Standards and Guidelines

for the Medical Management of Victims of Sexual and Gender-Based Violence in Benue State, Nigeria

Ipas Partners for Reproductive Justice
NIGERIA HEALTH FOUNDATION

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Foreword

The Federal Government of Nigeria, in its commitment to ending violence against persons in all facets of life, enacted the Violence Against Persons Prohibition (VAPP) Act in 2015. The Act provides the legal framework for advancing the noble fight to end or mitigate violence against individuals in areas relevant to the country.

This commendable effort at the national level was followed by concurrence in many State Assemblies, including Benue State, where the VAPP Bill was graciously signed into law by the then Executive Governor, His Excellency Dr Samuel Ortom, on May 28th, 2019. The purpose of this law is to eliminate violence in private and public life by prohibiting all forms of violence against persons and providing maximum protection and effective remedies for victims, as well as punishment for offenders.

An immediate consequence of the law, which is particularly relevant to victims, is the operationalisation of the health-related provisions that will translate into the provision of prompt and appropriate medical care. This care is intended to prevent, mitigate, or rehabilitate adverse medical conditions resulting from violence, as well as initiate the psychological healing of trauma in victims.

The Standards and Guidelines (S & G) presented here are for victim-centred medical care, which are not only evidence-based but also relevant and available in Benue State. They will assist healthcare providers and other relevant stakeholders at all levels to incorporate messages and information about the prevention and medical management of gender-based and other forms of violence into advocacy and sensitisation efforts. They will also support the capacity-building of healthcare providers in managing victims of gender-based and other forms of violence in accordance with established standards. Healthcare policymakers and managers will find the guidelines useful in policy formulation, budgeting, training requirements, and the equipping of facilities.

The multidisciplinary approach taken in drafting these guidelines ensures inclusiveness, comprehensive care, and proper documentation, preservation, and presentation of evidence for judicial proceedings. It will also encourage increased accountability, quality programming, and monitoring.

This document, which has emerged from several meetings and consultations with relevant

stakeholders under the guidance of the Benue State Ministry of Health and Human Services, will be instrumental in the prevention, management, and comprehensive care of victims of violence in Benue State.

Signed

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Honourable Commissioner for Health and Human Services,

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Acknowledgement

The Benue State Ministry of Health and Human Services acknowledges all the numerous stakeholders who contributed invaluably to the development of the Standards and Guidelines for the Medical Management of Victims of Violence in Benue State in accordance with the Violence Against Persons Prohibition Law 2019.

Worthy of note is the immense collaboration and support from Ipas Nigeria Health Foundation led by the Country Director, Dr Lucky Palmer, who teamed up with Benue State Ministries of Health and Human Services, Education and Knowledge Management, Justice and Public Order, Women Affairs and Social Welfare, Benue State Budget and Economic Planning Commission, Nigeria Police Force, Coalition of NGOs, CSOs and Persons with Disability, amongst other relevant stakeholders to make the health aspect of the VAPP Law, 2019 operational by actualising the development and production of this document.

These Standards and Guidelines for the medical management of victims of violence would not have been possible if there were no relevant laws in the form of the Violence Against Persons Prohibition Act, 2015, ratified in Benue State. On this note, the contributions of the Honourable members of the Benue State House of Assembly are especially appreciated for formulating the Benue State VAPP Law, 2019 after wide consultations.

Finally, I wish to profoundly appreciate His Excellency, the Executive Governor of Benue State, Rev. Fr. Dr Hyacinth Iormem Alia, for adopting and creating an enabling environment for the VAPP Law, 2019 which formed the basis for the development of this document towards the protection and improvement of the quality of life of victims of violence in Benue State.

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Document Preparation Process and Review

The enactment of the VAPP Act 2015 paved the way for state assemblies to begin the process of domesticating it to suit the contextual realities of their respective regions. Benue State achieved this on 28 May 2019, when Governor Samuel Ortom assented to the Bill, making it law in the State.

To ensure that the momentum of the process was not lost, Ipas Nigerian Health Foundation supported the state in moving forward by facilitating the development of the Standards and Guidelines for the Medical Management of Victims of Violence and inaugurating a technical committee to oversee its implementation.

Two consultants familiar with the process, Dr Godwin Akaba and Dr Talemoh Wycliffe Dah, were engaged to lead the exercise. Relevant stakeholders from the state were also involved in solidifying the process. They convened several times to review the draft Standards and Guidelines before validation.

Abbreviations

AZT	Zidovudine
CBOs	Community-Based Organizations
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHEW	Community Health Extension Worker
CHO	Community Health Officer
CLO	Civil Liberties Organization
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 Organizations
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
VAPP	Violence Against Persons Prohibition

Definition of terms

Violence Against Persons:

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

Violence Against Women

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 battery, sexual abuse of children in the household, dowry-related violence, 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.

(D.) Acts of violence against women also include forced sterilisation and forced abortion, coercive/forced use of contraceptives, female infanticide and prenatal sex selection.

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 by means of intimidation of any kind or by fear of harm or by means of 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.

Statutory rape: Nonforcible sexual intercourse with an individual younger than a specific age (18 years).

Date rape: Forcible sexual intercourse by a person(s)acquaintance during a voluntary social engagement in which the person 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 facts that the parties know each other or that the person willingly accompanied the other are not legal defences to a charge of rape.

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 for the purpose of producing a visual depiction of such conduct; or the rape and in some cases of caretaker or interfamilial relationships, statutory rape, molestation, prostitution, or other forms of sexual exploitation of children, or incest with children.

Incest: Knowingly and willfully having carnal knowledge of another within the prohibited degree of consanguinity and affinity as contained in the VAPP law 2019, with or without consent.

Spousal battery: This means the intentional and unlawful use of force or violence upon a person who is the perpetrator's spouse, including the unlawful touching, beating or striking of the person against his or her will with the intention of causing bodily harm to that person.

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 so as 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.

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.

Torture: Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him/her, or a third person, information or a confession, punishing him/her for an act he/she or a third person has committed or is suspected of having committed, or intimidating or coercing him/her or a third person, or for any reason based on discrimination of any kind when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions.

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. Examples include abduction and forceful marriage of a teenager with an unplanned pregnancy to an older man.

Harmful widowhood practices: Widowhood practices can be harmless or harmful. Harmful practices include shaving hair with a broken bottle, forcing the widow to sit on the floor perpetually, and forceful wife inheritance as a property against the woman's wish.

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 or other non-therapeutic reasons.
Gender-based violence: Physical, sexual, mental or economic harm inflicted on a person because of socially ascribed power imbalances between males and females. It also includes the threat of violence, coercion and deprivation of liberty, whether in public or private (unicef.org)

Reproductive health and sexual violence: Sexual harassment, forced exposure to pornography, forced abortion, virginity tests.

Victims: Individuals (i.e. women, men, or children) who report or were reported to have been sexually assaulted or suffered any form of violence as contained in the VAPP law, 2019.

Patients: Individuals receiving a service from or being cared for by a health worker.

Health workers: Professionals who provide health services; for example, doctors, nurses, community health extension workers and other professionals who have specific training in health care delivery.

Vulnerable groups include women, children, persons living in extreme poverty, persons with disability, the sick and the elderly, ethnic and religious minority groups, refugees, internally displaced persons, migrants and persons in detention.

Internally Displaced Persons are persons or groups of persons who have been forced or obliged to flee or leave their homes or places of habitual residence, in particular, as a result of or in order to avoid the effects of armed conflict, situations of generalised violence, violations of human rights, or natural or human-made disasters, and who have not crossed an internationally recognised state border.

Assent: The expressed willingness to participate in services. This applies to younger children who are by definition, too young to give informed consent but old enough to understand and agree to participate in services. Informed assent is, therefore, the expressed

willingness of the child to participate in services.

Informed Consent: Approval or assent, particularly and especially after thoughtful consideration. Free and informed consent is given based upon a clear appreciation and understanding of facts, implications and future consequences of an action. In order to give informed consent, the individual concerned must have all adequate, relevant facts at the time consent is given and be able to evaluate and understand the consequences of an action. They must also be aware of and have the power to exercise their right to refuse to engage in an action and/or to not be coerced. Children are generally considered unable to provide informed consent because they may not have the ability and/or experience to anticipate the implications of an action and because they may not understand or be empowered to exercise their right to refuse. There are also instances where consent might not be possible due to cognitive impairments and/or physical, sensory or intellectual disabilities.

Introduction

Acts of violence against persons in Nigeria are multifaceted and affect both genders, cutting across all cultures, socio-economic classes, religions, and age groups. Most often, these acts are not one-off occurrences in the lives of victims, as they are either accepted as norms or shielded by cultural and religious pillars of patriarchy. Women and children are most frequently the victims of violence.

