Standards and Guidelines for the Medical Management of Survivors of all forms of Violence Against Persons in Kebbi State, Nigeria

Sexual and Reproductive Health Violence, Female Genital Mutilation, Widowhood and other Harmful Traditional Practices, Torture and other Violence by State Actors and Others

Ipas Partners for Reproductive Justice
NIGERIA HEALTH FOUNDATION

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Foreword

Kebbi State in her commitment towards putting an end to violence against persons in every facet enacted the Violence Against Persons Prohibition (VAPP) Law 2022. The purpose of the Act is aimed at the elimination of violence in private and public life, by prohibiting all forms of violence against persons and to provide maximum protection and effective remedies for survivors and punishment of offenders. The act provides the legal framework for effecting the noble fight to end or mitigate violence against persons in all areas that are contextually relevant for the State.

The VAPP Law in Kebbi State was signed into law 2022 by the Executive Governor of Kebbi State, His Excellency Senator Abubakar Atiku Bagudu on 27th July 2022. Towards the operationalization of the health-related provisions of Kebbi State VAPP Law 2022, the development of standards and guidelines for the management of survivors by health providers and other care givers is imperative to ensure prompt and appropriate medical care. This care is meant to avoid, mitigate, or rehabilitate untoward medical conditions resulting from the violence as well as begin a psychological trauma healing in survivors.

These standards and guidelines will help health-care providers and other relevant stakeholders at all levels of care (primary, secondary, tertiary) to incorporate messages/information about prevention and medical management of gender and other forms of violence in advocacy and sensitization exercises. They will also help in building the capacity of health-care providers to manage survivors of gender and other forms of violence according to set standards.

Health-care policy makers and managers will find the guidelines useful in policy formulation, budgeting, training requirements and equipping facilities. The multidisciplinary approach taken in drawing these guidelines will ensure inclusiveness, comprehensive care and documentation, preservation, and presentation of evidence for judicial proceedings. It will also encourage increased accountability and quality programming and monitoring.

This document which has emanated from several meetings and consultations with relevant stakeholders under the guidance of the Kebbi State Ministry of Health will be vital in the prevention, management, and comprehensive care of survivors of violence in Kebbi State.

Comrade Yunusa Musa Ismail
Honorable Commissioner of Health, Kebbi State

Acknowledgements

The Kebbi State Ministry of Health acknowledges all the numerous stakeholders who contributed invaluably to the development of the Standards and Guidelines for the Medical Management of Survivors of Violence in Kebbi State in accordance with the Violence Against Persons Prohibition Law 2022.

I wish to appreciate Ipas Nigeria Health Foundation ably led by the Country Director Mr. Lucky Palmer , the members of the stakeholder's committee and the collective efforts and contributions of the Ministries of Health, Education, Justice, Women Affairs and Social Development, Kebbi State Primary Health Care Development Agency, Nigeria Police Force, National Human Rights Commission, Coalition of NGOs, CSOs and Persons Living with Disability, Society of Gynaecology and Obstetrics of Nigeria(SOGON), Medical Women Association of Nigeria (MWAN)and other professional associations amongst others to actualize the desire of the Kebbi State government to provide care and succor to survivors of violence by developing this document.

These Standards and Guidelines for the medical management of survivors of violence will not have been possible, if there were no relevant laws in the form of the Violence Against Persons Prohibition (VAPP) law, 2022, ratified in Kebbi State. On this note, I wish to especially appreciate the contributions of the Honourable members of the Kebbi State House of Assembly, who formulated the Kebbi State VAPP Law 2022 after wide consultations.

My sincere appreciations go to His Excellency, the Executive Governor, Senator Abubakar Atiku Bagudu for assenting to the VAPP Law 2022 which formed the basis for the development of this document towards the protection and improvement of the quality of life of survivors of violence in Kebbi State.

Dr Shehu Nuhu Koko
Permanent Secretary, Ministry of Health, Kebbi State

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Document Preparation Process and Review

The birth of the VAPP Act 2015 paved the way for state assemblies to commence the process of domesticating it to contextual realities of their respective domains. Kebbi State achieved this on 27th of July 2022 when the Executive Governor, Senator Abubakar Atiku Bagudu, assented to the Bill, making it Law in the State.

Towards ensuring that the momentum of the process was not lost, Ipas Nigeria Health Foundation supported the state to move forward by working to produce the Standards and Guidelines for the Medical Management of Survivors of sexual and gender-based violence and inaugurated a technical committee to see to the implementation.

A Consultant conversant with the process, Dr Godwin Akaba, was engaged to lead the exercise. Relevant stakeholders from the state were also engaged to concretize the process. They met several times to consider the draft standards and guidelines later validated it.

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
PRC-Post Rape Care
SOGON-Society of Gynaecology and Obstetrics of Nigeria
VAPP – Violence Against Persons Prohibition

Introduction

Acts of violence against persons in Nigeria are multifaceted and affects both genders, cutting across all cultures, socio economic, religious and age groups.[1] Most times, they are not one-off occurrences in the lives of the Survivors because they are either accepted as a norm or shielded by cultural and religious pillars of patriarchy.[2] Women and children are most often the survivors of violence.

Estimates published by the World Health Organization 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.[3] 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.[4]

In Nigeria, as reported in the 2018 Nigeria Demographic and Health Survey (NDHS), as high as 31 percent of women aged 15 to 49 years have experienced physical violence, while 9 per cent have experienced sexual violence. Four per cent experienced sexual violence before age 18. More than half of women (55 per cent), who have experienced physical or sexual violence, never sought help to stop the violence. For those who did, women's own families were the most common source of help (about 73 per cent). Only 1 per cent sought help from doctors or medical personnel, the police, or lawyers.[5]

The NDHS (2018) reported that 9.0% of women from Kebbi state have experienced physical violence since age of 15 years while 1.6% and 5.0% have experienced it often or sometimes respectively in the preceding 12 months.[5] Several factors including cultural, religious, social traditional practices have tended to enhance the increasing prevalence of the problem.

Despite the increasing prevalence of sexual and gender-based violence in Kebbi state, there is paucity of facilities for immediate care, support, referral, and comprehensive care for survivors. Kebbi state has its share of the challenges posed by violence against persons on its survivors, which includes but not limited to challenges in accessing affordable quality services, largely due to the limited availability of SGBV referral centers, many of which are underfunded and have low capacity. Where they do exist, women and girls face challenges in accessing services due to socio-cultural norms and fear of stigma and discrimination. Stigma

and fear of discrimination also leads to significant under-reporting of cases of SGBV, such that existing data only indicates the tip of the iceberg.

The enactment of the VAPP Law 2022 and other advocacy efforts including support from various stakeholders Such as the Ministry of Justice, Ministry of Women Affairs and Child Development, Sexual Assault Referral Center, Kebbi State Primary Health Care Development Agency are steps in the right direction towards addressing the problem of sexual and gender-based violence in Kebbi State.

The VAPP Law 2022 therefore provides the legal framework for effecting the noble fight to end or mitigate violence against persons in all areas that are contextually relevant for the State including the right of survivors to receive the necessary materials, comprehensive medical, psychological, social and legal assistance through governmental agencies or non-governmental agencies providing such assistance as well as to be informed of the availability of legal, health and social services and other relevant assistance and be readily accorded access to them (Kebbi State VAPP Law 2022).[6]

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

The realization of the objectives of the VAPP Law 2022 will require the strengthening of the health system and other relevant agencies institutional capacity to manage and provide the necessary care for survivors of violence. One crucial approach is the standardization of care through the development and implementation of Standards and guidelines that is contextually relevant to Kebbi State.

Offences Under the VAPP Law 2022

Offences under the VAPP Law 2022 are listed below:

- Rape
- Inflicting physical injury on a person
- Willfully 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 survivor's physical or psychological wellbeing
- Female genital mutilation (FGM)
- Frustrating an investigation
- Willfully 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 Survivors and need deliberate and clear guidelines to manage them. These Standards and Guidelines were prepared for the operationalization of these health-related provisions of the VAPP Law 2022.

Specifically, the Standards and Guidelines are meant to:

1. Help healthcare providers at all levels to incorporate messages/information about prevention and medical management of gender and other forms of violence in all communications to stakeholders and the communities (advocacy and sensitizations).
2. Build capacity of healthcare providers to manage Survivors of gender and other forms of violence, including female genital mutilation, harmful widowhood practices and their consequences.
3. Set standards for the medical management of survivors of gender and other forms of violence, including female genital mutilation and harmful widowhood practices.
4. Guide healthcare policy makers and managers on how to incorporate gender and other forms of violence when making policies, budgeting, training requirements and equipping facilities.
5. Enhancing quality programming and monitoring
6. Increasing accountability among all stakeholders

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.

Domestic violence: Any act perpetrated on any person in a domestic relationship where such act causes harm or may cause imminent harm to the safety. Health or well-being of any person

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 sterilization and forced abortion, coercive/forced use of contraceptives, female infanticide, and prenatal sex selection.

Rape: A person commits the offences of rape if:

- He or she intentionally penetrates the vagina, anus, or mouth of another person with any other part of his or her body or anything else.
- The other person does not consent to the penetration; or
- The consent is obtained by force or means of threat or intimidation of any kind or by fear of harm or by means of false and fraudulent representation as to the nature of the act, the use of any substance or additive capable of taking away the will of such person or in the case of a married person by impersonating his or her spouse.

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

Date rape: Forceful 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 fact that the parties knew each other or that the person willingly accompanied the other are not legal defenses 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 visual depiction of such conduct; or the rape, and in 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,2022 with or without consent.

Spousal battery: Means the intentional and unlawful use of force violence 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 a 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.

"Economic abuse" means-

Forced financial dependence:

Denial of inheritance or succession rights, the unreasonable deprivation of economic or financial resources to which any person is entitled or which any person requires out of necessity, including:

- Household necessities,
- Mortgage bond repayments, or
- Payment of rent in respect of a shared residence; or
- The unreasonable disposal or destruction of household effects or other

property in which any has an interest.

"Emotional, verbal and psychological abuse" means a pattern of degrading or humiliating conduct towards any person, including-

Repeated insults,

Ridicule or name calling:

Repeated threats to cause emotional pain; or

The repeated exhibition of obsessive possessiveness, which is of such a nature as to constitute a serious invasion of such person's privacy, liberty, integrity, or security.

"Forced isolation from family and friends" includes preventing a person from leaving the home or from having contact with family, friends or the outside community.

"Harassment" means engaging in a pattern of conduct that induces fear of harm or impairs the dignity of a person including-

Stalking: Repeatedly making telephone calls or including another person to make telephone calls to a person, whether or not conversation ensues; and repeatedly sending, delivering or causing delivery of information such as letters, telegrams, packages, facsimiles, electronic mail, text messages or other objects to any person

"Harmful traditional practices" means all traditional behavior, attitudes or practices, which negatively affect the fundamental rights of women, girls, or any person and includes harmful widowhood practices, denial of inheritance or succession rights, female genital mutilation or female circumcision, forced marriage and forced isolation from family and friends.

Harmful widowhood practices: Harmful widowhood practices include shaving hair with a broken bottle, forcing the widow to perpetually sit on the floor, 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 in private (unicef.org)

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

Survivors: 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 2022.

Patients: Individuals who are receiving a service from or are 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 the field of health care delivery.

Vulnerable groups: means women, children, persons living under 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/people 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 generalized violence, violations of human rights, or natural or human-made disasters, and who have not crossed an internationally recognized state border.

Assent: The expressed willingness to participate in services. This applies to younger children who are 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.

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") get raped. Any person can be a survivor of rape.
Boys/males don't get raped	People of any gender could be survivors 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.	Most 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.
Rape is reported immediately.	Survivors 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 **Survivors** simply feel that 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 categorization that fits offenders, although certain groups may be involved more often.

