Standards and Guidelines

for Medical Management of Victims of Violence in Akwa Ibom State, Nigeria

Ipas Partners for Reproductive Justice
NIGERIA HEALTH FOUNDATION

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Foreword

Violence against persons is defined as any act of gender-based violence that results in, or is likely to result in physical, sexual, or psychological harm or suffering to persons, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. It has been identified as the most pervasive human rights violation in the world.[1]

Violence against persons is a serious public health issue in Akwa Ibom state. Its true prevalence is difficult to determine because of so much secrecy and under-reporting. However, the 2013 National Demographic Health Survey (NDHS) puts the prevalence of violence against persons to be about 30% in women from 15yrs of age. In Akwa Ibom state, according to the United Nations Population Report, about 59% of women suffer domestic violence, giving a very high prevalence in the state.[2]

The Akwa Ibom State Violence against Persons (Prohibition) Law (VAPP) came into force in 2020 in the wake of the upsurge in sexual violence occasioned by the outbreak of the COVID-19 pandemic.

This led to a strong commitment by the Government of Akwa Ibom State to put an end to violence against persons in every facet of life. It is in pursuance of this commitment that the Violence against Persons (Prohibition) Law 2020 was enacted to set a standard in controlling and putting an end to all manner of violence against persons in the state. This violence includes, but is not limited to, sexual and psychological assault; rape; female genital mutilation and other harmful traditional practices; attack with harmful substance, spousal battery and forceful ejection from home.

Between January and November 2023, Akwa Ibom State recorded 321 cases of gender-based violence together with 120 rape cases. Out of the 321 cases, 170 cases were intimate partner violence, most of which led to physical injury on the victims (Kristina reports, 2023). The state has taken steps to address this issue.

The Akwa Ibom State Gender Based Violence Management Committee reported 53 convictions in 2024, facilitated by the VAPP Law and the establishment of a Sexual and Gender Based Violence Response Department in the Ministry of Justice (Business Day, Jan. 2024).

This worrisome statistic has made the Government and the people and of Akwa Ibom State to be determined more than ever, through the VAPP law to make perpetrators accountable for their actions and to provide care and support for victims and survivors of violence.

I, therefore, recommend the use of this document to ensure effective intervention if the war against violence is to be won in Akwa Ibom State.

Prof. Augustine Vincent Umoh
Honorable Commissioner of Health, Akwa Ibom State

May 2024

Acknowledgement

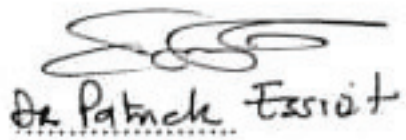
The Akwa Ibom State Ministry of Health acknowledges all the numerous stakeholders who have made invaluable contributions to the development of the Standards and Guidelines for the Medical Management of Victims of Violence in the State following the Akwa Ibom State Violence against Persons Prohibition (VAPP) Law 2020.

Worthy of note is the immense collaboration and support from Ipas led by the Country Director, Mr. Lucky Palmer. Our appreciation goes to the technical committee that sat for days to review these Standards and Guidelines to conform with the Akwa Ibom State VAPP Law, which has resulted to this document. This process was facilitated by Mr. Samsu Gombwer, of Ipas Nigeria Foundation, Professors Raphael Avidime Attah , and Patrick Haruna Daru, of the Aminu Kano Teaching Hospital, Kano and Jos University Teaching Hospital, Jos, respectively.

Our gratitude to the Ministries of Health, Education, Justice, Women Affairs and Social Welfare, Akwa State Primary Health Care Development Agency, Nigeria Police Force, Nigerian Security and Civil Defence Corps, National Human Rights Commission, Coalition of NGOs, CSOs, Joint National Association of Persons with Disabilities (JONAPWDs), Society of Gynaecology and Obstetrics of Nigeria(SOGON), Medical Women's Association of Nigeria (MWAN) AKS Branch, Akwa Ibom State Gender Based Violence Management Committee and other professional associations, who have shown commitment to the actualization of the desire of the Akwa Ibom State government to provide care and succour to victims and survivors of violence by developing this document.

The role played by the Akwa Ibom State House of Assembly in enacting the VAPP Law in 2020 cannot be overemphasized, as this action has led to the timely development of this document.

We deeply appreciate His Excellency, Pastor Umo Eno, the Executive Governor of Akwa Ibom State, for committing to the full implementation of the VAPP Law, 2020, which is the foundation of this document.



Dr Patrick Essiet
The Permanent Secretary,
Akwa Ibom State Ministry of Health, June, 2024

Abbreviations

AZT	Zidovudine
CBOs	Community Based Organisations
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHEW	Community Health Extension Worker
CHO	Community Health Officer
CLO	Civil Liberties Organisation
CNS	Central Nervous System
CVS	Cardiovascular System
DEVAW	Declaration on the Elimination of All forms of Violence Against Women
DFSA	Drug Facilitated Sexual Assaults
DNA	Deoxyribonucleic Acid
D & E	Dilatation and Evacuation
EEKs	Early Evidence Kits
EUC	Electrolyte, urea and creatinine
FBC	Full Blood Count
FBOs	Faith Based Organisations
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FIDA	International Federation of Women Lawyers
FLE	Family Life Education
FMOH	Federal Ministry of Health
FMWASD	Federal Ministry of Women Affairs and Social Development
HBeAg	Hepatitis B envelop Antigen
HBIG	Hepatitis B Immunoglobulin
HIV/AIDS	Human Immune Deficiency Virus/ Acquired Immunodeficiency Syndrome
HPV	Human Papilloma Virus
IEC	Information, Education and Communication
IDP	Internally Displaced Person
IUD	Intrauterine Device
IUCD	Intrauterine Contraceptive Device
LAC	Legal Aid Council
LACVAW	Legislative Advocacy Coalition on Violence Against Women
MWAN	Medical Women Association of Nigeria
MVA	Manual Vacuum Aspiration

NAAT	Nucleic Acid Amplification Technique
NACA	National Action Committee on AIDS
NAPTIP	National Agency for the Prohibition of Trafficking in Persons
NDHS	National Demographic and Health Survey
NGOs	Non-Governmental Organisations
NHIS	National Health Insurance Scheme
NHRC	National Human Rights Commission
NRTI	Nucleoside Reverse Transcriptase Inhibitors
NSAIDs	Non-Steroidal Anti Inflammatory Drugs
PEP	Post Exposure Prophylaxis
PI	Protease inhibitor
PO	Per Oris
PR	Per Rectum
PRN	Pro re nata
RH	Reproductive Health
SARC	Sexual Assault Referral Centre
SGBV	Sexual and Gender Based Violence
SHMB	State Hospitals' Management Board
SMoH	State Ministry of Health
SMoJ	State Ministry of JusitceSMWASI – State Ministry of Women Affairs and Social Inclusion
SPHCB	State Primary Health Care Board
SOGON	Society of Gynaecology and Obstetrics of Nigeria
STIs	Sexually Transmitted Infections
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Programme
UTI	Urinary Tract Infection
VAPP	Violence Against Persons (Prohibition)
VDRL	Venereal Disease Research Laboratory
VVF	Vesico-Vaginal Festibula
WACOL	Women's Aid Collective
WHO	World Health Organisation
WRAPA	Women's Rights Advancement and Protection Alternatives
3TC	Lamivudine

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Document Preparation Process and Review

The Violence Against Persons Prohibition Act – VAPP Act enacted in 2015 – is a bold move by the government to redefine the way gender-based violence is handled in Nigeria. First introduced to the National Assembly in 2002, several years of advocacy and lobbying by partners and stakeholders under the auspices of the Legislative Advocacy Coalition on Violence Against Women led to the passage of the Act by the National Assembly and the eventual assent by the President, Dr Goodluck Ebele Jonathan, on 25th May 2015.

In June 2015, the Federal Ministry of Health, with support from Ipas, held a stakeholder meeting in Abuja to strategize on the way forward regarding the operationalization of the health-related provisions of the Act. One major consensus at that meeting was the need for the development of Standards and Guidelines (S&G) to operationalize health aspects of the VAPP Act. A major outcome of that meeting was the nomination of the technical committee to implement the agreed next steps.

On 1st March 2016, the Honorable Minister of State for Health, Dr Osagie Ehanire inaugurated the technical committee with the GASHE division of the Federal Ministry of Health as secretariat and mandated the body with specific terms of reference for the implementation of the Health Sector component of the VAPP Act. The inauguration marked a major milestone in the process of achieving the goal of the Act.

The committee members unanimously agreed that a consultant conversant with the subject matter (VAPP Act) be engaged to study the terms of reference and develop a zero draft of the Standards and Guidelines; this development led to the engagement of Dr Dah Talemoh as the consultant who worked with the committee to develop the standards and guidelines.

Having gone through a series of work by the technical committee, the draft document titled “Standards and Guidelines for the Management of Victims of Violence in Nigeria” was eventually developed and subjected to a national stakeholders’ validation in a two-day meeting held in February 2017 - the valuable inputs from that stakeholder’s meeting led to the development of this final document.

However, the adaptation process of this document for Akwa Ibom state was supported by Ipas Nigeria Health Foundation, with the engagement of two consultants. The process involved 5 stages:

First Stage – Entry into Akwa Ibom State Ministry of Health and mobilization of relevant stakeholders for sensitization and initial adaptation of the document

Second Stage – Adaptation workshop involving the mobilized stakeholders from relevant ministries and agencies, which took place in a 2-day workshop in Akwa Ibom State on 7th-8th of May 2024.

Third Stage – Validation meeting for the adapted document held on 31st of May 2024.

Fourth Stage – Launching of the new Akwa Ibom State VAPP Protocol.

Fifth Stage – Technical workshop to train medical personnel on the use of the Standards and Guidelines.

1.0 Violence Against Persons in Akwa Ibom

Violence affects people of different demographic groups, including premenarcheal girls, prepubertal boys, young women and men, older women and men, and persons with disabilities. However, the majority of victims are females and the majority of perpetrators are males[1-3].

The majority of assaults occur in the daytime and by persons known to the victims[4]. Presentation is mostly late, after 24 hours[5] and even when the victims present, functional care is lacking. Sexual assault can happen anywhere, including victims' homes, neighbours' houses, schools, workplaces, abandoned buildings, health facilities, police stations, prisons, places of worship etc.

1.1 Background/Magnitude of the Problem

According to the 2013 National Demographic and Health Survey (NDHS), violence against women is common, experienced by nearly 3 in 10 women from age 15[6]. A situational analysis conducted by civil societies across Africa in 2010[7] reported that 18.3% of women in Nigeria reported that they had experienced intimate partner physical/sexual violence in their lifetime. When combined with non-intimate partner physical/sexual violence, it is 29.5%.

Domestic violence ranked among the top four most common types of crime and forms the largest category of complaints received by the National Human Rights Commission (NHRC)10. Child abuse constitutes the majority, variously reported as 95%9 and 94%[8]. About 47% of female child labourers have been sexually assaulted[11]. The 2013 NDHS report states that 28% of women of reproductive age in Nigeria reported physical violence, while 7% reported having experienced sexual violence at least once in their lifetime. 25% of ever-married women in the same age group (15–49 years) have experienced emotional, physical or sexual violence from their spouses.

Sexual violence may appear only as a craving for sex but it is also an aggression, a medium to express other feelings (anger, hate, inadequacy, frustration, etc.)[12]. The prevalence is reported to be increasing[12], although there is non-disclosure by victims or their parents and guardians due to stigma/shame, lack of appropriate services or confidence in them (both medical and legal) and fear of repercussions, hence, making documented prevalence underestimated[13]. The graphic and horrific abduction and incarceration of women by insurgents in the northeast is yet to be fully documented but adds to the rising prevalence.

Some cultural/traditional practices and some provisions under the Nigerian law tend to condone gender-based violence. Female genital mutilation, forced marriages and widowhood practices are still prevalent[14]. Domestic violence is considered culturally acceptable in most parts of Nigeria15. Some Nigerian legislations tacitly support wife battering (section 55 of the penal code as applicable in Northern Nigeria) and do not recognize rape within marriage (section 6 of the criminal code as applicable in Southern Nigeria). Sections 353 and 360 of the Criminal Code 1990, however, made some attempts to give some legal protection, albeit in a discriminatory manner, with assault to a male seen as a felony and assault to a female seen as a misdemeanour.

Section 353 says ''Any person who unlawfully and indecently assaults any male person is guilty of a felony and is liable to imprisonment for three years. The offender cannot be arrested without a warrant.'' Section 360 says '' Any person who unlawfully and indecently assaults a woman or girl is guilty of a misdemeanour and is liable to imprisonment for two years; however, efforts to address the problem have been ongoing.

Several laws passed by some state legislatures in recent times are aimed at protecting vulnerable persons, including women, children and persons with disability; these include Anambra and Ekiti state (Malpractices Against Widows and Widowers (Prohibition) Law 2005) Ebonyi, Edo (Inhuman Treatment of Widows (Prohibition) Law, 2004) Ekiti, Cross River (Law Number 10 of 2004 to Prohibit Domestic Violence Against Women and Maltreatment), Jigawa, and Lagos Rivers state (Abolition of Female Circumcision Law number 2 of 2001, Dehumanizing and Harmful Traditional Practices Law number 2 of 2003).

In addition, advocacy efforts of several non-governmental organizations (NGOs) are yielding fruit, evident from newspaper articles, discussions on radio and, recently, the signing into law of the Violence Against Persons Prohibition (VAPP) Act. These laws are strengthened by the support of the Federal Ministry of Women Affairs and Social Development (FMWASD), which has produced the National Guidelines and Referral Standards on Gender-Based Violence and, the National Plan of Action for Addressing Gender-Based Violence and HIV/AIDS Intersection, 2014-201616 in collaboration with the United Nations Program on HIV/AIDS (UNAIDS), National Action Committee on AIDS (NACA) and the United Nations Development Program (UNDP). In 2008, the World Health Organization (WHO) and the Federal Ministry of Health (FMOH) jointly produced the National Guidelines and Intervention Strategies on Gender-Based Violence[17].