Estimates published by the WHO indicate that globally, about 1 in 3 (30%) of women worldwide have been subjected to either physical and/or sexual intimate partner violence or non-partner violence in their lifetime. Globally, it is estimated that up to 1 billion children aged 2–17 years have experienced physical, sexual, or emotional violence or neglect in the past year.

In Nigeria, as reported in the 2018 Nigeria Demographic and Health Survey (NDHS), as many as 31% of women aged 15 to 49 years have experienced physical violence, while 9% have experienced sexual violence. 4% experienced sexual violence before the age of 18. More than half of women (55%) who have experienced physical or sexual violence never sought help to stop it. For those who did, women's families were the most common source of help (about 73%). Only 1% sought help from doctors, medical personnel, the police, or lawyers.

Studies from Benue State have also reported a high prevalence of domestic violence against women. The NDHS (2018) reported the prevalence of spousal physical, sexual, or emotional violence to range from 46% to 57%. Audu O and colleagues (2015) found that 67.2% of women had experienced domestic violence of different types, ranging from physical assaults (19.5%) to emotional/mental torture (30.2%). Okolo NC (2018) reported a prevalence of 63.3%. Major causes of domestic violence in the study area included specific cultural values, community norms, and harmful practices. There is also a widespread reluctance to speak about Sexual and Gender-Based Violence (SGBV), mainly because of its domestic, familial, and community nature, as well as fear of stigmatisation. This lack of openness leads to significant under-reporting.

Women and girls in conflict-affected states in Nigeria are said to be at increased risk of GBV due to deprived living conditions. The overcrowded housing conditions in camps exacerbate the dangers of intimate partner and other forms of domestic violence. Separation of children from their caregivers during displacement increases the number of female-headed households, adding financial burdens and exposing them to exploitation

and abuse. Within the context of camps, women and girls face a high risk of being forced into survival sex in exchange for mobility, safety, and access to resources. This situation, coupled with the emergence of the COVID-19 pandemic and the lockdowns implemented to curb its spread, has led to a marked rise in the burden of SGBV in Nigeria.

Benue State, located in North-Central Nigeria and perennially affected by herdsmen-farmer clashes and the COVID-19 pandemic, faces its share of challenges posed by violence against persons. These include but are not limited to, difficulties in accessing affordable quality services, largely due to the limited availability of SGBV referral centres, many of which are underfunded and lack capacity. Where services do exist, women and girls face barriers in accessing them due to socio-cultural norms and fear of stigma and discrimination. This also leads to significant under-reporting of SGBV cases, with existing data only representing the tip of the iceberg. Additionally, data collection on GBV is hampered by the lack of a centralised SGBV data collection mechanism.

Previous efforts by the Nigerian government in response to the rising prevalence of violence against persons include the establishment of agencies/units like the National Agency for the Prohibition of Trafficking in Persons (NAPTIP), the Nigeria Police Force Gender Unit, and the Legal Aid Council. These work synergistically with the Federal Ministry of Women Affairs and Social Development (FMWASD) and have produced National Guidelines and Referral Standards on Gender-Based Violence. In collaboration with the United Nations Programme on HIV/AIDS (UNAIDS), the National Action Committee on AIDS (NACA), and the United Nations Development Programme (UNDP), they also produced the National Plan of Action for Addressing Gender-Based Violence and the HIV/AIDS Intersection (2014–2016).

The enactment of the VAPP Act 2015 by the Federal Government of Nigeria and its ratification by the Benue State House of Assembly on 28 May 2019 further strengthened the commitment of both parties to address violence against persons. The Act provides the legal framework to combat violence in Nigeria and Benue State, including the right of victims to receive necessary comprehensive, material, medical, psychological, social, and legal assistance through governmental or non-governmental agencies. Victims are also entitled to be informed of the availability of legal, health, and social services and other relevant assistance and to have ready access to them (Benue State VAPP Law, 2019).

Knowledge about managing victims of violence is limited, and institutional capacity is largely lacking. Sexual assault and its management are scarcely covered in the curricula of most training institutions, such as medical schools, schools of nursing and midwifery, and health technology institutions.

Realising the objectives of the VAPP Law 2019 will require the strengthening of the health system and the institutional capacity of other relevant agencies to manage and provide the necessary care for victims of violence. A crucial step in this process is the standardisation ofstrengthening the health system and the institutional capacity of other relevant agencies to manage and provide the necessary care for victims of violence. A crucial step in this process is standardising care through the development and implementation of standards and guidelines contextually relevant to Benue State.

Offences Under the VAPP Law, 2019

Offences under the VAPP Law 2019 are listed below:

- Rape
- Inflicting physical injury on a person
- Wilfully placing a person in fear of physical injury
- 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

Reasons for the Standards and Guidelines

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 victims and need clear guidelines to manage them. These Standards and Guidelines were prepared for operationalising these health-related provisions of the VAPP Law, 2019.

Specifically, the Standards and Guidelines are meant to:
1.Help healthcare providers at all levels to incorporate messages/information about the prevention and medical management of gender and other forms of violence in all communications to stakeholders and the communities (advocacy and sensitisations).

1. Build the capacity of healthcare providers to manage victims of gender and other forms of violence, including female genital mutilation, harmful widowhood practices and their consequences.
2. Set standards for the medical management of victims of gender and other forms of violence, including female genital mutilation and harmful widowhood practices.
3. Guide healthcare policymakers and managers on incorporating gender and other forms of violence into policies, budgeting, training requirements, and facility equipping.
4. Enhancing quality programming and monitoring.
5. Increasing accountability among all stakeholders.

Common Myths/Facts About Rape

Myth	Fact
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 actually 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 industry, 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.
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.

Myth	Fact
Rape is reported immediately.	Victims do not report at all or delay reporting because they think nothing will be done, the perpetrator may have made threats against them or their families, they are afraid of family or community responses, or they are ashamed. Some victims simply feel it is a private matter or do not know where to report the incident.
People who are respected in society cannot be offenders.	There is no social categorisation that fits offenders, although certain groups may be involved more often.

Adapted from WHO guidelines (1)

Risk Factors for Sexual and Gender-Based Violence

Although sexual violence is more generalised and hardly dependent on individual-level background factors, certain circumstances place an individual at risk. These include:[13,14]

- Walking at odd times/places unaccompanied
- Female-headed households
- Children and young adults
- Children in foster care
- Physically and mentally challenged persons
- Persons in prison or detention
- Persons with mental illness
- Persons under the influence of alcohol or drug
- Single parent homes
- Persons with a history of rape or sexual abuse
- Persons involved in prostitution
- Persons in an abusive, intimate or dependent relationship
- Victims of war or armed conflict situations
- The homeless or impoverished
- Hawking
- Lower levels of education (perpetration of sexual violence and experience of sexual violence);
- A history of exposure to child maltreatment (perpetration and experience);
- Witnessing family violence (perpetration and experience);
- Antisocial personality disorder (perpetration);
- Harmful use of alcohol (perpetration and experience);
- Harmful masculine behaviours, including having multiple partners or attitudes that condone violence (perpetration);
- Community norms that privilege or ascribe higher status to men and lower status to women;
- Low levels of women's access to paid employment and
- Low level of gender equality (discriminatory laws, etc.).

Possible Health Consequences of Sexual and Gender-Based Violence

Sexual and Gender-Based violence causes serious short- and long-term physical, mental, sexual and reproductive health problems for women. They also affect their children's health and well-being. This violence leads to high social and economic costs for women, their families and societies. They include:

1. Fatal outcomes like homicide or suicide.
2. Physical Injuries:(Minor or major injuries)
   Minor injuries include (a) Abrasions and (b) Minor lacerations:
   Major injuries include: (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 to ankles, wrists and neck, (h) Pattern injuries (i.e. hand prints, finger marks belt marks, bite marks)
3. Unintended pregnancies, induced abortions, gynaecological problems and sexually transmitted infections, including HIV.
4. Intimate partner violence in pregnancy also increases the likelihood of miscarriage, stillbirth, pre-term delivery and low birth weight babies. Women who experienced intimate partner violence were 16 per cent more likely to suffer a miscarriage and 41 per cent more likely to have a pre-term birth.[14]
5. Psychological and mental health consequences:
   Rape-trauma syndrome – occurs after the assault and may last for weeks and even a lifetime.

   Acute phase – a disorganisation phase, characterised by physical reactions, like generalised body pains, eating disturbances, sleeping disturbances and emotional reactions, characterised by embarrassment, fear, anger, death wishes, anxiety, guilt, humiliation, depression, self-blame, mood swings (crying and sobbing, smiling and laughing, calm and controlled).

