviews. Likewise, these perspectives provided crucial knowledge in this field and corroborate the sociocultural context and boundaries in which HCPs practice. While this development has been considered a critical milestone in the field of CSA research and healthcare professionals, none of these aspects has been explored in Nigeria.

From this literature review, it is clear that there has been limited investigation into HCPs' views and practices, particularly regarding challenges that undermine their ability to recognise and respond to victims of CSA. Few studies have been conducted in this field even in western countries including the UK, US, and Canada, as well as those in Europe, and the Middle East. Limited evidence exists on the challenges undermining HCPs' efforts to identify and respond to CSA victims, particularly in low-income African countries. Only four of the studies were based in Africa (one in South Africa, two in Kenya and one in Zimbabwe) with none in Nigeria. The limited available empirical evidence on this social phenomenon globally showed that there are documented differences between these studied and unstudied settings. More

importantly, while no study has explored the issues and challenges in a Nigerian context, the available evidence suggests that HCPs do express frustration over their practice, and that the available services for sexually abused children in Nigeria are below the standards and comprehensive care required by sexually abused children. Also, a community-based study revealed children withhold their experiences of CSA, meaning HCPs are left to identify and respond to these victims by merely relying on probable signs.

Based on the above rationale, a qualitative exploration of issues faced by healthcare professionals CSA in Nigeria was conducted to set a conceptual framework for the current study. Therefore, it is crucial to explore and understand the issues and challenges undermining HCPs' roles in recognising and responding to victims of CSA in Nigeria. There may be important literature on the topic, that for a number of reasons has not been published in peer review journals and are not identified in this search. Therefore, the findings of the review should be considered in the light of these limitations.

3.10. Aims of the proposed PhD study

This study aims to explore primary HCPs' experiences and perceptions pertaining to issues and challenges in the recognition and protection of victims of CSA. From the findings of available studies, through in-depth interviews, the study aims to answer the following research questions:

1. How do HCPs understand CSA and perceive their role in supporting sexually abused children in Nigeria?
2. What are the real-life issues and challenges faced by healthcare professionals regarding recognising and responding to victims of CSA?

3. What are the implications of the identified challenges and issues on present and future practices?
4. What strategies can be instituted to mitigate identified challenges, promote effective safeguarding, reduce the negative implications on practice and to improve the quality of care to service users?

3.11. Summary

This chapter presents the existing theories of CSA, with emphasis on the aetiology, exploring explanations for sexual offending behaviour and their significance to the current study a brief explanation of Nigeria by discussing its geographical location, and the social, cultural and legal context of Nigeria. It also discussed the available services for sexually abused children, thereby outlining the roles of HCPs in responding to sexually abused children in Nigeria. The next chapter will discuss the research methodology.

CHAPTER FOUR: RESEARCH METHODOLOGY

This chapter presents the methodological and philosophical stance that guided this research. The qualitative approach, theoretical paradigm, and research strategies are explored and compared. The chapter describes how a selected methodological approach was used to gain insight into HCPs' daily experiences supporting sexually abused children. It explores HCPs' perceptions of best practice and their understanding of related issues and challenges. The chapter discusses Denzin and Lincoln's (2011) five key research processes, which are essential for conducting a systematic, rigorous inquiry into social phenomena.

4.1. Qualitative or quantitative: Selecting the most suitable methodology

In the last few decades, social scientists have applied diverse research approaches, producing extensive evidence highlighting the weaknesses, strengths, similarities and differences of numerous research methodological approaches.

Understanding all of the theoretical frameworks for research is challenging for researchers at the beginning of their careers; however, it is essential to adopt an approach suitable to answering the specific research questions. One method is to adopt a single philosophical view; another is to combine elements of various approaches. Blaikie (2007) argues that the latter is as easily achieved as it was in the past, but it is no longer defensible. There has also been extensive discussion among psychologists, social researchers and educators, in what has been dubbed a 'paradigm war,' arguing

against mixing different paradigms or methods (Clark *et al.*, 2008; Tashakkori and Teddlie, 2010; Teddlie and Tashakkori, 2012). Evidence has highlighted the impossibility of conducting a theoretical analysis of social phenomena and the human psyche, which cannot be clearly structured, with quantitative or mixed approaches (Blaikie, 2007; Dieronitou, 2014; Tashakkori and Teddlies, 2010). Therefore, a more comprehensive approach that can thoroughly explore social phenomena to address the human desire to acquire and advance knowledge is required.

There are two major theoretical philosophical perspectives in sociological research—positivism/post-positivism, and interpretivism/constructivism (Blaikie, 2007; Dieronitou, 2014; Maykut and Morehouse, 2005). 'Epistemology' refers to the theory or science of knowledge: how humans come to understand their worlds and question what knowledge is. The two approaches lead to different methodologies. Categorically, positivist research is performed according to a quantitative design: a controlled experimental approach in which data is collected from randomly selected samples with valid and reliable data-collection tools (Creswell, 2013; Flick, 2015). Conversely, interpretivism requires a qualitative design, as it focuses on understanding unique subjective individual experiences and is language- and narrative-based. Although these approaches differ in terms of design, process, and epistemological stance, both are useful in their own ways.

The two broad research methodological approaches—qualitative and quantitative—aim to discover reality, knowledge, or truth about the world (Blaikie, 2007; Denzin and Lincoln, 2011; Locke, 2008; Padgett, 2016). The approaches differ in terms of the assumed nature of reality, the relationship between the knower and the known, the purpose of inquiry, the generalisability of findings, the explanation of causal effects and, importantly, the consideration of social values and contexts (Blaikie, 2007; Flick,

2015). Qualitative researchers seek to empathetically understand human behaviour and social phenomena from participants' perspectives. For these researchers, knowledge is a combination of rationality and intuitiveness. The qualitative perspective assumes multiple realities (Creswell, 2008; Padgett, 2016). Qualitative research aims to understand social phenomena from the individual perspective in different contexts, both at the subjective and experiential levels (Flick, 2015; Rubin and Rubin, 2012). This is done in the interests of developing an idiographic and personalised body of knowledge and presenting meaning to people who are attached to their real-life situations. A linear cause-effect explanation is impossible with such enmeshed elements (Denzin, 1998; Levers, 2013; Schwandt, 1994). Thus, research results are interpreted in the context of multiple interacting factors, processes, and events. In quantitative research, the researcher and the observed experience subject-object dualism, where the researcher is distant from the observed subject of inquiry; while in qualitative research, both the researcher and the observed interact with and influence each other, becoming proactive in creating reality (Assalahi, 2015; Bernard, 2011; Locke, 2008).

This qualitative study aimed to understand how HCPs identify and respond to victims of CSA, the associated challenges, and the impacts on practice in the Nigerian context. This was done by interpreting HCPs' descriptions of their experiences, perspectives, words and actions (Flick, 2015; Krauss and Putra, 2005). Because these meanings and experiences are subjective and individualistic, a qualitative methodology was considered appropriate as it offered a subjective process of exploring human behaviour and social phenomena with an integrated consideration of social values and individual socio-cultural contexts.

Other rationales for selecting a qualitative approach include:

1. The research problem is complex and sensitive, and cannot be quantified, controlled, or predicted; therefore, it requires subjective knowledge and an analysis of multiple realities..
2. The research topic remains under-reported and under-researched; therefore, it demands a comprehensive and robust approach that permits detailed understanding and in-depth exploration to produce expanded knowledge (Padgett, 2016).
3. Identifying and responding to victims of CSA is a complex phenomenon. Qualitative methodology allows for a comprehensive understanding of the nature of healthcare interventions. CSA intervention or response requires a spectacular multidisciplinary approach to effectively address the difficulties and complexities of programs, the heterogeneity of individual involvement, and the diversity of contexts (Clark, 2013; Thirsk and Clark, 2017). It involves integrating material, human, theoretical, social and procedural elements. Therefore, a qualitative approach that assumes multiple realities is essential when exploring this social process.
4. The target population is under-researched and isolated; in particular, their views on CSA in Nigeria are unknown. A systematic literature review on CSA in Nigeria revealed that studies rarely explore healthcare perspectives and HCPs were not invited to participate in the formulation of child-safeguarding policies (Nwanna and Ogunniran, 2019). Currently available knowledge on CSA is based on the Western context: this body of knowledge may lack consideration of Nigerian socio-cultural values, and HCPs' voices need to be heard.

5. This research is contextual in nature, as I aimed to study the participants in their natural context, attempting to make sense of or interpret them, understand how participants respond to victims of CSA in Nigeria and the associated challenges and implications for practice, and explore the meanings attached to their experiences. More importantly, I sought to explore real-life strategies suitable for the Nigerian context that could minimise these challenges and improve victims' healthcare experiences.

Having justified the selection of qualitative methodology, I will proceed to discuss the process of conducting systematic and rigorous qualitative research.

4.2. Qualitative research

Denzin and Lincoln (2011) identified five key processes that a researcher should follow to conduct a systematic and rigorous qualitative research study. I adopted their research process, as illustrated in Table 5, to outline my research stance, chosen procedure and research strategies for this study. The first three elements will be discussed in this chapter, and the remaining two will be discussed in the next chapter.

Table 5: Research Process (Adopted from Denzin and Lincoln, 2005, p. 12)

Element of Qualitative Study	**Research Key Characteristics**
Phase 1: Researcher	History and research traditions Conceptions of the self and the other The ethics and politics of research
Phase 2: Theoretical paradigms and perspectives	Positivism and post-positivism Interpretivism, constructivism and hermeneutics Feminism Racialised discourse Critical theory and the Marxist model Postcolonialism
Phase 3: Research strategies	Grounded theory Case study and ethnography Participant observation Performance ethnography Phenomenology and ethnomethodology Life history and testimonials Action and applied research Clinical research
Phase 4: Methods of Collection and Analysis	Interviewing Observing Artefacts, documents and records Visual methods Auto-ethnography Data management methods Computer-assisted analysis

	Textual analysis Focus groups Applied ethnography
Phase 5: The art, practices, and politics of interpretation and evaluation	Criteria for judging adequacy Practices and politics of interpretation Evaluation traditions Applied research

4.3. Phase 1: Researcher - personal life and philosophical stances

Qualitative researchers are interested in "understanding the meaning people have constructed, that is, how people make sense of their world and the experiences they have in the world" (Merriam, 2009, p. 13). While quantitative researchers aggregate data through inventories or questionnaires, qualitative researchers are themselves considered the instrument of data collection and play a dual role of insider and outsider (Denzin and Lincoln, 2011). Qualitative research is co-constructed by researchers in partnership with research participants (Denzin and Lincoln, 2008); however, it is important to emphasise that the researcher's influence is extremely dependent on the participants' knowledge of the phenomena under study. Knowledge and social reality are systematically and socially constructed by the participant and the researcher. Therefore, as researchers are instruments for collecting, analysing and interpreting the data, their philosophical stance influences the choice of research approach (Charmaz, 2014). When choosing an approach, the researcher should discuss relevant aspects of

their personal life, experience, assumptions, bias and expectations and demonstrate an ability to conduct the research (Berger, 2015; Denzin and Lincoln, 2008). Readers must be clearly informed of the researcher's positionality as they assume either an *emic*, or insider, view or an *etic*, or outsider, view. This understanding allows the reader to see how the research process, the knowledge produced and the data interpretation was affected by the researchers themselves. As my philosophical assumption is framed by my social, personal and cultural factors, my background, positionality and philosophical stances regarding research are relevant.

As I mentioned in the introductory chapter, I am a public and mental health nurse of Nigerian origin. I practised nursing for 10 years in Nigeria before moving to the UK and am currently practising as a nurse in the UK. I grew up in an extremist culture of male supremacy and gender inequality, and a patriarchal society that mitigates, represses, and justifies child sexual abuse. Men are given a superior position in family decision-making under the patriarchal traditional system, and men are viewed as dominant individuals in society. Even if his life circumstances prevent a man from performing the duties of a primary breadwinner, the culture still grants him the final say with regard to any family matters: the man's interests thus overrule those of women and children. During my childhood, societal normalisation and justification, victim-blaming, and stigmatisation of CSA often initiated strong emotions and resentment that I had to handle. In my personal and professional life, I have consistently witnessed children and families unwilling to disclose their experiences of abuse and violence to protect family honour and avoid the shame or stigmatisation associated with disclosure. Children are typically compelled to remain silent with the phrase 'what happens under our roof remains behind the door,' making case identification challenging.

I consider myself a constructivist, and I assume subjectivity regarding knowledge and ways of knowing or acquiring knowledge. I strongly believe that knowledge is socially constructed through research participants. This is because reality is not something 'out there' but something that is local and specifically constructed. In other words, I consider my participants active knowers who understand and reflect on the process of identifying victims of CSA with its associated issues and challenges, as well as the implications for practice. I believe in multiple interpretations of an experience and that the meaning ascribed to such an experience varies among individuals and may change for individuals over time. Attitudes and responses to issues around CSA are socially defined and, therefore, require an inquiry design in which the participant reflects on their understanding. I embrace the convergence and divergence in my participants' perspectives on the issues and challenges they face in identifying and responding to victims of CSA. I am open-minded and eager to see things from different points of view and prefer to explore different perspectives on a phenomenon. I consider this to contribute to my strong ability to perform qualitative analysis. My research is guided by theories of social constructivism, and I draw heavily on knowledge and research frameworks from the fields of social science, health policy and public health.

My personal, professional and philosophical stances influence my impetus and approach to this work, and undoubtedly influence my construction of research tools and interview questions and my approach to data collection, analysis and interpretation. My beliefs about human experience are consistent with a qualitative approach, an interpretivist–constructivist paradigm and a transactional/subjective epistemology. I kept a research and methodology journal, explicitly documenting my reactions and reflections and my awareness of myself, my practice and my roles as a researcher.

4.4. Phase 2: Theoretical paradigms and perspectives

Research paradigms are interpretative frameworks, defined by Kuhn (1962) as sets of common beliefs, general perspectives, commitments, values, agreements and feelings about how problems should be understood, addressed or studied which are shared by a community of scientists or across a discipline (as stated in Chilisa and Kawulich, 2012). They refer to a set of beliefs, ideas and perceptions about the world and how it should be investigated (Denzin and Lincoln, 2008). These frameworks influence our understanding and interpretation of the complexity of the world and how we acquire and interpret knowledge and solve problems. They are informed by four philosophical assumptions: ontology, epistemology, axiology and methodology (Chilisa, 2012).

4.4.1. Research paradigm elements: Ontology, epistemology, axiology and methodology

Ontology refers to the study of being and existence, or philosophical assumptions about the nature of social reality (Assalahi, 2015; Denzin, 1998). **Epistemology** simply means 'way of knowing' and refers to the branch of philosophy that studies the nature of knowledge and truth, and the ways and processes by which knowledge is sought, acquired and substantiated (Killam, 2013; Klakegg and Pasian, 2016). **Axiology** refers to the analysis of the influence of values on people's daily experiences, and their meanings, characteristics, purposes, origins, and acceptance as true knowledge (Chilisa, 2012; Killam, 2013; Maykut and Morehouse, 2005). Axiology further explains the relationship between the inquirer and the known. Finally, **methodology** describes how we study the world, or the procedures used to acquire knowledge. It refers to the study of the epistemological assumptions embedded in

specific methods, thus incorporating our entire approach to research (DeMarrais and Lapan, 2004; Killam, 2013; Klakegg and Pasian, 2016). In other words, these elements in conjunction form a paradigm which structures a researcher's view of a research problem, ways of investigating it, and their design of methods to answer their research questions. However, each paradigm has different meanings, based on its underlying theoretical framework. As a constructivist, I embraced and prioritised a constructivist/interpretive paradigm in this study.

4.4.2. Rationale for choosing a constructivist/interpretive paradigm

The subject of inquiry is a complex and sensitive phenomenon, and my personal and professional experience highlighted both how challenging this subject is in the Nigerian context and its implications for HCPs' practice. Providing sexually abused children with effective support involves a multidisciplinary approach which includes their family and all of the child's social support systems. Although care professionals' disciplines are distinct and they have varied perspectives, their roles are interwoven in numerous social structures and processes, and I aimed to study them as part of the complex healthcare system in Nigeria. As social processes are socio-culturally based and highly contextualised, I assumed an ontological perspective which accounted for multiple socially constructed realities to acknowledge participants' different perspectives.

CSA research is relatively new in Nigeria. To date, no theoretical framework or theory has been developed to study the issues and challenges HCPs face when identifying and responding to victims of CSA. My study thus required an open-ended, multifaceted and flexible approach to understanding this social issue in the Nigerian context in

depth. There is a need this subject to be vigorously explored so that a better constructed theory can be developed from multiple realities or perspectives.

After significant reflection on alternative models of research, I concluded that constructivism-interpretivism was the most appropriate framework for my study. My research therefore adopts a subjective and transactional epistemological stance which emphasises that knowledge is co-created through a mutuality of meaning between the researcher and the researched. I worked for ten years in Nigeria, and my personal and professional experience is the main impetus for this research. I have worked in a similar context as my participants, and therefore I was less likely to distance myself from my experience and knowledge. Nevertheless, it is important to emphasise that my role was determined by the participants' perspectives and understanding of the study concept. Denzin and Lincoln (2011) suggest that individual experience is subjective and that the meanings or interpretations drawn by each participant are likely to differ. Creswell (2013) assumed that subjective meaning or interpretation is not rapidly learnt or independent of human behaviour; hence, it cannot be explored objectively, so study designs must take methodological positions that enable the researcher and the participants to discuss and explore their understandings, meanings and interpretations of their social realities.

The chosen research paradigm must be congruent with the study's aim and the researcher's philosophical stance. This study refrains from the use of roundtables or focus groups, as CSA is a very sensitive issue and participants may not feel comfortable sharing their views in such settings (Denzin and Lincoln, 2011; Flick, 2015).

The Concept of the constructivist/interpretivist paradigm

The constructivist/interpretivist paradigm is a qualitative research paradigm originating from the work of Guba and Lincoln in 1994. The main characteristics of the paradigm include:

1. Relativist ontology, emphasising that reality is constructed intersubjectively from meanings, understandings and perceptions created experientially in a social context.
2. Transactional or subjectivist epistemology, which assumes that humans and their knowledge are inseparable. According to this philosophical stance, people cannot be separated from their knowledge; therefore, there is a significant connection between the researcher and the researched (the participants). The research/researched relationship is characterised by significant interaction, participation and cooperation.
3. Hermeneutic-dialectic methodology, which posits that individual meaning, understanding and perspective are hermeneutically constructed and that each is compared dialectically to reach a mutual consensus. This is an integrative theoretical framework that merges interpretive and critical elements (Glaser *et al.*, 2019; Krauss and Putra, 2005).

Constructivists/interpretivists agree that to understand the world's meaning or reality one must interpret it. The researcher must clarify the process of meaning construction or meaning making and explore how meaning is personified in the language and actions of the researched (Denzin, 1998; Taghipour, 2014). Constructivist philosophy is pragmatic and studies both verbal and non-verbal systems of constructing the world through science, art, and the humanities. The constructivist process of inquiry seeks to find a world that has been reconstructed.

This study aimed to develop a theoretical framework/model from rigorous exploratory conclusions which discuss the following questions:

1. How does the HCPs understand CSA and perceive the roles identify and respond to victims of child sexual abuse in Nigeria?
2. What are the issues and challenges associated with supporting victims of CSA in the multi-perspective context of Nigeria?
3. What are the implications of these challenges for practice, on HCPs and sexually abused children?
4. How can strategies be instituted to mitigate identified challenges, promote effective safeguarding, reduce the negative implications on practice and to improve the quality of care to service users?

CSA is a complex and sensitive public health issue with devastating consequences that has been under-researched and underestimated. In this study I took a relativist, contextual-subjective approach, where the researcher and the researched population reflect on and explore their understanding, meanings and perceptions of social phenomena to mutually co-construct knowledge and social reality. I believe that the research questions discussed above can be best answered through the constructivist paradigm.

4.5. Phase 3: Research strategy

This is the third element of the qualitative research process: the plans and procedures that offer theoretical justifications for selecting a specific approach to data collection and analysis. As in the other elements of the qualitative research process, Denzin and Lincoln (2011) have suggested various approaches to inquiring into a research

question. I chose theoretical strategies that were congruent with constructivism, reflecting the theoretical basis of my data collection and analysis.

Phenomenology and grounded theory are both congruent with a constructivist worldview (Creswell, 2013; Denzin and Lincoln, 2011; Maykut and Morehouse, 2005). The following two sections compare the advantages of each of these approaches**.**

4.5.1. Phenomenology

Phenomenology either describes (according to Husserl's eidetic position) or interprets (according to Heidegger's hermeneutic position) the human lived experience (Creswell, 2013; Holloway and Galvin, 2016). It stresses the world as lived and experienced by an individual and that reality cannot be separated from that individual. Phenomenological research focuses on 'the structure of experience, the organising principles that give form and meaning to the life world' (Laverty, 2003, p. 27), but cannot generate a theory to address the gap in the CSA literature. I sought to explore all aspects of my research questions, moving from descriptive to interpretative approaches and emphasising historical meaning and the development of experience, as well as cumulative effects at the individual and social levels. Laverty (2003) describes phenomenology as foundationalist: it seeks a correct answer, a valid interpretation of texts that does not depend on the interpreter's biographical, social or historical position. I aimed to make my interpretative process relevant by demonstrating the mutuality between the participants and myself in co-constructing knowledge and a social reality. As I was undergoing a vigorous interpretive process to create a theory from the participants' perspectives, and given my professional socio-

cultural background, I was unlikely to distance myself from their perspectives and their understanding of the studied social phenomenon.

Furthermore, the complex philosophical underpinnings of phenomenology have faced criticism (Holloway and Wheeler, 2013), along with the concept of 'bracketing' (Flood, 2010) and some phenomenologists' unsophisticated methods of data collection. The phenomenologist approaches brackets, or sets aside, one's philosophical stances, biases and assumptions to protect the research from the imposition of the researcher's assumptions. I wanted to engage in a process of self-reflection with my philosophical assumptions embedded in and essential to the interpretive processes, incorporating my experience and explicitly claiming the ways in which my position and experience related to the subject being studied. I kept a reflective journal to assist in the processes of reflection and interpretation and in developing a theory. For these reasons, I did not take a phenomenological approach to this study.

4.5.2. Grounded theory

Grounded theory (GT), in contrast to phenomenology, extends beyond description to the inductive generation of theories from empirical data and explains both basic and complex social processes or interactions (Creswell, 2013). According to Charmaz (2014), grounded theory is a systematic, established, yet flexible procedure for collecting and analysing qualitative data to discover ideas and construct theories which are grounded in data. GT is used to uncover social processes such as relationships, behaviours, practices and group experiences. The theory was first developed in 1967 by Glaser and Strauss in a study entitled 'Awareness of Dying', which constructed a

theory grounded in systematically collected and analysed data. This is a set of methods to generate an inductive theory in a substantial area.

Features of grounded theory

1. Data collection and analysis occur simultaneously.
2. Identification, categorisation and analysis of codes developed from data ensures that the theory is data-driven.
3. No use of pre-existing theory.
4. Theoretical sampling ensures that theory develops from experts.
5. Abstract categories are constructed inductively.
6. Social processes are discovered in the systematically collected data.
7. The identified categories are integrated into abstract concepts in a theoretical framework (Charmaz, 2014).

GT can capture complexity, is well-connected to practice and supports the establishment of theories in new substantive areas while reviving existing theories (Birks and Mills, 2015; Charmaz, 2014). It is widely used in education, nursing, and psychology (Belgrave and Seide, 2019; Holloway and Wheeler, 2010).

Having identified and explored the basic concepts and features of both phenomenology and grounded theory, a methodological approach was selected based on the study's aims and the constructivist paradigm. As the study was intended to develop a theoretical framework for understanding the studied social process and phenomenon, Charmaz's GT approach was used.

Why grounded theory?

1. CSA is a complex and sensitive phenomenon and its exploration requires a systematic and rigorous methodology.

2. I make of grounded theory concepts to explore how HCPs identify and respond to sexually abused children. This includes exploring HCP's understandings of associated issues and challenges and the implications of this on their practice. Their opinions of best practice for handling CSA cases are also important. This is a broad and open inquiry with multiple perspectives that requires a sophisticated method to generate a substantial theory.
3. The issues and challenges associated with CSA which HCPs face are under-researched and knowledge should be expanded. Therefore, grounded theory is the most appropriate approach as it is particularly valuable when investigating previously unexamined topics; no theory exists on this topic in Nigeria. Additionally, GT can bring structure and rigour to the analysis of qualitative data (Foley and Timonen, 2015).
4. This study seeks to unearth the day-to-day processes experienced by many purposively selected HCPs. Grounded theory is appropriate for this study because it addresses the overall questions of how and why a process is happening and the issues and challenges associated with it by exploring experiences, descriptions and interpretations of the phenomenon.

Birds and colleagues (2013) identified various versions of grounded theory methodology, all of which focus on developing theories. However, there are two main approaches to grounded theory: objectivist GT and Charmaz's constructivist GT. Table 6 presents a comparison of these two main approaches. The first version of grounded theory I discuss is the version presented by Glaser in 1978, followed by Charmaz's constructivist version.

Objectivist grounded theory: The Glasserian approach

The Glasserian approach to grounded theory is based on an etic position (Taghipour, 2014), rooted in post-positivist theoretical assumptions and epistemology, and focuses on objectivity and external reality (Levers, 2013; Mills, Bonner and Francis, 2006). This worldview causally links objectivist epistemology and quantitative approaches. As my epistemology is subjectivist, I considered the objective grounded theory approach inappropriate for this study. Objective grounded theory treats data as factual and assumes that the theory already exists; therefore, the researcher is passive and focuses on discovering an existing theory from unbiased observer data. I disagree with objectivist grounded theory, as it assumes that I should seek to remain separate and

Table 6: Comparisons and contrasts between OGT and CGT (adapted from Charmaz, 2014)

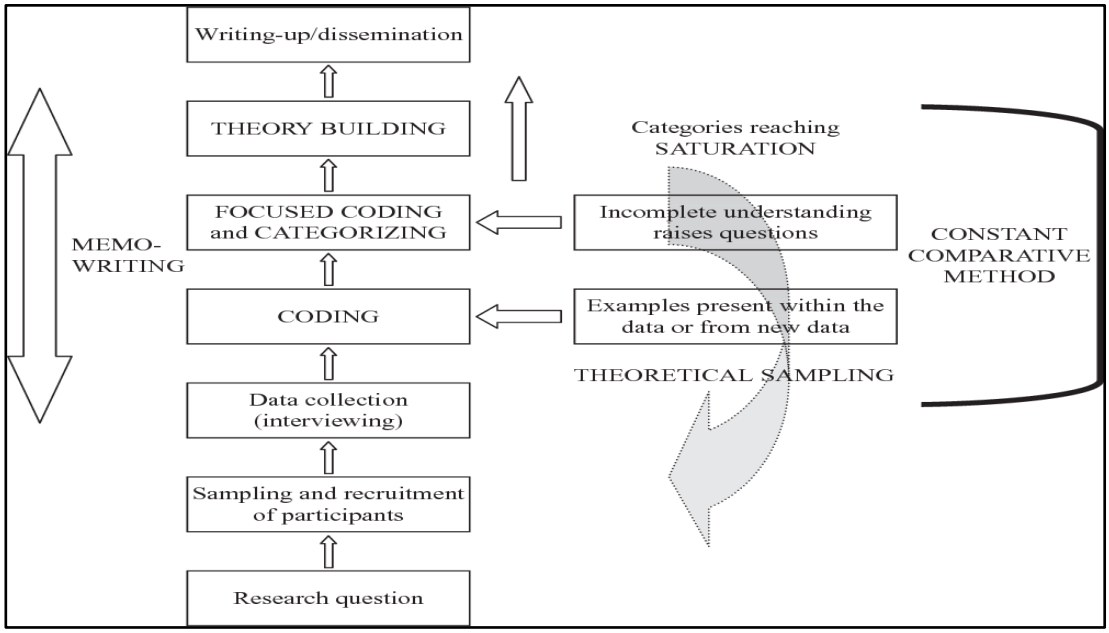
Objectivist Grounded Theory (OGT)	**Constructivist Grounded Theory (CGT)**
Foundational Assumptions ● Assumes the observer's neutrality, passivity, and authority ● Assumes an external reality awaiting discovery ● Views the representation of data as unproblematic ● Assumes that conceptualisations emerge from data analysis	**Foundational Assumptions** ● Assumes that the observer's values, priorities, positions, and actions affect their views ● Views the representation of data as problematic, relativistic, situational, and partial ● Assumes mutual construction of data through interaction ● Assumes multiple realities ● Assumes that the researcher constructs categories
Objectives ● Aims to achieve context-free generalisation ● Aims to create a theory that fits, works, has relevance and is modifiable ● Aims for parsimonious abstraction and conceptualisations that transcend historical and situational locations	**Objectives** ● Aims to create a theory that has credibility, originality, resonance and usefulness ● Aims for an interpretative understanding of historically situated data ● Views generalisations as partial, conditional, and situated in time, space, position, action and interaction ● Specifies a range of variation
Implications for Data Analysis ● Prioritises the researcher's analytic categories and voice ● Sees emergent categories as forming the analysis ● Views data analysis as an objective process ● Sees reflexivity as a potential data source	**Implications for Data Analysis** ● Seeks and represents participants' views and voices as integral to the analysis ● Views co-constructed data as directing the analysis ● Acknowledges subjectivities throughout the data analysis ● Engages in reflexivity throughout the research process

distant from research participants and their realities, and the theoretical philosophy underpinning it does not align with my constructivist paradigm (Charmaz, 2014).

Constructivist grounded theory

Constructivist grounded theory is based on an emic position (Taghipour, 2014). This is Charmaz's approach, rooted in the belief that concepts and ideas are constructed and not discovered. The researchers co-construct the data by adopting a position of mutuality and partnership with participants (Charmaz, 2014). It is an inductive, comparative and open-ended approach that employs theoretical sampling, continuous comparative analysis and memo writing, until the researcher achieves theoretical saturation and a theory has been completely developed. Researchers undergo vigorous processes to create a theory through the participant perspectives and interpretations embedded in the collected data. Constructivist grounded theory suggests that perception of social realities depends on mutual understanding between the researcher and the participants (Charmaz, 2014), which cannot be separated from their social, cultural and personal backgrounds. My participation in this research was intended to co-create and establish theory from my participants' views and perspectives. As the researcher in this study, on reflection I realised my similarity with the participants in terms of my background, socioeconomic level and cultural and professional context. My role in the analytical construction of the theory is crucial and can only be achieved with CGT. After significant consideration, I chose constructive grounded theory as the most appropriate approach for this topic. Figure 7 presents the diagrammatic process of using CGT, adapted from Charmaz (2014).

Figure 7: Visual representation of constructivist grounded theory



Source: Adapted from Charmaz, 2014

Data collection methods for grounded theory

The approach to the data collection process remains an important design element of the research process as it determines the knowledge to be constructed. According to Denzin and Lincoln, data collection processes include interviews, focus groups, observation, artefacts, documents and records, visual methods, autoethnography, data management methods, computer-assisted analysis, textual analysis and applied ethnography. I adopted a data collection method suitable for the objectives of this study and appropriate for the selected grounded theory strategy: individual interviews. The aim was to capture analysable, high-quality evidence to formulate a well-grounded and reliable theory that could answer the research questions. According to Flick (2015), qualitative interviewing is a prominent and omnipresent social science research method that explores participants' experiences in contemporary society in depth. Salmon (2015) describes individual interviews as one-to-one interactions between the participants and the researcher which act as a 'window' into an individual's lived experience. Each individual experiences life uniquely and is connected to their society

by the interpretation and reinterpretation of their experience through the lenses of identity, previous experience, memory and culture. This facilitates the co-creation of meaning with participants by re-forming their perceptions of the events and experiences being studied (King, Horrocks and Brooks, 2019). Focus groups were considered unsuitable for studying the subject this research focuses on, as CSA is a very sensitive issue and participants might not feel comfortable sharing their views in open discussions (Denzin and Lincoln, 2011; Flick, 2015). In addition, there may be political or personal repercussions if views are felt to be contentious. Therefore, I considered individual semi-structured interviews to be the most appropriate approach to data collection, as I wanted to explore healthcare professionals' experiences and their perspectives on identifying and responding to victims of CSA, the associated challenges and the effects on their practice.

4.6. Summary

This chapter presents the methodological framework for the current study. It begins by comparing the two main forms of research design, the qualitative and quantitative, and justifies employing an exploratory qualitative approach and a constructivist paradigm. The chapter then sets out the details of my personal life and how they influence the philosophical stance which influenced the research design, theoretical frameworks and data analysis used in this study. The chapter concludes with an explanation of suitable data collection approaches for working within grounded theory. The data collection and analysis process for this study will be discussed in detail in the next chapter.

CHAPTER FIVE: RESEARCH METHODS

This chapter presents details of the methods used in this study. It explains the research design and the process of obtaining ethical approval, recruiting participants, and collecting and analysing empirical data. It also outlines the research setting, inclusion and exclusion criteria, purposive-theoretical sampling, and the principles of grounded theory along with their application to this study. The chapter also discusses the research population and settings, participant recruitment processes, data collection, data analysis, and evaluation methods. Finally, the chapter describes my reflective journey, outlining my role as a researcher and the issues and considerations that occurred throughout the research process. The criteria used for drawing conclusions from qualitative research are discussed, as well as the researchers' reflective process during data collection and analysis.

5.1. Design

This study used a qualitative design and a grounded theory approach (see chapter 4, section 4.5 for a detailed description of grounded theory) to understand HCPs' perception of their professional practice of supporting sexually abused children and the associated challenges. The study also explored the meaning attached to their experience of social interactions and processes.

5.2. Ethical considerations

The study was approved by the Ethics and Governance Committee of the University of Sheffield in July 2020 (Appendix 3.1). I obtained ethical approval from the ethical committees from each institution involved in the research to ensure that it followed the

ethical principle of involving human participants and adhered to the research guidelines of all institutions involved in this study. The study involved two tertiary hospitals and one sexual assault referral centre (SARC), along with its partner organisations, in Nigeria. Following each of the institutions' guidelines, an appropriate ethical approval, a study proposal with supporting documents such as ethical approval from my university, an information sheet, consent forms and an invitation letter were submitted, reviewed and approved by each institution's ethics committee.

5.3. Study setting

This study was conducted in two selected tertiary hospitals and one SARC in Nigeria. SARCs are well-known institutions that specialise in providing comprehensive services to victims of CSA in Nigeria and employ diverse health and social professionals (Sodipo *et al*., 2018). Victims undoubtedly require multi-disciplinary services, which most healthcare institutions do not specialise in. While the healthcare system and most hospitals in Nigeria do not provide special departments for CSA victims, the two hospitals selected for this study practice integrated care of CSA victims and have even evaluated their services by conducting research in this field. In addition, the three settings were selected to ensure representation of the main three ethnic groups in Nigeria. This was necessary to explore this social phenomenon within the divergent socio-cultural context of Nigeria.

5.3.1. Description of settings: Hospitals

The two hospitals are located in the two largest cities in Nigeria, both of which are highly metropolitan, urbanised, and home to diverse people and cultures. Both state-of-the-art hospitals are flagship tertiary healthcare institutions for research, training

and services, with extensive community-based outreach activities in the suburbs offering primary and secondary healthcare services. In these hospitals, CSA victim care falls under the emergency, gynaecological and paediatrics department within the medical and social services department from which research participants for this study were recruited. Like other tertiary hospitals in Nigeria, both offer preventive, promotive and curative services. The core CSA-related services provided by the medical and social departments are crisis intervention, psychological care or counselling, social support, advocacy and securing accommodation for clients. The hospitals maintain a legal team to investigate cases of CSA, which collects evidence for cross-examination in court and proving its validity. The legal team can provide confidential advice and support to victims who are interested in subjecting perpetrators to the litigation process and is mandated to provide evidence in court to establish whether or not sexual abuse has occurred. However, legal personnel from these hospitals cannot represent victims in court because they are contractually employed by the hospitals and are therefore not independent legal counsels; they can only represent the hospitals if they are involved in any legal cases.

5.3.2. Sexual assault referral centres (SARCs)

The third setting is a renowned government funded SARC located in a state predominantly populated by the Ibo ethnic group in south-eastern Nigeria. This centre provides specialist medical, forensic, psychological, legal and rehabilitative services to victims of rape, sexual assault and other gender-based violence. It provides comprehensive health, social and legal services at no cost to all victims of sexual assault. Generally, SARCs are either privately owned or government-funded and provide person-centred multidisciplinary care for people who have experienced sexual

crimes. The multi-disciplinary staff consists of consultant family physicians, resident doctors, child psychologists, counsellors, nurses, social workers, trauma management experts, child advocates, lawyers and other support staff, all of whom have undergone training on CSA case management and forensic medical examination. SARCs function optimally when appropriately staffed, run according to an agreed core model of care—including but not limited to national and multi-agency guidelines and care pathways that are directly linked to forensic and police services—and supported with designated and sustainable finances. Additionally, SARCs provide individual and community education, awareness, and sensitisation and risk reduction programmes. These organisations and the professionals within them, with their wealth of experience, contribute to the development, evaluation and implementation of national strategies on domestic abuse, sexual and gender-based violence. There are currently 30 SARCs serving 36 states in Nigeria, the first one was established in 2013. Establishing SARCs and criminalising CSA in all the Nigeria states remains a problem, as 11 states have not domesticated the Child Right Act (2003). In addition, recent surveys of SARCs have indicated specific challenges including limited facilities across the country, weak government commitment and a lack of the necessary infrastructure and funding for optimal service.

5.4. Inclusion and exclusion criteria

For this study, HCPs aged 18 to 60 years of all genders were recruited. Only registered HCPs (including nurses, doctors, social workers, psychologists, and counsellors) with at least one year's experience, were invited to participate. This criteria was to reduce potentially wide gaps between participants' level and quality of knowledge and experience, and to make sure that each participant had enough experience to reflect on

their practice and associated challenges and recommended pragmatic approaches to mitigate these challenges. For these reasons, diploma and graduate nurses, certified general practitioners, medical officers and specialist doctors and nurses who were currently working with sexually abused children were included and students and specialists in non-child-related fields were excluded. In addition, four child advocate lawyers (who were professionals who typically represent or give a voice to children whose concerns are not being heard and interests not being represented) were included to validate emerging themes.

5.5. Sampling

This study employed both purposive and theoretical sampling methods, in line with the grounded theory approach. Purposive sampling facilitated the identification and selection of research settings and participants based on their characteristics—in this case, as HCPs directly caring for and supporting sexually abused children—to fit the parameters of the research questions (Charmaz, 2014; Etikan, Musa & Alkassim, 2016). Another important reason for using purposive sampling was the need to purposefully select data sources that would enrich the study's concepts, categories and theories.

5.5.1. Theoretical sampling

Theoretical sampling is fundamental to grounded theory design. It facilitates the evolution of theory and guides the selection of the criteria used to classify appropriate elements or themes in order to develop a data-driven theory (Charmaz, 2014). This form of sampling focuses on developed theoretical categories, not simple population representation. Birks and Mills (2015) define theoretical sampling as 'the process of

identifying and pursuing clues that arise during analysis in a grounded theory study' (p. 68).

As explained previously, purposive sampling was first adopted to recruit and select participants with specific characteristics that would reveal tentative theoretical categories from the data. I then used theoretical sampling to seek participants who could provide data to fill in the identified gaps and to help reach theoretical saturation. This process was facilitated by analytical coding, constant comparison and memo writing which enabled me to critically reflect on the emerging data and identify areas to further explore. I selected further participants on the basis of the emerging themes and tentative categories that were defined in the first stage of data analysis. Theoretical sampling helped me make conscious decisions about which questions to ask and how to ask them in subsequent rounds of data collection, the criteria to be used when choosing more participants to interview, and which categories required further development.

Theoretical sampling was first applied to discover variation and identify gaps in the collected data, and to set criteria for choosing and recruiting subsequent participants to fully develop the themes. For example, the analysis of interviews with hospital HCPs revealed that their capacity for legal support was limited when compared with HCPs from SARCs. The former did not handle the legal aspects of caring for victims of CSA; the cases were instead referred to the hospital's legal team for legal proceedings. At that point, to further develop the theoretical category of 'responding to victims of CSA' and analyse the divergence in experience, the legal team was interviewed to elucidate their practices of aggregating and validating evidence and securing justice for the victims of CSA. Theoretical sampling was also used to clarify, distil and saturate concepts.

Theoretical sampling was used throughout the data collection and analysis process to select participants and collect data based on emerging theoretical ideas and categories as the theory developed (Charmaz, 2014; Creswell, 2013). This sampling method was a strategic tool used to recruit participants who could provide diverse perspectives on the studied social phenomenon. Collecting data to generate theory is a daunting aspect of grounded theory; however, this strategy directs the identification and collection of relevant data to develop and verify categories in the emerging theory (Bryant and Charmaz, 2019; Charmaz, 2014). It also helps to focus the data collection and analysis. Theoretical sampling and its application in this study will be discussed further in this chapter.

I selected HCPs who were working in SARCs as participants because they specialised in treating the victims of CSA in Nigeria. When choosing research units, I considered that several important aspects of caring for sexually abused children are time-dependent: for example, resuscitation, the collection of forensic evidence, the repair of trauma or bruises, and post-exposure prophylaxis for HIV and emergency contraception. I recruited HCPs from the general outpatient clinic and the Paediatric, Accident and Emergency and Gynaecological units of the two selected hospitals, because these units provide initial care to traumatised children and treat most of the complications resulting from CSA (Hassan *et al.*, 2016; Ige and Fawole, 2012; Olatunya, 2013).

5.5.2. Sample size

In grounded theory, data collection and analysis occur simultaneously, with the aim of generating sufficient data to illuminate the patterns, concepts, categories and dimensions of the studied phenomena. This means that early interviews should be

analysed and subsequent participants selected and interviewed to elaborate on the ideas, themes, challenges and gaps in the developing theory. A qualitative study requires in-depth interviews to generate rich data for analysis and a sample size that allows deep engagement with the data. Thomson (2011) conducted a content analysis of 100 articles that used interviewing as a data collection instrument and grounded theory as their analytical framework. Thomson's findings indicate that sample size depends on data saturation; however, the point of theoretical saturation can be affected by the researcher's ability, the sensitivity of the studied phenomena, and the scope of the research question.

Therefore, sample size cannot be predetermined as it depends on the emerging theoretical categories. Securing a sample size that will generate sufficient data becomes imperative. In this study, I followed the Glaser and Strauss (1967) concept of theoretical saturation, which states that the sample size is sufficient when new data no longer generates new ideas and themes which contribute to constructing the theory. For example, in this study, five HCPs were initially interviewed, followed by 21 more interviews as I developed the theory. I expanded the sample size until new interviews supplied no new data, reaching a total of 26 participants. One of the instances in which theoretical sampling was operationalised was when a participant acknowledged that in developed countries the definition of CSA included non-contact forms of abuse; however, he said that applying a similar definition in Nigeria would make everyone a perpetrator. When further asked if non-contact forms of CSA were recognised in Nigeria, his response indicated that they are not overtly recognised. To clarify and distil this concept, more participants were recruited and asked about the perception of CSA in Nigeria, which showed that society did not regard non-contact sexual abuse as a form of sexual abuse and revealed discrepancies between the HCPs' and society's

perceptions of CSA. After 26 interviews, no new theoretical ideas were being generated, no major questions remained unanswered and my theory was fully developed.

Theoretical sampling helped me to explore and refine categories, providing a basis for recruiting specific participants for data collection and directing the analysis and development of emerging concepts, thereby facilitating my decision about reaching data saturation. In a certain interview a doctor explained that, in all cases, after medical care had been provided victims were referred to the hospital legal team and the medical team felt incapacitated afterward as they were unable to assess the victims and see how the court proceeding was unfolding or whether it was having negative impacts on the victims. At this stage, I sought and received permission to interview four legal practitioners who were also child advocates in the hospital in order to explore the litigation process.

5.6. Data Collection

Data collection is a mandatory, pivotal and fundamental aspect of research; however, it remains a daunting task with many aspects to consider. Data collection methods include literature reviews, case studies, observation, focus groups, interviews, surveys, checklists and reflections (Flick, 2015). Details about the methods, style, procedure and strategy of data collection used in this study are discussed in this section.

5.6.1. Participant identification and recruitment

I initially planned to travel to Nigeria to contact stakeholders from the selected institutions and discuss the research proposal, including the aims, the scope of the study, potential participants and methods and their organisations' involvement.

However, due to the outbreak of the Covid-19 pandemic and the subsequent restriction of movement, I instead conducted this study online. The stakeholders (managers, representative and executive directors of SARCs and heads of hospital departments) were identified through colleagues working in their institutions and comprehensive internet searches. I then contacted the stakeholders by email and phone. I formally introduced myself and the research rationale and endeavoured to develop professional relationships with the stakeholders and reassure them of the integrity of this research.

Next, I conducted short online informal meetings with each stakeholder, in which I explained the research further, answered their questions and concerns, and built a rapport with them. As key organisational personnel, they could provide detailed information about seeking ethical approval from their organisations, robust perspectives about the research area, and assistance in accessing and recruiting other participants.

When potential participants showed an interest, I requested a phone call with them, followed by a brief visual meeting to introduce myself, acknowledge their commitment to responding to victims of CSA in Nigeria, discuss the information sheet (Appendix 3.2) and encourage them to ask questions and verbalise their concerns. I focused on developing a rapport, emphasised their voluntary participation and right to withdraw, and ensured that interviews were scheduled at their convenience. Any questions raised were answered promptly and transparently to further gain their trust. After one week of brief virtual meetings, I contacted all participants to gain consent and to check their availability. Participants were asked to sign a consent form, complete a participant demographics form, scan both documents and return them to me by email. I then confirmed dates and times for formal semi-structured individual interviews based on their availability.

Invitation letters, information sheets, consent forms and participant demographics forms were sent to the stakeholders, each with the allocated ethical approval number and study duration. The stakeholders of the selected hospitals and SARCs approached and briefed potential participants on my behalf, providing information sheets and invitation letters containing my contact details so that potential participants could inquire about the research directly. Additionally, invitation letters were displayed in nurses,' doctors,' social workers' and psychologists' offices across the hospital and on notice boards. Interested participants were invited to contact me by phone or email.

5.6.2. Participant demographics/characteristics

A total of 26 participants including eight (30.7%) males and 18 (69.23%) females were interviewed. Information about each participant was collected through the participant demographics form which provided insight into the gender, age group, professional qualification, educational level and experience level (as years since qualification) of each participant. Table 7 presents the overall demographics of these participants and Appendix 3.3 summarises each participant's information using pseudonyms. Their age ranged from 30 to 59 years with a mean age of 43 years. Participants were purposefully recruited from all six geopolitical zones of Nigeria. The highest number of participants (9, 34.6%) hailed from the Southwest, followed by seven from the Southeast. The participants included five doctors, seven nurses, three social workers, three psychologists, three counsellors and five legal practitioners who were child advocates. The majority of the participants (16, 61.5%) worked in SARCs, while 12 (46%) worked in hospitals. Many of the participants had worked in accident and emergency units, child emergency units, maternal and child units, and paediatric units, while others had worked in either public or private SARCs.

Additionally, many participants were also active members of child protection networks in Nigeria. These networks included Rule of Law and Anticorruption (RoLAC) programmes, Northerners CSA Response Network, Violence Against Person Law

Table 7: Participant demographics

Characteristics	**N (Percentage)**
Total Participants	26 (100%)
Gender	
Male	8 (30.7%)
Female	18 (69.23%)
Age Group	
30-39	8 (30.7%)
40-49	11 (42.3%)
50-59	7 (26.9%)
Marital Status	
Single	6 (23%)
Married	19 (73%)
Separated	1 (3.8%)
Geopolitical Zone	
North-Central	2 (7.69%)
North-West	3 (11.5%)

North-East	3 (11.5%)
South-Central	3 (11.5%)
South-East	7 (26.9%)
South-West	9 (34.6%)
Discipline/Specialism	
Doctors	5 (19.2%)
Nurse	7 (26.9%)
Social worker	3 (11.5%)
Psychologist	3 (11.5%)
Counsellor	3 (11.5%)
Legal Practitioner/Child advocate	5 (19.2%)
Highest Level of Education	
Diploma	3 (11.5%)
Bachelor's Degree	15 (57.6)
MSc	7 (26.9%)
PhD	1 (3.8%)
Workplace	
SARC	16 (61.5%)
Hospital	12 (46.1%)
Years of Experience	

1-10 years	17 (65.3%)
11- 20 years	8 (30.7%)
21 and above	1 (3.8%)

Manage Committee, African Network for the Prevention and Protection Against Child Abuse and Neglect Nigeria Chapter (ANPPCAN) and International Network for Child Protection, among others. Two members were active clinical practitioners and had conducted research on gender based violence, including CSA.

5.6.3. Developing an interview guide

I followed Maykut and Morehouse's (2005) procedure for developing an interview guide, as shown in table 8. This interview guide is particularly effective when exploring phenomena about which little is known and is facilitated by brainstorming skills and concept mapping (Flick, 2015). According to Charmaz (2014), grounded theorists embark on research journeys with the intent to interview individuals whose experience and knowledge can illuminate the research question; carefully crafted and conducted interviews can be catalysts in this process. These guidelines facilitated the creation of open-ended, semi-structured questions that ranged from the general to the specific in order to help participants reflect on and describe their day-to-day practices of identifying and responding to victims of CSA and the associated challenges and implications, along with possible and realistic best practices. This interview guide contains related questions and probes, acting as reminders for the researcher to stay focused while allowing a certain amount of flexibility to probe interviewees' ideas and hence guide the interview process. Consultations with stakeholders also provided guidance which helped to align the questions with each discipline involved in identifying and supporting CSA victims. Social constructionists suggest that semi-

structured interviews are interactions between the researcher and interviewee in which both construct a narrative version of the social world (Flick, 2015; Salmon, 2015; Silverman, 2020). Thus, this study employed semi-structured interviews supported by occasional prompts and a rapport with the interviewee.

Table 8: Procedure for developing the initial interview guide

Steps	**Research activities**
1	Write out focus of enquiry (in question form)
2	Brainstorm phrase, word, concept, questions, topics relevant to focus of enquiry
3	Observe similarities, group similar phrases, concepts, ideas and questions to form potential categories of inquiry
4	Decide which category to include in interview schedule
5	Develop several open-ended questions for each category of inquiry and consult supervisors
6	Select most interested questions in exploring and arrange into useful sequence
7	Practice interviews with people who have similar characteristics to the participant and those that can provide feedback and assess interview skills
8	Make necessary review to interview schedule, receive feedback from supervisors
9	Begin interview

Following Maykut and Morehouse (2005), I developed a six-phase approach to the in-depth interviews to comprehensively answer the research questions. The first phase of each interview was introductory and focused on eliciting comprehensive information about the interviewee's professional and educational background, personal motivation and practice. This information could be coordinated with that collected from the

demographic forms to help the researcher put the interviewee's experience and perspective in context. The second phase explored the HCPs' understanding of CSA. The third phase addressed current practices of identifying and responding to CSA victims, and the fourth phase explored the associated issues and challenges. The fifth phase examined the implications of the challenges for practice, victims, families and society. The sixth and final phase discussed realistic practices and strategies that could be adopted to manage those challenges and improve victims' experiences.

As a qualitative researcher using a grounded theory approach, I primarily employed intensive interview strategies and sometimes employed informational and investigative interviewing as my study developed. The intensive approach creates a flexible but controlled interaction space that allows ideas and issues to emerge and immediately be followed up to co-construct the interview (Charmaz, 2014). Asking questions is an art that requires practice and persistence to improve in (Maykut and Morehouse 2005). My final interview guide (Appendix 3.4) was developed through knowledge acquired from the literature review, pilot study, initial interview reviews, initial coding, reflection, and consultation with my supervisors.

5.6.4. Pilot interviews

Two pilot interviews were conducted online in September 2020. The participants received an information sheet, demographic form and informed consent form, and I obtained ethical approval from both participants in the pilot study. The interviews were conducted through Googlemeet, which automatically recorded the interviews, and data were stored in Google Drive. Each interview lasted 60 to 90 minutes. Data gathered in these interviews were not included in the final data analysis.

The pilot interview gave me experience in conducting in-depth, semi-structured interviews and building rapport with participants, and improved my interviewing skills. It also helped to identify and address potential ethical and practical issues that could have affected the main study and be adjusted for successful subsequent interviews.

During the pilot interviews it became evident that the participants were conversant with the issues and challenges they faced in their roles supporting sexually abused children but had not reflected deeply on the implications of these issues. Therefore, prompts were added to explore the implications of these challenges for their practices, child victims, families and society. The participants were eager to discuss the impetus for their practice and their day to day activities from a personal perspective. These insights helped me shape and adapt the interview guide to engage with and empower my participants.

The pilot interviews allowed me to self-reflect on my interview techniques; I asked open ended questions, monitored the pace and tone of my voice, and increased my sensitivity to the types of interaction that occurred in online research settings. It is important to clarify that data from these two pilot interviews were not used in the analysis and findings: the main objective of these pilot interviews was to determine whether the interview questions were appropriate and assess the viability of the research tool.

5.6.5. Individual semi-structured interviews

Salmon (2015) describes individual interviews as one-to-one interactions between the participants and the researcher which act as windows into an individual's lived experience. Each person experiences life uniquely and, significantly, creates meaning

by interpreting and reinterpreting their experience through the lenses of identity, previous experience, memory and culture. The interviews facilitated the co-creation of meaning with my participants by means of reviewing their perceptions of events and experiences associated with responding to victims of CSA and the associated challenges (King *et al.,* 2019).

Online interview process

Online interviews have been described as a viable alternative to face-to-face interviews (Bauman, 2015; Salmon, 2015). Salmon (2015) has discussed a conceptual framework for emphasising reliability when conducting online interviews. Participants were instructed to return a signed copy of the consent form with information about the study and a completed demographic form before the scheduled interview date. All relevant documents were written in English and the interviews were conducted in English, the official language in Nigeria, which all the HCPs felt fluent and comfortable communicating in. However, a few participants used Yoruba, their first language, during the interviews to express an adage or a general truth either about the Nigerian context or the challenges they had experienced, when they felt this was the best way to express themselves. This posed no difficulty as my first language is Yoruba, and I was able to transcribe these phrases, as necessary.

Interviews were conducted through Google Meet, which securely recorded and stored each interview without recourse to third-party software. Using automated software that recorded both audio and video was a great relief: I worried less about losing data and the quality of the recordings. This allowed me to focus on probing ideas, clarifying understanding, attentively listening to participants' narratives and emerging emotions, and remaining sensitive to the context.

Before each interview began, participants were reminded that their participation was voluntary and asked to inform me if they had any concerns, after which I was able to answer questions or offer reassurance. I introduced myself again and explained the aims of the research and the interview question segments to the participant before asking their permission to record the interview. I started the interviews by asking participants about their educational and professional backgrounds. During the interviews, participants were prompted to reflect on the challenges they faced in their roles and to provide in-depth narratives. I carefully selected thought-provoking questions to subtly foster the participants' reflections and elicit their perspectives. I also allowed periods of silence throughout the interview to further facilitate the participants' reflections and narratives. As this research investigates a sensitive topic, I was careful to respect and acknowledge their assistance to victims. I made sure that I was non-confrontational and judgemental and asked encouraging questions without being overly direct.

At the end of each interview, participants were asked to share any aspects they found interesting or considered important, especially anything related to the topic that they felt had not been covered sufficiently and were invited to ask me questions. This added to the richness of the data, sparked ideas about the wider use of my research findings, and opened discussion about research areas to be explored and my plans for the future. The simultaneous recruitment of participants, collection of data and analysis helped identify other elements to be explored in depth.

I drew on my best human qualities and professional skills during the interviews to demonstrate empathy and respect, maintain trust and remain sensitive to the context. I employed thoughtful questioning, reflective listening and sensitive probing to navigate the interviews. In addition, I had a predetermined set of sub-questions, some of which

I omitted when I felt that participants had already answered them. Although I allowed flexibility, I focused on the most important questions, not necessarily in the same order in each interview, to explore controversial topics or aggregate ideas and reach theoretical saturation. I considered the implications of a non-physical environment and made every effort to fully engage my interviewees.

To ensure that I had baseline findings from all the disciplines recruited for this study, I first recruited and collected data from two participants from each of the five targeted disciplines: doctors, nurses, social workers, psychologists and counsellors. These early interviews included both gatekeepers and stakeholders, which worked to further facilitate the research process as being interviewed seem to alleviate their concerns about the research and they were then more useful in recruiting other participants for the study. I commenced data analysis by identifying and labelling themes and codes and continued to recruit from all five disciplines to clarify, differentiate or corroborate emerging codes and concepts and thus develop the theory. Recruitment, data collection, and analysis therefore occurred simultaneously, following the iterative principle of grounded theory. Both recruitment and data collection moved from purposive sampling to theoretical sampling until I reached data saturation. This will be discussed in detail in the next section.