The Nigeria Police has a Force Gender Unit headed by the Force Gender Advisor. It was established to address cases of violence against women and children. This unit is tasked with establishing a gender desk in all Police formations and to work to include gender

training in Nigeria Police curricula at all levels18. In Akwa Ibom State, the Police state command has a gender unit at the CID Ikot Akpan Abia; this unit has a gender sub-unit in all divisions in the various LGAs in the state.

Legal aid is provided by the government's Legal Aid Council (LAC), National Human Rights Commission (NHRC), National Agency for the Prohibition of Trafficking in Persons (NAPTIP), and civil society groups such as International Federation of Women Lawyers (FIDA), Women's Rights Advancement and Protection Alternatives (WRAPA), Women's Aid Collective (WACOL), and Civil Liberties Organisation (CLO), among others. Sadly, these services are inadequate and poorly utilized because of poor income and inadequate information.

Furthermore, only a few shelters and support services are available in the country. The FMWASD runs shelters in some cities (e.g., the Kurudu Centre for Women Victims of Domestic Violence in Abuja. In Akwa Ibom State, there are Shelters for GBV survivors at Atan Offot, Uyo, Shelter Afrique Uyo, Ikot Ekpene; all managed by the State Government).

Private efforts are available, like FIDA shelter in Ikot Ekpene, the Mirabel and Tamar Sexual Assault Referral Centre in Lagos and Enugu respectively, as well as some efforts by first ladies of a few states. Also, Akwa Ibom State has sexual assault centres located at Ikot Ekpene General Hospital, Immanuel Hospital in Eket and the Heartland Alliance Centre in Osong Ama in Uyo etc.

Knowledge about the management of sexual assault is limited and the institutional capacity is mostly lacking. Sexual assault and its management are scanty or lacking in most curricula of training institutions such as medical schools, nursing and midwifery schools and schools of health technology.

2.0 Justification

In Nigeria, violence is perpetrated against persons for different reasons. It is in recognition of this that the Violence Against Persons Prohibition Law – VAPP Law[19] – was enacted. This law is a milestone in curbing violence against persons – women, children, girls, boys, elderly, persons with disability, branding of child witchcraft etc. Adherence to harmful traditional practices, such as the humiliation of widows[14] and Female Genital Mutilation/Cutting (FGMC), contributes to moral decay and leads to various forms of violence, including sexual assault and domestic abuse. Additionally, impunity can result in brutality by military and paramilitary personnel, and ritualistic practices perpetuate different kinds of violence.

The signing into law of the Violence Against Persons Prohibition Law 2020, is the major step needed to curb violence against persons. Such a legal framework will punish offenders and serve as a deterrence to intending offenders while strengthening advocacy for children, women and human rights. Specifically, the law aims to "eliminate violence in private and public life, prohibit all forms of violence against persons and provide maximum and effective remedies for survivors and punishment of offenders and related matters connected therewith."[22]

In Akwa Ibom State, most incidences of rape and other sexual-based violence were not successfully prosecuted due to insufficient medical evidence necessary to secure convictions. Most healthcare service providers exhibit an inability or low capacity to document clear and concise medical reports especially compounded by late presentation by victims. There is a need for a guideline to educate and empower them.

3.0 Offences Under the Law

Violence Against Persons Offences under the Act are listed in the box below:

- Rape
- Inflicting physical injury on a person
- Wilfully placing a person in fear of physical injury
- Coercion: compulsion of a person, by force or threat, to engage in any conduct or act, sexual or otherwise, to the detriment of the victim's physical or psychological wellbeing
- Female Genital Mutilation (FGM)
- Frustrating an investigation
- Wilfully making false statements
- Offensive conduct
- Forceful ejection from home
- Depriving a person of his/her liberty
- Damage to property with intent to cause distress
- Forced financial dependence or economic abuse
- Forced isolation or separation from family and friends
- Emotional, verbal and psychological abuse
- Harmful widowhood practices
- Abandonment of spouse, children or other dependents without sustenance
- Stalking
- Intimidation
- Spousal battery
- Harmful traditional practices
- Attack with harmful substance
- Administering a substance with intent to stupefy or overpower
- Political violence
- Violence by state actors
- Incest
- Indecent exposure

The reproductive health components of violence (female genital cutting, sexual assault, incest, rape, etc.), which are probably the crux of the matter, have deeper and longer-lasting medical and psychological implications for survivors and need deliberate and clear guidelines to manage them. These Standards and Guidelines were prepared for the operationalization of these health-related provisions of the VAPP Law.

4.0 The Standards and Guidelines

4.1 Reasons for Standards and Guidelines

Specifically, the Standards and Guidelines are meant to:

a.) Help healthcare providers at all levels to incorporate messages/information about the prevention and management of gender and other forms of violence in all communications to stakeholders and the communities.

b.) Provide healthcare providers with the capacity to manage survivors of gender and other forms of violence including female genital mutilation, harmful widowhood practices and its consequences.

c.) Set standards for the medical management of survivors of gender and other forms of violence, including female genital mutilation and harmful widowhood practices.

d.) Guide healthcare policymakers and managers on how to incorporate gender and other forms of violence when making policies, budgeting, training requirements and equipping facilities.

4.2 Commitments and National/Policy Framework

4.2.1 Global Commitments

a.) UN Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) 1979

b.) UN Convention of the Rights of the Child 1989

c.) UN Declaration on Elimination of Violence Against Women (DEVAW) 1993

d.) UN Disability Convention 2006

e.) Protocol to Prevent, Suppress and Punish Trafficking in Persons especially Women and Children, Supplementing the United Nations Convention Against Transnational Organized Crime (the Palermo Protocol)

f.) ILO Convention 182 on the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour

g.) African Charter on the Rights and Welfare of the Child 1990

h.) Beijing Platform for Action 1995

i.) Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, 2003

j.) AU Solemn Declaration on Gender Equality 2004

4.2.2 National Legal/Policy Framework

a.) Constitution of the Federal Republic of Nigeria (1999) as amended

b.) National Gender Policy (2006)

c.) National Health Act (2014)

d.) National Policy on FGM (2014)

e.) National Health Policy, 2016

f.) Violence Against Persons Prohibition Act 2015 (as adopted in Akwa Ibom State as VAPP Law 2020)

5.0 Definition/Types of Violence Against Persons

5.1 What is Violence Against Women?

Any act of sexual assault that results in or is likely to result in physical, sexual or mental harm or suffering to women including threats of such acts, coercion or arbitrary deprivation of liberty whether occurring in public or private life[22].

Violence against women shall be understood to encompass, but not be limited to the following:

a.) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation.

b.) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation (at work, in educational institutions and elsewhere), trafficking in women and forced prostitution;

c.) Physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs. Acts of violence against women also include forced sterilization and forced abortion, forced use of contraceptives, female infanticide and prenatal sex selection[21].

5.2 What are Some of the Types of Violence Against Persons?

5.2.1 Rape

When a person intentionally penetrates the vagina, anus or mouth of another person with any other part of his or her body or anything else and the other person does not consent to the penetration or the consent is obtained by force or using intimidation of any kind or by fear of harm or through false and fraudulent representation as to the nature of the act or the use of any substance or addictive capable of taking away the will of such person.[21]

5.2.2 Statutory Rape

Consensual sexual intercourse with an individual younger than the age of consent.

5.2.3 Date Rape

Forcible sexual intercourse by a male acquaintance of a woman, during a voluntary social engagement in which the woman did not intend to submit to the sexual advances and resisted the acts by verbal refusals, denials or pleas to stop, and/or physical resistance. The fact that the parties knew each other or that the woman willingly accompanied the man is not a legal defence to a charge of rape, although one Pennsylvania decision ruled that there had to be some actual physical resistance.[23]

5.2.4 Child Abuse

The employment, use, persuasion, inducement, enticement, or coercion of any child to engage in any sexually explicit conduct or simulation of such conduct to produce a visual depiction of such conduct; or the rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other forms of sexual exploitation of children, or incest with children.

5.2.5 Incest

Knowingly and wilfully having carnal knowledge of another person within the prohibited degree of consanguinity and affinity as contained in the Akwa Ibom State VAPP law 2020 with or without consent.

5.2.6 Spousal Battery

This form of domestic violence can manifest in various ways, including hitting, slapping, kicking, or other forms of physical aggression. Emotional abuse such as verbal insults, threats, and manipulation, often accompanies physical violence, further undermining the victim's self-esteem and sense of safety. Spousal battery can have severe and long-lasting effects on the victim's physical and mental health, leading to injuries, chronic pain, depression, anxiety, and post-traumatic stress disorder (PTSD).

5.2.7 Administration of Substance

Intentionally administering a substance to, or causing a substance to be administered to or taken by another person with the intention of stupefying or overpowering that person to enable any person to engage in sexual activity with that person; this may also be with intent to affect the outcome of a pregnancy.

5.2.8 Reproductive and Sexual Coercion

Behaviour intended to maintain power and control in a relationship related to reproductive health by someone who is/was or wishes to be involved in an intimate or dating relationship with an adult or adolescent; this includes birth control sabotage, pregnancy pressure and coercion, intentionally exposing a partner to STIs, etc.

5.2.9 Torture

Any act where severe physical or mental pain is intentionally caused to someone for purposes like getting information or a confession, punishing them for something they or someone else did or is suspected of doing, intimidating or forcing them or others, or discriminating against them. This is done by or with the approval of a public official or someone in an official position. It does not include pain or suffering that comes from legal sanctions[24].

5.2.10 Harmful Traditional Practices

Forms of violence which have been committed primarily against women and girls in certain communities and societies for so long that they are considered, or presented by perpetrators, as part of accepted cultural practice.[25]

5.2.11 Violence Against Women

Encompasses, but is not limited to, the following:

a) physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;

b) physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;

c) physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs. Acts of violence against women also include forced sterilization and forced abortion, coercive/forced use of contraceptives, female infanticide and prenatal sex selection.[26]

5.2.12 Harmful Widowhood Practices

Widowhood practices can be harmless or harmful. Harmful practices include shaving hair with a broken bottle, drinking the bath water of the corpse, and forceful wife inheritance as a property (against the woman's wish).

5.2.13 Female Genital Mutilation or Cutting (FGM or FGC) or Female Circumcision

All procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons.[27]

5.2.14 Gender-Based Violence

The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a likelihood of resulting in injury, death, psychological harm or deprivation.[27]

5.2.15 Reproductive Health and Sexual Violence

This is a term that encompasses harmful acts directed at a person's reproductive organs, reproductive processes, or sexual intimacy, through coercion, threats, or force. This can include a wide range of abuses, from denying someone access to reproductive healthcare to forced pregnancy, female genital mutilation, sexual assault, forced marriage, sexual harassment, forced exposure to pornography, forced abortion and virginity tests.

5.2.16 Victims

Individuals (i.e., women, men, or children) who report that they have been sexually assaulted[28].

5.2.17 Patients

Individuals receiving a service from, or are being cared for by, a health worker[26].

5.2.18 Health Workers

Professionals who provide health services; for example, doctors, nurses and other professionals who have specific training in the field of health care delivery.[28]

6.0 Common Myths about Rape

Fact	Myth
Sex is the primary motivation for rape.	Power, anger, dominance and control are the main motivating factors for rape.
Only certain types of women are raped. Many people believe women who are of high moral character (“good girls”) don’t get raped and that females of low moral character (“bad girls”) do get raped.	Any person can be a victim of rape.
Boys / males don’t get raped	People of any gender could be victims of rape
Women falsely report rape.	Only a very small percentage of reported rapes are thought to be false reports.
Rape is perpetrated by a stranger.	The majority of rapes are perpetrated by a known assailant.
Rape involves a great deal of physical force.	Most rapes do not involve a great deal of physical force or the use of a weapon. Physical force is not necessarily used in rape, and physical injuries are not always a consequence.
When women say “no” to sex, they actu- ally mean “yes”.	“No” means no; a woman’s wishes in this regard should be respected at all times.
Sex workers cannot be raped.	Any man or woman, regardless of his/ her involvement in the commercial sex in- dustry, can be raped. Studies show that a significant proportion of male and female sex workers have been raped by their clients, the police or their partners.
A man cannot rape his wife.	Any forced sex or forced sexual activity constitutes rape, regardless of whether or not the woman is married to the per- pe- trator. However, some jurisdictions have marital rape exemptions in their laws; although married women are subject to rape by their husbands, the law does not recognize it as such in Nigeria.

Fact	Myth
Rape is reported immediately.	The majority of rapes are never reported to the police. Of those that are reported to the police, most are done more than 24 hours after the incident. Victims do not report at all or delay reporting be- cause they think nothing will be done, the per- petrator may have made threats against them or their families, they are afraid of family or community responses or they are ashamed; some victims sim- ply feel that it is a private matter or do not know where to report the incident.
People who are respected in society can- not be offenders.	There is no social categorization that fits offenders, although certain groups may be involved more often.

Adapted from WHO guidelines (3)

7.0 Drugs and Sexual Violence

Drugs are related to sexual violence in three ways:

a.) The use of drugs by persons places them at more risk of being abused by altering their consciousness, reducing their ability to resist attack and attracting them to risky places.

b.) Offenders can use drugs on the victims to achieve the alteration of the victim's consciousness and reduce their ability to resist abuse.

c.) The use of drugs by offenders may predispose them to violent behaviour.

Substances used vary according to location but include alcohol, marijuana, benzodiazepines, methamphetamine, raphenol, gamma hydroxybutyrate, cocaine, ketamine, etc. even though they may also be used in combination. Additionally, medications sold at pharmacy shops and patent medicine stores are also used – they may include tramadol, and benyllin cough syrup (with codeine).

8.0 Medical Consequences of Sexual Assault

8.1 Physical Injuries

Physical injuries are a common and immediate medical consequence of sexual assault. Victims may sustain a variety of physical harm which can be grouped into two broad categories: minor and major injuries.