Adapted from WHO guidelines (1)

Possible Health Consequences of Sexual And Gender-Based Violence

Sexual and gender-based violence cause serious short- and long-term physical, mental, sexual, and reproductive health problems for women. They also affect their children's health and wellbeing. 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 (b) Minor lacerations (c) Skin changes e.g Discolorations:
   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. Reproductive Health consequences: Unintended pregnancies, unsafe abortions, gynecological problems, and sexually transmitted infections, including HIV, and HPV. Long-term effects – diminished levels of function, feeling unhealthy, sexual dysfunction, chronic pelvic pain, infertility, dysmenorrhea, Post-traumatic stress disorder in pregnancy, labour and delivery, postpartum depression, postpartum psychosis, Frigidity, irritable bowel syndrome, vaginal pain, breast pain, headaches, rectal bleeding, non-menstrual vaginal bleeding or dis- charge, bladder infection, dysuria, and acute urinary retention.
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 percent more likely to suffer a miscarriage and 41 percent more likely to have a pre-term birth.[14]
5. Psychologic and mental health consequences: ***Rape-trauma syndrome*** - occurs after the assault and may last for weeks.
   Acute phase: a disorganization phase, characterized by physical reactions, like generalized body pains, eating disturbances, sleeping disturbances, and emotional reactions, characterized by embarrassment, fear, anger, death wish, anxiety, guilt, humiliation, depression, self-blame, mood swings (crying and sobbing, smiling and laughing, calm and controlled).

Delayed or organization phase - occurs weeks and months after the assault and varies from person to person, depending on age, life situation, personality traits, and support given. It is characterized by: (i) nightmares, flashbacks, phobias, and gynaecologic symptoms (sexual aversion, vaginismus, orgasmic dysfunction). Survivors 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 survivors who had a horrific experience, especially where force was used. The trauma is re-experienced; there are intrusions (flashbacks, nightmares), hyper arousal, 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 survivor 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 immunization rates).

Children who are survivors of SGBV are at risk of having delayed developmental milestones, and poor performance in school. Complications such as VVF, RVF, and infections with HIV, Hepatitis can also occur.

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

2. Offenders can use drugs on the Survivors to achieve the alteration of the Survivor'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, benyllin cough syrup (with codeine).

Male Survivors

This is probably much more underreported due to embarrassment. Settings where these occur are also 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 policy makers.[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 mobilization 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 promote 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 the safety of women; whose core elements involve challenging unequal gender power relationships; that are participatory; that address multiple risk factors through combined programming and 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 organizations. (RESPECT women: Preventing violence against women)

Section 37 of the Kebbi State VAPP Law 2022 has incorporated the seven strategies as follows:

(1) In addition to the rights guaranteed under Chapter IV of the Constitution of the Federal Republic of Nigeria, 1999, or any other International human rights instrument to which Nigeria is a party, every victim of violence, as defined in section

1 of this Law, is entitled to the following rights:

a) to receive the necessary materials, comprehensive, medical psychological, social and legal assistance through governmental agencies or non-governmental agencies providing such assistance;

b) to be informed of the availability of legal, health and social services and other relevant assistance and be readily afforded access to them

c) to rehabilitation and re-integration programme of the State to enable victims to acquire, where applicable and necessary formal education and access to micro credit facilities.

d) any rules and or regulations made by any institution or organization prohibiting or restraining the reporting of offenses or complaints with the provisions of this Law, shall, to the extent of inconsistencies be null and void, and

e) no complainant of any offense under this Law shall be expelled, disengaged, suspended, or punished in any form whatsoever by virtue of the action of compliance with the provision of this Law.

Guiding Principles

Survivor-centred approach: An approach that provides a supportive environment for the Survivor. Treatment must be in the best interest of the survivor. 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 analyze and address the root causes of discrimination and inequality to ensure that everyone has the right to live with freedom and dignity, safe from violence, exploitation, and abuse, 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 survivors of sexual and gender-based violence.

- **"Do no harm" approach**: A "do no harm" approach involves taking all measures necessary to avoid exposing Survivors to further harm as a result of medical management.

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

Role of the Health Sector

While preventing and responding to violence against person 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, sensitize and train health-care providers in responding to the needs of Survivors holistically and empathetically.
- Prevent 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
2. UN Convention of the Right of the Child 1989
3. African Charter on the Rights and Welfare of the Child 1990
4. UN Declaration on Elimination of Violence Against Women (DEVAW) 1993
5. Beijing Platform for Action 1995

6. Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, 2003 7. AU Solemn Declaration on Gender Equality 2004
8. UN Disability Convention 2006
9. Employment and occupation convention (No.169)
10. Universal Declaration of Human Rights 1948
11. Convention Against Torture and other forms of Cruel, Inhuman and Degrading Treatment 1984
12. International Covenant on Economic, Social and Cultural Rights 1966
13. 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
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
14. National Guidelines For HIV Prevention Treatment And Care 2020
15. National Policy on sexual and Reproductive Health and Rights of persons with Disabilities with emphasis on women and girls, 2018
16. National Health Insurance Authority, 2022
17. Standards and Guidelines for the Management of Victims of Sexual and Gender Based Violence in Nigeria

C. Kebbi State Legal/Policy Framework

1. Kebbi State VAPP Law, 2022

2. Kebbi State Penal Code Law 2021

3. Child Rights Law 2022

Medical management of survivors of sexual and gender-based violence

First Line Response

Listen - Inquire - Validate - Enhance Safety - Five easy steps that can be followed when providing a first-line response to those experiencing violence. These can be easily remembered by the acronym 'LIVES'

Listen	Listen to the woman closely, with empathy, and without judging.
Inquire About Needs And Concerns	Assess and respond to survivors' various needs. and concerns - emotional, physical, social and practical (e.g. Childcare).
Validate	Show her that you understand and believe her. Assure her that she is not to blame.
Enhance Safety	Discuss a plan to protect herself from further harm if violence occurs again.
Support	Support her by helping her connect to information, services, and social support.

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 to 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 stigmatized 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. Encourage the police to get the survivor 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 the 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. In the case of a minor, reporting is mandatory.
- Provide psychological first aid.
- Ask the Survivors 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 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 adults 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 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 distraction or interruption 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 Survivor'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 resolve 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
The nature of the physical contacts 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.
- 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.
- Survivors 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 occurrence of 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 Survivor 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 demeanor.
- Take the vital signs, i.e. pulse, blood pressure, respiratory rate, and temperature.
- 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.
- Inspect both sides of both hands for injuries. Examine the wrists for signs of ligature marks.
- 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 for inspection of the back of the legs. An inspection of the buttocks is also best achieved with the survivor standing.
- 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

- Try to make the survivor feel as comfortable and as relaxed as possible.
- Explain to them each step of the examination. For example, say, “I'm going to have a careful look. I'm going to touch you here in order to look a bit more carefully. Please tell me if you feel pain.”
- 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 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 (In a case of intact hymen speculum examination should not be done).

- Collect any trace evidence, such as foreign bodies and hairs, if found. Suture any tears, if indicated.
- Remove the speculum. Remember: Prepare/assemble the post-rape care (PRC) kit before the Survivor comes in.
- If available, ensure a trained support person of same sex accompanies the survivor throughout the examination.

Head to Toe Examination for Children

The physical examination of children should be conducted according to the procedures outlined for adult's section. Before examination, ensure that consent has been obtained from the child and/or the caregiver as appropriate. If the child refuses the examination, it would be appropriate to explore the reasons for refusal.

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 care giver'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 another 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 as a result of penetration. In this case:

- Help the child to lie on her back or side.
- Use a paediatric speculum and conduct the examination 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 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, sand).
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 specimen to be collected during the course of examination should include:

- Hair
- Nail scratches
- Bite areas
- Saliva
- Semen
- Survivors' 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

Note: When the perpetrator is known, they should also be screened

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

Urinalysis - microscopy
Pregnancy test
Spermatozoa/Blood
HIV Test
Haemoglobin (Hb) level
Liver Function Tests (where possible)
VDRL
Hepatitis B and C
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 health-care provider should preserve it for appropriate storage and hand it over to the police for further investigation and processing in the 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
Blood	drugs	Appropriate tube	Collect 10mls of venous blood
	DNA (Survivor)	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 vaginal 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	48 hours
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 secure Intravenous access and infuse crystalloids if necessary.
- Give tetanus toxoid injection 0.5mls intramuscularly.
- Give antibiotics for injuries, e.g., Ampiclox 500mg qid for 5 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 Integrase Strand Transfer Inhibitor for 28 days), e.g.: • Tenofovir and Lamivudine + Dolutegravir (preferred) 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 plus Dolutegravir each twice daily for 28 days (For children less than 10 years or less than 30kg) •Treat nausea and vomiting with domperidone 10mg tablet three times a day. •Treat diarrhoea with two tablets of loperamide 2mg and one PRN maximum 8 tablets in 24 hours. •Do HIV test at 3 months' post completion of Post Exposure Prophylaxis (PEP) and at 6 months.
Hepatitis B	• Hepatitis B immunoglobulin and vaccination – if survivor 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 survivor. • 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 Survivors)

- Give analgesics (diclofenac, ibuprofen)
- Give anxiolytics, if necessary (diazepam 5mg, or bromazepam 1.5mg)
- Refer more serious injuries to specialists (orthopaedic surgeon, gynaecologists, neurosurgeon, paediatric surgeon, 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 Survivor, 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 3 months, if positive.
- Hepatitis B, Hepatitis C - save sample and retest after 3 months, if positive.
- Neisseria Gonorrhoea – take specimen for gram stain for gram negative intracellular diplococci culture from site of penetration.
- Chlamydia trachomatis – take specimen from site of penetration for dual Nucleic Acid Amplification Technique (NAAT).
- Yeast – wet slide for microscopy and culture.
- Bacterial vaginosis – wet slide for microscopy, Schiff test.
- Trichomonas vaginalis – wet slide for microscopy and culture.

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

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

***5. Give* emergency contraception** (if 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

1. Refer to psychiatrist/clinical psychologist.
2. Refer to paediatrician in case of a child.

8. Refer for forensic medical examination, if service is available within facility or close by.
9. 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 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 presenting after three months, screen for STIs, do Full Blood Count, Liver Function Tests, Urea and Electrolytes, Fasting blood sugar, Lipids and Amylase, If patient presents after two weeks and 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 Survivor and her family
- Disruption of the Survivor's education and career
- Health risks associated with pregnancy and delivery
- Unsafe abortion

Each of these negative effects may have far-reaching consequences. Family and personal shame may lead to feelings of guilt and other emotions, which ultimately may force the survivor to seek unsafe abortion that endangers her life or, at worst, consider suicide. Suicide can also result from continued stigmatization. Shame and stigmatization may prevent a survivor from getting antenatal care and/or delivering under skilled care and both of these may lead to maternal mortality or devastating morbidity, like vesico-vaginal fistula (VVF). Disruption of the survivor's education means that her future is marred, and this also impacts on her other health outcomes.

When pregnancy test is negative, follow the guideline for pregnancy prevention above. A Survivor, who is presenting within 10 days of assault and whose pregnancy test is positive, is likely to have been pregnant before the assault. If it is a recent conception the survivor may assume it is as a result of the assault but if she has been amenorrhoeic for several weeks before the assault she might have known, she was pregnant. Some survivors may feel the pregnancy at this point had been "contaminated" or "defiled" as a result of the assault. Where a victim of forceful sexual intercourse conceived, the victim may request the pregnancy to be aborted in accordance with the provisions of Islamic Law and medical advice from government hospital. Also, when her life is in danger, the provider should consider a therapeutic termination of the pregnancy to save her life. This is in accordance with the Nigerian law. Other conditions, where the life of the woman is in danger, include (but not limited to) end-stage renal disease, severe heart failure, cancers (cervix or uterus, kidney, etc.) and severe pre-eclampsia/eclampsia.

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

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

For survivors who are already pregnant before the sexual assault took place, they should be appropriately counselled for pregnancy continuation. The growing fetus should be taken into consideration for 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

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

Psychological Support

Counselling
Provision of shelter, where available
Social education
Skill acquisition
Introduce survivors to support services, such as HIV counselling, drug rehabilitation and mental services if indicated.

Referrals

The referral standards based on the point of first identification of gender-based violence include the following:
When a report is made first to a health facility, the needs of survivors may vary but prompt referrals should be made as soon as there is need after the care above has been

offered. Referrals can be to different medical disciplines but may also be made to different support services which include:

- Sexual assault and rape centers (SARC)
- Citizens' Right Department, Ministry of Justice
- Shelters or safe houses
- HIV/AIDS counselling
- Legal Aid Council
- Survivor witness programmes
- Support groups
- Therapists
- Financial assistance agencies
- Social service agencies

Government and non-governmental bodies working in this area like SMWASD, NHRC, International Federation of Women Lawyers (FIDA), Medical Women Association of Nigeria (MWAN), SMOH, Society of Gynaecology and Obstetrics of Nigeria (SOGON), etc.

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

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

1. Direct survivor to the child protection officers or gender desk officers within the specialized unit at the station.
2. Specialized unit refers survivors to appropriate health care facilities.
3. Survivor's account should be documented by specialized units. Specialized unit follows up on and document updates on survivor status. Follow-up could be through telephone calls to Survivors and to a service provider at the unit to which the Survivor was referred.