Conducting online interviews required significant effort to engage my participants and found it impractical to take notes. This is contrary to Glaser's argument that taking notes during an interview enables a grounded theory researcher to record essentials without becoming lost in details (Glaser, 2001, as stated in Charmaz, 2014, p. 91). Notes cannot be sufficient to record the participant's tone, silences, emotions, statements and flow of response. Charmaz (2014) recommends audiotaping or video recordings to capture changes in tone and tempo, use of silence, non-verbal actions

and the flow of responses to questions, and suggests that taking notes during interviews can result in the loss of situational details and negatively impact the construction of the interview. Other important reasons for the use of automated digital recording included to ensure storage and accessibility, unlimited replay to uncover non-verbal cues and expressive behaviour, and easy transcription for data analysis (Charmaz, 2014; Tessier, 2012).

I embraced constructivist perspectives and treated the interviews as emergent interactions which facilitated social bonds and built mutuality which allowed the exploration and understanding of emergent ideas and the validation of experience, rather than mere data collection. I endeavoured to ensure that the interviews were conducted with good internet connectivity and minimal disruptions. I confirmed that the participants had the necessary devices connected to network services. I requested that participants each secure a private, safe space where they would not be disturbed or overheard. However, two interviews were rescheduled due to poor internet connections and some were interrupted by colleagues at work, family members (especially children), and unexpected visitors.

Data saturation

Theoretical saturation distinguishes grounded theory from other methodologies and indicates a point in the analysis at which collecting new data no longer sparks new theoretical insights or reveals new properties of the core category. At data saturation stage, the central category's properties and dimensions have been fully developed with no new properties emerging (Charmaz, 2014; Taghipour, 2014). Charmaz clarified that theoretical saturation should not be confused with the repetition of events, actions, or statements. This idea is similar to Glaser's (2001, as stated in Charmaz, 2014) explanation that saturation is not the identification of similar patterns in data but the

conceptualisation of a comparison of their incidence that yields different properties of the patterns, until no new properties emerge (p. 213). This process results in theoretical density that can be integrated into the hypotheses that form the basis for the grounded theory.

To ensure theoretical saturation in this study, I examined how I made comparisons between and within my data and categories, and how these comparisons illuminated theoretical categories. My analysis checked for the presence and directions of new conceptual relationships. Therefore, in this study, saturation was not simply assessed by sample size or the repetition of an incidence, process or concept but by 'theoretical sufficiency.' In the context of this study, theoretical saturation was reached when the categories and core theoretical models' properties, variations and dimensions had been fully developed. At that point, I had established the relationships between categories and no new properties emerged. In addition, my initial analytical work, including my codes, memos, categories and theoretical model, was presented to my supervisors to review how the categories developed from the collected data, and we engaged in reflective discussion of data saturation.

5.7. Data analysis

The process of analysing qualitative data is systematic, interactive and iterative. Analysis involves organising, condensing, interpreting and finding distinctive, logical patterns in raw data (Flick, 2015; Richards, 2014). Data analysis constructs knowledge about social phenomena as perceived in their natural context. As with data collection, there are numerous potential methodological approaches to analysing qualitative data, and the choice of methods depends on the researcher's philosophical stance and study objectives. According to Flick (2015), there are three main aims in analysing

qualitative data: to describe a phenomenon, to identify a basis for similarities and convergence, or to theorise about a social phenomenon. In this study, a bottom-up approach to data analysis was employed, which is often used in grounded theory to develop concepts that lead to theories (Charmaz, 2014). The analytical process remains the strength of constructive grounded theory and is used to maintain subjectivity when identifying emergent themes, ideas, categories and concepts and developing a theory (Charmaz, 2014, p. 247). This study followed Charmaz's (2014) critical steps of analysis to generate theory, and involved analytic coding, memo writing, theoretical sampling, continuous comparative analysis, theoretical sorting and saturation.

5.7.1. Analytical coding

Coding can be described as a pivotal link between the collected data and emergent theories to explain it (Charmaz, 2014; Flick, 2015; Tie, Birks and Francis, 2019). Coding is an analytical process of identifying concepts, similarities, divergence patterns and conceptual recurrences in data. Codes are words or short phrases assigned to capture a summative meaning attributed to text-based or visual data. They provide the basis and framework of analysis. In this study, I assigned codes to capture and summarise participants' responses and meanings and to generate a data-driven theory. Following Charmaz's (2014) classical grounded theory approach, this study employed two main coding phases: (a) the initial line-by-line coding or the naming of each transcribed line of data, followed by (b) focused coding, in which I used the codes with the most analytical meaning, or frequently occurring initial codes or phrases, to organise, categorise, sort and integrate many codes.

5.7.2. Initial coding: Line by line

Initial coding, in which words or groups of words in the data are identified and labelled, is the preliminary step of data analysis (Birks and Mills, 2015; Charmaz, 2014; Flick, 2015). I used line-by-line coding, which created an interactive process with the collected data to understand the participants' actions and experiences, as well as the context of their narratives. This form of coding helped me assess the data in depth. Additionally, I understood the theoretical ideas each line of the data suggested. Line-by-line analysis fragmented participants' narratives with labels to accentuate underlying meanings that I might have overlooked (Charmaz, 2014). Labelling helped me describe participants' actions, experiences and contexts and revealed their everyday lives and practices.

During the initial coding, I used gerunds to label the text line by line to preserve participants' actions and clarify meaning as it emerged from the data (Charmaz, 2014; Saldana, 2016). The analytical idea helped me swiftly identify actions and processes in the data. Saldana (2016) calls this usage of gerunds 'process coding'. It provides a way to define both observed and conceptual actions, such as changes in or the emergence of processes. I sometimes used in-vivo codes rather than gerunds by directly applying participants' phrases or words as independent initial codes. In-vivo codes remained a significant feature of coding in this study. Phrases and words were taken directly from the language and statements the HCPs used to encapsulate and emphasise their processes, actions, experiences and ideas (Charmaz, 2014). In-vivo codes were useful as they added analytical depth to the descriptive codes and allowed theoretical insight into the participants' direct experience of the processes involved in their practice and the associated challenges and implications, without requiring further abstraction. For example, the codes 'climbing out of the dark hole,' 'giving voice to

the voiceless,' 'battling incest,' 'traumatic to HCPs', 'walking through the child's mind' and 'feeling trapped and isolated' were phrases directly used by the participants.

The advantages of using the line-by-line approach in this study were cumulative. It served as a heuristic device that facilitated analytical thought, generated ideas embedded in participants' narratives, allowed thorough, active engagement with the data and allowed me to see the data from a new perspective, rather than creating a summative idea alone. This approach captured ideas that could have gone unanalysed and uncovered fundamental processes. Table 9 shows a sample of the initial codes from a participant's interview transcript.

Table 9: Initial coding

Mrs. Ugo (pseudonym), female, 45 years old, a social worker and CEO of a SARC, was asked about the challenges experienced from society in her role.	
Interview Transcript	**Initial Coding**
Of course. Because the culture, the religion, whatever, the norms, you know, we were wrong, when we change all these our norms, you know the cultural practices, it will help us a lot, because this stigmatisation is not just by anybody, it is by the society. You know? A woman was telling me, "Please don't push the case forward. How will my people feel? Well, how will my daughter get married?" You know, when people know that she was raped, then it will be hard for her to get married. And you understand that and you know our society now, when a young girl is being raped and is made open, when she is passing, everybody will be pointing at her, that girl that was raped, what do you want to go and do with her? She is now a public toilet, you know, that type of thing. So, this is what we need to change.	Unhealthy society cultures Need to change social norms Prevailing societal stigmatisation Parent begging HCPs not to prosecute Parent concerned about victim future Prosecuting brings negative publicity Social discrimination of victims Social stigmatisation of raped child Regarding victim as public toilet Seeing victim as dirty Requiring change in cultural

My initial codes were mainly descriptive, to capture meaning and provide insight into particular actions, and gerunds were used to elucidate actions. These codes included ‘striving culture of silence,’ ‘victim blaming’ and ‘reaching for voiceless.’

Although line-by-line technique was rigorous, time-consuming and generated many codes, I found it extremely useful for understanding my participants’ perceptions and experiences of the study phenomena. It identified gaps in my data and generated data-driven theory (Charmaz, 2014). After initial coding, the theoretical categories these data indicated were extended and defined through focused coding, as detailed in the next section.

5.7.3. Focused coding

Focused coding is the second phase of coding. The researcher focuses on the most significantly occurring codes that demonstrate analytical strength, and upgrades them to a tentative category (Charmaz, 2014; Flick, 2015; Richards, 2014). While I generated many codes that offered multiple directions for analysis, I needed to devise collective codes or choose from significantly recurring codes. Therefore, I began to create codes with greater analytic power: those codes that made the most analytical sense or could become central to a theory. Through this process, the initial codes were condensed and focused to generate important ideas, which expedited the analysis process without losing detail from the data and initial coding. This process made the focused codes more selective, directed and conceptual. It also directed my analysis by incisively categorising my data and initial codes.

At this stage of the data analysis, the transcripts were carefully revisited, reread and compared to previous codes, concepts and categories. Then, early codes were compared and contrasted against new data as I sifted through the transcripts to develop

meaning, ensuring abstraction and corresponding adequacy within the data. Comparison of the focused codes was useful for identifying the emergence, frequency and gaps of ideas in the data. These focused codes explain ideas, events or processes across the data and help categorise it overall (Charmaz, 2014).

My research involved collecting data across multiple research settings, moving from SARCs to hospitals and exploring the perspectives of different disciplines in healthcare. Hence, the continual comparison of the focused codes and concepts resulted in the identification of the differences and overlapping words between the participants' descriptions of actions during their narratives when discussing the same phenomena. For instance, when describing the process of responding to victims of CSA, members of each discipline described their roles based on priority and relevance to their field: 'providing psychological support,' 'conducting physical assessment,' 'aggregating evidence,' 'verifying aggregated evidence' and 'obtaining justice'.

The analytical process of focused coding and constant comparative analysis continued with theoretical coding, resulting in the collection of new data to further develop the properties and dimensions of the emerging categories until six theoretical categories emerged. For example, the theoretical category 'nature and process of practice' developed from focused codes such as 'confrontation from perpetrators' and 'threats from perpetrators;' disguising oneself for safety and fear of the unknown were implied in early narratives and were further explored and developed through constant comparisons with the focused code of 'professional vulnerability,' a subcategory of 'nature and process of practice.'

The process of developing focused codes continued to capture comparisons and connections and crystallise generated ideas. This process ran concurrently with constant comparisons and memo writing to construct the theoretical categories.

Constant comparative analysis is an analytical way to develop codes and categories, while memo writing is another crucial GT principle that captures connections and comparisons, creating an interactive space with data and ideas that are vital to the construction of theoretical categories (Charmaz, 2014; Saldana, 2016; Tie, Birks and Francis, 2019).

5.7.4. Constant comparative analysis

Constant comparative analysis is finding consistencies and differences in data by persistently refining codes, concepts and theoretical categories. It involves continual systematic movement between data, codes, memos and categories to confirm that the constructed theory is grounded in the data. According to Charmaz (2014), constant comparison is a method of analysis that generates successively more abstract concepts and theories through an inductive process of comparing data with data, data with code, code with code, code with categories and categories with concepts (p. 342).

Constant comparative analysis differentiates grounded theory approaches from other forms of qualitative methodology that are purely descriptive (Chamberlain-Salaun, Mills and Usher, 2013; Saldana, 2016). I began the process of developing focused codes and categories through constant comparison with the initial data and continued throughout the research process. Previously generated incidences and codes were compared with each other, and the compared codes were collapsed into related categories. Then, new codes and categories were compared with the categories and data previously developed during the analysis phases. This cyclical process required active inductive thinking to reach logical conclusions about the collected data.

Constant comparison increased the abstraction of my data analysis, as I repeatedly read and compared each interview transcript, the initial codes, the focused codes and my

memos to identify divergence and convergence in the data. This process helped me better understand and interpret social processes and interactions from HCPs' perspectives.

The inductive process and constant comparisons generated more abstract concepts and ideas. Constant comparison and memo writing occurred simultaneously throughout the analysis process. I will next discuss memo writing, as another significant aspect of data analysis.

5.7.5. Memo writing

Memos are written, informal analytical notes or records of codes and data that are created throughout the research process. Memo writing is a crucial intermediate process that occurs from data collection until draft writing and keeps the researcher actively engaged and reflecting on the data. Additionally, the process of memo writing maximises the analytical abstraction process of developing ideas. According to Charmaz (2014), memo writing helps the researcher 'stop, focus, take codes and data apart, compare data, and define links within data' (p. 164). Memos practically and efficiently capture connections between theoretical ideas and make the analysis process concrete and manageable (Carmichael and Cunningham, 2017). My memos were analytical notes that facilitated my thought process and engagement in critical reflexivity. They allowed me to converse with and compare my data, codes and ideas and to validate or discard my hunches when developing theoretical concepts. Throughout data collection and analysis, memo-writing improves the research process and assists in revealing the interactions within the collected data, maximising the abstraction of researchers' ideas (Charmaz, 2014).

I wrote memos spontaneously to improve and speed up the analytical process. I kept a methodological journal of my decisions, considerations and problems. All memos were dated, and were written to be informal, integrative and analytical. My memos also included quotes from participants' narratives to ensure that the emerging concepts were data-driven. Starting to write memos early in the research process revealed perceptive hints that directed subsequent interviews and data collection processes, gathering emergent ideas and concepts that could otherwise have been missed. My early memo on 'Healthcare professionals' understanding of CSA' (see Appendix 3.5) is an example. An HCP acknowledged that in developing countries, the definition of CSA includes non-contact forms of abuse; however, he also stated that applying a similar definition in Nigeria would make everyone a perpetrator. When asked whether non-contact forms of CSA were recognised in Nigeria, his response was that they are not overtly recognised. His narratives inspired reflexive processes that led to the following questions: 'What do his narratives signify? Was the participant talking about his understanding of CSA? Or the reality of what is happening in Nigerian society? Or a way to justify his subconscious thoughts? Or was his response influenced by his gender and the way women are perceived in this society?' To clarify and answer these questions, I decided to explore further questions about HCPs' understanding of CSA to develop this category with responses from other male and female participants of similar and different ranks.

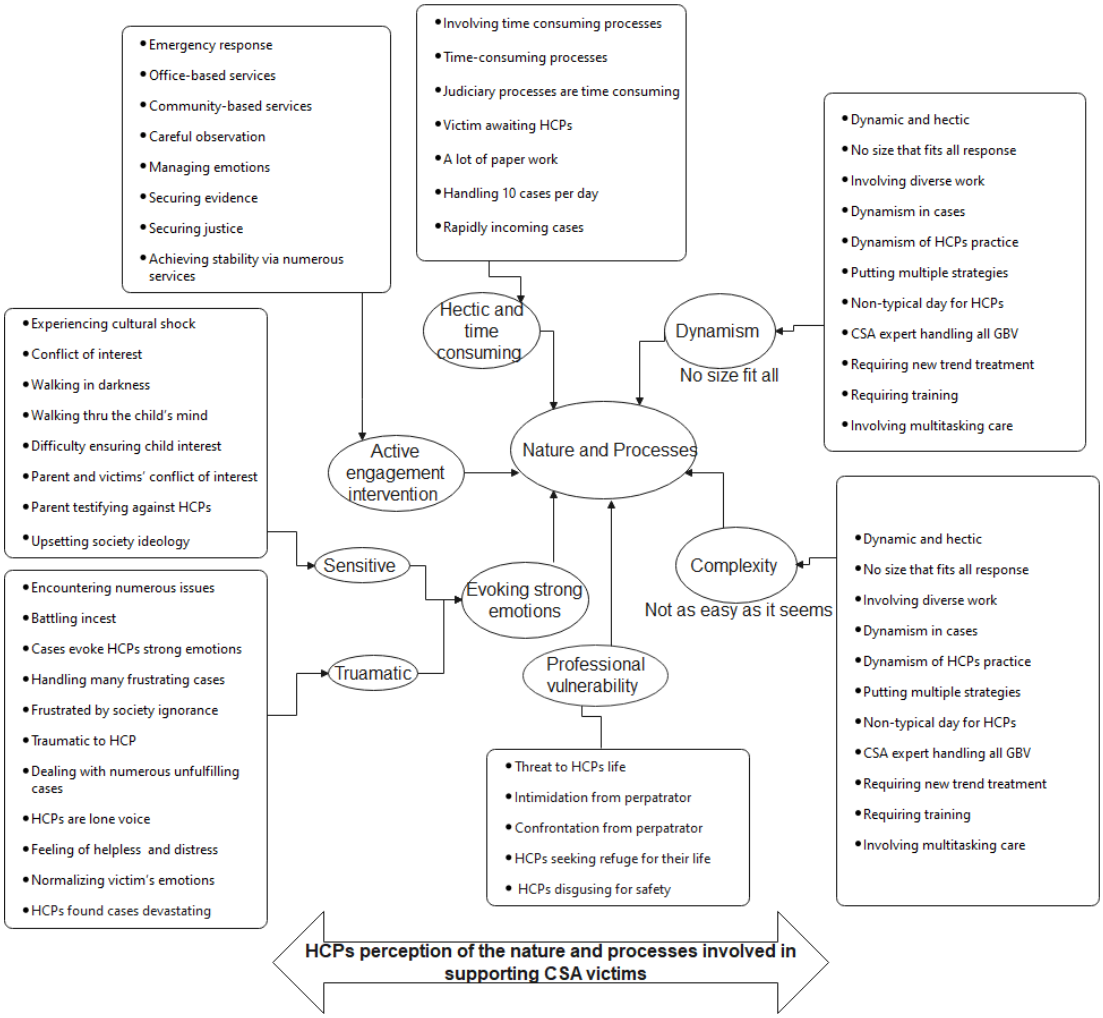
A theoretical category moves beyond the descriptive and interprets the process occurring in the data. As I progressed with memo-writing and redefined my focused codes, I developed theoretical categories which grew into an analytical framework that a theory could be constructed around.

5.7.6. Diagramming

Diagrams are visual representations that allow the researcher to visualise the ‘relative power, connection, relationships, scope and direction of the categories’ as they develop during the analysis (Charmaz, 2014, p. 218). Diagrams allowed me to succinctly present my ideas and clarify processes and positions. Diagramming is a non-linear, flexible technique for creatively and concisely organising tentative relationships in generated data. This technique visually depicts relationships between codes, categories and other phenomena. One of the early diagrams in this research presents the relationships between codes forming subcategories and how they became a theoretical category describing HCPs’ professional perception of the context in which they practice, which was described as the ‘nature and process of supporting victims of CSA in Nigeria.’ As HCPs discussed their day-to-day activities, codes relating to different aspects of the perceived nature and process of practice emerged, and diagramming revealed the interactions between these codes and the emergence of categories from those codes.

This helped me see that caring for victims of CSA is complex, sensitive, dynamic, hectic, time-consuming, and can even result in professional vulnerability due to confrontations with perpetrators. It also illustrated my participants’ perceptions of interventions and highlighted complex and clear connections between codes, subcategories and categories as seen in figure 8.

Figure 8: Codes and subcategories that developed into the theoretical category 'nature and process of supporting the victim'



5.7.7. Theoretical sorting

Sorting, diagramming and memo integration are intertwined processes that are essential for theoretical development during analysis (Charmaz, 2014). Theoretically sorting my analytic memos had cumulative benefits. It progressively clarified my analysis, making it stronger and more theoretically sound. As I continued to write my analytical journal, sorting allowed me to create, refine and theoretically integrate my categories. This process also prompted and sustained the comparison of abstract categories and facilitated reflexivity. It helped me consider the logic of my emerging

theory and draft my findings. For example, sorting theoretical categories into the main category of ‘personal motivations’ led me to gradually recognise the interplay of self, expert, and society.

5.7.8. Development/emergent of core category

Following the development of the six categories, I undertook a further analysis process to study the relationship between categories and develop an overarching category known as the core category. I continued to abstract and conceptualise data to generate theory as the analysis progressed. I identified and verified relationships between emerging categories and their data properties to ensure conceptual relationships were data-based. Because this study provided substantial empirical data due to the robust methodology approach employed, it became difficult to conclude on only one core category to ensure the cogent aspect of the analytical data was not lost. Additionally, my understanding of Charmaz’s (2014) perspective and guidelines on developing the core category discouraged arriving at only one core category and basic social process. Although I agree that arriving at only one cogent core category may limit a qualitative researcher’s ability to theorise about the kinds of complex situations or social phenomena initially drawing their attention, so I remained open-minded to further explore the relationship across the categories.

According to experts in grounded theory (Charmaz 2014; Glauser and Strauss, 1967; Glauser 1992; Ralph, Birks and Chapman, 2015), the researcher can arrive at more than one category, provided that they have considered the level of theorisation and abstraction. As I focused on theorising and abstraction, I realised all six categories, including the three core categories, were connected. If the process of theorising evolves until the explanatory hypothesis of the social phenomenon emerges, one

central concept or core category that aggregates all categories is more likely to emerge. To develop a middle range theory that explains the social phenomena under study, I focused on increasing the level of theorisation achieved to ensure my data analysis led to the development of a central point (core concept) through which all categories could be explained.

5.8. Phase 5: Criteria for evaluating qualitative research

The criticism qualitative research has received from positivists led to the formation of evaluative criteria to judge the credibility and relevance of qualitative studies. The criteria for grounded theory were originally established by its founders, Glaser and Strauss, to defend the quality and rigour of the research processes and emphasise its unique power as a qualitative method of producing theory (Charmaz, 2014; Taghipour, 2014). Quantitative researchers use fundamental parameters such as validity and reliability to determine the accuracy, generalisability and replicability of a study, but these parameters do not apply to qualitative research (Denzin and Lincoln, 2011). Charmaz (2014) redefined the Glaser and Strauss criteria for evaluation and, as this study is based on Charmaz's constructivist grounded theory, I used those criteria—credibility, originality, resonance and usefulness—to critically appraise and evaluate the grounded theory in this study.

5.8.1. Credibility

Credibility describes the quality and trustworthiness of an interpretation of a phenomenon and the congruence of research findings with reality. In qualitative research, analytical credibility demonstrates the dependability and integrity of the research findings, and the strength of grounded theory resides in its strategies for

analysing data (Glaser, and Strauss, 2017). As Charmaz (2014) stated, the research focus or studied social phenomena should resonate well with the social setting, social interaction and practice. This study explores the issues and challenges underlying HCPs' practices when identifying and responding to victims of CSA, an important and highly relevant area in the health and social care system. Theoretical sampling was employed to ensure sufficient data were collected to support the research findings. The depth, dimension and variation of data were considered as well as the sample size. The incidence of patterns in the data, observations, categories and concepts were systematically compared and the categories thus developed covered a wide range of observations and dimensions. Further reflecting the rigour of my analysis, the concepts, categories, arguments and analyses I derived are supported by the collected narrative data. There are strong logical links between the data collected and the analytical codes, categories and arguments I present, and sufficient logical evidence for a reader to independently assess my conclusions and arguments.

5.8.2. Originality

Originality describes whether the study's contribution is meaningful. Original work should show how the resulting concepts, categories and arguments either challenge or extend existing practices. Charmaz (2014, p. 337) asks whether the categories the researcher developed are fresh and generate new insights and concepts. This evaluative criterion emphasises the importance of the social and theoretical significance of the work and how it extends or challenges existing ideas, concepts, knowledge and practice. The social phenomenon explored in this study is a relatively new but relevant area of inquiry in Nigeria and the analysis generates new categories and concepts that offer fresh perspectives and dimensions that contribute immensely to current practice

when supporting victims of CSA. The analysis conceptualised a set of ideas and concepts that make sense of HCPs' practice when supporting victims of CSA in social situations. The theoretical analysis explains these social phenomena in healthcare practice and provides a new perspective on the practices, issues and challenges encountered, as well as realistic strategies for future progress.

5.8.3. Resonance

According to Charmaz (2014), resonance defines the extent to which the findings make sense to the people affected by the studied social phenomenon. In other words, the participants should be able to make sense of the categories and the theoretical concepts or ideas that result from the analysis of their data, and the findings should portray the fullness of their experience. In this study, the ideas, concepts and categories were data-driven and directly developed from the participants' narratives, meanings and perspectives.

5.8.4. Usefulness

This is the fourth and final criterion Charmaz proposed to evaluate constructivist grounded theory. My analysis offers an interpretation of realistic strategies applicable to HCPs' everyday worlds, which can minimise the identified issues and challenges and improve the practice of supporting victims. Additionally, the findings will spark further substantive research on the healthcare system. The usefulness of the theoretical categories and theory derived from the data is dependent on their contribution to existing knowledge and how they inform practice.

In this study, credibility and originality were prioritised, which increases the study's resonance, usefulness and value (Charmaz, 2014). Following the grounded theory

methodology, I used line-by-line coding and participants' language (in-vivo coding) at all levels of coding, which formed the foundation of the grounded theory and increases the credibility of my findings. During the study, the codes, categories and theoretical construction developed were checked against participants' perceptions and understanding of the phenomenon. This occurred at two levels. Firstly, as codes were developed through incoming data from participants, the interview questions were modified to generate the required data to fully develop my theory. Secondly, as the theory developed, participants occasionally verified the relevance of the codes, categories and ideas. Thus, participants were actively involved in developing, refining and revising the emerging theoretical structure. Finally, reflective practice produces models by questioning: (a) What is happening in the data? (b) What do the narratives mean? (c) Does the code or conceptual label represent participants' narratives or part of their vocabulary? (d) In what context is the code or action used? (e) Is the code related to another code? (f) Does the code encompass a broader code? (g) What are the relationships or patterns within codes? and (h) How are these codes different or similar to each other?

By following the principles of grounded theory and applying various evaluative strategies, the rigour, credibility, confirmability, and theoretical and interpretive validity of this study has been comprehensively demonstrated. There are strong logical links between the collected data and my arguments. Given the variation and subjectivity of qualitative research methods, this study comprehensively explains the issues and challenges facing HCPs when identifying and supporting the victims of CSA in Nigeria.

5.9. Reflexivity: Reflection on my beliefs and the research process

Reflexivity is a crucial quality control strategy in qualitative research, as understanding how the process may be influenced by the researcher's characteristics and experiences is of paramount importance. Reflexivity is 'the process of reflecting critically on the self as researcher, the human as instrument' (Lincoln *et al*., 2011, p. 124) and is essential to the knowledge-generating process (Berger, 2015). In qualitative research, reflexivity demonstrates the trustworthiness and credibility of the research process and findings. The positionality of the researcher is another important element, in terms of the impact of acting as an insider, an outsider or assuming dual roles, as previously mentioned. To ensure reflexivity as a qualitative researcher, an important aspect of my research process was discussing my values and beliefs about the study topic, my experiences, and how my background influenced the data collection, analysis and interpretation processes. While the reasons for my ideas, decisions and actions have been discussed in the methodology chapters, I believe concrete reflective reports may help my readers understand my position as both an insider and outsider and the possible impacts of my orientation on the research process and interpretation.

The impetus for conducting this research stemmed from my personal and professional experience, as stated in chapter 1. The first driving factor was my childhood experience in a collectivistic patriarchal society where children are socially invisible—meant to be seen and not heard—and consequently subjected to various forms of abuse, including sexual abuse. The second was my professional experience practising in various hospital units and supporting young people and their families. During childhood, my perception of CSA was driven by the social classification of children

or social structural factors that increased children's vulnerability to sexual abuse. From my perspective, CSA remains a devastating childhood experience caused by cultural practices, upbringing, the social invisibility of children and parenting styles. The need to respect one's elders in African societies is overwhelming and potentially subjects children to different forms of exploitation, molestation, violence and abuse. While this is not far from the truth, my research revealed that these vulnerabilities are multifaceted, and caused by interwoven networks of factors.

Before conducting this study, I believe my inability to explicitly identify cases of CSA was merely professional incompetence. The complex interplay of individual, person–situation and socio-ecological contextual factors that masked the occurrence challenged and undermined my and other HCPs' ability to identify and respond to sexually abused children in Nigeria.

5.9.1. Reflection: Obtaining ethical approval

At the first research setting, full ethical approval was granted by the ethics committee under the Institute for Advanced Medical Research and Training (IAMRAT), and by an approval letter from the chief medical directors of the hospital. At the second research setting, permission was obtained from the Department of Obstetrics and Gynaecology and the Department of Medicine. The third research setting provided ethical approval through the Federal Ministry of Women Affairs and Justice Affairs of the State.

The approval process was rigorous and both hospitals' ethical committees' feedback and suggestions required consultation with my supervisor as well as full use of my analytic and diplomatic skills. Undeniably, this was an explorative learning process

for me; the stakeholders were kept updated on the progress of the study and I continued to maintain a positive rapport with them.

Adapting my study proposal to each institution's ethical approval process was a challenging and informative process. All ethical committees and research governance groups are concerned with the fundamental principles and ethics of human participation in research. This includes participants' rights, their consent to participation, their dignity, safety and well-being, and confidentiality and data security, especially as interviews were conducted online. These principles were defined according to the University of Sheffield research ethics guidelines (2017).

All information collected during the research was kept strictly confidential and stored in accordance with the Data Protection Act 2018. Pseudonyms and identifier codes were used to anonymise the data, which could not be connected to any individual or institution. Information and data were anonymised before being shared with my supervisors. The raw data and recorded videos of the interviews were destroyed immediately after they had been transcribed and checked for accuracy, and the journal notes I took were kept anonymous. All transcripts were anonymised: any identifiable or personal data such as individual and institution names were removed and identifier codes were attached to each transcript. The transcripts were then stored on PebblePad, Google Documents and on a password-protected hard drive and computer. The signed consent forms, fieldwork papers, methodology journal and memos were kept as soft copies and in a separate file on the password-protected computer and hard drive.

I was mindful that CSA is a sensitive topic that could result in the need to disclose information and made plans to handle such situations. For instance, if a participant disclosed that their daughter had been abused or they were being sexually abused at work, or if a participant revealed that they were harming someone else, I planned to

inform the institution's designated security officer. If I had further concerns, I would inform the local security authority or police for further investigation. This was made clear to participants at the beginning of the study.

This study adhered to the Data Protection Act 2018 and the general ethical principles stipulated by the University of Sheffield and the Research Institute for the collection, processing, storage, use and destruction of data.

5.9.2. Managing personal safety issues and potential harm to participants

Participation in this research carried no direct physical risk; however, there was a risk of participants reacting emotionally to the sensitive topics. More importantly, the participants may have become emotionally disturbed if they had experienced CSA, were experiencing sexual victimisation, or during continuous reflection on their roles supporting sexually abused victims and the challenges they faced, either as a result of their own experiences or their clients' stories.

I completed a detailed departmental risk assessment and management plan based on the predicted risk as part of the ethical research protocol. When initially developing the interview guide, I carefully avoided direct or indirect questions that would involve participants' sexual experiences as children. Before the interviews, although participants were HCPs themselves, they were provided with useful information on where and how to seek support if they had any concerns, security issues or need for psychological support.

As sexual violence occurs across gender, race, ethnicity and socioeconomic class lines, during interviews I remained aware that my participants might be victims or survivors. My sensitivity to the context was important when promptly identifying and negotiating

the difficulties that arose during interview interactions. Unsurprisingly, some participants reported specialising in supporting the victims of CSA due to a combination of factors that included experiencing sexual abuse during childhood. However, their disclosures did not elicit emotional reactions; instead, they highlighted their motivation and sense of responsibility towards victims of CSA.

As much as my research prioritised participants' privacy in all circumstances, security issues were never neglected. During the interviews, if concerns or issues were disclosed that implied serious harm to the participant or the public, I was prepared to encourage and support the participants in disclosing that information to the appropriate institutions to receive support. If the person was reluctant, and especially if a minor were involved, I would have informed the relevant local authorities in Nigeria and the women's affairs authority for further investigation. These exceptions were included in the consent form as confidentiality limitations. Finally, if a person were in immediate danger, the police would be informed immediately.

5.9.3. Reflection: Data collection and analysis

The data collection for this study was interesting, explorative and challenging due to unexpected difficulties in accessing and recruiting participants, as well as using a robust grounded theory approach as an early-career researcher. Understanding the theoretical basis and principles of grounded theory was very different from applying it and adapting it to my research process, which was a daunting task. I realised that I vacillated, checking and cross-checking in search of validation until I achieved some stability. In the early stages in this study, I spent most of my time reflecting on and querying my methods and approaches and was preoccupied with whether I was collecting the right data to build the theory. As I commenced analytical memo-writing

on each emerging theme, it became easy to explore the social phenomenon being studied, reflect on and compare the available data, examine relationships, and challenge interpretations. This process not only gave me some form of stability and validated the process, but also provided a pathway to further exploring the studied social phenomenon.

Rather than conducting face-to-face interviews, which are common in Nigeria, I conducted online interviews. However, I realised that participants were concerned about their identities, privacy and confidentiality due to the sensitivity of the study topic and conducting the interview online, despite my explanation of the ethics and principles guiding this study. Many prospective participants who had indicated interest later withdrew due to these concerns. Those that participated raised concern about the data management, whether their superiors have access to their interview, and the possibility of leaked files to the public.

Initially, I encouraged participants to schedule interviews in their offices to avoid noise, distraction or interruptions from family. I realised they felt restricted in that context discussing the challenges they encountered during their practice, especially institutional issues. Participants felt more comfortable discussing these issues in their homes. Using Google Meet, a software platform that has the capacity to record both audio and video, increased participants' concerns about their privacy and confidentiality and they frequently reaffirmed that their information would not be personally identifiable.

Additionally, my distance and perceived positionality were significant sources of social differences, which I believe interfered with the participants' development of trust in me. Despite a comprehensive explanation of the study aims, potential participants were concerned about my intentions and the possibility that I would judge

their practices. As a recruitment strategy, my early engagement with potential participants focused on developing trust and a rapport and appreciating their choice of career path. I believe that this researcher–researched interaction may have influenced participants' perception of my position and the information they provided during data collection.

During the interviews, I moved from general to specific questions to allow a rapport to develop. This funnelled approach, as well as being interviewed from the comfort of their homes, helped participants develop the trust and confidence to discuss the issues in detail. I shared the same ethnic, cultural and professional background as the participants and I understood their social norms and expectations, which facilitated our rapport. During the interviews, I realised that I was simultaneously an insider and an outsider. My role as an outsider helped me to distance myself from participants' narratives, personalise their experiences and accept the meanings they attached to their experiences and practice. As an insider, I understood the context in which HCPs operate, which helped me to uncover the underlying meaning in their narratives.

The pre-recruitment tools, such as the information sheet, consent form and briefing about the interviews, allowed participants to make informed choices, assured them of their information's privacy and confidentiality, and facilitated meaningful participation. I later realised that this information may have influenced participants to conduct independent research and provide theoretical or expected information rather than information which reflected the reality of their practice, especially given their assumptions about my intentions. To handle this participant bias and the social desirability effect, I started each interview by explaining my motivation, expressing my appreciation for their work, and emphasising that all disclosed information would be treated anonymously. I shared with participants my hope that their contributions

could help to strengthen child protection policies in Nigeria and thereby improve the effectiveness of services for sexually abused children. During the interviews, I avoided framing my questions in such a way that participants felt pressured to provide a desirable response. For example, instead of asking participants what they could do differently to mitigate challenges, I asked 'Looking at your practice, what do you think will have changed in 5 or 10 years?' This approach was effective as participants could identify the steps they would take to improve their practice rather than merely making general recommendations for society and the government. Additionally, during my research report, I assiduously refrained from discussing areas that would make my participants feel like their practices were being judged, as this was not the purpose of the research.

In addition to the interview strategies and skills I developed before the fieldwork, I focused on flexibility during the interviews. Although I used interview guides to direct the process, I focused on exploring participants' distinctive experiences and practices as narrated and wrote memos after each interview to identify and collect more conceptual data. I began to see logic, patterns, relationships and nuance among the emerging concepts throughout the data analysis processes. My relevant reflections are documented in the data analysis section.

5.10. Summary

This chapter discusses the methods used in this current study. It explains the research settings and the process involved in obtaining ethical approval from the University and the three research settings. It lays out the critical ethical principles followed by this study when involving human participants in the research. It outlines the recruitment of participants, development of tools for data collection, and analysis process in detail.

The chapter then sets out details about the participants' demographics and level of experience and expertise. It also explains how the criteria for evaluating the quality of qualitative studies and grounded theory have been applied in this study. This chapter ends by outlining my reflection on my personal beliefs and perspective on CSA, and on the data collection and analysis processes. The discussion of the final analysis and findings of this study is introduced in the next following chapter, which also covers the first two categories.

CHAPTER SIX: RESEARCH FINDINGS

The previous chapter explained the methods used in the study. This chapter reports the findings from 26 semi-structured online interviews that contribute to our understanding of issues and challenges related to supporting victims of CSA, as perceived by HCPs. The findings of this study are presented in four categories, and this chapter discusses the first three overarching theoretical categories: HCPs' understanding of CSA, their personal motivations, and their perception of the dimension of practice of identifying and responding to sexually abused children. It also presents the focused codes that were determined as offering the greatest analytical value and relevance, as will be discussed in the next section.

I developed a fictional case study to depict narratives from all the theoretical categories. This approach was employed to succinctly depict the participants' practices and to help readers understand how the participants interpreted their experiences. The case study titled 'The Casey Team' provides a broad representation of the HCPs and the context in which they operate in Nigeria.

A collection of verbatim extracts from participants illustrates the emerging themes across the categories. In this findings chapter, while there are no criteria set for the selection of quotes to illustrate emerging themes, various excerpts from participants have been carefully observed and reflected upon in order to select quotes that best illustrate these themes. There were participants who were passionate about certain aspects of their practice, which was reflected in their comprehensive and vivid narratives. In particular, those participants who declare themselves to be victims of CSA during the data collection process. Due to their personal experience of CSA as well as their professional background and practice, they were able to demonstrate a

deeper understanding of certain aspects of this topic and explore it from multiple perspectives. Through their participation in this study, they were able to share the challenges faced by them in their various roles, and the implications of these challenges. As CSA survivors, certain participants considered themselves an active voice for victims, which indirectly adds depth to this study's findings. Although their voices may appear frequently in the following sections, their views were not given precedence over others. Moreover, these participants were passionate and offered in-depth explanations of their experiences, which is important for descriptive qualitative study. It is interesting to note that few participants present a strongly opposing view to others, which allows constant comparison and provides opportunity for analysing divergent and convergent ideas. These dissenting opinions were inculcated into the themes to deepen our understanding of the research findings. While it initially raised concerns and disparities, further critical exploration indicated that participants' understandings of CSA were framed by their cultural background, social practices, professional and personal experiences, and the context of practice. Also, it was considered the reality of the participants' experiences. It was considered valuable to include excerpts from participants who were able to share a complex knowledge of the impact of CSA and the rules and procedures associated with professional work with CSA victims. Similarly, excerpts from other participants who showed limited knowledge of CSA and its practice but held mandatory responsibilities to respond to sexually abused children in Nigeria were used to illustrate relevant themes, thereby providing a holistic account of study participants.

Table 10: Fictional case study

Fictional Case Study: The Casey Team

Casey is the pseudonym for a team of six practitioners who worked in a government owned SARC located in a patriarchal society in Northern Nigeria. The six team members are diverse in their ethnic, religious, social and cultural affiliations, as well as their disciplines, while working towards a common goal of supporting sexually abused children. The group was led by Mrs. Ugo, a social worker, and consisted of a nurse, a doctor, a counsellor, a psychologist and a child advocate. Sexually abused children came into contact with the team through five pathways: self-referrals from victims or their families, organised community awareness and sensitisation programmes, referrals from other healthcare and social care professionals and institutions, and through the observation of specific physical and behavioural signs during contact with the child by HCPs.

Depending on the severity of the incident, the Casey team followed either an emergency or a non-emergency pathway. In emergency situations, the team leader, Mrs. Ugo, mobilised the emergency rescue team. These teams provided on-site emergency care to the victim before transferring them to a hospital for immediate medical or surgical intervention. This emergency intervention was followed by a mandatory medical assessment. When the patient was stabilised, they were transferred to the non-emergency pathway, which began with an introduction to the SARC and the team members. Obtaining parental consent was essential at this stage, especially when initiating a legal or litigation process. The team also offered psychosocial intervention or psychotherapy and holistic referral systems, to which the victims were referred on the basis of their needs. The team was not required to report cases of CSA to the police and they strove to work with the police system to aggregate evidence and seek justice for victims. In both pathways, the Casey team mobilised law enforcement to apprehend the perpetrator and aggregate evidence, referring the perpetrator to the legal system and treating the victim's complications.

In addition to these two pathways, the Casey team provided child protection programs, such as alternative living, shelter, adoption to prevent re-victimisation,

social welfare and rehabilitation services, and community-based projects to involve the child in a wider system. These processes subjected the team to many issues and challenges that undermined their efforts to identify and respond to sexually abused children. They perceived these challenges and construed them as inherent elements of their professional practice, meaning that their experience, perception and understanding of the experience is unique, providing a basis for addressing these problems.

6.1. Category 1: HCPs' meaning and understanding of CSA

In this category, participants' broad understanding of the concept of CSA was uncovered. These narratives emerged when participants were asked to define CSA in their own words. The evidence indicated that HCPs' understanding of CSA is shaped by their early life experiences, particularly the childhood experience of sexual abuse, socialisation and ideology, cultural and religious background and beliefs, and their professional practice of supporting sexually abused children. Thus, each individual conceptualised CSA differently, and these differences are significant for this study. Together, these varied constructs provide important insights into HCPs' breadth of knowledge and understanding of the studied social phenomena. The HCPs' understanding of CSA, their perspectives and the meaning they attached to it varied. Some HCPs constructed their ideas from adverse childhood experiences, others from professional practice and understanding, while a few constructed them from the practice context. The category is divided into four subcategories: (1) personal meaning and definition of CSA, (2) forms of CSA, (3) factors Contributing to CSA, and (4) consequences and impacts of experiencing CSA. The next section presents the four subcategories HCPs used to narrate their understanding of CSA.

6.1.1. Personal meaning and definition of CSA

For some participants, CSA was not only a solitary act but a process involved in grooming children with an intention to molest them (for example, offering gifts or shelter), or the actual or attempted involvement of a child in any form of sexual activity. Across all conceptualisations by the HCPs, irrespective of the details, intent was often highlighted, which will be discussed later. The HCPs indicated that special attention, protection and provisions given to the child that are intended to attract the child's attention and involve them in any form of sexual activity mean that the individual is guilty of CSA. The excerpt below reflected participants' conceptualisation of CSA as all processes involved with the intention of molesting the child and not necessarily limited to involving a child in sexual activities:

'It is all the process involved, where we have somebody trying to involve a child in sexual activities. It starts by offering things or gifts to gain the attention or affection of a child, so that such a child can be used for sexual purposes.'

(Mrs. Obor, counsellor)

The participants' narratives reflect that CSA is not only a social, public and health issue but also an economic issue, which will be discussed in detail as a contributing factor. Most participants viewed CSA through the lens of culture, religious customs, the human relational context and the legal framework. CSA was described as a crime against the state and humanity, as a taboo and as a sin against God. It was perceived through the lens of spiritual beliefs:

'If you have sexual activity with a child, you have committed a crime, rape is a crime against God, humanity and the State.'

(Mrs. Oge, social worker)

Respondents repeatedly described CSA using idioms and symbols; these conceptions became evident as participants reminisced about their experience of CSA or their clients' experiences of it, and their professional practice of supporting victims of CSA. Participants claimed the experience of sexual abuse left the victims with feelings of being trapped without hope of escaping the abuse. Participants felt that perpetrators had inflicted long-lasting pain on victims, which continued to encroach on the victims' present, always catching up with them. Recalling her professional practice and interaction with the victims, Mrs Oge, an experienced social worker and manager of a SARC, described CSA as '*an act of imposing excruciating pain*.' Apart from the past pains that encroach on the present, other participants likened the experience of sexual abuse in childhood to a '*dark hole*' that comes with the feeling of being trapped. Mrs. Ugo, also a social worker, reminisced about her childhood experience of sexual abuse as well as her clients' experiences:

'I was sexually abused as a child. It is the pains on your past that can always catch on with you. I went through a lot of all the effects and the consequences. I was able to climb out of that dark hole. Sometimes also, the child really doesn't know what to do, has nobody around them to talk to, you know, and so they just feel trapped in their situation.'

(Mrs. Ugo, social worker)

Participants described CSA as any form of sexual activity that involves a child or sexually arouses a child, either by force, coercion, threat or manipulation. These acts can be attempted or actual, with the use of any body parts or objects or even by making a child touch another person. All definitions specified that anyone under the age of 18 was a child, as stipulated by the Nigerian constitution. Participants used the words 'rape,' 'defilement' and 'molestation' interchangeably to discuss the sexual abuse of

children. The words ‘perpetrator’ and ‘abuser’ were used interchangeably to refer to the person who perpetrated the act. Talking about what constitutes CSA, one participant explained:

‘CSA is any sexual activity carried out on the child (under 18), either through force, cohesion, enticement or deceit and this involves both sexual abuse through physical touch or not, where the perpetrator makes physical contact with the child and either through using of objects, body parts in the genitals of the child or making the child touch another person sexually.’

(Mrs. Ugo, social worker)

In conceptualising CSA, the relevance of the age of consent and its implications on the criminality of CSA was discussed. A common view amongst participants, was that children are not deemed competent to consent and therefore any form of sexual activity with a child is illegal. The age of majority is based on Nigerian constitutional law. In Nigeria, the ‘age of majority’ is 18, at which point a person is considered old enough to make informed decisions.

One participant, however, felt that some children were culpable while acknowledging that legally children are not competent to consent to sexual activities. He referred to some young people wearing revealing clothes with seductive intentions. He considered children who behaved in such a manner as guilty:

‘Many of these children who are complaining are culpable. Despite the fact that in the eyes of the law these children are not competent to give consent some of them are culpable. The way they (children) dress to seduce men, you know, this sexual activity is a thing of the mind.’

(Barrister Ojo, legal practitioner and child advocate)

Surprisingly, Barrister Ojo was not the only one with this narrative; another participant subtly mentioned children's culpability as:

'I do not consider non-penetration as a form of sexual abuse, and when children are sexually molested, some of these children are not innocent like that, they understand all these things more than you think. They ask for so many things from the man and may be expecting sex in return. You know, this is a thing of the mind, but sometimes when it is done and there is trauma and the child requires help, we attend to them.'

(Professor Nasir, general practitioner)

While these two men's narratives highlighted the culpability of children, other participants (including other male HCPs) portrayed children who experienced CSA as victims and predominantly focused on unfortunate vulnerabilities to explain the occurrence of CSA. Some participants also considered CSA from the perspective of the imbalanced power dynamics between the perpetrator and the child, as in situations when an adult, adolescent, young person, or another child in a position of power, known or unknown, takes advantage of the victim's vulnerability and naivety.

As well as inferring the culpability of children, these two male HCPs also specifically emphasised variation of the definition of CSA in different social contexts; meaning that what may be considered sexual abuse in one context might not necessarily be in another context, considering culture, practices and social norms. Putting context into perspective, both contended that non-penetrative or non-contact sexual activities cannot be categorically regarded as CSA in Nigeria. Participants emphasised that disregarding social norms in different contexts could result in labelling the majority of men in Nigeria as perpetrators, as acts that constitute non-penetrative CSA are social

norms in Nigerian society. Commenting on the discrepancies in the definition of CSA, a participant stated:

'The definition of CSA, assault or rape in Western world is different from what we have in Nigeria. In Western world, if you look at woman's breasts you can be charged for sexual assault but in Nigeria the man can even plug his eyes through the breast nothing will happen. The definition of all these offences is different from one jurisdiction to another. So, in Western world what we necessarily constitutes as rape or assault may not even constitute a name or can be overlooked in Nigeria and vice versa.'

(Barrister Ojo, lawyer, head of hospital legal department)

Another participant also emphasised the contextual variance:

'But this is how I prefer to make it look like something that is more of a penetration (CSA). Because in this part of the world, if you define it like the Westerners define it over there, then everybody is a sexual abuser. Mostly in this environment, when we say sexual abuse, is a penetrating sexual abuse, that's rape.'

(Professor Nasir, general practitioner)

While discussing practices that could be considered CSA across geographical boundaries, Barrister Ojo brought up the cultural and religious practice of child marriage in Nigeria. He explained that child marriage occurs in Nigeria, reinforced by Sharia law and the customary practices of the northerners. These laws seem to overrule the Child Rights Act (2003) in Nigeria, which set the minimum age for marriage at 18 years old; however, only 23 states in Nigeria have adopted this act. The northern states, in general, have not adopted this act and certain states have controversially set the minimum age of marriage as low as 12 years old. He further cited other countries with

very young ages of consent and questioned whether we should consider any form of sexual activities with anyone under the age of 18 as CSA within the geographical borders of countries such as the Philippines and Angola, where 12 is the age of consent. For him, the sexual activities that are allowed in the social, cultural and religious context of a country, especially when supported by local customary law, cannot be considered as CSA, implying that the practice of child marriage and low age of sexual consent cannot be called CSA. While this may be the participant's reality, it was difficult to elicit this participant's position on harmful cultural and religious practices:

'In northern parts of the country, a child can even get married as backed by Sharia law, despite the fact that the constitution has made it clear that a child should not be forced to do things against their will and spell out fundamental human rights. Some of Nigeria's laws still allow a child of 13 years to get married and you will see that minors are forced to marry an adult, they are asked to marry someone who is older to be their grandfather, and nothing will happen, even if it has been done against the child's will. Will you call that sexual abuse also? Even other countries like Philippine and Angola.'

(Barrister Ojo, lawyer, head of hospital legal department)

Although Barrister Ojo initially emphasised children's culpability, he prioritised obtaining justice for victims. His definition of victimhood aligned with the criteria or parameters stated by Nigerian law, which subtly disregards forms of sexual abuse other than penetrative sexual abuse. As a legal practitioner with high esteem for Sharia law and the Nigerian constitution, he further contextualised CSA within the Nigerian legal framework as he prioritised designated parameters for determining whether CSA had occurred or not. Considering his perspective, his reasons for discounting non-penetrative or non-contact sexual abuse and potentially disregarding penetrative sexual

abuse for sexually active children became clear. For him, situations where there is no proof of a broken hymen and penetration, as the law states, may be disregarded:

'Anyways, our own thing is to make sure that all aspects of the law (three designated parameters) come into play to ensure abuse has occurred and victims get the justice they deserve. There are parameters we are looking through first; if the child is a virgin, is there a break of hymen and whether ejaculation actually occurs. Because the law says there must be penetration and ejaculation before we can say assault has occurred. These parameters have to be present.'

(Barrister Ojo, Lawyer, Head of Hospital legal department)

Moving from individual perspectives to wider social contexts, another area of contention in this study was whether non-penetrative sexual abuse is considered sexual abuse in Nigeria. The findings revealed discrepancies between what is considered sexual by HCPs working in hospitals and those working in SARCs. While this study does not focus on comparative analysis or evaluate HCPs' knowledge, it highlights significant definitional discrepancies even among professionals, bearing in mind the importance of multidisciplinary approaches to treating CSA victims. The evidence shows HCPs in hospitals only considered penetrative sexual activity that resulted in injuries as requiring HCP intervention, unlike participants from SARCs. While they accepted that non-penetrative sexual abuse exists, they asserted that it was never reported or recognised as a form of CSA which required hospital treatment or professional intervention in Nigeria. Only penetrative cases that resulted in trauma or injury requiring immediate medical or surgical intervention are reported, meaning many penetrative cases of CSA with mild consequences are not likely to be reported. This professional experience and practice strongly influenced how Professor Nasir understood and described CSA:

'I prefer to make it look like something that is more of a penetration thing. So definitely non-contact abuse exists, but, of course, I think it is not being reported here. Even the ones [penetrative forms of CSA] that are being reported were because there were obvious injuries, which parents of the victim/guardians feel the child might need some medication or surgical attention, most likely.'

(Professor Nasir, general practitioner)

In addition, the evidence reinforced an important element of a few participants' stances: while they conceptualised CSA from their professional perspectives, cultural and religious beliefs heavily influenced their positions. Regardless of their educational or professional attainment, sociocultural and religious beliefs influenced their understanding of social phenomena, resulting in paradoxical narratives. Comparing these contrasting perspectives reveals that cultural and religious context, personal experience and professional practice all contribute to shaping HCPs' perceptions, understandings and conceptualisations of CSA.

In terms of this sub-categories relevance to the main category, all the themes and subthemes that emerged demonstrated HCPs' understanding of CSA, as well as the meaning they attach to it. Their narratives enrich our understanding of HCPs' perceptions of CSA in Nigeria. As the analysis progressed, different understandings of CSA emerged, which will be discussed in the next subcategory.

6.1.2. Forms of CSA

Throughout the study, participants classified sexual abuse into contact or non-contact, penetrative or non-penetrative and indefinite forms.

Contact CSA: The findings show that contact CSA describes any form of CSA in which the perpetrator makes physical contact with a child. This includes sexual touching of any part of a child's body with or without clothes on and using any body part or object to rape or penetrate a child. Attempted rape, rape, sexual assault, molestation, defilement, fondling, incest and inappropriate sexual touching, whether penetrative or non-penetrative, were mentioned. Both penetrative and some non-penetrative forms of CSA are classified as contact CSA. Participants further explained that inappropriately touching a child's body, developed or undeveloped and clothed or unclothed, is a form of CSA. Participants reported that while contact forms of abuse are the most reported form of CSA, incest is the most common reported penetrative form and is currently the most challenging to respond to in Nigeria:

'It could be contact and non-contact; you are either having contact with the child or you are not having contact with the child and you are still molesting the child. Touching/ contact form, which could not necessarily be penetration or rape, it could be fondling, making a child touch another child, or a child touching you, could be oral, anus and vaginal.'

(Mr. Oke, child/clinical psychologist)

Non-contact CSA: Participants claimed that CSA be categorised by acts other than rape. Non-contact abuse describes all forms of sexual abuse in which the perpetrator sexually abuses a child without making physical contact. Participants identified flashing, indecent exposure, grooming, making sexual gestures, making a child masturbate, exhibitionism, voyeurism, showing pornography, providing a child with age-inappropriate information, sexting, simulating sexual activities and exposing children to sexual content. This includes sexual activity in the presence of a child and coercing them to watch, listen or create or share child abuse images or videos.

Participants considered other sexual activities that occurred online, such as sharing sexual images with children, to be forms of CSA. There was a perception that not implementing measures to protect children or prevent them from being exposed to sexual activity was abuse:

'This includes masturbating in front of a child, having sex in front of a child, watching pornography, or showing a child. The online aspect of it, sexting, exhibitionism, voyeurism, showing pornography…, asking a child to send their picture—it can be an adult, a younger person, or a child. Also, when an adult does not protect the child from sexual abuse.'

(Mr. Oke, child/clinical psychologist)

Indefinite CSA: Participants described all forms of exploitative practices and unhealthy traditions, including social and cultural practices, that children are subjected to in Nigeria which include elements of sexual abuse. Participants described these unhealthy practices as deep-seated practices in Nigeria that encouraged the sexual abuse of girls in particular. Participants considered these activities to be both illegal and exploitative, saying that they violated children's rights and were forms of CSA. These practices included child marriage, female genital mutilation, child prostitution, child sex trafficking, child sexual exploitation, transactional sex and peer-perpetrated CSA:

'Then, this is difficult to classify because it is part of our cultural practice. The northerners still have the argument of age, once a child enters puberty, such a child is due for marriage; once you enter puberty, you are marriable. Also, female genital mutilations, children trafficking for sexual purpose and those sexual abuse perpetrated by a child to another child.'

(Mrs. Oge, social worker)

The themes under the "form of CSA' subcategory emerged after the HCPs' careful consideration of the sociocultural, legal and healthcare systems in which they operate in Nigeria. This evidence further reflects the understanding of HCPs and how this is influenced by their cultural and religious background, individual values and the context of their professional practice.

6.1.3. Factors contributing to CSA

The participants argued that the factors contributing to CSA are multifactorial. While they attested to the universality of CSA, they identified various factors that contributed to or increased children's vulnerability and risk of being sexually abused in Nigeria. Participants expressed many perspectives on this. Across all narratives, HCPs reported numerous intertwined or interconnected vulnerability factors, emphasising individual characteristics, family dynamics and characteristics, the environment, socioeconomic situations, and societal norms, attitudes, and cultural practices. These factors were classified into three themes: child-related factors, family–parent factors and societal factors.