8.1.1 Minor Injuries

a.) Abrasions
b.) Minor lacerations
c.) Superficial burns
d.) Joint dislocations
e.) Dental fractures
f.) Minor injuries to the eye (i.e., black eye)

8.1.2 Major Injuries

a.) Deep lacerations
b.) Fractures
c.) Head injury
d.) Bullet wounds
e.) Genital lacerations of varying degrees
f.) Anal or rectal trauma
g.) Ligature marks on ankles, wrists and neck
h.) Pattern injuries (i.e., hand prints, finger marks, belt marks, bite marks)
i.) Chemical burns
j.) Traumatic tooth extractions
k.) Eye injury leading to loss of sight
l.) Penile injuries including fracture

8.2 Sexual and Reproductive Health Consequences

a.) Unintended pregnancies
b.) Unsafe abortions
c.) Urinary tract infections
d.) Sexually Transmitted Infections (STIs) – Syphilis, Gonorrhea, Human Papilloma Virus (HPV), Herpes simplex, Hepatitis, HIV, etc.
e.) Long-term effects – diminished levels of function, feeling unhealthy, sexual dysfunction, chronic pelvic pain, infertility, dysmenorrhea, Post-Traumatic Stress Disorder (in pregnancy, labour and delivery), Frigidity, irritable bowel syndrome, vaginal pain, breast pain, headaches, rectal bleeding, non-menstrual vaginal bleeding or discharge, bladder infection, dysuria, post-traumatic psychosis, puerperal

psychosis, dyspareunia.

8.3 Psychologic and Mental Health Consequences

8.3.1 Rape-Trauma Syndrome

This typically occurs after the assault has taken place and may last for weeks.

There are two phases:
Acute phase or a disorganization phase: This is characterized by physical reactions like generalized body pains, eating and sleeping disturbances, emotional reactions characterized by embarrassment, fear, anger, death wish, anxiety, guilt, humiliation, depression, self-blame, mood swings (crying and sobbing, smiling and laughing, calm and controlled).

Delayed or organization phase: occurs weeks and months after the assault and varies from person to person depending on age, life situation, personality traits and support given (WHO). It is characterized by nightmares, flashbacks, phobias and gynaecological symptoms (sexual aversion, vaginismus, orgasmic dysfunction). This phase can result in severe cases of withdrawal where victims relocate or change telephone numbers.

8.3.2 Depression

This can be characterized by persistent feelings of sadness, hopelessness, and a lack of interest or pleasure in activities once enjoyed. It affects an individual's daily function, leading to emotional and physical problems, and can impair the ability to perform at work or school and maintain healthy relationships.

8.3.3 Social Phobias

This would involve an intense fear of social situations where one might be judged, embarrassed, or scrutinized by others. This condition can severely impact individuals' ability to interact socially, attend school, or work, leading to significant isolation and distress.

8.3.4 Early Intercourse and Multiple Partners

This may often become a coping mechanism for the trauma experienced. Victims may engage in these behaviors due to feelings of worthlessness, low self-esteem, or a distorted sense of normalcy in relationships. These actions can further exacerbate mental health issues such as depression, anxiety, and Post-Traumatic Stress Disorder (PTSD).

8.3.5 Post-Traumatic Stress Disorder

This is common in victims who had a horrific experience, especially cases where force

was used. This may appear after months or years. The trauma is re-experienced through intrusions (flashbacks, nightmares and hyperarousal encounters), even though some people employ avoidance, numbness, isolation, distractions, increased substance abuse, high-risk behaviours etc. as ways to deal with it.

8.3.6 Alcohol Abuse, Illicit Drug Abuse

Victims often turn to alcohol and illicit drugs as a means to cope with trauma and emotional pain. This substance abuse can lead to a cycle of addiction, further exacerbating mental health issues and hindering recovery

8.3.7 Risk-taking Behaviours

There could be increased engagement in risk-taking behaviours such as reckless driving, unsafe sex, and self-harm, as a way to cope with trauma and regain a sense of control; however, these behaviors can result in further physical and emotional harm.

8.3.8 Smoking

Victims may turn to smoking to deal with stress, anxiety, and depression resulting from their trauma. However, smoking can lead to numerous health issues, compounding the survivor's physical and mental health challenges

8.3.9 Suicidal Tendencies

These are feelings of severe emotional distress and hopelessness, resulting in suicidal thoughts or tendencies. Victims may feel overwhelmed by their trauma and see suicide as the only escape.

8.3.10 Eating Disorders

Eating disorders such as anorexia, bulimia, and binge eating, can develop as a way to exert control over their bodies and cope with emotional pain. These disorders can have serious physical and psychological consequences.

8.4 Death

Victims may face extreme physical injuries that can be life-threatening, or they may develop severe mental health conditions such as any of the above listed and suicidal tendencies that could result in fatal outcomes - death. Additionally, engagement in substance abuse and risk-taking behaviours as coping mechanisms can also increase the likelihood of fatal accidents or overdoses.

9.0 Male Victims

Sexual abuse cases occur with men just as they do with women. Cases of abuse in men are likely significantly underreported due to feelings of embarrassment. Places where these occur also vary and include homes, prisons, schools, religious houses, etc.

When the offenders are males, it is homosexuality and is prohibited under Nigerian law. Additionally, Rituals may also be the reason for assault. Sometimes, perpetrators are mature females abusing young boys or initiating them into heterosexual acts.

Abused males may experience the same physical and psychological effects as women. In addition, they are likely to be concerned about their masculinity, sexuality and the fact that people may think they are homosexuals.

10.0 Management of Victims

10.1 Prevention

Since anyone can be a victim, and offenders cannot always be predicted, it is necessary to carry out broad preventive measures. Legislation alone cannot significantly reduce sexual and gender gender-based violence. Adopting a preventive approach by expanding awareness is likely to guarantee better outcomes in the long run.

10.1.1 Raising Public Awareness

Raising public awareness about the VAPP Law should be carried out using different local and national languages including sign language, and all available channels such as social media, radio, television, print media, religious institutions, traditional institutions, schools, judiciary, police, military, customs, immigration, prisons, civil defense, DSS, Peace Corps, vigilante, civil societies, professional bodies, others.

The different ways through which awareness can be created across different groups include:

Group	Programmes/Messages
Media	• Interviews/discussions • Commentaries • Documentaries • Jingles/adverts • Reports of incidences • Social Media Influencers
Religious institutions	• Strengthen and emphasize on relevant injunctions regularly at meetings/worship sessions • Engage Religious / Traditional institutions

Group	Programmes/Messages
Schools	• Develop and disseminate Information, Education and Communication (IEC) materials (posters, handbills, stickers, etc.) • Talk to clubs and societies using the Akwa Ibom state training Manual on GBV • Family Life Education (FLE) in primary and secondary schools • Story Books • Counselling units in primary and secondary schools to include Sexual and Gender Based Violence (SGBV) • SGBV as a course in tertiary institutions
Judiciary	• Advocacy, sensitization and training for judges, prosecutors and other judicial personnel
State actors and MDAs	• Develop written policies and disseminate • Develop and disseminate IEC materials (posters, handbills, stickers, etc.) • Create units for instruction on and actions against sexual assault
Civil Society groups [NGOs, Faith Based Organisations (FBOs) and Community Based Organisations (CBOs)]	• Encourage to include sexual assault in programmes such as: • Research – to document the nature and scale of sexual violence, identify more risk factors and preventive measures for advocacy and action • Continued advocacy for law implementation, funding and policy formulation • Community sensitization • Promotion of gender equality and gender mainstreaming • Regular capacity building • Other gender activities

Key Messages for Awareness Creation

a.) Definitions of Violence Against Persons
b.) Explanations of the legal and policy frameworks
c.) Prevalence of Violence Against Persons in our society
d.) Risk factors
e.) Features of sexual abuse
f.) Common types of grooming patterns used by perpetrators
g.) What to do when you suspect an attempt is likely
h.) What to do when you are a victim
i.) Helplines (for Complaints/reports)
j.) Policies guiding engagement of civilians by state actors
k.) Consequences of Violence Against Persons

10.1.2 Proper Segregation of Students in Schools, Bathrooms in the Correctional Centres and IDP Camps

At school and all camping grounds, teachers and organizers should ensure proper segregation of males and females. Also, Proper security and complaint-lodging mechanisms should also be provided for schools and the same should be done for IDP Camps and correctional centres. Furthermore, it is important to also regularly spell out punishments.

10.1.3 Proper Security and Complaint-Lodging Mechanisms to be Provided.

Mechanisms that ensure ease in lodging complaints, as well as providing security for potential victims should be put in place as part of preventive initiatives. The benefits of these mechanisms are to:

a.) Encourage anonymous reports from neighbours, colleagues, etc.

b.) Ensure offenders are punished: there should be proper enforcement of extant laws to punish offenders, this will serve as deterrence to intending offenders.

c.) Publicize the identity of convicted offenders.

d.) Provide free telephone helplines: these lines can offer guidance on what steps an endangered potential victim can take to anticipate assault. These helpline numbers should regularly be publicized on billboards, posters/handbills, radio and television jingles.

e.) Manage offenders to prevent or reduce recidivism: provide psychological and biological treatment for offenders in the correctional centres or outside the correctional centres as soon as legal proceedings are concluded, to prevent the reoccurrence of their deviant behaviours.

f.) Enact ''sexually violent predator'' laws (like long sentencing, mandated treatment, community registration and notification and protracted supervision during reintegration from the correctional centre).

g.) Consider measures for prevention in IDP Camps.

10.2 Management Before Arrival at the Hospital

The handling of a victim after Sexual and Gender-Based Violence (SGBV) before a decision is taken to report can impact the outcome. How the victim and the circumstance are handled should form part of the message for all stakeholders, especially the public.

a.) Report incidents of Sexual and Gender-Based Violence (SGBV) as soon as possible: Delays in reporting are common, but they can lead to severe consequences. Failing to report promptly or not reporting at all allows the negative impacts of SGBV to persist. Additionally, delayed reporting can result in the loss of crucial forensic evidence and

provide the perpetrator an opportunity to evade justice.

b.) Maintain confidentiality and avoid creating a scene when a sexual assault is reported or discovered: The initial responder should keep the information as private as possible to prevent further psychological trauma and societal stigmatization of the victim. Information should be shared only with individuals directly involved in providing support, such as parents or guardians, necessary witnesses, medical personnel, and the police. If reporting to the police before visiting a medical facility, request a private conversation with the officer on duty to ensure discretion. Encourage the police to facilitate prompt medical attention for the victim.

c.) Provide cover/clothing for the victim after taking pictures for evidence and ensure to protect the identity of the victim (e.g., blurring of face).

d.) Keep all evidence intact, like soiled/torn clothing. The victim should not take a bath before reporting.

e.) Secure the crime site if possible.

10.2.1 Involvement of Law Enforcement Agencies

When a victim arrives at any Law Enforcement Agency immediately following the assault, before receiving medical attention, the officer on duty must promptly transport the victim to a health facility while continuing investigative procedures. Even in cases of delayed reporting, referral to a health facility should still occur.

No victim should face denial of immediate attention or be turned away if they present themselves to a health facility without accompaniment by law enforcement agents. In instances where a victim reports without police involvement, their consent must be obtained before involving law enforcement.

Additionally, all health facilities must maintain functional communication channels with the police, regardless of their remoteness.

Service providers must resist any pressure exerted by Law Enforcement Agencies or other investigators, directing them to higher authorities if they perceive any requests as unethical.

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10.3 Management in Hospital

As it relates to SGBV, the medical findings and the care given all add up to evidence leading to that diagnosis. This calls for proper procedures at medical facilities (courtesy, documentation, confidentiality, respect, victim's choices and consent, informing facility head and police, good record keeping and protection). Qualitative medical care, however, should have priority over legal considerations. The medical and

psychological sequelae call for thorough care so as to prevent or discover and treat medical problems.

These guidelines apply to all medical facilities. Healthcare providers should offer the best possible care within their capabilities and refer patients when necessary. All levels of care — primary, secondary, and tertiary — as well as both private and public facilities, are expected to provide support and treatment for victims of sexual assault.

10.4 Equipment List

The table below provides an equipment list adapted from WHO1. However, every facility should optimize its available space, personnel and equipment to render the care possible and refer the victim after that.

Table: Equipment list for the provision of medical and forensic services to victims of sexual violence

Item	Comments
Fixtures	
Examination couch*	Multi-functional couch (Disability, young and elderly people)
Desk, chairs* and filing cabinet	For victim, accompanying persons and health worker
Light source*	Ideally mobile, including Anglepoise lamps
Washing facilities and toilet*	Facilities should be available for the victim(s) to wash at the conclusion of the examination. There should also be a facility for the health worker to wash their hands before and after an examination. Facilities should include a shower, a hand basin and soap.
Refrigerator and cupboard	For the storage of specimens, preferably lockable
Telephone, Fax Machine and Internet facility*	
General Medical Items	
Tourniquet*	It is crucial to ensure a clear field for medical examinations and specimen collection.
Syringes, needles and sterile swabs*	They must be sterile to prevent infection and ensure patient safety.
Specimen bottles (various)*	For collecting and storing biological samples, such as urine or blood, for laboratory analysis. They are essential for diagnostic testing and monitoring the patient's health status.