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

1. Inform the survivor of the available support options (healthcare, psychosocial,

legal).

2. Inform the survivor on the need to preserve evidence and guide the survivor as appropriate.
3. Document each case.
4. Refer survivor to appropriate healthcare facility immediately.
5. Provide (directly or via referral) counselling and/or legal aid, and/or shelter as needed (or as the case may be).

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

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

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

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

Prevention of Sexual and Gender Based Violence

Since anyone can be a survivor 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 National Orientation Agency(NOA) sensitization and public enlightenment programmes, social media, radio, television, print media, religious institutions, traditional institutions, schools, judiciary, police, military, custom, immigration, correctional services, civil defense 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 emphasize 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, sensitization and training for judges, prosecutors and other judicial personnel, state actors as well as Ministries, Departments and Agencies.

Civil society groups [NGOs, Faith-Based Organizations (FBOs) and Community-Based Organizations (CBOs)] 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 sensitization

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
- Help lines (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 organizers 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 publicize 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 Help lines: These lines can offer guidance on what steps an endangered potential SURVIVOR can take to forestall assault. Billboards, posters and handbills, radio and television jingles should regularly publicize the numbers.

Manage offenders to prevent or reduce recidivism.
Provide psychological and bio- logical treatment for offenders in prisons or outside the prisons as soon as legal proceedings are concluded to prevent future repeat of their deviant behaviours.

Preparation of Report and Giving Evidence

From the first interaction through follow-up to referrals/discharge, proper documentation is important, especially for reports. Seek legal advice from the hospital legal unit or other sources, including National Agency for the Prohibition of Trafficking in Persons, 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 theSurvivor regarding the assault. This is preferable to writing down your own interpretation of the statements made. Review or go through with the Survivor.
• Record the extent of the physical examination conducted and 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

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

Giving evidence

1. Be prepared.
2. Listen carefully.
3. Speak clearly.
4. Use simple and precise language.
5. Stay within your field of expertise.
6. Separate facts and opinion.
7. Remain impart

Police Involvement

When the survivor is brought to the Police Station immediately after the assault before medical attention is given, the officer on duty should not delay but bring the survivor to the health facility forthwith, while carrying on investigations. When the reporting period is late, referral should still be made to the health facility. No survivor should be denied prompt attention or turned away if she/he reports to the health facility without police accompaniment. When a survivor reports without police involvement, her/his consent should be sought before informing the police. Functional communication lines with the police must be kept by all health facilities, however remote the location is. Service providers must avoid succumbing to pressure from the police or other investigators and refer them to higher authorities, whenever they feel pressured to do anything they feel is unethical.

Interaction with Providers of other Services

Besides the police, health workers must interface/interact with other service providers to ensure well-coordinated and multidisciplinary comprehensive care. Adherence to professional conduct and ethics should also guide all interactions. Counsellors (who may be social workers, psychologists, support, or religious groups), laboratory staff, lawyers and NGOs are some of the group's health workers may interface with. A good working relationship should exist between these groups. Sometimes, health workers may have to play the role of counsellors and laboratory staff where these groups are not present.

Equipment List

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

Table: Provision of medical and forensic services to Survivors of sexual violence: equipment list

Item	Comments
Fixtures	
Examination couch*, Wheelchair	Multi-functional couch (Disability, young and elderly people)
Desk, chairs* and filing cabinet	For Survivor, accompanying persons and health worker
Light source*	Ideally mobile, including Anglepoise lamps
Washing facilities and toilet*	Facilities should be available for the Survivor to wash at the conclusion of the examination. There should also be a facility for the health worker to wash their hands before and after an examination. Facilities should include a shower, a hand basin and soap.
Refrigerator and cupboard	For the storage of specimens, preferably lockable
Telephone, voice recorder, and Internet facility*	

Item	Comments
General Medical Items	
Tourniquet* IVF giving set, IVF (crystalloids)	For resuscitation when necessary
Syringes, needles and sterile swabs*	
Specimen bottles (various)*	
Specula both Sims and Bivalve (various sizes) *	
Sterilizing equipment	(For sterilizing instruments, e.g., specula).
Proctoscope/anoscope*	
Examination gloves*	
Pregnancy testing kits*	
STI / HIV collection kits	
Sharps container*	
Scales and height measure	For examining children
Manual vacuum aspirator, tenaculum/vulsellum, forceps, cannulae of various sizes	
Forensic Items	
Swabs (cotton wool or similar) and containers for transporting swabs*	For collection of foreign material on SURVIVOR (e.g., se- men, blood, saliva). Do not use medium when collecting forensic specimens.
Microscope slides*	For plating of swabs
Specimen bottles*	Blood is used for Deoxyribonucleic Acid (DNA) or toxicological analysis.
Urine specimen containers*	For pregnancy and toxicological testing
Sheets of paper (drop sheet) *	For patient to stand on whilst undressing, for collection of loose, fine materials
Paper bags*	For collection of clothing and any wet items

Plastic specimen bags*	For collection or transport of other (dry) forensic items
Item	Comments
Tweezers, scissors, comb	For collecting foreign debris on skin. Use scissors or comb to remove and collect material in hair.
Treatment Items	
Analgesics*	A range of simple analgesics may be useful.
Emergency contraception*	
Suture materials	
Tetanus and hepatitis prophy- laxis/vaccination	
STI prophylaxis*	
HIV post-exposure prophylaxis	
Misoprostol and mifepristone	
Linen	
Sheets and blankets*	For examination couch
Towels*	
Clothing	To replace any damaged or retained items of the survivor's clothing
Patient gowns*	To allow patient to fully undress for examination
Sanitary items (e.g. pads, tam-pons)*	
Stationery	
Examination record or proforma	For recording findings (see Annex 1)
Labels	For attaching to various specimens
Consent form	This should be completed as required by local rules or protocols (see Annex 1).

Pathology/radiology referral forms	For referring patient for further investigation or tests
Item	Comments
Information brochure	Ideally the patient should be provided with information about the service they have accessed, methods of contacting the treating practitioner if required and details of follow-up services. These brochures should supplement any verbal information that the survivor has been provided with. In addition to reinforcing important information that the survivor may forget, brochures may provide information to other potential service users.
Sundry Items	
Digital camera and film	Photography is useful but not necessarily an essential tool for injury documentation. Police or hospitals may also be able to assist.
Colposcope or magnifying lens	Useful for obtaining a magnified view of a wound
Microscope	May be used by the practitioner to check for the presence of spermatozoa, particularly if no laboratory facility is accessible
Swab dryer	Forensic swabs should be dried before being packaged. This can be done with the use of a dryer or the swabs can be air-dried so long as they are protected from foreign DNA.
Measuring device (e.g., ruler, tape measure, callipers)	For measuring the size of wounds
Pens, pencils	
Computer and printer	
Sterilization equipment	For medical instruments

NB:

1. Items marked with an asterisk are considered essential for providing a minimum level of service.
2. Can be held individually or as part of a pre-packaged rape kit.

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

Monitoring and Evaluation

This is necessary for improving services, maintaining high-quality services, and getting the necessary information for managers to allocate resources. This function should be organized, carried out or supervised by the Local Government Reproductive Health (RH) Coordinators, State RH Coordinator, Local government, and state M&E officers as the case may be. Monitoring and Evaluation should determine:

- The quality of services given
- The output, performance and type of services provided
- Patient outcomes (STIs, pregnancies, trauma, etc., from assault)
- The improvements needed
- Monitoring and evaluation should be done quarterly

Management of other Offences Under the VAPP Law 2022

Interference with Contraception

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

Female Genital Mutilation

The practice of FGM varies from place to place but involves cutting the external genital area to close the genital area, leaving a small opening for passage of urine and menstrual flow. The 2018 NDHS estimated FGM to be up to 20 per cent among the female population in Nigeria. The prevalence in the states ranges from 0.0 in Adamawa – 61.7 per cent in Imo State, with that in Kebbi state being 1.6per cent. FGM is classified into four types, depending on the extent of the mutilation.

Type I: The prepuce is excised with or without part or whole of the clitoris.

Type II: The prepuce, clitoris, and part or whole of the labia minora are excised.

Type III: 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: This consists of any other mutilating procedure not described above. It may involve pricking, piercing or incision of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissues; angurya cuts (scrapping of tissues surrounding the vaginal orifice); gishiri cuts (incision of the anterior and sometimes posterior vaginal walls); introduction of corrosive substances or herbs into the vagina with the aim of tightening or narrowing it; etc. All sorts of instruments are used, including knives, scalpels, razor blades, sticks and broken glasses. These are usually not sterile. Perpetrators are usually traditional birth attendants and healers. However, health workers sometimes ignorantly perform the procedure in an attempt to "medicalize" it. Health workers are increasingly performing FGM. This is prohibited under the VAPP law 2022. It is carried out anytime from infancy to adulthood. The reasons also vary but are often related to attempts at curbing the sexual drive of the woman to protect virginity or prevent promiscuity but may also include purification, family honour, hygiene and aesthetics and also for religious purposes. Other reasons

include ensuring husband's sexual pleasure, rite of passage for girls and myths like the prevention of perinatal mortality (baby will die if head touches the clitoris at delivery).

Cases of FGM will not usually present immediately to the hospital except when complicated 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 SURVIVOR and her restraint by the perpetrators may cause other types of injuries, like fractures and lacerations.

Late presentation may be incidental (scar tissues and keloids) findings or when it interferes with sexual function (dyspareunia, apareunia, vaginismus, frigidity), voiding (dysuria, VVF, recurrent urinary tract infections (UTIs), menstrual function (dysmenorrhea, haematocolpos), conception or delivery (dystocia from soft tissue and perinatal mortality). Cases of late presentation will usually need specialist (gynaecologist or plastic surgeon) management.

Some patients may also develop psychological problems (low self-esteem, fear, suppression of feelings, bitterness, anger, feeling of betrayal) and will need counselling and other therapy. Since perpetrators are family members or those invited by them, it is difficult for consent to be given for reporting to the police, but health workers should ask for it and record 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., Kebbi State VAPP Law 2022 and VAPP Act 2015, Childs Right Law,2022)

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 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 medicalization 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 summarize the care health workers should give Survivors 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 – patient's bio-data, date and time of procedure, place 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, 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

Full history and physical examination

Discuss the diagnosis and treatment options

May do deinfibulation or dilatation

Widowhood and Other Harmful Traditional Practices

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

- Forced shaving of hair.
- Forced wearing of black/white clothes.
- Forced sleeping on the floor or mat.
- Forced sleeping with corpse in a lock-up room.
- Forced to refrain from taking bath for a period.
- Forced to swear with husband's corpse.
- Forced to drink bath water of the husband's corpse.
- Forced to seclude.
- Seizing of the deceased property and sometimes with the children from the widow.
- Forced marriage of the widow to a member of the family of the deceased husband.

Ingestion of poisonous substances – some widows are made to ingest water used to bath their husband's corpse or other substances to prove their innocence and absolve themselves from having a hand in their death. These widows should be carefully checked to know the kind of fluid ingested and to check for any physical manifestation of poisonous substances. They should be observed, preferably in the hospital, if the substance is suspected to be poisonous and treated, accordingly.

Laboratory tests should be done to ascertain proper organ functions, like liver function tests, renal function tests, full blood count, etc.
Trauma/Physical injury – take history, examine, and record findings in detail and manage, accordingly.
Psychological trauma – give psychosocial counselling. May give anxiolytics or refer to a psychologist/psychiatrist and/or ask to change environment.

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 survivor. All cases of violence should be treated as emergency.

Documentation
Proper and detailed documentation should be done as this may help in 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.

Survivors Brought in Dead

Make a careful examination and give detailed description of the corpse (swellings, wounds, fractures, etc.) and possibly take pictures before sending the corpse to the mortuary. If services are available, get permission and send for postmortem. Prepare a report and inform the police.

Cost of Care

The cost of treatment for survivors of sexual and gender-based violence should be covered by the budgetary provision for emergency under National Health Act (2014), when it becomes operational. In the meantime, the cost of care should be covered by any other health insurance scheme under which the survivor is covered, where applicable. Where the survivor is not covered, the offender or his/her relations should bear the cost; when the offender cannot be found or is a stranger and the survivor's relations cannot cover the cost, the health facility shall bear the cost and proper records kept to that effect. The facility, whether public or private, will then apply for reimbursement from the social welfare department of the relevant level of government, which will receive regular funding for this purpose.