Child-related Factors: These are the characteristics of a child that make them vulnerable to sexual abuse. Most participants cited age and gender as the first factors to be considered; there was consensus that sexual abuse occurred across all ages, but that children and young people are extremely vulnerable. There was a consistent perception that the availability, vulnerability and naivety of children were the main contributing factors. Participants stated that perpetrators could easily access children to satisfy their sexual needs and that children are vulnerable and believed to be unable to comprehend CSA acts or judge perpetrators' behaviours and intentions. It was felt

that children may be unaware of the nature of the acts or their deviancy due to the level of their development. Participants argued that children's inability to adequately discern or judge a sexual abuse situation increases the likelihood that the child will not disclose the abuse, a factor that permits the perpetrator to continue the abuse. In this sense, they suggested that the alarming prevalence of sexual abuse among children is due to perpetrators' ability to take advantage of children's availability, vulnerability and naivety:

As Mrs Oge explained, '*Most of our clients are children and young people. Right now, the most vulnerable are the children, naive, and do not know people's intentions, they are always there to be used for sexual reason.'*

(Mrs. Oge, social worker)

Gender is also a major factor in CSA; while both genders are vulnerable to sexual abuse, female children were mentioned across all narratives. Participants agreed that girls are more vulnerable to victimisation than boys, while a minority expressed their concerns that the number of boys experiencing sexual abuse is increasing. For participants, while this new trend may be the result of frequent awareness and sensitisation programmes, it could also indicate that perpetrators are now turning to boys, especially with evidence of homosexuality in society and increasing numbers of female perpetrators, as shown in the excerpt below:

'We do encounter both girls and boys, but definitely the number of girls is more. We have about maybe 97% being girls and just maybe 3% being boys, or 1:9 ratio. But boys are reporting more, we have to be careful now, are they aware or are they now being targeted.'

(Barrister Agboola, child protection specialist)

As a result of societal perceptions of gender roles, sexuality, and masculinity, which expose girls to CSA and prevent boys from disclosing their experiences of sexual abuse. Participants felt that boys were starting to overcome such social vulnerability and some of the masculine norms and stereotypes previously preventing them from disclosure. This positive change was attributed to the intensive implementation of educational and awareness programmes focusing on the sexual abuse of boys in the community:

'We definitely see more girls, but we are concerned because we know that boys have also been abused… we focus on raising awareness about boys being sexually abused. And with that we have seen some more males, and some more boys coming over to report. Like I mentioned, this may be caused by other factors.'

(Mrs. Ugo, social worker)

While some participants attributed children's vulnerability to CSA to insufficient parental supervision, others considered children's socioeconomic status. Children who lack basic necessities are vulnerable to adults who promise them affection and provide for their basic survival needs in exchange for sexual satisfaction, especially when children perceive sexual exploitation as a means of survival. Many participants mentioned that children from very poor backgrounds may lack the opportunities or privileges enjoyed by other children their age and often shoulder the responsibility of providing for their families. Evidence from the narratives indicates that these children are used for child labour. Participants suggested that the more children are subjected to any form of employment, the more available they seem to become for perpetrators. Examples of such exploitative practices include using children as household servants or asking them to sell goods in public marketplaces or on the street. Participants

believe that these children are away from parental protection and security and entrusted to people who are believed to be 'respectable,' making them more vulnerable:

'*Perpetrators can offer less privileged children in poor settings biscuits. Some of the cases that we have are what we call the house-help syndrome. They are taken from a place of poverty and their parents ask them to stay with an uncle or auntie in the city and they are sexually abused. Poverty contributes to it. Children who are hawking on the street, they have left the home and exposed to the higher vulnerability on the street, mostly, petty traders, perpetrators just grab them and then molest them.'*

(Mrs. Ajededun, practising nurse)

While participants identified vulnerabilities that put children at higher risk of being sexually abused, they also identified attributes that could drive individuals to commit CSA While they clarified that they were not excusing perpetrators' acts, their social-cultural background and professional practice informed their understanding of this aspect. These factors are discussed in the following section.

Perpetrator-related Factors: This theme discussed perpetrator characteristics and attributes. Participants agreed that there was 'no excuse' for sexually abusing a child while deducing from their professional practice that certain attributes are characteristic of perpetrators. The first factor noted was the perpetrators' gender; while anyone can perpetrate sexual abuse, men are commonly perpetrators in both male and female sexual victimisation cases. These views surfaced in relation to men's genetic make-up, arguing that men have limited control their sexual urges:

'The man and woman's genetic makeup is different. Not making excuses for men but men cannot stay without sex and is because the abuser wants to just satisfy sexual urge and children are more vulnerable and available.'

(Mrs. Obisesan, social worker)

Another important factor mentioned was the perpetrator's marital status; many perpetrators were said to be widowers who turned to children to satisfy their sexual needs. Power relations and dynamics were also identified. They mentioned the perpetrators' sense of power, control and entitlement, which drove them to use power and violence to control or coerce victims. Participants cited perpetrators violating victims because they felt entitled to do so, believing that they 'owned' their children:

'*Let me just put it as a power relation, they feel they can do whatever to children. I have the right to do this to you*.'

(Mrs. Ogbenne, psychologist)

Participants emphasise the gender socialisation that creates the sense of entitlement. They explained that during childhood and adolescence, boys are socialised to emulate stereotypical masculine attitudes and behaviours. There is a perception that such socialisation shapes gender attitudes, perceptions and expectations, including the display of sexual prowess. Boys grow up believing that displaying sexual prowess is fundamental to their masculinity, a situation the HCPs felt was exacerbated by Nigeria's patriarchal society, the trivialisation of CSA and excessive exposure to pornography:

'Another reason is the cultural norms that we have, the way we are raising our boys, dominating girls, and boy's preference. The rights over the girl child and mindset that sex is a thing of conquest and to express and to show masculinity, I can imagine somebody with this mindset and watching pornography, the impunity in the society as well in the way issues of sexual violence are being addressed, is not widely talked about. You can imagine the escalations.'

(Mrs. Ugo, social worker)

Few participants identified the link between the addictive practice of viewing pornography and the perpetration of CSA. They claimed that while these two variables are not widely discussed, a causal connection has been established, as seen in Mrs. Ugo's statement:

'Though not widely talked about, there is a relationship between pornography and sexual violence.'

(Mrs. Ugo, social worker)

Mythical beliefs apparent in Nigerian culture were also identified. Participants explained that individuals who clung to the belief that sexual intercourse with a virgin is medicinal are more likely to commit CSA. In certain communities, people believe intimacy with young children can cure many diseases, including HIV:

'*This myth says that when you're HIV-positive you can sleep with a child (virgin) and you can become negative…because some people believe that if you sleep with a virgin, it will cure you of any disease.'*

(Mr. Ike, social worker)

Moving from religious mysticism to pathology, participants explained that antisocial behaviours are not the only reason for committing CSA; psycho-medical pathologies have also been implicated. There is a notion that people with any psychological or physiological dysfunction that causes compulsive obsession with or attraction towards people or objects with certain characteristics are more likely to offend:

'People commit CSA not only for several reasons that are associated with antisocial behaviours but also for reasons associated with psycho-medical problems that induce compulsive sexual attraction and urge towards specific types of persons and objects.

Psycho-medical problems include hypersexual disorders, psychopathy, paraphilia disorders, influence of alcohol and drug abuse, infantophilia disorder have exclusive sexual attraction and urge towards infants.'

(Barrister Saliu, practising lawyer and child advocate)

Family–Parent Factors: As previously mentioned, certain family factors, such as family structures, living arrangement, power dynamics and economic factors were implicated as contributing factors for sexual abuse during childhood. Early in the analysis, most participants agreed that CSA cuts across all socioeconomic groups but is highly prevalent in families with low socioeconomic status. There was a perception that children in a family where the parents faced financial difficulties and economic distress were more at risk of being sexually abused. This does not mean only children from poor backgrounds are affected by this form of abuse; children with higher socioeconomic status can also be sexually abused, especially when their parents are busy with their working commitments:

'I would say it would be economic incapability for a lot of people. Now you will discover that a lot of homes where these things happen are poor. It does not mean that it's within the poor people alone. But it is an economic issue in the sense that if you even look at the so-called rich people. They are busy doing what we call the rat race neglecting their children.'

(Barrister Agboola, child protection specialist)

Elaborating on parental negligence, participants mentioned the habit of prioritising economic gain and neglecting parental responsibilities as serious vulnerability factors for children. Participants explained that CSA is more prevalent in families where the parents, as primary caregivers, are not actively involved in their children's lives,

instead trusting their children's care to others while they seek economic gains. Participants identified a lack of care or supervision and parents neglecting or abandoning children as strong predisposing factors for CSA. Parental ignorance, disbelief and denial or attempts to maintain secrecy also increased the likelihood of CSA. In the presence of parental negligence, perpetrators made themselves available as safe people for the children and earned the family's trust with an intention to sexually abuse the child, as shown below:

'Parents who are the primary caregivers are not as involved and committed in the lives of their children as they should. And so, because the perpetrators prey on the ease of the children and make themselves available, become the caregivers and minders of the children because, again, remember abusers are known by victims and family members, you know, they not only seek children's trust, they did for their parents as well to accept them. Especially when parents ignore or psychologically back the occurrence.'

(Mrs. Ugo, social worker)

Mrs Ugo was not the only one in these narratives to reflect on her personal experience and discuss parental displays of ignorance and disbelief when children disclose to them. She explained that parents often cannot accept that their child has been abused due to the significant relationship between them and the perpetrator. She explained that, after her uncle abused her, her mother's disbelief and inappropriate response to her disclosure left her devastated, which harmed their relationship:

'Let me use myself as an example, when I told my mum that my uncle was sexually abusing me, my mother didn't believe me because when my father died, my uncle stood

by my mother, it took 18 years for my mother to believe me, by that time the relationship between my mother and I has been broken.'

(Mrs. Obor, counsellor)

A recurrent theme in the interviews was a sense amongst participants that living arrangements, community parenting and extended family childcare practices subjected children to sexual abuse and exploitation. Barrister Agboola said, '*Another issue is that we have community parenting where all of you can go and drop your kids with one father or one mother anywhere and some individual can take advantage of these children and sexually exploit them.'*

(Barrister Agboola, child protection specialist)

Due to their professional experience, participants were able to link internal family problems or life situations to vulnerability to CSA. Others noted the psychological implications of parents' unresolved adverse childhood experiences. When individuals' parents had been abused sexually and struggled to address their trauma due to a lack of health and social services and rehabilitation, this psychological trauma can make the parents struggle and become emotionally unavailable for their children:

'We have a lot of broken mothers, a lot of women who are not healed and some who will become mothers tomorrow, who will not be emotionally present in the life of their children. When someone is ill it is difficult to take care of another person.'

(Mrs. Obor, counsellor)

Overall, children from lower social-economic backgrounds with extremely busy parents desperate to make a living and without alternative childcare options are more likely to experience sexual abuse. Children living with family conflict, with or without extended family or compound living arrangements, were believed to be more likely to

be abused. The next section discusses societal components; the mesosystem factors that may contribute to CSA.

Societal Factors: The HCPs emphasised the cultural and religious practices, societal traditions and social norms in Nigeria that they believe predispose Nigerian children to sexual abuse and victimisation. They identified the patriarchal system in Nigeria, gender discrimination, religious beliefs, the conservative culture and practices of respect as strong risk factors predisposing children in Nigeria to experiencing sexual abuse. From the participants' perspective, the patriarchal system in Nigeria normalises husbands intimidating and physically abusing their wives, as well as having forceful sexual activities with them. They see Nigeria as a country where women and children are socially denied human rights and subjected to various forms of abuse, and where women are expected not to refuse sexual advances from men, but married men's extramarital affairs are regarded as more acceptable. Participants highlighted the patriarchal culture in Nigeria and how it subjected children and women to sexual abuse, violence, and inequality:

'In our culture, a married man can have children outside of the marriage, men think they have the right to beat and rape their women. You cannot tell the man you do not want because our culture shows women don't have any right to say no.'

(Mrs. Obi, mental health nurse)

As previously stated, gender discrimination, misogyny and male dominance invariably increase girls' vulnerability to CSA and prevent boys from disclosing sexual abuse:

'Another reason I would say is probably the cultural norms that we have the way we are raising our boys, dominating girls, and boy's preference. The rights boys have over the girl child and then it is in sex is a thing of conquest. That is the way females

have been socialised, to be so silent and passive in all aspects of life, and that makes you a modest girl in Nigeria, and any outspoken girl will be considered as a very wayward girl, while an outspoken boy is brave. Then another one is gender discrimination, if a female child is raped, society will say is normal, but if it is a male child, they'll say no, it can't happen.'

(Mrs. Ugo, social worker)

In addition to the patriarchal nature of Nigerian society, the unsafe cultural practice and tradition of child marriage and female genital mutilation, which is especially prevalent in the northern part of Nigeria, was pointed out. Participants felt that child marriage should be outdated; however, it remains prevalent and participants considered it a fundamental cause of CSA. A participant provided accounts of how children refused to be married at that age, but parents continued to force them to marry as children. There is consensus that politicians and parents have used religious and cultural tactics to satisfy their interest in marrying young girls or marrying their children off for financial purposes or ambitions for power:

'In the North Central, children are seen as women, being married off. This week I had a case where around 12 midnight a young girl was beaten to stupor, the parents said they had married her off to one man and she ran back, and that she must return to her husband. At that point, we brought the parents and the guidance to the office to interview them. The woman spoke in Hausa and told me that it is their culture.'

(Mrs. Oge, social worker)

In this study, the influence of ecological factors is highly considered by HCPs. A participant described the common occurrence of adults involving children in pornography, which often leads to actual molestation of these children by an adult or

experimentation among their peers. The ways in which society perceives children were also explored. Participants claimed that children are objectified in Nigeria and they believe this has led to dehumanisation, as children are not seen as individuals with human rights:

'*I do not know if it is African society or is a Nigerian thing, we have decided to look at children as objects that are owned. So many people do not realise that a child is the right owner of his or her own self.*'

(Mrs. Oge, social worker)

As the analysis progressed, the issue of over-sexualisation in society recurred and was discussed in relation to the media and pornography. There were concerns about media content, including music, adverts, movies and cartoons being over-sexualised. These views surfaced in relation to unregulated media and online content. Fast-paced technology outstrips laws that could regulate cybercrime and exposes children to sexual content, abuse and exploitation. For example, one participant said:

'The nation and the world are growing in technology, industrialised, we are going at a fast pace too. But at whose expense? At the expense of children...let me start with the media….lots of things children are exposed to.'

(Mrs. Ugo, social worker)

Another important challenge for the HCPs' practice was society's limited reaction to CSA: the tolerance of CSA and the impunity enjoyed by perpetrators. Participants claimed there were no punitive measures for perpetrators; society excused them while victims were blamed for their experiences. This societal insensitivity was considered a predisposing factor for CSA. Rather than perpetrators being subjected to proper litigation, abused children are often blamed and forced to marry their perpetrators:

'Society gives perpetrators more impunity when they see that nothing is being done. It is the victims that are blamed anyway when they are raped, you see that there are no punitive measures, they continue because they can get away without being punished.'

(Mrs. Ugo, social worker)

When discussing societal ignorance and insensitivity to CSA, participants claimed that society trivialised the victims' experience even in cases of penetrative CSA, suggesting only medical care to manage the injuries incurred. They felt that people are ignorant of the impacts of such experiences on the victims, families and society at large, and so sexually abused children are neglected and unsupported. They then continue to struggle with the psychological consequences of their experience and may abuse other children, continuing the victim–perpetrator cycle:

'Some people do not even know the gravity of what we are talking about. They will say he did not kill her, he only had sex with her, get medication and the child will be alright.' People do not know there are the aftermath effects in that child's life, which will impact the life of the child, family and society...and because people don't have a good understanding of the issues, children that have been abuse now abusing other children, the cycle now continues and they are growing in that behaviour.'

(Dr. Adeyemi, practising psychologist)

In commenting on how societal factors increase children's vulnerabilities, participants noted the powerful cultural norm of children respecting adults. Participants felt that families and society emphasise tradition, culture and respect and expect deference to any individual who is in a position of power, including parents, relatives, and unrelated older people. As the analysis progressed, a culture of family and community members trusting each other with their children emerged as prevalent in Nigeria, which makes

it easy for perpetrators to molest a child without being detected. Participants identified Nigeria as a collectivistic society where children are socialised to obey and respect adults. Parents attempting to reinforce this culture of respect predispose their children to sexual abuse:

'Nigerians trust people easily and this socio cultural practice that a child should always listen to and respect an adult, you see mothers telling their children that one brother in the neighbourhood requested to send the children on errand. People will knock on the parent door, asking to send their children an errand, just to have access to the molest child, when the child refuses the mother asks them to get up immediately and listen to the neighbour.'

(Dr. Adeyemi, practising psychologist)

Participants opined that experiencing sexual abuse during childhood is associated with an increased risk of adverse outcomes, including physical, psychological, behavioural, social-economic and educational consequences. It was felt that victims in unidentified cases, unsupported victims and victims in ineffectively managed cases may experience these consequences. This subcategory provides a comprehensive explanation of the aetiology of CSA using multiple but interconnected factors drawn from HCPs' perspectives. The aetiological factors identified in this subcategory provide a critical contribution to the findings on HCPs' understanding of CSA.

6.1.4. Consequences and impacts of experiencing CSA

This subcategory discusses the possible short and long-term detrimental and interrelated outcomes of experiencing sexual abuse in childhood. While participants were not directly asked about the consequences of CSA, their narratives demonstrated their clear understanding of the possible impacts of this adverse childhood experience.

Additionally, participants felt that these consequences are not just experienced in the short- and medium-term but can endure for a lifetime. Participants emphasised that outcomes could occur or recur at any stage of the victim's life. The outcomes that emerged from the data analysis have been grouped into five categories: physical/medical, psychological, behavioural, moral and educational consequences.

Physical/Medical: Participants associated the experience of CSA with a wide range of adverse physical health outcomes that required immediate multidisciplinary responses, including emergency treatment for victims in critical states. These outcomes range from acute physical injuries to the genitals or other body parts, as CSA often occurs under coercion, especially penetrative abuse. Other physiological conditions include head injuries, sexually transmitted infections including HIV, sepsis, damage to the child's reproductive system, vesicovaginal fistula, lower limb paralysis and mobility dysfunction. In most cases, victims can experience rapid health deterioration and have poor prognosis, as the following excerpt describes:

'She came in a very critical condition, unconscious, infected with sexually transmitted infection, HIV-positive stage 4, her condition was going down on a daily basis healthwise, some of these children who marry early suffer from what we called VVF (vesicovaginal fistula).'

(Mrs. Ogbenne, psychologist)

In the longer term, participants linked a range of enduring illnesses and disabilities to CSA, such as spinal cord injuries. They claimed that the consequences can require various professional interventions that mean frequent hospital visits or prolonged hospital stays, and some of the injuries lead to death.

Psychological: Participants identified the detrimental effects of experiencing CSA on victims' overall emotional well-being and psychological health from childhood through to adulthood. Recurrent themes indicate that victims struggle with excruciating psychological pain and trauma, which comes with many psychological issues that may persist into adulthood, as discussed below. The narratives indicate that victims can become socially withdrawn, feel depressed, self-harm, attempt or commit suicide and can exhibit many other mental health conditions. Some mentioned psychological trauma and emotional difficulties following CSA; in particular, post-traumatic stress disorder and somatic disorders. They claimed that many victims had attempted or committed suicide to escape from the psychological trauma associated with CSA:

'It affects the child psychologically till and after marriage, the serious pains and trauma; Pains on your past that can always catch on with you, so I just say so many issues around it, like the child is withdrawn, depressed, flashback that haunts, and post-traumatic stress disorder and others died in the process.'

(Mrs. Obi, mental health nurse)

Behavioural: Participants' narratives revealed that CSA is associated with an increased risk of externalising behaviours. Participants explained how victims display antisocial or age-inappropriate behavior, anger outbursts, offensiveness, substance abuse, rude and disrespective, running away from home and inappropriate or risky sexual behaviour. A common view amongst interviewees was that delinquency was the victim's way of retaliating against the perpetrator who used authority to exploit them. Many interviewees suggested that such unruly behaviour was due to victims feeling that their family had failed them, basing this view on personal experiences of behavioural changes after experiencing CSA and their professional practice:

'Unnecessarily aggressive, become really rude and unruly, disrespectful, stubborn, so it's the only way they can just show their anger, some of them intentionally become unruly to authority, especially when it was done by someone in a place of authority, so they feel anything authority shouldn't be obeyed, most of the survivors right now feel their family has failed them.'

(Barrister Agboola, child protection specialist)

Educational: Participants explained that people who had experienced CSA might miss school and perform poorly academically, or their educational journey may be limited due to unplanned pregnancy. Another reason for disengagement with the education system and careers was the psychological trauma victims experienced, which reduced their concentration. A participant further explained that during childhood the victim might not realise the consequences of the experience, and the burden would only be felt by the parent until the victim reached adulthood:

'Being absent-minded in school because of what they have gone through. It is the parents that are feeling that burden until they [victims] become adults when they now see that they left school because they [victims] became pregnant and then they could not continue.'

(Mr. Oke, child/clinical psychologist)

Socioeconomic: Participants explained that victims might struggle with CSA-related consequences such as an unplanned pregnancy, vesicovaginal fistula, deterioration or a poor prognosis for physiological or psychological conditions. They may then become incapacitated and may be less productive or employable, limiting their ability to become financially independent like others without this adverse childhood experience.

Victims are unable to contribute optimally to the national income; rather, they become dependent and may even become a national socioeconomic burden:

'*Such a person you want to say becomes an added burden to the nation because the person will not be contributing optimally to the nation… he/she is down with illness or unplanned pregnancy.'*

(Mr. Oke, child/clinical psychologist)

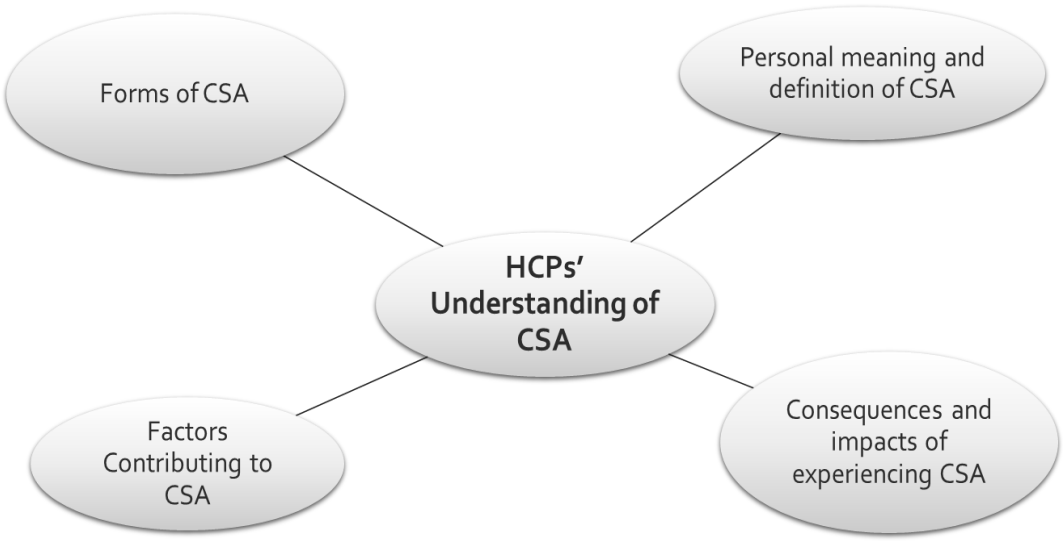
Morals and Values: Reflecting on various cases, participants commented on how this experience had influenced the victim's values, morals, and attitude. Reminiscing about their clients, HCPs narratives repeatedly showed that some victims become wayward and promiscuous and unruly:

'*She has gotten to the extent that even as young as she is, under the age of 14, she can spend two, three nights in a man's house. When the father punished her, she ran out and spent almost three weeks, so somebody now saw her and brought her to the father... and she started moving on and sleeping with everyone.*'

(Mrs. Ajededun, practising nurse)

This subcategory considers the meaning HCPs attached to their personal and professional experience of CSA, as well as their understanding of its consequences across all spheres of victim life. They conclude that experiences of CSA affect all domains of an individual's life, influencing their physiology, psychology, and behaviour, their educational situation, and their socio-economic status as well as their morals and values. Figure 9 shows themes derived from HCPs' understanding of CSA.

Figure 9: Diagram of themes derived from HCPs' understanding of CSA



Overall, various themes emerged in this category that provide an insight into HCPs' understanding of CSA, ranging from personal understandings to legal definitions, perceived forms of CSA, vulnerability factors and consequences, along with convergences and nuances in these understandings. It also highlighted what the HCPs considered predisposing factors, forms of CSA and consequences for victims, families and society. It describes how HCPs' early life experiences, cultural and religious traditions, and their professional background and practice, influenced their understanding of CSA. Exploring and uncovering their understanding of the concept of CSA provides an insight into the scope and dimensions of CSA in Nigeria and the context in which HCPs practice. The next section explains category two: the personal motivation for choosing a career in supporting sexually abused children.

6.2. Category 2: Personal motivation

This category explains the interplay between HCPs, their expertise, and social context, describes their inspirations, and emphasises their commitment to supporting victims. 'Personal motivation' revealed various reasons for HCPs' choice of a career in supporting victims of CSA. The three recurring themes are discussed as subcategories: (1) personal experience and expertise, (2) negative societal attitude including children's social invisibility, and (3) poor available support systems. The passage below illustrates the cultural, educational, and professional background of an HCP in Nigeria. While it is informed by empirical data from this study, this example is fictional to ensure confidentiality, privacy and anonymity. This category comprises three subcategories that are discussed in detail in this section.

6.2.1. Personal experience and expertise

The initial analysis revealed that being an expert in child-related fields was a fundamental inspiring factor. Participants considered their skills, competence, expertise, experience and knowledge about child development important influences on their decision to support victims of CSA, and also on their successful practice. The HCPs' narratives show that their professionalism and expertise were intertwined and indistinguishable from their self-motivation and commitment to caring for CSA victims and survivors. Working in a child healthcare setting inspired some of the HCPs, who were unable to separate their expertise from their practice and themselves. Like other participants, Mrs. Ugo considered herself an expert, which became a strong impetus towards a career of supporting sexually abused children.

'I am a social worker. So, you can see that what I am doing is also my area of expertise.'

(Mrs. Ugo, social worker)

For other participants, working in child healthcare services or being educated in child developmental psychology and understanding human development were motivating factors. In addition to these reasons, Mrs. Obi opined that her expertise, as a competent mental health expert who could identify CSA victims' mental health needs, led to her holding critical roles in providing psychosocial therapy and support and minimising the mental health impacts of CSA. Participants perceived themselves as experts due to their educational and teaching backgrounds and their professional practice. They were determined to prevent CSA, detect it early, and respond to and treat sexually abused children. They considered formal education and clinical experience formative influences, indicating that they prioritise technical knowledge or at least have some expertise beyond a passion for supporting victims of CSA. In participants words:

'Being a clinical psychologist alone is an impetus, the developmental psychology focusing on the child and adolescents area, and across almost every facet of life.'

(Mr. Oke, child/clinical psychologist)

'Sexually abused children come down with mental health problems and we are fit to help them as mental health nurses.'

(Mrs. Obi, mental health nurse)

Most HCPs started their careers by majoring in child health and welfare-related fields such as child psychology, social work, clinical psychology, medicine, paediatrics and mental health, and even constitutional law. This indicates that they were not just passionate about helping victims of CSA but had backgrounds and education in related

fields, and that acquiring the knowledge, experience, skills and competence essential for supporting sexually abused children contributed to their decision to support victims of CSA.

HCPs also reflected on their childhood experiences and struggles with sexual abuse and explained that these were strong influences on their career choices. Some participants disclosed that they had also been abused and molested and that their experiences gave them a personal understanding of CSA and its consequences and emphasised the importance of supporting the victims. HCPs described their experiences of childhood sexual abuse as *'struggling with the dark hole,'* '*walking in the dark*,' '*imposing excruciating pains*,' '*past excruciating pains always catching up*' and '*past pains encroaching on the presence*'. These terms illustrate the sense of helplessness, hopelessness and trauma they coped with as young people and the struggle to live a normal life after the experience, with or without help. The excerpt below shows that these experiences were central to their commitment to becoming CSA experts and supporting victims:

'I am a survivor of child sexual violence myself; I was sexually abused as a child when I was age 4 to 13 by the family member, and I went through a lot of all the effects and the consequences. I was able to climb out from that dark hole, some people even died in the process.'

(Mrs. Ugo, social worker)

Mrs Ugo was not alone in this; many participants told similar stories about being sexually abused as children and the consequences they experienced:

'For me it was a personal experience, an excruciating pain that always catches up with the present. I was sexually abused by my uncle from the age of 12. Because of the

psychological effects- severe depression and suicidal ideation and the years it took me to seek professional counselling, get help and live a normal life. That is the reason why I am helping the victims of CSA. I had to be checked into a mental health facility. I later realised that there are adults like myself who have been sexually abused as children who are broken and have not healed and are living with this trauma, which is why I decided to go into this field.'

(Mrs. Obor, counsellor)

Participants shared that personal experience of CSA and its impact promoted empathy and a sense of responsibility to protect other children. They suggested that it was unbearable to see others undergoing the same trauma, so their career choices were inevitable. Even participants who tried to repress the connection between their experience and career revealed in their narratives that they construed their careers as callings from God.

'*I am a survivor, but that has nothing to do with why I am doing this work. I got a calling from God and this is the area I focus on. I am doing this work because I am a survivor and I do not want to hear this happening to others.'*

(Dr. Adeyemi, practising psychologist)

These narratives suggest that while the participants make conscious efforts to separate their childhood experiences of sexual abuse from their careers by focusing instead on their spirituality, conflict arises between their conscious and subconscious, again highlighting the experience of CSA as a strong predictor of an interest in supporting victims. This is especially true for individuals who were not supported during childhood and suffered effects that started in their formative years and extended to their adulthood. Participants understood the devastating consequences that can

develop into a complex and dynamic situation for the victim; the impacts can occur, or recur, at any stage of a survivor's life. Simply because victims and survivors are not experiencing a particular outcome at one point does not mean they will not experience it later. Therefore, they were driven to specialise in careers where they seek to identify victims early on and avert or minimise the consequences. Personal experience of CSA and understanding of its consequences resulted in a great sense of responsibility among the HCPs in this study. Responding to victims became a personal quest to combat and address the culture of silence around CSA in Nigeria, and a means of acquiring peace of mind and committing to supporting victims:

'*I came out with my story, if we don't treat them at this early stage, it'll affect them in the future.*'

(Mrs. Ugo, social worker)

This subcategory is highly relevant to our understanding of both internal and external factors that become personal motivations for HCPs' choice of a career in responding to CSA. It shows that being an expert, having knowledge of child development, and being at the forefront of a sector with direct or indirect access to children plays an influential role in their choices. Similarly, being a victim of CSA plays a critical role in understanding the struggles of victims and the care they require. These experiential factors become a personal motivation for choosing this career.

6.2.2. Negative societal attitude including children's social invisibility

How participants viewed children in Nigeria also had an impact on their choice of profession. Many participants felt that children are vulnerable, oppressed and socially invisible in Nigeria, which puts them at a higher risk of being sexually abused without

being able to disclose it or receive the necessary social and healthcare support. One participant mentioned:

'*I think in our society, children are a marginalised population of the society, there is this social invisibility of children and they can't even contribute when elders are talking. I like helping the vulnerable, the oppressed and supporting families that require assistance.'*

(Mr. Ike, general practitioner)

Mr. Ike was not alone in this; participants told similar stories about voiceless, vulnerable, or oppressed children in Nigeria. HCPs believed they should advocate for children due to their position as members of the social elite. According to the HCPs in this study, children face social, cultural, economic, and political deprivations. Their stories showed that children are unaware of their rights, victimised, and exploited, and unable to seek help. Participants agreed that children are not responsible for CSA and are unable to recognise it.

'*There should be programs to protect children's rights, let them know their rights, unfortunately, that is where we are, we have not grown up as a nation*.'

(Mr. Ike, general practitioner)

In addition, participants considered silencing, shaming, labelling, blaming or stigmatising the victim a negative societal and national attitude; this is a common practice in Nigeria that became a clarion call for HCPs to support victims. Participants consider themselves learned members of society and, as adults, they decided to shoulder the responsibilities of advocating for children's rights and supporting victims of CSA. As Mr Okonkwo said:

'*It's true the children are voiceless, but we, the elite, we are their voices.*'

(Mr. Okonkwo, psychologist)

Most participants were disheartened by the alarming rate of CSA in their areas. They claimed their extrinsic motivators were not personal or familial experiences of child abuse but witnessing increasing numbers of sexually abused children in their neighbourhoods. Residing in a society that has normalised the sexual abuse of children, especially children from low socioeconomic backgrounds, was an impetus for the participants. They suggested that the normalisation of CSA has driven its prevalence to soar unbearably, motivating them to get involved:

'*When I came to the south, I was shocked to see numbers of children sexually abused. I can say I did not suffer any CSA, and then I stayed in neighbourhoods where children are frequently abused, especially those with this label of house help. I just realised that our society is not safe for our young girls. It is alarming and affecting young boys too, it is becoming a pandemic and nobody cares.*'

(Mrs. Chukwu, nurse)

This subcategory makes clear that HCPs have an important external motivation for supporting sexually abused children. They choose their careers because of the social construction of childhood and the invisibility of children in society, and because of the society's negative attitude towards sexually abused children.

6.2.3. Poor available support systems

This theme described the poor support system available to victims of sexual abuse in Nigeria. HCPs believed the road to recovery for sexually abused children is a personal journey that requires the support of their social network, empowerment and autonomy. Unfortunately, participants felt that society did not provide victims of CSA with a

social support system that benefited their general well-being and mental health. Instead, victims experience negative societal reactions, such as blame, shame, accusations of lying, silencing, and labelling at the time they require the most support. Participants felt that Nigerian society benefited perpetrators by channelling available support to perpetrators while neglecting victims. Professional narratives showed that the societal practice of supporting perpetrators while neglecting and failing to support victims influenced HCPs' decision to utilise their resources to support victims of CSA:

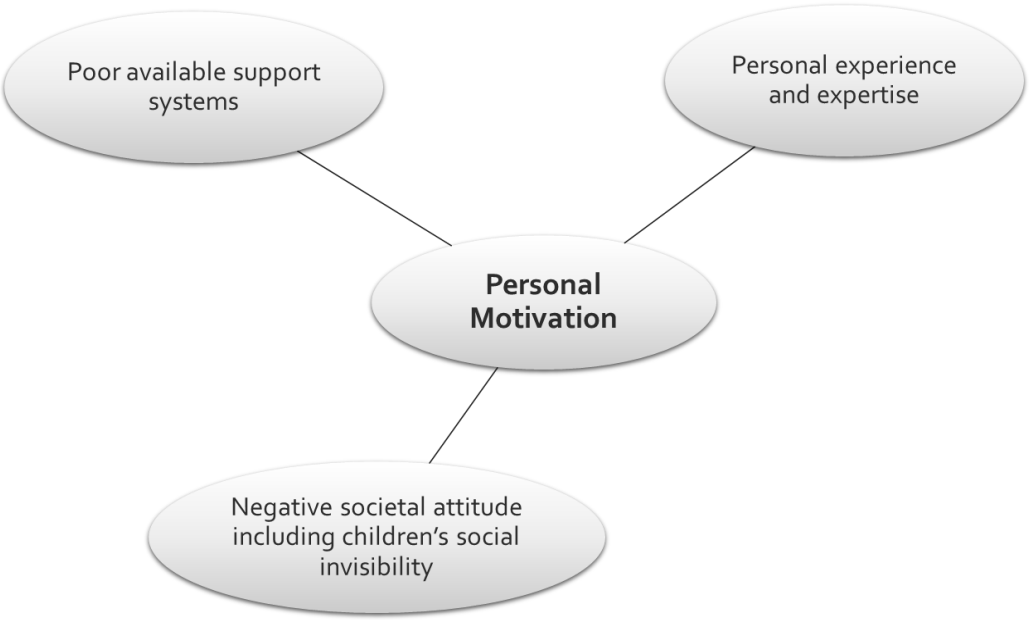
'*I looked at the whole country, every special attention is on the accused person/perpetrator and none for the victim. The legal framework simply talks about the perpetrators, nothing whatsoever on the victim. You will see like 100 people at the police station actually there to support the perpetrator and only two people are there for the victims, so this means that there is a need for more support to the victims.'*

(Barrister Agboola, child advocate)

This subcategory shows how HCPs' perception of the poor national child welfare and support system becomes a strong factor in making the personal decision to support victims. HCPs understood the implications of a poor support system on society's perception of children and the quality of care available to them; this understanding influenced their decisions to support victims of CSA. Additionally, participants claimed that children's social invisibility and negative societal attitudes towards victims, inappropriate victim and perpetrator support systems, and the soaring prevalence of CSA due to factors ranging from negative societal attitudes to the normalisation of sexual abuse, also influenced their career decisions. They explained that despite increasing awareness of its prevalence, national organisations, society and families appear indifferent to CSA. Therefore, participant concluded that there is a need for immediate preventive actions and responses to minimise the effects of CSA.

Figure 10 presents a diagrammatic illustration of this category. Having discussed the pertinent motivating factors that led HCPs to support victims of CSA in Nigeria, I will next discuss the third category, which explores the nature and process of supporting sexually abused children.

Figure 10: Diagram of the personal factors that motivate HCPs to support sexually abused children



6.3. Category 3: Dimension of practice ('Walking through the darkness with the victim')

Participants' definitions and broad conceptualisations of the nature and process involved in identifying and supporting victims of CSA emerged as they described a typical day at work and the distinctive features of supporting victims of CSA. Throughout the data collected, respondents repeatedly described the nature and process of their practice, not necessarily to present challenges or difficulties but to illuminate our understanding of the processes inherent in identifying and supporting

the victims of CSA. While the nature and process of supporting sexually abused children differ from one SARC to another, and the meaning attached to this differs from one HCP to another, the descriptive fictional case study depicts the typical day-to-day experience of many HCPs who support sexually abused children in Nigeria. The three recurring themes are discussed as subcategories: (1) dynamism and complexity, (2) sensitive and evoking strong emotions, and (3) professionals' and victims' vulnerability. The next section presents the three subcategories used by HCPs to conceptualise the dimensions and nature of supporting CSA victims.

6.3.1. Dynamism and complexity

Participants explained their perspective on the dynamism and heterogeneity of CSA cases, victims' characteristics and needs, perpetrators' characteristics, person–situation interactions and intersecting contextual factors. Due to this heterogeneity, the process lacks a typical nature beyond multitasking, constant adjustment and the need to employ evolving or new approaches. Participants described their practices as '*no size fits all*,' as supporting victims of CSA involves diverse practices and strategies. In Nigeria, practitioners who are responsible for victims of CSA are also responsible for handling other gender-based and domestic violence, which they found challenging. Some participants described the high diversity of the cases they handled and the multiple disciplines involved in victim care. The narratives highlighted the involvement of counselling teams, medical intervention, legal teams, social welfare teams and monitoring and evaluation units. Some participants considered various modes of contacting and responding to the forms of gender-based violence they encountered daily and how they required special attention. In one participant's words:

'*We do not have a typical day. We have different units that handle different aspects, medical unit, counselling unit, legal unit, Monitoring & Evaluation unit, and the social welfare units. We have a network of government agencies, which we work with. Our work is dynamic, nothing like a cool day. We have walk-in clients or call out to see, clients seriously injured requiring immediate rescue team and community programmes.'*

(Mr. Oke, social worker)

Participants thoroughly explained the intricate combination of various processes, such as investigating cases, securing evidence, providing medical and psychosocial support, managing cases and securing justice for victims. They also emphasised the complexity of the bureaucratic judicial, legal and medical processes and the magnitude of training required in child protection case management to consistently improve their knowledge. According to participants, the health, social and legal needs of sexually abused children are complicated and systematic, which means HCPs' practices and responses are often unpredictable and involve more than merely understanding an individual. The complex adaptive system must include various processes, stages and interventions to provide each victim with holistic care. Participants also mentioned the complexity inherent in the heterogeneity of CSA cases and the practices involved in supporting sexually abused children and working with their families, especially in cases of intra-familial CSA. According to the participants, their jobs are rarely hospital-based. An important aspect of their practice is community-based intervention: implementing various projects, working with and empowering the community, and establishing community-based structures for early identification. These practices include organising training to recognise and respond to CSA and addressing the dominant culture of silence and unhealthy cultural norms and practices. Participants claimed that

they gained stability, despite the inherent complexity of their work, by implementing various projects and working with the community. Participants also noted that acquiring and undergoing various training programmes and qualifications and building team capacity had widened their horizons, given them more expertise in their chosen fields and establishing some stability:

'Then a lot of what we do gives us some form of stability. We are working in communities trying to establish community-based structures and child protection committees so that committee members are able to recognise and respond to sexual abuse of children. We work with team members and leaders and then equip them with the skills to recognise CSA. We create awareness about the culture of silence and address cultural norms. You know, that affects response to sexual violence. At the same time, I am responding to any cases that come into the office. We just recently opened a Support Centre for these children, it is not as easy as I'm making it sound. It is a whole lot.'

(Mrs. Ugo, social worker)

When discussing the complexity of their practice, HCPs also mentioned that their tasks were chaotic and time-consuming. Case work is made potentially more difficult by the complexity of individual cases alongside the soaring number of cases being reported. Cases are reported rapidly and the tasks involved in addressing them are demanding; HCPs reported that they found this challenging. Participants felt that they often experienced a chaotic, busy schedule and hectic environment, a situation made worse by increased workloads due to staff shortages.

This subcategory adds to the depth and quality of the description of the nature and process of supporting sexually abused children. It shows the enormous complexities

of care, dynamism and multi-diversity of practice as HCPs navigate through both the micro and wider system of the victim. It also shows that HCPs found some form of stability through this complexity and dynamism, because they considered these challenges to be inherent elements of their practice.

6.3.2. Sensitive and evoking strong emotions

Another important theme that emerged as participants described the nature and process of their practice of supporting sexually abused children was that it evoked strong emotions. This phrase referred to the sensitivity and traumatic nature of CSA cases and the practice involved. HCPs found themselves engaged in sensitive aspects of victims' lives, their families' lives, and even perpetrators' lives, which required a diplomatic approach. In certain cases, HCPs verbalised intense feelings of being traumatised due to the emotional cases they handle daily, indicating that sexual abuse is not only traumatic to the victim but also has a significant impact on HCPs' lives:

'*First, they may be traumatised, the crying may not even allow them to talk, try to reassure them and calm them down first and you don't feel right about it, you become emotional.'*

(Mrs. Obi, mental health nurse)

All of the participants' narratives highlighted the strong emotion their practice evoked:

'In fact, with what we handle each day is so traumatic to us as staff here, because right now what we're even battling in Nigeria now is incest.'

(Mrs. Oge, social worker)

'It was one of the most devastating cases that I ever handled. I cried so much, cried so much because I knew what the girl went through and what I was reading in the

newspaper and social media. I started crying, shouting, what do I do? Who should I call? The judiciary is not helping, I was so heartbroken for a long time.'

(Mrs. Obor, counsellor)

In addition, participants' stories about their practice emphasised that, despite their unrelenting effort, HCPs were disheartened and felt helpless and frustrated by societal ignorance, ideology and the cultural shock often exhibited when children are sexually abused. HCPs used terms such as *'traumatic,' 'feeling disappointed,' 'helpless,' 'unfulfilled', 'handicapped', 'frustrated' and 'being a lone voice',* which evoked strong emotions. As Mrs. Obor's narrative revealed:

'*We felt really helpless. She has been victimised, threatened and was not ready to go forward with the case, and because it was their staff who was involved [police officer was the perpetrators], they tried to cover the case and also, we couldn't have access to the girl to take her through counselling at that time.*'

(Mrs. Obor, counsellor)

Some interviews reveal that societal and family responses to sexually abused children can dishearten HCPs. Participants described dismay that victims were subjected to corporal punishment and victimisation, which they felt contributed to further traumatising the children. In Mr. Okonkwo's words:

'*The boy was sexually abused and everybody was blaming him, the parents gave him corporal punishment, I have to call the young boy, and stabilise them emotionally and the thought of it is traumatic.'*

(Mr. Okonkwo, social worker)

HCPs claimed they often experienced either child–parent conflicts of interest or HCP–parent conflicts of interest and that protecting a child's best interests in these contexts

required care. Participants realised that becoming involved in the family's private life while dealing with conflicts of ideas, ignorance and negative attitudes among the family and community members towards CSA was a very sensitive and traumatic experience. However, despite the resulting emotional disturbance, they asserted that as child protection experts they had to stand up for children's rights and make decisions in their best interest. To do so, participants described acting as 'voices' for children and focusing their energies on the child's psychological and emotional well-being, while silently dealing with their frustration. Another important aspect explained by the participants was the overwhelming emotional effect of fulfilment associated with securing justice for vulnerable and victimised children:

'*Is so fulfilling and emotional seeing them get justice, seeing them being treated like every other child irrespective of their family background and for them to have a better future.'*

(Mr. Okonkwo, social worker)

The HCPs ensured that sexually abused children received equal treatment irrespective of background and provided an environment in which they could harness their potential and succeed in the future. While they emphasised strong negative emotions, some of the participants also acknowledged a sense of fulfilment from successful cases.

While discussing the sensitivity of the child–HCP or HCP–family interactions, HCPs expanded on the sensitivity of their practice and their clients, who are the core element of care. They were conscious of children's sensitivity, their interactions with victims and the importance of using appropriate techniques or approaches. They understood the delicacy of their roles in this context and worried about handling cases improperly,

because if the child felt uncomfortable they might withhold disclosure and that could limit case identification and management. Building trusting relationships with children to extract evidence from them, working with families and following all necessary procedures was not only time-consuming but also extremely sensitive work, as this excerpt demonstrates:

'Thinking about the whole stuff, you realise how self-conscious you are. During the interview session, you are concerned the child may not feel comfortable talking about it or maybe the way I or previous HCPs handled it, the child feels bad, withdraws some information from you and that's where you start having problems, especially since children are more sensitive.'

(Mrs. Okafor, nurse)

The HCPs conceptualised their practice as a '*daily battlefield,'* emphasising trauma, especially when addressing cases of intrafamilial CSA. Because such cases occurred in a context that was supposed to be the child's safe space they were difficult to address and discuss, and both the child and the HCPs found it distressing to engage with these forms of abuse as their roles put them in opposition to family decisions about responding to the situation. Overall, it became evident that, as much as the experience of sexual abuse emotionally disturbs victims, the HCPs caring for them are also grossly affected.

We have gained a deeper understanding of practice through this theme, which has provided a situational analysis of certain unfortunate events that affect HCPs emotionally. Constantly caring for sexually abused children who are helpless, powerless and have suffered sexual abuse, exploitation and victimisation by people in

position of power who were supposed to safeguard them and maintain their rights evokes strong emotional reactions and can be traumatic for HCPs.

6.3.3. Professionals' and victims' vulnerability

Further into the analysis of participants' narratives on how their day-to-day practice evoked strong emotions, the issue of professional vulnerability emerged. Professional vulnerability emerged as being associated with threats from perpetrators' families, media coverage, perpetrators' influence and the ineffectiveness of the judiciary system. Participants described feeling insecure due to their encounters with perpetrators and their family members during and after court proceedings. They felt insecure due to their visibility, and the confrontational behaviour, threats, assaults and violence from perpetrators and their families experienced during the processes of identifying or aggregating and presenting evidence in court. These threats during the prosecution of the perpetrators were devastating. A participant described the sense of insecurity:

'Most often your life is not safe because when you go to court to testify and give a report of the forensic or physical examination. The perpetrator and his family have already seen and know your face. So, if care is not taken, they become a threat to you, but it does not matter, evil is evil. We have to live up to our responsibility, exposing those perpetrators, bringing them to book.'

(Mr. Okonkwo, social worker)

The participants felt a real threat to their lives due to the cases they had handled, and without governmental protection or security they have had to adopt measures to ensure their safety. Some of the participants resorted to numerous safety measures, which included relocating to a safer residence or disguising their physical appearance, even

when doing so compromised their religious beliefs and personality, when travelling between home and work. Participants reported that even when the perpetrator was apprehended, victims, their families and HCPs remained in danger. In addition, the participants' accounts indicated that perpetrators and their families often intimidated victims and their families, and the community and property owners could expel the victim's family from their house and community if they insisted on seeking support and justice for their sexually abused children. This is because Nigeria is a collectivist society which prioritises the relationship dynamics and harmony of the group over the needs, well-being and desires of each individual**:**

'Due to the threat, I have to disguise myself when going home or coming from work. At some point, we had to relocate to a more secure residential area for security purposes. Sometimes when I am going out, I can decide to wear a wig, hijab, dress like a Muslim to disguise, because at a point my life was in danger. The perpetrator family most of the time will intimidate the victim's family, even on the street the landlord can even ask the victim to leave their house if the victim's family insist they want to seek justice.'

(Mrs. Obor, counsellor)

Further exploration showed that perpetrators often confront HCPs after proving their innocence, bribing their way through the prosecution process or serving their jail terms. Participants felt threatened by direct and indirect accusations from perpetrators and had to prove their innocence in such cases. They described employing diplomatic approaches to handle these situations due to the fear of uncertainty and threats to their lives. In Mrs. Okafor's words:

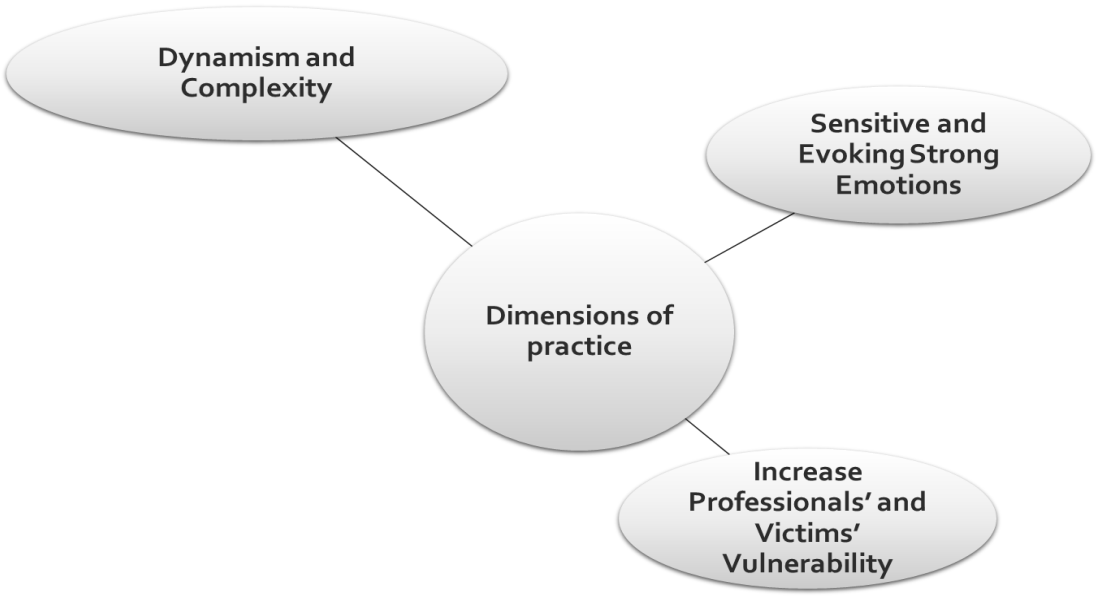
'Perpetrators come after you when the prosecution is over and maybe they have served their jail term or they managed to prove their innocence or bribe their way. I had to portray myself as innocent and use diplomacy.'

(Mrs. Okafor, nurse)

The theme discussed the sense of insecurity and violence that HCPs experience when walking with victims through dark times. It explained that HCPs working with sexually abused children and their families are exposed to a lot of insecurities and violence. By doing this, it provides an insight into a critical aspect of the practice of supporting sexually abused children in Nigeria.

In summary, participants described the dynamism, complexity and chaos involved in the early identification of sexually abused children and appropriate response to such cases. They considered the investigative process of identifying victims, securing evidence and managing cases, as well as the hospital procedures and bureaucratic processes involved in obtaining justice for victims, complex and dynamic. Participants discussed the necessary training, qualification and skills required to safely practise in this field and how doing so has widened their horizons and professional practice. Dynamism and complexity were also discussed with regard to various essential community projects that were daunting but necessary for professional and personal development and the achievement of stability. In addition, participants reflected on the strong emotions evoked by their practice in terms of involvement in the sensitive sphere of victims and their family lives, negative societal responses, and feelings of frustration from inappropriate responses by agencies that should advocate for and protect CSA victims. Finally, this subcategory further contextualises the degree and severity of HCPs professional vulnerability to insecurity, threats and confrontations and explained the diplomatic and safety-related approaches they employed.

Figure 11: Diagram of the dimensions of practice of identifying and responding to sexually abused children, as described by HCPs



6.4. Summary

This chapter introduces the research findings. It discusses the first three categories: the HCPs' understanding of CSA; 'personal motivation,' highlighting both the internal and the external factors that lead HCPs to focus on supporting sexually abused children; and the nature and process of the professional practice of identifying and responding to sexually abused children. It outlines that the active interaction and involvement of HCPs with children's social systems, the socio-cultural context, and collaboration with multidisciplinary teams are all challenges for practice in this field. It sets out the nature of practice as complex, dynamic, sensitive and evoking strong emotion, as well as increasing professional vulnerability. The fourth category, which examines the issues and challenges faced by HCPs, will be discussed in detail in the next chapter.

CHAPTER SEVEN: RESEARCH FINDINGS

This chapter discusses category four, which explains the issues and challenges undermining HCPs' identification of and response to sexually abused children, and their implications. While the issues and challenges SARCs and HCPs encounter vary, the Casey team demonstrates the typical challenges of identifying and responding to sexually abused children in Nigeria irrespective of the geographical location, team discipline or team dynamics.

7.1. Category 4: Contextual issues and challenges undermining HCPs' practice

In this category, narratives about the participants' day-to-day personal experience and their understanding of the challenges they encounter in their professional practice emerged. These challenges are discussed in relation to the core elements of their practice, and particularly their sociocultural context. The implications of these challenges for practice, victims, families and society also emerged. The analysis of the collected data produced deep insights into the specific issues and challenges associated with identifying and supporting sexually abused children and their families in Nigeria. The five recurring themes are discussed as subcategories: (1) HCP-related challenges, (2) victim-related challenges, (3) family interference, (4) institutional or systemic challenges, and (5) sociocultural challenges. The next section presents the six subcategories HCPs used to narrate their understanding of CSA.

7.1.1. HCP-related challenges

This subcategory discusses issues related to HCPs themselves, as the key personnel shouldering the responsibility of supporting victims of CSA.

Lack of professionalism and competence: Professionalism and competence are fundamental elements of all practices of supporting CSA victims and their families. However, most HCPs who shouldered the responsibility of supporting victims stated that they did not have the ability, competence and professionalism to effectively manage these cases. They considered the problem to be compounded by a lack of relevant experience, training and professional development, a lack of support from employers and institutions, a lack of resources, and discrepancies in multidisciplinary perspectives. Most HCPs in Nigeria have degrees in their respective disciplines without specific training in CSA. One example is Mrs. Ajededun, an emergency nurse, who reported uncertainty and limited knowledge of the concept of CSA and the professional response to sexually abused children:

'*Well, I work at a children's emergency and I have seen a few cases. I do not know what they expect, we just send them to the social worker, who hands cases to the police.'*

(Mrs. Ajededun, practising nurse)

When asked about her understanding of CSA, she provided a short response after a few signs of hesitation: *'forcefully having sex with a male or female child.'* In addition, there were indications of HCPs' uncertainty around forms of CSA, for example: '*I can't tell you the forms, because I only saw one case.'*

This incompetence was attributed to a lack of adequate training, knowledge and experience in this field, as well as a lack of organisational support. When asked if her

organisation provided any form of training or support relating to CSA and its frequency, this participant said '*No, our organisation doesn't organise such training, no support*.' Some participants claimed there was no training recently due to the global pandemic, which resulted in social restrictions across the nation: '*No training this year because of the Covid-19.'* A lack of adequate knowledge, training and experience was a theme that consistently emerged in participants' narratives. As the analysis progressed, it became evident that some of the HCPs only possessed general knowledge about child abuse. For example, Mrs. Ajetumobi said:

'*We've not gotten such training anyways; we've have the general knowledge of child abuse.'*

(Mrs. Ajetumobi, mental health nurse)

Contextualising HCPs' incompetence, participants cited a lack of knowledge about appropriate approaches and competence to move beyond assumptions and personal convictions to explore suspected cases; as a result, they felt incapable of identifying unreported suspected cases. Participants explained that such cases being reported in the office would be success stories, as they could then work to their full capacity to collect all vital evidence, manage the case and follow up on it. They claimed that acting on professional curiosity to effectively and independently collect strong corroboratory evidence, identify unreported cases and support victims was challenging and came with a sense of disappointment. Exemplifying this professional incompetence, a psychologist working at a SARC said:

'The girl did not report her abuse at the office, otherwise, it would have been better, it was within the neighbourhood. Personally, I knew something was going on between

the small girl and the man, but I did not know how to approach it, I didn't have any evidence, so it was frustrating at times.'