Item	Comments
Sterilizing equipment	(For sterilizing instruments, e.g., specula).
Proctoscope/anoscope*	For examining the rectum and anus. They are essential for detecting injuries, infections, or other abnormalities in the lower gastrointestinal tract.
Examination gloves*	To protect both the patient and the provider from contamination and the spread of infectious diseases.
Pregnancy testing kits*	To detect the presence of human chorionic gonadotropin (HCG) in urine or blood, indicating pregnancy. They are essential for confirming pregnancy status and informing medical management decisions.
STI / HIV collection kits	Contain necessary supplies for collecting specimens, such as swabs or blood samples, for testing for sexually transmitted infections (STIs) and HIV. They are crucial for diagnosing and managing these infections.
Sharps container*	For safely disposing of needles, syringes and other sharp medical instruments. Proper disposal helps prevent needlestick injuries and transmission of bloodborne pathogens.
Scales and height measure	For examining children
Manual vacuum aspirator, te- naculum, forceps, cannulae of various sizes	Used in procedures such as manual vacuum aspiration for uterine evacuation, tenaculum for cervix stabilization, forceps for tissue grasping, and cannulae for various medical applications. They are crucial for gynecological examinations and procedures.
Infection prevention items	Scrubs, bleach, goggles
Forensic Items	
Swabs (cotton wool or similar) and con- tainers for transporting swabs*	For collection of foreign material on victim (e.g., semen, blood, saliva). Do not use medium when col- lecting forensic specimens.
Microscope slides*	For plating of swabs
Microscope slides*	For plating of swabs

Item	Comments
Specimen bottles*	Blood is used for Deoxyribonucleic Acid (DNA) or toxicological analysis.
Urine specimen containers*	For pregnancy and toxicological testing
Sheets of paper (drop sheet) *	For patient to stand on whilst undressing, for collection of loose, fine materials
Paper bags*	For collection of clothing and any wet items
Plastic specimen bags*	For collection or transport of other (dry) forensic items
Tweezers, scissors, comb	For collecting foreign debris on skin. Use scissors or comb to remove and collect material in hair.
Treatment Items	
Analgesics*	A range of simple analgesics may be useful.
Emergency contraception*	For providing timely and effective contraception options to sexual assault survivors.
Suture materials	Used for closing wounds or surgical incisions. Proper wound closure is essential for promoting healing and reducing the risk of infection.
Tetanus and hepatitis prophylaxis/vaccination	Administered to prevent these potentially life-threatening infections in individuals who have sustained wounds or exposure to contaminated materials.
STI prophylaxis*	Administration of antibiotics or antiviral medications to prevent the development of sexually transmitted infections (STIs) in individuals at risk, such as sexual assault survivors.
HIV post-exposure prophylaxis	Administration of antiretroviral medications to prevent HIV infection after potential exposure, such as sexual assault. Prompt initiation of PEP is crucial for its effectiveness.
Misoprostol and mifepristone	Essential for providing safe and effective options for managing unwanted pregnancies.
Linen	
Sheets and blankets*	For examination couch.
Towels*	To be provided in private bathrooms for the victims' use after bathing post examination.

Item	Comments
Clothing	To replace any damaged or retained items of the victim's clothing.
Patient gowns*	To allow patient to fully undress for examination
Sanitary items (e.g., pads, tampons) *	For the comfort and hygiene of the patient, particularly during medical examinations or procedures involving genitalia or menstrual hygiene.
Examination record or proforma*	For recording findings (see Annex 1)
Labels*	For attaching to various specimens
Consent form*	This should be completed as required by local rules or protocols (see Annex 1).
Pathology/radiology referral forms	For referring patient for further investigation or tests
Information brochure	Ideally the patient should be provided with informa- tion about the service they have accessed, methods of contacting the treating practitioner if required and details of follow-up services. These brochures should supplement any verbal information that the victim has been provided with. In addition to reinforcing important information that the victim may forget, brochures may provide information to other potential service users.
Sundry Items	
Camera and film	Photography is useful but not necessarily an essential tool for injury documentation. Law Enforcement Agencies or hospitals may also be able to assist.
Colposcope or magnifying lens	Useful for obtaining a magnified view of a wound
Microscope	May be used by the practitioner to check for the presence of spermatozoa, particularly if no laboratory facility is accessible
Swab dryer	Forensic swabs should be dried before being packaged. This can be done with the use of a dryer or the swabs can be air-dried so long as they are protected from foreign DNA.
Measuring device (e.g., ruler, tape measure, callipers) *	For measuring the size of wounds
Pens, pencils*	Necessary for documenting medical assessments, collecting patient information, and completing necessary paperwork.

Item	Comments
Computer and printer	for maintaining electronic medical records, accessing medical information and resources, and generating printed materials, such as medical reports or referrals.
Sterilization equipment	For medical instruments
Children's drawing materials/ toys	Useful to keep children occupied

NB:

a.) Items marked with an asterisk are considered essential for providing a minimum level of service.

b.) They can be held individually or as part of a pre-packaged rape kit.

c.) Patients may present with a range of physical conditions. There should be ready access to the facilities, equipment and items required to treat these conditions. If not held at the centre they should be available nearby (e.g., at a hospital or clinic). Other medications (e.g., for the treatment of insomnia and anxiety) may also be required.

Adapted from WHO29

10.5 Cost of Care

The cost of treatment for victims of sexual and gender-based violence should be borne on the budgetary provision for emergency care under the Akwa Ibom State Social Health Insurance (AKSSHIS) or any other health insurance scheme under which the victim is covered.

Where the victim is not covered, the offender or his/her relations should bear the cost; when the offender cannot be found or is a stranger and the victim's relations cannot cover the cost, the health facility shall bear the cost and proper records kept to that effect.

The facility, whether public or private, will then apply for reimbursement from the social welfare department of the relevant level of government which will receive regular funding for this purpose.

10.6 Interaction with Providers of Other Services

In addition to law enforcement officers, health workers and social workers must collaborate with other service providers to ensure well-coordinated and multidisciplinary care. All interactions should adhere to professional conduct and ethical standards.

Health workers may interact with various groups, including counsellors (such as social workers, psychologists, or support and religious groups), laboratory staff, lawyers, and NGOs. A strong working relationship should be fostered among these groups.
In cases where specific groups are unavailable, health workers may need to assume the roles of counsellors and laboratory staff as needed.

10.7 Interaction with Victim

Sexual assault survivors are in a vulnerable state and need the highest level of compassion and understanding. Their unique needs call for courteous and empathetic treatment. It is crucial to approach them with dignity, respect, and a commitment to strict confidentiality, hence, creating a safe environment is essential for their well-being. Healthcare providers must offer unwavering support, remain objective, and avoid passing judgment.

To ensure effective care, these steps should be followed13:

a.) Greet the patient by name. Use her/his preferred name and make her/him your central focus.
b.) Introduce yourself to the patient and tell her/him your role, i.e., physician, nurse, or health worker.
c.) Aim for a respectful and professional interaction within the boundaries of your patient's culture.
d.) Have a calm demeanour. A victim who has been frightened and has experienced fear wants to be in the company of people who are not frightened.
e.) Do not be in a hurry, give time.
f.) Maintain eye contact as much as is culturally appropriate.
g.) Be empathetic and non-judgmental as your patient recounts their experiences
h.) Where possible, a health worker of the same sex as the victim should carry out the initial interaction.

10.7.1 Dealing with Victim's Emotions

Be ready to deal with their various emotions/feelings. The following are suggested responses:

Hopelessness: Reassure the person and tell her/him encouraging things

Despair: Focus on the strategies and resourcefulness through which the person will get better.

Powerlessness and loss of control: Say, "You have choices and options today on how to proceed."

Flashbacks: Say, "These will resolve with the healing process."

Disturbed sleep: Say, "This will improve with the healing process."

Denial: Say, "I'm taking what you have told me seriously. I will be here if you need help

in the future."

Guilt and self-blame: Say, "You are not to blame for what happened to you. The person who assaulted you is responsible for the violence."

Shame: Say, "There is no loss of honour in being assaulted. You are an honourable person."

Fear: Emphasize, "You are safe now." You can say, "That must have been very frightening for you."

Numbness: Say, "This is a common reaction to severe trauma. You will feel well again. All in good time."

Mood swings: Explain that these are common and should resolve with the healing process.

Anger: A legitimate feeling and avenues can be found for its safe expression. Assist the patient in experiencing those feelings. For example, "You sound very angry."

Anxiety: Tell the patient that these symptoms will ease with the use of the appropriate stress management techniques and offer to explain these techniques.

Helplessness: Say, "It sounds as if you were feeling helpless. We are here to help you."

10.7.2 Consent

Get a signed or finger-printed consent from the victim or that of the parent/guardian by politely requesting for it at every process needing physical exposure, medical procedure or involvement/disclosure to the police or other authorities. These processes, options and their likely consequences should be explained to the patient and/or her/his guardian. Where consent is not given, this must be respected and proper records should be kept to that effect.

Where the victim is unconscious or incapacitated and a surrogate decision maker is unavailable consent cannot be given, treatment should not be withheld. However, attempts should be made to get consent afterwards.

10.7.3 Promptness

Whenever victims report after an assault, it should be treated as an emergency.

10.7.4 History and Exmination

History and physical examination will reveal the needs of the patient. A detailed history should be taken if the level of injury allows that. All levels of care (primary, secondary and tertiary) should initiate care before appropriate referral.

The room must allow for confidentiality as much as possible. When this is not possible, the health worker should politely ask people around to leave, letting only trusted companions be present at the request of the patient. As much as possible, communication should be

in the language the victim understands well and the process must respect the cultural sensibilities of the patient.

The following details should be covered well in the history. Use a standardized examination record (Appendix 1).

- Full names, age, sex
- Presenting complaint
- History of presenting complaints including:
    - date of assault, approximate time,
    - location,
    - the sequence of events,
    - number and character of perpetrators (family, acquaintance, stranger, date, etc.),
    - injuries and weapons used,
    - routes (vaginal, oral, anal) and body parts used (finger, penis),
    - the extent of penetration,
    - ejaculation and use of condoms.
- Ask for medication/alcohol/injections/inhaled substances used or forced on the patient.
- Ask if the victim presented elsewhere and what treatment has been given.
- Genitourinary – genital bleeding, pain, itching, sores, discharge, anal bleeding, urinary symptoms
- Medical and social history of the perpetrator if known (sick, HIV-positive, drug addict, alcoholic, manic, etc.)
- Pre- and post-assault history (medications/alcohol/substance use, illness, sexual intercourse, offender's gender, injuries)
    - Medical – previous illnesses and their treatment (including STIs and Human Immune Deficiency Virus/ Acquired Immunodeficiency Syndrome (HIV/AIDS), allergies,
    - Surgical – previous surgeries and complications
    - Gynaecological – menstrual history, sexual history, pelvic surgeries, contraceptive history
    - Obstetric – parity, past obstetric history
    - Mental health history
    - Medication and known allergies

The examination should be top-to-toe and detailed. Take photographs and videos if available and consent is given. First, explain the process to the patient and ensure gloves are worn. Processes should include the following:

- General examination: appearance, nutritional status, clothing (soiled, torn, offensive odour), hair arrangement (disheveled), bruises/cuts, temperature,

pallor, jaundice, oedema

- Oral cavity – injuries, teeth, bleeding, soiling with semen
- Systemic examination
    - Cardiovascular System (CVS) – pulse rate and volume, blood pressure, apex beat, heart sounds, murmurs
    - Respiratory – respiratory effort and rate, noisy breathing, chest excursion, flail chest, air entry, respiratory sounds
    - Abdominal – fullness, movement with respiration, organs, masses, fluid/gaseous distension
    - Musculoskeletal – swelling, bruises, tone/power, reflexes
    - Central Nervous System (CNS) – if you suspect trauma or drug-facilitated violence, check for impaired consciousness, memory loss, disorientation or confusion, 'talk about an out-of-body experience,' impairment of speech or coordination.
    - Genitourinary system – inspect the external genitalia for normalcy, bruises, soiling with semen, and bleeding. Take forensic samples if services are available. For females, do a speculum examination and check for deeper genital lacerations and a bimanual examination if necessary. For males, examine the genitalia and perianal area for injuries, infection and soiling with semen.
- Do proctoscopy if history is given of anal penetration.

Alternatively, the systematic ''top-to-toe'' physical examination can be adopted (WHO48). It starts with general appearance, vital signs, hands, wrists, forearms for defense injuries and intravenous puncture sites; upper arms, armpits; face, eyes, nostrils, teeth, ears (also use otoscope if available), hair, scalp, neck, breast and trunk, shoulders; abdomen; lower limbs, buttocks; genitourinary and anal area.

Findings and injuries should be described in detail. The table below will help in the documentation of injuries.

Table: Findings and injuries

Feature	Notes
Site	Record the anatomical position of the wound(s).
Size	The dimensions of the wound(s) should be measured.
Shape	Describe the shape of the wound(s) - e.g., linear, curved, irregular
Surrounds	Note the condition of the surrounding or the nearby tissues (e.g., bruised, swollen).
Colour	Observation of colour is particularly relevant when describing bruises.
Course	Comment on the apparent direction of the force applied (e.g., in abrasions).
Contents	Note the presence of any foreign material in the wound (e.g., dirt, glass).
Age	Comment on any evidence of healing. Note that accurate ageing is impossible and great caution is required when commenting on this aspect.
Borders	The characteristics of the edges of the wound(s) may provide a clue as to the weapon used.
Classification	Use accepted terminology wherever possible (see section 4.5.2 Classification of wounds).
Depth	Give an indication of the depth of the wound(s); this may have to be an estimate.

Depth Give an indication of the depth of the wound(s); this may have to be an estimate. Forensic/laboratory specimens should be collected during the examination (hair, nail scratches, bite areas, saliva, semen, torn clothing).

Diagnosis

In the diagnostic process, it is crucial to meticulously itemize the patient's presenting symptoms and concerns, allowing for a comprehensive assessment of their condition. By carefully documenting each aspect of the patient's experience, healthcare providers can formulate a provisional diagnosis, which serves as a preliminary identification of the potential underlying health issues. This step lays the foundation for further investigation and treatment planning, guiding subsequent medical interventions to address the patient's needs effectively.

10.7.5 Forensic Evidence

Preserve forensic evidence. The victim should avoid bathing, washing clothes, brushing teeth or drinking liquids before a forensic medical examination (a medical examination conducted in the knowledge of the possibility of judicial proceedings in the future requiring medical opinion). Preserve tampons, sanitary pads and clothes worn during the assault.

When available, use early evidence kits (EEKs) which contain a urine sample pot, mouth swab and mouth rinse. Wear gloves and handle all samples carefully to avoid contamination. They should be labelled properly and secured well during transportation or storage. The table below shows some samples and how they should be collected.