   Delayed or organisation 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 characterised by: (i) nightmares, flashbacks, phobias and gynecologic symptoms (sexual aversion, vaginismus, orgasmic dysfunction, Figidity). Victims may relocate or change telephone numbers. (ii) Depression (iii) Social phobias (iv) Multiple partners (v) Post-traumatic stress disorder - may appear after months or years. It is common in victims who had a horrific experience, especially where force was used. The trauma is re-experienced; there are intrusions (flashbacks, nightmares), hyperarousal,

avoidance (numbness, isolation, distractions, increased substance abuse and high-risk behaviours), etc. (vi) Alcohol abuse, illicit drug abuse (vii) Risk-taking behaviour (viii) Smoking (ix) Suicidal tendencies (x) Eating disorder.

6. Health effects can also include headaches, pain syndromes (back pain, abdominal pain, chronic pelvic pain), gastrointestinal disorders, limited mobility and poor overall health.
7. Sexual violence, particularly during childhood, can lead to increased smoking, substance use and risky sexual behaviours. It is also associated with the perpetration of violence (for males) and being a victim of violence (for females).

Impact on Children

Children who grow up in families where there is violence may suffer a range of behavioural and emotional disturbances. They can also be associated with perpetrating or experiencing violence later in life.

Intimate partner violence has also been associated with higher rates of infant and child mortality and morbidity (through, for example, diarrhoeal disease or malnutrition and lower immunisation rates).

Social and Economic Costs

The social and economic costs of intimate partner and sexual violence are enormous and have ripple effects on society. Women may suffer isolation, inability to work, loss of wages, lack of participation in regular activities and limited ability to care for themselves and their children.

Drugs and Sexual Violence

Drugs are related to sexual violence in three ways:

1. 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.
2. Offenders can use drugs on the victims to achieve the alteration of the victim's consciousness and reduce their ability to resist abuse.
3. Use of drugs by offenders may predispose them to violent behaviour.

Substances used vary according to location but include alcohol, marijuana, benzodiazepines, methamphetamine, gamma hydroxybutyrate, cocaine and ketamine. They may be used in combination. Medications sold at pharmacy shops and patent medicine stores are also used. They may include Tramadol or Benyllin cough syrup (with codeine).

Male Victims

This is probably much more underreported due to embarrassment. Settings where these occur are varied and include homes, prisons, schools, religious houses, etc. When the offenders are males, that is homosexuality. This is prohibited under the Nigerian law. 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 homosexual.

Prevention and Response

There is growing evidence on what works to prevent violence against women, based on well-designed evaluations. In 2019, WHO and UN Women, with endorsement from 12 other UN and bilateral agencies, published ***"RESPECT Women"*** - a framework for preventing violence against women aimed at policymakers.[15]

Each letter of **RESPECT** stands for one of seven strategies:

Relationship skills strengthening
Empowerment of women
Services ensured
Poverty reduced
Enabling environments (schools, workplaces, public spaces) created
Child and adolescent abuse prevented and
Transformed attitudes, beliefs and norms.

For each of these seven strategies, there are a range of interventions in low and high-resource settings with varying degrees of evidence of effectiveness. Examples of promising interventions include psychosocial support and psychological interventions for survivors of intimate partner violence; combined economic and social empowerment programmes; cash transfers; working with couples to improve communication and relationship skills; community mobilisation interventions to change unequal gender norms; school programmes that enhance safety in schools and reduce/eliminate harsh punishment and include curricula that challenge gender stereotypes and promotes relationships based on equality

and consent; and group-based participatory education with women and men to generate critical reflections about unequal gender power relationships.

RESPECT also highlights that successful interventions are those that prioritize safety of women; whose core elements involve challenging unequal gender power relationships; that are participatory; address multiple risk factors through combined programming that start early in the life course.

To achieve lasting change, it is important to enact and enforce legislation and develop and implement policies that promote gender equality, allocate resources to prevention and response, and invest in women's rights organisations.

(RESPECT women: Preventing violence against women)

Guiding Principles

- **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:

    - **Safety:** The safety and security of survivors are primary considerations in managing them.
    - **Confidentiality**: Survivors have the right to choose whom they will or will not tell their story, and any information about them should only be shared with their informed consent.
    - **Respect:** Health personnel should respect the choices, wishes, rights and dignity of the survivor.
    - **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.

- **Rights-based approach:** A rights-based approach seeks to analyse 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, in accordance with principles of human rights law.
- **Humanitarian principles:** The humanitarian principles of humanity, impartiality,

independence, and neutrality should underpin the medical management of victims of Sexual and Gender-Based Violence.

- **"Do no harm" approach:** A "do no harm" approach involves taking all measures necessary to avoid exposing victims to further harm due to medical management.
- **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 among the different disciplines within a health facility and the different actors involved, including the Police, NGOs, support groups, etc.

Role of the Health Sector

While preventing and responding to violence against persons requires a multi-sectoral approach, the health sector has an important role to play. This includes:

- Advocate to make violence against persons unacceptable and for such violence to be addressed as a public health problem.
- Provide comprehensive services, sensitise, and train healthcare providers to respond holistically and empathetically to survivors' needs.
- Prevent the recurrence of violence through early identification of persons and children who are experiencing violence and providing appropriate referral and support.
- Promote egalitarian gender norms as part of life skills and comprehensive sexuality education curricula taught to young people.
- Generate evidence on what works and on the magnitude of the problem by carrying out population-based surveys or including violence against persons in population-based demographic and health surveys, as well as in surveillance and health information systems.

Global Commitments and National/Policy Framework

A. Global Commitments

1. UN Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) 1979
1. UN Convention of the Rights of the Child 1989
2. African Charter on the Rights and Welfare of the Child 1990

3. UN Declaration on Elimination of Violence Against Women (DEVAW) 1993
4. Beijing Platform for Action 1995
5. Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, 2003
6. AU Solemn Declaration on Gender Equality 2004
7. UN Disability Convention 2006
8. Employment and Occupation Convention (No.169)
9. Universal Declaration of Human Rights 1948
10. Convention Against Torture and Other Forms of Cruel, Inhuman and Degrading Treatment 1984
11. International Covenant on Economic, Social and Cultural Rights1966
12. International Covenant on Civil and Political Rights 1966

B. National Legal/Policy Framework

1. 1999 Constitution of the Federal Republic of Nigeria (as Amended)
2. National Gender Policy (2006)
3. National Health Act (2014)
4. National Policy on FGM (2014)
5. National Health Policy, 2016 12.0 Management
6. Standard Operating Procedures (SOPs) for Gender-Based Violence Prevention and Response, Nigeria (2019)
7. Violence Against Persons Prohibition Act 2015
8. Administration of Criminal Justice Act 2015
9. Anti- Torture Act 2017
10. Evidence Act as amended 2011
11. National Agency for the Prohibition of Trafficking in Persons Act 2015
12. HIV/AIDS Anti-Stigma and Discrimination Act, 2014
13. Police Act 2019

C. Benue State Legal and Policy Framework

1. The Benue State Violence Against Persons (Prohibition) Law, 2019

Medical Management of Victims of Sexual and Gender-Based Violence

Management Before Arrival at the Hospital

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

1. Report as soon as possible: Late reporting is not uncommon. Late reporting or not reporting at all will allow all the possible consequences of Sexual and Gender-Based Violence run their courses. It will also allow time for forensic evidence to disappear and for the culprit to escape.
2. Maintain confidentiality and do not create a scene: When sexual assault has been made known or discovered, the first person to know should keep the information as closed as possible. Making the knowledge public will increase the survivor's psychological trauma and get him/her more stigmatised in society. Information should be limited to those who will act in place of the parents/guardian, necessary witnesses, medical personnel and the police. If the case gets to the police first before the hospital or medical facility, request to speak in confidence with the police on duty rather than talking loudly for everyone to hear when presenting the case. Request the police to get the victim to the hospital as soon as possible.
3. Provide cover/clothing for the survivor after taking pictures for evidence.
4. Keep all evidence intact, like soiled/torn clothing.
5. Secure the crime site if possible.

Management in Hospital

Evaluate the survivor in a room that satisfies the guiding principles of safety, confidentiality, etc., and always get ready all you need for sample collection, including rape kits.

Step One: A survivor-centred approach starts with preparing the survivor for evaluation. This includes the following:

- Introduce yourself
- Limit the number of people in the room to the minimum necessary. If the survivor wishes, ensure that a trained support person or trained health worker of the same sex

accompanies the survivor throughout the examination. Ask if they also want to have a specific person present (e.g., family member or friend)

- Determine the best way to communicate and adapt to the survivor's communication skill level and language. Avoid medical terminology and jargon
- Obtain informed consent (or a parent's informed consent in the case of a child)
- Explain what is going to happen during each step of the examination, why it is important, what it will tell you and how it will influence the care you will give. Make sure the survivor understands everything.
- Reassure the survivor they are in control of the examination.
- Explain that they can refuse any aspect of the examination they do not wish to undergo and that this will not affect their access to treatment or care but may affect the extent of treatment or prevention if that is later decided. Document the survivor's decision.
- Reassure the survivor that the examination findings will be kept confidential unless the survivor decides to bring criminal charges.
- Provide psychological first aid.
- Ask the survivor if they have any questions

Step Two: Obtain consent/assent. Consent may be needed for most court cases. The table below is adapted from the IRC.