(Mrs. Ogbenne, psychologist)

Furthermore, participants claimed that the practices, knowledge and competencies required to support sexually abused children rapidly change and the lack of professional training and development programmes has a ripple effect on professional practice. Participants also reported feeling inadequately equipped and inefficient, and often questioned their professional expertise and performance when confronted with cases of CSA. Moreover, participants considered their current practices to be substandard:

'There is no size that fits all responses and you cannot even consider yourself as an expert due to the different care the victims required, very complex and the perpetrator coming with a new trend. Truthfully when I look at our intervention presently, we still see it as a drop in the ocean, and not fulfilled.'

(Barrister Agboola, child protection specialist)

Due to this sense of incompetence and inexperience, HCPs were afraid of mismanaging cases even when victims disclosed their experiences of sexual abuse and victimisation. Some participants worried about the consequences of making the wrong decisions or mismanaging situations. Participants thus preferred not to respond to victims rather than display incompetence and mismanagement that could leave the child even more devastated or re-victimised. Echoing this view, Barrister Agboola said:

'Victims themselves will come to you. If you do not know how to respond to them, you have failed them more. There is something we always say that it's better for you not to even respond at all than for you to respond and mismanage.'

(Barrister Agboola, child protection specialist)

This theme is significant in building understanding about the nature of some of the intrapersonal issues participants encountered in their roles. The theme not only indicates the competence of the HCPs, but also offers explanations such as the lack of training and professional development programs, limited experience with cases of CSA, and lack of organisational support resulting in a serious sense of incompetence. It also depicts how the complexity and dynamism of care required the HCPs to mask this sense of incompetence.

Discrepancies among HCP disciplines: A multidisciplinary approach in practice is essential to providing effective and comprehensive care to sexually abused children (Hornor, 2022). It allows professionals from different disciplines to combine their expertise and resources to resolve complex cases and provide medical, psychosocial and legal support for the victims (Hornor, 2022). Unfortunately, discrepancies exist across disciplines and perspectives, which present serious challenges for the management of CSA cases. Surprisingly, participants reported that some of their colleagues were uncompassionate and merely seeking financial benefits or the recognition that the practice of supporting victims offers:

'*Some colleagues are after monetary rewards, no passion for this job. Sometimes on a victim's phone, you discover that your colleagues have been collecting money from the victims.*'

(Mrs. Obisesan, social worker)

Evidence of negative attitudes and biases among professionals results in discrepancies and unprofessionalism, which reduces the quality of care victims receive. The participants believed that such negative attitudes discredit their professional values, affect their enthusiasm about partnering with each other, and damage the victim's trust. Explaining the impact of unprofessionalism on victims' help-seeking behaviour, Mrs. Oge, a social worker, said:

'The attitude and perception of people that are meant to support the survivors of CSA is challenging. The police officer blamed a young girl for staying out at night and wearing short dresses and being raped. These kinds of conversation should not arise for any reason. And the child said, "I don't want to go back to that police station;" in that case, you can't push further.'

(Mrs. Oge, social worker)

Conflicts of personal and professional values: Mrs. Oge, like other participants, mentioned that conflicts of personal and professional values interfered with her colleagues' responses to sexually abused children. This has been construed as the fundamental cause of the nonchalant, uncompassionate and even uncaring attitudes of some professionals towards victims:

'For some reasons, I have noticed some of my colleagues are laid back in supporting victims under 18 who are sexually active before the abuse. I can relate, but it is not applicable in practice.'

(Mrs. Oge, social worker)

Some professionals may not consider a minor who is sexually active prior to sexual abuse a victim, as they would not meet one of the three legal criteria for confirming CSA—breakage of the hymen, penetrations and ejaculation. While Mrs. Oge

condemned HCPs' nonchalance towards sexually active children, she could easily understand her colleagues' approach.

Aside from personal morals and values, participants argued that some of their colleagues did not perceive acts that constitute or are defined as CSA as necessarily sexual abuse, possibly because their religious and cultural beliefs and practices tolerate CSA, as previously discussed in category three. One described a scenario in which the first responder told victims to withhold their experience of sexual victimisation to avoid social stigmatisation and shame. This behaviour is counter to the principle of responding to sexually abused children and damages the work of devoted and competent HCPs who adopt a firm policy to address CSA. As she described it,

'*I heard my colleague telling a girl who was sexually abused and reported at the hospital to go home, keep quiet, so she can see husband. She even told the girl that she was not the first to be sexually abused and she was not even a virgin. Very devastating to hear.'*

(Mrs. Oge, social worker)

The conflict of personal and professional values often results in an ethical dilemma. These dilemmas reveal one's judgement of what is important in life; that set of personal or shared beliefs which influence one's actions. In this situation, HCPs struggle to balance their mandatory role of making decisions in the child's best interest, encouraging disclosure and also protecting the child from negative social reactions by advocating the withholding of information. This theme discusses conflicts that may arise within practice, why they occur, and what must be done.

Nascent stages of key disciplines: Some of the disciplines involved in supporting victims of CSA are relatively nascent or remain unrecognised in Nigeria. These

professions lack accrediting bodies, licensing processes and standards for education and experience: the criteria for registration and membership are unrestrictive. For example, social work, counselling and psychology are newer disciplines in Nigeria than they are in Western countries and some other African countries. Respondents claimed that the lack of accreditation and licensing bodies poses a two-fold challenge. First, there is an influx of untrained and unqualified individuals in the profession, which is difficult to address without a clear accreditation and licensing body. Moreover, in Nigeria any individual, irrespective of their background, education or qualifications, can currently practise as a frontline responder and even establish a child protection institution; this means that HCPs must rely on untrained individuals for collaborative case management, which often results in calamity:

'In Nigeria, because social work, counselling are new professions, there is no licensing or regulating body, so everybody is doing social work, anybody can run a child institution and orphanages. They were not trained, it was a bad experience...not only could we not convict the father, we lost access to the children.'

(Mrs. Obisesan, social worker)

Second, children and their families were unaware of these professions and their roles; therefore, participants had to expend significant efforts to come across to families as professionals, gain their trust, and encourage their acceptance of the participants' services. In certain cases, services were refused, which produced psychological distress and a sense of subtle disapproval and intimidation that negatively affected their practice.

'*It is challenging, the hassle of trying to make the family see you as a profession, is a lot to take in.'*

(Mrs. Obisesan, social worker)

As the interviews progressed, participants moved from issues relating to HCPs to victim-related challenges, which will be discussed next.

7.1.2. Victim-related challenges

According to the participants, CSA cannot be identified presumptively or responded to except when it has been reported. Therefore, it is vital that victims disclose their sexual victimisation. Western literature frames children as social actors because they have different skills and competencies, and it is impossible to group them into a single cohort. This means that some can easily express themselves, while others cannot (James and James, 2017). According to Ellis 2019, children sometimes withhold their experiences of sexual abuse since they considered this as a way of choosing the least worst option available to them. Therefore, they keep their CSA experience private to avoid blame and shame. The expectations for children are different in the Nigerian context as children are considered the property of their parents. As a consequence, participants noted that often children do not disclose their experience of sexual victimisation due to the many reasons, which will be further discussed in this chapter:

'*Most children that we have supported, one fundamental thing reoccurring is that they can't disclose or they can't walk up to any adult, let alone HCP*.'

(Barrister Agboola, child protection specialist)

Participants discussed various challenges arising from the victims and a combination of factors that limit victims' disclosure of their abuse and lead them to refuse treatment after disclosure.

Non-disclosure/delayed disclosure: One prominent challenge is non-disclosure, or victims' withholding of their experience of CSA. HCPs attributed this behaviour to various factors. They mentioned that children are often unaware and unable to comprehend or recognise an experience as abusive. They do not understand the meaning, severity and implications of their experiences. In addition, due to their young age, sexually abused children do not have the cognitive ability necessary to ascertain and communicate their experiences and may therefore deny or disregard it. In situations where the victims can comprehend their experience, the child's fear of not being believed or being blamed, punished, judged and seen as culpable for their abuse limits disclosure:

'A child will normally not walk up to the adult and disclose. The first reason is that sometimes the children do not recognise or understand that they are even abused. They are like, how will I put it? What will I call it? The fear of being blamed, punished, or will be made to suffer, they will be blamed for what happened.'

(Mrs. Ugo, social worker)

According to the participants in this study, children's fear of not being believed can be attributed to three main factors: parenting styles and patterns, the perpetrator's significance to or emotional connection with the child, and extremely harsh disciplinary or parenting styles. Victimised children can be very sensitive and tend to observe and elucidate adult dispositions and possible reactions to similar cases or situations, to ensure that they will not be blamed or judged. To provide insight into these challenges, several participants cited the strategies used by victims to understand an adult's position on CSA before disclosure. During sensitisation and awareness programmes, children tend to use projection or third-person language to relate their experiences and assess how HCPs respond to this:

'*They speak in third person. 'Someone I know" or "a cousin of mine," but oftentimes when we eventually get into the whole thing, we discover that it's actually the person asking the question that has experienced it*.'

(Barrister Agboola, child protection specialist)

Other relational barriers, such as an internalised fear of parents or other family members' reactions and the corporal punishment that might follow disclosure, further intensified victims' decision to withhold disclosure. Participants also explained that CSA is often perpetrated by people who are significant to the child, have family ties with them, are supposed to safeguard them, and form a part of their social support system, thereby making disclosure of CSA and the subsequent identification of victims and response to them extremely difficult.

'Imagine a young girl being raped by an uncle who was supposed to be a protector, a guidance to her. How would you [referring to me] feel as a mother, when your younger brother that came for visiting rape your daughter?'

(Mrs. Oge, social worker)

Apart from the prevailing societal culture of victim-blaming, she noted that victims internalise blame and self-blame from when the abuse takes place, which prevents them from disclosing it. Mrs. Oge said, 'He or she [the victim] starts from day one blaming himself/herself.' Internalisation of this blame is one of the main barriers to disclosure, which constrains HCPs' efforts to identify and respond to victims in order to minimise or avert the possible consequences of experiencing CSA. A pervasive theme was threats from a perpetrator to harm or kill the child or their loved ones. The thought of endangering their loved ones often resulted in victims withholding their experience. Participants believed that perpetrators' threats, manipulations, tricks,

coercion and monitoring interfered with victims' decisions to disclose their abuse. In addition, there were concerns regarding children's awareness of the culture of victim-blaming, shaming and stigmatisation that follows disclosure, especially in the African context. When defining these barriers, the participants claimed that some level of professional competence and intelligence is required to view them from a child's perspective:

'They are being tricked into silence, threatened by the abuser threatening to kill them or kill their mothers and their loved ones. Think of it in the position of a child? We are afraid the child is aware of the stigma, the blame, shame is usually on the victim who has been abused.'

(Mrs. Ugo, social worker)

The situational factors that can prevent victims from disclosing their abuse were also considered. In situations where victims have no-one to confide in and are unaware of the actions they could take or the facilities they could seek help from, they experience helplessness and isolation, and feel trapped in the situation. Similarly, participants claimed that most sexually abused children come from low socioeconomic backgrounds and are subjected to child labour. Live-in housemaids, for example, may depend on perpetrators for basic needs such as food, shelter, clothing and education. Disclosure in such circumstances may terminate their source of essential goods and educational opportunities, subjecting victims to further destitution. The fear of returning to a poor life and hopelessness undermines their courage and dissuades them from disclosing their abuse. Therefore, victims may consider CSA the cost of their survival and achievement in life, and not necessarily victimisation to be disclosed:

'Sometimes the child does not have anybody to confide in, so they feel trapped in their situation, especially in what we call the house-help syndrome. They are taken from a place of poverty to stay with their uncle or auntie and they know that if they report this abuse, then their chances of going to school are over, so they just see it as a necessity.'

(Mrs. Ugo, social worker)

Another important challenge mentioned by Mrs. Ugo was the children's awareness of the nonchalant attitudes and ineffectiveness of law enforcement personnel, who are supposed to be first responders. In addition, participants claimed that victims may also withhold their abuse because of their knowledge of previous unsupported victims and mismanaged cases in which the victim did not receive the necessary legal support but attracted negative publicity. Consequently, with zero assurance of appropriate support and justice, as well as knowledge of the possible negative consequences associated with disclosure (particularly victim-blaming and negative publicity), victims preferred to remain silent about their sexual victimisation:

'*This is because they know somebody else that it happened to and no legal support and it's just become a circus and nobody forgets that the child was raped*.'

(Mrs. Ugo, social worker)

Mrs. Ogbenne further mentioned that some sexually abused children claim to consent to the sexual abuse and exploitation, believing that they are in a mutual relationship with the perpetrators, and therefore, refuse some or all treatment. Another situation HCPs find challenging, as expressed by Mrs. Ogbenne, is when victims are uncooperative after the HCPs have invested effort in the case; this was also observed in other participants' narratives. Delayed disclosure can result in a lack of evidence, making corroboration of their claims difficult. In the words of Mrs Ogbenne:

'*When you are doing your best to help the victims and they are not willing to cooperate, claimimg they agreed to sexual abuse, not disclosing*.'

(Mrs. Ogbene, psychologist)

Discrepancy or Inconsistency in the Victim's Story: As the interviews progressed, the narratives shifted from factors influencing children's ability and decision to disclose their experience to other issues that accompany victims' disclosures and also challenge HCPs' day-to-day practices of supporting sexually abused children. A major issue was the presence of discrepancies or inconsistencies in victims' stories, especially when participants had to rely on victims' evidence to confirm the occurrence of sexual abuse. Without cohesive information and evidence, the identification of such cases becomes impossible. According to Mr. Agboola, victims stories are often felt to be unbelievable because they contain gaps and contradictions. While all participants emphasised the gravity of this problem, two participants critically analysed and rationalised the peculiarities of this behaviour in sexually abused victims. Both these participants claimed to have come to better understand the mechanism of victims' psychological states following sexual abuse, which influences the quality of the information they disclose. In this sense, participants mentioned that it is necessary to have very low expectations of the precision, clarity and breadth of children's stories of their sexual victimisation. Participants explained that during disclosure, victims consciously or unconsciously block parts of the factual reports from their experience, or they only disclose those parts that they are comfortable disclosing; hence the contradictions in their stories. Repression, blocking, denial, selective disclosure, and intentional and unintentional omissions of information are mechanisms that victims employ to deal with the psychological turbulence, self-blame and shock caused by

their experience. While the role of HCPs is not to seek logic and consistency, relying on disjointed and incoherent pieces of evidence is challenging.

'People do not believe because they feel that the story does not add up, we've come to realise that you never expect the story to add straight up like that because their minds are shot to some facts and may only say those they are comfortable with. They want to deny, block and repress whatever they want to repress. The brain just plays tricks on them. So different situations determine what they remember, they are hurting at that time, so all they need basically is for you to believe them. There are a lot of gaps that make you think, how will I put these pieces together?'

(Barrister Agboola, child protection specialist)

Unawareness of available support services: As the analysis progressed, it became evident that the participants felt that children are unaware of the services available and how to seek support when they require help. They are unable to seek or receive intervention without their guardian's knowledge or consent. As Mrs. Obi indicated, *'They don't know what help they need and how to go about it. We cannot do more than the family because you know we need their consent to proceed.'* Other participants mentioned that some of the clinical evidence essential for diagnosis is distorted in cases of delayed disclosure. For example, bleeding from injuries sustained from physical violence during the abuse would have stopped and wounds on the genitals would have healed, especially in younger children. With the disappearance of indicators and evidence, most cases are abandoned as cases cannot be presumptively identified:

'*We rely on direct oral evidence from a victim, credible witness to the act, or through the trace of tangible physical evidence at the crime scene, or when the accused person acknowledges his guilt by confession, the case is dead on arrival.'*

(Mrs. Ugo, social worker)

Overall, this theme explains individual, interpersonal, situational or contextual factors that debar victims from disclosing their abuse and how these barriers has made it difficult to work with CSA victims. It analyses problems stemming from victims, such as discrepancies in their narratives and accounts of CSA.

7.1.3. Family-related challenges

Family interference emerged as a main theme, encompassing challenges from both the victims' and perpetrators' family members that are faced by HCPs. While participants regarded the family as the core element of intervention and the fundamental social support system of a child, they could not deny that family interference in victim care challenges their practice.

Family's refusal of professional treatment or services: In addition to victims' families disregarding or disbelieving victims' accounts of sexual victimisation, even in the face of evidence, they also often refuse professional services which could support the sexually abused child. There are circumstances in which the victim's desire to receive medical, psychosocial and legal support conflicts with the parent's decision to refuse some or all care for their child. As Barrister Agboola said:

'*The most challenging thing is family interference, the child can be saying they want psychosocial support and justice, the parent will be saying they don't want, that HCPs should leave them alone.*'

(Barrister Agboola, child protection specialist)

According to the HCPs, parents often cite a desire to avoid negative publicity, social stigmatisation and other consequences as a reason for refusing treatment or services. On several occasions, participants claimed that they had been accused of negatively influencing families' emotional bonds or interfering in a family's private life. Referring to a certain case in which the victim's family wrote a petition against the HCPs and withdrew the ongoing litigation process:

'The family wrote a petition that they are withdrawing the case with their lawyer, at that point, the case was trashed.'

(Mrs. Ugo, social worker)

She stated that such accusations and conflicting ideas and decisions undermined HCPs' efforts to ensure children's best interests.

The participants stated that some parents only accept medical and psychosocial treatment and resort to settling the legal matter out of court, thereby addressing CSA as a domestic case. Another important issue raised was that parents prefer not to disclose their child's sexual abuse due to threats from perpetrators, and normally resort to home remedies unless medical risks or complications requiring medical attention become evident. Parents also seem ignorant of the future consequences of such abuse for their children, especially the psychological and mental health conditions associated with childhood experiences of sexual abuse. Non-offending parents who should seek, protect and maintain their child's best interests often approach HCPs with unworkable situations, such as asking them if they can shoulder the family's financial responsibilities if the perpetrator is found guilty and imprisoned. As a result, they

either refuse or withdraw from treatment and subject victims to self-care or home remedies.

'Parent ignorance, they did not know that this thing might even affect their children in future, they said "Nurse don't worry, I did a sitz bath already," except the child needs urgent medical attention or the reproductive system is damaged, they didn't know about psychological trauma on the child.'

(Mrs. Obi, mental health nurse)

Participants pointed out that they face demands from victims' parents for rapid, one-day justice, as the parents consider obtaining justice a matter of immediate revenge. Once a victim's family realises that justice cannot be served immediately, they become uninterested and hamper the HCP's efforts to provide victims with comprehensive care:

'*Some of them [victims' parents] want justice the same day. To them it is a revenge and it must happen now, if not, they lose interest and become uncooperating*.'

(Mrs. Obi, mental health nurse)

Families often deny the occurrence of CSA and refuse treatment to preclude societal or public knowledge of their private life and reduce the potential social stigma. Mr. Arghur said:

'*They just deny and disappear with the kid, thinking the more they accept the intervention, the more people out there will stigmatise them. It is the major stumbling block*.'

(Mr. Arghur, social worker)

Other participants said parents often prefer to conceal intrafamilial CSA, which undermines their efforts to support victims. To their dismay, even when participants successfully persuaded families to accept intervention, the families were sometimes discouraged by community members, which eventually curtailed the support process and limited justice.

Participants noticed that in ongoing cases victims' families came to be financially dependent on the organisation. The participants often felt compelled to provide for these basic needs despite the financial constraints of their organisations:

'*If families agree to progress with cases, they begin to request for financial support and become dependent on HCPs for basic needs such as feeding, shelter and clothing and even holding them responsible for unrelated medical cases to CSA, because they really don't have anywhere else to go.*'

(Mrs. Ajededun, practising nurse)

Participants attributed refusal of treatment to the family and society's lack of understanding of the gravity of such crimes and their consequences for victims, victims' families and society. HCPs claimed that people often encouraged victims' families to use self-medication or home remedies after CSA, without properly disclosing incidents to HCPs or seeking appropriate care for the victim. Explaining the depth of societal trivialisation of the sexual abuse of children, a participant exemplified the immediate societal reaction in most cases:

'Some people do not even know the gravity of what we are talking about. They will say "se bi won ba sun ni" meaning he only had sex with her, and society are fond of encouraging parent to get self-prescribed medication that child would be all right.

People do not know there are consequences that will impact the life of the child, family and society.'

(Mrs. Oge, social worker)

Sudden withdrawal of cases: HCPs also identified sudden withdrawals of cases or disinterest in receiving required services and seeking justice as a challenge. They stated that it was disheartening to see some parents use their child's sexual victimisation or abuse to make money, especially when it was directly offered by the perpetrator or their family. These occurrences, they said, strongly influence parents' decision to suddenly withdraw cases. Some families involved community leaders in order to prove their disinterest in continuing ongoing cases. Participants mentioned that interference by such powers made providing comprehensive support and maintaining the child's best interests difficult, leaving the HCPs unable to complete the litigation process and convict the perpetrator. Participants claimed that most cases are suddenly withdrawn by victims' families after HCPs have put in their best efforts and resources, resulting in a sense of frustration.

'Initially, the victim's mother was very keen on receiving service, for some reasons, she asked and collected money from the perpetrator and his family, he compensated with five million naira [approx. £7000]. Then, she said she is no longer interested, that this is her child that we should not bother her again and to the extent that she reported us to the community leader.'

(Mr. Oke, child/clinical psychologist)

In cases that were not suddenly withdrawn, Mr. Oke claimed that the victim's family often sabotaged the process by leaking information on the prosecutor or legal team's plans to perpetrators, perpetrators' families, and their legal teams. He found it

unbelievable that parents, who are supposed to protect their child's best interests, safeguard them and seek justice, would endanger their children's lives.

'*They sabotage, any moves you make they will also disclose that to the other party [the perpetrator's legal team]. You realise parents work against the child, they do not see the child as someone they should protect, can you imagine what kind of danger that child is in.*'

(Mr. Oke, child/clinical psychologist)

As the analysis progressed, it became evident that family interference was not limited to victims' families; perpetrators and their families exert a huge influence on victims' families, which poses a challenge to HCPs' practice. Perpetrators and family members often plead, bribe, manipulate, intimidate or threaten victims, their families, HCPs, and other social or public officers dealing with the case, in order to escape the consequences of their crime.

Without doubt, this theme added to the depth of the contextual issue and challenges being studied by analysing those challenges presented by the victim's immediate microsystem. Without blaming the parents, this outlines HCPs' experiences with victims' families and how these critical encounters have challenged their professional practice.

7.1.4. Institutional/systemic-related challenges

In this section, institutional challenges are discussed in the context of structural and resource components that are beyond HCPs' control. The healthcare sector and the judicial and social support system shoulder the critical responsibilities of providing the necessary medical and surgical care, and psychosocial and legal support, to sexually

abused children in Nigeria. Unfortunately, participants identified avoidable inefficiencies in these sectors. While the HCPs identified the dynamism and diversity of victim care, their narratives show that partnership and collaboration with other child protective systems has resulted in many dilemmas.

Non-prosecutory nature of SARCs and survivor organisations: The first issue noted in this theme is that the healthcare institutions (hospitals and SARCs) which adopt cases of CSA are non-prosecutory, meaning they are unable to prosecute cases and must rely on officials from the national judicial system, some of whom the participants considered incompetent and corrupt. Mrs. Obor said:

'*We are not a persecutory organisation, we rely on police and judiciary system, they do nothing, very incompetent and corrupt*.'

(Mrs. Obor, counsellor)

Another participant argued that they become incapacitated once cases are referred to the judicial system for prosecution, especially when the officials are ineffective and not proactive in prosecuting the case.

Financial constraints: Many participants emphasised the financial and resource challenges that undermine their efforts to support victims of CSA. Participants stated that NGOs and SARCs offer all necessary medical, psychosocial and legal services without the victim or their family incurring a financial burden. Mr. Agboola said:

'*We don't collect a dime from all our clients, from the counselling to the medical to the justice, the services are free to victims and we don't have enough funds to manage all this services*.'

(Barrister Agboola, child protection specialist)

Participants claimed that cases crumble due to insufficient funds and that, in most cases, they relied on personal funds to manage cases. They said that financial constraints prevented their organisations from employing qualified professionals, which worsened the already low staffing levels and professional capacities of the organisations while they experienced high workloads. Most SARCs rely on the services of volunteer employees:

'*Funding is the most basic of it all, we do not have external funding, we make do with whatever we can get from within us [HCPs]. Now you can imagine responding and having to spend hundreds of thousand on one case*.'

(Barrister Agboola, child protection specialist)

Participants provided several examples of cases being abandoned due to financial constraints and a lack of resources. Exemplifying these financial difficulties, Mr. Agboola said:

'*We got a video of defilement of some secondary school girls, the school is situated in very rough terrain and we don't have a truck, but police said they don't have either and that was how that case died a natural death.'*

(Barrister Agboola, child protection specialist)

Participants stated that financial difficulties occurred not only in private SARCs but also in government organisations due to mismanagement of funds by government officials and the low priority of this sector, forcing them to rely on personal contributions from individual HCPs. Participants discussed how the lack of basic medical resources such as medication (analgesics, antibiotics, emergency contraceptives and post-exposure prophylaxis) and personal protective equipment affects HCPs' practice. They explained that victims report to SARCs with high

expectations but are disappointed by the lack of medication. Financial constraints also led HCPs to complain about the poor incentives and share their concern that seeing them in poor-quality workspaces would undermine their clients' perception of their professionalism.

Corruption and insensitivity among law enforcement agencies: According to the participants, some police officers have been found to financially and sexually exploit victims of sexual abuse. In certain cases, law enforcement agents and police officers advocate out-of-court settlement of CSA cases and discourage victims and their families from arresting perpetrators and completing the litigation process. This is especially true in cases involving individuals with powerful social, economic or political backgrounds, or cases involving police officials.

'Police requested the victims to pay money to log their case. And if they do not have the money, they push further to sexually victimise them as alternative means of paying. One example is Abuja RAID, 2018 or 2019. Police always claimed the victims are the one that attracted the abusers by the way they dress and we never persecute cases of perpetrators in high social class.'

(Mrs. Oge, social worker)

'Another issue is the insensitivity of law enforcement agents, conniving with the perpetrators to frustrate the process and procedures so that it does not get justice. Unfortunately, police stations are the first place victims report most times in Nigeria.'

(Mrs. Oge, social worker)

Participants felt that insensitivity and corruption among police officers, and their accusations of evidence falsification, have a strong negative influence on identifying

and responding to sexually abused children, as police stations are the first place victims go to seek support and justice.

Unsuitability of conventional family courts: Among the issues raised as systemic challenges was the unsuitability of conventional family courts for prosecuting cases of CSA. Participants agreed that the judiciary process is unsuitable for children, especially victims, as it stresses them, violates their privacy and subjects them to social stigmatisation. Several reasons were put forth to justify this opinion, including but not limited to the fact that court assessors and judges are not child psychologists and do not understand children's developmental milestones; they often neglect the fact that these children have experienced adverse events that may influence their responses during cross-examination. One participant said*:*

'*These judges do not have knowledge of child's development and don't understand that children are not comfortable with all the procedures.*'

(Mrs. Obisesan, social worker)

Participants also mentioned that family courts across the country have limited availability and lack the mandate to prosecute gender-based violence, including CSA, as they mainly focus on divorce, adoption, and child paternity:

'Is a major challenge even in the Federal Capital Centre, there is one or two family courts, presently, these courts are not mandated to try cases of sexual violence, they are only seating for cases such as paternity of children, you know, other family matters, adoption, family dispute and divorce.'

(Mr. Oke, child/clinical psychologist)

In addition, references were made to the poor welfare and child social support system in Nigeria compared with developed countries. Nigeria lacks the mandatory reporting

of CSA cases and social support system that is available for children in developed countries. Participants were concerned that sexually abused children are aware that the country has no support system in place for them, which results in victims losing trust in the system.

Unavailability of relevant national guidelines on CSA: A cogent theme that emerged under this subcategory was the lack of national medico-legal guidelines to direct, coordinate and improve the quality of care and services provided to victims of gender-based violence and CSA in Nigeria. With no blueprint, participants claimed they had to rely on the Child's Right Act 2003 (CRA), which merely focused on those acts that legally constitute CSA. Apart from the CRA, participants claimed they relied on personal experience and ethical principles in healthcare, and international guidelines and procedures that are difficult to navigate. Participants argued that navigating international guidelines and protocols is difficult as the health and social service systems necessary to provide the holistic and comprehensive care described in international guidelines are unavailable in Nigeria. In addition, they argued that there was a lack of a structured counselling system or procedures which affected the unity of care within and beyond their institutions:

'There are no guidelines, we rely on the Child's Right Act 2003, and that talks about what the law regards as being illegal in terms of CSA and what it comprises. When it comes to processes and procedures, it is the previous experience, ethics and [we] had to use international guidelines, which is difficult to go.'

(Mrs. Ugo, social worker)

Only three states out of 36 have created domestic versions of international guidelines, and these three states have only developed a standard plan of operation for all gender-

based violence cases; there are no specific or separate guidelines for CSA. One of the participants emphasised that it was extremely difficult to adopt a robust guide in a country with limited resources such as Nigeria. Apart from the lack of national guidelines, participants also noted the lack of a mandatory statutory obligation for HCPs to report cases of sexual abuse to the authorities, a situation they found challenging:

'Only three active states in SouthWest domesticated international protocol; Lagos, Ekiti and Ogun state, have been able to come up with a standard operating procedure. But it cuts across all GBV [gender-based violence], CSA is not yet separated from other types of GBV. We still do not have a medico-legal protocol. No mandatory report system.'

(Dr. Adeyemi, psychologist)

Unclear and Complicated Referral System: According to the participants, the referral process is an integral part of victim and survivor care. Having said that, the participants admitted to feeling incapacitated after the referral process, especially as regards the national police and the judicial system, a situation that they explained was complicated by the unclear referral system. Mrs. Oge said that the processes followed by hospitals and the judicial system when providing comprehensive care for CSA victims are complex, bureaucratic and time-consuming. In Mrs. Oge's words:

'*My work stops at that referral's services. We refer to the police and National Agency for the Prohibition of Trafficking in Persons (NAPTIP), which is not clear. But you see at times we do not get justice and cases are abandoned. Following a tough and thorough process at the police station and hospital, pay for these and that, but it seems those officers are gaining from the whole process.*'

(Mrs. Oge, social worker)

Participants reported feeling frustrated to learn that government officials complicated enforcement processes for financial gain. Participants claimed that victims felt humiliated by unnecessary wasting of time that re-victimised them or prolonged or curtailed the process of doing justice for them. This was a frustrating reality in their practice:

'Apart from corruption in the system, the bureaucracy of the process, the justice system is difficult and time consuming, I think that was done by the officials. It is humiliating and re-victimising for the survivor again. There is corruption, lack of professionalism and proportionality. With no justice, it can be very frustrating.'

(Mrs. Ugo, social worker)

Mrs. Ugo was not the only one with these views. Reflecting on his experience, Mr. Oke, a clinical child psychologist, emphasised the numerous tactics judicial officials used to delay and deny justice to victims. These tactics included creating lengthy bureaucratic processes, unnecessarily delaying proceedings, losing evidence or case files, requesting funds from victims and their families to purchase stationery, and adjourning or eventually throwing out cases. Participants claimed that the bureaucratic process in the judicial system becomes physically and emotionally exhausting for victims and their families, making them unenthusiastic about continuing with legal processes. Participants also noted that challenges such as these make the victim, their family, witnesses and HCPs feel like their time, effort and resources are being wasted and that the NGO has lost money. Such experiences, the participants stated, are overwhelmingly frustrating and exhausting:

'They have these strategies, lots of delays, they will create lots of bureaucratic processes because they are benefiting from these processes and justice delayed may be denied at some point. Their hustle becomes dry, because it takes too long. You have wasted your time, even your resources as the caregiver, as witness, as family. They will ask for money so that we can buy papers or pen, you will really become frustrated, exhausted and not interested in the case again.'

(Mr. Oke, child/clinical psychologist)

Social and healthcare systems play a vital role in providing medical, psychosocial, and legal services to sexually abused children, but their presence does not come without challenges. This theme provides a basis for the contextualisation of the challenges HCPs experienced which stemmed from institutions including SARCs, hospitals and the other social, legal and healthcare systems they dealt with when providing necessary care for victims.

7.1.5. Sociocultural-related challenges

For the participants in this study, the social and cultural context of Nigerian society involved many issues and challenges that undermined their practice of supporting victims of CSA.

Patriarchal Society: Participants described Nigeria as a strongly patriarchal society with an elevated level of gender discrimination, prescribed gender roles and expectations, and objectification of women and children. They discussed this problem as a deep-rooted factor which anchors all socio-cultural challenges in the country. Due to its patriarchal nature, Nigerian society embraces polygamous marriage and normalises extramarital affairs for men, whereas women are expected to maintain a culture of silence that subjects women and girls to different forms of violence,

including sexual abuse. One participant expressed concerns about the culture of objectifying women and girls and normalising the subjection of women to physical and sexual violence. Other participants also claimed that the cultural practice and social norm of objectifying women and viewing them as men's property remains a social problem. They further expressed that, while predisposing women and children to sexual abuse, the patriarchal society also makes identifying and responding to sexually abused children almost impossible. This is because societal attitudes compel victims, who are mostly female, to keep silent about their experiences:

'The patriarchy system, men think they have the right to beat or even rape women, especially their wife, female are subjected to different violence. As nobody is complaining, the victim will keep quiet and most victims are female and in our society we still view the woman as an object; as a man's property. So, the woman is not expected to speak.'

(Dr. Adeyemi, psychologist)

Unhealthy Cultural Practices: Many participants remarked on the unsafe and unhealthy social, cultural and religious practices and norms in Nigeria, such as child marriage (especially in the northern part of Nigeria) and female genital mutilation, a practice considered important to prevent promiscuity. Participants claimed that Nigerian society is quite myopic about children's rights and CSA, which they described as a challenge to their practice. Participants felt that existing unhealthy social practices caused society to trivialise the occurrence of CSA. Despite Nigeria's adoption of the CRA, most northern states still practise child marriage: reaching puberty signifies the age of marriage. Cultural and religious controversies about marriageable age still exist in the country as society believes that children are marriageable when they reach puberty, which is against the CRA. Participants noted

that these unhealthy beliefs, perceptions and practices undermine their efforts to manage cases, as they often conflict with societal ideas and beliefs. They were concerned that perpetrators use culture and religion to sexually abuse children:

'In northern states, there is an argument on marriage age, once a child enters puberty, such child is due for marriage and they will marry the child out. Most northern states have not accepted the Child's Right Act (2003), they hide under culture and religion to legalise marriage and sex with children.'

(Dr. Adeyemi, psychologist)

Societal Ignorance: Apart from common traditional practices such as childhood marriage and female genital mutilation in Nigeria, societal ignorance is another issue HCPs face. Participants said the magnitude of prevailing forms of unhealthy practices, such as the rampant practice of child marriage, signifies the level of ignorance in the country. The HCPs explained that society had a limited understanding of children's rights and the age of sexual consent. They reported that in Nigerian society, people often lacked the understanding that sexual activities require the consent of two competent adults and that minors under the age of 18 are incapable of consenting to sexual activities. This ignorance, participants claimed, challenged their efforts to identify and respond to sexually abused victims, further predisposing these children to re-victimisation.

'You see that this ignorance about age of consent and society involving children in sexual activities is a serious problem, people don't understand children cannot consent to these things. With that ignorance, children are abused, before you could help them and they get abused again.'

(Mrs. Ugo, social worker)

While discussing the challenges of societal ignorance, participants identified other general issues, such as misconceptions about non-contact sex and non-penetrative sexual activities, which was suggested as being 'normal' childhood play in Nigeria. Participants explained that in their attempts to enlighten society they have been warned not to commit the taboo of meddling with children's innocence—HCPs find this frustrating, as it puts them in conflict with the community and signifies the magnitude of societal ignorance they must handle:

'We have a general issue that we have, you know, and the issue of sexual abuse without touch also, where I mentioned where it is, it is believed that it is only when penetration has taken place. The society will say, 'They are just playing with themselves, please don't corrupt them.'

(Barrister Agboola, child advocate)

The culture of victim-blaming also came up. Participants explained that society often blames children for putting themselves into situations of abuse. In addition to victim-blaming, participants complained about societal stigmatisation, discrimination and the shaming of victims and their families. Participants stated that seeking support and justice for victims may attract negative publicity. In Nigeria, children are blamed and made to feel responsible for their abuse:

'Instead of the society supporting the child, they will blame the child, you will hear them asking the child, why did you sit on his legs and collect gifts from him. In some cases, they claimed the child seduced the man and eventually blamed the victims for what had happened to them. Then they start stigmatising the child, the attitude of the society is a major stumbling block for our practice.'

(Mrs. Ugo, social worker)

HCP's reported that sexually abused children were sometimes perceived by others as '*dirty*' or '*public toilets*.' It was felt that this would negatively affect children's chances of securing suitors in the future. HCPs explained that victims' parents are concerned about this situation and often react by suddenly withdrawing ongoing cases or refusing to seek legal support for the victims. They therefore recommend changes in such unsafe social practices and an end to the stigmatisation of victims:

'The stigmatisation by the society – the attitudes of the society... Let me just make it clear that some parents prefer to marry the children to perpetrators rather than seeking professional support, is a major stumbling block.'

(Dr. Adeyemi, practising psychologist)

In addition to the deep-rooted culture of victim-blaming, shaming and stigmatisation, participants also mentioned the culture of silence around CSA in the community. In an attempt to cover up incidents, most parents marry their children to the perpetrators. Participants explained that their responsibility to support victims became challenging in such situations.

Interference of Traditional Rulers: Traditional ruler interference, especially in ongoing cases, was yet another issue emphasised by participants as they analysed the challenges to their practice. HCPs described traditional leaders as lacking an understanding of CSA and its criminality; therefore, they trivialise incidents, plead on behalf of the perpetrators and seek to amicably settle the issues between the families involved without following proper litigation processes. This is a situation participants believed to be caused by the communal nature of Nigerian society, where members respect elders and prioritise community peace and unity over individual or family

needs. When faced with such situations, HCPs often find themselves overwhelmed by the level of societal ignorance exhibited with regard to CSA. They said such encounters made them doubt the effectiveness of massive sensitisation and awareness programmes, and suggested the need for continuous community education:

'Old members in the neighbourhood will come to beg the victim's family and the family become afraid to seek support from professionals. The chief will say go and bring a goat and one ram and they will cleanse the man, traditional ruler interference. It occurs across everywhere because they don't understand it is criminal. There are times you will go into that mood, surprised that how can this unbelievable incident happen in this westernised/urbanised city.'

(Mrs. Ugo, social worker)

Negative Influence of Social Media: While participants previously acknowledged the importance of social media in creating sensitisation and awareness programmes and as one of the key modes of identifying victims, they also recognised the challenges it presents. Social media was implicated in overturning, altering and even falsifying clients' stories, an experience HCPs found devastating. Social media interference brought negative publicity and different versions of the victim's story, causing confusion and affecting its authenticity, which often had massive psychological and financial consequences. Furthermore, it demotivated the victim from seeking support and justice. Illustrating these challenges of social media, a participant said:

'I was handling a case but I don't know how it got to social media. The things I was reading on social media were lies, they are lying, the case really opens my eyes to see how the media can manipulate sexual violence.'

(Mrs. Oge, social worker)

Mrs. Oge was not the only one to discuss this. Dr. Adeyemi also described how social media negatively influenced ongoing case management. She said that HCPs value their clients' privacy and always maintain confidentiality. However, the drama of revealing the accused, or key personnel trying to protect the perpetrator, may sometimes attract the attention of the media. Participants felt that as they lacked control over other key personnel involved in these cases, the principles of privacy and confidentiality in victim care could easily be violated. Dr. Adeyemi explained that victims are often devastated by situations like this; they lose trust in HCPs, feel depressed, suffer from suicidal thoughts and withdraw from the case to avoid further social stigmatisation and negative publicity.

This theme shows how the socio-cultural context of the child, including their shared social norms, beliefs, culture and practices and their way of life, challenges HCPs' practice of identifying and responding to victims. It provides a comprehensive understanding of social and cultural factors and how these have acted as mechanisms predisposing children to abuse, preventing disclosure and challenging responses. It helps us to contextualise and analyse the issues and challenges faced by HCPs in the child's wider system, highlighting that while this system may not have a direct impact on the child's interaction with HCPs, it has a major adverse effect on the help-seeking behaviour of victims and their families. Diagram 12 illustrates the issues and challenges faced by HCPs discussed above. I will now turn to recommendations for future practice, put forward by participants.

Figure 12: Diagram of identified issues and challenges

7.2. Summary

This chapter explained the issues and challenges discussed by the participants, ranging from intrapersonal and interpersonal challenges to organisational and socio-ecological challenges, as well as the associated implications for practice, victims and society. The next chapter discusses how the theoretical analysis reached the highest level of abstraction, describes the emerging three core categories, and presents a grounded theory of the issues and challenges facing HCPs in their roles with reference to the nature of practice and the socio-ecological framework.

CHAPTER EIGHT: CORE CATEGORY AND GROUNDED THEORY

The previous chapters present four theoretical categories that emerged from the analysis of the data collected for this study: HCPs' meaning and understanding of CSA, personal motivations, the dimensions and processes of practice, contextual issues and challenges of identifying and responding to victims and the implications for practice. This chapter discusses the core category and its relationships to other categories. Also, it presents the grounded theory of practice challenges discussion, the issues and constraints facing HCPs with mandatory roles of supporting sexually abused children in Nigeria, setting out the underpinning theoretical statements. Finally, this chapter contextualises the new theory in the framework of existing pertinent CSA theories, highlighting how the new theory explains the phenomenon under study by comparing and contrasting it with existing CSA theories, and highlighting the importance and significance.

8.1. The core category

According to Birks and Mills (2011), the core category helps us understand the dynamics and circumstances of a phenomenon so that we can better understand how human behaviour is shaped and patterned. Gaining a better understanding of volitional motivations within a person's worldview requires examining how they make sense of their experiences and how they comprehend a phenomenon that influences their actions in a social context (Charmaz, 2006; 2000). In order to understand the occurrence of social processes, it is necessary to define how and why they take place, providing an explanatory schema (Mills *et al.,* 2006). This is an overarching category

that has the ability to encompass all the previously discussed theoretical categories and explain the core process of issues and challenges facing HCPs in their roles of identifying and supporting sexually abused children. Since identifying and integrating the core category concludes the theoretical construction (Charmaz, 2006), there is a need to identify a core category that will serve as a theoretical basis to develop a constructive grounded theory.

A closer examination of the initial codes, higher level concept codes, theoretical categories and memos indicates that the previously described four categories are interconnected. As I moved across the previously discussed theoretical categories, I identified critical relationships between the 'dimension of the practice' category and the 'context of the practice challenges' category. Both categories anchored all other recurring patterns in the data and higher-level concepts across all categories. These two categories remain at the core of all CSA practice dimensions, individual and contextual factors that undermine HCPs' practices of identifying and responding to sexually abused children. These factors either raise issues or challenge HCPs' practice while HCPs interact with the child/victim or the child's microsystem (interaction with the child, perpetrators, and family members; the immediate environment) and macrosystem in suspected or identified cases of CSA. As shown in figure 13, the 'practice challenges' are the anchor between the two theoretical categories, namely, the 'dimensions of practice' and the 'context of practice challenges'.

Figure 13: The core category

Across categories, findings showed that the 'dimension of practice' involved in supporting sexually abused children cannot be segregated from the context of practice challenges. The context of practice highlights the complexity, sensitivity, and traumatic nature of care, hence challenging HCPs' practice. For example, the context in which HCPs work, i.e., the interactional-contextual space, is ingrained with individual and contextual factors that, when combined with the sensitive and invasive nature of practice, make practice challenging for HCPs and undermine their efforts, resulting in practice challenges. This core category, 'the practice challenges,' remains the central phenomenon that shows how other categories are connected. Apart from interconnecting with the higher-level concepts, these categories seemed to influence and overlap each other significantly (see figure 14), and the practice challenges appeared to be a thread joining them together and preserving the analytical features of the categories, which will be discussed later in this chapter. It is also the basis for my theory about the issues and challenges that HCPs face, which will be discussed in more detail in section 8.5.

8.2. The core category: The practice challenges

The constant comparison approach made sure that I understood how the different theoretical categories interacted with each other, that the analysis was valid, and that the theory I produced fit well with what the participants thought about the social phenomenon. The 'practice challenges' remain the overarching theme and encompass all the challenges inherent in the dimensions of practice and process of supporting sexually abused children and those in the context of practice as shown in figure 14.

First, the dimensions of practice category, also known as '*walking through the darkness with the victim,'* is all about the challenges and issues inherent in the dimension of practice and process of supporting sexually abused children. For HCPs in this study, practice relating to how to identify and respond to children who have been sexually abused differed from their other forms of practice. The form of care required by sexually abused children is complex and dynamic in nature, and therefore requires sensitive approaches. This is because it further evokes strong emotions, can be traumatic to HCPs, and increases their vulnerability to violence. CSA cases are highly dynamic, versatile and diverse and therefore may present HCPs with varied challenges, starting from case identification. HCPs reported that often cases were not identified presumptively except when disclosed by children or witnesses, and unfortunately children seldom spontaneously disclose their sexual abuse. Even if they self-report, there is a dilemma in providing inconsistent stories.

The overall dimension of the practice challenge lies in HCPs ensuring victims receive medico-legal care, psychosocial support, have access to justice, and are protected from re-victimisation. This category discussed the major challenges in identifying cases and providing CSA support and in navigating the enormous case management

requirements, which includes getting the victims or family to report the incident, securing medical services, aggregating evidence, and engaging with the litigation process and legal system to ensure justice for the victims.

As CSA indicators are often not definite, HCPs found it difficult to detect them unless they were reported. Additionally, in the course of their practice, HCPs realised that all the dimensions of practice including CSA disclosure process are complex. It was conceptualised by HCPs as '*walking through the darkness with the victim*,' a daunting process for both the HCPs and the victim. HCPs also problematised the dynamism of care. This has been discussed in light of the broad, multifaceted and rapidly changing nature of the practice, which requires professional adaptability and advanced practice (see section 6.3). It requires constant adjustment, adaptation, reflexivity, and new approaches, made worse by the individual factors of a lack of training, continuous professional development, and management support. In the context of practice, individual and contextual factors play a role in aggravating the practice dimensional factors, such as complexity and dynamism of practice, involved in supporting sexually abused children.

Participants in this study also highlighted the sensitivity of the level of interaction that takes place between them, the child, and the child's ecosystem, as seen in figure 14. HCPs are involved in victims', families', and perpetrators' private lives, requiring a sensitive approach. HCPs problematised their involvement in the child and family's private sphere of life, especially since each sphere in child ecological theory comes with its own challenges that undermine HCPs' practice. HCPs reported that families with suspected cases of CSA and/or sexually abused children preferred not to disclose, especially in intrafamilial cases, when the family is aware of the consequences for the

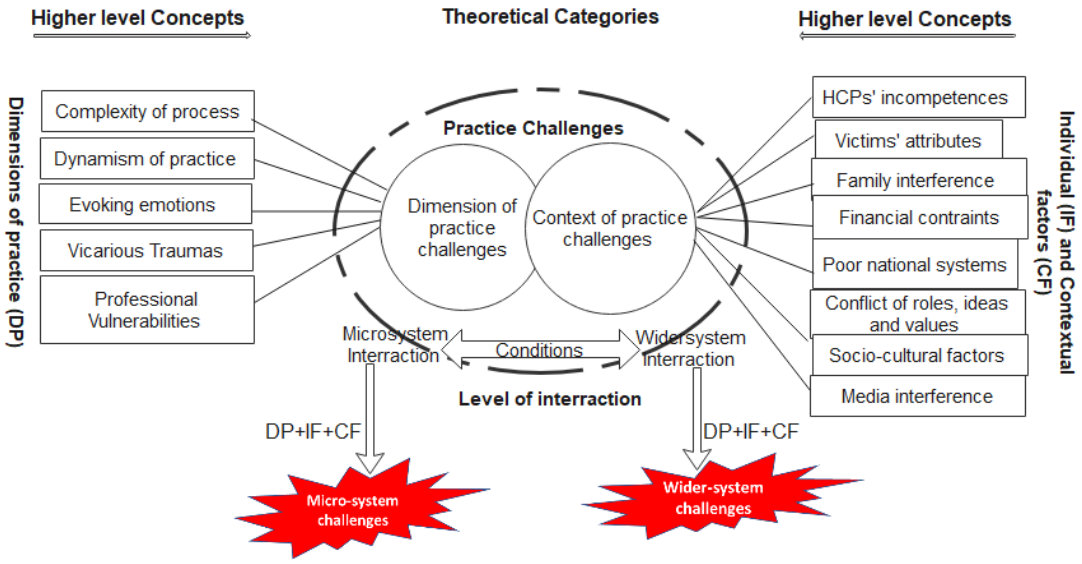
perpetrator. HCPs' investigations and attempts to identify the victim and respond was considered to be invasive by family members.

My research found that HCPs are faced with negative attitudes from adults who are supposed to safeguard children, as these adults hold the socio-cultural norms that predispose children to different forms of sexual abuse. HCPs are persistent in situations where the child's wishes, the family's choices, ideas, and decisions, as well as cultural and social norms, are often at odds with their professional practice. This means that their professional practice and code of practice potentially subject them to conflict, confrontation, and a variety of negative attitudes put up by the child's microsystem and wider system. HCPs do not care for the child in isolation, as the child's ecological system is of great importance in his/her care. Their constant exposure to graphic accounts of victim experiences, especially when perpetrated by individuals with parental obligations or who share a familial relationship with the victim, as well as the negative reactions from the family, evoke strong emotions and cause vicarious trauma for HCPs. Conspicuously, there is evidence of professional vulnerability inherent to the practice of supporting sexually abused children in Nigeria. In the African context of Nigeria, HCPs are not only subjected to physical threats or assault; perpetrators and their families have also threatened and attacked them with supernatural powers, threatening to kill them and their families in retaliation for their family member (the perpetrator). Ensuring and maintaining the child's best interests within the family, a key element of the victims' care, remains a challenging task.

Second, the category of context of practice challenges discusses all the individual and interpersonal challenges and those embedded in the context of practice itself. This category explains how the immediate and wider system raises some level of issues and challenges at each level of interaction with the child, undermining their services to

victims and families. It further discussed how the individual and contextual factors in the context of practice play a major role in challenging HCPs. This has been explained as (1) HCP-related challenges, (2) victim-related challenges, (3) family interference, (4) institutional or systemic challenges, (5) process and procedural challenges, and (6) sociocultural challenges, in section 7.1.

Figure 14: The relationship between the core category and higher-level concepts, showing the practice dimensions, as well as individual and contextual factors

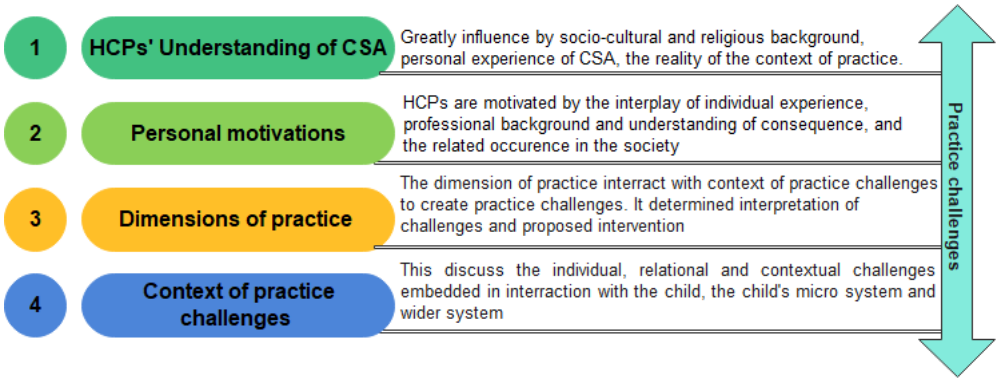


8.3. Association between the core categories and the higher-level concepts

Figure 14 shows the heuristic processes in both categories that make up the core category. It examines the relationship between the higher-level concepts within the categories and how practice challenges emerge from such interaction. The diagram depicts the higher-level concepts that comprise the dimensions of practice and of practice challenges, as well as how they are interconnected to frame these challenges. The microsystem interaction and macro-system interaction remain the constructs for conceptualising or explaining the practice challenges. The interplay of either or both

of these factors in the microsystem results in microsystem challenges, and if they occur in the wider system they are formulated as macrosystem challenges, as shown in Figure 14. It shows that both are embedded in the interactive-contextual process and space, meaning that they are underpinned by the interaction of HCPs within the microsystem and macrosystem of the child. Therefore, the practice challenges arise out of these interactions, so the challenges are constructed using a similar concept. For example, the dimension of practice factors only becomes evidently challenging in the interactive contextual space when the individual and contextual factors have synergistically resulted in the 'context of practice challenges.' This means that the practice challenges only result from the interplay or combination of the dimension of practice and the context of practice challenges, either within the microsystem or wider system of the child, as shown in Figure 14. For example, besides CSA being a complex problem, the practices for supporting sexually abused children are non-typical when compared to other areas of expertise or healthcare practices. The practice requires highly dynamic, versatile, and diverse interventions and approaches, as well as professional curiosity and intuition that help to proceed from mere assumption to the identification of cases. However, in the presence of individual factors such as limited experience, sense of incompetence, and absence of continuous professional development, navigating through the enormous requirements of case management, the litigation process, securing effective support in healthcare and social care and obtaining justice in the judiciary system become practice challenges. Additionally, figure 14 illustrates the connection between the higher-level concepts in each of the categories that form the analytical construct for the core category of practice challenges. The analytical result of this higher-level concept framed HCPs' perceptions and conceptualisations of the dimensions of their practice, the individual and contextual factors.

Figure 15: A diagrammatic presentation of relationships and interconnectivity across the four categories

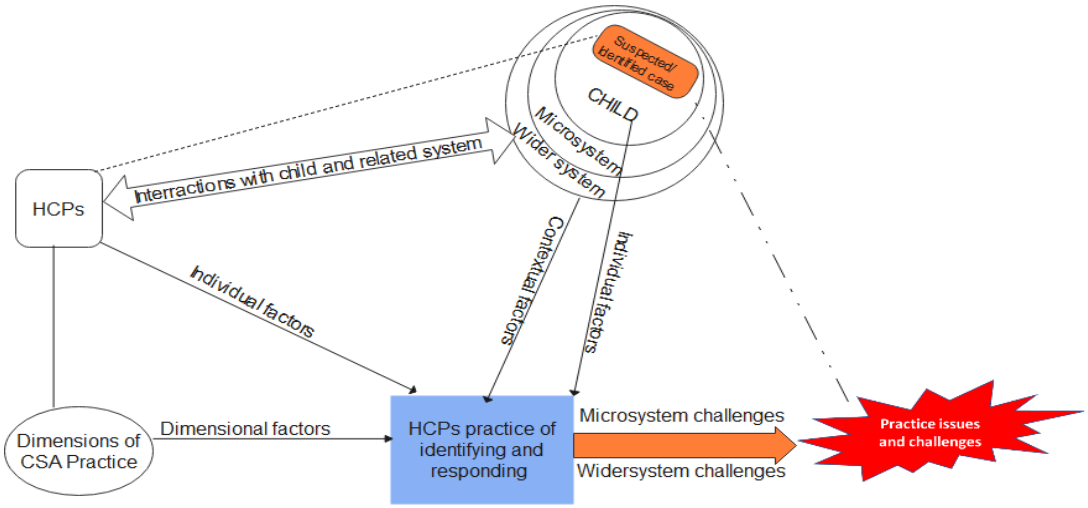


After looking at the connections between the two categories, it is important to think about the connections between them and the remaining two: HCPs' understanding and meaning of CSA, and personal motivation. Figure 15 illustrates the relationships and interconnections between the four categories, emphasising the content of each category and how it relates to the 'practice challenges'. The category of HCPs' understanding of CSA and personal meaning ascribed to CSA showed that despite contradictory ideology or views, the individual's background, experience, and professional practice, as well as the context in which they practise, shaped their conceptualisation of CSA and even their practice. Personal motivations for HCPs are constructed within the interplay of various factors, such as individual or personal experience, the professional's knowledge and insight into the consequences of CSA and occurrences in society — the context of practice, which highlights the challenges associated with practice. Individual and contextual factors that motivated HCPs to choose a career path of supporting sexually abused children in Nigeria can be seen to have equally challenged their practice and shaped the proposed methodological and strategic approaches.