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Appendices

Appendix 1: Consent Form

Consent for Release of Information.

This form should be read to the client or guardian in their 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 agree that my information can be 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)

_____
_____

Signature/thumbprint and date

Appendix 2

MEDICAL HISTORY AND EXAMINATION SAMPLE FORM

1. **GENERAL INFORMATION**

   First Name_____ Other Name_____ Last Name_____

   Address_____
   _____

   Phone (Parent/guardians {for minors}) _____

   Sex_____ Date of Birth_____

   Age_____

   Date and time of examination_____

   In the presence of

   _____

   Next-of-kin

(Relationship)_____Phone_____
Address of Next-of-
Kin_____

2. THE INCIDENT (if SURVIVOR is able to communicate)
Ask the SURVIVOR:

Has this happened before?	Yes	No
When was the first time?.....		
How long has it been happening?.....		
Who did it?		
Is the person still a threat?	YES	No
ask about bleeding from the vagina or the rectum		
pain on walking		
pain on passing urine		
pain on passing stool		
Signs of discharge		
Any other sign(s) or symptom(s).		

Date of incidence	Time of incidence	Location:
Description of incidence (Survivor)		

Physical violence	Yes	No	Location on body
Type (beating, biting, pulling hair, etc)			
Use of restraint			
Use of weapon(s), If yes specify			
Drug/alcohol involved			

PENETRATION	YES	NO	NOT SURE	DESCRIBE (ORAL, VAGINAL, ANAL, TYPE OF OBJECT)
Penis				
Finger				
Others (describe)				
	YES	NO	NOT SURE	LOCATION (ORAL, VAGINAL, ANAL, OTHER)
EJACULATION				
CONDOM USE				

3. Medical History

Since the alleged offence took place has the patient:

Changed Clothes Yes☐ No ☐ Unknown ☐
Had Sexual Intercourse Yes☐ No ☐ Unknown ☐
Condom Used Yes☐ No ☐ Unknown ☐
Bathed/Washed/Showered Yes☐ No ☐
Urinated Yes☐ No ☐
Defecated Yes☐ No ☐
Wiped Yes☐ No ☐
Used Tampons Yes ☐ No ☐
Currently Pregnant Yes☐ No ☐ Unknown ☐
Menstruated Yes☐ No ☐
Contraception use
Pills..... IUCD.....Injectables .....
Condoms.....Sterilization.....
Others.....

4. Menstrual/Obstetric History

Last menstrual period (dd/mm/yyyy)_____ (indicate if a minor)
Menstruating at time of event __ Yes☐ No☐
Evidence of pregnancy__ Yes ☐ No ☐
If Yes, No. of weeks pregnant _____weeks

History of Consenting Intercourse
(ONLY IF SAMPLE HAS BEEN TAKEN FOR DNA ANALYSIS)
Has samples been taken for DNA analysis Yes ☐ No ☐
Last consenting intercourse within week prior to the assault:
Date (dd/mm/yyyy)_____ Name of individual_____
Existing Health Problems
History of female genital mutilation__ Yes ☐ No ☐
If yes, type_____
Allergies_____
Others (Describe) _____
Current medication_____
Vaccination Status

	Vaccinated	Not Vaccinated	Unknown	Comments
Hepatitis B				
Tetanus				
HPV				

HIV/AIDS Status____-- Positive/ Negative

5. **Medical Examination**
Appearance (clothing, hair, obvious physical or mental disability)
_____
Mental state (calm, crying, anxious, cooperative, depressed, others)
_____
Weight: _____Height: _____ Pubertal stage (pre-pubertal, pubertal, mature):_____

Pulse rate: _____ Blood pressure:_____ Temperature:_____

Respiratory rate..... Other relevant clinical signs.....

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 SURVIVOR.
Head and face
Mouth and nose
Eyes and ears
Neck
Chest/Breast
Back
Abdomen
Buttocks
Arms and hands
Legs and feet

6. 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)
For genital examination: _____
For anal examination: _____

7. Investigations Done

Type And Location	Examined/Sent To Laboratory (Yes/No)	Result
Pregnancy test		
HVS/ECS		
Hep B AND C surface antigen		
RVS		
Anal swab		
Oral swab (ejaculation)		
Others		

8. Evidence Taken

Type And Location	Sent To/Stored	Collected By/Date

Photography of injuries	Body ☐ Genital ☐	Yes ☐ No ☐

9. Treatment Prescribed

Treatment	Yes	No	Type And Comments
STI prevention/treatment			
Emergency contraception			
Wound treatment			
Tetanus prophylaxis			
Hepatitis B vaccination			
Post-exposure prophylaxis for HIV			
Analgesics			
Antibiotics			
Others (specify)			

10. Counselling, Referrals, 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 __ Yes ☐ No ☐
Has someone accompanying 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.

Action	Responsible	Timeline	Status

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, etc) _____ Contact Tel. no. _____

Additional information:

Has a charge been laid?

If yes: Police Station_____

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

Consent

Authorization for collection of evidence and release of Information: I hereby authorize _____ and _____

print name) (signature/thumb print)

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 recognize 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/thumb print and date)

Witness: _____ _____

(print name) (signature/thumb print and date)

Parent/guardian: _____
(print name) (signature/thumb print)
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:**

If patient knows or remembers, circle choice.
Survivor'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 ☐ (tick as apropriate)
Can the survivor 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 the survivor remember the type of sexual act, if any, that occurred during the attack? State whether oral, genital, anal or any other.
_____
_____
_____

Since rape, has patient:
Douched Yes ¨ No ¨ Unknown ¨
Bathed Yes ¨ No ¨ Unknown ¨
Urinated Yes ¨ No ¨ Unknown
Others (specify) ..... ¨
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:

Survivor _____

(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. 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 patient under influence of alcohol/drugs: Yes ¨ No ¨ If yes, describe 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 the eyes (left & right) for haemorrhages (throttling) Yes ¨ No ¨
Describe: _____
_____ Mouth & Lips (note any injury, abrasions/bruising/cuts): Yes ¨ No ¨ (take oral swab) Describe: _____ Scalp (lacerations etc.): Yes ¨ No ¨ Describe:
_____ Neck (bruises/lacerations etc.): Yes ¨ No ¨ Describe:
_____ Other:
_____
Xxxxpicture of face xxxxxxpicture of mouth

BODY Bruises/scratches/lacerations/abrasions: Yes ¨ No ¨
Indicate which of the above: _____ Size: _____ Number: _____ Location (note on anatomical drawing)
_____
_____
_____

ATOMICAL 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 Yes ¨ ☐ No ¨ ☐
(Struggle while lying on back) Yes ¨ ☐ No ¨ ☐

Other (describe details noted above)

_____

_____

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

	Anus:	Vulva:
Swelling	Yes ¨□ No ¨□	Yes ¨ □ No ¨□
Redness	Yes ¨ □ No ¨ □	Yes ¨□ No ¨ □
Bruises	Yes ¨□ No ¨ □	Yes ¨□ No ¨□
Lacerations	Yes ¨ □ No ¨	Yes ¨□ No ¨ □
Tenderness	Yes ¨□ No ¨□	Yes ¨□ No ¨ □
Bleeding	Yes ¨ □No ¨ □	Yes ¨ □ No ¨ □
Discharge	Yes ¨ □No ¨ □	Yes ¨ □ No ¨ □

Other (specify):

_____

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°)

Check the state of the hymen(intact or not)

. Note shape, bumps, synechiae, clefts, type

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 or Oroscope in not sexually active clients) 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 findings below:

_____

Xxxxxxxpix of vulva and perineum

Cervix (erosion, bleeding, discharge, etc.)

_____

_____

_____

Colposcopic examination:

Evidence of microtrauma: Yes ¨□ No ¨ □
Was O" toludine blue used? Yes ¨□ No □
Lugols iodine ¨ Yes ¨□ No □
3-5 % acetic acid Yes ¨□ No □

If yes, describe findings

_____

_____

_____

Was a photograph of injuries taken? Yes □ No □

Male Genitalia

	Penis/Scrotum:	Anus:
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: _____

_____

_____

Xxxxx pix of penis and scrotum, AP &Lateral

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____

Foreign Fluid.....

Scalp hair combed ☐ Shaved ☐ Plucked □

Pubic Hair – specify Combed ☐ Shaved ☐ Plucked □ ¨

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____

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. Others etc

_____

_____

_____

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

1. Handed to relevant Law Enforcement Agency: Yes ¨ ☐ No ☐

Name:_____ Number:_____
Station and telephone number: _____

2. Placed in cupboard: Yes ¨ □ No □
   By whom – Name: _____
   Contact details: _____
3. Other disposal: _____
   _____

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 Per Rectum
OR
Maxolon 10mg 8 hourly per oral.
Insert IUCD if > 72 hours and < 5 days.
2. SEXUALLY TRANSMITTED DISEASES Yes ¨ □ No ¨ □

Non-pregnant:	Pregnant:
.Ciprofloxacin 500mg p/o stat dose	Ceftriaxone 125mg IM stat dose
Doxycycline 100mg 8 hourly for seven days	Erythromycin 500mg 6 hourly for seven days . Metronidazole 2g stat (warn against alcohol intake)

4. ANTI-RETROVIRAL POST EXPOSURE PROPHYLAXIS Yes ¨ □ No ¨ □
   In individual cases, discuss the possibility of Tenofovir, Lamivudine and Dolutegravir prophylaxis against HIV transmission, if rape occurred less than 72 hours before presentation.

<u>Recommendations/Referrals</u> (eg urgent need for further medical review, psychiatric mental status assessment)

Age Assessment □ Urgent Pediatric Review □ Psychotherapy□ Children Service □
Others (Specify) .....

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.HbSAg, HC antibody 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 (Date)_____ at (Place)_____,
and was examined at (Time)_____ on (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 (sign with facility stamp)

To: Family Planning Clinic _____ _____
Dear Colleague Please assist ((Name of Survivor)) _____ with a follow-up consultation. She was given ((Treatment)) _____ as post-coital contraception on (Date) _____ at (Time)_____.
Please offer her whatever examination and contraceptive counselling you deem necessary.

Yours sincerely,

MEDICAL OFFICER ON CALL
(sign on facility stamp)

Appendix 3- Forensic Medical Examination Report- Medical Practitioner

THE KEBBI STATE
FORENISC MEDICAL EXAMINATION REPORT (P3)
(The issuance and completion of this form is free of charge)

This form is to be completed by a police officer and a trained medical practitioner (Public officers); electronically or manually in CLEAR and LEGIBLE handwriting and signed on every page; please complete one copy. Additional pages may be used, stapled and every page signed by the medical practitioner and the police officer.

PART ONE - DETAILS OF COMPLAINT/INCIDENT (Completed by the police officer in charge of investigations if applicable)

NATURE OF ALLEGED OFFENCE/INCIDENT _____
DATE AND TIME OF ALLEGED OFFENCE/INCIDENT_____
DATE AND TIME REPORTED TO POLICE/SARC _____
POLICE OCCURRENCE BOOK NUMBER _____
PARENT POLICE STATION _____
SERVICE NO AND NAME OF INVESTIGATING OFFICER
NAME: _____ SIGNATURE_____

FORENSIC MEDICAL EXAMINATION OF:

COMPLAINANT ☐ SUSPECT/ACCUSED ☐
NAME_____
AGE_____ SEX_____ ID No./Birth Certificate No._____
OTHER: _____
ESCORTED TO MEDICAL FACILITY BY (fill as applicable):
1.Police Officer Name and Service No._____ Signature_____
2. Accompanying Authorized Guardian Name_____ ID No._____
(In the "Escorted By" section to the medical/forensic facility fill in the Name of Police Officer and/ or Authorised Guardian)

BRIEF DETAILS OF THE ALLEGED OFFENCE/INCIDENT

_____
_____
_____
_____
_____
_____

PURPOSE OF EXAMINATION (eg. to conduct a forensic examination for suspected defilement/physical assault/torture)

_____
_____
_____
_____

OFFICER COMMANDING STATION/WARD COMMANDER:

NAME: _____SIGNATURE: _____

PART TWO - DETAILS OF THE FORENSIC MEDICAL EXAMINATION (to be completed by the medical practitioner/nursing officer)

MEDICAL/FORENSIC FACILITY REFERENCE/CODE _____

PRACTITIONER NAMES	MEDICAL/FORENSIC FACILITY NAME
PRACTITIONER REGISTRATION NUMBER	PATIENT RECORD/FILE/REFERENCE NUMBER
PRACTITIONER QUALIFICATIONS	FACILITY TELEPHONE CONTACT
PRACTITIONER TELEPHONE CONTACT	FACILITY PHYSICAL ADDRESS

SECTION B. PATIENT INFORMATION

CONSENT/ASSENT FOR FULL FORENSIC MEDICAL EXAMINATION

I understand that this examination will include:

☐ Full Medical History and a Complete Forensic Medical Examination

☐ Collection of Forensic specimens and/or Medical samples

☐ Taking of notes, photographs, videos, digital images for recording and evidential purposes including second opinions from forensic/medical experts and peer reviews

☐ I have been informed that any sensitive photographs, videos, and or digital images will be stored securely and only be made available to other non-medical persons on the order of a Court.