Age group (years)	Child	Caregiver	If no caregiver or not in the child's best interest	means
0 – 5	-	Informed consent	Other trusted adults or case worker's informed consent	Written consent
6 – 11	Informed assent	Informed consent	Other trusted adults or case worker's informed consent	Oral assent, Written consent
12 - 14	Informed assent	Informed consent	Other trusted adult's or child's informed assent	Oral assent, Written consent
15 - 18	Informed consent	Informed consent with child's permission	Child's informed consent and sufficient level of maturity takes due weight	Written consent

Step Three: HISTORY

The third step is to take the history. Ensure the following:

- If the history-taking is conducted in the treatment room, cover the medical instruments until they are needed.
- Before taking the history, review any documents or paperwork brought by the survivor. Do not ask questions that have already been asked and documented by other people involved in the case except to seek more clarification.
- Avoid any distractions or interruptions during the history-taking.
- Make sure the survivor feels comfortable. Use a calm tone. If culturally appropriate, maintain eye contact.
- Be aware of the survivor's body language and your own.
- Be systematic. Proceed at the survivor's own pace. Be thorough, but don't force the survivor.
- Let the survivor tell their story the way they want to.
- Document the incident in the survivor's own words.
- Avoid questions that suggest blame (e.g., What were you doing there alone?).
- Be compassionate and non-judgmental.
- Explain what you are going to do at every step.

Dealing with Victim's Emotions

Be ready to deal with their various emotions and 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 be resolved with the healing process. 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.”

Sexual Violence History

- The date and time of the sexual violence
- The location and description of the type of surface on which the violence occurred
- The name, identity and number of assailants (if known)
- The nature of the physical contact and detailed account of violence inflicted
- Use of weapons and restraints
- Use of any medications/drugs/alcohol/inhaled substances
- Use of condoms and lubricants
- Any subsequent activities by the survivor that may alter evidence, e.g. bathing, douching, wiping, the use of tampons and changing of clothing
- Any symptoms that may have developed since the violence, e.g., Genital bleeding, discharge, itching, sores or pain
- Current sexual partner/s (be tactical about this, especially for singles/divorced/widowed/separated)
- Last consensual sexual intercourse

Gynaecological history:

- Last menstrual period
- Number of pregnancies
- Use (and type) of current contraception methods
- Male-specific history
- Any pain or discomfort experienced in the penis, scrotum or anus
- Any urethral or anal discharge
- Difficulty or pain in passing urine or stool

Ask questions to elicit risk factors. These may include

- Lower levels of education (perpetration of sexual violence and experience of sexual violence);
- A history of exposure to child maltreatment (perpetration and experience);
- Witnessing family violence (perpetration and experience);
- Antisocial personality disorder (perpetration);
- Harmful use of alcohol (perpetration and experience);
- Harmful masculine behaviours, including having multiple partners or attitudes that condone violence (perpetration);
- Community norms that privilege or ascribe higher status to men and lower status to women;
- Low levels of women's access to paid employment and
- Low level of gender equity (discriminatory laws, etc.).
- Past history of exposure to violence;
- Marital discord and dissatisfaction;
- Difficulties in communicating between partners and
- Male controlling behaviours towards their partners.
- Beliefs in family honour and sexual purity;
- Ideologies of male sexual entitlement and
- Weak legal sanctions for sexual violence.
- Walking at odd times/places unaccompanied
- One female head of household
- Children and young adults
- Children in foster care
- Physically and mentally challenged persons
- Persons in prison or detention
- Persons with mental illness or under the influence of alcohol or drug
- Single parent homes
- Persons with a history of rape or sexual abuse
- Persons involved in prostitution

- Persons in an abusive, intimate or dependent relationship
- Victims of war or armed conflict situations
- The homeless or impoverished
- Hawking
- Orphans and Vulnerable Children (OVC)

For children, the questions may be a little different.

- When did this happen?
- Was this the first time this happened, or has it happened before?
- What threats were made? Or incentives that were given?
- What part of your body was touched or hurt?
- Do you have any pain in your bottom or genital area?
- Is there any blood in your panties?
- Do you have difficulty or pain with voiding or defecating?
- Have you taken a bath since the sexual violence?
- When was the last time you had sexual intercourse? (explain why you need to ask about this).
- When was your last menstrual period? (girl)

Step four: Physical Examination

The fourth step is the physical examination (which includes the genital examination and forensic evidence collection)

- Reassure the survivor again and seek further consent.
- Try to make the victim feel comfortable and relaxed as much as possible.

A systematic ''Head to Toe'' approach may ensure all is covered.

- First, note the survivor's general appearance and demeanour.
- Take the vital signs, i.e. pulse, blood pressure, respiration and temperature.
- Inspect both sides of both hands for injuries. Examine the wrists for signs of ligature marks.
- Inspect the face and the eyes. If there is pain in a particular area, reassure and perform that examination last.
- Gently palpate the scalp to check for tenderness, swelling or depression.
- Inspect the ears, not forgetting the area behind the ears, for evidence of shadow bruising; shadow bruising develops when the ear has been struck onto the mastoid.
- Carefully examine the neck. The neck area is of great forensic interest; bruising can indicate life-threatening violence.
- Examine the breasts and trunk with as much dignity and privacy as can be afforded.
- Inspect the forearms for defense-related injuries. These are injuries that occur when the subject raises a limb to ward off force to vulnerable areas of the body, and include

bruises, abrasions, lacerations and incised wounds.

- Examine the inner surfaces of the upper arms and armpit or axilla for bruises.
- Recline the position of the survivor for abdominal examination, which includes abdominal palpation to exclude any internal trauma or detect pregnancy.
- While in the reclined position, examine the legs, starting with the front.
- If possible, ask the survivor to stand to inspect the back of the legs. Standing also best allows for inspection of the buttocks.
- Collect any biological evidence with moistened swabs (for semen, saliva, blood) or tweezers (for hair, fibres, grass and soil).

The Genito-Anal Examination for Adults

- Prepare/assemble the PRC kit before the survivor comes in.
- If available, ensure a trained support person of the same sex accompanies the survivor throughout the examination.
- Try to make the victim feel as comfortable and as relaxed as possible.
- Explain each step of the examination to them. For example, say, “I’m going to look carefully. I’m going to touch you here to look a bit more carefully. Please tell me if anything feels tender.”
- Examine the external areas of the genital region and anus, as well as any markings on the thighs and buttocks.
- Inspect the mons pubis; examine the vaginal vestibule, paying special attention to the labia majora, labia minora, clitoris, hymen or hymenal remnants, posterior fourchette and perineum
- Take a swab of the external genitalia before attempting any digital exploration or speculum examination. Gently stretch the posterior fourchette area to reveal abrasions that are otherwise difficult to see. If any bright blood is present, gently swab in order to establish its origin, i.e. whether it is vulval or vaginal.
- Warm the speculum prior to use by immersing it in warm water. Insert the speculum. Inspect the vaginal walls for signs of injury, including abrasions, lacerations and bruising.
- Collect any trace evidence, such as foreign bodies and hairs, if found. Suture any tears, if indicated.
- Remove the speculum.

Head to Toe Examination for Children

The physical examination of children should be conducted according to the procedures outlined for the adult section. Before examination, ensure consent is obtained from the child and/or the caregiver as appropriate. If the child refuses the examination, exploring the reasons for refusal would be appropriate.

When performing the head-to-toe examination of children, the following points are important:

- Record the height and weight of the child.
- In the mouth/pharynx, note petechiae of the palate or posterior pharynx and look for any tears to the frenulum.
- Record the child's sexual development and check the breasts for signs of injury.
- Note: Consider examining very small children while on their mother's or caregiver's lap. If the child still refuses, the examination may be deferred or even abandoned. Never force the examination, especially if there are no reported symptoms or injuries, because findings will be minimal, and any coercion may mean yet more violence to the child.
- Consider sedation or a general anaesthetic only if the child refuses the examination and conditions requiring medical attention, such as bleeding or a foreign body, are suspected.

The Genito-Anal Examination for Girls

Whenever possible, do not conduct a speculum examination on girls who have not reached puberty. It might be very painful and cause additional trauma. A speculum may only be indicated when the child has internal bleeding arising from a vaginal injury because of penetration. In this case:

- Help the child to lie on her back or side.
- Use a paediatric speculum and examine under general anaesthesia.
- Check for blood spots or trauma to the urethra.
- Examine the anus for bruises, tears or discharge. You may need to refer the child to a higher-level health facility for this procedure.