8.4. A grounded theory of challenges facing HCPs' role in responding to sexually abused victims

The aim of the present study is to construct a substantively grounded theory of the issues and challenges facing HCPs in their roles of identifying and responding to victims of CSA. A grounded approach is used to uncover how HCPs construct the social actions, interactions and experiences of identifying and responding to sexually abused children in Nigeria. It is important to ensure that the theory developed is based on systematically collected and analysed data. This section presents the grounded theory of issues and challenges faced by HCPs in their role of identifying and responding to sexually abused children.

Figure 16: The interplay of practice dimensions and individual and contextual factors on practice resulting in practice challenges



From the perspective of the HCPs that participated in this study, issues and challenges in their practice are caused by the interplay of the dimensions of care, the individual and contextual factors that come into play at each stage of interaction with the child, and the child's micro- and wider systems, as seen in figures 16 and 17. Figure 16 shows how different factors interact with each other and how these factors cause HCPs to

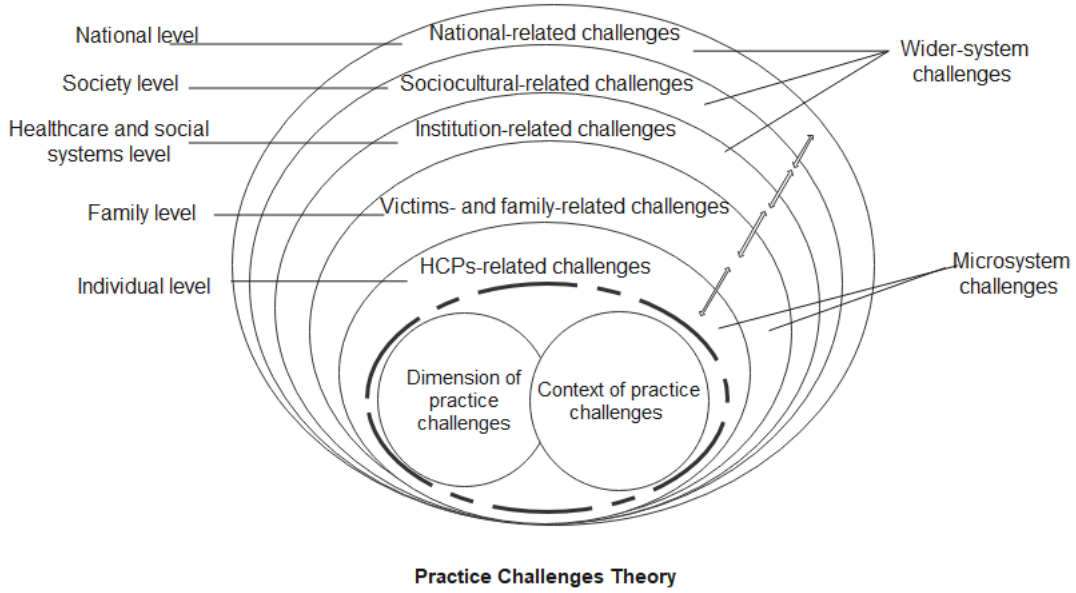
face challenges in both micro- and wider systems as they move through the child's ecological space. As illustrated in figure 16, this theory posits that in suspected or identified cases of CSA, in an attempt to effectively identify and respond, HCPs will have to interact with the child and the child's micro- and wider system. In certain situations, before accessing the affected child, HCPs have to navigate all the significant components of these socio-ecological systems and are faced with practice-dimensional factors, individual and contextual factors that challenge their practice, as shown in figure 16. This interaction leads to a number of problems and challenges, which have been grouped into practice-related microsystem challenges and wider-system challenges. Together, these challenges make up the practice challenges. They impair HCPs' practice, whether they have direct access to the child or the child has self-disclosed. HCPs need to interact with the child and the socio-ecological system to gather evidence, provide medical and psychosocial support, as well as provide legal support and initiate litigation processes to obtain justice for the victim.

As previously mentioned in section 7.1.2, findings from this study showed that there are also individual challenging factors arising from the child/victim. These include claiming that the abuse is consensual, not disclosing abuse and/or refusing treatment. In some cases, when abuse is disclosed, there are typical discrepancies that negatively affect the diagnosis and quality of treatment and have legal implications. Therefore, either in suspected cases or disclosed cases, HCPs interact with essential agencies in both micro-and wider systems, which results in experiencing challenges. For example, during this interaction, HCPs learned that getting involved in the private lives of children and families, including the personal lives and families of the perpetrator, requires a sensitive approach. This is especially true when taking into account the fact that sexual issues and incidents are often kept quiet. This already sensitive situation is

complicated by individual factors such as HCPs' limited experience, incompetence, and victim reluctance to disclose abuse, all of which impede efforts to gather critical information and evidence to confirm a case and initiate the treatment and legal processes.

Another microsystem challenge found in this study shows the interplay of individual attributes of HCPs and victims in practice. For example, due to personal values on sexuality, and the idea of asexuality for children, there can be a challenge to HCPs' practice when supporting sexually active children who claim that the sexual abuse is consensual and are adamant about protecting the identity of the perpetrator. It has been found that this situation causes a conflict between personal and professional values, which could hurt the relationship between the child and HCP that is important for successful practice. Similarly, interaction with a wider system result in the interplay of practice dimensional factors, individual or contextual factors, resulting in wider system practice challenges. The next section discusses the interplay of these factors as HCPs interact with important agencies within the microsystem and wider system, and how they constrain and impact practice. From this, we can understand the occurrence of social processes in the data, and can define how and why they take place, providing an explanatory schema (Mills et al., 2008).

Figure 17: The practice challenges theory for identifying and responding to sexually abused children



The practice challenges theory proposes that issues and challenges faced by HCPs in the role of supporting sexually abused children in Nigeria result from the constant and complex interplay of many practice-dimensional factors as well as individual and contextual factors. The practice theory in figure 17 showed how challenges faced by HCPs are classified into both microsystem and wider-system challenges, based on the important agencies at the level of interaction that resulted in challenges.

The Microsystem Practice challenges: This explains three main forms of challenges, which are those that HCPs encounter at an individual level and those during interactions with the child, perpetrator, and their families, as shown in figure 17.

At an individual level, this theory proposes that when HCPs are confronted with suspicion or self-disclosure of CSA cases, they are faced with the reality of lacking specified training on CSA and having limited experience in this field. These individual factors, activated by the context of practice, result in a significant sense of incompetence and unprofessionalism. Due to this perceived sense of incompetence,

HCPs reported that they struggled to move from merely assuming or feeling suspicious that a child has been sexually abused or has experienced abuse to professional intuition and curiosity, which are essential for early identification of cases. Therefore, most cases of CSA evade detection by HCPs, which subsequently can leave children vulnerable to re-victimisation and other devastating, life-changing consequences. In addition, the lack of standardised training and licensure have resulted in an influx of untrained individuals, which has further exacerbated the tensions with those who are committed to securing the best outcomes for young victims. Another important explanation for HCP-related challenges is the existence of discrepancies among HCPs holding statutory responsibilities for safeguarding and protecting children, especially in the incidence of CSA. Discrepancies about views concerning age of consent, victimology, criminality, and culpability have caused key variations in the ways sexually abused children are portrayed and responded to by HCPs and other partner professionals such as police and judiciary officials. The practice challenges posit that a multidisciplinary approach is the hallmark of services to victims of CSA, yet discrepancies exist between HCPs' perspectives on CSA and core values. This situation is made worse by the varied organisational procedures, protocols, and situation analysis of CSA cases and priority of care. HCPs and statutory agencies have been found to exhibit negative and non-empathetic behaviours, holding firm to personal values and assessing victim's cases based on these personal values.

At the interpersonal level, when HCPs interact with the affected children, perpetrators and families, this theory proposes that HCPs encounter numerous issues, challenges and circumstances that make working with sexually abused children extremely difficult. The theory proposes that as HCPs interact with the child and family members, there is an interplay of individual attributes of the child, individual and contextual

factors that impede their practice. Due to the sensitivity of the interaction with both victims' and perpetrators' families, HCPs are faced with contextual challenges, made worse by or impacted by the conflict of ideas, beliefs, preferences and decisions. Hence, the conflict between personal values, religious beliefs and practices, and professional values has caused discrepancies in the perception and response to CSA, which further undermines their professionalism.

First, it shows that children or victims are sometimes unaware of the deviancy of the sexual act and may claim to be in a consensus relationship with their perpetrator. Similarly, HCPs report that children may be afraid of the repercussions of their abuse on loved ones and therefore are afraid of not being believed or being blamed for their abuse. On this basis, HCPs felt that victims make decisions to withhold their experience, refuse treatment and hide the perpetrator's identity. Therefore, it is very difficult to identify them as victims. Family interference is another major barrier to practise. This theory proposes that families consider HCPs' interactions with them as invasive and involved in their private sphere of life; as a result, they can become defensive, aggressive, confrontational, refuse treatment, suddenly withdraw from treatment, and revoke HCPs' access to victim. It has been found that perpetrators often offer bribes, due to which victims' families often sabotage the intervention process by settling out of court, denying that the sexual victimisation happened, and marrying their child to the perpetrator, especially when the abuse has led to a pregnancy. Also, HCPs claimed they experienced insecurity, threats, confrontation, and physical assault from perpetrators and/or victims' families. In the African context of Nigeria, HCPs are not only faced with physical threats or vulnerabilities, but perpetrators and/or communities have sometimes threatened HCPs with supernatural powers and attacked

them spiritually, even threatening to take their names to a traditional shrine and causing sudden death on them and their family to take revenge.

The constant exposure to graphic accounts of sexual victimisation can evoke strong emotions and cause vicarious trauma as seen in other studies (Chouliara, Hutchison and Karatzias, 2009). Put together, HCPs' involvement in a family's private sphere of life alongside dealing with conflict of ideas, ignorance, and negativity displayed by family and society when addressing an incidence of CSA is traumatic and requires sensitive approach as they are unable to separate the child from the microsystem and its impact on the child and their practice. A combination of these factors can impede their effort of identifying and responding to the victims and ensuring and maintaining the child's best interests within the family, a key element of the victims' care, remains a dilemma.

Macro-system challenges: This theory proposes that HCPs encounter challenges at every stage of interactions with agencies and systems in the child's wider system, as shown in figure 17. The child's wider system includes the community, society, media, social and healthcare systems, and the nation at large. These agencies and systems are critical for HCPs to effectively identify and respond to sexually abused children and their families. However, HCPs encounter numerous issues related to these mandatory roles as they interact and navigate through relevant healthcare and social systems.

First, Nigeria's health and social care systems are non-prosecutorial, which means they have no judicial or prosecutorial features or powers to investigate or prosecute CSA cases and have to rely on the judiciary system, which comes with a sense of incapacitation, a feeling that is made worse by the fact that HCPs are unable to monitor the effect of the ongoing litigation process on the victim and their family once cases are referred. This is especially challenging with the HCPs' knowledge of the deep-

rooted issues of corruption and incompetence within the judiciary system and police, and the common practice of financially and sexually exploiting the victims and their families. These institutional challenges also address how the judicial system intentionally delays and unnecessary adjourns cases, altering evidence to falsely accuse victims due to bribes received from perpetrators. Additionally, the family court proceedings are not child friendly as the existing prosecution processes are complicated and traumatic for the victim and family to navigate. This has resulted in loss of interest and withdrawal of cases, denying victims justice, and only attracting negative publicity from both the community and media.

The theory also proposes that a faulty hierarchical system, embezzlement and mismanagement of allocated funds in the healthcare sector remain an underlying cause of financial constraints that have led to the inability of the system to employ and sustain qualified HCPs, meaning that the sector has to rely on the services of volunteers. In addition, HCPs are faced with a lack of the medical supplies and resources needed to provide medical and psychosocial support to sexually abused children, which has resulted in a loss of trust in the system for children and their families. Financial difficulties experienced by the sector mean that HCPs lack basic amenities to cater for sexually abused children. This means that their efforts to help and their ability to relieve victims' suffering are hampered and they are unable to prevent re-victimisation due to a lack of secure accommodation and shelter.

According to this theory, socio-cultural issues are deeply ingrained in Nigerian patriarchal society, as Nigeria's social system is based on male dominance and preferences, causing discrimination against women, and the social invisibility of children. Not only are children and women in this society at high risk of being abused and exploited sexually, but it is also nearly impossible to identify and respond to

sexually abused children. Additionally, unhealthy cultural practices, norms, beliefs, and perceptions often place HCPs at odds with society, preventing them from working collaboratively to identify and respond to sexually abused children. Apart from the objectification of children, other unhealthy cultural practices discussed are child marriage and female genital mutilation, especially prevalent in the northern part of Nigeria. In Nigerian society, CSA incidences are often trivialised and normalised, and there is a common practice of stigmatising and blaming the victims, which discourages self-disclosure and effective case management. The theory also shows that the fact that Nigeria is a collectivistic society makes community and religious leaders more important. These leaders often push for settling disputes outside of court, making amends, and putting community peace and tranquillity ahead of individual well-being. In the context of all these interconnected contextual factors, rooted in socio-cultural justifications, identifying and responding to sexually abused children remains challenging.

The theory proposes that contextual factors in Nigeria challenge the practice of identifying and supporting sexually abused children at a national level. These contextual challenges are deeply rooted in the poorly governed, structured, and funded healthcare and social services systems in Nigeria. Evidence from this study shows there are no structures or implemented policies in child welfare, social services, or healthcare systems that focus on safeguarding children and maintaining their rights. A few functioning family courts exist in Nigeria but are not mandated to prosecute cases of CSA. There are concerns that the proceedings are unsuitable for children and that the court officials, including judges, have limited knowledge of child development and the impacts of sexual abuse on children. Also, the practice challenges theory says that the fact that children and families know about these critical system failures has a big

effect on how they act when they need help, and that victims have lost trust in the system. Policies aimed at protecting children from abuse and maintaining their best interests are not widely implemented. Some states have rejected the introduction of the Child Rights Act (CRA, 2003). In spite of Nigeria's adoption of the CRA, many northern states have refused to adopt the law and still take the age of menarche as the age of marriage. Thus, perpetrators who should be prosecuted and litigated are free to molest children and even marry their victims. This theory argues that with the variance between multiple legal systems, identifying and responding to sexually abused victims is difficult for HCPs, as it puts them in conflict with victims, their families, and the community's religion and cultural practice. Another problem is that there are not any national rules about how to find and deal with CSA. Instead, most SARCs use the international protocols and guidelines. This theory proves that HCPs find it difficult to navigate due to the lack of standard health and social structures, resources, and systems to support sexually abused children in Nigeria. HCPs were left to rely on limited experience, deal with unacceptable variation in sexually abused children's care, and lack guidelines for evaluating their practices' performance. Again, with such contextually challenging factors, providing comprehensive support, maintaining children's best interests and prosecuting perpetrators is difficult.

In summary, the practice challenges theory provides an encompassing framework that moves beyond restricting the issues and challenges experienced by healthcare professionals to those resulting from individual characteristics and seeks to uncover the more complex context of interacting systems involving the victim, perpetrator, families, neighbourhoods, community, the health and social care system, society, and the nation at large. It provides the basis for understanding the influence of multiple contexts in HCPs' practice of supporting sexually abused children. Apart from

individual challenges, it became evident that HCPs encountered numerous challenges at each level of interaction with the core elements of care in the microsystem and wider social system of the child. It considers the complex interplay and overlap between these socio-ecological contextual factors. This means the issues and challenges are determined by a complex interplay of factors related to HCP and child characteristics, working environment, family attributes and reactions, community influences, and socio-cultural practices and societal attitudes. Besides helping to understand and analyse those issues, the theory highlights the need to act across multiple levels of the interaction simultaneously to identify and respond to victims, rehabilitate them and prevent re-victimisation. The theory not only provides comprehensive frameworks for understanding the multiple and interacting determinants of identified issues and challenges, but it also forms the basis for developing comprehensive interventions and approaches that systematically target mechanisms of change at each level of influence, as well as considering the nature of practice.

8.5. Contextualising with existing theories on CSA

This section discusses the new emerging theory in light of the biological, psychological, sociological-feminist and ecological theories discussed in chapter 3. While none of these studies provided sufficient explanation of the issues and challenges faced by HCPs, previous work provides a framework to understand the context within which HCPs operate. These existing theories are used as a yardstick to critique the newly developed theory from this study.

Findings in this study show that HCPs adopted a context-based theory. This means that the new theory was constructed through the experiencer's reflection on the actual practical experience to explain the issues and challenges they faced. The social

phenomenon of identifying and responding to sexually abused children in Nigeria was considered subjective and relative in nature because it was based on human behaviour and experience. According to the results of this study, healthcare providers conceptualised the issues and challenges they face whilst responding to the needs of victims of CSA and from the contextual interaction with the child microsystem and wider system. Urie Bronfenbrenner's ecological systems theory, which provides a holistic, context-based, multi-systemic view of CSA, has been used to describe certain concepts in the field of CSA. An important contribution of this theory is that it has been used to discuss the aetiology of CSA abuse (Martinello, 2020), causes of offending behaviour (Martinello, 2020), influential factors that discourage disclosure (Alaggia, 2005; Münzer *et al.,* 2016), and prevention of CSA (Hirsch and Keller, 2015; Martinello, 2020). Although these explanations may have some validity, they are difficult to apply because they require extensive ecological detail in order to construct, so that every interaction in the child/victim's environment must be taken into consideration. This may be difficult to achieve without acknowledging how the practice of supporting sexually abused children has influenced social interaction and phenomena and vice versa. This is to say that ecological theory only considers the contextual-relational and neglects the nature of the social phenomenon under study: CSA and associated practice. Despite its universality, it has yet to provide an explanation for the challenges HCPs face in supporting sexually abused children. The practice challenges theory has made a critical contribution omitted from the ecological theory, as it highlights the challenges inherent in practice and the interactive contextual challenges at individual, microsystem and wider systems, which is crucial to understanding the issues and challenges faced by HCPs.

The practice challenges theory proposes that the issues and challenges faced by HCPs can best be understood if they are analysed multidimensionally with emphasis on the dynamic interaction between the individual, family, social environment, and cultural milieu. This theory appears appropriate for the study of issues and challenges faced by HCPs in Nigeria, and its application is advocated as a vehicle for improving the quality of CSA research, improving our understanding of the context in which HCPs operate, and the associated issues and challenges. This theory led to the realisation that much more can be done to improve the quality of service delivered to sexually abused children. Research can thereby offer a comprehensive framework to help HCPs and policy makers to consider best practice when working with victims of CSA.

While evidence from previous studies proved the validity of biological theory explanation as discussed in section 3.1.1. (Faupel, 2015; Marques *et al.,* 2002; De Bellis *et al.,* 2011; Wiss *et al.,* 2021), it neglected an important aspect of human interaction, the sociocultural context, and only offered explanations for sexual offending behaviours. It is therefore unable to provide insight into the context of professional practice as related to CSA. The majority of etiological and remedial approaches to comprehending and treating sexually abusive behaviour are still based on psychological theories of CSA (Lim *et al.,* 2021; Macdonald *et al.,* 2016; Stinson et al., 2008). The cultural and social dimensions of CSA and related practices have been overlooked despite the desire of psychological researchers to develop comprehensive, highly integrated theories (Lim *et al.,* 2021; Purvis and Ward, 2005). In particular, attachment theory focuses on the child's family context, dynamics, and relationships to understand vulnerabilities, victimology, familial antecedents, and long-term impacts of sexual abuse (Ensink *et al.,* 2020; Fitzgerald, 2020; Perring,

2014), without considering how this impacts the child-professional interaction during identification of cases and intervention.

Feminist theory offers a perspective for understanding human behaviour in the social environment by centring women and the issues that women face in contemporary society. The feminist worldview emphasises the value of women and confronts systematic injustices based on gender. Feminists consider the social, political, economic, ethnic, and cultural contexts of individuals, groups, families, and organisations. Feminism theory advocates see CSA in terms of patriarchy and masculinity and emphasise the state's role in supporting patriarchal family connections that result in CSA but fail to consider how this same system can be used to keep the abuse in secrecy, preventing disclosure or influencing victims' decisions to seek care, or challenging HCPs' practice of victim identification and offering support as they navigate this space. The 'context of practice challenges' theory considered how Nigeria's patriarchal society, harmful cultural practices, and children's social invisibility may reinforce CSA, influence victims' decisions to disclose or seek professional help, and highlight how it challenges professional practice in such a setting. While feminist theory has attempted to consider the social, political, economic, ethnic, and cultural contexts of an individual, it is extremely focused on women's rights and heavily depends on a reductionist view.

Previous theories have shown that as children are reliant on the adults around them to keep them safe, they can be subjected to various forms of abuse and molestation and have their rights denied by significant people and agencies who are meant to safeguard them. Therefore, it is important that research and practice challenge the social order at all levels of interaction that makes children and young people vulnerable to abuse. This newly constructed theory has identified issues and challenges within the social

structure and provided a preventive framework that does not merely target social restructuring but also all ecological-contextual interactions.

Previous theories have neglected the inherent and unique challenges associated with the practice of identifying and supporting sexually abused children. Effort has been concentrated on offering unidimensional and multidimensional explanations on the aetiology, victimology and effectiveness of psychosocial therapy. An important theoretical aspect has been omitted and the current theory has provided detailed explanation to add to this body of knowledge and filled the theoretical gaps. The theoretical framework cannot move from aetiology of CSA to providing psychosocial treatment without exploring the social phenomenon and practice of identifying the victims and responding to their needs. This is especially true, considering the complex and dynamic nature of CSA practice and sensitive and conflictual nature uncovered by the practice challenges theory. Existing theories have neglected a crucial aspect of CSA, which has been filled by current theoretical knowledge. However, while critiquing the above theories, keep in mind that each has been constructed based on the focus and interest of the author at the time. The relevance and significance of this theory will be discussed in the chapter 10.

8.6. Summary

HCPs face a variety of challenges and issues. This chapter explains the emergence of the core category by exploring the association across the theoretical category, and outlines the issues and challenges faced by HCPs in their roles. This chapter critiques the ‘practice challenge theory,’ contextualises it with the existing theories of CSA, explaining its significance in the body of literature on CSA.

CHAPTER NINE: DISCUSSION AND IMPLICATIONS

This study explored and conceptualised challenges facing HCPs in identifying and supporting sexually abused children in Nigeria. In the process, the study explored HCPs' understanding of CSA, perceptions of their roles and practice, and the associated challenges. Further, this study looked at the implications of the identified challenges on practice, victims, families, and society, as well as practical strategies and approaches for promoting effective safeguarding and reducing challenges. This chapter discusses the major findings in the context of existing national and international relevant literature in the CSA field. It considers the research objectives and research questions, as stated in section 1.9, for a logical and consistent analysis.

9.1. HCPs' perceptions and understanding of CSA

As discussed in the findings chapters, the definition of CSA is not universally agreed, instead its meaning varies across ethnic groups, tribes, and contexts. Different professionals and disciplines in the health, social, and legal sectors in Nigeria have different definitions of CSA, preventing multi-professional approaches to responding to sexually abused children. The present study indicates that CSA is defined differently and there is a need for a consensus on a conceptual model or definition (Barth *et al.*, 2013; Haugaard, 2000; Mathews and Collin-Vézina, 2019; Trickett, 2006; Veenema *et al.*, 2015; WHO, 2006). Nigeria's unique socio-cultural context, multiethnicity, multi-cultural and multi-legal systems further complicates this issue (Ifechelobi, 2014; Udebunu, 2011).

9.2. Construct of CSA among HCPs

As discussed in section 6.1, a majority of participants describe CSA as involvement of a child in any form of activity that is sexual in nature, in accordance with the WHO definition of CSA in 2006, although a few disagree. Some individuals with mandatory roles in supporting sexually abused children stated they only considered penetrative sexual activities with the child abusive, and they did not consider non-contact, non-penetrative sexual activities abusive. This narrative was prominent among the professionals in hospitals, who explained that they only attended to victims of penetrative sexual abuse with severe medical complications. This finding is consistent with Haugard (2000), who says the term is used in many contexts and by professionals from multiple fields, who may have different mandates and goals when working with sexually abused children. Due to this, one professional group's definition may be viewed negatively by another. For example, this research found that nurses, social workers and psychologists understood the all-encompassing consequences of CSA on victims and their families. In other words, they used an inclusive, inexact definition to work with children and families, whereas doctors and lawyers tended to define CSA as merely penetration. As a result of these discrepancies, many CSA cases go undetected by HCPs, and victims may suffer re-victimisation and other consequences.

Aside from discrepancies observed among HCPs, this study revealed controversies regarding the construct of activities and behaviours that make up CSA. In the present study, the concept of intention was highlighted as critical to conceptualising CSA, determining its victimology, culpability, and criminology; this remains another area of dispute.

HCPs in this study believed that CSA is not just an act, but also all processes involved in grooming children or gaining their trust with the intention of molesting them (for example, providing gifts or shelter), or engaging a child in sexual activity. Grooming is a method that perpetrators use to gain access to and prepare future victims to be compliant with abuse. However, a few participants who adhere to the Nigerian constitution and legal framework disagree with these claims. They cited the Nigerian law, which stated that three criteria must be met for a case to be classified as CSA: penetration of the genitals, damage to the hymen, and ejaculation. The characteristics considered when determining if a behaviour is child sexual abuse are on a continuum (Haugaard, 2000; Mathews and Collin-Vézina, 2019). A behaviour must be placed at some point on this continuum to determine if it is abusive or not, which is challenging. In the current study, it became evident that when determining whether a behaviour is abusive, the context and characteristics of the act are often considered, and not merely the process as assumed by the majority in the present study. Existing literature indicates that there are endless contexts and characteristics to consider when determining if a behaviour is abusive and there is no consensus on the meaning of both context and characteristics of an act (Haugaard, 2000; Mathews and Collin-Vézina, 2019). This uncertainty gives some support to the point of view of those who label all the steps, processes, and interactions that the perpetrators used to get close to the child in order to molest them. However, the proactive approach to definition taken by most participants in this study is consistent with previous literature (Bennett and O'Donohue, 2014). It was stressed that valid measures should be developed in order to detect grooming, and it is not ideal to detect grooming entirely after abuse has taken place. Adults should be able to intervene to prevent future abuse if grooming acts appear inappropriate at the time they occur. As seen in certain developed countries,

grooming requires a valid definition, psychometrically appropriate assessment procedures, and effective criminalisation. This study is important and timely considering the fact that countries, such as the UK, the US, and Europe, consider child grooming to be a crime under the Sexual Offences Act, even if no sexual activity actually occurs.

The practice of child marriage in Nigeria and the early age of sexual consent in other countries, such as the Philippines and Angola, cannot be called CSA, demonstrating the role of practice context in the understanding and perception of CSA among HCPs in Nigeria (Haugaard, 2000). However, existing literature has questioned the context and standards used when determining which adult-child interactions and activities are harmful and could be considered CSA (Bennett and O'Donohue, 2014; Haugaard, 2000; Mathews and Collin-Vézina, 2019). Due to the lack of a clear distinction between adult-child interactions, the approach of criminalising all the processes and strategies perpetrators use to gain children's attention and trust and increase their vulnerability should be interpreted with caution in Nigeria. Furthermore, it may be difficult to situate this narrative of CSA within the Nigerian legal framework and context, considering the legal criteria necessary to pronounce an incident as CSA in Nigeria.

Even though there are controversies, this study shows the importance of considering grooming, individual intentions, and the capability to detect abusive interactions between adults and children. According to the present study findings, CSA is no longer defined globally as forceful acts, deviant behaviour, or coercion, but also includes socially acceptable actions or behaviours with mischievous intent. CSA is defined, therefore, as not only the involvement of children in sexual activities but also the strategies used by perpetrators to molest them.

For the primary prevention of CSA, understanding the grooming process and educating children and young people to identify these grooming strategies might be an effective approach, which has both clinical and legal implications (Bennett and O'Donohue, 2014; Craven, Brown and Gilchrist, 2006). Preventive child protection requires both retrospective and prospective grooming detection. In the future, it will be important to examine the perceptions of HCPs regarding grooming, the degree and type of grooming that should be defined as a crime, and the necessity for both retroactive and prospective grooming detection.

The concept of 'intention' has been used to discuss children's victimology and culpability. According to the WHO, children under 18 cannot consent to sexual activities. However, some participants still believe that children may not always be innocent and describe instances where they believe children are culpable. As an example, participants considered children wearing revealing clothes and asking or receiving money from an adult to be intentional seductive approaches, thereby making children culpable for their experience. The findings from the present study are in line with an ethnographical study conducted by Ellis (2019), where sexually abused children in secure care claimed professionals and agencies considered them responsible for their abuse. That study further explained the agency's perception of the child victims in determining the type or quality of services available to them. HCPs in my research claimed that sexually active children who seek help from professionals are rarely considered as victims of CSA, since professionals downplay the severity of the crime. This study's findings show that sexually aware children are at risk of being judged by professionals as wayward and not in need of protection due to the social stigmatisation of abuse, and misguided views about childhood asexuality. Woodiwiss (2014) reported that a sexually 'active' child is still seen as making herself 'available'

for sex. The present finding is consistent with previous literature that states that sexually active children are considered by professionals working in child protection services to have lost their innocence and therefore stand accused of intentionally offering themselves to abuse (Ellis, 2019; O'Neill, 2001; 2013; Sharpe, 2012; Woodiwiss 2014). These findings suggest that HCPs in Nigeria hold a limited understanding of CSA and its victimology.

Confirming that abuse has occurred is further complicated by Nigerian law. For any adult-child interaction or activity to be legally pronounced as CSA, the hymen must break in girls. However, when sexually active children report abuse, HCPs cannot determine this, resulting in fewer HCPs initiating or referring cases for litigation and obtaining justice. HCPs' professional practice with sexually abused children regularly raises ethical dilemmas, particularly when there are conflicts between the HCP's professional and personal values, as previously discussed in section 7.1.1. Children refusing treatment or claiming a consensual relationship with an adult causes HCPs difficulty in balancing confidentiality with their duty to protect.

In addition, HCPs often referred to perpetrators as 'monsters.' Such strong feelings towards perpetrators might explain the lack of professional care or services for convicted sexual offenders in Nigeria. In 2019, the Federal Government of Nigeria launched its first sex offender and service provider databases to address child sexual abuse. Under section 1(4) of the Violence Against Persons Prohibition Act, sexual offender registers include individuals convicted since 2015, and a service provider register contains contact information for those aiding domestic violence victims and survivors. This development was considered a crucial preventive measure with a focus on shaming the offenders and an important step in deterring perpetrators. There has been no provision made for sexual offenders other than imprisonment in Nigeria,

contrary to what has been observed in other countries (Beech and Fischer, 2004; Yates, 2013). Aborisade and Colleagues (2018) examined the accounts, excuses, and apologies of child sexual offenders in Nigeria and concluded that multidimensional factors contribute to CSA. That study indicated abusive behaviour towards children is triggered by a combination of developmental experiences, biological processes, cultural norms and psychological vulnerability. This calls for a broader approach to reconceptualising child sexual offending, to provide an extensive body of knowledge and expertise that could be devoted to developing literature on prevention and treatment of offenders.

9.2.1. HCPs' understanding of contributing factors to CSA

The majority of participants believe that the factors contributing to a child becoming a victim of CSA are multifactorial and interconnected. These factors are described in reference to the individual's characteristics, family dynamics, environment, socioeconomic situations, societal norms and cultural practices. While both genders were vulnerable to sexual abuse, female children were mentioned across all narratives as being more vulnerable, which is consistent with the findings of studies previously conducted in Nigeria and other countries (Aderinto, 2011; Ezechi *et al.,* 2016; Hassan *et al.*, 2016). This finding was attributed to societal perceptions of gender roles, sexuality, and masculinity, which expose girls to CSA and prevent boys from disclosing experiences of sexual abuse.

Participants in this study claimed women are seen as the main victims of this act, while men are commonly perpetrators in both male and female sexual victimisation cases. While not making excuses for the perpetrators, HCPs suggested that men's genetics and sexual hormones mean that they are more likely to offend. A national study

conducted in Sweden by Långström *et al.* (2015) found genetic factors contributed 40% of the variability in any sexual crime, compared with 2% by the shared family environment, which they interpreted as parental attitudes and the neighbourhood. This finding is supported by others who have highlighted the importance of biological factors in explaining offending sexual behaviour of adults, especially men, such as defective genes and hormonal imbalances (Faupel, 2015; Långström *et al.,* 2015; Marques *et al.,* 2002). As a result of gendered socialisation perpetrators of these crimes coerced or controlled their victims by using force and violence. These findings are consistent with feminist explanations of sexual offending behaviour that provide a gender-based analysis of the patriarchal social order that gives men power and privilege over women and children, which has been used to abuse and victimise children and women (Azzopardi *et al.,* 2018; Harnois, 2012).

In this present study, participants believed in causal association between pornography addiction and the perpetration of CSA. However, there is disagreement regarding whether a causal connection exists empirically (Diamond, Jozifkova and Weiss, 2011; Wolak, Finkelhor, Mitchell and Ybarra, 2010). Inconsistent findings regarding pornography as a predictor or precursor to sexual offense have been reported in the research literature for a variety of reasons, including variations in sampling techniques, types of pornography, and measures of exposure (Bensimon, 2007). Currently, little research has been conducted on the effects of pornography, and most of the studies used convicted subjects, which may have influenced the findings.

The HCPs in this study believed that all children are vulnerable to sexual abuse, but children from low socioeconomic backgrounds and those with financial problems are most likely to experience sexual abuse. They also suggested that parental neglect, as well as disbelief or attempts to maintain secrecy, predisposes children to CSA and also

acts as a mechanism for re-victimisation. The findings of this study confirm those from previous studies conducted in Nigeria which found that poverty, low socioeconomic status, and basic deprivation are constant predictors and mechanisms of CSA (Kunnuji and Esiet, 2015; Oteh *et al.,* 2009). A recent longitudinal study (Lancey *et al.,* 2020) found poverty was strongly associated with increased odds of a child reporting adverse childhood experiences, including being sexually abused. Lancey's study analysed data taken over two decades from 14,000 women, their children and partners, to explore the connections between commonly investigated adverse childhood experiences (ACEs). As a result of that study, reducing child poverty might be one strategy for reducing adverse childhood experiences. Given the influence of basic deprivation on sexual abuse, a programme addressing the basic needs and material conditions of Nigerian children is recommended. Consistent with previous studies (Aderinto, 2010; Audu *et al.,* 2009; Envuladu *et al.,* 2013), children living in families with unresolved conflict or with emotionally unavailable parents are more likely to experience sexual abuse. Also, the study emphasises the role of imbalanced power dynamics between the child and the perpetrator in coercing the child in the grooming process, which is believed to be made worse by the extreme deferential respect given to men in Nigerian society. HCPs in this study agreed with radical feminist authors that patriarchy and masculinity are the main reasons men overlook sexual offenses. According to the researchers, CSA is the result of societal factors including patriarchy, social norms and cultural practices.

This study is in consensus with previous empirical literature with respect to the tremendous consequences of CSA in both childhood and adulthood (Bentovim, 2009; Radford *et al.,* 2011). As well as affecting victims' physiological and psychological functions, social life, and interactions. There is a perception that sexually abused children interject the experience to other significant individuals, authorities, and the

society's value system. Therefore, they become disrespectful, disregarding rules and regulations, as they have lost respect for the systems and structures that failed to protect them.

9.3. HCPs' perceptions of their roles and nature of practice

As evidenced by others (Mkonyi *et al.,* 2021; Olatunya *et al.,* 2013; Tener and Silberstein, 2019), HCPs reported that their roles were crucial in identifying victims and ensuring that victims receive medico-legal care, psychosocial support, have access to justice, and are protected from re-victimisation. Despite acknowledging the significance of their roles, HCPs reported that what was expected of them went far beyond what they were currently doing and offering. Participants stated that they rely on ethical principles, professional experience, and a person-centred approach when dealing with CSA cases. Most of the HCPs in hospitals with a more clinical orientation perceived their roles more as providing medical care and did not consider psychological and legal support. Therefore, most of their descriptions of practice were based on providing medical care for sexually abused children. As these activities were outside the scope of their medical practice and did not directly fall under the purview of hospital settings, they were less likely to offer the victims psychosocial and legal support. In contrast, HCPs working within SARCs described their roles from a medico-psychosocial and legal perspective and emphasised the importance of identifying and providing a person-centred approach to the victim. Thus, the latter felt they were responsible for providing a comprehensive service, which included mandatory reporting, collecting information, conducting a history and forensic interview, and providing psychosocial and medicolegal support as well as child welfare and rehabilitation services.

Perceptions regarding the nature and procedures of professional practice involved in recognising and responding to sexually abused children in Nigeria persisted as a major theme throughout the study. According to the study, this practice is characterised by uncertainties, complexities, and dynamism. As evidenced in section 6.3, the nature of practice evokes strong emotions, is traumatic, and increases the vulnerability of HCPs to violence and assault, as well as increasing the risks to child victims. Findings from this study are in line with previous research that emphasised the overly complex and dynamic nature of practice involved in identifying and supporting sexually abused children, especially when the 'best interest' of the child is at stake (Franklin and Smeaton, 2016; Kwhali *et al.*, 2016; Schiller, 2017). This was also described in relation to navigating the bureaucratic process in the child protection systems, including the social and healthcare systems and the complexity of the legal, medical, and judicial systems. Furthermore, HCPs faced uncertainties such as when and how to report allegations of sexual abuse and felt incompetent in dealing with these matters. Inadequate specialised services and bureaucratic judicial processes contribute to re-victimisation. This finding is contrary to previous studies in other countries which have suggested that service providers understand and respond to complex challenges associated with disclosure and management of CSA even among marginalised populations (Franklin and Smeaton, 2016; Sivagurunathan *et al.*, 2019). This contrasting view may be due to differences in sample characteristics. For example, Franklin and Smeaton (2016) only explore the perspectives of stakeholders and not the HCPs at the frontline of identifying and responding to sexually abused children. This present study has created unique and important evidence from less researched samples in this field, by exploring the issues and challenges directly from the perspective of

five main healthcare professional disciplines with mandatory safeguarding roles for sexually abused children in Nigeria.

While previous studies have discussed the dynamism in the nature of CSA (Franklin and Smeaton, 2016; Kwhali *et al.*, 2016; Schiller, 2017), this study highlighted that caring for sexually abused children requires similar approaches. This dynamism was explained in terms of heterogeneity of CSA cases, the diversity of care and frequent rigorous training, as well as the multi-professional approach required to provide person-centred care. This study remains critical as it identified a multi-professional approach as the backbone of care for sexually abused children in Nigeria and revealed the associated or inherent multisystemic challenges undermining their work.

Saltiel (2016) explores the nature of practice and decision-making among social workers, uncovering some of the issues they face in gathering and assessing information. Findings from that study identified a lack of information, poorly defined situations, and the complexity and heterogeneity of many of the referred family cases of CSA, which made gathering accurate information very difficult. The present study also attributes their ineffective performance to non-disclosure by victims and the fact that issues around sexuality and CSA are kept secret in Nigeria.

Evidence from the present study shows a similar pattern with a study that aggregates evidence on vicarious traumatisation among practitioners working with CSA survivors (Chouliara *et al.*, 2009). Both studies indicated the sensitivity of practice to the person–situation interaction, the interplay of contextual factors at multiple levels and how these shaped the way in which HCPs perceived their roles. HCPs who participated in this study felt this was not only traumatic to the victims but also to them as a result of listening to victims, empathic engagement with victims, and exposure to traumatic material. In contrast to other practices, participants in this study claimed there are

unique features in working with sexually abused individuals that contribute to the development of a significant level of vicarious traumatisation. This, they believed, was caused by listening empathically as survivors shared graphic details of their victimisation experiences, the severity of the abuse victims encountered and the negative disposition of the supposed family social system and HCPs' inability to provide effective care. Also, HCPs claim they are constantly faced with a high volume of cases that are traumatic to them, and there is not enough time to resolve associated trauma before receiving another case. Numerous studies have described pervasive changes that occur within clinicians over time as a result of working with clients who have experienced sexual trauma (Chrestman, 1999; Ghahramanlou and Brodbeck, 2000; VanDeusen and Way, 2006; Way *et al.*, 2004), including to the clinician's sense of self, spirituality, worldview, interpersonal relationships, and behaviour. Scholars such as Søftestad and Toverud (2013) note the need for emotional and professional support for those working around potentially traumatic topics. Participants in their study valued such support after each demanding experience, as they needed to debrief and express their emotional responses. In contrast, a study by Hatchera and Noakes (2010) examined the effects of working with sex offenders on a nationwide sample of service providers from correctional settings. Their results show a low level of vicarious trauma, and a low to moderate level of compassion fatigue and burnout. Over 85% of the sample in Hatchera and Noakes (2010) also reported moderate to high levels of compassion satisfaction, indicating that they derived pleasure from their work, as opposed to the current study where participants explained that frustration and a lack of accomplishment contributed to the secondary traumatic stress. Although there are consistencies between this research and previous studies regarding secondary trauma stress among professionals working with victims or survivors, there is still a need for

caution when interpreting and applying these findings due to the differences in the study samples (e.g., profession, work setting), context of practice, variables measured, and methodologies. There is a need to explore the severity of vicarious trauma among professionals working with victims and those working with sex offenders, as the effects of vicarious traumatisation are far-reaching. An ethical concern is that vicarious trauma may interfere with clinicians' ability to work effectively with victims, and many professionals have disengaged with practice due to its effect (VanDeusen and Way, 2006; Way *et al.,* 2004). Because of this, it is important for both clients and clinicians to be able to recognise and deal with vicarious traumatisation.

Evidence suggests that becoming involved in families' sensitive and private lives in the practice of supporting sexually abused children can be sensitive, evoke strong emotions, arouse inner ambivalent feelings and result in vicarious trauma (Kraft, Rahm and Eriksson, 2017). Similarly, the uncertain situations, stressful investigations, and dilemmas that come with each case and inevitable occurrences of not recognising CSA are distressing, frustrating and provocative for most HCPs (Kwhali *et al.*, 2016; Saltiel, 2016; Søftestad and Toverud, 2013). Moreover, the process of identifying the victims and obtaining formal disclosure may have significant emotional, interpersonal, social, financial and legal consequences for the victims and their family members (Søftestad and Toverud, 2012). Therefore, this study has uncovered a critical aspect in the field of CSA, as it explores and provides explicit understanding of the dynamics within the social and healthcare systems, as well as of interaction between HCPs and the families.

Lastly, HCPs in this study added a new perspective to the nature of practice. The participants explained that working to support victims of CSA often increased their own vulnerability to threats and violence. This theme was explained due to their view that their efforts to protect and safeguard the children and make decisions in the child's

best interest have been misinterpreted by the child, the child's family and the community. In most cases, HCPs have found themselves in conflict with the victim's decisions and preferences, family's ideas and cultural values, and social norms and practice. The conflictual nature of care was a major challenge and a detriment to their practice in Nigeria. However, caution should be taken in interpreting these findings as the Nigerian context in which these HCPs practise may have influenced the nature of their work. Evidence from this study reinforces the fact that the geographical context in which a study is conducted has a great impact on what constitutes challenges, how they are framed, and their impact on practice and pragmatic approaches.

9.4. Issues and challenges facing HCPs and their implications

The HCPs in this study have used a person-in-environment approach to conceptualise the issues and challenges faced in their roles. The depth of this conceptualisation is beneficial for HCPs because it provides a way for us to incorporate various system foci in our client work (such as individual, family, group, health and social agencies, and community), explaining that there are value-based conflicts among these systems that are the cause of the difficulties. The complex difficulties that HCPs encounter when interacting with clients and their families have long been acknowledged in CSA literature (Ajema *et al.,* 2018; Alsaleem *et al.,* 2019; Bryant and Milsom, 2015; Wangamati *et al.,* 2019). Findings from the current study suggest that HCPs encounter a number of overlapping problems when trying to identify and respond to sexually abused children that exist on four different yet interrelated levels. Some of these challenges and constraints are congruent with those reported in previous studies (Ajema *et al.*, 2018; Alsaleem *et al.*, 2019; Bryant and Milsom, 2015; Wangamati *et*

al., 2019). To an extent, finding similar results is encouraging and shows that irrespective of the context, there is a high level of insight present among HCPs about the issues and challenges associated with the practice of supporting CSA victims.

9.4.1. HCPs related challenges

At the intrapersonal level, findings from this study are in line with research from other countries that have identified issues and challenges facing healthcare professionals. The mandatory responsibilities are to assess the risk of CSA, identify cases of CSA, and provide the right level of intervention to ensure necessary protection and prevent re-victimisation. A main finding in this study was the respondents' emphasis on the importance of adequate competence and professionalism. In their opinion, they lacked training, knowledge and experience in dealing with the complex circumstances around CSA. They thought their education was basic or unrelated to CSA and had little experience. The majority of them had completed a bachelor's degree in their respective fields. In line with what other studies have found (Ajema *et al.*, 2018; Alsaleem *et al.*, 2019; Franklin and Smeaton, 2016; Schiller, 2017), this study found that the majority of HCPs felt inexperienced and unable to effectively manage CSA cases. This problem was felt to be rooted in the lack of specific training in this area and discrepancies in HCPs' understanding and multidisciplinary perspectives, as well as conflict between personal and professional values, as discussed in chapter seven. Provider capacity in the delivery of services to child survivors of abuse is critical. These results are also similar to those presented by Ajema *et al.* (2011, 2018) who found that in Kenya most providers did not have enough training to help people who had been sexually abused. The capacity gap among healthcare providers can be improved by using specialised

training modules on identifying cases, reporting them, and managing the cases of children who have been sexually abused.

Additionally, this study revealed that HCPs' suspicion of CSA is seldom reported due to the lack of professional curiosity essential to detecting abuse. Therefore, decision making in cases of unsubstantiated or ambiguous suspicion comes with several dilemmas and uncertainty regarding identification and necessary intervention. This is usually a dominant part of the picture, as observed in previous studies (Bryant and Milsom, 2005; Franklin and Smeaton, 2016; Martin, 2016). In a qualitative study conducted in the US (Bryant and Milsom, 2005), school counsellors from one Midwestern state were examined for their reporting behaviours, factors that influenced their decisions, and perceived barriers to reporting child abuse. Despite the fact that schools are a major source of reported abuse, only a fraction of their suspicions is reported (Bryant and Milsom, 2005). Despite the differences in the samples and contexts, these findings suggest there is a risk of HCPs failing to identify and provide intervention when needed results in considerable re-victimisation of the child and subjecting the child to the long-term devastating consequences of CSA. Evidence from the current research showed a lack of awareness and knowledge of the indicators of CSA among HCPs, leading to the under-recognition of cases. Only reported cases are identified, meaning most cases are unrecognised since children rarely disclose (Kogan, 2004; Schönbucher *et al.*, 2012). Similar to previous research on CSA in Nigeria, HCPs in this study feel the available resources, capacity, staffing level, and level at which the practitioners currently operate in Nigeria are substandard and likened the situation to 'the tip of an iceberg' compared to the comprehensive person-centred care required by victims (Adeleke *et al.*, 2012; Ige and Fawole 2012; Olatunya *et al.*, 2013). However, these studies have failed to extensively discuss the required services for

sexually abused children in Nigeria, which further propagates the idea that HCPs in Nigeria possess limited understanding regarding case management in CSA. The present study has disregarded an existing unilateral approach of care and recommended multidimensional approaches that consider all aspects of practice, and the child-HCPs interaction in the microsystem and wider-system of the child and the family: succinctly, moving from merely medical approaches to medico-legal and biopsychosocial approaches.

9.4.2. Child and family-related challenges

Participants claimed that their inability to identify cases of CSA is exacerbated by a number of factors. For instance, participants described that some children were not aware that they are being abused or exploited and instead claimed that they are in consensual relationships. Other participants noted that children were scared of the reaction from their loved ones. Finally, there were concerns that children did not report CSA because they were unaware that they were entitled to receive professional support. These findings are consistent with evidence from systematic reviews of literature on the victims' perspectives of barriers to self-disclosure and seeking professional support (Crisma *et al.,* 2004; Münzer *et al.,* 2016; Wager, 2015), as discussed in chapter two. HCPs explained they are sometimes faced with sensitive situations where CSA victims do not perceive themselves as sexual abuse victims, especially when CSA take the form of female genital mutilation and child marriage, which are socially accepted and practised in Nigeria. The current findings are in line with previous studies from other countries that explored barriers to disclosure among victims of CSA and identified various individual, intrapersonal, and interpersonal factors among the participants that prevented them from disclosing and seeking

professional support (Alaggia, 2005; Crisma *et al.,* 2004; Münzer *et al.,* 2016; Wager, 2015). Participants in this study attributed children's and family's unawareness of the responsibilities of key disciplines to sexually abused children to the nascent stage of these professions in Nigeria. As in many previous studies, respondents claimed that a lack of awareness of existing and functioning protective agencies was a major impediment to seeking professional help (Crisma *et al.,* 2004; Münzer *et al.,* 2016; Wager, 2015). Although these issues raised by victims do not directly affect HCPs, they identify the interplay of factors that make working with children and families extremely difficult and also highlight barriers to accessing professional support. For instance, literature shows that young people are reluctant to share details of their abuse (Collin-Vézina *et al.,* 2015; Hunter, 2011) and therefore HCPs need to overcome these challenges by creating safe spaces for young people and their families. HCPs reported their own difficulties in creating these safe spaces, therefore an understanding of constraints for both professionals and victims will be crucial in developing robust strategies for protecting sexually abused children.

In this study, participants expressed concern about interference from victims' and perpetrators' families. Families have been found to withhold information, withdraw cases, refuse treatment and prevent HCPs from accessing the victim by relocating the child, and may even marry their children to the perpetrator. Additionally, families of both victims and perpetrators have been found to confront, threaten, and even assault HCPs, especially when HCPs' intervention has been perceived as a destructive mechanism with the potential to alter family dynamics. Negative responses and attitudes towards the child and HCPs can sabotage the intervention process and frustrate HCPs' efforts. Research by Nwanna and Ogunniran (2019) explored the issues and challenges faced by social workers working in child protection service in

Nigeria. They found that family court reported parents of sexually abused children were uncooperative and reluctant to seek and receive professional services, which challenged their efforts to provide effective services and obtain justice for sexually abused children. These findings from Nigeria stand in contrast with international findings that show that in the process of identifying and supporting sexually abused children, parents have been supportive and non-controversial regarding HCPs' practice of caring for and safeguarding sexually abused children (Kraft *et al.,* 2017; Søftestad and Toverud, 2013). However, it is important to mention that HCPs in these international studies had started working with the child and the family before the suspicion of sexual abuse. This previous relationship and cooperation in meeting the child's needs might have prevented uncooperative behaviour from the families. Similarly, parents who understand the consequence of sexual abuse on their child might have chosen to engage with the intervention offered by professionals.

9.4.3. Institutional challenges

Previous literature has discussed both structural and logistical challenges in the healthcare and social systems in Nigeria, resulting in poor health budgets and allocation of resources and poor quality of care. The healthcare system is poorly developed with a lack of reimbursement to HCPs, and no regulatory bodies to inspect the health and social care services, resulting in a number of health workforce crises (Adeloye *et al.,* 2017; Innocent *et al.,* 2014; Omoruan *et al.,* 2009). My findings provide empirical evidence to substantiate that HCPs in Nigeria encounter financial, resource constraints, and lack basic medical amenities essential in identifying sexually abused children, aggregating evidence and responding to their needs. Financial constraints prevented healthcare organisations from hiring qualified professionals,

which worsened already low staffing levels and professional capacities. HCPs instead often depended on their personal money or relied on the services of volunteers. Other studies conducted outside Nigeria also identify similar institutional challenges that undermine their confidence to practise and consequently restrain service delivery (Ajema *et al.*, 2018; Kwhali *et al.*, 2016; Muridzo *et al.*, 2018; Saltiel, 2016; Schiller, 2017). As part of an exploratory study conducted in Kenya to assess the comprehensiveness and quality of sexual violence services for children, Ajema and colleagues (2018) found healthcare facilities lacked the necessary equipment for collecting forensic evidence from children and private rooms for conducting clinical examinations. HCPs cited challenges in offering psychosocial support to children. Similarly, a study that was undertaken by Wangamati and colleagues (2016) in Kenya revealed that shortages of equipment, supplies, and drugs were some of the hindrances to the delivery of high-quality post-rape care services in public health facilities. There are numerous institutional and systemic challenges, as discussed extensively in the present and previous findings, but little is being done to address them. In these studies, it was suggested that health facilities must enhance their human resources and infrastructure to facilitate comprehensive care for child survivors.

HCPs in this study stated that institutional challenges were further exacerbated by procedural and systemic issues such as lack of national guidelines, corruption in the police system, and unsuitability of the available family courts. According to Kenyan guidelines for the management of survivors of sexual violence, all survivors must receive comprehensive care (Ministry of Health, 2014). The Ministry of Health in 2014 mandated post-exposure prophylaxis (PEP), emergency contraceptives, STI drugs, counselling, and laboratory-related services, and stated that service provision should be properly documented, but Ajema *et al.* (2018) noted that even though there are

national protocols to guide service delivery, not much is known about how well they meet the needs of child survivors of sexual abuse because they do not set specific standards to be followed in these cases. Additionally, Ajema's study revealed there is inadequate use of existing national documentation protocols by providers as the analysis of the medical records of child sexual abuse survivors indicated that only one of the 19 survivors has a record of completed treatment. Similarly, a qualitative study conducted in South Africa using focus groups of 71 social workers indicates that existing South African policies, conventions and legislation do not always complement each other, but create challenges and uncertainties amongst social workers in this field (Ajema *et al.*, 2018). This, together with insufficient resources for service delivery, often leads to re-victimisation of the child who have been sexually abused. This implies that lacking national protocol and guidelines is not the problem per se, but the policymakers in Nigeria, while developing the national guidelines, should ensure it is clear what measures have been put in place by providers to ensure CSA victims receive standardised, quality, and comprehensive services.

This study reported that police have been found to be sexually and financially exploiting sexually abused children and families, truncating or delaying the judicial process by hiding criminal evidence, accepting bribes from the perpetrators, and falsifying evidence. In a particular study in Nigeria, Nwanna and Ogunniran (2019) identified corrupt practices among police officers as some of the challenges militating against the implementation of the law and services to protect and safeguard children. This current finding is supported by a study conducted in Kenya to examine the healthcare system (Ajeema *et al.*, 2018). The study found inadequacies in caring for sexually abused children and highlights the service delivery gaps in the management of children who have experienced sexual abuse within public health facilities. This

outcome is contrary to that of earlier findings by Panayiotopoulos (2011), in a study conducted in Cyrus that found evidence of good practice amongst the police force and social services. HCPs in Nigeria clearly identified the importance of working with police systems in case management, and extensively discussed how the unprofessionalism and corruption in the police system undermine their practice. This may be related to previous studies in Nigeria indicating that the majority of the referrals to the centre were from the police (76.7%), while self-referrals made up 8% of referrals (Sodipo *et al.,* 2018). While no international study has expressed similar results, considering the implication of this unprofessional behaviour and action, it is important that the activities of the police officers should be strictly monitored and severe punishment should be meted out to any official that manipulates or stands in the way of the law.

This research found that HCPs prioritise the referral process in responding to sexually abused children. However, the issue of unclear protocols and procedures undermined their support for sexually abused children (Kwhali *et al.*, 2016; Panayiotopoulos, 2011; Saltiel, 2016; Wanlass *et al.,* 2006). These studies cited different reasons for the protocol and procedural challenges: either a lack of specific procedures, or the complexity of protocols for collecting and reporting evidence and connecting victims to available support. Participants from a study by Saltiel (2016), conducted in the UK, claimed referral processes are written by administrative staff who do not know the cases and terms used. As a result, incomplete information was reported and cases with further devastating risks were not flagged up, placing the victim at risk. Findings from that study also revealed that reports from the police and other professionals often lacked key details such as phone numbers, requiring a great deal of time to track down information and provide a prompt response to sexually abused children. In this

research, HCPs are concerned about being unable to monitor the progress of the prosecution, identify the negative impact of the prosecution on the victims and family, and provide effective support. This feeling of incapacitation, exhaustion, and serious concerns for victim safety and emotional well-being, which can be explained by the findings that law enforcement agencies subject sexually abused children and their families to sexual and financial exploitation. Also, the unnecessary delays in prosecution and tampering with the evidence and the process of obtaining justice for victims in the judiciary system remain a problem.