Table: Forensic specimens

Source	Material	Equipment	Sampling Instructions
Anus (rectum)	Semen	Cotton swabs and microscope slides	Use swab and slides to collect and plate material; lubricate instruments with water, not lubricant.
	Lubricant	Cotton swab	Dry swab after collection
Blood	Drugs	Appropriate tube	Collect 10mls of venous blood
	DNA (victim)	Appropriate tube	Collect 10mls of blood
Clothing	Adherent foreign material e.g. semen, blood, hair, fibre	Paper bags	Clothing should be placed in a paper bag(s). Collect paper sheet or drop cloth. Wet items should be bagged separately.
Genitalia	Semen	Cotton swabs and microscope slide	Use separate swabs and slides to collect and plate material collected from the external genitalia, vaginal vault and cervix; lubricate speculum with water not lubricant or collect a blind vaginal swab (see Fig. 11).
Hair	Comparison to hair found at scene	Sterile container	Cut approximately 20 hairs and place in sterile container.
Mouth	Semen	Cotton swabs, sterile container (for oral washings) or dental flossing	Swab multiple sites in mouth with one or more swabs (see Fig. 12). To obtain a sample of oral washings, rinse mouth with 10ml water and collect in sterile container.
	DNA (victim)	Cotton swab	

Source	Material	Equipment	Sampling Instructions
Nails	Skin, blood, fibres, etc. (from assailant)	Sterile toothpick or similar or nail scissors/clippers	Use the toothpick to collect material from under the nails, or, the nail(s) can be cut and the clippings collected in a sterile container.
Sanitary pads/ tampons	Foreign material (e.g. semen, blood, hair)	Sterile container	Collect if used during or after vaginal or oral penetration.
Skin	Semen	Cotton swab	Swab sites where semen may be present.
	Saliva (e.g. at sites of kissing, biting or licking), blood	Cotton swab	
	Foreign material (e.g., vegetation, matted hair or foreign hairs)	Swab or tweezers	Place material in sterile container (e.g., envelope, bottle).
Urine	Drugs	Sterile container	Collect 100ml of urine

Forensic Timescales

Type of Assault	Female	Male
Kissing, licking, biting	48 hours or longer	48 hours or longer
Oral penetration	48 hours (two days)	48 hours (two days)
Vaginal penetration	7 days	Not Available
Digital (finger) penetration	12 hours	12 hours
Anal penetration	72 hours (three days)	72 hours (three days)

In Drug Facilitated Sexual Assaults (DFSA), detection times of substances used are within three days in blood and four days in urine. Hair analysis is sometimes done in delayed presentation of suspected DFSA.

10.7.6 Classification of Management of Victims' Needs, Follow-up and Psychological Support

Several victims react to assault differently, and the time of reporting plays a crucial role in the management of the needs of the victim. This is broadly classified into three:

A. Immediate Needs

1. Treatment of injuries

a) If necessary, and the patient agrees, take photographs first
a) Clean abrasions with chlorhexidine solution
b) Arrest bleeding and manage lacerations accordingly
c) Give tetanus toxoid injection of 0.5mls intramuscularly
d) Give antibiotics for injuries, e.g., ampiclox 500mg for 5 days
e) Give medications/vaccinations for prophylaxis

STI	Medication/Vaccination
HIV	Post-exposure prophylaxis (2 Nucleoside Reverse Transcriptase Inhibitors + I Protease inhibitor for 28 days), e.g.: • Truvada (Tenofovir and Emtricitabine) one tablet once a day with or without food • Kaletra (Lopinavir (400mg) and Ritonavir (100mg)) two tablets twice a day with or without food • Zidovudine (AZT) 300mg + lamivudine (3TC) 150mg each twice daily for 28 days Treat nausea and vomiting with domperidone 10mg tablet three times a day. Treat diarrhoea with two tablets of loperamide 2mg and the one PRN () maximum 8 tablets in 24 hours Do HIV test at 3 months' post completion of Post Exposure Prophylaxis (PEP) and at 6 months
Hepatitis B	Hepatitis B immunoglobulin and vaccination – if victim has not received complete dose of vaccination before. • Hepatitis B Immunoglobulin (HBIG) (especially if offender is Hepatitis B envelop Antigen (HBeAg) positive). HBIG is not contraindicated in pregnancy • Hepatitis B vaccination (within 6 weeks of exposure) 1ml Im in adults and adolescents > 13 years of age (Engerix B 20mcg three times or HBvaxPro 10mcg three times). Give half dose to younger victims. • Either dose is given at 0, 7, 21 days' post exposure with booster dose at 12 months (super accelerated or very rapid schedule) or at 0, 1, 2 months after exposure with booster at 12 months (acceler- ated schedule) Repeat test at 3 and 6 months' post assault
Gonorrhoea	Ceftriaxone 1000mg as a single stat I.V slowly dose + Azithromycin 1g Per Os (PO) stat
Chlamydia	Azithromycin 1g PO single stat dose (all patients) or Doxycycline 100mg bd for 14 days(non-pregnant) Erythromycin 500mg orally 4 times a day for 7 days (pregnant) or Amoxicillin 500mg orally 3 times a day for 7 days (pregnant) or

STI	Medication/Vaccination
Trichomonas Vaginalis	Metronidazole 2g PO single stat dose
Bacterial vaginosis	Metronidazole 2g stat Doxycycline 100mg bd for 10 days
Syphilis	Benzathine Penicillin G 2.4 MIU IM single dose (pregnant and non- pregnant) or Doxycycline 100mg bd for 14 days (non-pregnant) or Tetracycline 500mg qid for 14 days(non-pregnant) Erythromycin 500mg orally 4 times a day for 14 days (pregnant victims)

a) Give analgesics (diclofenac, ibuprofen)
b) Give anxiolytics if necessary (diazepam 5mg, or bromazepam 1.5mg)
c) Refer more serious injuries to specialists (orthopaedic surgeons, gynaecologists, neurosurgeons, paediatric surgeons, etc.)

2. Baseline screening for STIs

- Counselling and tests for HIV – save sample and retest after 3 months if positive. The risk for HIV is higher if the offender is from a high-risk group. If penetration took place, the presence of other STIs in the victim, genital injuries and multiple offenders.
  - Risk of HIV Transmission = offender's risk x risk of exposure.

- Risk of transmission from a known HIV-positive source (11)

Site of Infection	Risk
Receptive anal sex	0.1-3.0%
Insertive anal sex	0.06%
Receptive vaginal sex	0.1-0.2%
Insertive vaginal sex	0.03-0.09%
Receptive oral sex (fellatio)	0-0.04%
Mucous membrane exposure	0.09%
Needle stick injury	0.30%

- Syphilis –VDRL or other serology - save sample and retest after 3 months if positive
- Hepatitis B, Hepatitis C - save sample and retest after 3 months if positive
- Neisseria Gonorrhoea – take specimen for gram stain for gram-negative intracellular diplococci culture from site of penetration
- Chlamydia trachomatis – take specimen from site of penetration for dual Nucleic Acid Amplification Technique (NAAT)
- Yeast – wet slide for microscopy and culture
- Bacterial vaginosis – wet slide for microscopy, Schiff test
- Trichomonas vaginalis – wet slide for microscopy and culture

3. **Other investigations** – Full Blood Count (FBC), liver enzymes if PEP is given, others as dictated by other findings

4. **Pregnancy test** (when facilities are available, use blood test) – see below for management of positive pregnancy test

5. **Give emergency contraception** (if the pregnancy test is negative and the patient presents within five days of assault)
   - Copper Intrauterine Device (IUD) up to 5 days post assault on any day of the menstrual cycle
   - Levonorgestrel 1.5mg single dose up to 5 days after the assault. Double the dose (to 3mg) if the patient is on liver enzyme-inducing medications like HIV PEP
   - Ulipristal (Ellaone) 30mg up to 5 days after assault
   - Postinor 2 two tablets single dose up to 120 hours after assault

6. Refer to a psychiatrist/clinical psychologist

7. Refer for forensic medical examination if service is available within the facility or close by

8. **Give a follow-up date**

B. Medium-Term Needs (Patient reports after seven days of assault)

a) Treat injuries (dressing, debridement, antibiotics)
b) Screen for STIs and treat them according to sensitivity tests or syndromic management if there are no facilities for screening
c) Test for pregnancy; if positive see below for management of positive pregnancy test
d) Give Hepatitis B vaccination
e) Refer to psychiatrist/clinical psychologist

f) Link to Sexual Assault Referral Centre (SARC) if accessible
g) Give follow-up date

If presenting after three months, screen for STIs, do Full Blood Count, Liver Function Tests, Urea and Electrolytes, Fasting blood sugar, Lipids and Amylase

If a patient presents after two weeks and the pregnancy test is positive, she may be offered paternity testing if available.

Management of Pregnancy/Positive Pregnancy Test

Pregnancy resulting from assault is certainly unwanted and must be prevented as much as possible. The negative effects of unwanted pregnancy include the following:
a) Personal and family shame
b) Stigmatization of the victim and her family
c) Disruption of the victim's education and career
d) Health risks associated with pregnancy and delivery
e) Unsafe abortion

Each of these adverse effects can have profound and far-reaching consequences. Feelings of family and personal shame may trigger guilt and other complex emotions, potentially driving the victim towards seeking an unsafe abortion, posing life-threatening risks, or in the worst-case scenario, leading to suicide.

Continued stigmatization can exacerbate these risks, contributing to suicidal ideation. Moreover, shame and social stigma may deter victims from seeking essential antenatal care or skilled delivery assistance, increasing the likelihood of maternal mortality or severe complications like vesicovaginal fistula (VVF). Also, interruption of the victim's education not only jeopardizes her prospects but also detrimentally impacts her overall health outcomes.

When a pregnancy test is negative, follow the guidelines for pregnancy prevention above. A victim who is presenting within 10 days of assault whose pregnancy test is positive is likely to have been pregnant before the assault. If it is a recent conception, the victim may assume it is as a result of the assault but if she has been amenorrhoeic for several weeks before the assault she might have known she is pregnant.

Some victims may feel the pregnancy at this point has been ''contaminated'' or ''defiled'' as a result of the assault. She may then have already taken concoctions or begun to have suicidal ideation. The provider should counsel the patient and seek psychiatric

consultation where such service is available. When her life is in such danger, the provider should consider a therapeutic termination of the pregnancy to save her life as this is under Nigerian law. Other conditions where the life of the woman is in danger include (but are not limited to) end-stage renal disease, severe heart failure, cancers (cervix or uterus, kidney, etc.) and severe pre-eclampsia/eclampsia.

Victims who present several weeks after the assault and whose pregnancy tests are positive should be further examined using a bimanual exam to ascertain the gestational age. They should be counselled, treated or given other preventive measures and referred for antenatal care or given options as discussed accordingly above. If they have already taken concoctions to terminate the pregnancy, more investigations should be carried out to check for possible organ damage; these laboratory tests should include renal function tests (electrolyte, urea and creatinine (EUC)), liver function tests and full blood count among others.

Where the medications or concoctions ingested by the victim for pregnancy termination have led to fetal demise, appropriate measures should be carried out for safe uterine evacuation. Manual Vacuum Aspiration (MVA) or medical means (misoprostol alone or in combination with mifepristone) should be used when the uterine size is before 13 weeks. For larger uterine sizes, medical induction or dilatation and evacuation (D&E) should be used. Uterine evacuation by any means should be performed only by trained persons.

For victims who were already pregnant before the sexual assault took place and who opt for, or are fit for a continuation of pregnancy, the growing fetus should be taken into consideration for all preventive measures and treatment regimens. The following adjustments should be particularly noted:

a) Hepatitis B Immunoglobulin should be given instead of the active vaccine
b) Doxycycline should be avoided as a treatment for syphilis, chlamydia or bacterial vaginosis. Tetracycline should be avoided for syphilis too.
c) Prolonged use (longer than a day) of Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) should be avoided.
d) Avoid anaesthetic agents that may cause uterine contractions.
e) Avoid multiple x-ray exposures to the abdomen. The abdomen should be shielded when carrying out radiological (X-ray) examinations of other parts of the body.

C. Long-Term Needs (patient reports after one year)

a) Counsel and screen for STIs/HIV and manage accordingly
b) Refer for management of psychological consequences at SARC
c) Take notice and modify care at antenatal, delivery and postnatal periods

D. Follow up

The follow-up schedule should be discussed with the patient. However, this depends on the findings, the nature of the injuries and the care given. Vaccination schedules should be followed. It may take a few days to inspect wounds (or longer as the case may dictate), therefore, discuss culture results and check improvements for other ailments. Check HIV status and syphilis at three and six months.

E. Psychological Support

a) Counselling
b) Provision of shelter where available
c) Social Education
d) Skill Acquisition
e) Introduce victims to support services such as HIV counselling

11.0 Interference with Contraception

Some men, intending to get their partners pregnant, interfere with their family planning methods. They may hide contraceptive pills, intentionally refuse to use condoms, etc. In such cases, the health worker, when reported to, should refer the patient to the family planning clinic or offer appropriate services. Postinor 2, IUCD or other emergency contraception should be given within 72 hours of unprotected sexual intercourse or a broken condom. When pills are missed for one day, the pill should be taken the next day and another taken within 12 hours. If pills are missed for two days, two pills should be taken 12 hours apart for two days and the normal routine should continue thereafter. If a patient misses a pill for three or more days, the patient should be assessed for pregnancy or given menstrual induction.

12.0 Female Genital Mutilation

The 2013 NDHS estimated FGM to be up to 25 % among the female population. The prevalence in the state ranges from 0.1 – 77 %.

The practice of FGM varies from place to place but involves cutting the external genital area to close the genital area leaving a small opening for passage of urine and menstrual flow. Depending on the extent it is classified into four types.

Type I: Also called ‘’sunna.’’ The prepuce is excised with or without part or whole of the clitoris.

Type II: The prepuce, clitoris and part or whole of the labia minora are excised.
Type III: Also called Pharaonic circumcision. All or almost all of the external genitalia are excised followed by stitching together the vaginal opening to narrow it and allow space for urine to pass.
Type IV: Unclassified. This consists of any other mutilating procedure not described above. It may involve pricking, piercing or incision of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissues; angurya cuts (scrapping of tissues surrounding the vaginal orifice); gishiri cuts (incision of the anterior and sometimes posterior vaginal walls), the introduction of corrosive substances or herbs into the vagina to tighten or narrow it etc.

All sorts of instruments are used, including knives, scalpels, razor blades, sticks and broken glasses. These are usually not sterile. Perpetrators are usually traditional birth attendants and healers. However, health workers sometimes ignorantly perform the procedure in an attempt to ''medicalize'' it. Health workers are increasingly performing FGM. This is prohibited under the law.

It is carried out anytime from infancy to adulthood. The reasons also vary but are often related to attempts at curbing the sexual drive of the woman to protect virginity or prevent promiscuity but may also include purification, family honour, hygiene and aesthetics and also for religious purposes. Other reasons include ensuring the husband's sexual pleasure, the rite of passage for girls and myths like the prevention of perinatal mortality (baby will die if head touches the clitoris at delivery).