The Genito-Anal Examination for Boys

- Check for injuries to the skin that connects the foreskin to the penis.
- Check for discharge at the urethral meatus (tip of the penis).
- In older boys, pull back the foreskin to examine the penis. Do not force it since doing so can cause trauma, especially in younger boys.
- Help the boy to lie on his back or on his side and examine the anus for bruises, tears or discharge.

- Avoid examining the boy in a position in which he was violated, as this may mimic the position of abuse.
- Consider digital rectal examination only if medically indicated.

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
Depth	Give an indication of the depth of the wound(s). This may have to be an estimate.

Investigations

Forensic/laboratory specimens to be collected during the course of the examination should include:

- Hair
- Nail scratches
- Bite areas
- Saliva
- Semen
- Victim's clothing, especially soiled or torn clothing

Investigations are carried out for two purposes:

i. To know the general condition of the survivor
ii. For forensic evidence purposes

Investigations done on various specimens (urine, blood and swabs) will include:

Urine

- Urinalysis - microscopy
- Pregnancy test
- Spermatozoa/Blood
- HIV Test
- Haemoglobin (Hb) level
- Liver Function Tests (where possible)
- VDRL
- Hepatitis B Anal Swab High Vaginal Swab Oral Swab
- For evidence of spermatozoa

Note: Specimens to check for spermatozoa should only be collected when a survivor presents to the health facility within five days of sexual violence. On collection of the forensic evidence, the healthcare provider should preserve it for appropriate storage and hand it over to the police for further investigation and processing in a court of law.

Forensic Specimens

Source	material	equipment	Sampling technique
Anus (rectum)	Semen	Cotton swabs and microscope slides. Swab Blood Drugs	Use swab and slides to collect and plate material; lubricate instruments with water, not lubricant
	lubricant	Lubricant Cotton	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
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
Nails	Skin, blood, fibres, etc. (from assailant)	Sterile toothpick or similar or nail scissors/ clippers	Use the toothpick to collect materials from under the nail(s) or the nails can be cut, and 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 hair)	Swab or tweezers	Place material in sterile container (e.g. envelope, bottle)
Urine	Drugs	Sterile container	Collect 100mls of urine

Forensic Timescales

TYPE OF ASSAULT	FEMALE	MALE
Kissing, licking, biting	48 hours or longer	48 hours or longer
Oral penetration	48 hours (2 days)	48 hours (2 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 Assault (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.

Treatment

Immediate Needs

1. Treatment of injuries

- If necessary, and the patient agrees, take photographs first.
- Clean abrasions with chlorhexidine solution.
- Arrest bleeding and manage lacerations accordingly.
- Give tetanus toxoid injection of 0.5mls intramuscularly.
- Give antibiotics for injuries, e.g., Ampiclox 500mg for five days.
- Give medications/vaccinations for prophylaxis.
- If patient is already on ARVs, to continue his or her medications.

STI	MEDICATION/VACCINATION
HIV	Post-exposure prophylaxis (2 Nucleoside Reverse Transcriptase Inhibitors + 1 Protease inhibitor for 28 days), e.g.: • Truvada (Tenofovir and Emtricitabine) or Tenofovir and Lamivudine 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 • Tenofovir +Lamivudine +Doglutegravir (fixed combination) once 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 one PRN maximum eight 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 (accelerated schedule) Repeat test at 3 and 6 months' post assault
Gonorrhea	Ceftriaxone 500mg as a single stat 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)
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)

- Give analgesics (diclofenac, ibuprofen)
- Give anxiolytics, if necessary (diazepam 5mg, or bromazepam 1.5mg)
- 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. Risk for HIV is higher if offender is from high-risk group, if penetration took place, 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.

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 three months if positive.
- Hepatitis B, Hepatitis C - save sample and retest after three 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 pregnancy test is negative and 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 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 or Post pill up to 120 hours after assault

6. ***Refer to psychiatrist/clinical psychologist***
7. ***Refer for forensic medical examination,*** if service is available within facility or close by
8. ***Give follow-up date***

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

1. Treat injuries (dressing, debridement, antibiotics)
2. Screen for STIs and treat according to sensitivity tests or syndromic management if no facilities for screening
3. Test for pregnancy. If positive, see below for management of a positive pregnancy test
4. Give Hepatitis B vaccination
5. Refer to psychiatrist/clinical psychologist
6. Link to Sexual Assault Referral Centre (SARC), if accessible
7. Give follow-up date

If the patient presents after three months, screen for STIs, do a Full Blood Count, Liver Function Tests, Urea and Electrolytes, Fasting blood sugar, Lipids, and Amylase. If the 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:

- Personal and family shame
- Stigmatization of the victim and her family
- Disruption of the victim's education and career
- Health risks associated with pregnancy and delivery
- Unsafe abortion

Each of these negative effects can have far-reaching consequences. Family and personal shame may lead to feelings of guilt and other emotions, which may ultimately force the

victim to seek an unsafe abortion that endangers her life or, in the worst case, consider suicide. Suicide can also result from continued stigmatisation. Shame and stigmatisation may prevent a victim from accessing antenatal care or delivering under skilled care, both of which can lead to maternal mortality or devastating morbidity, such as vesico-vaginal fistula (VVF). Disruption of the victim's education means that her future is marred, which also impacts her overall health outcomes.

When pregnancy test is negative, follow the guidelines for pregnancy prevention above.
A survivor presenting within 10 days of assault a positive pregnancy test is likely to have been pregnant before the assault. If it is a recent conception, the survivor may assume it is a result of the assault, but if she has been amenorrhoeic for several weeks before the assault, she might have been aware of the pregnancy. Some survivors may feel that the pregnancy has been "contaminated" or "defiled" as a result of the assault. In such cases, she may have already taken concoctions or begun experiencing suicidal ideation. The provider should counsel the patient and seek psychiatric consultation where such services are available. When her life is in danger, the provider should consider a therapeutic termination of the pregnancy to save her life, in accordance with Nigerian law. Other conditions where the woman's life may be in danger include but are not limited to, end-stage renal disease, severe heart failure, cancers (such as cervical, uterine, or kidney cancers), and severe pre-eclampsia/eclampsia.

Victims presenting several weeks after the assault with positive pregnancy tests should undergo further examination, including a bimanual exam, to ascertain gestational age. They should be counselled, treated, provided with preventive measures, and referred for antenatal care or given options as previously discussed. If they have already taken concoctions to terminate the pregnancy, additional investigations should be conducted to check for possible organ damage. These laboratory tests should include renal function tests (electrolytes, urea, and creatinine), liver function tests, and a full blood count.

If the medications or concoctions ingested by the victim for pregnancy termination have led to fetal demise, appropriate measures should be taken for safe uterine evacuation. Manual Vacuum Aspiration (MVA) or medical methods (misoprostol alone or combined with mifepristone) should be used if the uterine size is less than 13 weeks. For larger uterine sizes, medical induction or dilatation and evacuation (D&E) should be used. Uterine evacuation by any method should only be performed by trained personnel.

For victims who were already pregnant before the sexual assault took place, they should receive appropriate counselling regarding pregnancy continuation or termination. For those who opt for, or are fit for pregnancy continuation, the growing fetus should be considered

in all preventive measures and treatment regimens. The following adjustments should be particularly noted:

- Hepatitis B Immunoglobulin should be given instead of the active vaccine
- Doxycycline should be avoided as treatment for syphilis, chlamydia or bacterial vaginosis.
- Tetracycline should be avoided for syphilis too.
- Prolonged use (longer than a day) of Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) should be avoided.
- Avoid anaesthetic agents that may cause uterine contractions.

Long-Term Needs (patient reports after one year)

1. Counsel and screen for STIs/HIV and manage accordingly
2. Refer for management of psychological consequences at SARC
3. Take notice and modify care at antenatal, delivery and postnatal periods

Follow-Up

The follow-up schedule should be discussed with the patient, and it will depend on the findings, the nature of the injuries, and the care provided. Vaccination schedules should be adhered to. Follow-up may occur within a few days to inspect wounds, discuss culture results, and assess improvements in other conditions, or it may be longer, depending on the case. HIV status and syphilis should be checked at threemonths, and six months.

Psychological Support

- Counselling
- Provision of shelter, where available
- Social education
- Skill acquisition
- Introduce support services, such as HIV counselling

Prevention of Sexual and Gender-Based Violence

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-based violence. Raising public awareness about the VAPP should be carried out using different local and national languages and all available channels, such as social media, radio, television, print media, religious institutions, traditional institutions, schools, judiciary, police, military, customs, immigration, prisons, civil defence corps, department of state security, peace corps, vigilante, existing community channels and health Institutions amongst others.