☐ I understand and agree that copy of the medical notes/statement/report and expert testimony may be given to professionals involved in the case and may be used in court.

☐ I agree to the use of anonymized photographs/imaging/videos for teaching and research purposes.

☐ I have been advised that I may stop the examination at any point.

CONSENT GIVEN ☐ BY WHOM:_____

DATE OF BIRTH ____/____/___ AGE:_____ SEX : M☐ F☐ Intersex ☐

PERSONS PRESENT DURING EXAMINATION:

1. _____
2. _____

PART 3: SECTION A: RELEVANT MEDICAL HISTORY

(Note any notable disabilities/impairments; document relevant medical history. Include details relevant to the offence and previous injuries that may affect interpretation of findings. Additional notes may be attached)

_____

_____

_____

_____

_____

_____

_____

_____

ADDITIONAL MEDICAL HISTORY RELEVANT TO SEXUAL OFFENCES

Since the alleged offence took place has the patient:

CHANGED CLOTHES	YES☐ NO ☐ UNKNOWN ☐
CONDOM USED	YES☐ NO ☐ UNKNOWN ☐
BATHED/WASHED/SHOWERED	YES☐ NO ☐
URINATED	YES☐ NO ☐
DEFECATED	YES☐ NO ☐
WIPED	YES☐ NO ☐
CURRENTLY PREGNANT	YES☐ NO ☐ UNKNOWN ☐
CURRENTLY MENSTRUATING	YES☐ NO ☐

Notes_____
_____
_
_____
_
_____
_
_____
_

History given by:

Name: _____ Relationship:_____ Signature_____

SECTION B: GENERAL EXAMINATION

(All specimens collected must be properly packaged, labelled and preserved. Indicate relevant clinical signs.)

VITAL SIGNS

Heart Rate___ Respiratory Rate___ Blood Pressure ____ Temperature ____

Other relevant clinical signs _____

STATE OF CLOTHING

Torn/damaged/blood stained/soiled/washed. Indicate if clothes were changed prior to examination.

_____
_____
_____
___

Describe the stains/debris (eg. white colored discharge possibly semen)

_____
_____
__

Clothing Collected For Forensic Analysis YES☐ NO☐ IF NO GIVE REASONS_____

Describe the physical appearance and behavior (eg orientation,grooming,coherent,anxious)

_____
_
_____
_
_____
_
_____
_

Height_____ Weight_____ Head Circumference (under 2 yrs)_____

General Body Build(frail/normal/obese/other)

_____

Other Relevant Information

_____
_____
_____

Clinical evidence of intoxication (e.g. slurred speech, dilated pupils, ataxia, altered consciousness)

_____
_____
_____

SAMPLES COLLECTED FOR TOXICOLOGY WHERE RELEVANT

BLOOD	YES ☐ NO ☐
URINE	YES ☐ NO ☐

SECTION C: PHYSICAL EXAMINATION

(Describe the nature, position, shape, extent of injuries on the body. The general position of all injuries must be denoted on the annexed body charts. Note any traditional marks/ornaments. Photographs must be documented) Refer to annexes for labeled diagram of anatomy)

Head and Neck

Oral (note any injuries in the mouth)

Eye/Orbit (Left and Right, including petechiae, peri-orbital edema, intra-orbital /retinal hemorrhage)

Scalp

ENT (including any injuries within and around the ears)

CNS (level of consciousness – A.V.P.U, Gait, other)

Chest (note any distension, tenderness, abnormality, irregular breathing, cardiac disorders)

Abdomen (note any distension, tenderness, abnormality)

Upper Limbs

Lower Limbs

ESTIMATE AGE OF INJURY(S)

PROBABLE MECHANISM OF INJURY(S)

_____

_____

ADDITIONAL NOTES (INCLUDING PREVIOUS TREATMENT AT OTHER FACILITIES) CAN BE ATTACHED AND NUMBERED AND SIGNED. ADDITIONAL NOTES ☐ YES ☐ NO

_____

_

_____

_

_____

_

TREATMENT/REFERRAL PLAN

_____

_____

_____

_____

____

I conducted the above examination on the ___/_____/____ and declare that the contents of this form is true to the best of my knowledge and belief and I am making this statement knowing that, if it were tendered in evidence, I would be liable to prosecution if I willfully stated in it anything I knew to be false or which I do not believe to be true.

Name of medical practitioner (full names) _____ Sign _____

PART 4: GENITAL EXAMINATION TO BE COMPLETED IN ALLEGED SEXUAL OFFENCES AFTER THE COMPLETION OF PART 2 AND 3. (Refer to annexes for labelled diagram of anatomy)

SECTION A: FEMALE GENITAL EXAMINATION

Tanner Stage (children - refer to annex):

_____

_

_____

_

Describe the physical state (anatomy) and any injuries to the genitalia with reference to:
Labia majora:

_____

_

Labia minora:

_____

_

Clitoris and peri-urethral area:

_____

_

Hymen: describe the posterior rim, edges of the hymen, posterior fourchette including any injuries

_____

_____

__

Vagina including the opening: ; Indicate speculum use if relevant.

_____

_

Cervix:

_____

_

Note and describe any presence of discharge, blood or infection

_____

_

B: SPECIMEN COLLECTION (2 swabs per sample). Indicate if Evidence kit is used, include serial No.

MEDICAL SAMPLES		
Blood	YES ☐	NO ☐
Urine	YES ☐	NO ☐
FORENSIC SEROLOGY SAMPLES		
Reference sample – buccal swab ☐ blood sample ☐	YES ☐	NO ☐
Oral Swab (In case of ejaculation)	YES ☐	NO ☐
Bite mark Swab	YES ☐	NO ☐
Pubic Hair – specify Combed ☐ Shaved ☐ Plucked ☐	YES ☐	NO ☐
Low vaginal swab	YES ☐	NO ☐
High Vaginal Swab	YES ☐	NO ☐
Endo-cervical swab	YES ☐	NO ☐
Anal Swab	YES ☐	NO ☐
Finger nail clippings/scrapings	YES ☐	NO ☐
Photography of injuries Body ☐ Genital ☐	YES ☐	NO ☐

C. MALE GENITAL EXAMINATION

Tanner stage (children - refer to Annex):
_____
_____
Describe in detail the physical state (anatomy) of and injuries to the:
Prepuce/frenulum: _____
Shaft: _____
Scrotum: _____
Anus: _____
_____
Note presence of discharge from the prepuce, around anus, or/ on thighs, etc; whether recent or of long standing
_____
_____

D. SPECIMEN COLLECTION (2 swabs per sample. Indicate if Evidence kit is used, include serial No.)

MEDICAL SAMPLES		
Blood	YES ☐	NO ☐
Urine	YES ☐	NO ☐
FORENSIC SEROLOGY SAMPLES		
Reference sample – buccal swab ☐ blood sample ☐	YES ☐	NO ☐
Oral swab (In case of ejaculation)	YES ☐	NO ☐
Bite mark Swab	YES ☐	NO ☐
Pubic Hair – specify Combed☐ Shaved☐ Plucked☐	YES ☐	NO ☐
Anal Swab	YES ☐	NO ☐
Rectal swab	YES ☐	NO ☐
Finger nail clippings/scrapings	YES ☐	NO ☐
Photography of injuries Body ☐ Genital ☐	YES ☐	NO ☐

E.ADDITIONAL REMARKS/OPINION BY THE PRACTITIONER

_____
_____
_____
_____
_____

F. MEDICATION ADMINISTERED (Note any medication administered prior to or after examination eg. PEP,EC,TT,Hep B) _____
_____
_____
_____

G. RECOMMENDATIONS/REFERRALS (eg urgent need for further medical review, psychiatric mental status assessment)

AGE ASSESSMENT ☐ URGENT PEDIATRIC REVIEW ☐ PSYCHOTHERAPY☐ CHILDREN SERVICE ☐

_____
_____
_____
_____
_____

PART 5: CHAIN OF CUSTODY (List the specimens/photographs collected)

S/No	Evidence/ Item(s) description	No. of Items	Evidence/ Item(s) Received From	Evidence/ Item(s) Delivered To	Date (DD/MM/YY)	Comments/ Remarks

SPECIMENS COLLECTED BY MEDICAL PRACTITIONER

FULL NAME: _____ ON THIS DAY ___/____/___AT __:___ HOURS

FACILITY STAMP WITH DATE CLEARLY MARKED ON COLLECTION DATE

_____

SPECIMENS RECEIVED BY POLICE OFFICER

FULL NAME/SERVICE NO: _____ON THIS DAY___/____/___ AT __:___ HOURS

FACILITY STAMP WITH DATE CLEARLY MARKED ON RECEIVED DATE

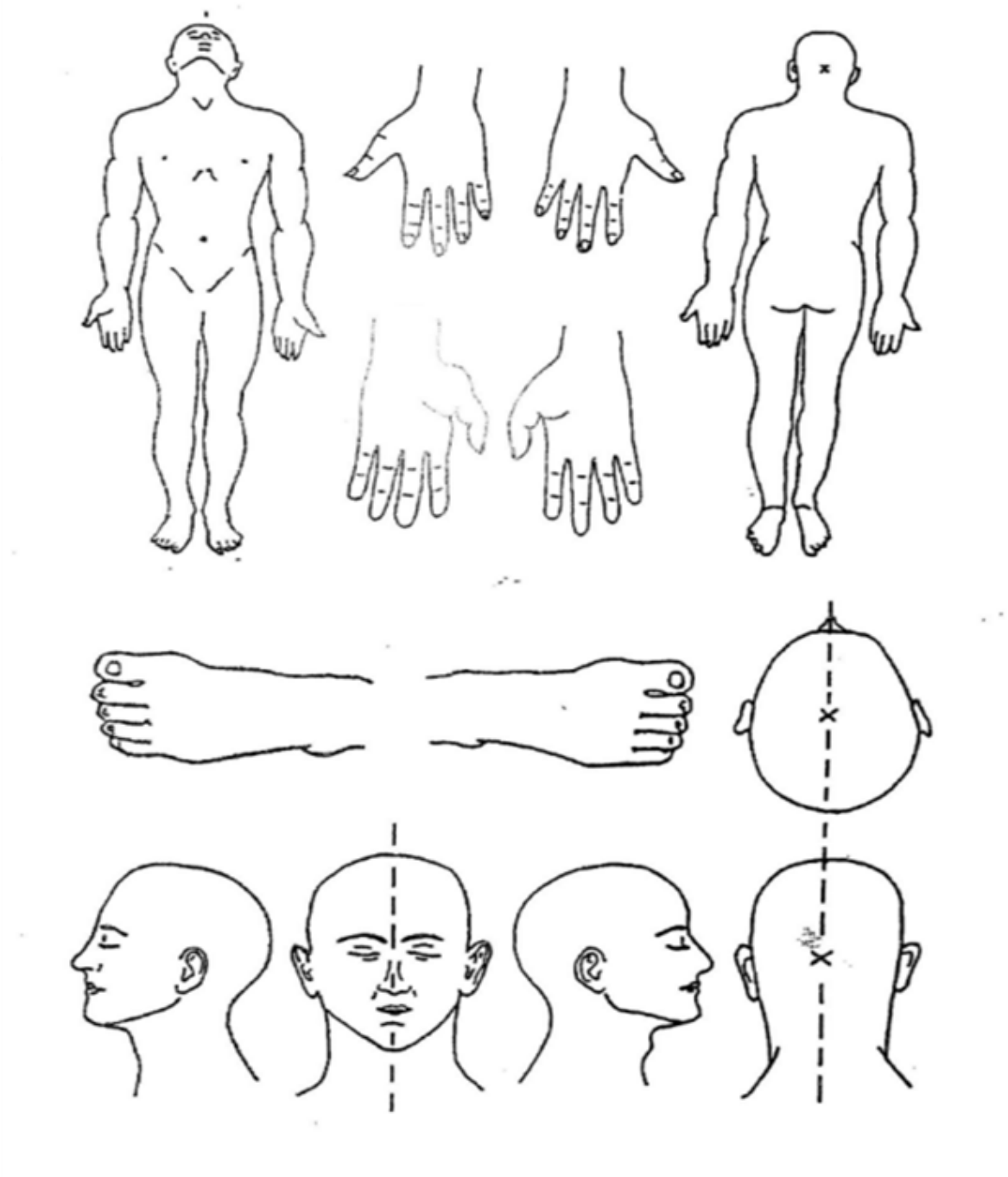
_____

The content of this declaration is true and of my knowledge and belief. I am aware that should it be submitted as evidence and I know that something appears herein which I know to be false or believe not to be true, I could be liable for prosecution. 1. I know and understand the contents of this declaration 2. I have no objection to taking the prescribed oath 3. I consider the prescribed oath to be binding to my conscience