9.4.4. Socio-cultural issues

Apart from working in the patriarchal society of Nigeria, which has been discussed in chapter 7, section 7.2.5, where some cultural practices and norms place children at risk of sexual abuse, HCPs raised concerns about interference by traditional and religious rulers. Participants explained that religious and traditional rulers prioritise societal harmony over individual well-being and always advocate to settle cases of CSA amicably without reporting to the HCP and judiciary system. This practice has not only challenged the identification of cases but also made responding to identified or suspected cases difficult. Studies conducted in Kenya (Ajema *et al.,* 2011; Wangamati *et al.,* 2016) found it is not uncommon in Kenya for CSA survivors' families to settle CSA cases using traditional approaches and courts to resolve any crime considered mild in severity. The trivialising of CSA cases was also evidenced in this present study, as minority of participants considered all non-penetrative sexual abuse as irrelevant and 'child's play,' especially when it occurred among peers or siblings. This variance in perspectives and understanding held by Nigerian has put the HCPs in a persistently conflictual relationship and interaction with society while supporting sexually abused

children. Therefore, cases of non-penetrative abuse and penetrative cases with no life-threatening trauma or injuries are not reported in Nigeria, meaning that there are no services available for victims of such abuse.

9.5. Strategies to mitigate challenges and improve services

During this study, HCPs identified practical strategies to mitigate the challenges they encountered and to improve victims' experiences, which are in line with previous studies (Ajema *et al.*, 2018; Alsaleem *et al.*, 2019; Franklin and Smeaton, 2016). Participants discredit the current traditional symptomatic approaches to treating CSA cases and emphasise the importance of case management approaches that cater for the psychological, social and general welfare of the sexually abused child and their family. On this note, participants recommended mandatory CSA-specific professional training and personal development. As part of CSA case management, HCPs recommend specific training around screening, forensic examination, and child protection principles, as well as training to address potential psychological and mental health issues, CSA prevention programmes, and forensic counselling training for HCPs to work with perpetrators within the criminal justice system. These findings are similar to those of previous studies (Ajeema *et al.*, 2018; Franklin and Smeaton, 2016; Green, 2005).

As with previous studies advocating multi-professional approaches, the findings of this study emphasise the importance of comprehensive care to facilitate efficient and high-quality care and facilitate interactions between different professions (Franklin and Smeaton, 2016). Participants highlighted the importance of partnerships and networking with other child protection and child safeguarding organisations which address CSA both nationally and internationally. At the national level, they felt that

working in partnership with social support and cultural, religious and educational groups would enable them to effectively provide comprehensive care to sexually abused children and their family. Children, their families, and professionals can benefit from education, training, and increased awareness and sensitisation programmes in Nigeria. Participants advocated for a strong political will and active national government participation in children's welfare, social support, the development of victim and child-friendly programmes, and the provision of adequate operational logistics and resources for security. They believed that with stable national financial support and grants adequate free services (including medical, psychosocial, welfare and rehabilitation services) could be provided promptly. In addition, they recommended the implementation of existing dormant laws and the making of new child-friendly mandatory policies and systems. The need for full implementation of child protection and safeguarding laws and national guidelines for healthcare professionals with a focus on CSA must be addressed. This study not only identified the intersection of technology and CSA, but also demonstrated that technology and software can be used to deter perpetrators, to prevent primary crimes, and to identify and treat cases early, without generating negative publicity.

9.6. Contribution to knowledge

This thesis contributes to the body of knowledge in the field of CSA by focusing on the issues and challenges HCPs face when identifying and responding to sexually abused children. It does this in a number of ways. First, the primary contribution to knowledge is that it enhanced our understanding of the HCPs perception of the concept of CSA, the personal meaning attached to this experience, as well as the discrepancies in their understanding. It revealed areas of discrepancies and a number of factors

responsible for these discrepancies and how it framed their understanding and perception of CSA. It revealed how personal experiences, socio-cultural background, professional practice, statutory roles in relation to CSA, and the context of practice framed the understanding of HCPs. Hence, it provides a comprehensive explanation of the controversies and discrepancies in HCPs' perception of CSA, age of consent, and portrayal of victims. We gain a deeper understanding of their views on victimology and criminology of CSA and attitudes towards sexually abused children in Nigeria as well as how their understanding influences their practice. Through HCPs' perspective, this study also broadened our understanding of the vulnerability factors of CSA in Nigeria, the spectrum of activities considered CSA, and those sexual activities justified by sociocultural practice and norms constructed. By using an exploratory approach to explore HCPs understanding, this study uncovered the social construction of childhood in Nigeria, society's attitude towards victims and perpetrators and more importantly how these narratives undermined HCPs practice. By exploring HCPs understanding of CSA, we are better able to understand why HCPs lack the skills, knowledge, and professional curiosity needed for identifying CSA victims and providing effective support to them. These voices add a new conceptual understanding with which to view CSA in this specific context.

Second, findings from this study contribute to our understanding of HCPs' perceptions of their roles and the dimension of practice of identifying and responding to sexually abused children in Nigeria. We now understand that the roles of HCPs are crucial in identifying victims and ensuring that victims receive medico-legal care, and psychosocial support, have access to justice, and are protected from re-victimisation. However, the current performance is substandard compared to the required care of sexually abused children. These findings revealed the need to move from the

unidirectional approach of the medical model of treatment to multidimensional approaches of medico-legal and biopsychosocial approaches that include active engagement of the parent/guardian, stakeholder, the child's social cycle, school, and community in Nigeria. The nature of practice remains complex and dynamic, sensitive, evoking strong emotion, and increasing HCPs' vulnerability to abuse and violence. Our understanding of the nature of practice is an essential framework to develop quality education, training, professional development opportunities for practitioners, and supportive programmes that cater to their well-being.

Third, in addition to shedding light on the important issue of child sexual abuse, this research has also deepened our understanding of the challenges that HCPs face when it comes to identifying and responding to victims of CSA. By conducting an exploratory and contextually based study, we were able to gain valuable insights into the unique issues that HCPs encounter in their roles, and these insights can help to inform future efforts to support and empower these professionals in their work. We have a better understanding of the all-encompassing challenges undermining the practice of HCPs, ranging from intrapersonal and interpersonal challenges to organisational and socio-ecological challenges, as well as the associated implications for practice, victims, and society. These challenges were conceptualised from the source, using a subjective-specific approach to broaden our understanding. As a result, we have a better knowledge on the ways in which these challenges can be addressed; a piece of evidence that is important to help inform and guide future policy, practice, and research related to CSA in the country.

Fourth, this study makes a more important contribution by theorising the issues and challenges faced by HCPs in their role of supporting victims of CSA in the Nigerian

context, which provided an opportunity for theory-based practice and policy development. With the 'practice challenges' theory, we have a better understanding that these challenges were caused by the constant interaction of practice-dimensional factors, individual factors, and contextual factors. Also, the 'dimension of practice' involved in supporting sexually abused children cannot be segregated from the context of practice. Unlike ecological theory, practice challenges theory emphasises both the inherent element and dimension of practice and the interactive contextual challenges at individual, microsystem, and wider systems levels. Hence, developing an integrated, culturally sensitive, multi-systemic theory using a grounded theory approach. The 'practice challenge' theory provides a multidimensional explanation of issues and challenges facing HCPs, emphasising the nature of practice and dynamic interactions between the individual, family, social environment, and cultural milieu. In addition to providing comprehensive frameworks for understanding the multiple and interacting determinants of identified issues and challenges, the theory also provides a framework for developing comprehensive interventions and approaches that target mechanisms of change at each level of influence systematically, while considering the nature of the practice itself.

Fifth, this study adds crucial evidence to the field of CSA by exploring the social phenomenon of CSA, its practice, and associated challenges from the perspective of HCPs in Nigeria, providing an opportunity to hear an important but under-researched and unheard voice. To date, most research regarding HCPs' perceptions and experiences of issues and challenges in identifying and responding to sexually abused children has been carried out in Western countries, with only a minority conducted in Africa. As a result, this thesis enriches the literature in the field of CSA and significant evidence is drawn from the Nigerian context. The first of its kind in Nigeria and

contributes to the body of knowledge by providing an in-depth exploration of HCPs' experience and perspective. This research was ground-breaking in that it sought to provide a platform for HCPs to express their views on child sexual abuse, issues and challenges they are facing in their practice, and its implications. By understanding the perceptions of these professionals, it is possible to develop better strategies for addressing CSA and providing support to victims and HCPs.

Apart from the above-stated contributions to knowledge, this study is the first study in Nigeria to use a multidisciplinary approach to enrich and diversify research findings by interviewing five different disciplines with statutory responsibilities for sexually abused children. This approach resonates with the reality of the multi-agency practice, that remains the backbone of supporting sexually abused children. Additionally, these findings provide a deeper understanding of how HCPs can effectively respond to children who have experienced sexual abuse and how to ensure the best possible outcomes. This research provides evidence that HCPs have limited skills and knowledge needed to provide effective support to victims of CSA and that there is a need to improve in identifying and responding to these children. Furthermore, the findings of this thesis can help to inform the development of evidence-based policies and practices for HCPs in order to ensure that they are properly equipped to identify and respond to sexual abuse in an effective and timely manner. This research can also be used to inform similar studies in other contexts, helping to further our understanding of CSA around the world.

9.7. Summary

This chapter discusses the project's major findings and considers them in relation to the research aims and research questions and existing relevant literature in the field of CSA. It discusses the present study's contribution to knowledge of CSA, highlighting the study's significance. The next chapter discusses the recommendations and conclusion of the study.

CHAPTER TEN: RECOMMENDATIONS AND CONCLUSION

This chapter presents the reflections of the researcher, the overall findings of the study and discuss the significance of the key findings. The study's predominant themes were outlined using available research evidence, the project's strengths and limitations were identified and acknowledged. Finally, this chapter explores the implications and recommendations for four key areas of practice. This chapter presents my research contribution to knowledge and the conclusion drawn from the study's findings.

10.1. Reflection on research processes

During the course of this study my personal and professional knowledge of CSA in Nigeria helped me to better understand participants' meaning and understanding of CSA, the nature of their practice and the issues and challenges they faced. I paid attention to my own self-awareness in order to avoid interfering with my knowledge of UK child rights and child protection policies and practices. My own experiences and knowledge of the Nigerian healthcare system and culture, combined with knowledge of my awareness around children's practice and policy in the UK helped to provide additional insight into participants' narratives. It was particularly interesting to hear about the issues and challenges HCPs faced in Nigeria, as well as their suggestions for how to mitigate these issues, improve the service experience of the victims, and prevent CSA. Since I have worked in Nigeria and the UK, I have experience of practice related to safeguarding children and addressing CSA in both contexts. Furthermore, I became aware of my personal biases, as it seemed that women participants who explicitly or implicitly disclosed their experiences of sexual abuse as

children appeared to be more empathic in their narratives and perspectives on victims compared to men. While conducting the research, I shifted from being an insider to an outsider depending on the context (Berger, 2015; Denzin and Lincoln, 2011). Moreover, the knowledge constructed in this thesis is a combination of my sense-making of the data as an insider/outsider, as well as the insights of the participants. During the data analysis process, I found the process of co-constructing the emerging theory challenging at first, since I continuously subconsciously suppressed my own worldview and perspective while attempting to provide an explanatory schema for the way my participants interpreted the social phenomena and processes under study. This approach has been useful in developing data-driven theory. Writing the research reports definitely pushed my limits in academic literacy, and I often found myself striving to use the appropriate academic vocabularies to explicitly discuss my participants' ideas, narratives, and perspectives without appearing judgmental. At the initial stage of writing the thesis, I was preoccupied and worried that my writing was not perfect, or I was not providing detailed information on my ideas. In this process, I was repeating myself which affected the clarity, consistency and my ability to present a logical write up. An approach I found really helpful was writing using a concept map to structure and arrange my ideas before I started writing about them. As I constantly revisited the write up, improving and expanding them, I realised how much I have improved the quality of my content and ability to provide coherent and logical explanations and arguments.

10.2. Summary of overall research findings

This study revealed HCPs' broad understanding of the concept of CSA and the meaning attached, based on their personal experience and their practice of supporting

sexually abused children. This findings allows us to gain a deeper understanding of how HCPs perceive CSA, ranging from their own personal understanding to legal definitions, vulnerability factors, and consequences. Findings from this study indicated how important to explore CSA through the lens of culture, religious customs and legal frameworks. It revealed how HCPs' early life experiences, cultural and religious traditions, and their professional background shaped their understanding of CSA. A combination of these factors leads to variation in HCPs' constructions of CSA and reveals their breadth of knowledge and understanding. Even though most of the participants portrayed sexual abuse victims as victims and explained the occurrence by unfortunate vulnerabilities and perpetrators exploiting and taking advantage of the power imbalances and children's naivete, a few of them disagreed. Few Nigerian HCPs, however, believe children are culpable, despite their incapacity and incompetence to consent to sexual activity. This study's findings highlighted numerous intertwined or interconnected vulnerability factors, emphasising individual characteristics, family dynamics and characteristics, the environment, socioeconomic situations, and societal norms, attitudes, and cultural practices. The definition and range of activities that can be considered CSA, as well as the global issues of differences in the age of consent based on geography and ethnicity within and outside of Nigeria, are also discussed.

This nature and process involved in their practice was conceptualised by HCPs as 'walking through the darkness with the victim' and 'daily battlefield.' According to this study, the practice of supporting sexually abused children is both complex and dynamic in nature, and extremely sensitive, causing strong emotions and vicarious trauma as well as placing HCPs at risk of abuse and violence. The disclosure process is complex, requiring exploratory discussion with the child and sometimes family to

unravel the occurrence—an approach HCPs found daunting. In Nigeria, children are vulnerable, oppressed, and socially invisible, making them more vulnerable to sexual abuse. In addition to not being aware of their rights, being victimised, exploited, and being unable to seek help, these children also suffer social, cultural, economic, and political deprivations. Findings showed that rather than society supporting sexually abused children, they are subjected to silencing, shaming, labelling, blaming, or stigmatisation. For sexually abused children, recovery is a personal journey that requires support from their social network, empowerment, and autonomy. Unfortunately, social support systems were not provided to CSA victims in a way that benefited their general mental health and well-being, and resources are channelled by society to support perpetrators.

This research found that HCPs do not care for children in isolation. They are involved in the child and family's private sphere of life and ecological system and each sphere comes with its own challenges that were felt by HCPs to undermine their practice. HCPs are in persistent conflict with a child's preferences, the family's ideas and decision, cultural and society practice. It became clear that society's trivialisation, normalisation, and advocacy of self-medication and self-treatment to victims and their families had jeopardised HCPs' unwavering efforts to encourage victims and their families to disclose incidents and seek professional services. This is made worse by the discrepancies in the understanding of HCPs on what constitutes abuse and what victims and families consider CSA.

Reflecting on their practice, these issues and challenges are discussed in relation to the pathways of care, individual factors, and victims' ecological and social support systems. This research suggests that a significant number of HCPs mandated to support victims lack the abilities, skills, and professionalism needed to manage their cases

effectively. Even though professionalism and competence are still the most important standards and principles of practice, this study showed that there are deep-seated problems with unprofessionalism and a lack of competence. As a result of professional issues, HCPs frequently feel underequipped, inefficient, and that their performance and expertise are being called into question, robbing them of a sense of accomplishment. Because there are no accrediting bodies, licensing processes, or standards for education and experience, membership and registration criteria are open to non-professionals and incompetent individuals to shoulder the responsibilities of identifying and responding to cases of CSA.

HCPs also face victim-related challenges, which are embedded in intrapersonal, relational, and situational factors. HCPs are faced with sexually abused children withholding their experiences, or delaying disclosure, while others refuse part or all of the treatment, not recognising themselves as sexually abused and exploited victims that need professional intervention, but as individuals with consensual intimate relationships. Children act in this manner for a variety of reasons previously discussed, yet HCPs acknowledge that having these aforementioned experiences while working with children makes their lives more challenging. HCPs deal with the discrepancy or inconsistency in the victim's story, especially as it represents crucial evidence to confirm the CSA incident. In spite of the fact that HCPs provide numerous reasons for these discrepancies, relying on these fragmented or disjointed pieces to initiate treatment, apprehend the perpetrator, or even obtain justice became increasingly challenging. Furthermore, sexually abused children are often unaware they require professional support, unaware of the types of services available to them, and unable to seek help on their own, which creates additional barriers for the HCPs who are attempting to support them.

The child's family remains the central component of intervention and the primary social support system, but their interference significantly complicates HCPs' efforts to identify, respond to, and obtain justice for victims. HCPs are faced with a magnanimous level of family ignorance resulting in disregarding or disbelieving victims' accounts of sexual victimisation and trivialising CSA incidents, even in the face of evidence. Family refusing treatment remains a strong barrier for detecting and responding to sexually abused children in Nigeria. Aside from treatment refusal, abrupt withdrawal of cases becomes an opposing factor, severing HCP's effort and practice of supporting victims and resulting in a direct waste of CSA service resources. More disturbingly, families have been found to prioritise protecting the perpetrator rather than protecting and focusing on the victim's recovery and wellbeing.

Regarding the institutional challenges, SARCs are non-prosecutory, meaning HCPs are unable to prosecute cases and rely on the services of public officials working in the judiciary system, whom the HCPs consider incompetent and corrupt. They become incapacitated, especially when judicial officials are not proactive or ineffective in prosecuting the case. They are also incapable of assessing the impact of the legal proceedings on the child and his or her family in the event that litigation occurs. HCPs operate in a capital-constrained environment, with no sufficient funds to recruit qualified professionals, constraining existing low staffing levels and relying on volunteer workers. Additionally, the lack of national medico-legal guidelines to direct, coordinate, and improve the quality of care and services provided to victims of gender-based violence and CSA in Nigeria remains a problem. With no blueprint, HCPs depend on their personal experience, which was previously described as limited. Additionally, there are no health and social services systems in Nigeria that can

provide holistic and comprehensive care, which makes it difficult to comply with international guidelines and protocols.

The sociocultural challenges in Nigeria are deeply rooted in the sociocultural practice of being a patriarchal society with a high level of discrimination, prescriptive gender roles and expectations, and objectification of women and children.

10.3. Importance and significance of research findings

The findings from this study have enriched our knowledge of HCPs' understanding and perceptions of the concept of CSA and the personal meaning attached to this experience in Nigeria, as well as the discrepancies in their understanding. The factors that influenced their understanding and how it shaped their conceptualisation of CSA were identified, which include personal experiences, socio-cultural background, professional practice, and statutory roles in relation to CSA. These study's findings provide important insights into HCPs' breadth of knowledge and understanding of the studied social phenomena and their disposition toward sexually abused children and HCPs' safeguarding practice in Nigeria. These research findings reveal that a significant number of HCPs in Nigeria (who are mandated to safeguard and protect children), have limited knowledge and understanding of the concept of CSA, as well as limited experience and competence in dealing with cases of CSA. This findings are highly significant in the early identification and prevention of CSA, especially in a country where child grooming, non-contact and non-penetrating sexual abuse have not been criminalised and are not included in the constitution or child protection policy. This research indicates gaps on HCPs knowledge and the need to improve practice, training, and policy of HCPs who work with sexually abused children, including skills and competence assessment. For better preparation for front line work, these research

findings called for further training in critical aspects of tackling or managing CSA cases, including risk assessments, forensic examination, and psychosocial therapies. In this way, confidence can be built within the workforce and professional competence can be developed, thereby resulting in effective CSA services for sexually abused children. These findings deepen our understanding of how the HCP perceptions impact upon their portrayal of sexually abused children, their perceived roles and the quality of care made available for CSA victims and their families. Exploring and uncovering their understanding of the concept of CSA provides an insight into the scope and dimensions of CSA in Nigeria, practice related to CSA and the contexts in which HCPs practice. These findings showed how the individual factors and the socio-cultural context of the child, including their shared social norms, beliefs, culture and way of life, challenged HCPs' practice of identifying and responding to victims.

We gained a deeper understanding of how the social construction of childhood in Nigeria affects the quality of social support available to sexually abused children. In addition to serving as a wake-up call for HCPs, a strong message to policy makers, directors, government officials, and politicians, on the needs of children in Nigeria.

This study also broadened our understanding of the vulnerability factors of CSA in Nigeria, the spectrum of activities considered CSA, and those sexual activities justified by sociocultural practice and norms constructed around those activities. This research, therefore, enables a deeper understanding of HCPs' perceptions of their roles, their views on CSA victimology and criminology, and their attitude toward sexually abused children. In spite of the difficulty in eliciting the position of these participants on harmful cultural and religious practices, these discrepancies among HCPs enhanced the study's depth and richness and provided insight into the concept of CSA in Nigeria and the reality of the context in which HCPs practice. This knowledge is important as

it helps us develop an in-depth understanding of the challenges in supporting children who have experienced CSA and thereby acts as a force for driving changes, and to identify areas where more research is needed. Through this study, we have been able to understand the pathway of care available for sexually abused children in Nigeria and get a detailed description of how HCPs perceive and experience their practice. The findings thus demonstrated the process and nature of identifying and responding to sexually abused children in Nigeria and signalled attention to how HCPs can be best supported to become effective in their practice. More importantly, this study explored and theorised the issues and challenges faced by HCPs in their role related to CSA in the Nigerian context and their implications, which provided an opportunity for theory-based practice and policy development. Additionally, it provided evidence-based strategies to mitigate these challenges from the perspective of experts in this field.

10.4. The relevance of the 'Practice challenge theory'

The underpinning framework for practice challenges remains interactive and contextual in nature. Context plays an important role in both improvement science and implementation science; limited understanding of context therefore limits understanding of both the fundamental principles of improvement and the actions that put improvements into practice. Despite the importance of context, much of it remains obscure in relation to the field of CSA. This field lacks a specific mechanism by which local context affects victim identification, practice of HCPs, and implementation of improvement interventions and policies. Therefore, this context-based and all-encompassing practice challenges theory developed from this study fills an important gap in understanding of CSA and the constraints within which HCPs practise. It offers a highly relevant theoretical framework that explains the context in which healthcare

professionals operate in Nigeria, as well as the issues and challenges of identifying and responding to sexually abused children.

In addition, this theory has contributed to theoretical frameworks in the field of CSA. By conceptualising these problems, HCPs can gain a better understanding of the intrapersonal and interpersonal problems that interfere with their ability to provide services. This research therefore provides an opportunity to reflect on the practice of HCPs and explore the contexts and circumstances within which they are operating.

It explains how the micro- and wider system of the child influences all aspects of the child's life including experience of CSA and interaction with the professional agencies. This understanding prompts HCPs and institutions with child safeguarding roles to provide contextual-based and socio-culturally sensitive interventions to improve service for victims and prevent re-victimisation. Additionally, this theory conceptualises the issues and challenges from the sources, providing subject-specific challenges as discussed in chapter seven, which provide the basis for subject-specific implementations and approaches to mitigate the issues and challenges. This study has revealed CSA information that was previously unknown in the Nigerian context about the everyday challenges experienced by HCPs. This evidence is important in helping researchers and policy makers to understand the contexts of professionals working in similar contexts.

10.5. Research strengths

This study has generated important data in Nigeria in an area that has previously received little attention. This study explores CSA in a way that has not been done before and considers the challenges facing those most able to help and support young people in crisis. A particular strength of the research was being able to ensure that the

voices of HCPs who hold a mandatory obligation to identify and support sexually abused children in Nigeria were heard. Besides the theoretical contribution of this study, it has strengths that increase its significant contribution to practice.

This study collected data from five different healthcare professionals and included the perspectives of doctors, nurses, social workers, psychologists, and child advocates. The use of theoretical sampling ensured the inclusion of a diverse sample that varied in terms of cultural background, discipline, years of experience, practice setting, mandatory roles, and time of contact with the victim in the pathway of care. The study used a combination of highly relevant research settings specific to identifying and responding to sexually abused children in Nigeria, including hospitals and SARCs. These unique approaches resulted in the production of highly relevant diverse perspectives, providing data that is rich in depth and quality. Nigeria is a multi-ethnic community, with multiple legal systems across the country. This study collected data across the three main tribes: the southerners, westerners and northerners, and three main languages: Yoruba, Igbo and Hausa. Therefore, this study remains context-based and culturally sensitive. This means that the constructed theory provides the basis for developing systems to address mechanisms of change at every level of influence through comprehensive, sensitive, and contextual interventions.

By using a grounded theory methodology, involving theoretical sampling and constant comparison of data, similarities and differences between HCPs' perceptions and experiences of practice and associated challenges were identified, leading to the development of a theory based on data. To provide a substantial explanation of issues and challenges facing HCPs, numerous aspects and nature of practice and the interaction between the HCP and the child or victim as well as the victim microsystem and wider system were considered.

10.6. Research limitations

Despite its many positive contributions, the findings of this study should be interpreted cautiously. Charmaz (2006) proposes longitudinal interviews as a more effective method since they allow the researcher to examine phenomena over time and verify interpretations of data, however, this study used in-depth individual interviews for data collection. Although longitudinal interviews might have been beneficial, time constraints and resource limitations prevented them from being conducted. In this study, the findings are based on the Nigerian context, so applying them to other contexts requires caution and may pose challenges. Readers of this study should assess the applicability of the findings to different settings, cultures, and geographies based on this information.

A further limitation with regard to the method of data collection was that participants were recruited using purposeful and theoretical sampling. This means that subsequent participants were identified based on the researcher's interest and perception of a gap in ideas to explore, meaning there was likely to be some selection bias in recruitment that could lead to the under-or over-representation of particular groups within the sample. The study may also not be able to comprehensively capture the challenges faced by each discipline since professionals from five different professions participated. Since this research focuses on participants' experiences and perceptions of practice and associated challenges, and since the participants were aware of the researcher's professional background, this may have influenced their responses, in terms of what they decided to disclose.

The study presents only a substantive theory about the challenges faced by HCPs in their roles of supporting sexually abused children and the findings are based on

participants' perceptions, experience and views. While participants were not asked to disclose their personal experiences, a few revealed that they were themselves victims of CSA. While this may enhance the richness and reality of the findings, it may have affected their perceptions and narratives of their current roles. There is a possibility of participants discussing the professional support they wished they had access to during their own experience rather than providing their current perspective and experience of their practice. Whatever their stance, there is no doubt that their childhood experiences may have influenced their responses in this present research.

While the 'practice challenges' theory has offered a comprehensive approach to understanding the issue and challenges HCPs are facing in supporting sexually abused children, this theory is contextual in nature and caution should be taken in applying it to another research setting, especially when the framework for practice differs.

10.7. Implication and recommendations

A number of implications and recommendations were discussed earlier in chapter nine that facilitate the connection between findings, implications and recommendations. However, there are other specific areas that need addressing. The study focuses on four key areas: recommendations for HCPs and practice, policy, training and education, and research.

10.8. Recommendation for HCPs and practice

When working in the field of child protection, HCPs should identify their personal professional development needs and stay up to date with the latest research on CSA. Due to the difficulty in identifying CSA, HCPs should be familiar with the physical, behavioural, and emotional indicators of this type of abuse. This study clearly

demonstrates the need for a comprehensive and specialised national protocols, procedures, and guidelines to help healthcare providers identify CSA by providing information around indicators and vulnerabilities. A context-based guideline and protocol will help Nigerian HCPs successfully navigate both the micro and macro systems and respond to different aspects of the child's needs. Additionally, since findings from other countries show inadequate use of existing national documentation protocols by professionals, it will be beneficial to have plans in place to monitor the activities of HCPs regarding the use of this protocol. A significant number of HCPs are very passionate about supporting victims, but the findings from this study show there are financial constraints and lack of resources to execute their practice, which is believed to be caused by mismanagement by leaders, embezzlement and the small fraction of the national budget being allocated to this sector. As a result, this sector should be prioritised and strict budgeting and expenditure controls should be implemented. To enhance the multiagency nature of mandatory reporting and to overcome technical obstacles to sharing information, an integrated, computer-based information and assessment framework should be developed across all agencies. By using the 'practice challenge' theory, HCPs would be required to provide services to children who have been sexually abused by including and engaging with all actors from different sectors and all levels of support for children. It is important for HCPs to partner and network with other child protection systems and child safeguarding organisations which address CSA both nationally and internationally. They should collaborate with the core components of the children's wider support systems, which include key stakeholders and gatekeepers such as child protection networks, community committees, traditional rulers, and faith-based organisations. Collaborating with these powerful decision-makers and influencers who hold

important community influence will minimise the challenges and improve services to victims and family.

Since supporting victims and families with differing ideas can trigger conflict of values, HCPs must control those conflicts and control their mixed feelings. Victims should not be labelled, their experiences must be acknowledged and validated, and their reactions must be understood in relation to others. It is important for HCPs to consider that difficult victims or sexually active victims are still children, and to understand that affected children are victims of society and therefore perceived deviant behaviours, which may be coping mechanisms to deal with trauma, should trigger additional support and understanding (Hebb, 2013). HCPs must be held accountable by their organisations, interagency collaboration and, most importantly, by children. In other words, it is not a matter of defending professional culture, but a matter of cultural and ethical considerations. Lastly, to help professionals cope with the demands of working in stressful and traumatic environments, it is recommended that CSA centres and hospitals provide professional support services such as debriefing sessions and clinical supervision.

10.8.1. Recommendation for policy and law

These challenges led to the recommendation, among others, that the law be revised and published and implemented. The establishment of national CSA policies and the revision of child protection protocols and laws are crucial to identifying gaps, as well as ensuring that specialised services are implemented where necessary. Implementation of existing dormant laws and the making of new child- or victim-friendly mandatory policies and systems. All 36 states in Nigeria, including those governed by Sharia law, should be required to adopt the Child's Right Act 2003, which

would criminalise those who carry out child marriage and other practices abusive to children. To ensure the 'best interest of the child' and to prevent re-victimisation, specialised services should be offered in all state and local governments. Furthermore, it is recommended that the government participate actively in providing basic amenities and infrastructure, as well as sustainable security services to HCPs.

10.8.2. Recommendations for research

The findings from this study highlighted the important area for future research, which has been discussed earlier in this chapter. Further research is needed to test the relevance of this theory of issues and challenges facing HCPs in other similar or different research settings in Nigeria and other countries. A test of the theory's relevance and applicability should be conducted among professionals in the legal and social systems such as the police, who are at the forefront and received the highest report of cases of CSA in Nigeria, especially as the current findings reported inadequacy, negative attitudes and unprofessionalism among police officials. To understand the importance and contribution of this study to the field of CSA, the various themes identified in this study should be explored further in different settings in Nigeria, such as the nature of practical challenges, microsystem challenges, and wider system challenges. More importantly, future research should explore the barriers for disclosure and seeking professional support from the perspective of sexually abused children in Nigeria.

10.8.3. Recommendation for training and education

In Nigeria, HCPs' ability to identify and respond to sexually abused children needs to be improved. Despite the fact that the majority of participants understood their roles

and the consequences for sexually abused children, they reported that they lacked the competence, skill, and professional intuition to identify suspected cases and unreported incidents. This was attributed to the lack of specialised training, continuous development programmes, and organisational support. Therefore, training institutions should collaborate and emphasise aspects of CSA in their teaching. Specialised undergraduate training and postgraduate training and continuous professional development should be made more available and accessible for all professionals working with CSA victims. Diverse basic and advanced forms of training would be helpful for HCPs work, and should focus specifically: on screening, body and bruise mapping, case management, psychosocial and forensic counselling, child protection programmes, and forensic interviewing. Participants identified personnel that would benefit from such training, including HCPs, stakeholders, police, child handlers, and volunteers. By doing so, they will be equipped with the latest knowledge and expertise to provide appropriate services.

For each discipline, accreditation and licensing bodies should be established to regulate education and training, as well as to determine the competence of healthcare professionals who are mandated to support sexually abused children. It is also necessary to organise capacity-building for the judiciary system and strictly monitor police activities.

10.9. Conclusion

The purpose of the study was to generate theory on HCPs' perceptions and understandings of the issues and challenges they encountered as they identified and responded to sexually abused children in Nigeria. Using qualitative design and constructivist grounded theory methodology, data was collected from 26 HCPs who

work with sexually abused children. Using a comprehensive and exploratory qualitative approach, we can contextualise the unique experiences of the HCPs, their perception of their roles and responsibilities towards sexually abused children, as well as the issues and challenges they encountered with the implications. This approach was very useful for understanding the HCPs' social realities, meaning that HCPs attached to their experiences and uncovered the underlying reasons for their beliefs and perceptions about CSA. This study has made a unique contribution to academic knowledge by exploring HCPs' understanding of the social phenomenon of CSA, in terms of its personal meaning and definition and the activities they considered to be CSA. Previous studies in Nigeria have explored the prevalence, causes, and experiences of CSA victims using a quantitative approach, which decontextualised the subjectivity and complexity of that experience. As a result, this study is a first of its kind in Nigeria, and therefore is pioneering in its scope and findings.

The perceptions of HCPs, their roles and the nature and processes involved in supporting sexually abused children, were also examined in this study, which suggests that the available services for sexually abused children are indeed substandard compared to the comprehensive care required by victims. The findings from this study deepen our understanding of the social construction of childhood and sexuality, as well as the way CSA is conceptualised in Nigeria's health, legal, and socio-cultural domains, which is crucial to the significance attached and the quality of care the victims get. This study helps us develop an in-depth understanding of the research problems, acts as a force for making impacts and driving changes, and helps identify areas where more research and policy development are needed.

In addition, this research study demonstrates how individual factors and their socio-cultural contexts have a significant impact on HCPs' practice of identifying and

responding to victims. This provides opportunities to identify and acknowledge all-encompassing challenges and to implement effective approaches. To date, most research on HCPs' perceptions and experiences of identifying and responding to sexually abused children has been conducted in western countries, with only a few conducted in African countries and none in Nigeria. In this way, this thesis contributes to the literature in this area and adds significant Nigerian-specific evidence and makes space for the development of policy in this particular context.

Based on the study findings, a grounded theory of issues and challenges facing HCPs in their mandatory roles was developed. From the sources, issues and challenges were synthesised and analysed using the overarching theoretical statement, revealing issues and challenges related to the nature of practice, interactions between HCPs and children, and the broader health care system. Through this ‘practice challenge’ theory, we can understand how local context affects victim identification, portrayals of victims, the practice of HCPs, as well as the implementation of improvement interventions.

An important feature of this study is that it provides a comprehensive theoretical framework that explains both the context in which healthcare professionals work in Nigeria as well as the issues and challenges they face in identifying and responding to sexually abused children. This study has revealed CSA information that was previously unknown in the Nigerian context, an important but under-researched aspect of CSA, and the perspectives of unheard voices. By adding these voices to the discussion, we gain a deeper understanding of CSA in this particular context. This study provides a new understanding of the multi-level system affecting all domains associated with supporting victims of CSA. In conclusion, this study not only provides comprehensive frameworks for understanding the numerous interconnecting factors

causing the identified issues and challenges, but it also forms the basis for developing comprehensive interventions and approaches that systematically target mechanisms of change at each level of influence, resulting in comprehensive interventions and policies.

REFERENCES

Abdulkadir, I., Musa, H.H., Umar, L.W., Musa, S., Jimoh, W.A. and Aliyu-Na'uzo, M. (2011) Child sexual abuse in Minna, Niger State Nigeria. *Nigerian Medical Journal*, *52*(2), pp. 79-82.

Abdulkadir, I., Umar, L.W., Musa, H.H., Musa, S., Oyeniyi, O.A., Ayoola-Williams, O.M. and Okeniyi, L. (2011) Child sexual abuse: A review of cases seen at General Hospital Suleja, Niger State. *Annals of Nigerian Medicine*, *5*(1), pp. 15-19.

Aborisade, R.A., Adeleke, O.A. and Shontan, A.R. (2018) Accounts, excuses and apologies of juvenile sexual offenders in selected prisons in Lagos, Nigeria. *AFRREV IJAH: An International Journal of Arts and Humanities*, *7*(1), pp. 85-97.

Adeloye, D., David, R.A., Olaogun, A.A., Auta, A., Adesokan, A., Gadanya, M., Opele, J.K., Owagbemi, O. and Iseolorunkanmi, A. (2017) Health workforce and governance: The crisis in Nigeria. *Human Resources for Health*, *15*(1), pp. 1-8.

Aderinto, A.A. (2010) Sexual abuse of the girl-child in urban Nigeria and implications for the transmission of HIV/AIDS. *Gender and Behaviour*, *8*(1), pp. 2735-2761.

Adeyemi, A.B., Irinoye, O.O., Oladimeji, B.Y., Fatusi, A.O., Fatoye, F.O., Mosaku, S.K. and Ola, B.A. (2008) Preparedness for management and prevention of violence against women by Nigerian health professionals. *Journal of Family Violence*, *23*(8), pp. 719-725.

Agnew, R. and Brezina, T. (2019) General Strain Theory. In: Krohn, M., Hendrix, N., Penly Hall, G., Lizotte, A. (eds) Handbook on Crime and Deviance. Handbooks of Sociology and Social Research. Switzerland: Springer, Cham.

Ajema, C., Undie, C.C., Mbugua, C., Kyongo, J. and Digolo, L. (2018) Health sector inadequacies in attending to child survivors of sexual abuse in Kenya: An operations research. *Child Abuse Review, 27*(6), pp. 475-485.

Ajuwon, A., Olley, B.O., Akin-Jimoh, I. and Akintola, O. (2001) Experience of sexual coercion among adolescents in Ibadan, Nigeria. *African Journal of Reproductive Health,* pp. 120-131.

Akinlusi, F.M., Rabiu, K.A., Olawepo, T.A., Adewunmi, A.A., Ottun, T.A. and Akinola, O.I. (2014) Sexual assault in Lagos, Nigeria: A five year retrospective review. *BMC Women's Health, 14*(1), pp. 1-7.

Akin-Odanye, E.O. (2018) Prevalence and management of child sexual abuse cases presented at Nigerian hospitals: A systematic review. *Journal of Health and Social Sciences*, *3*(2), pp. 109-124.

Alaggia, R. and Kirshenbaum, S. (2005) Speaking the unspeakable: Exploring the impact of family dynamics on child sexual abuse disclosures. *Families in Society*, *86*(2), pp. 227-234.

Alaggia, R. (2005) Disclosing the trauma of child sexual abuse: A gender analysis. *Journal of Loss and Trauma, 10*(5), pp. 453-470.

Alaggia, R. (2010) An ecological analysis of child sexual abuse disclosure: Considerations for child and adolescent mental health. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 19*(1), pp. 32-39.

Alaggia, R., Collin-Vézina, D. and Lateef, R. (2019) Facilitators and barriers to child sexual abuse (CSA) disclosures: A research update (2000–2016). *Trauma, Violence, and Abuse*, *20*(2), pp. 260-283.

Alsaleem, S.A., Alsaleem, M.A., Asiri, A.M., Alkhidhran, S.S., Alqahtani, W.S., Alzahrani, M.S., Assiri, H.A., Alshahrany, K.M. and Alsamghan, A.S. (2019) Knowledge and attitude regarding child abuse among primary health care physician in Abha, Saudi Arabia. *Journal of Family Medicine and Primary Care*, *8*(2), pp. 706-710.

Amoran, O.E., Onadeko, M.O. and Adeniyi, J.D. (2003) Parental influence on adolescent sexual initiation practices in Ibadan, Nigeria. *International Quarterly of Community Health Education*, *23*(1), pp. 73-81.

Anderson, P. and Kitchin, R. (2000) Disability, space and sexuality: Access to family planning services. *Social Science & Medicine*, 51(8), pp.1163-1173.

Andrews, G., Corry, J., Slade, T., Issakidis, C. and Swanston, H. (2004) Child sexual abuse. Comparative quantification of health risks. Geneva: WHO.

Angelides, S. (2004) Feminism, child sexual abuse, and the erasure of child sexuality. GlQ: *A Journal of Lesbian and Gay Studies*, 10(2), pp. 141-177.

Aromäki, A.S., Lindman, R.E. and Eriksson, C.P. (2002) Testosterone, sexuality and antisocial personality in rapists and child molesters: A pilot study. *Psychiatry Research*, 110(3), pp.239-247.

Aromataris, E. and Pearson, A. (2014) The systematic review: An overview. *AJN The American Journal of Nursing*, *114*(3), pp. 53-58.

Ashimi, A.O., Amole, T.G. and Ugwa, E.A. (2015) Reported sexual violence among women and children seen at the gynaecological emergency unit of a rural

tertiary health facility, northwest Nigeria. *Annals of Medical and Health Sciences Research*, *5*(1), pp. 26-29.

Assalahi, H. (2015) The philosophical foundations of educational research: A beginner's guide. *American Journal of Educational Research*, *3*(3), pp. 312-317.

Audu, B., Geidam, A. and Jarma, H. (2009) Child labour and sexual assault among girls in Maiduguri, Nigeria. *International Journal of Gynaecology and Obstetrics*, *104*(1), pp. 64-67.

Ayeni, B. (2021) Language Choices and its Effect in a Culturally Diversified Nigeria Business Places: Adopting Giles' Communication Accommodation Theory. *International Journal of Applied Linguistics and English Literature*, *10*(1), pp. 80-87.

Azzopardi, C., Alaggia, R. and Fallon, B. (2018) From Freud to feminism: Gendered constructions of blame across theories of child sexual abuse. *Journal of Child Sexual Abuse*, 27(3), pp. 254-275.

Baguley, T. (2012) Calculating and graphing within-subject confidence intervals for ANOVA. *Behaviour Research Methods*, *44*(1), pp. 158-175.

Balogun, F.M. and Adenowuso, O.E. (2020) Prevalence and pattern of child sexual abuse: A cross-sectional study among male secondary school adolescents in Ibadan, Nigeria. *J Child Adolesc Health*, *4*, pp. 1-8.

Barber, J.P. and Solomonov, N. (2016) Psychodynamic theories. In J. C. Norcross, G. R. VandenBos, D. K. Freedheim, and B. O. Olatunji (Eds.), APA handbook of clinical psychology: Theory and research (pp. 53–77). Washington, DC: American Psychological Association.

Barnardo, I. (2011) Puppet on a string: The urgent need to cut children free from sexual exploitation. Ilford, Essex: Barnardo's.

Barron, I.G. and Topping, K.J. (2013) Exploratory evaluation of a school-based child sexual abuse prevention program. *Journal of Child Sexual Abuse*, *22*(8), pp. 931-948.

Barth, J., Bermetz, L., Heim, E., Trelle, S. and Tonia, T. (2013) The current prevalence of child sexual abuse worldwide: A systematic review and meta-analysis. *International Journal of Public Health*, 58(3), pp.469-483.

Bauman, A. (2015) Qualitative online interviews: Strategies, design, and skills. *Qualitative Research in Organizations and Management: An International Journal*, 10, pp. 201-202.

Baur, E., Forsman, M., Santtila, P., Johansson, A., Sandnabba, K. and Långström, N. (2016) Paraphilic sexual interests and sexually coercive behaviour: A population-based twin study. *Archives of Sexual Behaviour*, 45(5), pp. 1163-1172.

Bazeley, P. and Jackson, K. (2013) Qualitative data analysis with NVivo. London, UK: Thousand Oaks.

Beech, A. R. and Fisher, D. D. (2004) *Treatment of sex offenders in the UK in prison and probation services*. In H. Kemshall & G. McIvor (Eds.), *Managing sex offender risk* (pp. 137−163). London: Jessica Kingsley Publishers.

Bennett, N. and O'Donohue, W. (2014) The construct of grooming in child sexual abuse: Conceptual and measurement issues. *Journal of Child Sexual Abuse*, 23(8), pp. 957-976.

Bentovim, A., Cox, A., Bingley Miller, L. and Pizzey, S. (2009) *Safeguarding children living with trauma and family violence.* London: Jessica Kingsley Publishers

Berger, R. (2015) Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research, 15*(2), pp. 219-234.

Bernard, H.R. (2011) *Research methods in anthropology: Qualitative and quantitative approaches*. New York. A division of Rowman and Littlefield Publishers.

Bettany-Saltikov, J. (2016) *How to do a Systematic Literature Review in Nursing: A step-by-step guide.* Berkshire, UK: McGraw-Hill Education.

Birks, D.F., Fernandez, W., Levina, N. and Nasirin, S. (2013) Grounded theory method in information systems research: Its nature, diversity and opportunities. *European Journal of Information Systems*, *22*(1), pp. 1-8.

Birks, M. and Mills, J. (2015) *Grounded theory: A practical guide*. London, UK: Sage Publication.

Bisong, P.B. and Ekanem, S.A. (2014) The contemporary Nigerian summum bonum and its effect on the economy. *Sophia: An African Journal of Philosophy, 15*(1), pp.57-61.

Blaikie, N. (2007) *Approaches to social enquiry: Advancing knowledge*. UK: Polity Press.

Boillat, C., Deuring, G., Pflueger, M.O., Graf, M. and Rosburg, T. (2017) Neuroticism in child sex offenders and its association with sexual dysfunctions, cognitive distortions, and psychological complaints. *International Journal of Law and Psychiatry,* 54, pp. 83-89.

Bornstein, R.F. (2005) Interpersonal dependency in child abuse perpetrators and victims: A meta-analytic review. *Journal of Psychopathology and Behavioral Assessment*, 27(2), pp. 67-76.

Bornstein, R. F., Denckla, C. A., & Chung, W. J. (2012) *Psychodynamic models of personality.* In I. B. Weiner, H. A. Tennan, & J. M. Suls (Eds.), *Handbook of psychology, personality and social psychology* (2nd ed., Vol. 4, pp. 43–64). New York: John Wiley & Sons, Inc.

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), pp. 77-101.

Bronfenbrenner, U. (1979) *The ecology of human development: Experiments by nature and design.* Cambridge: Harvard university press.

Bryant, A. and Charmaz, K. (2012) *The SAGE Handbook of Grounded Theory.* London, UK: SAGE Publications Limited.

Bryant, J. and Milsom, A. (2005) Child abuse reporting by school counsellors. *Professional School Counselling*, 9(1), pp. 63-71.

Bryman, A., 2004. Qualitative research on leadership: A critical but appreciative review. *The Leadership Quarterly*, *15*(6), pp. 729-769.

Bugaje, M.A., Ogunrinde, G.O. and Faruk, J.A. (2012) Child sexual abuse in Zaria, Northwestern Nigeria. *Nigerian Journal of Paediatrics*, *39*(3), pp.110-114.

Burk, L.R. and Burkhart, B.R. (2003) Disorganized attachment as a diathesis for sexual deviance: Developmental experience and the motivation for sexual offending. *Aggression and Violent Behaviour*, 8(5), pp. 487-511.

Burn, M.F. and Brown, S. (2006) A review of the cognitive distortions in child sex offenders: An examination of the motivations and mechanisms that underlie the justification for abuse. *Aggression and Violent Behaviour*, 11(3), pp. 225-236.

Campbell, R., Dworkin, E. and Cabral, G. (2009) An ecological model of the impact of sexual assault on women's mental health. *Trauma, Violence, & Abuse*, 10(3), pp. 225-246.

Carmichael, T. and Cunningham, N. (2017) Theoretical data collection and data analysis with gerunds in a constructivist grounded theory study. *Electronic Journal of Business Research Methods*, *15*(2), pp. 59-73.

Carson, D.K., Foster, J.M. and Chowdhury, A. (2014) Sexual abuse of children and youth in India. *The Oriental Anthropologist*, *14*(2), pp. 343-364.

Chaffin, M., Hanson, R., Saunders, B.E., Nichols, T., Barnett, D., Zeanah, C., Berliner, L., Egeland, B., Newman, E., Lyon, T. and Letourneau, E. (2006) Report of the APSAC task force on attachment therapy, reactive attachment disorder, and attachment problems. *Child Maltreatment*, 11(1), pp. 76-89.

Chamberlain-Salaun, J., Mills, J. and Usher, K. (2013) Linking symbolic interactionism and grounded theory methods in a research design: From Corbin and Strauss' assumptions to action. *Sage Open*, *3*(3), pp. 1-10.

Charmaz, K. (2006) *Constructing grounded theory: A practical guide through qualitative analysis*. London, UK: SAGE Publications Limited.

Charmaz, K. (2014) *Constructing grounded theory*. London, UK: SAGE Publications Limited.

Chen, Y.C., Fortson, B.L. and Tseng, K.W. (2012) Pilot evaluation of a sexual abuse prevention program for Taiwanese children. *Journal of Child Sexual Abuse*, 21(6), pp. 621-645.

Chilisa, B. (2012) *Indigenous Research Methodologies*. London, UK: SAGE Publications Inc.

Chilisa, B. and Kawulich, B. B. (2012) *Selecting a research approach: Paradigm, methodology and methods.* In Wagner, C. Kawulich, B. and Garner, M. (eds.) Doing Social Research: A global context. London, UK. McGraw-Hill Education.

Chinawa, J.M., Aronu, A.E., Chukwu, B.F. and Obu, H.A. (2014) Prevalence and pattern of child abuse and associated factors in four secondary institutions in Enugu, Southeast Nigeria. *European Journal of Pediatrics, 173*(4), pp. 451-456.

Chrestman, K. R. (1999) *Secondary exposure to trauma and self-reported distress among therapists*. In B. H. Stamm (Ed.), Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators (2nd ed., pp. 2936). Baltimore, MD: Sidran Press

Chun Tie, Y., Birks, M. and Francis, K. (2019) Grounded theory research: A design framework for novice researchers. *SAGE Open Medicine, 7*, pp1-8

Collin-Vézina, D., Daigneault, I. and Hébert, M. (2013) Lessons learned from child sexual abuse research: Prevalence, outcomes, and preventive strategies. *Child and Adolescent Psychiatry and Mental Health, 7*(1), pp. 1-9.

Collin-Vézina, D., De La Sablonnière-Griffin, M., Palmer, A.M. and Milne, L. (2015) A preliminary mapping of individual, relational, and social factors that impede disclosure of childhood sexual abuse. *Child Abuse & Neglect*, *43*, pp. 123-134.

Cooney, L. and Rogowski, S. (2017) Towards a critical feminist practice with children and families: Child sexual exploitation as an exemplar. *Practice*, 29(2), pp. 137-149.

Cossins, A. (2000) Masculinities, sexualities, and child sexual abuse. The Hague, the Netherlands: Kluwer Law International.

Craven, S., Brown, S. and Gilchrist, E. (2006) Sexual grooming of children: Review of literature and theoretical considerations. *Journal of Sexual Aggression*, *12*(3), pp. 287-299.

Creswell J. (2013) Research Design: Qualitative, Quantitative, and Mixed Methods Approaches. London, UK: SAGE Publications Ltd.

Crisma, M., Bascelli, E., Paci, D. and Romito, P. (2004) Adolescents who experienced sexual abuse: Fears, needs and impediments to disclosure. *Child Abuse and Neglect*, *28*(10), pp.1035-1048.

David, N., Ezechi, O., Wapmuk, A., Gbajabiamila, T., Ohihoin, A., Herbertson, E. and Odeyemi, K. (2018) Child sexual abuse and disclosure in South Western Nigeria: A community based study. *African Health Sciences*, *18*(2), pp. 199-208.

De Bellis, M.D., Spratt, E.G. and Hooper, S.R. (2011) Neurodevelopmental biology associated with childhood sexual abuse. *Journal of Child Sexual Abuse*, 20(5), pp. 548-587.

De Marrais K, and Lapan S.D. (Eds.) (2004) *Foundations for* Research: *Methods of Inquiry in Education and the Social Sciences.* New Jersey: Lawrence Erlbaum

Denzin, N.K. and Lincoln, Y.S. (eds.) (2011) *The Sage handbook of qualitative research*. Thousand Oaks, CA: Sage Publication Ltd.

Diamond, M., Jozifkova, E. and Weiss, P. (2011) Pornography and sex crimes in the Czech Republic. *Archives of Sexual Behaviour*, *40*(5), pp. 1037-1043.

Dietrich, J., Sikkema, K., Otwombe, K.N., Sanchez, A., Nkala, B., De Bruyn, G., Van Der Watt, M. and Gray, G.E. (2013) Multiple levels of influence in predicting sexual activity and condom use among adolescents in Soweto, Johannesburg, South Africa. *Journal of HIV/AIDS & Social Services*, 12(3-4), pp. 404-423.

Dinwiddie, S., Heath, A.C., Dunne, M.P., Bucholz, K.K., Madden, P.A., Slutske, W.S., Bierut, L.J., Statham, D.B. and Martin, N.G. (2000) Early sexual abuse and lifetime psychopathology: A co-twin–control study. *Psychological Medicine*, *30*(1), pp. 41-52.

Duane, Y. and Carr, A. (2006) *Prevention of child sexual abuse*. In A. E. Carr (Eds.), Prevention: What works with children and adolescents (pp. 181–204). New York, NY: Brunner-Routledge.

Duru, C.O., Ederiane, O.E. and Akinbami, F.O. (2014) Child sexual abuse: a review of cases presenting at the outpatient clinic of a tertiary health centre in Bayelsa state, Nigeria. *Global Adv Res J Med Med Sci*, *3*(11), pp. 345-361.

Early, B.P. and Grady, M.D. (2017) Embracing the contribution of both behavioral and cognitive theories to cognitive behavioral therapy: Maximizing the richness. *Clinical Social Work Journal*, *45*(1), pp. 39-48.

Ebuenyi, I.D., Chikezie, U.E. and Dariah, G.O. (2018) Implications of silence in the face of child sexual abuse: Observations from Yenagoa, Nigeria. *African Journal of Reproductive Health, 22*(2), pp. 83-87.

Edinburgh, L., Saewyc, E. and Levitt, C. (2008) Caring for young adolescent sexual abuse victims in a hospital-based children's advocacy center. *Child Abuse and Neglect, 32*(12), pp. 1119-1126.

Ekhator, E.O. (2015) Women and the law in Nigeria: A reappraisal. *Journal of International Women's Studies*, *16*(2), pp. 285-296.

Ellis, K. (2019) Blame and culpability in children's narratives of child sexual abuse. *Child Abuse Review*, *28*(6), pp. 405-417.

Ensink, K., Borelli, J.L., Normandin, L., Target, M. and Fonagy, P. (2020) Childhood sexual abuse and attachment insecurity: Associations with child psychological difficulties. *American Journal of Orthopsychiatry*, *90*(1), pp. 115-124.

Etikan, I., Musa, S.A. and Alkassim, R.S. (2016) Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics*, *5*(1), pp. 1-4.

Evans, R. (2010) Children’s caring roles and responsibilities within the family in Africa. *Geography Compass*, *4*(10), pp. 1477-1496.

Ezechi, O.C., AdesolaMusa, Z., David, A.N., Wapmuk, A.E., Gbajabiamila, T.A., EugeniaIdigbe, I., Ezeobi, P.M., Ohihoin, A.G. and Ujah, I.A.O. (2016) Trends and patterns of sexual assaults in Lagos south-western Nigeria. *The Pan African Medical Journal*, *24*.

Ezema, P.A. (2009) The English language, politics and the issue of multiethnicity in Nigeria. *Bassey Andah Journal*, *2*, pp. 115-123.

Fanslow, J.L., Robinson, E.M., Crengle, S. and Perese, L. (2007) Prevalence of child sexual abuse reported by a cross-sectional sample of New Zealand women. *Child Abuse & Neglect, 31*(9), pp. 935-945.

Farrow, V.A., Bosch, J., Crawford, J.N., Snead, C. and Schulkin, J. (2018) Screening for history of childhood abuse: Beliefs, practice patterns, and barriers among obstetrician-gynecologists. *Women's Health Issues, 28*(6), pp. 559-568.

Faupel, S. (2015) *Etiology of adult sexual offending.* Sex Offender Management Assessment and Planning Initiative Research Brief, July 2015. Available at: https://smart.gov/pdfs/ EtiologyofAdultSexualOffending.pdf (accessed 28 March 2022)

Federal republic of Nigeria (1999) Federal Republic of Nigeria. Constitution of the Federal Republic of Nigeria 1999. Lagos: Federal Government Printer.

Finkelhor, D., Shattuck, A., Turner, H.A. and Hamby, S.L. (2014) The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence. *Journal of Adolescent Health, 55*(3), pp. 329-333.

Flick, I., (2015) *Introducing research methodology: A beginner's guide to doing a research project.* London, UK: Sage Publication Limited.

FMOH (2004) Federal Republic of Nigeria: Revised National Health Policy, Nigeria: Federal Ministry of Health Abuja.

Foley, G. and Timonen, V. (2015) Using grounded theory method to capture and analyse health care experiences. *Health Services Research, 50*(4), pp. 1195-1210.

Fontes, L.A. and Plummer, C. (2010) Cultural issues in disclosures of child sexual abuse. *Journal of Child Sexual Abuse, 19*(5), pp. 491-518.

Franklin, A. and Smeaton, E. (2017) Recognising and responding to young people with learning disabilities who experience, or are at risk of, child sexual exploitation in the UK. *Children and Youth Services Review*, *73*, pp. 474-481.