Group Programmes/Messages

Media

- Interviews/Discussions
- Commentaries
- Documentaries
- Jingles/Adverts
- Reports of incidences

Religious institutions

Strengthen and emphasise relevant injunctions regularly at meetings/worship sessions

- Engage Religious/Traditional institutions

Schools

Develop and disseminate Information, Education and Communication (IEC) materials (posters, handbills, stickers, etc.) • Talks to clubs and societies • Family Life Education (FLE) in primary and secondary schools • Counselling units in primary and secondary schools to include SGBV • SGBV as a course in tertiary institutions

Judiciary

- Advocacy, sensitisation and training for judges, prosecutors and other judicial personnel, state actors, and Ministries, Departments and Agencies.

Civil Society Groups: Groups including faith based organizations, community based organizations and civil society are encouraged 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 sensitisation

Promotion of gender equality and gender mainstreaming

Other gender activities

Key Messages for Awareness Creation

- Definitions of violence against persons
- Explanations of the legal and policy frameworks
- Prevalence and consequences on the society
- Risk factors
- Features of sex abuse
- Common types of grooming patterns used by perpetrators
- What to do when you suspect an attempt is likely
- What to do when you are a survivor
- Helplines (Complaints/Reports)
- Policies guiding engagement of civilians by state actor

Proper segregation of students' bathrooms in prisons and IDP camps: At school and at all camping grounds, teachers and organisers should ensure proper segregation of males and females. Proper security and complaint-lodging mechanisms should also be provided. This should be the same for IDP Camps and prisons. Regularly and clearly spell out punishments.

Encourage anonymous reports from neighbours, colleagues, etc. Get dedicated police and health lines and publicise them.

Ensure offenders are punished: There should be proper enforcement of extant laws to punish offenders and to serve as deterrence to intending offenders.

Free Telephone Helplines: These lines can offer guidance on what steps an endangered potential victim can take to forestall assault. Billboards, posters and handbills, radio and television jingles should regularly publicise the numbers

Manage offenders to prevent or reduce recidivism.

Provide psychological and biological treatment for offenders in prisons or outside the prisons as soon as legal proceedings are concluded to prevent future repeat of their deviant behaviours. Enact ''sexually violent predator'' laws (like long sentencing, mandated treatment, community registration and notification and protracted supervision during reintegration from prison).

Preparation of Report and Giving Evidence

Proper documentation is important from the first interaction through follow-up to referrals/ discharge, especially for reports. Seek legal advice from the hospital legal unit or other sources, including the National Agency for the Prohibition of Trafficking in Persons, the National Human Rights Commission, and NGOs that provide such specialized services. Follow the checklist in the box below.

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 likely to be far more accurate than when created 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, as this is preferable to writing down your own interpretation. Review these statements with the victim to ensure accuracy.
● Document the extent of the physical examination conducted, including all "normal" or relevant negative findings.

Guiding Principles

Below are some guiding principles for health workers on reports and court evidence in sexual violence cases.

Writing reports

- Explain what you were told and what you observed.

- 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.”
- Maintain objectivity.
- Stay within your field of expertise.
- Distinguish findings and opinions.
- Detail all specimens collected.
- Write what you would be prepared to repeat under oath in court.

Police Involvement

When a victim is brought to the police station immediately after an assault, before receiving medical attention, the officer on duty should not delay, but take the victim to a health facility without hesitation, while continuing the investigation. If the report is made later, the victim should still be referred to a health facility. No victim should be denied prompt attention or turned away if they report to the health facility without police accompaniment. If a victim reports without police involvement, their consent should be sought before informing the police. Functional communication lines with the police must be maintained by all health facilities, regardless of their location. Service providers must avoid succumbing to pressure from the police or other investigators and should refer them to higher authorities if asked to do anything they feel is unethical.

Interaction with Providers of Other Services

In addition to the police, health workers must interact with other service providers to ensure well-coordinated and multidisciplinary comprehensive care. Adherence to professional conduct and ethics should guide all interactions. Counsellors (who may be social workers, psychologists, support or religious groups), laboratory staff, lawyers, and NGOs are some of the groups health workers may collaborate with. A good working relationship should exist among these groups. In some cases, health workers may need to take on the roles of counsellors and laboratory staff where these groups are unavailable.

Monitoring and Evaluation

Monitoring and evaluation (M&E) are essential for improving services, maintaining high-quality care, and providing necessary information for managers to allocate resources. This function should be organised, carried out, or supervised by the Local Government Reproductive Health (RH) Coordinators, the State RH Coordinator, and local and state M&E officers, as applicable. M&E should assess:

- The quality of services provided
- The output, performance and type of services rendered
- Patient outcomes (STIs, pregnancies, trauma, etc., from assault)
- Areas needing improvement. Monitoring and evaluation should be conducted twice a year.

Management of Other Offences Under the VAPP Law, 2019

Interference With Contraception

Some men intending to get their partners pregnant interfere with their family planning methods. They may hide contraceptive pills, refuse to use condoms or engage in other acts of sabotage. When such cases are reported, the health worker should refer the patient to a family planning clinic or offer appropriate services. Emergency contraception, such as Postinor-2, an intrauterine contraceptive device (IUCD), or other options, should be provided within 72 hours of unprotected sexual intercourse or condom failure. If a pill is missed for one day, the missed pill should be taken the following day, and another pill should be taken within 12 hours. If two days of pills are missed, two pills should be taken 12 hours apart for two days, followed by the regular schedule. If pills are missed for three or more days, the client should be assessed for pregnancy or provided with menstrual induction.

Female Genital Mutilation

The practice of female genital mutilation (FGM) varies from place to place. Still, it typically involves cutting the external genital area, sometimes leaving only a small opening for the passage of urine and menstrual flow. The 2018 Nigeria Demographic and Health Survey (NDHS) estimated FGM prevalence at 20% among the female population in Nigeria, with state rates ranging from 0.0% in Adamawa to 61.7% in Imo State. In Benue State, the prevalence is 5.3%. FGM is classified into four types, depending on the extent of the mutilation:

- Type I: Also called “sunna.” The prepuce is excised, with or without the removal of part or all of the clitoris.
- Type II: The prepuce, clitoris, and part or all of the labia minora are excised.
- Type III: Also called Pharaonic circumcision. All or almost all of the external genitalia is excised followed by stitching together the vaginal opening to narrow it and allow space for urine to pass.
- Type IV: Unclassified. This includes any other mutilating procedures not described above, such as pricking, piercing, or incising the clitoris and/or labia; cauterizing the clitoris and surrounding tissue; angurya cuts (scraping of tissue surrounding the vaginal orifice); gishiri cuts (incisions of the anterior, and sometimes posterior, vaginal walls); and the introduction of corrosive substances or herbs into the vagina to tighten or narrow it.

Various instruments are used for FGM, including knives, scalpels, razor blades, sticks, and broken glass, most of which are not sterile. Perpetrators are often traditional birth attendants and healers, but health workers sometimes unknowingly perform the procedure in an attempt to "medicalize" it. This practice is increasingly performed by health workers, despite being prohibited under the Violence Against Persons Prohibition (VAPP) law. FGM may be carried out at any age, from infancy to adulthood. Reasons for the practice vary but are often linked to controlling a woman's sexual desire to ensure virginity or prevent promiscuity. Other motivations include purification, family honour, hygiene, aesthetics, religious beliefs, ensuring a husband's sexual pleasure, rites of passage for girls, and myths such as the belief that perinatal mortality will occur if the baby's head touches the clitoris during delivery.

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

Late presentation of FGM may manifest as incidental findings, such as scar tissue or keloids, or when it begins to interfere with sexual function (e.g., dyspareunia, apareunia, vaginismus, frigidity), voiding (e.g., dysuria, vesico-vaginal fistula [VVF], recurrent urinary tract infections [UTIs]), menstrual function (e.g., dysmenorrhea, haematocolpos), conception, or delivery (e.g., dystocia due to soft tissue damage and perinatal mortality). Cases of late presentation typically require specialist management, often by a gynaecologist or plastic surgeon.

Additionally, some patients may develop psychological problems such as low self-esteem, fear, suppression of feelings, bitterness, anger, or feelings of betrayal. These patients will need counselling and other forms of therapy. Since the perpetrators are often family members or those invited by them, it is challenging to obtain consent to report the case to the police. However, health workers should always seek consent and document any refusal.

Nigerian National Response Towards Eradication of FGM

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

- Baseline surveys and research to document the extent and impact (NDHS, National Baseline Survey, Best practices)

- National Policy and Plan of Action on Female Genital Mutilation (2002-2008, 2013-2017)
- Legislation in state and national assemblies (e.g. VAPP Act 2015, Benue State VAPP Law 2019)
- Community-level education and awareness creation
- Collaboration with national and international agencies

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:

1. Strengthen relevant existing systems
2. Strengthen inter-sectorial collaboration
3. Reduce the proportion of women and girls undergoing FGM from 30 per cent as reported in 2008 NDHS to less than 20 per cent in 2017
4. 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
5. Eradicate medicalisation of FGM by 2015. 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 summarise 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.