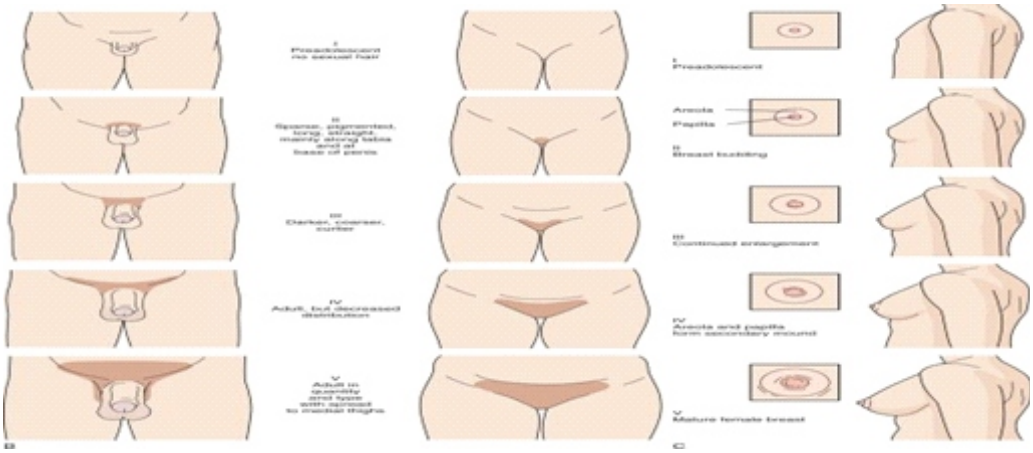
PRACTITIONER SIGNATURE_____ POLICE OFFICER SIGNATURE _____

BODY CHART

APPENDIX i: TICK THE APPROPRIATE BOX : CHILD ADULT MALE FEMALE INTERSEX

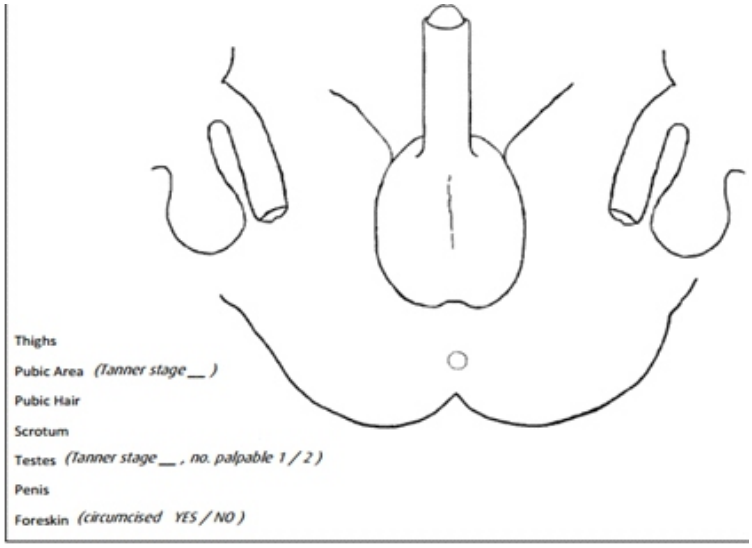


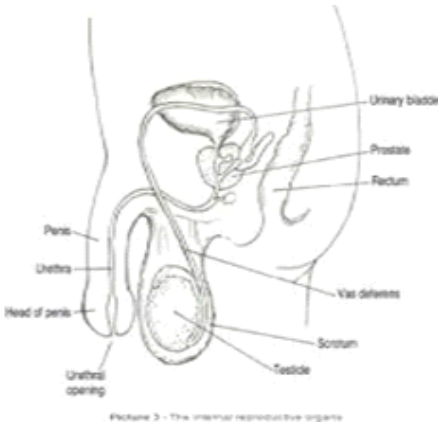
APPENDIX ii: TANNER STAGE (this does NOT give an age estimate)



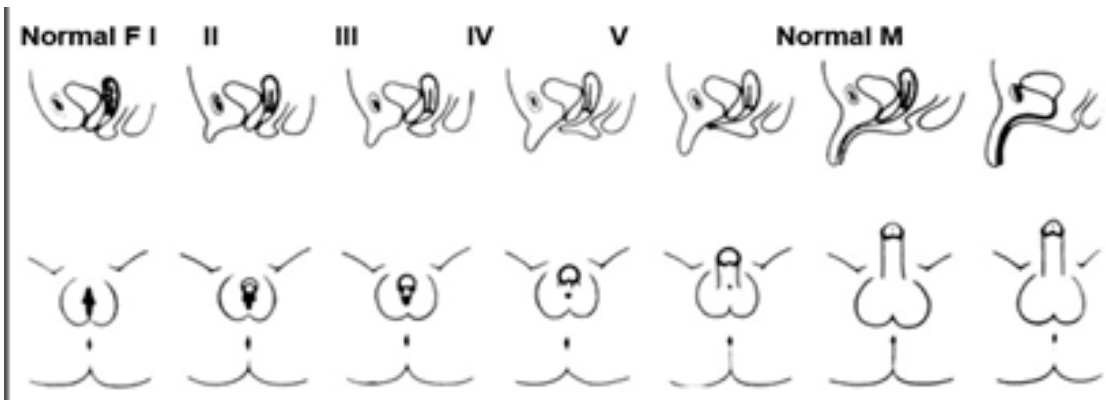
APPENDIX iii: GENITALIA

DETAILS OF MALE GENITAL FINDINGS





INTERSEX GENITALIA



DETAILS OF FEMALE GENITAL FINDINGS

Thighs

Mons pubis

Pubic hair *(tanner stage 1 / 2 / 3 / 4 / 5 and description , eg shaved, cut)*

Labia majora

Labia minora

Clitoris

Fourchette

Fossa Navicularis

Vestibule

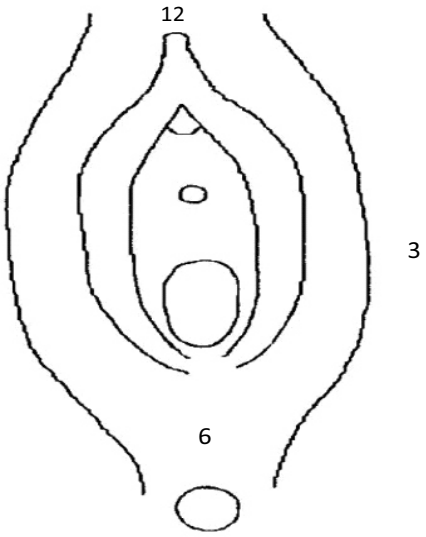
Hymen (diagram when indicated)

Internal findings (if applicable)

Vaginal wall

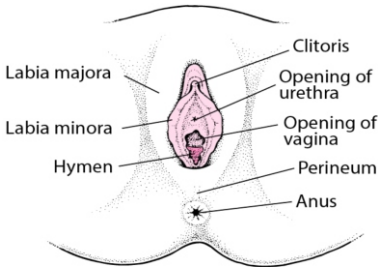
Cervix

Speculum used: YES / NO



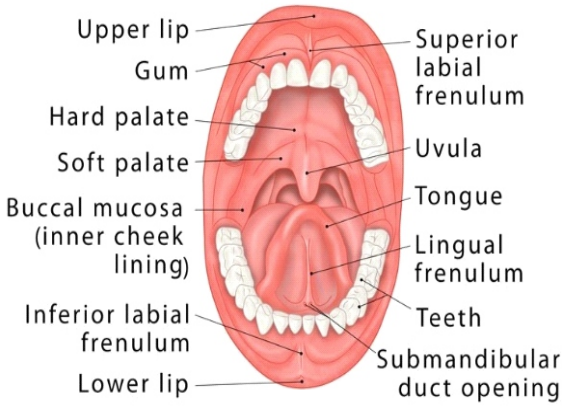
POSITION DURING EXAMINATION

Supine **YES** ? **No** ?
Left lateral **YES** ? **No** ?
Knee chest **YES** ? **No** ?

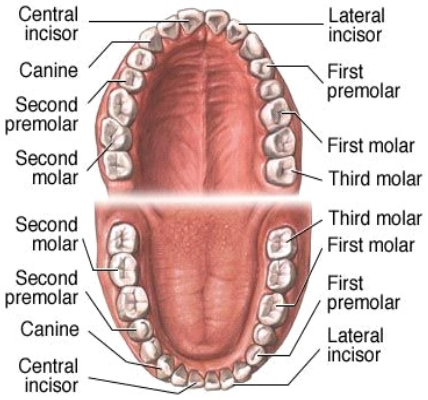


APPENDIX iv: ORAL CAVITY AND DENTITION

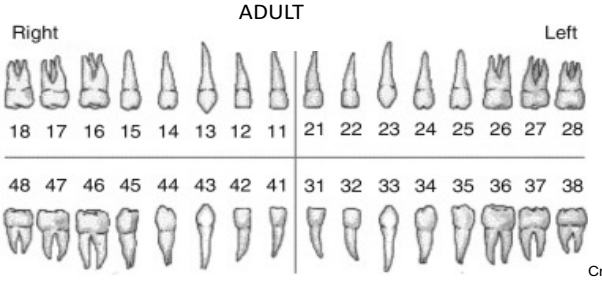
ORAL CAVITY

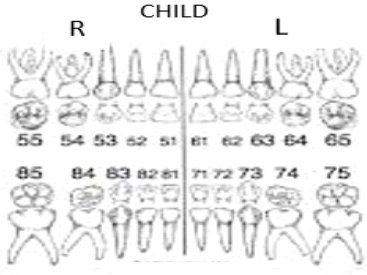


DENTITION



Credit The Respiratory System, Available at https://www.therespiratorysystem.com/glossary/oral-cavity/





Credit Science Direct.

Appendix 4- Forensic Medical Examination Report- Law Enforcement

THE KEBBI STATE
FORENISC MEDICAL EXAMINATION REPORT (P3)
(The issuance and completion of this form is free of charge)

This form is to be completed by a police officer and a trained medical practitioner (Public officers); electronically or manually in CLEAR and LEGIBLE handwriting and signed on every page; please complete one copy. Additional pages may be used, stapled and every page signed by the medical practitioner and the police officer.

PART ONE - DETAILS OF COMPLAINT/INCIDENT (Completed by the police officer in charge of investigations if applicable)

NATURE OF ALLEGED OFFENCE/INCIDENT _____

DATE AND TIME OF ALLEGED OFFENCE/INCIDENT_____

DATE AND TIME REPORTED TO POLICE/SARC _____

POLICE OCCURRENCE BOOK NUMBER _____

PARENT POLICE STATION _____

SERVICE NO AND NAME OF INVESTIGATING OFFICER

NAME: _____ SIGNATURE_____

FORENSIC MEDICAL EXAMINATION OF:

COMPLAINANT ? SUSPECT/ACCUSED ?