Friedman, M.S., Marshal, M.P., Guadamuz, T.E., Wei, C., Wong, C.F., Saewyc, E.M. and Stall, R. (2011) A meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals. *American Journal of Public Health*, *101*(8), pp. 1481-1494.

Gadda, A. and Taylor, J. (2016) Child sexual exploitation: where are the nurses?. *Journal of Advanced Nursing*, *72*(4), pp.721-722.

Gannon, T.A., Collie, R.M., Ward, T. and Thakker, J. (2008) Rape: Psychopathology, theory and treatment. *Clinical Psychology Review*, *28*(6), pp. 982-1008.

Gavril, A.R., Kellogg, N.D. and Nair, P. (2012) Value of follow-up examinations of children and adolescents evaluated for sexual abuse and assault. *Paediatrics*, *129*(2), pp. 282-289.

Ghahramanlou, M. and Brodbeck, C. (2000) Predictors of secondary trauma in sexual assault trauma counsellors. *International Journal of Emergency Mental Health*.

Gill, P., Stewart, K., Treasure, E. and Chadwick, B. (2008) Methods of data collection in qualitative research: interviews and focus groups. *British Dental Journal*, *204*(6), pp. 291-295.

Giotakos, O., Markianos, M., Vaidakis, N. and Christodoulou, G.N. (2004) Sex hormones and biogenic amine turnover of sex offenders in relation to their

temperament and character dimensions. *Psychiatry Research, 127*(3), pp. 185-193.

Giotakos, O., Markianos, M., Vaidakis, N. and Christodoulou, G.N. (2003) Aggression, impulsivity, plasma sex hormones, and biogenic amine turnover in a forensic population of rapists. *Journal of Sex & Marital Therapy, 29*(3), pp. 215-225.

Glaser, B.G. and Strauss, A.L., 1967. *The discovery of grounded theory: Strategies for qualitative research.* New York. Aldine Publishing Company.

Glaser, B.G. (2001) *The grounded theory perspective: Conceptualization contrasted with description*. Mill Valley, California: Sociology Press.

Goodman-Brown, T. B., Edelstein, R. S., Goodman, G. S., Jones, D. P. H., and Gordon, D. S. (2003) Why children tell: A model of children's disclosure of sexual abuse. *Child Abuse and Neglect, 27*, pp. 525–540

Grant, M.J. and Booth, A. (2009) A typology of reviews: An analysis of 14 review types and associated methodologies. *Health Information & Libraries Journal, 26*(2), pp. 91-108.

Gruenfeld, E., Willis, D.G. and Easton, S.D. (2017) "A very steep climb": Therapists' perspectives on barriers to disclosure of child sexual abuse experiences for men. *Journal of Child Sexual Abuse, 26*(6), pp. 731-751.

Guba, E. G., and Lincoln, Y. S. (1994) *Competing paradigms in qualitative research.* In K. Denzin and Y. S. Lincoln (Eds.), Handbook of qualitative research (pp. 105-117). Thousand Oaks, CA: Sage

Harnois, C.E. (2012) Feminist measures in survey research. London: Sage Publications.

Harper, G.W., Riplinger, A.J., Neubauer, L.C., Murphy, A.G., Velcoff, J. and Bangi, A.K. (2014) Ecological factors influencing HIV sexual risk and resilience among young people in rural Kenya: Implications for prevention. *Health Education Research*, *29*(1), pp. 131-146.

Hassan, M., Awosan, K.J., Panti, A.A., Nasir, S., Tunau, K., Umar, A.G., Shehu, C.E., Ukwu, A.E. and Sulaiman, B. (2016) Prevalence and pattern of sexual assault in Usmanu Danfodiyo University Teaching hospital, Sokoto, Nigeria. *The Pan African Medical Journal*, *24*, pp. 332.

Hatcher, R. and Noakes, S. (2010) Working with sex offenders: The impact on Australian treatment providers. *Psychology, Crime & Law*, *16*(1-2), pp. 145-167.

Haugaard, J.J. (2000) The challenge of defining child sexual abuse. *American Psychologist, 55*(9), pp. 1036-1039.

Hebb, J. (2013) 'Social work values are essential in my work with high risk offenders'. Community Care. [online] Available at www.communitycare.co.uk [Accessed 15 July 2022]

Hillberg, T., Hamilton-Giachritsis, C. and Dixon, L. (2011) Review of meta-analyses on the association between child sexual abuse and adult mental health difficulties: A systematic approach. *Trauma, Violence, & Abuse*, *12*(1), pp. 38-49.

HM Government (2017) Tackling Child Sexual Exploitation Progress Report. Available:https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/592588/Tackling_Child_Sexual_Exploitation_Progress_Report__web_.pdf [Accessed 3rd June 2021].

Holloway, I. and Galvin, K. (2016) *Qualitative research in nursing and healthcare*. West Sussex: John Wiley and Sons.

Hornor, G. (2010) Child sexual abuse: Consequences and implications. *Journal of Paediatric Health Care*, 24(6), pp. 358-364.

Hunter, S.V. (2011) Disclosure of child sexual abuse as a life-long process: Implications for health professionals. *Australian and New Zealand Journal of Family Therapy*, *32*(2), pp.159-172.

Ichoku H. (2005) Income Redistributive Effects of the Health Care Financing System in Nigeria. University of Nigeria and African Institute for Applied Economics.

Ifechelobi, J. (2014) Feminism: Silence and voicelessness as tools of patriarchy in Chimamanda Adichie's purple hibiscus. *African Research Review, 8*(4), pp. 17-27.

Ige, O. and Fawole, O. I. (2011) Preventing child sexual abuse: parents' perceptions and practices in urban Nigeria. *Journal of Child Sexual Abuse*, *20*(6), pp. 695-707.

Ige, O.K. and Fawole, O.I. (2012) Evaluating the medical care of child sexual abuse victims in a general hospital in Ibadan, Nigeria. *Ghana Medical Journal*, *46*(1).

Ikechebelu, J.I., Udigwe, G.O., Ezechukwu, C.C., Ndinechi, A.G. and Joe–Ikechebelu, N.N. (2008) Sexual abuse among juvenile female street hawkers in Anambra State, Nigeria. *African Journal of Reproductive Health, 12*(2), pp. 111-119.

Ilesanmi, O.S., Adebiyi, A.O. and Fatiregun, A.A. (2014) National health insurance scheme: How protected are households in Oyo State, Nigeria from catastrophic health expenditure?. *International Journal of Health Policy and Management*, *2*(4), pp. 175-180.

Innocent, E.O., Uche, O.A. and Uche, I.B. (2014) Building a solid health care system in Nigeria: Challenges and prospects. *Academic Journal of Interdisciplinary Studies*, *3*(6), pp. 501-501.

Izdebska, A. (2021) Personality disorders in adult female child sexual abuse survivors: Dimensions of personality pathology and characteristics of abuse. *Journal of Interpersonal Violence, 36*(23-24), pp.NP13487-NP13516.

James, A. and Prout, A. (2018) *Constructing and reconstructing childhood: Contemporary issues in the sociological study of childhood.* London, UK: Falmer Press.

James, A. and James, A. (2017) *Constructing childhood: Theory, policy and social practice*. London, UK: Bloomsbury Publishing.

Jensen, T.K., Gulbrandsen, W., Mossige, S., Reichelt, S. and Tjersland, O.A. (2005) Reporting possible sexual abuse: A qualitative study on children's perspectives and the context for disclosure. *Child Abuse & Neglect*, *29*(12), pp.1395-1413.

Jewkes, R., Martin, L. and Penn-Kekana, L. (2002) The virgin cleansing myth: Cases of child rape are not exotic. *The Lancet*, *359*(9307), p. 711.

Jewkes, R., Penn-Kekana, L. and Rose-Junius, H. (2005) ‘‘If they rape me, I can’t blame them”: Reflections on gender in the social context of child rape in South Africa and Namibia. *Social Science and Medicine, 61*(8), pp. 1809-1820.

Jordan, K., Fromberger, P., Stolpmann, G. and Müller, J.L. (2011) The role of testosterone in sexuality and paraphilia—A neurobiological approach. Part II: Testosterone and paraphilia. *The Journal of Sexual Medicine, 8*(11), pp. 3008-3029.

Keenan, T. and Ward, T. (2000) A theory of mind perspective on cognitive, affective, and intimacy deficits in child sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, *12*(1), pp. 49-60.

Kennedy, C., Morrissey, J. and Donohue, G. (2021) Mental health nurses' perceived preparedness to work with adults who have child sexual abuse histories. *Journal of Psychiatric and Mental Health Nursing*, *28*(3), pp.384-393.

Kenny, M.C., Capri, V., Ryan, E.E. and Runyon, M.K. (2008) Child sexual abuse: From prevention to self-protection. *Child Abuse Review: Journal of the British Association for the Study and Prevention of Child Abuse and Neglect*, *17*(1), pp. 36-54.

Killam, L. (2013) *Research terminology simplified: Paradigms, axiology, ontology, epistemology and methodology*. Sudbury, ON: Laura Killam.

King, N., Horrocks, C. and Brooks, J. (2018) *Interviews in qualitative research*. sage. 2nd ed. London, UK: SAGE Publications Limited.

Klakegg, O.J. (2016) *Ontology and epistemology. In Designs, Methods and Practices for Research of Project Management*. London, UK: Routledge

Ko, S.F. and Cosden, M.A. (2001) Do elementary school-based child abuse prevention programs work? A high school follow-up. *Psychology in the Schools*, *38*(1), pp. 57-66.

Koss, L.G. and Melamed, M.R. (eds.) (2006) *Koss' diagnostic cytology and its histopathologic bases* (Vol. 1). Philadelphia: Lippincott Williams and Wilkins.

Kraft, L., Rahm, G. and Eriksson, U.B. (2017) School nurses avoid addressing child sexual abuse. *The Journal of School Nursing*, *33*(2), pp. 133-142.

Krauss, S.E. (2005) Research paradigms and meaning making: A primer. *The Qualitative Report, 10*(4), pp. 758-770.

Kunnuji, M.O. and Esiet, A. (2015) Prevalence and correlates of sexual abuse among female out-of-school adolescents in Iwaya community, Lagos state, Nigeria. *African Journal of Reproductive Health*, *19*(1), pp. 82-90.

Kwhali, J., Martin, L., Brady, G. and Brown, S.J. (2016) Child Sexual Abuse and Exploitation: Knowledge, confidence and training within a contemporary UK social work practice and policy context. *The British Journal of Social Work, 46*(8), pp. 2208-2226.

Lai, Y.C. (2006) A preliminary study of teachers' perceptions of sex education in Hong Kong preschools. *Australasian Journal of Early Childhood, 31*(3), pp. 1-5.

Långström, N., Babchishin, K.M., Fazel, S., Lichtenstein, P. and Frisell, T. (2015) Sexual offending runs in families: A 37-year nationwide study. *International Journal of Epidemiology*, *44*(2), pp. 713-720.

Laverty, S.M. (2003) Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, *2*(3), pp. 21-35.

Lay, K. and Daley, J.G. (2007) A critique of feminist theory. *Advances in Social Work, 8*(1), pp. 49-61.

Leclerc, B., Wortley, R. and Smallbone, S. (2011) Victim resistance in child sexual abuse: A look into the efficacy of self-protection strategies based on the offender's experience. *Journal of Interpersonal Violence, 26*(9), pp. 1868-1883.

Leguizamo, A. (2011) *The object relations and victimization histories of juvenile sex offenders.* In Schwartz, B. The sex offender: Current treatment modalities and systems issues (Vol. 4, pp. 4-1-4-39). Kingston, New Jersey: Civic Research Institute

Levers, M.J.D. (2013) Philosophical paradigms, grounded theory, and perspectives on emergence. *Sage Open, 3*(4), pp. 1-6.

Lim, M.L., Tran, M., van Schooten, K.S., Radford, K.A., O'Dea, B., Baldwin, P. and Delbaere, K. (2022) A Self-Guided Online Cognitive Behavioural Therapy to Reduce Fear of Falling in Older People: A Randomised Controlled Trial. *International Journal of Behavioral Medicine*, pp.1-8.

Linares-Espinós, E., Hernández, V., Domínguez-Escrig, J.L., Fernández-Pello, S., Hevia, V., Mayor, J., Padilla-Fernández, B. and Ribal, M.J. (2018) Methodology of a systematic review. *Actas Urológicas Españolas (English Edition)*, 42(8), pp.499-506.

Macdonald, G., Livingstone, N., Hanratty, J., McCartan, C., Cotmore, R., Cary, M., Glaser, D., Byford, S., Welton, N.J., Bosqui, T. and Bowes, L. (2016) The effectiveness, acceptability and cost-effectiveness of psychosocial interventions for maltreated children and adolescents: An evidence synthesis. *Health Technology Assessment*, *20*(69), pp. 1–508.

Manly, J.T. (2005) Advances in research definitions of child maltreatment. *Child Abuse and Neglect, 29*, 425–439.

Manyike, P.C., Chinawa, J.M., Aniwada, E., Udechukwu, N.P., Eke, C.B. and Chinawa, T.A. (2015) Impact of parental sex education on child sexual abuse among adolescents. *Nigerian Journal of Paediatrics*, *42*(4), pp. 325-328.

Manyike, P., Chinawa, J., Aniwada, E., Odetunde, O. and Chinawa, A. (2015) Child sexual abuse among adolescents in southeast Nigeria: A concealed public health behavioral issue. Pakistan Journal of Medical Sciences, 31(4), pp. 827-832

Martin, E.K. and Silverstone, P.H. (2013) How much child sexual abuse is "below the surface," and can we help adults identify it early?. *Frontiers in Psychiatry, 4*, pp. 58.

Martin, G., Bergen, H.A., Richardson, A.S., Roeger, L. and Allison, S. (2004) Sexual abuse and suicidality: Gender differences in a large community sample of adolescents. *Child Abuse and Neglect*, *28*(5), pp. 491-503.

Martin, J. (2014) "It's just an image, right?": Practitioners' understanding of child sexual abuse images online and effects on victims. *Child and Youth Services*, *35*(2), pp. 96-115.

Martin, J. (2016) Child sexual abuse images online: Implications for social work training and practice. *The British Journal of Social Work, 46*(2), pp. 372-388.

Martinello, E. (2020) Applying the ecological systems theory to better understand and prevent child sexual abuse. *Sexuality and Culture, 24*(1), pp. 326-344.

Mathews, B. and Collin-Vézina, D. (2019) Child sexual abuse: Toward a conceptual model and definition. *Trauma, Violence, and Abuse, 20*(2), pp. 131-148.

Maykut, P. and Morehouse, R. (2002) *Beginning qualitative research: A philosophical and practical guide*. London, UK: Routledge.

Maykut, P. and Morehouse, R. (2005) *Beginning qualitative research a philosophic and practical guide.* 2nd ed. London: The Falmer Press.

McGee, H., Garavan, R., de Barra, M., Byrne, J. and Conroy, R. (2002) *The SAVI Report: Sexual abuse and violence in Ireland.* Executive Summary. Dublin: Dublin Rape Crisis Centre.

McLaren, H.J. (2013) (Un)-blaming mothers whose partners sexually abuse children: in view of heteronormative myths, pressures and authorities. *Child and Family Social Work, 18*(4), pp. 439-448.

McNeish, D. and Scott, S. (2018) Key messages from research on intra-familial child sexual abuse. Ilford: Centre of expertise on child sexual abuse.

Melrose, M. and Pearce, J. (Eds.) (2013) *Critical perspectives on child sexual exploitation and related trafficking*. Hampshire: Palgrave Macmillan..

Merdian, H.L., Curtis, C., Thakker, J., Wilson, N. and Boer, D.P. (2014) The endorsement of cognitive distortions: Comparing child pornography offenders and contact sex offenders. *Psychology, Crime and Law, 20(*10), pp. 971-993.

Mills, J., Bonner, A. and Francis, K. (2006) The development of constructivist grounded theory. *International Journal of Qualitative Methods, 5*(1), pp. 25-35.

Mkonyi, E., Mwakawanga, D.L., Rosser, B.S., Bonilla, Z.E., Lukumay, G.G., Mohammed, I., Mushy, S.E., Mgopa, L.R., Ross, M.W., Massae, A.F. and Trent, M. (2021) The management of childhood sexual abuse by midwifery, nursing and medical providers in Tanzania. *Child Abuse and Neglect, 121*, p.105268.

Mohamed, E.R. (2013) It takes a whole village to raise a child. In *Mentors and Mentoring* (pp. 57-63). New York: Routledge.

Mullers, E. S. and Dowling, M., 2008. Mental health consequences of child sexual abuse. British journal of nursing 17(22), pp. 25-35.

Munn, Z., Peters, M.D., Stern, C., Tufanaru, C., McArthur, A. and Aromataris, E. (2018) Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC Medical Research Methodology, 18*(1), pp. 1-7.

Münzer, A. and Fegert, J. M. (2015) Please tell ! barriers to disclosing sexual victimization and subsequent social support perceived by children and adolescents. *Journal of Interpersonal Violence, 31*(2), pp. 355-377.

Muridzo, N., Chikadzi, V. and Kaseke, E. (2018) Challenges faced by professionals working in child sexual abuse multi-sectorial forums: A case of the victim-friendly system in Zimbabwe. *Social Work, 54*(4), pp. 452-468.

Murray, L.K., Nguyen, A. and Cohen, J.A. (2014) Child sexual abuse. *Child and Adolescent Psychiatric Clinics, 23*(2), pp. 321-337.

Neal, J.W. and Neal, Z.P. (2013) Nested or networked? Future directions for ecological systems theory. *Social Development, 22*(4), pp. 722-737.

Nisha, K.P. (2014) Understanding psychological theories and aetiology of child sexual abuse. *Psychology,* 3(8).

Nlewem, C. and Amodu, O.K. (2017) Family characteristics and structure as determinants of sexual abuse among female secondary school students in Nigeria: A brief report. *Journal of child sexual abuse, 26*(4), pp. 453-464.

Nwanna, C.R. and Ogunniran, I. (2019) Challenges of Lagos State Child's Rights Law: Social Welfare Officers' Perspective. *African Journal of Criminology and Justice Studies*, *12*(1).

Obisesan, AA Adeyemo, RA Onifade, K. (1999) Childhood sexuality and child sexual abuse in southwest Nigeria. *Journal of Obstetrics and Gynaecology*, *19*(6), pp. 624-626.

Ogunyemi, B. (2000) Knowledge and perception of child sexual abuse in urban Nigeria: Some evidence from a community-based project. *African Journal of Reproductive Health*, *4*(2), pp. 44-52.

Okeafor, C.U., Okeafor, I.N. and Tobin-West, C.I. (2018) Relationship between sexual abuse in childhood and the occurrence of mental illness in adulthood: a matched case–control study in nigeria. *Sexual Abuse*, *30*(4), pp. 438-453.

Okeke, T.C., Anyaehie, U.S. and Ezenyeaku, C.C.K. (2012) An overview of female genital mutilation in Nigeria. *Annals of Medical and Health Sciences Research*, *2*(1), pp.70-73.

Olafson, E. (2002) Attachment theory and child abuse: Some cautions. *Journal of Child Sexual Abuse*, *11*(1), pp. 125-129.

Olatunya, O.S., Akintayo, A.A., Olofinbiyi, B., Isinkaye, A.O., Ogundare, E.O. and Akinboboye, O. (2013) Pattern and medical care of child victims of sexual abuse in Ekiti, south-western Nigeria. *Paediatrics and International Child Health*, *33*(4), pp.247-252.

Omoruan, A.I., Bamidele, A.P. and Phillips, O.F. (2009) Social health insurance and sustainable healthcare reform in Nigeria. *Studies on Ethno-Medicine*, *3*(2), pp.105-110.

O'Neill T. (2001) Children in secure accommodation. London. Jessica Kingsley: Publishers Ltd.

O'Neill, T., 2013) Girls in trouble in the child welfare and criminal justice system. In *'Problem'girls* (pp. 111-125). London, UK: Routledge.

Opekitan, A.T., Bolanle, F., Olawale, O. and Olufunke, A. (2019.)Awareness of social infrastructures for victims of child abuse among primary health Workers in Ogun State, Nigeria. *International Quarterly of Community Health Education*, *40*(1), pp.23-28.

Oteh, C.O., Ogbuke, M.U. and Iheriohanma, E.B.J. (2009) Child abuse as a setback on nation building: A study of Ezza community in Ebonyi state, Nigeria. *International Journal of Development and Management Review*, *4*(1), pp.86-95.

Oyekola, I.A. and Agunbiade, O.M. (2018) Teacher-parents' involvement in the prevention and management of child sexual abuse amongst in-school adolescents in Osun State, Nigeria. *IFE PsychologIA: An International Journal*, *26*(2), pp. 129-139.

Pack, M. (2013) Vicarious traumatisation and resilience: An ecological systems approach to sexual abuse counsellors' trauma and stress. *Sexual Abuse in Australia and New Zealand, 5*(2), pp. 69-76.

Padgett, D.K. (2016) *Qualitative methods in social work research* (Vol. 36). California:Sage publications Inc.

Panayiotopoulos, C. (2011) Mandatory reporting of domestic violence cases in Cyprus; barriers to the effectiveness of mandatory reporting and issues for future practice. *European Journal of Social Work, 14*(3), pp. 379-402.

Paranal, R., Washington Thomas, K. and Derrick, C. (2012) Utilizing online training for child sexual abuse prevention: Benefits and limitations. *Journal of Child Sexual Abuse, 21*(5), pp. 507-520.

Pereda, N., Guilera, G., Forns, M. and Gómez-Benito, J. (2009)The international epidemiology of child sexual abuse: A continuation of Finkelhor (1994). *Child Abuse and Neglect, 33*(6), pp. 331-342.

Perring, C.D. (2014) A relationship problems disorders? In Perring C., Wells L., (2014): (Eds) Diagnostic dilemmas in child and adolescent psychiatry, Oxford: Oxford University Press.

Petersen, I., Bhana, A. and McKay, M. (2005) Sexual violence and youth in South Africa: The need for community-based prevention interventions. *Child Abuse and Neglect, 29*(11), pp. 1233-1248.

Pistorius, K.D., Feinauer, L.L., Harper, J.M., Stahmann, R.F. and Miller, R.B. (2008) Working with sexually abused children. *The American Journal of Family Therapy, 36*(3), pp. 181-195.

Pollock, S. and Brunet, M.H. (2018) " When it became equal": How historical consciousness and theories of agency can explain female students' conceptions of feminism. *Canadian Social Studies, 50*(1), pp. 11-24.

Pratt, J., Roland, M., Gordon, P. and Plamping, D. (2018) *Practitioners and practices: a conflict of values?* Oxford: Radcliffe Medical Press

Price, J.L., Hilsenroth, M.J., Callahan, K.L., Petretic-Jackson, P.A. and Bonge, D. (2004) A pilot study of psychodynamic psychotherapy for adult survivors of childhood sexual abuse. *Clinical Psychology and Psychotherapy: An International Journal of Theory and Practice, 11*(6), pp. 378-391.

Purvis, M. and Ward, T. (2006) The role of culture in understanding child sexual offending: Examining feminist perspectives. *Aggression and Violent Behaviour, 11*(3), pp. 298-312.

Radford L, Corral S, Bradley C, Fisher H, Bassett C, Howat N, Collishaw S. (2011) Child abuse and neglect in the UK today. London: NSPCC.

Raine, A. and Scerbo, A. (1991) *Biological theories of violence. In Neuropsychology of aggression (pp. 1-25).* Boston: Kluwer Academic Publishers.

Ratliff, L. and Watson, J. (2014) A descriptive analysis of public school educators arrested for sex offenses. *Journal of Child Sexual Abuse, 23*(2), pp. 217-228.

Rheingold, A.A., Zajac, K. and Patton, M. (2012) Feasibility and acceptability of a child sexual abuse prevention program for childcare professionals: Comparison of a web-based and in-person training. *Journal of Child Sexual Abuse, 21*(4), pp. 422-436.

Richards, L. (2015) *Handling qualitative data: A practical guide (3rd ed.).* London, UK: SAGE Publication Inc.

Robinson, K.H. (2012) 'Difficult citizenship': The precarious relationships between childhood, sexuality and access to knowledge. *Sexualities, 15*(3-4), pp. 257-276.

Robinson, K.H. (2013) *Innocence, knowledge and the construction of childhood: The contradictory nature of sexuality and censorship in children's contemporary lives*. London, UK: Routledge.

Robinson, K.H., Smith, E. and Davies, C. (2017) Responsibilities, tensions and ways forward: Parents' perspectives on children's sexuality education. *Sex Education, 17*(3), pp. 333-347.

Rösler, A. and Witztum, E. (2000) Pharmacotherapy of paraphilias in the next millennium. *Behavioural Sciences and the Law, 18*(1), pp. 43-56.

Royal commission of Australia (2017) Australian Government. 2017e. Australian Royal Commission into Institutional Responses to Child Sexual Abuse. Volume 4: Identifying and Disclosing Child Sexual Abuse. In Final Report: Australian Royal Commission into Institutional Responses to Child Sexual Abuse; Canberra: Commonwealth of Australia. Available online: https://www.childabuseroyalcommission.gov.au/identifying-and-disclosing-child-sexual-abuse (accessed on 2 October 2021).

Rubin, H. and Rubin, I. (2012) *Qualitative interviewing: The art of hearing data. 2nd ed.* London: SAGE Publications Inc.

Saldaña, J. (2016) *The coding manual for qualitative researchers*. London, UK: SAGE Publication Inc.

Salmon, G., Ross, B., Pechenkina, E. and Chase, A.M. (2015) The space for social media in structured online learning. *Research in Learning Technology*, 23(1), pp. 1-14.

Saltiel, D. (2016) Observing front line decision making in child protection. *British Journal of Social Work, 46*(7), pp.2104-2119.

Sanderson, C. (2006) *Counselling adult survivors of child sexual abuse*. London, UK. Jessica Kingsley Publishers.

Schaffnit, S.B., Urassa, M. and Lawson, D.W. (2019) "Child marriage" in context: Exploring local attitudes towards early marriage in rural Tanzania. *Sexual and Reproductive Health Matters*, 27(1), pp. 93-105.

Schiller, U. (2017) Child sexual abuse allegations: Challenges faced by social workers in child protection organisations. *Practice*, *29*(5), pp. 347-360.

Schönbucher, V., Maier, T., Mohler-Kuo, M., Schnyder, U. and Landolt, M.A., 2012. Disclosure of child sexual abuse by adolescents: A qualitative in-depth study. *Journal of Interpersonal Violence*, *27*(17), pp. 3486-3513.

Schwandt, T.A. (1994) *Constructivist, interpretivist approaches to human inquiry*. In N.K. Denzin and Y.S. Lincoln (Eds.), Handbook of qualitative research (pp. 118–137). Thousand Oaks, CA: Sage Publication Inc.

Sekhar, D.L., Kraschnewski, J.L., Stuckey, H.L., Witt, P.D., Francis, E.B., Moore, G.A., Morgan, P.L. and Noll, J.G. (2018) Opportunities and challenges in screening for childhood sexual abuse. *Child Abuse and Neglect*, *85*, pp.156-163.

Sexual Offences Act (2003) Guidance on Part 2 of the Sexual Offences Act 2003, 1–62. Available at Sexual_Offences_Act_2003.pdf (unodc.org)

Shafe, S. and Hutchinson, G. (2014) Child sexual abuse and continuous influence of cultural practices: A review. *The West Indian Medical Journal*, *63*(6), p. 634-637.

Sharpe, G. (2013) *Offending girls: Young women and youth justice*. London: Routledge

Silverman, D. (2020) Collecting qualitative data during a pandemic. *Communication and Medicine*, *17*(1), pp. 76-84.

Singh, M.M., Parsekar, S.S. and Nair, S.N. (2014) An epidemiological overview of child sexual abuse. *Journal of Family Medicine and Primary Care*, *3*(4), pp. 430-435.

Sivagurunathan, M., Orchard, T., MacDermid, J.C. and Evans, M. (2019) Barriers and facilitators affecting self-disclosure among male survivors of child sexual abuse: The service providers' perspective. *Child Abuse and Neglect, 88*, pp. 455-465.

Smallbone, S., Marshall, W.L. and Wortley, R. (2013) Preventing child sexual abuse: Evidence, policy and practice. London, UK: Willan.

Smith, M. and Woodiwiss, J. (2016) 'Sexuality, Innocence and Agency in Narratives of Childhood Sexual Abuse: Implications for Social Work'. *British Journal of Social Work, 46*(8), pp. 2173–2189.

Smith, N. and Harrell, S. (2013) *Sexual abuse of children with disabilities: A national snapshot.* Brooklyn, New York: Vera Institute of Justice.

Sodipo, O. O. et al. (2018) The pattern and characteristics of sexual assault perpetrators and survivors managed at a sexual assault referral centre in Lagos. *African Journal of Primary Health Care and Family Medicine, 10*(1), pp. 1-5.

Søftestad, S. and Toverud, R. (2013) Challenges and opportunities: Exploring child protection workers' experiences of ensuring protection of the child during child sexual abuse suspicion. *British Journal of Social Work, 43*(8), pp. 1510–1526.

Spence, S.H. (2013) *Psychosexual therapy: A cognitive-behavioural approach* (Vol. 6). Kent, UK: Springer.

Stallard, P. (2002) Cognitive behaviour therapy with children and young people: A selective review of key issues. *Behavioural and Cognitive Psychotherapy, 30*(3), pp. 297-309.

Statistics Canada (2011) Family violence in Canada: A statistical profile. Statistics Canada, Catalogue no. 85-002-X

Staufenberg, H., 2010. Attachment theory and its relation to adult men who sexually offend. *The Journal of Behaviour Analysis of Offender and Victim Treatment and Prevention, 2*(3), pp. 144-160.

Stavrianopoulos, T. and Gourvelou, O. (2012) The role of the nurse in child sexual abuse in USA. *Health Science Journal, 6*(4), pp. 647–653.

Stephen, S., William, L. M. and Richard, W. (2013) Preventing child sexual abuse: Evidence, policy and practice. Cullompton, Devon: Willan Publishing.

Stinson, J.D., Becker, J.V. and Sales, B.D. (2008) Self-regulation and the aetiology of sexual deviance: Evaluating causal theory. *Violence and Victims, 23*(1), pp. 35.

Stinson, J.D., Sales, B.D. and Becker, J.V. (2008) *Sex offending: Causal theories to inform research, prevention, and treatment.* Washington, US. American Psychological Association.

Stoltenborgh, M., Van Ijzendoorn, M.H., Euser, E.M. and Bakermans-Kranenburg, M.J. (2011) A global perspective on child sexual abuse: Meta-analysis of prevalence around the world. *Child Maltreatment, 16*(2), pp. 79-101.

Sumner, S.A., Mercy, J.A., Saul, J., Motsa-Nzuza, N., Kwesigabo, G., Buluma, R., Marcelin, L.H., Lina, H., Shawa, M., Moloney-Kitts, M. and Kilbane, T. (2015) Prevalence of sexual violence against children and use of social services—seven countries, 2007–2013. *Morbidity and Mortality Weekly Report, 64*(21), pp. 565-569.

Swick, K.J. and Williams, R.D. (2006) An analysis of Bronfenbrenner's bio-ecological perspective for early childhood educators: Implications for working with families experiencing stress. *Early Childhood Education Journal, 33*(5), pp. 371-378.

Taghipour, A. (2014) Adopting Constructivist versus Objectivist Grounded Theory in Health Care Research: A Review of the Evidence. *Journal of Midwifery and Reproductive Health, 2*(2), pp. 100-104.

Tashakkori, A. and Teddlie, C. (2010) Putting the human back in ‘‘human research methodology’’: The researcher in mixed methods research. *Journal of Mixed Methods Research, 4*(4), pp. 271-277.

Teddlie, C. and Tashakkori, A. (2012) Common “core” characteristics of mixed methods research: A review of critical issues and call for greater convergence. *American Behavioural Scientist, 56*(6), pp. 774-788.

Tener, D. and Silberstein, M. (2019) Therapeutic interventions with child survivors of sibling sexual abuse: The professionals’ perspective. *Child Abuse and Neglect, 89*, pp. 192–202.

Todres, J. and Clayton, E. W. (2014) Responding to the sexual exploitation of minors. *New England Journal of Medicine, 370*(14), pp. 1282-1283.

Udebunu, C. (2011) Nigeria and the Dialectics of Multiculturalism. Ogirisi: *A New Journal of African Studies, 8*(1), pp. 1-15.

UNCRC (2005) General Comment No. 6 On the Treatment of Unaccompanied and Separated Children Outside their Country of Origin. UN Document CRC/GC/2005/6.

UNICEF (2007) *Implementation handbook for the convention on the rights of the child.* Geneva, Switzerland: United Nations.

United Nations International Children’s Emergency Funds (2015) *The economic burden of violence against children. Analysis of Selected Health and Education Outcomes Nigeria Study.* Available at: www.unicef.org.

Uvere, E.O. and Ajuwon, A.J. (2021) Sexual abuse among female adolescent hawkers in selected markets in Ibadan, Nigeria. *Journal of Child Sexual Abuse, 30*(5), pp. 579-596.

VanDeusen, K.M. and Way, I. (2006) Vicarious trauma: An exploratory study of the impact of providing sexual abuse treatment on clinicians' trust and intimacy. *Journal of Child Sexual Abuse, 15*(1), pp. 69-85.

Veenema, T.G., Thornton, C.P. and Corley, A. (2015) The public health crisis of child sexual abuse in low and middle income countries: An integrative review of the literature. *International Journal of Nursing Studies, 52*(4), pp. 864-881.

Wager, N. M. (2015) Understanding children's non-disclosure of child sexual assault: Implications for assisting parents and teachers to become effective guardians. *Safer Communities, 14*(1), pp. 16–26.

Wangamati, C. K., Sundby, J., Izugbara, C., Nyambedha, E.O. and Prince, R.J. (2019) Challenges in Supporting Survivors of Child Sexual Abuse in Kenya: A Qualitative Study of Government and Non-governmental Organizations. *Journal of Interpersonal Violence, 36*(15-16), pp. NP8773-NP8799.

Wanlass, J., Moreno, J. and Thomson, H. M. (2006) 'Group therapy for abused and neglected youth: Therapeutic and child advocacy challenges.' *Journal for Specialists in Group Work*, 31(4), pp. 311–326.

Ward, T., Polaschek, D. L. L., and Beech, A. R. (2006) *Theories of sexual offending.* Chichester, UK: Wiley.

Way, I., VanDeusen, K.M., Martin, G., Applegate, B. and Jandle, D. (2004) Vicarious trauma: A comparison of clinicians who treat survivors of sexual abuse and sexual offenders. *Journal of Interpersonal Violence, 19*(1), pp. 49-71.

Wiss, D.A., Brewerton, T.D. and Tomiyama, A.J. (2021) Limitations of the protective measure theory in explaining the role of childhood sexual abuse in eating disorders, addictions, and obesity: An updated model with emphasis on biological embedding. *Eating And Weight Disorders-Studies On Anorexia, Bulimia And Obesity, 27*(4), pp. 1249-1267.

Wolak, J., Finkelhor, D., Mitchell, K.J. and Ybarra, M.L. (2010) Online "predators" and their victims: Myths, realities, and implications for prevention and treatment. *Psychology of Violence, 1*, pp. 13–35

Woodhouse, S.S. (2018) Attachment-based interventions for families with young children. *Journal of Clinical Psychology, 74*(8), pp. 1296-1299.

Woodiwiss, J. (2014) Beyond a single story: The importance of separating 'harm' from 'wrongfulness' and 'sexual innocence' from 'childhood' in contemporary narratives of childhood sexual abuse. *Sexualities*, *17*(1-2), pp. 139-158.

World Health Organization (2013) Transforming and Scaling up health professionals' education and training. *International Nursing Review, 60*(2), 124.

World Health Organization (2006) *Preventing child maltreatment: A guide to taking action and generating evidence*. Geneva, Switzerland: World Health Organisation Press.

Yates, P.M. (2013) Treatment of sexual offenders: Research, best practices, and emerging models. *International Journal of Behavioural Consultation And Therapy*, *8*(3-4), pp. 89-95.

Yuce, M., Karabekiroğlu, K., Yildirim, Z., Şahin, S., Sapmaz, D., Babadağı, Z., ... and Aydin, B. (2015) The psychiatric consequences of child and adolescent sexual abuse. *Nöro Psikiyatri Arşivi, 52*(4), pp. 393-399.

Zolotor, A.J., Runyan, D.K., Dunne, M.P., Jain, D., Péturs, H.R., Ramirez, C., Volkova, E., Deb, S., Lidchi, V., Muhammad, T. and Isaeva, O. (2009) ISPCAN Child Abuse Screening Tool Children's Version (ICAST-C): Instrument development and multi-national pilot testing. *Child Abuse and Neglect*, *33*(11), pp.833-841

List of Appendices

Appendix 1

1.1. Extensive list of search terms

PEO framework	**Population**	**Exposure**		**Outcome**
Keywords	Healthcare professional	Recognising/responding child sexual abuse (CSA)		Identify issues and challenges
Alternative search terms	Primary health worker Healthcare workers Doctors Nurses Dentists Social workers Midwives Obstetricians Gynaecologist Psychologists Physicians	Identifying Recognising Responding Reporting Protecting Referring Treating Intervening	Sexual assault Sexual abuse Child molestation Child abuse Adolescents sexual abuse Child sexual trauma Rape	Barriers Hindrance Challenges Constraints Problems Difficulties Opposition

1.2. Search results

	Date limits	**January 1999 to May 2022**					
	Date searched	**10/05/22**	**13/05/22**	**15/05/22**	**18/06/22**	**18/06/22**	**18/06/22**
Search terms		CINHAL	PubMed	PSYCHINFO	ASSIA	Medline	AJOL
1. HCPs		167	1540	204	600	300	57
2. CSA		Total = 2868					
3. Recognising and responding							
4. Issues and challenges							
1 AND 2 AND 3 AND 4							

1.3. CASP checklist for included qualitative studies

Methodological quality of included studies assessed with CASP checklist (2018): Qualitative research checklist.		
Reporting Criteria (CASP)	**Number of qualitative studies (n = 15)**	**ID of study following the criteria**
1. Was there a clear statement of the aims of the research?		
2. Consider: (Yes/No/Comments)		
Hint: Consider		
• what was the goal of the research	15	3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 16, 19, 20, 21, 22
• why it was thought important	15	3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 16, 19, 20, 21, 22
• its relevance	15	3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 16, 19, 20, 21, 22
3. Is a qualitative methodology appropriate? Consider		
• If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants	15	3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 16, 19, 20, 21, 22
• Is qualitative research the right methodology for addressing the research goal	15	3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 16, 19, 20, 21, 22
4. Was the research design appropriate to address the aims of the research? **Consider**		

• if the researcher has justified the research design (e.g., have they discussed how they decided which method to use)	13	3, 4, 5, 6, 7, 9, 11, 12, 13, 16, 19, 20, 21
5. Was the recruitment strategy appropriate to the aims of the research? **Consider**		
• If the researcher has explained how the participants were selected	15	3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 16, 19, 20, 21, 22
• If they explained why the participants, they selected were the most appropriate to provide access to the type of knowledge sought by the study	15	3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 16, 19, 20, 21, 22
• If there are any discussions around recruitment (e.g., why some people chose not to take part)	15	3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 16, 19, 20, 21, 22
6. Was the data collected in a way that addressed the research issue? **Consider**		
• If the setting for the data collection was justified	13	3, 4, 5, 6, 7, 9, 11, 12, 13, 16, 19, 20, 21
• If it is clear how data were collected (e.g., focus group, semi-structured interview etc.)	13	3, 4, 5, 6, 7, 9, 11, 12, 13, 16, 19, 20, 21
• If the researcher has justified the methods chosen	13	3, 4, 5, 6, 7, 9, 11, 12, 13, 16, 19, 20, 21
• If the researcher has made the methods explicit (e.g., for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)	13	3, 4, 5, 6, 7, 9, 11, 12, 13, 16, 19, 20, 21
• If methods were modified during the study. If so, has the researcher explained how and why	13	3, 4, 5, 6, 7, 9, 11, 12, 13, 16, 19, 20, 21

• If the form of data is clear (e.g., tape recordings, video material, notes etc.)	13	3, 4, 5, 6, 7, 9, 11, 12, 13, 16, 19, 20, 21
• If the researcher has discussed saturation of data	13	3, 4, 5, 6, 7, 9, 11, 12, 13, 16, 19, 20, 21
7. Has the relationship between researcher and participants been adequately considered?		
• If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location	13	3, 4, 5, 6, 7, 9, 11, 12, 13, 16, 19, 20, 21
• How the researcher responded to events during the study and whether they considered the implications of any changes in the research design	13	3, 4, 5, 6, 7, 9, 11, 12, 13, 16, 19, 20, 21
8. Have ethical issues been taken into consideration? **Consider**		
• If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained	13	3, 4, 5, 6, 7, 9, 11, 12, 13, 16, 19, 20, 21
• If the researcher has discussed issues raised by the study (e.g., issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)	13	3, 4, 5, 6, 7, 9, 11, 12, 13, 16, 19, 20, 21
• If approval has been sought from the ethics committee	13	3, 4, 5, 6, 7, 9, 11, 12, 13, 16, 19, 20, 21
9. Was the data analysis sufficiently rigorous? **Consider**		

• If there is an in-depth description of the analysis process	12	4, 5, 6, 7, 9, 12, 13, 16, 19, 20, 21
• If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data	9	8, 11, 12, 15, 16, 19, 20, 21, 22
• Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process	13	3, 4, 5, 6, 7, 9, 11, 12, 13, 16, 19, 20
• If sufficient data are presented to support the findings	14	3, 4, 5, 6, 7, 9, 11, 12, 13, 16, 19, 20, 21
• To what extent contradictory data are taken into account	14	3, 4, 5, 6, 7, 9, 11, 12, 13, 16, 19, 20, 21
• Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation	14	3, 4, 5, 6, 7, 9, 11, 12, 13, 16, 19, 20, 21, 22
10. Is there a clear statement of findings? **Consider**		
• If the findings are explicit	17	3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 16, 19, 20, 21, 22, 23, 24
• If there is adequate discussion of the evidence both for and against the researcher's arguments	17	3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 16, 19, 20, 21, 22, 23, 24
• If the researcher has discussed the credibility of their findings (e.g., triangulation, respondent validation, more than one analyst)	14	3, 4, 5, 6, 7, 9, 11, 12, 13, 16, 19, 20, 21, 22

• If the findings are discussed in relation to the original research question	17	3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 16, 19, 20, 21, 22, 23, 24
11. How valuable is the research? **Consider**		
• If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research based literature	14	3, 4, 5, 6, 7, 8, 9, 11, 13, 16, 19, 20, 21, 22
• If they identify new areas where research is necessary	14	3, 4, 5, 6, 7, 8, 9, 11, 13, 16, 19, 20, 21, 22
• If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used	14	3, 4, 5, 6, 7, 8, 9, 11, 13, 16, 19, 20, 21, 22

Critical Appraisal Skills Programme (2018). CASP Qualitative Checklist. Available at: file:///C:/Users/sline/Desktop/CASP-Qualitative-Checklist-2018_fillable_form.pdf. Accessed: 22nd June 2019.

1.4. CASP checklist for included quantitative studies

Methodological quality of included studies assessed with CASP checklist (2018): Quantitative research checklist.				
Reporting Criteria (CASP)				
	1	2	14	18
1. **Did the study address a clearly focused issue?** **Consider: (Yes/No/Comments)**				
Hint: A question can be 'focused' in terms of				
• the population studied	Yes	Yes	Yes	Yes
• the risk factors studied	Yes	Yes	Yes	Yes
• is it clear whether the study tried to detect a beneficial or harmful effect	Yes	Yes	Yes	Yes
• the outcomes considered	Yes	Yes	Yes	Yes
2. **Was the cohort recruited in an acceptable way?**				
Hint: Look for selection bias which might compromise the generalizability of the findings				
• was the cohort representative of a defined population	Yes	Yes	Yes	Yes
• was there something special about the cohort	Yes	Yes	Yes	Yes
• was everybody included who should have been	Yes	No	Yes	Yes
3. **Was the exposure accurately Yes measured to minimize bias?**				

Consider				
Hint: Look for measurement or classification bias				
• did they use subjective or objective measurements	Yes	Yes	Yes	Yes
• do the measurements truly reflect what you want them to (have they been validated)	Yes	Yes	Yes	Yes
• were all the subjects classified into exposure groups using the same procedure	Yes	Yes	Yes	Yes
4. **Was the outcome accurately measured to minimize bias?**				
Hint: Look for measurement or classification bias				
• did they use subjective or objective measurements	Yes	Yes	Yes	Yes
• do the measurements truly reflect what you want them to (have they been validated)	Yes	Yes	Yes	Yes
• has a reliable system been established for detecting all the cases (for measuring disease occurrence)	Yes	Yes	Yes	Yes
• were the measurement methods similar in the different groups	Yes	Yes	Yes	Yes
• were the subjects and/or the outcome assessor blinded to exposure (does this matter)	No	No	No	No
5a) Have the authors identified all important confounding factors? **Consider**				
Hint: List the ones you think might be important, and ones the author missed	Yes	Yes	Yes	Yes
5b) Have they taken account of the confounding factors in the design and/or analysis?	Yes	Yes	Yes	Yes
Hint: look for restriction in design, and techniques e.g., modelling, stratified-, regression-, or sensitivity analysis to correct, control or adjust for confounding factors	Yes	Yes	Yes	Yes

6a) Was the follow up of subjects complete enough?	No	No	Yes	Yes
Hints:				
• the good or bad effects should have had long enough to reveal themselves	No	No	No	No
• the persons that are lost to follow-up may have different outcomes than those available for assessment	No	No	No	No
6b) Was the follow up of subjects long enough?	Yes	Yes	Yes	Yes
6. What are the results of this study? **Consider**				
• what are the bottom line results	Yes	Yes	Yes	Yes
• have they reported the rate or the proportion between the exposed/unexposed, the ratio/rate difference	Yes	Yes	Yes	Yes
• how strong is the association between exposure and outcome (RR)	Yes	Yes	Yes	Yes
• what is the absolute risk reduction (ARR)	Yes	Yes	Yes	Yes
7. How precise are the results?				
Hint: look for the range of the confidence intervals, if given	No	No	No	No
8. Do you believe the results?				
• big effect is hard to ignore	Yes	Yes	Yes	Yes
• can it be due to bias, chance or confounding	No	No	No	No
• are the design and methods of this study sufficiently flawed to make the results unreliable	No	No	No	No

• Bradford Hills criteria (e.g., time sequence, dose-response gradient, biological plausibility, consistency)	Yes	Yes	Yes	Yes
9. Can the results be applied to the local population? **Consider whether**				
• a cohort study was the appropriate method to answer this question	Yes	Yes	Yes	Yes
• the subjects covered in this study could be sufficiently different from your population to cause concern	Yes	Yes	Yes	Yes
• your local setting is likely to differ much from that of the study	Yes	Yes	Yes	Yes
• you can quantify the local benefits and harms	Yes	Yes	Yes	Yes
10. Do the results of this study fit with other available evidence?	Yes	Yes	Yes	Yes
11. What are the implications of this study for practice? **Consider**				
• one observational study rarely provides sufficiently robust evidence to recommend changes to clinical practice or within health policy decision making	Yes	Yes	Yes	Yes
• for certain questions, observational studies provide the only evidence	Yes	Yes	Yes	Yes
• recommendations from observational studies are always stronger when supported by other evidence	Yes	Yes	Yes	Yes

1.5. CASP checklist for included mixed method studies

Types of mixed methods study components or primary studies	Methodological quality criteria	ID no. of included research		
		10	15	17
Screening questions (for all types)	Are there clear qualitative and quantitative research question (or objectives*), or a clear mixed methods question (or objectives*)?	Yes	Yes	Yes
	Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).	Yes	Yes	Yes
1. Qualitative	1.1 Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?	Yes	Yes	Yes
	1.2 Is the process for analysing qualitative data relevant to address the research question (objective)?	Yes	Yes	Yes
	1.3 Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?	Yes	Yes	Yes
	1.4 Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?	Yes	Yes	Yes
2. Quantitative randomized controlled (trials)	2.1 Is there a clear description of the randomization (or an appropriate sequence generation)?	Yes	Yes	Yes
	2.2 Is there a clear description of the allocation concealment (or blinding when applicable)?	Yes	Yes	Yes
	2.3 Are there complete outcome data (80% or above)?	Yes	Yes	Yes
	2.4 Is there low withdrawal/drop-out (below 20%)	Yes	Yes	Yes

3. Quantitative non-randomized	3.1 Are participants (organizations) recruited in a way that minimizes selection bias?			
	3.2 Are measurement appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?			
	3.3 In the groups being compared (exposed vs. non-exposed; with intervention vs. without; case vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?	-	-	
	3.4 Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?	-	-	-
4. Qualitative descriptive	4.1 Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?	Yes	Yes	Yes
	4.2 Is the sample representative of the population understudy?	Yes	Yes	Yes
	4.3 Are measurements appropriate (clear origin, or validity known, or standard instrument)?			
	4.4 Is there an acceptable response rate (60% or above)?			
5. Mixed methods	5.1 Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?	Yes	Yes	Yes
	5.2 Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?	Yes	Yes	Yes
	5.3 Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?	Yes	Yes	Yes
Criteria for the qualitative component (1.1 to 1.4), and appropriate criteria for the quantitative component (2.1 to 2.4, or 3.1 to 3.4, or 4.1 to 4.4), must be also applied.				

MMAT Criteria (Pluye et al. 2011)

1.6. Summary of purpose of reviewed literature

ID	Authors & years	Purpose
1	Bryant and Milsom 2005	To identify the prevalence of child abuse reporting behavior, influencing factors, and perceived barriers to reporting process of school counselors.
2	Feng and Levine 2005	To determine how Taiwanese nurses perceive the new child abuse reporting law, as well as to determine whether nurse attitudes correlate with their intention to report abuse
3	Wanlass *et al.* 2006	To discover issues around CSA identification and discuss methods employed by therapists in recognising and handling challenges of advocating for and victims of CSA
4	Pistorius *et al.* 2008	To explore experience of therapist working with sexually abused children
5	Panayiotopoulos 2011	To identify obstacles to the efficacy of compulsory reporting and investigate implications for future practice
6	Søftestad and Toverud 2013	To explore views of child protection workers' (CPW) regarding working with suspected victims of CSA and their families
7	Martins 2014	To explore CSA practitioners' perspective regarding online abuse images
8	Saltiel 2016	To discover issues social workers faced in their role of making difficult decision with CSA victims
9.	Kwhali *et al.* 2016	To assess social workers' knowledge, competence, and awareness of CSA
10	Franklin and Smeaton 2016	To investigate facilitators and barriers to safeguarding practice from the perspective of practitioners, and policymakers
11	Schiller 2017	To discover the challenges facing social workers when dealing with allegations of CSA

12	Kraft *et al.* 2017	To assess school nurses' ability to detect and support CSA victims
13	Sekhar *et al.* 2018	To elucidate the challenges and opportunities associated with CSA screening through qualitative research
14	Alsaleem *et al.* 2018	To evaluate the physicians' knowledge and attitude regarding sexually abused children
15	Ajema *et al.* 2018	To establish the quality of services provided to survivors of sexual violence at two public health facilities in Kenya
16	Muridzo *et al.* 2018	To examine the barriers faced by professionals working with CSA survivors
17	Brady 2018	To investigate the level of confidence paramedics in the UK have in recognising CSA.
18	Farrow *et al.* 2018	To explore gynaecologists' knowledge, and barriers regarding screening sexually abused children
19	Sivagurunathan *et al.* 2019	To discover HCP views and understanding of barriers and facilitators amongst male survivors
20	Tener and Silberstein 2019	To explore the experience of survivors from the perspective of mental health professionals and assess challenges to the therapeutic process
21	Wangamati *et al.* 2019	To examine the challenges facing HCPs who provide care to sexually abused children
22	Kennedy *et al.* 2021	To explore MHNs' perceived preparedness to work with adults who have CSA histories, and to elicit their views, skills and confidence in relation to working with this sensitive issue

1.7. Summary of literature review

ID	Authors & years	Design & Method of data collection	Settings and Country	Participants	Results & Conclusion
1	Bryant and Milsom 2005	Quantitative Questionnaire Purposive sampling Analysis: An analysis of variance (ANOVA)	Midwestern Iowa City, USA	263 Occupation: School Counsellors	**Results** Besides having a legal and ethical responsibility to report child abuse, school counsellors are mandated reporters and must demonstrate competence **Issues and challenges** According to respondents, they are able to recognise physical abuse easily, but not sexual abuse. Factors that influence their ability to report cases are; A sense of obligation to comply with school regulations and policies There was convincing evidence that abuse had taken place. Administrative support. Concern for student safety. Factors that influence their ability to report cases are; Lack of strong evidence, Concern that no investigation will be conducted by the organisation to confirm abuse

					Concerned about the consequences for the child and his/her family.
2	Feng and Levine 2005	Quantitative Questionnaire Stratified Quota sample	Taiwan	A total of 1400 questionnaires from 1617 nurses	Nursing staff (86%) said they had never reported child abuse and 21% said they had failed to report suspected abuse cases In 80% of cases, no child abuse education was provided, and 75% of participants felt their nursing education and in-service training was inadequate. The nurses had insufficient knowledge of the reporting law (mean score: 60% correct) and were able to correctly answer only 17 to 43% of the questions. The majority accepted the professional responsibility to report. In general, Taiwanese nurses had negative attitudes toward corporal punishment and abusive parents.
3	Wanlass *et al.* 2006	Qualitative Case studies Purposive sampling	US	Two therapists in group therapy with 8 to 12 girl's cases of incest	A number of therapists reported that establishing and maintaining therapeutic relationships and coordinating therapy was difficult. The emotional difficulties were attributed to victims' experience of being violated by designated protectors, resulting in violation of personal safety Seeing therapists as potential abusers, and unable to trust them The feeling of incapacity therapists experienced due to the enormity of the child welfare system Professional Strategies used to mitigate these challenges are; Facilitate safe and effective containment Therapists foster member self-exploration.

					Maintaining safe boundaries in therapy groups React instead of repressing the messages underneath children's actions Facilitate teamwork Find a solution to problems by identifying a pathway
4	Pistorius *et al.* 2008	Qualitative design Interview	USA	Ten female therapists who were currently working with sexually abused children	As a result of hearing stories of sexual abuse, participants reported experiencing vicarious trauma. It was sometimes devastating for therapists to hear stories because the images of what had happened lingered in their minds. According to participants in this study, therapists carry an immense burden of trauma on behalf of their clients. In addition to compassion fatigue and exhaustion, participants reported extreme sadness, dissociation, or isolation as symptoms of vicarious trauma. Therapists in this study revealed that working with sexually abused children interfered with their ability to maintain appropriate boundaries. They discussed the boundaries between their roles as wife, mother, and neighbor, as well as their role as therapists. It was evident that the therapists recognised the importance of their own lives after witnessing the devastation caused by sexual abuse.
5	Panayiotopoulos 2011	Qualitative approach Semi-structured interviews	Cyprus	10 school teachers Two principal health visitors	Several professional groups, including teachers and health care providers, were found to be undertrained The definition controversy

		Focus group Random sampling		11 social services- family social workers	Professionals who believe mandatory reporting is not part of their duties are less concerned about mandatory reporting A lack of coordination between multidisciplinary agencies and a failure to keep case records. Fear of parent reaction and protection of their school status
6	Søftestad and Toverud 2013	Qualitative Semi-structured Interview Purposive Sampling Ground theory approach	Local Child Protection Services Southern Norway.	11 respondents Occupation: Child protection workers	**Issues and challenges:** Insufficient training, knowledge, and experience Incompetent in understanding and handling CSA-exposed children Comprehensive workload of the child protection services Insufficient time to critically explore suspicious case Challenges regarding ensuring further personal contact with the child The participants feel competent in dealing with suspicions and cases of CSA and are supported by their colleagues and management
7	Martins 2014	Qualitative Interview Snowball and purposive sampling	Ontario, Canada	14 respondents Occupation: CSA practitioners	When investigating, identifying, and responding to sexually abused children, CSA practitioners feel competent and confident. There is, however, limited confidence with identifying and responding to victims of online image sexual abuse. Other challenges mentioned were: Lack of CSAIO-specific protocols

		Ground theory approach			Limited understanding of the 'potential deviant nature' of CSAIO. The possibility of not discovering cases was difficult for most HCPs The emotional trauma suffered by victims of CSAIO may require a different approach, due to its permanence and unending nature The victim is re-victimized each time the image is viewed
8	Saltiel 2016	Qualitative research Ethnography Semi-structured interview Observation Purposive sampling Thematic analysis	Two social work teams North of England	Two team Occupation: Social workers	Results showed social workers experience difficulties working on incomplete information and dealing with heavy case notes under limited time Professional awareness of their limited resources and the pressure of constant referrals
9.	Kwhali *et al.* 2016	Qualitative Semi-structured interview Focus group Purposive sampling	Local safeguarding boards across six local authorities, England.	24 First-line, middle and senior managers 2 Chairs of local safeguarding boards 54 Social workers	Some participants felt experienced and knowledgeable about CSA work, while others lacked experience and were cautious when asserting suspicions. There are well-developed procedures and support from other staff members and managers. **Challenges:** As a fundamental element of social workers' safeguarding duties, HCP views the management of CSA cases stressful and complex

		Framework Analysis			Lack of staff and high caseloads undermine confidence Insufficient time and space for preparation and reflection The role of HCPs in supporting victims and their families during the investigation and therapy processes is unclear. Access to therapeutic support for children is delayed. Uncertainty about their role in partnership Rather than based on experience or expertise, cases are allocated according to the number of staff members available. Therapeutic interventions rely heavily on the voluntary sector. Service-disturbing realities are concerned with sustainability.
10.	Franklin and Smeaton 2016	Mixed method Online questionnaire survey Interview Snowball sampling SPSS software	UK	34 professional stakeholders 27 young people with disability	Lack of knowledge and awareness on how to recognize victims of CSA and special needs necessary to victims with learning disabilities. Lack of services for special groups and social isolation of young people with learning disabilities. A lack of consistency in national and local policies, as well as non-implementation of current guidelines.
11	Schiller 2017	Qualitative Purposive sampling	Six Child Protection Organisations	71 respondents	When children are reported to authorities, it is difficult to ensure the 'Best Interest of the Child' principle is followed It is frustrating to lose control over the proceeds.