Management in Early Presentation

- Take a full history—the patient's biodata, date and time of procedure, place where procedure was done, who performed the procedure, type and sterility of instruments used, anaesthesia given, quantity of blood loss, loss of consciousness, fever, etc.
- 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.
- Carry out laboratory investigations according to findings and need.
- Manage according to findings – treat sepsis/septicaemia (antibiotics, dressing/sitz bath, incision and drainage), arrest bleeders, give analgesics and tetanus diphtheria(Td). Investigate for infection or anaemia. Give haematinics and transfuse blood, if necessary.

- Give psychosocial counselling.
- Refer to appropriate medical discipline and/other agencies who can meet the identified need.

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.

Widowhood and Other Harmful Traditional Practices

The solution to the issue of widowhood practices primarily lies in public education. These practices vary, and the management of those with medical implications should follow the standard approach of taking a detailed history, conducting a physical examination, performing relevant medical investigations, and providing appropriate treatment. A few examples are mentioned below:

- Shaving of hair
- Wearing black or white clothes
- Sleeping on the floor or mat
- Forced to sleep with the corpse in a locked room
- Refraining from bathing for a period of time
- Being made to swear with husband's corpse
- Seclusion
- Seizing of the deceased property and sometimes with the children from the widow
- Forced marriage of the widow to a member of the deceased husband's family
- Ingestion of poisonous substances – Some widows are forced to ingest water used to bathe their husband's corpse or other harmful substances to prove their innocence and distance themselves from accusations of involvement in their husband's death. These widows should be carefully assessed to determine the type of substance ingested and check for any physical signs of poisoning. They should be observed, preferably in a hospital setting, if a poisonous substance is suspected, and treated accordingly.
- Laboratory tests should be conducted to assess proper organ function, including liver function tests, renal function tests, full blood count, etc.
- Trauma/Physical injury – Take a detailed history, conduct a thorough examination,

record all findings, and manage accordingly.

- Psychological trauma – Provide psychosocial counselling. If needed, administer anxiolytics or refer the patient to a psychologist or psychiatrist. A change of environment may also be recommended.

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. Involve the police at some point if the case is not brought by the police.

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.

Documentation

Proper and detailed documentation should be done to help with proper treatment, referrals, police reports and/or court evidence.

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.

- 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.
- 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 or calling in appropriate departments in the facility or referring to another facility if capacity is not available at your facility.

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.

Victims Brought in Dead

Conduct a thorough examination of the body and provide a detailed description of any visible injuries, such as swellings, wounds, fractures, or other notable findings. If possible, take photographs of the body before it is transferred to the mortuary. If post-mortem services are available, seek permission from the appropriate authorities and arrange for a post-mortem examination. Ensure that a comprehensive report is prepared, and promptly inform the police of the situation.

Cost of Care

Once the budgetary provision for emergency care under the National Health Act (2014) becomes fully operational, the cost of treatment for victims of sexual and gender-based violence should be covered. In the interim, the cost of care should be borne by the National Health Insurance Scheme (NHIS) or any other applicable health insurance scheme under which the victim is covered.

Where the victim is not insured, the offender or their family should cover the cost of treatment. If the offender is unavailable or unknown, and the victim's family cannot afford the cost, the health facility shall cover the expenses, with proper documentation of the costs incurred. The health facility, whether public or private, can then apply for reimbursement through the social welfare department of the relevant governmental authority, which will receive regular funding to support this purpose.

References

1. World Health Organisation. Guidelines for medicolegal care of victims of violence. 2003.

2. Power and Patriarchy. Asian Pacific Institute on Gender Based Violence. 2016. Accessed at https://www.apigbv.

3. Violence against women Prevalence Estimates, 2018. Global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. WHO: Geneva, 2021

4. Global prevalence of past-year violence against children: a systematic review and minimum estimates. Hillis S, Mercy J, Amobi A, Kress H. Pediatrics 2016; 137(3): e20154079

5. National Population Commission (NPC) [Nigeria] and ICF. 2019. Nigeria Demographic and Health Survey 2018. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF

6. Audu O, Bako I.A, Jogo A.A, Ojabo C.O,Ogbeyi G.O et al. Prevalence of Domestic Violence against married women: A case study of Oiji ward, a rural setting in North Central Nigeria. Journal of Community Medicine and Primary Health Care.2015;.27(2):20-29

7. Okolo NC, Okolo C.PW 0246 Gender based violence in Nigeria: a study of Makurdi metropolis in Benue state, Nigeria. Injury Prevention. 2018;24:A99.

8. Benebo, F.O., Schumann, B. & Vaezghasemi, M. Intimate partner violence against women in Nigeria: a multilevel study investigating the effect of women's status and community norms. BMC Women's Health 18, 136 (2018). https://doi.org/10.1186/s12905-018-0628-7

9. UN Women, 2020, "Violence against Women and Girls: The Shadow Pandemic", https://www.unwomen.org/en/news/ stories/2020/4/statement-ed-phumzile-violence-against-women-during-pandemic.

10. National Plan of Action for Addressing Gender Based Violence and HIV/AIDS Intersection, 2014-2016

11. National Guidelines and Intervention Strategies on Gender Based Violence.2008.

12. Benue State of Nigeria Gazette: The Violence Against Persons Prohibition Law,2019; No 22, Vol. 44,29th May,2019

13. Federal Ministry of Health, Nigeria (2017). Standards and Guidelines for the Medical

Management of Victims of Violence in Nigeria. Abuja, Nigeria: Federal Ministry of Health.

14. WHO Fact Sheet: Violence Against Women.5th March, 2021.Available at : https://www.who.int/news-room/fact-sheets/detail/violence-against-women#

15. WHO.RESPECT Women. Preventing Violence Against Women. 6th April,2019. Available at: https://www.who.int/publications/i/item/WHO-RHR-18.19

Appendices

Appendix 1

CONSENT FORM

Consent for Release of Information.

This form should be read to the client or guardian in the first language. It should be clearly explained to the client that they can choose any or none of the options listed. I, _____ , give my permission for (Name of Organization _____) to share information about the incident I have reported to them as explained below:

1. I understand that in giving my authorization below, I am giving (Name of Organization _____) permission to share the specific case information from my incident report with the service provider(s) I have indicated, so that I can receive help with safety, health, psychosocial, and/or legal needs. I understand that shared information will be treated with confidentiality and respect, and shared only as needed to provide the assistance I request. I understand that releasing this information means that a person from the agency or service ticked below may come to talk to me. At any point, I have the right to change my mind about sharing information with the designated agency/focal point listed below. I would like information released to the following: (Tick all that apply, and specify name, facility and agency/organization as applicable)

   YES/ NO Safe shelter/house (Specify)

   _____

   YES/NO Psychosocial Support Services (Specify)

   _____

   YES/NO Health/Medical Services (Specify)

   _____

   YES/NO Law Enforcement/Security Services (Specify)

   _____

   YES/NO Legal Assistance Services (Specify)

   _____

Appendix 2

MEDICAL HISTORY AND EXAMINATION 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

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 in walking, pain in passing stool, signs of discharge, and any other signs or symptoms.

Date of incident:	Time of incident:	Location:
Description of incidence (supervisor's description)		

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?		
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
Hepatitis B				
Tetanus				
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	Anus
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 3

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. Other CHO, CHEW, e.t.c) _____ Contact Tel. no _____

Additional information

Has a report been made?