NAME_____

AGE_____ SEX_____ ID No./Birth Certificate No._____

OTHER: _____

ESCORTED TO MEDICAL FACILITY BY (fill as applicable):

1.Police Officer Name and Service No._____ Signature_____

2. Accompanying Authorized Guardian Name_____ ID No._____

(In the "Escorted By" section to the medical/forensic facility fill in the Name of Police Officer and/ or Authorised Guardian)

BRIEF DETAILS OF THE ALLEGED OFFENCE/INCIDENT

_____
_____
_____
_____
_____
_____

PURPOSE OF EXAMINATION (eg. to conduct a forensic examination for suspected defilement/physical assault/torture)

_____

_____
_____
_____

OFFICER COMMANDING STATION/WARD COMMANDER:

NAME: _____SIGNATURE: _____

PART TWO - DETAILS OF THE FORENSIC MEDICAL EXAMINATION (to be completed by the medical practitioner/nursing officer)

MEDICAL/FORENSIC FACILITY REFERENCE/CODE _____

SECTION A. DETAILS OF PRACTITIONER AND FACILITY

PRACTITIONER NAMES	MEDICAL/FORENSIC FACILITY NAME
PRACTITIONER REGISTRATION NUMBER	PATIENT RECORD/FILE/REFERENCE NUMBER
PRACTITIONER QUALIFICATIONS	FACILITY TELEPHONE CONTACT
PRACTITIONER TELEPHONE CONTACT	FACILITY PHYSICAL ADDRESS

SECTION B. PATIENT INFORMATION

CONSENT/ASSENT FOR FULL FORENSIC MEDICAL EXAMINATION

I understand that this examination will include:

? Full Medical History and a Complete Forensic Medical Examination
? Collection of Forensic specimens and/or Medical samples
? Taking of notes, photographs, videos, digital images for recording and evidential purposes including second opinions from forensic/medical experts and peer reviews
? I have been informed that any sensitive photographs, videos, and or digital images will be stored securely and only be made available to other non-medical persons on the order of a Court.
? I understand and agree that copy of the medical notes/statement/report and expert testimony may be given to professionals involved in the case and may be used in court.
? I agree to the use of anonymized photographs/imaging/videos for teaching and research purposes.
? I have been advised that I may stop the examination at any point.

CONSENT GIVEN ? BY WHOM:_____

DATE OF BIRTH ____/____/___ AGE:_____ SEX : M? F? Intersex ?

PERSONS PRESENT DURING EXAMINATION:

1. _____
2. _____

PART 3: SECTION A: RELEVANT MEDICAL HISTORY

(Note any notable disabilities/impairments; document relevant medical history. Include details relevant to the offence and previous injuries that may affect interpretation of findings. Additional notes may be attached)

_____
_____
_____
_____
_____
_____
_____

ADDITIONAL MEDICAL HISTORY RELEVANT TO SEXUAL OFFENCES

Since the alleged offence took place has the patient:

CHANGED CLOTHES	YES? NO ? UNKNOWN ?
CONDOM USED	YES? NO ? UNKNOWN ?
BATHED/WASHED/SHOWERED	YES? NO ?
URINATED	YES? NO ?
DEFECATED	YES? NO ?
WIPED	YES? NO ?
CURRENTLY PREGNANT	YES? NO ? UNKNOWN ?
CURRENTLY MENSTRUATING	YES? NO ?

Notes_____
_____
_____
_____

History given by:

Name: _____ Relationship:_____ Signature_____

SECTION B: GENERAL EXAMINATION
(All specimens collected must be properly packaged, labelled and preserved. Indicate relevant clinical signs.)

VITAL SIGNS
Heart Rate___ Respiratory Rate___ Blood Pressure ____ Temperature ____
Other relevant clinical signs _____

STATE OF CLOTHING

Torn/damaged/blood stained/soiled/washed. Indicate if clothes were changed prior to examination.
_____
_____
_____

Describe the stains/debris (eg. white colored discharge possibly semen)
_____
_____

Clothing Collected For Forensic Analysis YES? NO? IF NO GIVE REASONS_____

Describe the physical appearance and behavior (e .g orientation, grooming, coherent, anxious)
_____
_____
_____
_____

Height_____ Weight_____ Head Circumference _____

General Body Build(frail/normal/obese/other)
_____

Other Relevant Information

_____
_____
_____

Clinical evidence of intoxication (e.g. slurred speech, dilated pupils, ataxia, altered consciousness)

_____
_____
_____

SAMPLES COLLECTED FOR TOXICOLOGY WHERE RELEVANT

BLOOD YES ? NO ?
URINE YES ? NO ?

SECTION C: PHYSICAL EXAMINATION

(Describe the nature, position, shape, extent of injuries on the body. The general position of all injuries must be denoted on the annexed body charts. Note any traditional marks/ornaments. Photographs must be documented) Refer to annexes for labeled diagram of anatomy)

Head and Neck

_____
_____
_____

Oral (note any injuries in the mouth)

_____
_____
_____

Eye/Orbit (Left and Right, including petechiae, peri-orbital edema, intra-orbital /retinal hemorrhage)

_____
_____

Scalp

_____
_____
_____

ENT (including any injuries within and around the ears)

_____
_____
_____

CNS (level of consciousness – A.V.P.U, Gait, other)

_____
_____
_____

Chest (note any distension, tenderness, abnormality, irregular breathing, cardiac disorders)

_____
_____
_____

Abdomen (note any distension, tenderness, abnormality)

_____
_____
_____

Upper Limbs

_____
_____
_____

Lower Limbs

_____
_____
_____

ESTIMATE AGE OF INJURY(S)

_____
_____

PROBABLE MECHANISM OF INJURY(S)

_____
_____

ADDITIONAL NOTES (INCLUDING PREVIOUS TREATMENT AT OTHER FACILITIES) CAN BE ATTACHED AND NUMBERED AND SIGNED. ADDITIONAL NOTES ? YES ? NO

_____
_____
_____

TREATMENT/REFERRAL PLAN

_____
_____
_____
_____

I conducted the above examination on the ___/_____/____ and declare that the contents of this form is true to the best of my knowledge and belief a nd I am making this statement knowing that, if it were tendered in evidence, I would be liable to prosecution if I willfully stated in it anything I knew to be false or which I do not believe to be true.

Name of medical practitioner (full names) _____ Sign _____

PART 4: GENITAL EXAMINATION TO BE COMPLETED IN ALLEGED SEXUAL OFFENCES AFTER THE COMPLETION OF PART 2 AND 3. (Refer to annexes for labelled diagram of anatomy)

SECTION A: FEMALE GENITAL EXAMINATION

Tanner Stage (children - refer to annex):

_____
_____

Describe the physical state (anatomy) and any injuries to the genitalia with reference to:
Labia majora:

_____

Labia minora:

_____

Clitoris and peri-urethral area:

_____

Hymen: describe the posterior rim, edges of the hymen, posterior fourchette including any injuries

_____
_____

Vagina including the opening: ; Indicate speculum use if relevant.

_____

Cervix:

_____

Note and describe any presence of discharge, blood or infection

_____

B: SPECIMEN COLLECTION (2 swabs per sample). Indicate if Evidence kit is used, include serial No.

MEDICAL SAMPLES		
Blood	YES ?	NO ?
Urine	YES ?	NO ?
FORENSIC SEROLOGY SAMPLES		
Reference sample – buccal swab ? blood sample ?	YES ?	NO ?
Oral Swab (In case of ejaculation)	YES ?	NO ?

Bite mark Swab	YES ?	NO ?
Pubic Hair – specify Combed ? Shaved ? Plucked ?	YES ?	NO ?
Low vaginal swab	YES ?	NO ?
High Vaginal Swab	YES ?	NO ?
Endo-cervical swab	YES ?	NO ?
Anal Swab	YES ?	NO ?
Finger nail clippings/scrapings	YES ?	NO ?
Photography of injuries Body ? Genital ?	YES ?	NO ?

C. MALE GENITAL EXAMINATION

Tanner stage (children - refer to Annex):
_____
_____
Describe in detail the physical state (anatomy) of and injuries to the:
Prepuce/frenulum: _____
Shaft: _____
Scrotum: _____
Anus: _____
_____
Note presence of discharge from the prepuce, around anus, or/ on thighs, etc; whether recent or of long standing
_____
_____

D. SPECIMEN COLLECTION (2 swabs per sample. Indicate if Evidence kit is used, include serial No.)

MEDICAL SAMPLES		
Blood	YES ?	NO ?
Urine	YES ?	NO ?
FORENSIC SEROLOGY SAMPLES		
Reference sample – buccal swab ? blood sample ?	YES ?	NO ?
Oral swab (In case of ejaculation)	YES ?	NO ?
Bite mark Swab	YES ?	NO ?
Pubic Hair – specify Combed? Shaved? Plucked?	YES ?	NO ?
Anal Swab	YES ?	NO ?
Rectal swab	YES ?	NO ?
Finger nail clippings/scrapings	YES ?	NO ?
Photography of injuries Body ? Genital ?	YES ?	NO ?

E.ADDITIONAL REMARKS/OPINION BY THE PRACTITIONER

_____
_____
_____
_____ _____

F. MEDICATION ADMINISTERED (Note any medication administered prior to or after examination eg. PEP,EC,TT,Hep B) _____
_____
_____
_____

G. RECOMMENDATIONS/REFERRALS (eg urgent need for further medical review, psychiatric mental status as

AGE ASSESSMENT ? URGENT PEDIATRIC REVIEW ? PSYCHOTHERAPY? CHILDREN SERVICE ?

_____
_____
_____
_____
_____

PART 5: CHAIN OF CUSTODY (List the specimens/photographs collected)

S/No	Evidence/ Item(s) description	No. of Items	Evidence/ Item(s) Received From	Evidence/ Item(s) Delivered To	Date (DD/MM/YY)	Comments/ Remarks

SPECIMENS COLLECTED BY MEDICAL PRACTITIONER

FULL NAME: _____ ON THIS DAY ___/____/___AT __:___ HOURS

FACILITY STAMP WITH DATE CLEARLY MARKED ON COLLECTION DATE

_____

SPECIMENS RECEIVED BY POLICE OFFICER

FULL NAME/SERVICE NO: _____ON THIS DAY___/____/___ AT __:___ HOURS

FACILITY STAMP WITH DATE CLEARLY MARKED ON RECEIVED DATE

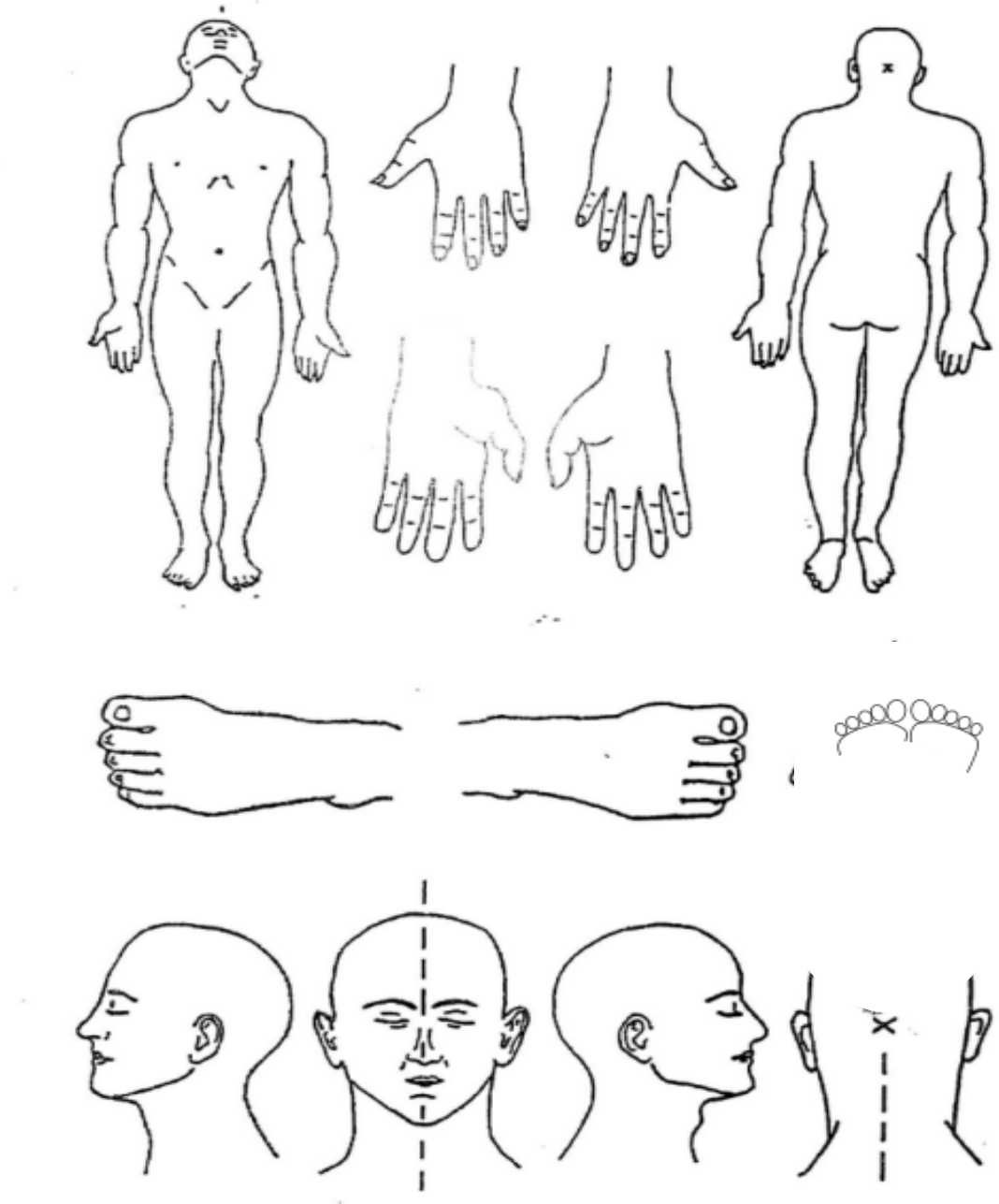
_____

The content of this declaration is true and of my knowledge and belief. I am aware that should it be submitted as evidence and I know that something appears herein which I know to be false or believe not to be true, I could be liable for prosecution. 1. I know and understand the contents of this declaration 2. I have no objection to taking the prescribed oath 3. I consider the prescribed oath to be binding to my conscience