		Focus group Thematic analysis	(CPO) in six different provinces. South Africa.	Occupation: Social workers	Procedure often disregards the child's socioemotional needs Aware of their onus to report to authority but do feel reluctant knowing the system will fail the child Organisational judicial procedures can also result in re-victimization and HCPs found it difficult in addressing re-victimization in CSA investigations Human resource shortages and low motivation among key workers Uncertainties surrounding the reporting of sexual abuse allegations and case management incompetence
12	Kraft *et al.* 2017	Qualitative Interview Focus Group Purposive sampling Thematic analysis	Sweden	23 school nurses	School nurses avoid inquiring about CSA and avoid talking or thinking about illegal acts of CSA As CSA pertains to the family's sensitive private sphere, there were ambivalent feelings about involvement since the perpetrator is a known perpetrator to the child (victim-perpetrator relationship). Disclosure is considered to be a complex process by both children and health care professionals. More younger children have trouble putting their experience into words.
13	Sekhar *et al.* 2018	Qualitative Focus group Purposive sampling	Peninsula US	62 participants Occupation: School nurses, schoolteachers, counsellors and administrators,	The participants identified regular daily contact as a way for them to build a therapeutic relationship and trust with the pupil. It also allows early screening and identification-from nursery However, the hidden, secretive nature of CSA, particularly among older children, makes it difficult to detect

		Descriptive content analysis		Paediatric providers, and parents.	Maintaining privacy and confidentiality of student records, as well as safeguarding procedures. The reporting structure of online surveys is varied, and there are concerns about uncertainty and record-keeping Professionals may also be unable to screen young children because they are unable to understand confidentiality. Routine identification should be conducted in a less intrusive and offensive manner.
14	Alsaleem *et al.* 2018	Quantitative Cross-sectional study Questionnaire Sampling method not stated SPSS version 20 and two-tailed tests with	PHC Center Abha Capital of Aseer Province Saudi Arabia	300 respondents Occupation: physicians Age: 25 to 50years	Physician awareness is high (96.3%), and 64% of respondents report underreporting of child abuse. Challenges and issues Underreporting is an epidemic due to unclear reporting procedures, fear of parents or child's family's response toward the child and cultural beliefs
15	Ajema *et al.* 2018	Mixed method Questionnaire In-depth interview	One rural and one urban public health facility. Kenya	164 child survivor medical records. 31 healthcare providers.	Issues and challenges identified are; There are fewer staff members who are trained to deal with cases of CSA. National protocols are not being used appropriately. Psychosocial support for survivors is hindered by obstacles.

		Purposive sampling SSPP 22 and Thematic analysis		14 child survivors and their caregivers Occupation: Health providers	For storing evidence, there is no lockable cupboard or security. A long waiting period for assessments and evaluations.
16	Muridzo *et al.* 2018	Qualitative Interview Purposive sampling (theoretical) Thematic analysis	29 government and non-governmental organisations. Zimbabwe	38 participants Occupation: social workers, medical doctors, nurses, police, magistrates and prosecutors, counsellors, educationists and psychologists	Recruiting, training, and retaining qualified and experienced staff are challenges in human resources Funding withdrawals and family costs of intervention are among the resource limitations Long distances and poor roads make remote areas inaccessible
17	Brady 2018	Mixed method Online Questionnaires Focus group	UK	276 respondents Occupation: Paramedics	Due to infrequent exposure to CSA cases, participants lack confidence Some cultural practices, such as female genital mutilation, are intertwined with CSA Participants do not feel qualified to examine or inspect paediatric genitalia unless clinically indicated There is uncertainty surrounding these non-physical signs and behaviours It is difficult to distinguish sexual abuse from FGM due to a lack of training

18	Farrow *et al.* 2018	Quantitative Questionnaire Convenient and Stratified sampling SPSS 24.0	California	145 respondents Occupation: Physicians	Time constraints There is no clear system for connecting victims with support services There is not enough time to conduct a thorough investigation Screening is impossible due to a lack of support staff Staffing shortages and lack of measurement tools
19	Sivagurunathan, *et al.* 2019	Qualitative Semi-structure interview Snowball sampling Thematic analysis	2 Cities in southern and central Ontario Canada	11 Child service providers	Barriers and facilitator to disclosure: Personal characteristics including individual feelings, values and beliefs that delay disclosure. Also, sexual orientation, emotions, inner strength and denial. Social norms-Attitude around sex and sexual abuse and masculinity. The fear of social reaction to disclosure and possible social rejection from friends, family members impede victims from disclosing. Advocate for public education and services
20	Tener and Silberstein 2019	Qualitative Interview Purposive sampling Thematic analysis	Jerusalem	20 participants Occupation: Mental health professionals	Dealing with “grey cases” When the victims do not see themselves as victims. Professional perceptions differ from survivor perceptions since survivors are too young and not aware of their acts' deviance. Raise difficult questions concerning how ethical and therapeutic it would be to "force" the survivor into a “victim” narrative.”

					When professionals cannot identify one of the siblings as a "perpetrator" A professional perceives sexual abuse cases as mutual and reciprocal, with both siblings initiating the abuse. It was especially important when victims did not feel victimised by the organisation, but considered it as a safe haven instead. Neither of the siblings can be labelled a "perpetrator" or a "victim," which is essential for presenting a case in welfare and justice systems. As professionals, we must stand with the patient's internal perception of sexual acts as mutual, normative, comforting, havens, intimacy, or rescuing As professionals, we need to see both siblings as survivors of the family circumstances rather than as individual victims.
21	Wangamati *et al.* 2019	Qualitative Interview and focus group Thematic analysis	Kenya	61 Participants Occupation: Community health workers NGO workers Children Officers Police officers Community leader	There is a lack of infrastructure, such as gender desks, temporary shelters for victims, and children's courts. Services are not coordinated effectively across the continuum of care An insufficient number of counsellors to provide psychosocial support. Interviews Lack of and late reporting, especially in cases of incest. In police stations, there is no gender desk that specifically addresses gender-based violence Corruption among officials and uncooperative witnesses.

				Clerical officer Prosecutors Magistrates	Administrative-related challenges: unnecessary adjournment of cases which reduced the survivors and their families level of motivation. Harmful patriarchal norms that hinder reporting of abuse
22	Kennedy *et al.* 2021	Qualitative Descriptive methodology semi-structured interviews Thematic analysis framework	Ireland	Five mental health nurses	In addition to education and training specific to CSA, MHNs also cited the need for clinical supervision and additional guidelines to enhance their preparedness for CSA. A major barrier to preparing nursing students to work with survivors of CSA is the absence of CSA in nursing curricula and of role models within clinical practice. Recommendations are made for training, education and the inclusion of clinical supervision.

Appendix 2

2.1. Extensive list of search terms

PEO framework	Population	Exposure	Outcome
Keywords	Nigerian Context	Child Sexual Abuse (CSA)	Concepts on CSA Identify Issues and Challenges
Alternative search terms	Sexually abused children CSA victims Primary health worker Healthcare workers Doctors Nurses Dentists Social workers Midwives Obstetricians Gynecologist Psychologist Physicians	Sexual assault Sexual abuse Child molestation Child abuse Adolescents sexual abuse Child sexual trauma Rape	The prevalence and pattern of CSA, Causes and determinant/predictor Impact on victims, Society's awareness, HCPs' perceptions and practices and available services Identifying issues and challenges

2.2. Search results

	Date limits	**January 1999 to May 2022**					
	Date searched	**10/05/22**	**13/05/22**	**15/05/22**	**18/06/22**	**18/06/22**	**18/06/22**
Search terms		CINAHL	PubMed	PSYCHINFO	ASSIA	PILOTS	AJOL
1. HCPs		35	130	25	271	202	662
2. CSA		Total = 1325					
3. Recognizing and responding							
4. Issues and challenges							
1 AND 2 AND 3 AND 4							

2.3. CASP checklist for included qualitative studies

Methodological quality of included studies assessed with CASP checklist (2018): Qualitative research checklist.		
Reporting Criteria (CASP)	**Number of qualitative studies (n=5)**	**ID of study following the criteria**
1. Was there a clear statement of the aims of the research?		
Consider: (Yes/No/Comments)		
Hint: Consider		
• what was the goal of the research	5	7, 8, 14, 18, 23
• why it was thought important	5	7, 8, 14, 18, 23
• its relevance	5	7, 8, 14, 18, 23
2. Is a qualitative methodology appropriate? Consider		
• If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants	5	7, 8, 14, 18, 23
• Is qualitative research the right methodology for addressing the research goal	5	7, 8, 14, 18, 23
3. Was the research design appropriate to address the aims of the research? Consider		
• if the researcher has justified the research design (e.g., have they discussed how they decided which method to use)	5	7, 8, 14, 18, 23
4. Was the recruitment strategy appropriate to the aims of the research? Consider		

• If the researcher has explained how the participants were selected	5	7, 8, 14, 18, 23
• If they explained why the participants, they selected were the most appropriate to provide access to the type of knowledge sought by the study	5	7, 8, 14, 18, 23
• If there are any discussions around recruitment (e.g., why some people chose not to take part)	5	7, 8, 14, 18, 23
5. Was the data collected in a way that addressed the research issue? Consider		
• If the setting for the data collection was justified	5	7, 8, 14, 18, 23
• If it is clear how data were collected (e.g., focus group, semi-structured interview etc.)	5	7, 8, 14, 18, 23
• If the researcher has justified the methods chosen	5	7, 8, 14, 18, 23
• If the researcher has made the methods explicit (e.g., for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)	5	7, 8, 14, 18, 23
• If methods were modified during the study. If so, has the researcher explained how and why	4	7, 8, 18, 23
• If the form of data is clear (e.g., tape recordings, video material, notes etc.)	4	7, 8, 18, 23
• If the researcher has discussed saturation of data	4	7, 8, 18, 23
6. Has the relationship between researcher and participants been adequately considered?		
• If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location	4	7, 8, 18, 23
• How the researcher responded to events during the study and whether they considered the implications of any changes in the research design	5	7, 8, 14, 18, 23

7. Have ethical issues been taken into consideration? Consider		
• If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained	5	7, 8, 14, 18, 23
• If the researcher has discussed issues raised by the study (e.g., issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)	4	7, 8, 14, 18, 23
• If approval has been sought from the ethics committee	5	7, 8, 14, 18, 23
8. Was the data analysis sufficiently rigorous? Consider		
• If there is an in-depth description of the analysis process	5	7, 8, 14, 18, 23
• If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data	4	7, 8, 14, 18, 23
• Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process	4	7, 8, 14, 18, 23
• If sufficient data are presented to support the findings	4	7, 8, 14, 18, 23
• To what extent contradictory data are taken into account	4	7, 8, 14, 18, 23
• Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation	4	7, 8, 18, 23
9. Is there a clear statement of findings? Consider		
• If the findings are explicit	5	7, 8, 14, 18, 23
• If there is adequate discussion of the evidence both for and against the researcher's arguments	5	7, 8, 14, 18, 23

• If the researcher has discussed the credibility of their findings (e.g., triangulation, respondent validation, more than one analyst)	5	7, 8, 14, 18, 23
• If the findings are discussed in relation to the original research question	5	7, 8, 14, 18, 23
10. How valuable is the research? Consider		
• If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research based literature	5	7, 8, 14, 18, 23
• If they identify new areas where research is necessary	5	7, 8, 14, 18, 23
• If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used	5	7, 8, 14, 18, 23

Critical Appraisal Skills Programme (2018). CASP Qualitative Checklist. Available at: file:///C:/Users/sline/Desktop/CASP-Qualitative-Checklist-2018_fillable_form.pdf. Accessed: 22nd June 2019.

2.4. CASP checklist for included quantitative studies

Methodological quality of included studies assessed with CASP checklist (2018): Quantitative research checklist			
1. Did the study address a clearly focused issue? Consider: (Yes/No/Comments)	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
Hint: A question can be 'focused'in terms of:			
• the population studied	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• the risk factors studied	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• is it clear whether the study tried to detect a beneficial or harmful effect	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• the outcomes considered	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
2. Was the cohort recruited in an acceptable way?			
Hint: Look for selection bias which might compromise the generalizability of the findings:			
• was the cohort representative of a defined population	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31

• was there something special about the cohort	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• was everybody included who should have been	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
3. Was the exposure accurately Yes measured to minimize bias? Consider			
Hint: Look for measurement or classification bias:			
• did they use subjective or objective measurements	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• do the measurements truly reflect what you want them to (have they been validated)	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• were all the subjects classified into exposure groups using the same procedure	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
4. Was the outcome accurately measured to minimize bias?	Yes	20	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
Hint: Look for measurement or classification bias:			
• did they use subjective or objective measurements	Yes	20	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• do the measurements truly reflect what you want them to (have they been validated)	Yes	20	1, 3, 4, 5, 6, 11, 12, 13, 15, 16, 17, 20, 21, 22, 24, 25, 27,29, 30, 31

• has a reliable system been established for detecting all the cases (for measuring disease occurrence)	Yes	20	1, 3, 4, 5, 6, 11, 12, 13, 15, 16, 17, 20, 21, 22, 24, 25, 27,29, 30, 31
• were the measurement methods similar in the different groups	Yes	20	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• were the subjects and/or the outcome assessor blinded to exposure (does this matter)	Yes	20	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
5(a) Have the authors identified all important confounding factors? Consider	Yes	20	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
Hint: list the ones you think might be important, and ones the author missed	Yes	20	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
5(b) Have they taken account of the confounding factors in the design and/or analysis?	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
Hint: look for restriction in design, and techniques e.g., modelling, stratified-, regression-, or sensitivity analysis to correct, control or adjust for confounding factors		24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
6(a) Was the follow up of subjects complete enough? **Hint:**	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• the good or bad effects should have had long enough to reveal themselves	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• the persons that are lost to follow-up	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31

may have different outcomes than those available for assessment			
6(b) Was the follow up of subjects long enough?	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
7. What are the results of this study? Consider:			
• what are the bottom line results			
• have they reported the rate or the proportion between the exposed/unexposed, the ratio/rate difference	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• how strong is the association between exposure and outcome (RR)			
• what is the absolute risk reduction (ARR)			
8. How precise are the results?	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
Hint: look for the range of the confidence intervals, if given			
9. Do you believe the results?	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• big effect is hard to ignore	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• can it be due to bias, chance or confounding	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• are the design and methods of this study sufficiently flawed to make the results unreliable	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31

• Bradford Hills criteria (e.g., time sequence, dose-response gradient, biological plausibility, consistency)			
10. Can the results be applied to the local population? **Hint:** Consider whether	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• a cohort study was the appropriate method to answer this question	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• the subjects covered in this study could be sufficiently different from your population to cause concern	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• your local setting is likely to differ much from that of the study	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• you can quantify the local benefits and harms			
11. Do the results of this study fit with other available evidence?	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
12. What are the implications of this study for practice? **Hint:** Consider			

• one observational study rarely provides sufficiently robust evidence to recommend changes to clinical practice or within health policy decision making	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• for certain questions, observational studies provide the only evidence	Yes	24	1, 3, 4, 5, 6, 10, 11, 12, 13, 15, 16, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31
• recommendations from observational studies are always stronger when supported by other evidence	Yes	22	1, 3, 5, 6, 10, 11, 12, 13, 15, 17, 19, 20, 21, 22, 24, 25, 26,27,29, 30, 31

2.5. CASP checklist for included mixed method studies

Types of mixed methods study components or primary studies	Methodological quality criteria	ID of Mixed study	
		2	**28**
Screening questions (for all types)	Are there clear qualitative and quantitative research question (or objectives*), or a clear mixed methods question (or objectives*)?	Yes	Yes
	Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).	Yes	Yes
1. Qualitative	1.1 Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?	Yes	Yes
	1.2 Is the process for analysing qualitative data relevant to address the research question (objective)?	Yes	Yes
	1.3 Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?	Yes	Yes
	1.4 Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?	Yes	Yes
2. Quantitative randomized controlled (trials)	2.1 Is there a clear description of the randomization (or an appropriate sequence generation)?	Yes	Yes
	2.2 Is there a clear description of the allocation concealment (or blinding when applicable)?	Yes	Yes
	2.3 Are there complete outcome data (80% or above)?	Yes	Yes

	2.4 Is there low withdrawal/drop-out (below 20%)	Yes	Yes
3. Quantitative non-randomized	3.1 Are participants (organizations) recruited in a way that minimizes selection bias?		
	3.2 Are measurement appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?		
	3.3 In the groups being compared (exposed vs. non-exposed; with intervention vs. without; case vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?	-	-
	3.4 Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?	-	-
4. Qualitative descriptive	4.1 Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?	Yes	Yes
	4.2 Is the sample representative of the population understudy?	Yes	Yes
	4.3 Are measurements appropriate (clear origin, or validity known, or standard instrument)?		
	4.4 Is there an acceptable response rate (60% or above)?		
5. Mixed methods	5.1 Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?	Yes	Yes
	5.2 Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?	Yes	Yes
	5.3 Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?	Yes	Yes

MMAT Criteria (Pluye et al. 2011)

2.1. Summary of reviewed literature in Nigeria

ID	Authors & years	Purpose
1.	Obisesan *et al.* 1999	To examine childhood sexuality and CSA in southwest Nigeria
2.	Ogunyemi 2000	To assess the current knowledge, awareness, beliefs, and practices related to CSA
3.	Ajuwon *et al.* 2001	To explore the magnitude and patterns of sexual coercion experienced by adolescents
4.	Audu *et al.* 2009	To determine the relationship between child labor and sexual assault among girls
5.	Bankole *et al.* 2008	To assess the knowledge and attitudes of Nigerian dentists towards child abuse
6.	Ikechebelu *et al.* 2008	To examine the impact of sexual abuse on juvenile street hawkers as well as the extent of the problem
7	Oteh *et al.* 2009	To explore the impact of child abuse on economic development.
8.	Aderinto 2010	To provide an analysis of the scope and determinants of CSA in Nigeria.
9.	Abdulkadir *et al.* 2011	To assess the pattern and the nature of sexual abuse
10.	Ige and Fawole 2011	To uncover the perceptions and practices of parents in an urban community regarding CSA
11	Adeleke *et al.* 2012	To review the patterns of sexual violence against women treated at the hospital over a 7-year period
12.	Ige and Fawole 2012	To evaluate the medical care provided to victims of Child Sexual Abuse (CSA)

13.	Olatunya *et al.* 2013	To review the pattern and medical care of victims of CSA in a tertiary hospital over a 39-month period.
14.	Aborisade and Vaughan 2014	To investigate the consequences of incidence of rape on the victims
15.	Akinlusi *et al.* 2014	To assessed characteristic of sexual abuse victims, circumstances of assault and offered treatment
16	Badejoko *et al.* 2014	To determine the burden, periodicity, presentation and management of SA in Ile-Ife, Nigeria
17.	Chinawa *et al.* 2014	To determine the prevalence, pattern, socioeconomic implication, and factors associated with child abuse among secondary school students
18.	Ashimi *et al.* 2015	To review reported cases in the facility, determine the prevalence and pattern of presentation.
19.	Manyike *et al.* 2015	To determine the socioeconomic determinant and pattern of child sexual abuse among adolescent attending secondary schools
20	Manyike *et al.* 2015	To determine the impact of sex education on child sexual abuse among secondary school adolescents.
21	Kunnuji and Esiet 2015	To uncover prevalence and predictors of sexual intercourse with persons below the age of consent (statutory rape) and outright sex without consent (rape) among out-of-school adolescents
22	Nwolisa *et al.* 2016	To document the socio-demographic features of these victims and the event characteristic of the rape act.
23	Aborisade *et al.* 2017	To examine the psychosocial and psychosexual histories of offenders and presented the accounts, excuses and apologies of child sexual offenders.
24	Nlewem and Amodu 2017	To investigate family characteristics and structure as determinants of sexual abuse among female secondary school students.

25	David *et al.* 2018	To determine population level data on the burden and pattern of child sexual abuse among adolescents in Southwestern Nigeria
26	Okeafor *et al.* 2018	To examine the association between exposure to childhood sexual abuse (CSA) and the occurrence of mental illness in adulthood in Nigeria.
27.	Olatosi *et al.* 2018	To determine the experience and knowledge of CAN among a group of Nigerian dental residents
28.	Oyekola and Agunbiade 2018	To investigates the prevalence of child sexual abuse and teacher-parents' involvement in its prevention and management
29.	Sodipo *et al.* 2018	To report the pattern and characteristics of sexual assault perpetrators and survivors
30.	Opekitan *et al.* 2019	To assess the level of awareness of social and legal structures among primary health-care workers
31	Uvere and Ajuwon 2021	To assess experiences of sexual abuse (SA) among Female and Adolescent Hawkers (FAHs) in selected markets in Ibadan, Nigeria

2.2. Summary of reviewed literature

ID	Authors & years	Design & Method of data collection	Setting and Geopolitical zone	Participants	Results & Conclusion	Limitation
1.	Obisesan *et al.* 1999	Quantitative Cross Sectional study Questionnaire Multi-stage sampling	7 Local Government Areas (LGAs) Oyo State Southwest Nigeria	4000 (2000 men and 2000 women) **Occupation:** Not mentioned **Age:** Adult	**Prevalence :** 2.1% About 5% of respondents aged 6-10 had unwanted sex. Boarding house students have 5 9 times the chance of being sexually abused compared to other students living with their parents. In contrast to expectations, boys are more likely to be abused sexually than girls (2.4%). **Conclusion:** More studies on CSA are needed in Nigeria	Memory recall and response bias Limited reliability and validity of data collection tool
2.	Ogunyemi 2000	Mixed method Interview Focused group Questionnaire Random sampling techniques	Ijebu Ode Community Ogun State, Southwest Nigeria	958 participants **Occupation**: Market leaders, Religion group leaders, School Principal, and Occupational leaders	**Prevalence** – Girls-38% Boys-28% Rape/date rape is the leading cause of sexual initiation followed by childhood marriage, boyfriend/girlfriend relationship and pornography CSA acts such as rape, date rape, and child prostitution were condemned by a significant percentage of respondents, but there is evidence of supporting gender stereotyping. The main reason for not reporting experience of CSA was social stigma	Response and Recall bias.

				Aged: Adult	**Conclusion:** Male and female perceptions of stereotypes differ, which has implications for CSA and sexual acts. There was a culture of secrecy surrounding sex issues. It is therefore important for girls to be empowered to feel comfortable disclosing their sexual experience	
3.	Ajuwon *et al.* 2001	Quantitative Questionnaire Random Sampling technique	Ibadan South-West Nigeria	1,025 **Occupation:** Adolescent students and Apprentices **Age:** 15 to 19 years	**Overall Prevalence**- 68% to 70% **Students:** 68% of female and 42% of male (total 68%) **Apprentices:** 70% of females and 40% of male had experienced at least one coercive sexual behaviour. Over 50% of girls have collected money or gifts for sex. Perpetrators are boyfriends and adult male. Among the most common types of sexual coercion experienced are unwanted sexual touch, verbal threats, unwanted kisses, and breast contact.	Limited reliability
4.	Audu *et al.* 2008	Quantitative Questionnaire Simple random sampling	Maiduguri Nigeria	316 girls **Occupation**: Salesgirls **Age:** 8 to 19	**Prevalence:** 77.7% The perpetrators are male customers who purchase goods from girls. Sexual assault was more likely to occur in girls under 12 who were not in formal education, working over eight hours a day, and working two or more jobs simultaneously	Limited reliability

5.	Bankole *et al.* 2008	Quantitative Questionnaire Random Sampling	UCH, Ibadan, Nigeria. Southwest	175 participants **Occupation**: Dentists **Age:** Adult	While 39.4% of dentists suspected child abuse, only 6.9% reported it to the authorities Most dentists cannot identify all forms of child abuse, are uncertain about the diagnosis, and are afraid to be sued	Memory bias
6.	Ikechebelu *et al.* 2008	Quantitative Descriptive survey Questionnaire Convenient Sample	Two urban settlements in Anambra State Southeast Nigeria	186 girls **Occupation:** Salesgirls **Age:** 7 to 16	**Prevalence:** 7 in 10 female (69.9%) 17.2% had actual penetration. 75% did not disclose, 25% disclosed to family members and friends, and only one case was reported to the police.	Small sample Limited generalisation
7	Oteh *et al.*2009	Qualitative Interview Purposive sampling	Ezza community Ebonyi state. Southeast Nigeria.	60 participants Fifty children (50) and ten (10) parents	Majority of the parents claimed they subjected their children to abuse because of economic burden. Child exploitation prevents their educational career (35%), reduces their future capacity (40%), and their future contribution to economic development (20%).	Small sample size Limited generality
8.	Aderinto 2010	Qualitative Focus Group Discussions Interviews	Ibadan Southwest Nigeria	Adolescents girls **Age:** 18 to 20 years	**Causes:** Child labor is a common cause of CSA. In most cases, victims disclose to friends and sisters**.** Police rarely receive reports of sexual abuse cases from victims	Limited generality

		Convenient sampling		Communities and religious leaders **Age:** Adults	In some other cases, perpetrators either married the victims or disappeared. **Suggestion:** The government should outlaw early marriages, child labor, street trading, and children dropping out of school.	
9.	Abdulkadir *et al.* 2011	Quantitative Retrospective study of cases	General Out-patient Department, General hospital Minna. North Central Nigeria.	32 cases of penile penetration	90.1% of cases reported are children under 17 years. 75% were aged 6 to 15 years. Only two boy's cases are seen out of 32 cases. 9 in every 10 cases reported are children, aged 6 to 15. **Form of abuse reported**: vaginal penile and anal penetration. There was only a 24 hour interval between the incident and hospital presentation in four cases, and a 72 hour interval in 21 cases **Conclusion**: Urgent need to build the capacity of health care providers to ensure appropriate management of child sexual abuse and its long-term consequence	Small sample size
10.	Ige and Fawole 2011	Quantitative Questionnaire	Idikan Ibadan Southwest Nigeria	387 parents and caregivers of under 15 children **Occupation:** Petty Traders And Artisans	All have good knowledge of CSA; >90% discusses with children about stranger danger. 47% felt their children could not be abused, and over a quarter (27.1%) often left their children unsupervised	Limited generalisation

				Age: Adult	Recognizing genital or anal injuries and child's abnormal interest in sexual activity are the most popular way parent identify CSA. In the case of CSA, 64.6% preferred to report to the police, 46% preferred to take the victim for examination.	
11	Adeleke *et al*. 2012	Quantitative study Retrospective study descriptive statistics and Chi squire test.	State hospital, Asubiaro, Osogbo, Nigeria	Hospital records of victims	Most (73.7%) were less than 18 years while 93.2% were single (never married). About 81% of the victims less than 18 years were sexually abused in the daytime. Majority (79.6%) knew their assailant. About 40% of the victims presented within 24 h of sexual abuse but none had postexposure prophylaxis. Sexual assault among women is an important health problem in this environment. There is need for hospital based management protocol	Limited generalisation
12.	Ige and Fawole 2012	Quantitative Retrospective cross sectional study. (June 2008-May 2009)	University College Hospital Ibadan Southwest Nigeria	Age: 3 to 17 years	Cases were reported between one hour and 30days. About three quarters of patients in this study had investigations for sexually transmitted infections Antibiotics were only prescribed for 34% of the victim, follow by analgesic, vitamin, only negligible victim were refer to counseling and receive contraceptive. **Conclusion:** Huge gap exists between the health care needs of victims of CSA and the medical services provided for victims of CSA in Nigeria.	Limited generalisation Clinical sample

13.	Olatunya *et al.* 2013	Quantitative Retrospective, descriptive study	Pediatric out-patient department Ekiti State University Teaching Hospital Southwest	28 cases of CSA **Occupation:** Not mentioned **Age**: 4 to 17 years	**Perpetrator:** Adult male. **Management:** 60.7% were screened for hepatitis B and C and HIV None was given prophylaxis against viral hepatitis B and C. The police were involved in 60.7% of cases but there was no prosecution.	Clinical and small sample.
14.	Aborisade and Vaughan 2014	Qualitative study Interview Convenient Sampling	Tai Solarin University of Education	27 Participants 23 rape victims and four key informants	Prevalence: Over 50% experienced stranger and gang rape. Only three out of 23 received family support after rape. 60.87% were subjected to secondary victimisation by their parents, medical personnel, families, neighbours and other significant others. Only two out of 23 can be said they have fully adjusted. None of the victims seek legal action and only one underwent comprehensive medical and psychological care. **Consequence:** psychological problem (suicide attempts, depression, post-traumatic stress disorder, and emotional (fear and anxiety) and behavioral difficulties	Response bias
15	Akinlusi *et al.* 2014	Retrospective study Epi-info 3.5 statistical software	Lagos State University Teaching Hospital, Ikeja, between January 2008	304 case notes reviewed	304 were alleged sexual only 287 case notes had sufficient information for statistical analysis. 83.6% of the victims were under 19 years old, 73.1% knew their attackers (mostly neighbors), most assaults (54.6%) occurred in neighbours' homes, and over 60% presented within 24 hours of the assault.	Clinical sample

			and December 2012.		Threat and physical violence were mostly used to overcome victims. There was one positive HIV test at onset in 73.6% of cases. Post Exposure Prophylaxis for HIV was given in 29.4% of those eligible and emergency contraception in 22.4% of post-menarche victims. No forensic specimen collected nor referrals for psychotherapy. No record of post-assault conception or HIV infection was found during follow-up. The most vulnerable group is adolescents, who require life skills training to protect themselves. Survivors delay in presenting for care. Public awareness of the benefits of early intervention and comprehensive care is therefore necessary	
16	Badejoko *et al.* 2014	Quantitative study Retrospective analysis- 5years (2007-2011)	Obafemi Awolowo University Teaching Hospitals complex (OAUTHC), Ile-Ife	Hospital records of 76 SA survivors managed	Majority (62%) of the victims knew their assailant(s), neighbours were the commonest perpetrators and the assailants' house was the commonest location. Perpetrator used weapon in 29.6% out of the of the reported cases, Weapons were involved in 29.6% of cases and various injuries were identified in 28.2% of the survivors. Approximately 76 of cases were presented in the hospital within 24 hours of their experience, however, rape kit examinations were not performed as the kits were not available. Although appropriate medical management was routinely commenced, only 12.7% of victims came to follow-up visits.	Clinical sample

					It was concluded that personnel training, protocol development, provision of rape kits and free treatment of SA survivors are, therefore, recommended. Public enlightenment on preventive strategies based on the observed periodicity and age patterns is also suggested.	
17.	Chinawa *et al.* 2014	Quantitative, Questionnaire Systemic Sampling	Private Secondary school setting Enugu Metropolis Southeast Nigeria	372 Teenagers 192 females and 180 males.	77.2 % of participants belongs to upper social class **Prevalence** -10.2% 81.6% of which were females. 42.1% experienced unwanted sexual intercourse. 44.8 % were emotional abuse while 16.8 were physically abused. Medical personnel need a high index of suspicions. Education to create awareness To curb this menace, there is a need for zero tolerance legislation.	Limited reliability and validity
18	Ashimi *et al.* 2015	prospective longitudinal study -2 years	Gynecological Emergency Unit of a Tertiary Health Facility in a rural setting Northwest Nigeria. Jigawa State	24 case notes of children under 16	**Prevalence** Three percent (24/973) for sexual violence. 91.7% of case notes belong to children under 16. 45.8% (11/24) had no formal education while 33.3% (8/24) hawked homemade drinks and snacks.	Limited reliability and validity Small sample

					The assailants were known in 83.3% (20/24) of the cases. They were neighbours, customers and family members. The prevalence of reported sexual violence in this facility was low with the majority of the survivors being children and nonstranger assailants mostly neighbors	
19.	Manyike *et al.* 2015	Quantitative study Questionnaires Simple random sampling	Three secondary school, Enugu and Ebonyi state Southeast, Nigeria.	506 Participants **Age:** 10 to 24 years	**Prevalence**: Overall prevalence and one time prevalent is 40% and 11.5% respectively and almost half had lost count of pattern. Females were four times more likely to report sexual abuse than males. It is also noted that 1 in 4 girls (25%) are sexually abused by the age of 18. **Commonest form of abuse reported:** Pornographic pictures, films, videotapes or magazine. Perpetrators exposing genitals and masturbating, and coerced into full sexual intercourse ; vaginal or anal penetration	Limited reliability and validity
20	Manyike *et al.* 2015	Quantitative Cross-sectional study Simple random Sampling	Three secondary schools in Enugu and Ebonyi state. Southeast Nigeria.	506 adolescents **Occupation:** Secondary school students. **Age: 10 to 24 years**	80 percent were educated by parents, majority by mother only (46.2%) and both parents (45.2%). 72.1% were not informed that family member and friends can sexually abused them. 73.8% were not informed to report to adults if it happens to them. Adolescents educated by parents were 1.23 times less likely to be abused compared to non-educated adolescents.	Limited reliability and validity Limited Generalisation

21	Kunnuji and Esiet 2015	Quantitative Questionnaires Convenient Sample	Iwaya Community, Lagos State, Southwest Nigeria	480 Adolescents girls **Occupation**: Out of school students	Prevalent rate- 18% experienced coerced sex Statutory rape: 45% There is a positive association between age and experience of statutory rape.	Limited Generalisation
22	Nwolisa *et al.* 2016	Case review Retrospective analysis of medical records	Mirabel Centre, Lagos State University Teaching Hospital (LASUTH), Ikeja Lagos State Southwest Nigeria	153 cases of sexual assault **Age:** under 18 victims **Occupation:** Not mentioned	148 out of 153 patients were victim of rape-96.7% There were 147 (99.3%) females and 1(0.7%) male. Sixty-one (41.2%) knew their assailant(s) while 85(57.4%) did not know. While 101(68.2%) victims had achieved menarche, 47(31.8%) had not. In the rape of 67.6% of victims, no weapons were used while in 27% a weapon of some sort was used.	Limited Generalisation Limited reliability and validity
23	Aborisade *et al.* 2017	Qualitative Interview Purposive sampling	Ikoyi Prison Kirikiri Medium and Maximum Prisons Ikoyi, Lagos state Southwest Nigeria	29 perpetrators of child under 15 currently in prison **Occupation**: Not mentioned **Age:** Adult	Majority of their victims are under 12years. Childhood sexual abusive experience is an indicator for abusive behaviour in adulthood. **Excuses:** (58.62%) stated “I did not know what I was doing” 13.79%- state of drunkenness 10.35 %- ignorance of the law of child age to give consent for sex.	Recall and response bias Limited Generalisation

					3.45%- attributed it spiritual machinations. 19 Offenders are aware and feel remorse for psychological trauma and social stigma that their victims while the remaining eight only feel remorse because of their prison condition and the impact it has on their family. Two offenders felt they are not guilty.	
24	Nlewem and Amodu 2017	Quantitative study Cross sectional study Questionnaires Four stage sampling method	Three secondary school Aba zone, Abia State Nigeria, Southeastern Nigeria	350 Student Female adolescent only **Occupation:** Students **Age: 13 to 17years**	Prevalence 42.5% rate among age 13 to 15; 48.5% rate among 16–17year. Female adolescents living with parent are two times less likely to be sexually abused, and female adolescents with separated or divorced parents are six times likely to be abused.	Limited generalisation Limited reliability and validity
25	David *et al.* 2018	Quantitative Questionnaire Multistage sampling technique	Mushin Community Lagos Southwest Nigeria	398 adolescents **Occupation:** Not specified **Age:** 10–19 years	The prevalence- 25.7% Penetrative abuse- 7.5%, Forced sex- 46.2% **Type of sexual abuse:** Kissing Touching private parts Show me their private parts Showing pornographic magazine/films Took pictures of me naked Sexual intercourse **Disclosure:** 61% did not 34.4% disclosed	Limited reliability and validity

					Reason for Non-Disclosure: Majority feel ashamed people would not believe and nothing would come of my telling	
26	Okeafor *et al.* 2018	Quantitative Case control study Systematic sampling	The mental health and the general out-patient clinics of the University of Port-Harcourt Teaching Hospital in Rivers State. South South Nigeria	304 participants Case-152 Control – 152 **Occupation**: Non- specified **Age:** 18 to 60years	**Prevalence:** 21.4% Statistically significant association between exposure to CSA and occurrence of mental illness in adulthood exist. (Pair-matched odds ratio = 3.25, 95% CI = [1.70, 6.21]). The association between CSA and mental illness was still significant (adjusted odds ratio = 3.11, 95% CI = [1.67, 5.82]) after controlling for family functionality.	Reliability and validity problems
27.	Olatosi *et al.* 2018	Quantitative Questionnaire Convenient Sampling	Lagos University Teaching Hospital, Idi-Araba, Lagos, Southwest Nigeria	179 respondents **Occupation:** Dentist **Age:** Adult	Physical, sexual and emotional abuse and neglect were majorly identified as bruises behind the ears, oral warts, poor self-esteem, and untreated rampant caries Seventy-four (46.5%) of the respondents did not evaluate children for abuse and only 12 (14.1%) of those who observed suspected cases reported to the social service	Limited generalisation
28.	Oyekola and Agunbiade 2018	Mixed method Questionnaires Interview	Ile-Ife and Modakeke Southwest Nigeria	443 Adolescents **Occupation:** Student	**Prevalence: 59.8%** **Major Causes:** Low standard of living and sexual desire	Recall and response bias

				Age: 9 to 20. AND Ten teachers (with parenting roles)	Insecurity of children and lack of love, and care **Management:** Counselling, followed by Inform parents or friends. Majority prefer to keep to themselves. Parental involvement in the sexual issues affecting their children was negative. Consequently, child education, child security, and severe punishments to offenders would help prevent and manage this menace	
29	Sodipo *et al.* 2018	Case review	Mirabel Centre, Lagos State University Teaching Hospital (LASUTH), Ikeja Lagos State Southwest – A three-year review	2160 cases of rape	**Survivors:** female 97.7% Male: 2.3% **Perpetrator**: The majority of the perpetrators were known to the survivors with 10.3% being family members. **Common form of abuse:** Defilement (71.6%) Rape (20.3%) being the The majority of the referrals to the center were from the police (76.7%), while self-referrals made up 8% of referrals.	Secondary data Reliability and validity problem
30.	Opekitan *et al.* 2019	Quantitative cross-sectional survey Questionnaire	Twenty selected health facilities in Ogun state. Southwest Nigeria	86 respondents Occupation : Health workers	68.4% of medical officers, 54.5% of nurses, and 66.7% of other health workers did not know about any social infrastructure or hospital protocol for reporting child abuse. There is a need for deliberate training among health workers on social infrastructure, which can help victims of child abuse.	Small sample Limited generalisation

		Purposive sampling				
31	Uvere and Ajuwon 2021	Quantitative Cross-sectional study Interviewer administered questionnaire Descriptive statistics, chi-square and logistic regression	Selected market in Ibadan	410 participants Female Adolescent hawker (FAHs)	The majority (69.0%) of female adolescent hawking had experienced at least a form of SA, of which 68.3% occurred 3 months preceding the study. Male customers, traders and peers were perpetrators of the act. About 67.5% of victims of SA did not seek help. Sexual abuse is a major problem among FAHs. Age-appropriate sexuality education and life-building skills interventions should be targeted at FAHs while advocacy is recommended for caregivers and market stakeholders	Recall and response bias

Appendix 3

3.1. Ethical approval from the university

The University Of Sheffield.

Downloaded: 22/07/2020
Approved: 22/07/2020

Monlnuola Ifayoml
Reglstratlon number: 180286665
School of Nursing and Mldwlfery
Programme: PhD In Nursing and Mldwlfery

Dear Monlnuola

PROJECT TITLE: Issues and challenges facing healthcare professional in their roles of identifying and responding to victims of CSA In Nigeria.
APPLICATION: Reference Number 035065

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 22/07/2020 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 035065 (form submission date: 14/07/2020); (expected project end date: 15/02/2021).
- Participant Information sheet 1080317 version 4 (14/07/2020).
- Participant consent form 1080318 version 2 (10/07/2020).

If during the course of the project you need to deviate significantly from the above-approved documentation please inform me since written approval will be required.

Your responsibilities in delivering this research project are set out at the end of this letter.

Yours sincerely

Kate Chadwick
Ethics Administrator
Health Sciences School

Please note the following responsibilities of the researcher in delivering the research project:

- The project must abide by the University's Research Ethics Policy: https://www.sheffield.ac.uk/rs/ethicsandintegrity/ethicspolicy/approval-procedure
- The project must abide by the University's Good Research & Innovation Practices Policy: https://www.sheffield.ac.uk/polopoly_fs/1.671066!/file/GRIPPolicy.pdf
- The researcher must inform their supervisor (in the case of a student) or Ethics Administrator (in the case of a member of staff) of any significant changes to the project or the approved documentation.
- The researcher must comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data.
- The researcher is responsible for effectively managing the data collected both during and after the end of the project in line with best practice, and any relevant legislative, regulatory or contractual requirements.

3.2. Information sheet for participants

Research Project Title: Issues and Challenges Facing Healthcare Professionals when supporting Victim of Child Sexual Abuse in Nigeria

Invitation paragraph: You are being invited to take part in a research project. Before you decide whether or not to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the study?

This study aims to explore how healthcare professional (doctors, nurses, social workers, psychologists, and councillors) identify and responds to victims of child sexual abuse, and to identify and understand the issues and challenges they encounter in this process. It will also explore the implication of the challenges on practice and identify strategies for best practice.

Why have I been chosen?

You have been invited to take part because of your experience of working as a Healthcare Professional providing care and support to victims of child sexual abuse in Nigeria. Due to the job, you do, you are considered an expert and therefore your experience could contribute important knowledge in the development of policy to protect and safeguard children experiencing child sexual abuse.

Do I have to take part?

No. Participation is entirely voluntary. If you do decide to take part, you will be given a copy of information sheet and be asked to sign a consent form. You will be able to withdraw at any time until a week after your interview when data analysis has begun and your information is combined with that of other participants, without giving any reason and without any negative consequence. You are free to refuse to answer or omit any questions or some question if you do not feel comfortable.

What will happen to me if I take part? What do I have to do?

The research involves taking part in an individual face to face interview with myself, at your workplace or a place of your preference or an online interview. Before the interview I will invite you to ask any questions about the research or raise any concerns you might have. I will also ask you to sign a consent form to confirm that you understand the purpose of the research. For online interview, you are required to find a private place/space, where you feel safe, undisturbed and cannot be overhead. Interviews are expected to last for approximately one hour and fifteen minutes. In the interview, you will be asked about your professional experience and views on how you identify, support victim of child sexual abuse in Nigeria. I will also ask you to reflect

on the associated issues and challenges that you encounter within your practice and the associated impacts of this.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will inform practitioners and policy makers in making policies and procedures to protect and safeguard children.

What are the possible disadvantages and risk of taking part?

I do not see any risk or potential harm during participation in this research. However, there may be some questions that can make you reflect on personal experience or client's stories. The interview will be stopped if you show any sign of being distressed or if you ask for it. Your wishes will be respected in all circumstances and without question. You will be provided with a list of organisations that may be able to help. You may also be advised to contact your GP.

What if something goes wrong?

If you have any complaints about the project in the first instance you can contact my first supervisor. If you feel your complaint has not been handled to your satisfaction you can contact the Postgraduate Lead of Nursing and Midwifery Division, University of Sheffield's, to take your complaint further. Contact details are provided on this sheet.

Will my participation be confidential?

All information about you collected during the research will be kept strictly confidential and stored in accordance with the Data Protection Act, except you raise a safeguarding issue. Pseudonyms will be used, so these anonymous data cannot be identified by any individual or your institution. The only people who will access your information are my supervisors. Data collected will be shared in an anonymised form to allow reuse by the researcher and the university. For example, information provided can be used for academic purpose or may be published in peer reviewed journal. These anonymised data will not allow any individuals or their institutions to be identified or identifiable. All data, whether electronic or paper or in any other form will be destroyed after the completion of this research and when the final submission is published.

What happened if I raise safeguarding issue about myself or others?

If any of my participant raise concerns or any safeguarding issues. For instance, if a participant discloses that their daughter is being abused or they are being sexually abused at work or If a participant reveal that they are harming someone else. I will inform the designated safeguarding officer, and if I have further concern, the local safeguarding authority or police will be informed for further investigation.

What is the legal basis for processing my personal data?

As we will be collecting some data that is defined as personal (Name, Gender, Professional and Academic background), we also need to let you know that we are applying the following condition in law: that the use of your data is necessary for scientific research purposes.

Will I be recorded, and how will the recorded media be used?

Yes. So that I do not forget what you tell me. In light of the ongoing global pandemic of Covid-19, it is you will participate in online interview, which will be digitally recorded, and transcribed for data analysis, after obtaining your consent. In case of face to face interview, if possible, our interview will be recorded on voice recorder for transcribe after permission being gained from you. The audio recordings made during this research will be used only for analysis and for illustration in conference presentations and lectures. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings.

Who is organising and funding the research?

This is a self-funding research, independently funded by Moni.

What will happen to the results of the research?

The findings of this research will be presented in a short report and made available to you. A detailed report of the research will form part of a PhD thesis and results of the research will be published and may be published in a peer-reviewed- journal. You will not be identified in any report or publication, which will be available at the University of Sheffield's library.

Will there be payment?

Yes. You will receive reimbursement or payment of £10 for your transportation and refreshment and in case of online interview, as 'a thank you for your time'.

Who is the Data Controller?

The University of Sheffield will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly.

Who has ethically reviewed the research?

The University of Sheffield's Research Ethics Committee has approved the research.

Contact for further information:

Moninuola Ifayomi, PhD student, Division of Nursing and Midwifery, Health Sciences School, University of Sheffield, Barber House Annexe, 3a Clarkehouse Road, Sheffield, S10 2LA. UK. Cell Phone: 07305996223, email: maolorunfemi1@sheffield.ac.uk

For any complaints, contact:

Dr Parveen Azam Ali, Senior Lecturer & Lead Supervisor, University of Sheffield, UK. Email: parveen.ali@sheffield.ac.uk

If you need to take a complaint further contact:

Dr Sharron Hinchliff**,** PGR Lead for Division of Nursing and Midwifery University of Sheffield, UK. Email: s.hinchliff@sheffield.ac.uk

Thank you for taking time to read this information sheet and for taking part in this research.

3.3. Participant's demographics form

(Please kindly fill in as relevant)

Name:	Surname:	Forename:
Gender:		
Age:	Give in range, e.g 20-25	
Ethnicity:		
Marital Status:		
Employment:		
Profession	Doctors Nurse Social worker Psychologist/councilor (Delete as appropriate)	
Years of Experience		
Highest level of Education:		
Organization/institution you work for		

Thank you for your time

3.4. Final interview guide

Research Project Title: Issues and Challenges Facing Healthcare Professionals when supporting Victim of Child Sexual Abuse in Nigeria

Research Questions

Can you tell us about your background (professional, education)?

Why are you interested in this career/ discipline? In supporting sexually abused children or victim of gender-based violence

What is a typical day of work for you?

What do you enjoy most about your job?

1. **You as healthcare professional that specialises in CSA, can you discuss with us your understanding of child sexual abuse.**
   a. Can you explain, in your own words, what you would define as constituting CSA?
   b. Have you got a recent training that relates to CSA? Do you know the type of CSA? What are the possible signs of sexual abuse?
   c. What are the difficulties (if any) a child would have if they were to report that they were sexually abused?
   d. Children are social actor, who can express themselves, their views, report on and discuss their experience. Why are they not expressive with CSA experience?
   e. Has there ever been a situation in your working practice when you have felt that you were not able to help a child in the way that you wanted?
2. **How do you (HCP in Nigeria) identify and respond to victims of child sexual abuse?**
   a. Can you tell me a bit more about how you came to do your current job? Like step by step or process involve in supporting victims
   b. Can you tell us more about your day to day's activities at place of work?
   c. How do victims come into contact with your service? Do other professionals refer young people to you or do victim seek help for themselves?

   How do you or your organization identify victims?

   If cases are not referred or reported to them, how will HCPs identify the victim? Is there any available method of identifying?

   If victims seek support for themselves, what type of help do they seek? Most of your clients are children and young people, how do you think they contact your services? Are there challenges or barrier getting help?

d. What kind of cases have you had in the past and how have you responded to it? Do you encounter both male and female victims? Which would you say you see most regularly?
e. How do you feel about your contribution to identify and respond to victims of CSA?
f. Is there any national guideline available to support your practice, how has the guideline help you in previous practice?
g. How does the absent or presence of national framework help you in the past to support your victims or provide care?
h. What kind of organization have provided support in the past, in what way have they support you in identifying the victims and responding to their needs?

3. **What are the issues and challenges facing healthcare professionals as they recognize and response to victims of child sexual abuse? Main aims**
   a. What do you find most challenging regarding your practice?
   b. Drawing from day to day working experience, describe one or two situations where you face challenges caring for victims and how you have managed it- (prompt to explores any challenges mentioned)
   c. Do you experience challenges from the child's parents to report CSA.
   d. Can you think of any challenges from victims themselves or family or society?
   e. Why are victim not receiving justice in Nigeria?
   f. Do you think it is more challenging to recognise victims or to responds to victims? Which is more challenging for you and why?
   g. What are other things you think makes it difficult to identify or responds to victims' needs?
   h. What has helped you in the past to manage those difficult time and situation
4. **What are the implications of those challenges you have mentioned on your practice? Main aim**
   a. How do you think those challenges impact on your day to day professional practices/activities?
   b. Can you tell if those challenges have impact on victims and how? Family? society?
   c. What are the negative impacts of not obtaining justice for victim
   d. Do you think victims who are not supported can abuse other people?
5. **What are the real-world practices and strategies that health professionals adopt to safeguard victims of CSA- main aim**
   a. Can you share with us a time you have supported the victims very well, what have you done differently? what other factors contributed to the case success?
   b. Imagine your practice and working condition have improved in the future? What would be different? What will still be the same?
   c. Based on your experience, can you tell us ideas, type of training or ways to improve the experience of victims of CSA?

d. Are there any organization you would like to involve? And how important are they or why are they important?
e. In future, what will you do differently or what do you think you can do differently to improve victims experience?
f. Do you have anything you want to say about CSA that is not mentioned in this interview?
g. You as healthcare professional, do you think your understanding is different from society perception? In what ways? What are community belief on CSA? How does it challenge HCPs practice?
h. What do you think about this, if there are differences, can you tell us about what contributed to differences and the possible impacts?
i. Do you have any question for me?

3.5. Memo: HCPs understanding of CSA

Journal Entry: 12/12/2020- I wrote this journal while still in the process of conducting interview, transcribing, coding and revisiting transcripts of data

Assessing the HCPs understanding of CSA is an interesting and critical part of the interview process and it represent the initial strategic point of discovering the challenges healthcare professional are facing. While few of the participants show versatile understanding of this phenomenon; in terms of definition, forms of CSA, probable signs and warning signs, as well as the contributing factors to CSA, majority of the participants demonstrated limited understanding. A striking difference was observed between the SARCs staff and hospital-based staff. Most of the participants from SARCs have good knowledge of CSA, while hospital based served defined CSA only as contact form, further narrowing to rape, where there are obvious trauma and bruises and in which the perpetrator uses force, threats, or take advantage of victims not able to give consent.

In a particular instance, the HCP acknowledge that in developing country definition of CSA included non-contact forms, however he demonstrated that applying similar definition in Nigeria context means everyone is a perpetrator.

"that I define it in my work because that's how I used to define it, is an unwanted sexual activity which is… in which the perpetrator uses force, threats, or take advantage of victims not able to give consent. I know over there, it is defined variably, even touching without permission there is abuse, abi? But this is how I prefer to make it look something that is more of a penetration thing, but, of course, because you say in my own word. Because in this part of the world, if you say… if you define it like you people define it over there (developing countries), then everybody is a sexual abuser. Even by touching someone."

When further asked if non-contact form of CSA is not recognized in Nigeria, the response shows is not obviously recognized.

"*Mostly in this environment (Nigeria), when we say sexual abuse, is a penetrating sexual abuse, that's rape. That is the one we are more concerned about in this environment (Nigeria). And you just talk of other ones in the… in that even by looking, touching, looking and touching. But the one that we refer to really sexual abuse here is when there is forceful… contact or penetration or attempt to penetrate or molestation, that one is… is the one we are particular about."*

What does the above signifies? Was the participant talking about his understanding of CSA? Or the reality of what is happening in Nigeria society? Or a way of justifying his subconscious thought? Or was the response influenced by his gender and way women are perceived in the society? Or the reality of the context in which he practices?

To clarify and provide answer to these above questions, I decided to further explore further questions, specific to understanding of HCPs on CSA to develop this category

3.6. Consent Form

The University Of Sheffield.

Participant Consent Form

Title of Research Project: Issues and Challenges Facing Healthcare Professionals (HCPs) in their roles of identifying and responding to Victim of Child Sexual Abuse (CSA) in Nigeria

Please tick the appropriate boxes	**Yes**	**No**
Taking part in the project		
I have read and understand the information sheet dated …. /…../…. and the project has been fully explained to me. (If you will answer No to this question please do not proceed with this consent form until you are fully aware of what your participation in the project will mean.)	☐	☐
I have been given the opportunity to ask questions about the project and know who to contact if I have any compliant.	☐	☐
I agree to take part in the project. I understand that taking part in the project will include either a face to face or an online interview that will take approximately one hour fifteen minutes, which will be audio recorded. I understand that should I be invited to a subsequent interview or research activity; I have the right to decline further involvement.	☐	☐
I understand that my participation is voluntary and that I am free to withdraw within a week after completing my interview. I do not have to give any reasons for why I no longer want to take part and there will be no adverse consequences if I choose to withdraw.	☐	☐

I know all information will be confidential, except if I raise any safeguarding issue about myself or others, the researcher can inform a designated safeguarding lead, or the local safeguarding authority.	☐	☐
How my information will be used during and after the project		
I understand my personal details such as name, phone number, address and email address etc. will not be revealed to people outside the project.	☐	☐
I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs unless I specifically request this.	☐	☐
I understand and agree that other authorised researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.	☐	☐
I understand and agree that other authorised researchers may use my data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	☐	☐
I give permission for the anonymised and confidential transcript that are created from my interview to be deposited the University of Sheffield's library and at White Rose Research Online depository so it can be used for future research and learning.	☐	☐
So that the information you provide can be used legally by the researchers		
I agree to assign the copyright I hold in any materials generated as part of this project to The University of Sheffield.	☐	☐

_____ _____ _____

Name of Participant Date Signature

_____ _____ _____

Name of Researcher Date Signature

Copies

Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form and researcher will keep one in the research data file.

Contact for further information

Moninuola Ifayomi, PhD student, Division of Nursing and Midwifery, Health Sciences School, University of Sheffield, Barber House Annexe, 3a Clarkehouse Road, Sheffield, S10 2LA. UK. Cell Phone: 07305996223, email: maolorunfemi1@sheffield.ac.uk

Contact for making complaints

Dr Parveen Azam Ali, Senior Lecturer & Lead Supervisor, University of Sheffield, UK. Email: parveen.ali@sheffield.ac.uk

Dr Sharron Hinchliff, PGR Lead for Division of Nursing and Midwifery University of Sheffield, UK.Email: s.hinchliff@sheffield.ac.uk