If yes : Police Station _____

If no : Does patient intend reporting/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 ❑

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:

_____

_____

_____

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 ❑

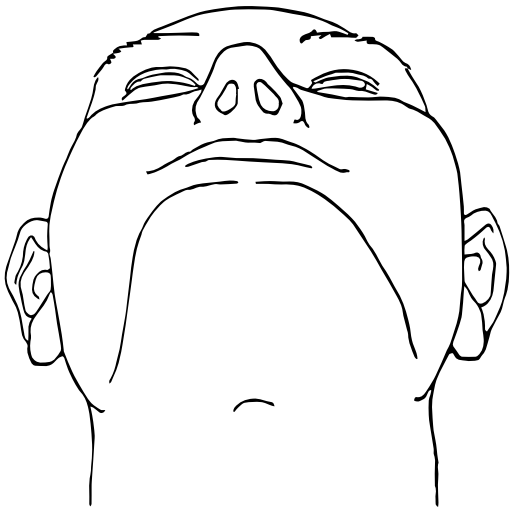
Describe:

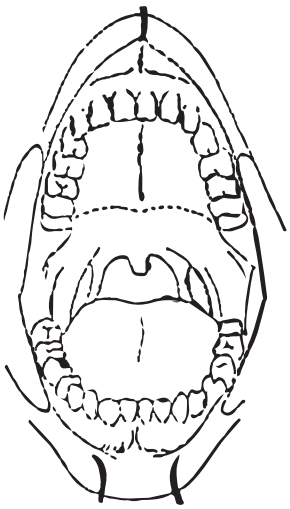
Neck (bruises/lacerations etc.):

Yes ❑ No ❑

Describe:

Other:





Body

Bruises/scratches/lacerations/abrasions:

Yes ❑ No ❑

Indicate which of the above: _____

Size: _____

Number: _____

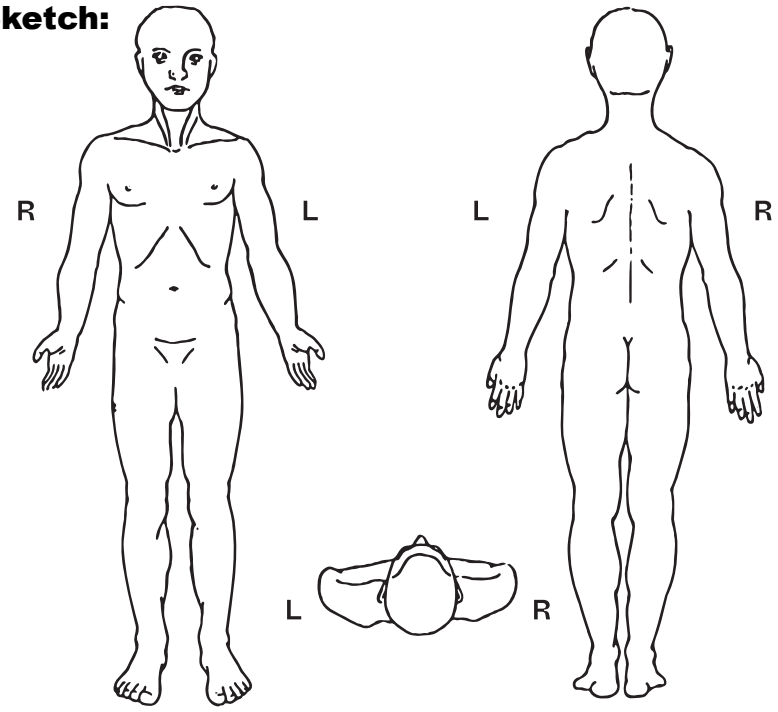
Location (note on anatomical drawing)

_____

_____

_____

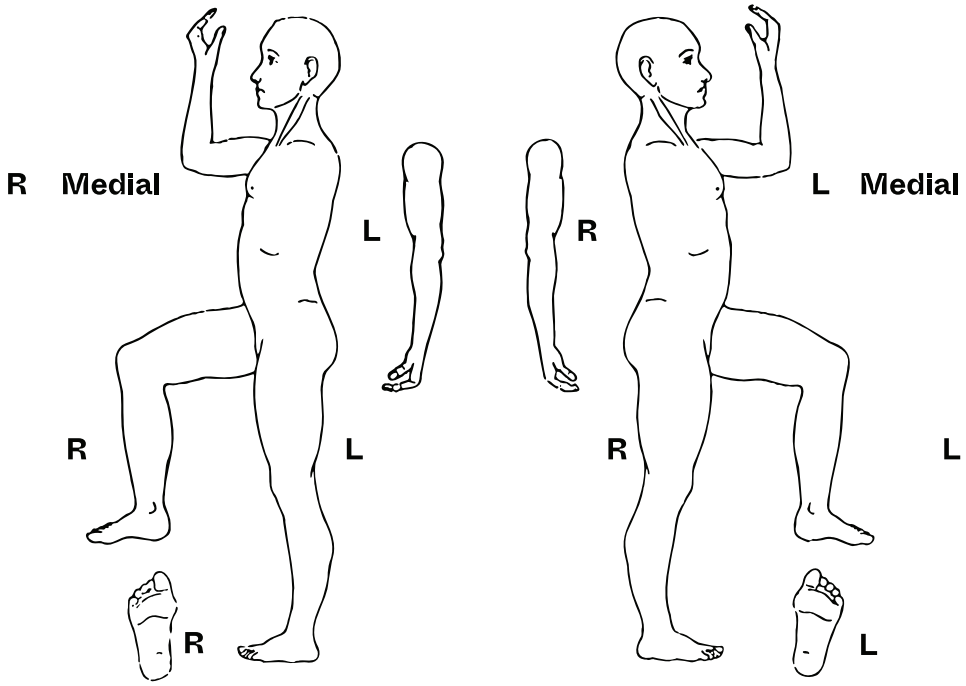
Anatomical Sketch:



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:
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°)

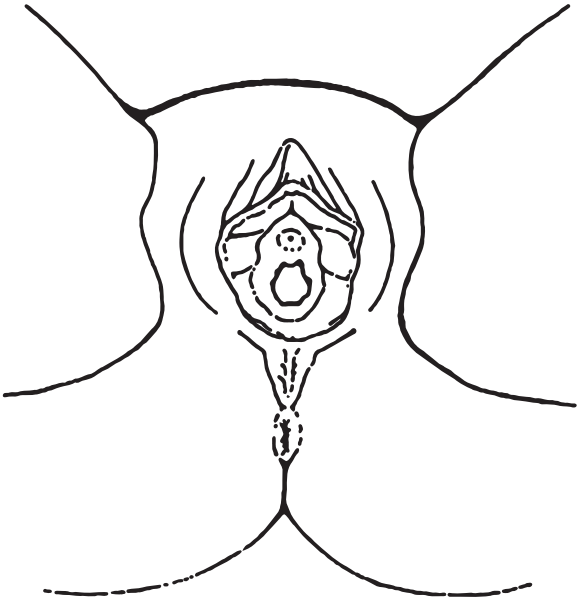
- Note shape, bumps, synechiae, clefts
- Tears (look for extension to vagina)
- Bruising
- Size of vaginal opening (whether admits 1, 2 or 3 fingers with ease or with difficulty alternatively estimate / measure in mm - in children).

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:

_____

_____

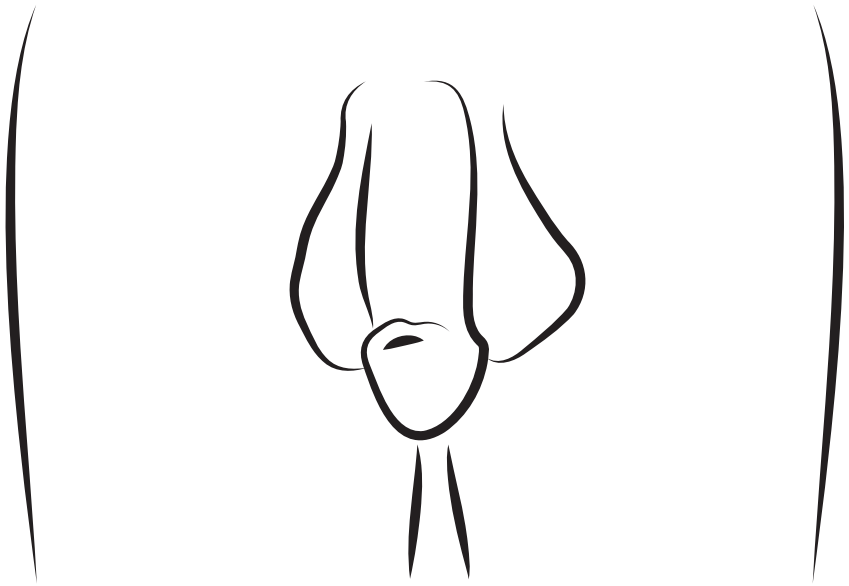
_____

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:
   ciprofloxacin 500mg po stat dose
   doxycycline 100mg 8 hourly for seven days

   Pregnant:
   ceftriaxone 125mg imi stat dose
   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 ❑

   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 _____

Please assist _____ , aged _____
(Name of survivor)

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

and was examined at _____ on _____
(Place) (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

CLINIC STAMP

APPENDIX 4

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 Women's Aid Collective (WACOL)
- Practical guide on partnering with Police to improve SRHR access developed by Ipas
- Management protocol/job aids
- Key messages for prevention in schools, etc

Help lines

1. Federal Government of Nigeria
   Toll Free Number for Violation of Girls and Women
   0705 357 6528

2. Child Domestic Violence Helplines
   0810 757 2829
   0813 164 3208

3. State Ministry of Women Affairs and Social Development,
   Makurdi
   Toll-free Number
   0803 1230 478
   0813 4901 226
   0805 470 7380

4. Nigerian Police Force,
   Benue State Command,
   Gender Desk
   0806 349 3609


UNITY AND FAITH, PEACE AND PROGRESS