Cases of FGM will not usually present immediately to the hospital except when complicated (haemorrhage, shock, sepsis, genital abscesses, septicemia, urinary retention, pains, injury to adjacent tissues, failure to heal, pelvic peritonitis, vesico-vaginal fistula, recto-vaginal fistula, acquired gynaetresia, etc). Because the procedure is usually not done under anesthesia, struggles by the victim and her restraint by the perpetrators may cause other types of injuries like fractures and lacerations.

Late presentations may be incidental (scar tissues and keloids) findings or when it interferes with sexual function (dyspareunia, apareunia, vaginismus, frigidity), voiding (dysuria, VVF, recurrent urinary tract infections (UTIs), menstrual function (dysmenorrhea, haematocolpos), conception or delivery (dystocia from soft tissue and perinatal mortality). Cases of late presentation will usually need specialist (gynaecologist or plastic surgeon) management. Some patients may also develop psychological problems (low self-esteem, fear, suppression of feelings, bitterness, anger, feeling betrayed) and will need counselling and other therapy.

Since perpetrators are usually family members, it is difficult for consent to be given for reporting to the police but health workers should ask for it and record any refusal.

12.1 The State and National Response to FGM

In 1994, the World Health Assembly passed a resolution to eliminate Female Genital Mutilation (FGM). The national response in Nigeria included:

a) Baseline surveys and research to document the extent and impact (NDHS, National Baseline Survey, Best practices)
b) National Policy and Plan of Action on Female Genital Mutilation (2002-2008, 2013-2017)
c) Legislation in state and national assemblies (e.g., VAPP Act 2015 and particularly section 6 of the VAPP Law 2020 of Akwa Ibom State)
d) Community-level education and awareness creation
e) Collaboration with national and international agencies
f) The 2013-2017 National Policy and Plan of Action for the Elimination of Female Genital Mutilation in Nigeria has four main objectives, the first of which is to reduce the prevalence of FGM in Nigeria. The targets for this objective are:
g) Strengthen existing relevant systems
h) Strengthen inter-sectorial collaboration
i) Reduce the proportion of women and girls undergoing FGM from 30 % as reported in 2008 NDHS to less than 20 per cent in 2017
j) Increase the number of primary, secondary and tertiary health care facilities that provide care, counselling and support to affected female persons to about 80 per cent by 2017
k) Eradicate medicalization of FGM by 2015
l) This objective and all its targets expect health workers to improve their knowledge and capacity to handle cases of FGM and to provide enlightenment to the community. The guidelines below summaries the care health workers should give victims of FGM when they present to health facilities. A training module, which is part of the plan of action can be used as a resource material.

12.2 Management in Early Presentation

a) Take a full history – patient's bio data, date and time of the procedure, place procedure was done, who performed the procedure, type and sterility of instruments used, anesthesia given, quantity of blood loss, loss of consciousness, fever, etc.
b) Do a comprehensive examination with particular emphasis on the external genitalia. Check vital signs, pallor, and jaundice; check perineum for cuts, pus, blood, type of circumcision, sutures, etc.
c) Manage according to findings – treat sepsis/septicaemia (antibiotics, dressing/sitz bath, incision and drainage), arrest bleeders, give analgesics and tetanus toxoid.

Investigate for infection or anaemia. Give haematinics and transfuse blood if necessary.

d) Give psychosocial counselling.

e) Refer to appropriate medical discipline and/or other agencies who can meet the identified need.

12.3 Management in Late Presentation

a) Full history and physical examination

b) Discuss the diagnosis and treatment options

c) You may do deinfibulation or dilatation

d) In labour, do deinfibulation or give bilateral episiotomy. You may consider caesarean section in extreme cases

e) Offer psychosocial counselling

13.0 Widowhood and Other Harmful Traditional Practices

The solution to the issue of widowhood practices lies in public education. These practices vary and management of those of medical import should follow the usual method of history, physical examination, medical investigations and treatment. Some examples are mentioned here:

a) Shaving of hair

b) Wearing of black/white clothes

c) Sleeping on the floor or mat

d) Sleeping with a corpse in a lock-up room

e) Refrain from taking baths for some time

f) Being made to swear with husband's corpse

g) Seclusion

h) Seizing of the deceased properties and sometimes with the children of the widow

i) Forced marriage of the widow to members of the family of the deceased husband

j) Ingestion of poisonous substances – some widows are made to ingest water used to bathe their husband's corpse or other substances to prove their innocence and absolve them from having a hand in their death. These widows should be carefully checked to know the kind of fluid ingested and to check for any physical manifestation of poisonous substances. They should be observed, preferably in the hospital, if the substance is suspected to be poisonous and treated accordingly. Laboratory tests should be done to ascertain proper organ functions like liver function tests, renal

function tests, full blood count, etc.

k) Trauma/physical injury – take history, examine and record findings in detail and manage accordingly.

l) Psychological trauma – give psychosocial counselling. You may give anxiolytics or refer to a psychologist/psychiatrist and/or ask to change the environment.

It is worth noting that according to section 15 of the Violence Against Persons Prohibition Law of Akwa Ibom State 2020, the law prohibits harmful widowhood practices with a conviction to confinement for a period not exceeding 4 years or a fine not exceeding 500,000 naira or both were found liable.

Also, the law prohibits certain obnoxious traditional widowhood practices and rites and other matters connected thereto which came into force on the 28th day of February 2013 stipulates in Section 1 other levels of prohibited traditional widowhood practices.

14.0 Violence/Torture by State Actors and Others

This includes violence by military and paramilitary personnel, political thugs, religious thugs, tribal conflicts, prison inmates, schoolmates, etc. The principles written for sexual violence should be followed. Documentation, detailed history and physical examination, medical investigations, treatment and referral where necessary should be done. It is important to involve security agencies and a GBV response team at some point.

Furthermore, it is worth stating that section 24 of the Violence Against Persons Prohibition Law of Akwa Ibom State prohibits any violence perpetrated by state actors.

14.1 Management in Early Presentation

A quick assessment will determine whether or not the patient needs resuscitation before history and examination. Patients needing resuscitation may be bleeding or having breathing difficulties. Follow the steps for resuscitation. Ensure normal breathing by clearing/ sucking the airway and putting an oropharyngeal airway. Stop bleeders using pressure or tourniquet.

a) Minor injuries – clean and dress/suture as appropriate; give analgesics, antibiotics and tetanus prophylaxis. Give hepatitis B, HIV and other prophylaxis if bites, sexual assault, etc., are suspected. Schedule follow-up.
b) Major injuries – major lacerations, muscle tears, fractures, crush injuries, etc. – resuscitate, arrest bleeding, give prophylaxis and commence antibiotics with or without analgesics and request laboratory tests before referring to /calling in appropriate departments in the facility or referring to another facility if capacity is

not available at your facility.

14.2 Management in Late Presentation

For patients presenting late, immediate resuscitative measures may not be necessary. Take a detailed history and perform a complete physical examination. Do relevant laboratory tests. Treat according to findings – wound dressings, debridement, incision and drainage, analgesics, antibiotics, etc. Refer accordingly or prepare reports.

14.3 Victims Brought in Dead

Make a careful examination and give a detailed description of the corpse (swellings, wounds, fractures, etc.) and possibly take pictures before sending it to the mortuary. If services are available, get permission and send for post-mortem. Prepare a report and inform the Police. (verbal autopsy may be necessary)

14.4 Medical Bills

As much as possible, the state or some other person should bear the cost of treatment so that prompt attention is given to the victim. All cases of violence should be treated as emergency. Victims can also be referred to one of the SARCs in the State. The Free, Compulsory Treatment of Victims of Sexual Abuse Law also provides for SARCs and mandates that victims of sexual assault have access to free medical treatment.

Also, section 41 of the VAPP Law of Akwa Ibom State provides for the need for protection officers and one of their roles is to ensure that victims and survivors of violence have easy access to transportation to an alternative residence or safe shelter, the nearest hospital or medical facility for treatment, if the complainant so requires.

14.5 Documentation

Proper and detailed documentation should be done as this may help in proper treatment, referrals, police reports or court evidence.

15.0 Monitoring and Evaluation

This is necessary for maintaining and improving high-quality services and getting the necessary information for managers to allocate resources. This function should be organized, carried out or supervised by the local government Reproductive Health (RH) Coordinator, State RH Coordinator or the Director of Public Health at the State Ministry of Health, as the case may be.

Monitoring and Evaluation should determine:

a) The quality of services given
b) The output, performance and type of services provided

c) Patient outcomes (STIs, pregnancies, trauma, etc., from assault)
d) The improvements needed
e) It is highly recommended for Monitoring and Evaluation to be done twice a year.

16.0 Preparation of Report for Use as Evidence

From the first interaction through follow-up to referrals/discharge, proper documentation is important, especially for reports. Seek legal advice from the hospital legal unit or other sources including the Sexual and Gender-Based Violence Response Department of the Ministry of Justice and NGOs (International Federation of Women Lawyers, (FIDA), Akwa Ibom State Branch) that provide such specialized services.

16.1 Documenting cases of sexual abuse: a checklist for health workers

The following checklist is intended to assist health workers develop their documentation skills:

- Document all pertinent information accurately and legibly.
- With the patient's consent, notes, pictures, videos and diagrams should be created during the consultation; this is more likely to be accurate than if recreated from memory.
- Notes should not be altered unless this is clearly identified as a later addition or alteration. Deletions should be scored through once and signed, and not erased completely.
- Ensure that the notes are accurate; deficiencies may cast doubts over the quality of the assessment.
- Record verbatim any statements made by the victim regarding the assault. This is preferable to writing down your own interpretation of the statements made. Review or go through with the victim.
- Record the extent of the physical examination conducted and all "normal" or relevant negative findings.

16.2 Writing Reports

1. Explain what you were told and what you observed.
2. Use precise terminology. For example, write ''about five o'clock" instead of ''in the evening''; "laceration across the left vulva" instead of "laceration in the private part."
3. Maintain objectivity.
4. Stay within your field of expertise.
5. Distinguish findings and opinions.
6. Detail all specimens collected.

7. Write what you would be prepared to repeat under oath in court.

16.3 Giving Evidence

a) Be prepared.
b) Listen carefully.
c) Speak clearly.
d) Use simple and precise language.
e) Stay within your field of expertise.
f) Separate facts and opinions.
g) Remain impartial.

17.0 Guiding Principles

Guiding Principles (Adapted from GBV Guiding Principles and approaches (i-a mimn stan for gbv in emergencies p)

17.1 Survivor-Centred Approach:

An approach that provides a supportive environment for the survivor. Treatment must be in the best interest of the victim. The following factors can ensure this:

a) Safety: The safety and security of survivors are primary considerations in managing them.
b) Confidentiality: Survivors have the right to choose to whom they will or will not tell their story, and any information about them should only be shared with their informed consent.
c) Respect: Health personnel should respect the choices, wishes, rights and dignity of the survivor.
d) Non-discrimination: Survivors should receive equal and fair treatment regardless of their age, disability, gender identity, religion, nationality, ethnicity, sexual orientation or any other characteristic.

17.2 Rights-Based Approach:

A rights-based approach seeks to analyze and address the root causes of discrimination and inequality to ensure that everyone has the right to live with freedom and dignity, safe from violence, exploitation and abuse, according to principles of human rights law.

17.3 Humanitarian Principles:

The humanitarian principles of humanity, impartiality, independence and neutrality should underpin the medical management of victims of sexual and gender-based

violence.

17.4 “Do no harm” Approach:

The “do no harm” approach involves taking all measures necessary to avoid exposing victims to further harm as a result of medical management.

17.5 Principles of Partnership:

All those involved in the management chain should see their work as complementary and manage the victim in partnership to achieve the best results. The Principles of Partnership apply both among the different disciplines within a health facility and the different actors involved, including the Police, NGOs, support groups, etc.

18 Referrals

The Akwa Ibom State Gender-Based Violence Management Committee (AKGBVMC) has developed guidelines and referral standards based on the point of first identification of gender-based violence.

When a report is made first to a health facility, the needs of victims may vary but prompt referrals should be made as soon as there is a need after the care above has been offered. Referrals can be to different medical disciplines but may also be made to different support services which include:

- Sexual Assault Referral Centre (SARC)
- Shelters or safe houses
- HIV/AIDS counselling
- Legal aid
- Victim/witness protection programmes
- Support groups
- Counsellors
- Financial assistance agencies
- Social service agencies
- Government and non-governmental bodies working in this area like MWASW, MOJ, NHRC, NAPTIP, International Federation of Women Lawyers (FIDA), Medical Women Association of Nigeria (MWAN), SMOH, Society of Gynaecology and Obstetrics of Nigeria (SOGON), etc.

A list of these services, their addresses and telephone numbers should be available in all facilities.

When a survivor visits or is referred to **the Police**, the Police officers are expected to:

a) Direct survivor to the child protection officers or gender desk officers within the specialized unit at the station

b) Specialized unit should refer the survivor to the appropriate healthcare facility

c) Survivor's account should be documented by specialized units. Specialized unit follows up on and documents updates on survivor status. Follow-up could be through telephone calls to survivors and to a service provider at the unit to which the survivor was referred.

When the survivor first visits or is referred to **a Non-Governmental Organization or Community-Based Organization**, the NGO or CBO is expected to:

a) Inform the survivor of the available support options (healthcare, psychosocial, legal)
b) Document each case
c) Refer survivor to the appropriate healthcare facility
d) Provide (directly or via referral) counselling and/or legal aid, and/or shelter as needed (or as the case may be)
e) Provide follow-up services until the case is appropriately handled

When a survivor confides in **an individual (a teacher, a friend, a relative or someone within the community)** the individual is expected to:

a) Refer survivor to a healthcare facility
b) Notify an NGO or a CBO. The individual can do this by calling any of the helplines provided in the referral directory where such is available. He/she should follow up with the NGO/CBO to find out what happened to the survivor.