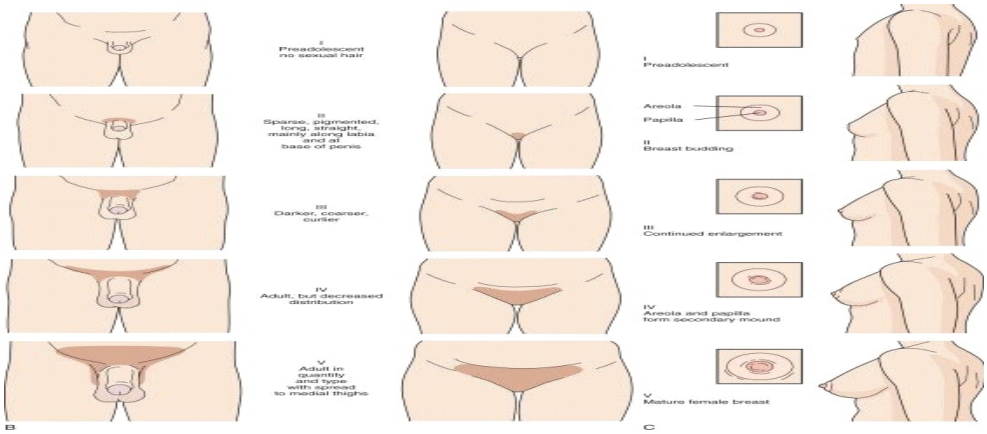
PRACTITIONER SIGNATURE_____ POLICE OFFICER SIGNATURE _____

BODY CHART

APPENDIX i: TICK THE APPROPRIATE BOX : ? CHILD ? ADULT ? MALE ? FEMALE ? INTERSEX

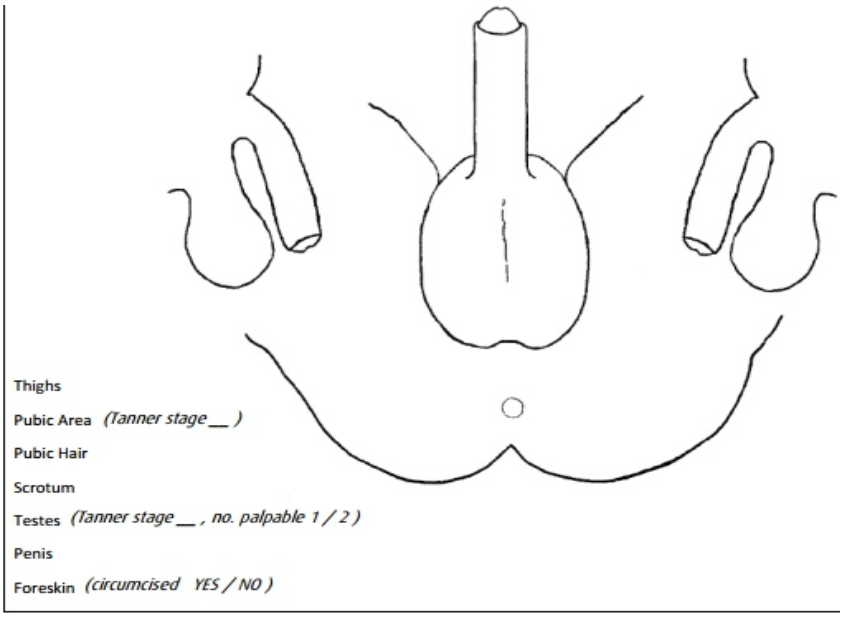


APPENDIX ii: TANNER STAGE (this does NOT give an age estimate)



APPENDIX iii: GENITALIA

DETAILS OF MALE GENITAL FINDINGS



Thighs

Pubic Area *(Tanner stage__)*

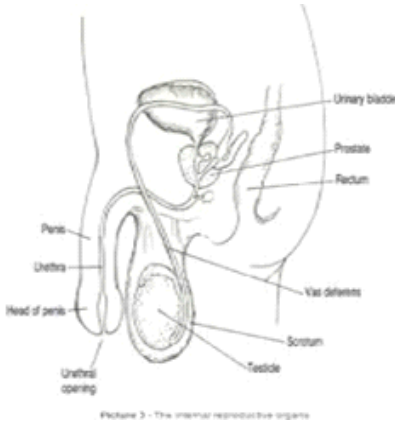
Pubic Hair

Scrotum

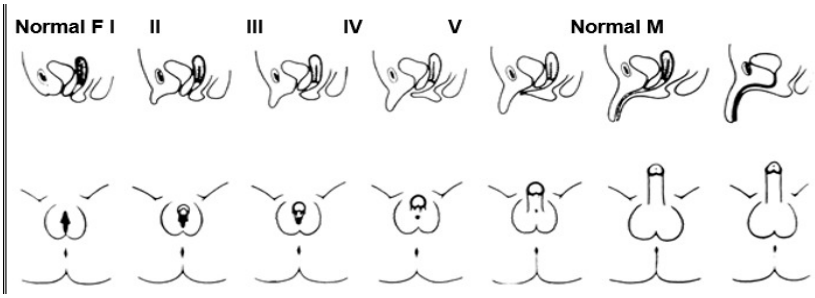
Testes *(Tanner stage__ , no. palpable 1 / 2)*

Penis

Foreskin *(circumcised YES / NO)*



INTERSEX GENITALIA



DETAILS OF FEMALE GENITAL FINDINGS

Thighs

Mons pubis

Pubic hair *(tanner stage 1 / 2 / 3 / 4 / 5 and description , eg shaved, cut)*

Labia majora

Labia minora

Clitoris

Fourchette

Fossa Navicularis

Vestibule

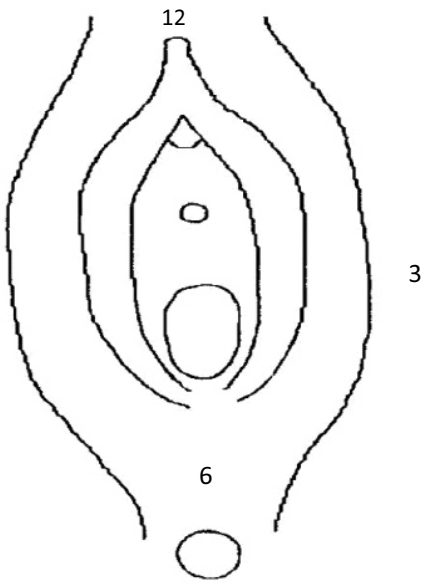
Hymen (diagram when indicated)

Internal findings (if applicable)

Vaginal wall

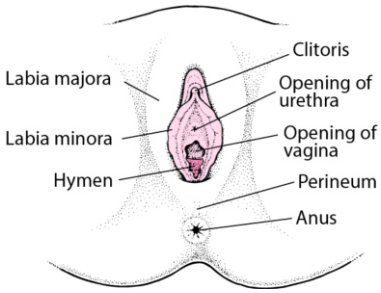
Cervix

Speculum used: YES / NO



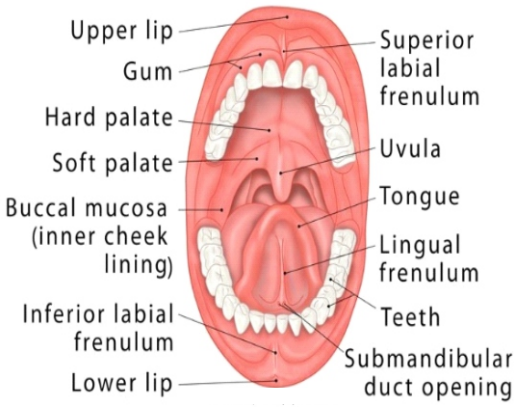
POSITION DURING EXAMINATION

Supine **YES** ? **No** ?
Left lateral **YES** ? **No** ?
Knee chest **YES** ? **No** ?



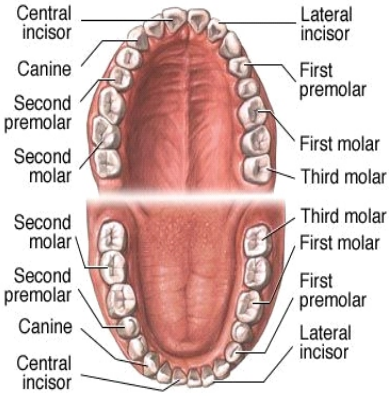
APPENDIX iv: ORAL CAVITY AND DENTITION

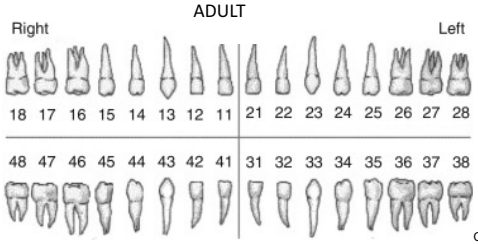
ORAL CAVITY

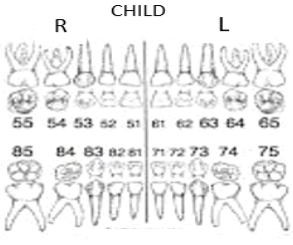


Credit The Respiratory System, Available at https://www.therespiratorysystem.com/gbssary/oral-cavity/

DENTITION







Credit Science Direct.

Appendix 5 Sample checklist of supplies/needs

1. PROTOCOL	AVAILABLE
• Written medical protocol in language of provider	
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	VAILABLE
• Room (private, quiet, accessible, with access to a toilet or latrine) • Examination table • Light, preferably fixed (a torch may be threatening for children) • Access to an autoclave to sterilize equipment	
4. SUPPLIES	AVAILABLE
• "Rape kit" for collection of forensic evidence, including: ➢ Speculum o 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
- WHO training manual
- Management protocol/job aids
- Key messages for prevention in schools, etc

APPENDIX 4

SAMPLE CHECKLIST OF SUPPLIES/NEEDS

1. PROTOCOL	AVAILABLE
• Written medical protocol in language of provider	
2. PERSONNEL	AVAILABLE
• Trained (local) health care professionals (on call 24 hours) • 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 table • Light, preferably fixed (a torch may be threatening for children) • Access to an autoclave to sterilize equipment	
4. SUPPLIES	AVAILABLE
• "Rape kit" for collection of forensic evidence, including: ➢ Speculum, Oroscope (Diagnostic kit) or 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.l NSAIDS) • Local anesthetic for suturing • Antibiotics for wound care . IV fluid (saline, Ringers lactate ETC)	
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	

Help Lines

1. SARC Hotline 08061434868
2. Centre Manager (Haj. Safiya Isa) 07063532324
3. COG (Dr. Nuraddeen Muhammad) 08035973776
4. CID GBV desk officer (CSP. Ladi Haruna) 07064755157
5. PPRO (SP. Nafiu Abubakar) 08065159812
6. NSCDC GBV Desk Officer(Hauwa Aliyu Musa) 08033579159
7. Legal Officer (Barr. Kudirat Shuaibu) 08060749978

8. Director Women Affairs (Haj. Maimuna Abdullahi) 08027313739
9. Community Mobilization and advocacy (Nasir Idris) 08037552567
10. HISBAH (AC Hamza Ahmed) 08062311209