When a person **witnesses an act (or acts) of GBV being perpetrated**, the witness should immediately:

a) Attempt to call for/mobilize help from passers-by and other people around
b) Place a telephone call to the helpline numbers of the designated offices within the police force
c) Place a call to any of the organizations listed in the referral directory that are based in the state or closest to where the action is taking place, for further guidance

18.1 Other Needs

a) Sick leave/ reports
b) Faith-based support - Prayer/religious counselling
c) Legal aid service providers
d) Support to go to court
e) Witness protection and support

19.0 References

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20.0 Appendices

Appendix 1 Medical history and examination sample form

1. GENERAL INFORMATION

First Name	Other Name	Last Name
Address		Phone
Sex:	Date of Birth	Age
Date and time of examination	In the presence of	
Next of kin		Phone
Address		

2. THE INCIDENT

Also, ask the victim: Has this happened before? When was the first time? How long has it been happening? Who did it? Is the person still a threat? Also ask about bleeding from the vagina or the rectum, pain on walking, pain on passing stool, signs of discharge, and any other signs or symptoms.

Date of incident:	Time of incident:	Location:
Description of incident		

PHYSICAL VIOLENCE	YES	NO	DESCRIPTION TYPE AND LOCATION ON BODY
Type (beating, biting, pulling hair, etc.)			
Use of restraints			
Use of weapons(s)			
Drug/ alcohol involved			

PENETRATION	YES	NO	NOT SURE	Type of Orifice (Anal, Vaginal, Oral, and others)
Penis				
Finger				
Others (Specify)				
	YES	NO	NOT SURE	LOCATION (ORAL, VAGINAL, ANAL, OTHER)
Ejaculation				
Condom used				

3. MEDICAL HISTORY

AFTER THE INCIDENT, DID THE VICTIM	YES	NO		YES	NO
Vomit?			Rinse mouth?		
Urinate?			Change clothing?		
Defecate?			Wash or bath/Douche?		
Brush teeth?			Use tampon or pad/Tissue?		

CONTRACEPTION USE					
Pill {Specify type}		IUCD		Sterilization	
Injectable		Condom		Others	

MENSTRUAL/OBSTETRIC HISTORY	
Last menstrual period (dd/mm/yy)	Menstruation at time of event Yes ❑ No ❑
Evidence of pregnancy Yes ❑ No ❑	No. of weeks pregnant_____ weeks

HISTORY OF CONSENTING INTERCOURSE (ONLY IF SAMPLE HAS BEEN TAKEN FOR DNA ANALYSIS)		
Last consenting intercourse within week prior to the assault	Date (dd/mm/yy)	Name of individual:

EXISTING HEALTH PROBLEMS
History of female genital mutilation, type
Allergies
Current medication

VACCINATION STATUS	VACCINATED	NOT VACCINATED	UNKNOWN	COMMENTS
Tetanus				
Hepatitis B				
Carrier	**POSTIVE**		**NEGATI VE**	
HIV/AIDS				

4. MEDICAL EXAMINATION

Appearance (clothing, hair, conscious, obvious disability status (physical or mental)		
Mental state (calm, crying, anxious, cooperative, depressed, others)		
Weight:	Height:	Pubertal stage Circle: (pre-pubertal, pubertal, mature):
Pulse rate:	Blood pressure: Temperature:	
PHYSICAL FINDING Describe systematically, and draw on the attached body pictograms, the exact location of all wounds, bruises, petechiae, marks, etc. Document type, size, colour, form and other particulars. Be descriptive, do not interpret the findings. Take photographs and video clips if consent is given by the victim.		
Head and face	Mouth and nose	
Eyes and ear	Neck	
Chest	Back	
Abdomen	Buttocks	
Arms and hands	Legs and feet	

5. GENITAL AND ANAL EXAMINATION

Vulva/scrotum	Introitus and Hymen (intact?) Yes/No	Anus (bleeding, evidence of lubricant, discharge.tear etc)
Vagina/penis	Cervix	Bimanual/rectovaginal examination
POSITION OF PATIENT (SUPINE, PRONE, KNEE-CHEST, LATERAL, MOTHER'S LAP, DORSAL)		
For genital examination:	For anal examination:	

6. INVESTIGATIONS DONE

TYPE AND LOCATION	EXAMINED/SENT TO LABORATORY	RESULT

7. EVIDENCE TAKEN

TYPE AND LOCATION	SENT TO/STORED	COLLECTED BY/DATE

8. TREATMENT PRESCRIBED

TREATMENT	YES	NO	TYPE AND COMMENT
STI prevention/treatment			

Emergency contraception			
Wound treatment			
Tetanus prophylaxis			
Hepatitis B vaccination			
Post-exposure prophylaxis for HIV			
Other			

9. COUNSELLING, REFFERALS, FOLLOW-UP

General psychological status	
Survivor plans to report to police OR has already made report Yes No	
Survivor has a safe place to go to Yes ❑ No ❑	Has someone accompany her/him Yes ❑ No ❑
Counselling provider:	
Referrals	
Follow-up required Date of next visit	

Name of health worker conducting examination/interview:

Title: Signature:

Date:

Adapted Source: WHO, UNFPA, UNHCR. 2004. "Clinical Management of Rape Survivors: Developing Protocols for use with Refugees and Internally Displaced Persons- Revised Edition," pgs. 44-47.

Appendix 2
Report on Sexual Assault Examination

Name: _____

Folder No: _____

Medical Facility Name: _____

Date of examination: _____/_____/_____

Time of examination: _____/_____/_____

Examination performed by: (Print name and phone no.)

1. Medical officer: _____ Contact Tel. no _____
2. Registered nurse/midwife: _____ Contact Tel. no _____
3. CHO, S-CHEW) _____ Contact Tel. no _____

Additional information

Has a charge been laid?
If yes : Police Station _____

If no : Does patient intend laying a charge? Yes ❑ No ❑ Unsure ❑

Consent

Authorisation for collection of evidence and release of Information:

I hereby authorise _____ and _____
(print name) (signature/thumbprint)

to collect any blood, urine, tissue or any other specimen needed and to supply copies of relevant medical reports, including laboratory reports to the Law Enforcement Agency if requested. **(delete if not applicable)**

I recognise that the Sexual Assault Examination Form is solely to direct the appropriate clinical and forensic management for me. I understand that the medical and forensic information handed over to the Nigeria Police Force will be treated with confidentiality.

Person examined: _____ _____
(print name) (signature/thumbprint)

Witness: _____ _____
(print name) (signature/thumbprint)

Parent/guardian: _____ _____
(print name) (signature/thumbprint)

Date: _____ /_____ /_____

Community Health Centre/ Hospital Stamp

History of Assault

Name: _____ Age _____ Sex _____

Date of alleged rape: _____ /_____ /_____ Time of alleged rape: _____

Was patient conscious at the time of the sexual assault? Yes ❑ No ❑
If no, specify details

_____

_____

_____

Patient's description of assault: (e.g. walking home, at work, on a date, etc.).

_____

_____

_____

Perpetrator/s
Number 1 ☐ >1 ☐ Unknown ☐ Uncertain ☐

Assailant/s known to patient Yes ☐ Unknown ☐ Uncertain ☐

☐ Any further comment

_____

_____

_____

Details of alleged sexual assault incident

If patient knows or remembers, circle choice.

Victim's Home	Assailant's Home	Work Place	Motor Car	Beach
Alley	Terminus	Open Space	Public Toilet	Other

_____

Surface/s on which rape occurred, e.g., bed, carpet, tar, sand

Abducted to another place: Yes/No (circle choice) _____

Can patient remember experiencing any of the following? Being punched, throttled, kicked, hit or other? (circle which)

Other: (Specify) _____

Was a weapon seen or used? Yes / No (circle choice)

If yes, was it a knife, gun, bottle, screwdriver or other? (circle which) If other,

specify _____

Sexual acts performed during rape:

Does patient remember the type of sexual act, if any, that occurred during the attack? State whether oral, genital, anal or any other.

_____

_____

_____

Since rape, has patient:

Douched	Yes ☐	No ☐	Unknown ☐
Bathed	Yes ☐	No ☐	Unknown ☐
Urinated	Yes ☐	No ☐	Unknown ☐
Others (specify)	Yes ☐	No ☐	Unknown ☐

Personal history

Gynaecological History: Parity _____ LMP: _____ /_____ /_____ Cycle: _____ /_____

Pregnant now? Yes ☐ No ☐ If yes, gestational age: _____

Current Contraception Usage:

Oral Contraceptive: Yes ☐ If yes, type: _____ No ☐

Injectable Contraceptive: Yes ☐ Date last injection _____ /_____ /_____ No ☐

IUCD: Yes ☐ Date insertion ____ /_____ /_____ No ☐

Coitus within 72 hours of assault: Yes ☐ If yes, Date _____ /_____ /_____ Time _____
No ☐
Condom used during that coitus: Yes ☐ No ☐ Does patient practice douching: Yes ☐ No ☐

Relevant Medical History:

Time: _____

_____

_____

_____

Allergies: _____

_____

_____

_____

Current Medication:

_____

History given by: Victim

_____

(others, please specify)

_____

History taken by: _____

Designation/Qualifications: _____

Physical Examination

1. Patient to change into clinic gown. (Undress over large catch sheet of paper, fold and place in envelope.)
2. Remember to take all forensic specimens simultaneously with examination to avoid contamination and losing evidence.

General appearance of patient:

Height: _____ Weight: _____

Appearance & description of clothing, including underwear etc.:

_____

_____

_____

NOTE: All clothing to be kept in separate paper bag for forensic tests if possible. Emotional status (describe: e.g., withdrawn, crying, hysterical, etc.):

Evidence that the patient is under the influence of alcohol/drugs: Yes ☐ No ☐

If yes, describe the condition: (distinguish between use of alcohol and inebriation)

Speech: _____

Gait: _____

Temperature: _____ Pulse: _____ BP: _____ RR: _____

Pregnancy Test:

Positive:☐ Negative: ☐

CVS/RS: (note any abnormality detected):

_____

_____

Head and Neck Examination (Tick Box if abnormality detected):

Check eyes for haemorrhages (throttling) Yes ☐ No ☐

Describe: _____

_____

Mouth & Lips (abrasions/bruising/cuts):
Yes ☐ No ☐ (take oral swab)

Describe: _____

Scalp (lacerations etc.):

Yes ☐ No ☐

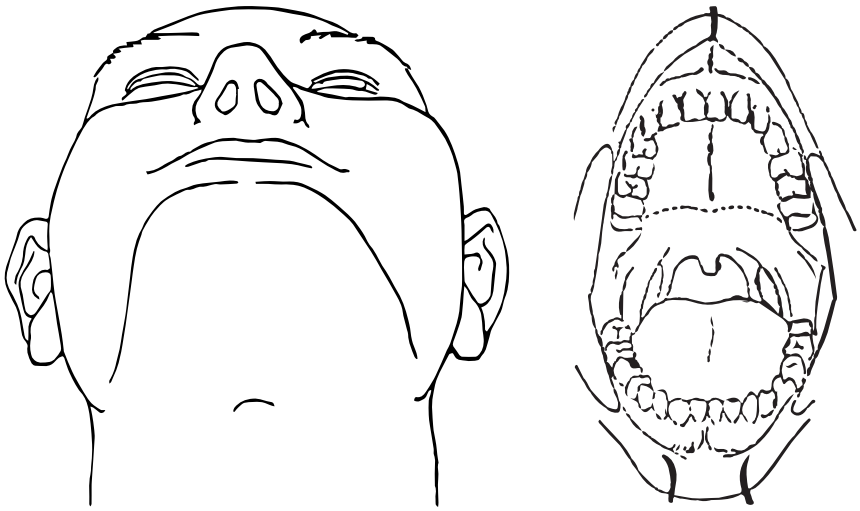
Describe: _____

Neck (bruises/lacerations etc.):

Yes ☐ No ☐

Describe: _____

Other: _____



Body

Bruises/scratches/lacerations/abrasions:

Yes ☐ No ☐

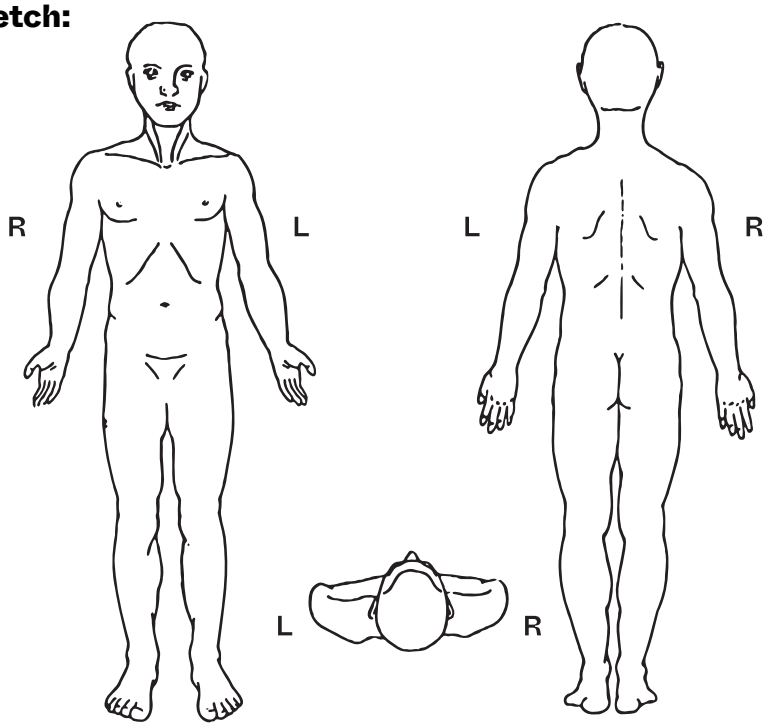
Indicate which of the above:

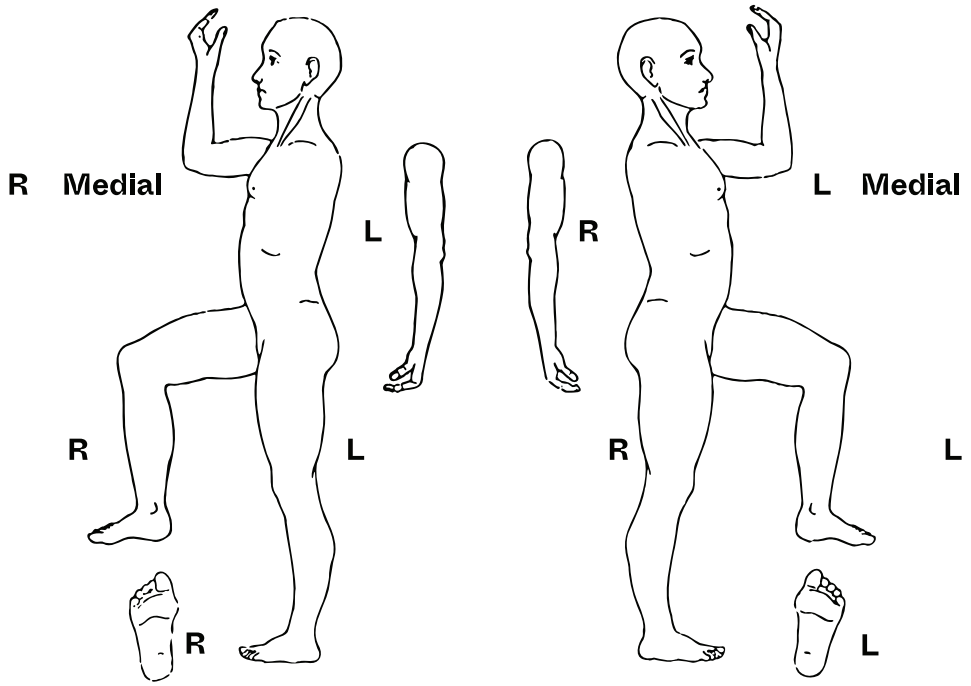
Size:

Number:

Location (note on anatomical drawing)

Anatomical Sketch:





Injuries:

Elbows	Yes ☐	No ☐
Ulna aspect of forearms	Yes ☐	No ☐
Hands	Yes ☐	No ☐
Fingers	Yes ☐	No ☐
Fingernails	Yes ☐	No ☐
Breast (especially bite marks)	Yes ☐	No ☐
Thighs (especially inner aspects)	Yes ☐	No ☐
Back, buttocks, calves (struggle while lying on back)	Yes ☐	No ☐

Other (describe details noted above)

Genital examination

External genital and anal examination:
(Take specimens simultaneously with examination in the following order– anal, rectal, external genital, deep vaginal, cervical)

	Anus:	Vulva:
Swelling	Yes ☐ No ☐	Yes ☐ No ☐
Redness	Yes ☐ No ☐	Yes ☐ No ☐

Bruises	Yes ☐ No ☐	Yes ☐ No ☐
Lacerations	Yes ☐ No ☐	Yes ☐ No ☐
Tenderness	Yes ☐ No ☐	Yes ☐ No ☐
Bleeding	Yes ☐ No ☐	Yes ☐ No ☐
Discharge	Yes ☐ No ☐	Yes ☐ No ☐

Other (describe details noted above)

Describe in detail any lesions noted above:

Special Areas for Attention:

Labia Majora/Labia Minora:

Inner aspects of the labia (may be injuries from assailant's fingers – fingernail scratches)

Urethral Orifice / para-urethral folds:

Clitoris / Prepuce of clitoris:

Check posterior commissure, perineum, natal cleft and rectum for tears/bruises Describe in detail:

Check hymen (need good light and examine hymen through 360°)

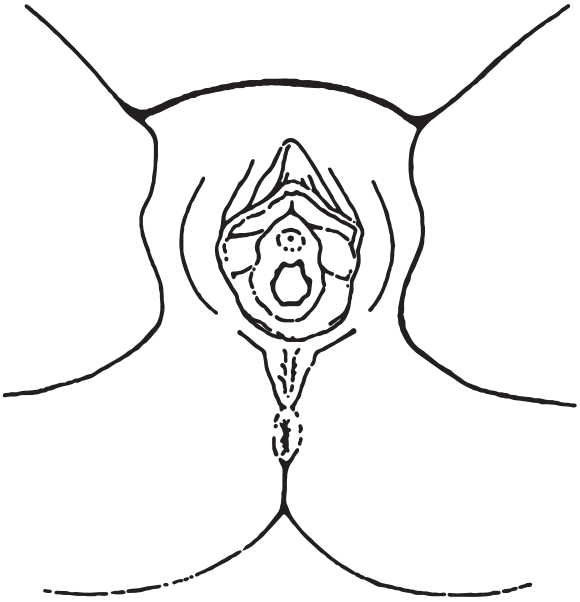
- Note shape, bumps, synechiae, clefts
- Tears (look for extension to vagina)
- Bruising
- Size of vaginal opening (whether admits 1, 2 or 3 fingers with ease or with difficulty alternatively estimate / measure in mm - in children).

Describe findings below:

Check vagina (preferably use plastic speculum and good light - do not use if painful, a virgin or presence of obvious trauma to vulva and hymen, e.g. tears):

- look for tears
- seminal fluid
- discharge
- bleeding

Describe the findings below:



Cervix (erosion, bleeding, discharge, etc.)

_____

_____

_____

Colposcopic examination:

Evidence of microtrauma: Yes ☐ No ☐ Was toludine blue used? Yes ☐ No ☐

If yes, describe findings

_____

_____

_____

Was a photograph of injuries taken? Yes ☐ No ☐

Male Genitalia

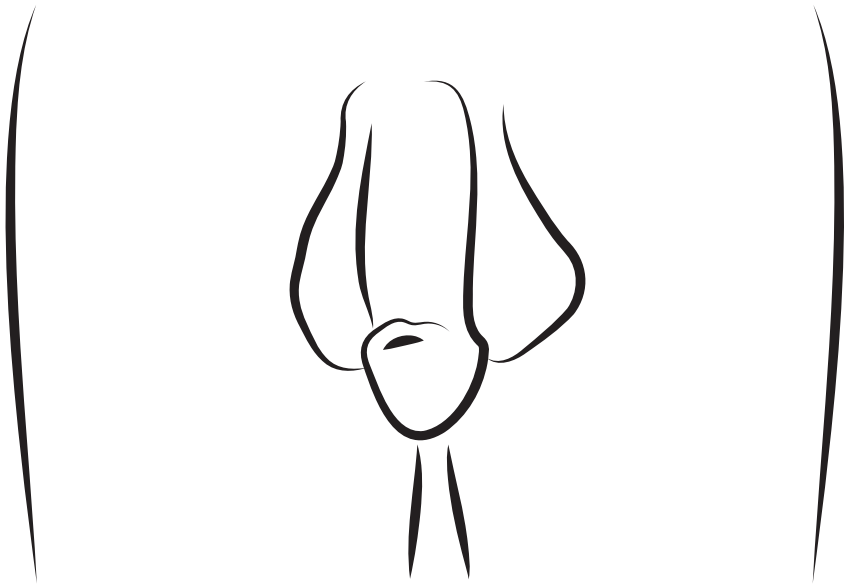
	Anus:	Vulva:
Swelling	Yes ☐ No ☐	Yes ☐ No ☐
Redness	Yes ☐ No ☐	Yes ☐ No ☐
Bruises	Yes ☐ No ☐	Yes ☐ No ☐
Lacerations	Yes ☐ No ☐	Yes ☐ No ☐
Tenderness	Yes ☐ No ☐	Yes ☐ No ☐

Bleeding	Yes ☐ No ☐	Yes ☐ No ☐
Discharge	Yes ☐ No ☐	Yes ☐ No ☐

SPECIAL AREAS FOR ATTENTION:
Foreskin:

Glans:

Shaft:



Record of forensic specimens taken:

Sexual Assault Evidence Collection Kit Yes ☐ No ☐

Crime Kit used (circle choice): 1 3 additional envelopes

Seal numbers: FSL (Forensic Science Laboratory) _____

SPECIMENS:

Blood (DNA) ☐	Fingernail scrapings ☐	Comnb ☐
Control pubic hair ☐	Control scalp hair ☐	Foreign Fluid ☐
Foreign hair ☐	Catch paper ☐	Tampon etc.☐

Other:

_____

_____

_____

if taken, put number taken in space beside Yes below:

	Swabs	Slides:
External genitalia	Yes ☐ No ☐	Yes ☐ No ☐
Deep vaginal	Yes ☐ No ☐	Yes ☐ No ☐
Cervical	Yes ☐ No ☐	Yes ☐ No ☐
Oral	Yes ☐ No ☐	Yes ☐ No ☐
Anal	Yes ☐ No ☐	Yes ☐ No ☐
Body surface	Yes ☐ No ☐	Yes ☐ No ☐
Discharge	Yes ☐ No ☐	Yes ☐ No ☐

If additional samples were taken, place into a clearly labelled official brown envelope, seal, sign across seal and hand in.

Any other evidence handed in, e.g., clothes

_____

_____

_____

Disposal of biological specimens (NB for chain of evidence):

1. Handed to relevant Law Enforcement: Yes ☐

   Name: _____

   Number: _____

   Station and telephone number: _____

2. Placed in cupboard: Yes ☐

   By whom – Name: _____

   Contact details: _____

3. Other disposal: [Ziploc, cellophane, etc.}

_____

_____

_____

Treatment for pregnancy, STDs and HIV (please record treatment as given in check boxes)
Immediate assessment and treatment of injuries Treat for:

1. **PREGNANCY PREVENTION**

   Yes ☐ No ☐

2 Ovral 28 stat and again 12 hours later (EGen-C also an option) if rape < 72 hours prior to treatment –

Provide anti-emetic and inform patient of side effects { Stemetil supps. 25mg 8 hourly PR / Maxolon 10mg 8 hourly PO

OR

Insert IUCD if > 72 hours and < 5 days.

2. **SEXUALLY TRANSMITTED DISEASES**

   Yes ☐ No ☐

Non-pregnant:	Pregnant:
ciprofloxacin 500mg po stat dose	ceftriaxone 125mg imi stat dose
doxycycline 100mg 8 hourly for seven days	erythromycin 500mg 6 hourly for seven days
	metronidazole 2g stat (warn re alcohol intake)

3. **ANTI-RETROVIRAL POST EXPOSURE PROPHYLAXIS**

Yes ☐ No ☐

In individual cases, discuss the possibility of TDLprophylaxis against HIV transmission if rape occurred less than 72 hours before presentation. (Refer to Addendum B: Treatment Guidelines for the use of TDL).

Post-Treatment Referral Options (use pre-printed referral letters, and record in check boxes as provided)

WARD ADMISSION

Yes ☐ No ☐

CLINIC OUTPATIENTS

1. For results of VDRL and HIV
2. Assessment of medical and emotional condition and need for psychological/psychiatric or other referral Yes ☐ No ☐
3. Contraception counselling FAMILY PLANNING CLINIC Yes ☐ No ☐
4. COUNSELLING SERVICE Yes ☐ No ☐

1. Social worker
2. District social services
3. Psychologist
4. Local resource
5. Private therapist

To: Rape Counselling Services

_____

_____

Dear Colleague

CLINIC STAMP

Please assist _____ , aged _____
(Name of survivor)

(S)he was raped/assaulted on _____ at _____,
(Date) (Place)

and was examined at _____ on _____
(Time) (Date)

at _____.
(Health Facility)

- The necessary documentation and forensic examination has been completed.
  (Delete sections which are not applicable)

- (S)he has / has not been treated for pregnancy prevention, and prevention of sexually transmitted diseases.

- The matter has / has not been reported to the police.

Yours sincerely,

MEDICAL OFFICER ON CALL

CLINIC STAMP

To: Family Planning Clinic

_____

_____

Dear Colleague

Please assist _____ with a follow-up consultation.
(Name of survivor)

She was given _____ as post-coital contraception
(Treatment)

on _____ at _____
(Date) (Time)

Please offer her whatever examination and contraceptive counselling you deem necessary.

Yours sincerely,

MEDICAL OFFICER ON CALL

APPENDIX 3
Sample checklist of supplies/needs

1. PROTOCOL	AVAILABLE
• Written medical protocol	
2. PERSONNEL	**AVAILABLE**
• Trained (local) health care professionals (on call 24 hours a day)	
• A "same language" female health worker or companion in the room during examination	
3. FURNITURE/SETTING	**AVAILABLE**
• Room (private, quiet, accessible, with access to a toilet or latrine)	
• Examination couch	
• Light, preferably fixed , angle-poised Lamp (a torch may be threatening for children)	
• Access to an autoclave to sterilize equipment	
4. SUPPLIES	
• "Rape kit" for collection of forensic evidence, including:	
◆ Speculum preferably disposable	
◆ Tape measure for measuring the size of bruises, lacerations, etc.	
◆ Paper bags for collection of evidence	
◆ Paper tape for sealing and labeling	
• Set of replacement clothes	
• Resuscitation equipment for anaphylactic reactions	
• Sterile medical instruments (kit) for repair of tears, and suture material	
• Needles, syringes	
• Cover (gown, cloth, sheet) to cover the survivor during the examination	
• Sanitary supplies (pads or local cloths)	
5. DRUGS	**AVAILABLE**
• For treatment of STIs as per country protocol	
• PEP drugs, where appropriate	
• Emergency contraceptive pills and/or IUD	
• For pain relief (e.g., paracetamol)	
• Local anesthetic for suturing	
• Antibiotics for wound care	

6. ADMINISTRATIVE SUPPLIES	AVAILABLE
• Medical chart with pictograms	
• Consent forms	
• Information pamphlets for post-rape care (for survivor)	
• Safe, locked filing space to keep confidential records	

Support Groups/Care Centres/Promoters

See Gender-based violence in Nigeria: National guidelines and referral standards, 2014 and the help lines listed below

Mainstreaming care capacity

Include sexual assault among modules in General Studies in tertiary institutions. Medical, residency, nursing and midwifery and CHEW curricula to include training in recognition, assessment and evidence-based management of sexual violence.

Suggested training curriculum

Going forward, we will need to develop:

- Police Training Manual developed by WACOL
- Practical guide on partnering with Police to improve SRHR access developed by Ipas
- WHO training manual?
- Management protocol/job aids
- Key messages for prevention in schools etc

Help lines

1. Sexual & Gender-Based Violence Response Department, Ministry of Justice - 08032713332
2. Ministry of Women Affairs and Social Welfare - 08031230382
3. Nigeria Police Force - 07038219036
4. FEYReP- 07064426577, 08033316234
5. National Human Rights Commission- 08182263936
6. NSCDC- 07033803019
7. FIDA, AKS Branch -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