EUROPEAN UNION

BRITISH COUNCIL

Towards Implementation of the Violence Against Persons (Prohibition) Act

Phase 1

Baseline Study of Reported Cases of Sexual and Gender-Based Violence in the Federal Capital Territory, Nigeria

Written by Abiodun Baiyewu
Introduction – Charmaine Pereira

Edited by Charmaine Pereira

LACVAW

LEGISLATIVE ADVOCACY COALITION ON VIOLENCE AGAINST WOMEN INTIATIVE

Phase 1 Research Report - LACVAW Intervention Strategy for the Effective Implementation of the VAPP Act, 2015.

Publication design by Safiya Pereira Ibrahim

Printed by Merciful Prints, Abuja.

Phase 1

Towards Implementation of the Violence Against Persons (Prohibition) Act

Baseline Study of Reported Cases of Sexual and Gender Based Violence in the Federal Capital Territory,

Nigeria
2021

Written by Abiodun Baiyewu
Introduction – Charmaine Pereira

Edited by Charmaine Pereira

Acknowledgements

This research study marks Phase 1 of LACVAW Initiative's intervention project on implementation of the VAPP Act. Many people and organisations were involved, not only in the research but in related components of the project. We are grateful to the Secretariat and the WRAPA office for the huge role they played in supporting the design of the project and in enabling it to get off the ground.

Enormous thanks are due to Abiodun Baiyewu, the researcher responsible for the field work, with the able assistance of research assistants, Tsema Ede and Ann Iyonu. Their dedication to the work, and perseverance in the face of bureaucratic and other hurdles, has been tremendous.

Thanks are due to our various institutional respondents, namely those working in health agencies, police and civil defence, government response institutions, and courts. Without their participation and responses, this research could not have been done.

LACVAW Initiative members in FCT – WRAPA, FIDA, CIRDDOC, NAWOJ, EVA – and our partners in civil society – Global Rights, Dorothy Njamanze Foundation, Cece Yara Foundation, SOAR Initiative, Women Friendly Initiative, Change Managers International, Disability Rights Advocacy Centre – constitute an essential pillar of the work. All are engaged in advocacy to undermine the widespread acceptance of gendered violence in society; some provide services for survivors. Their participation in the research has been invaluable.

We would like to thank the Rule of Law and Anti-Corruption (RoLAC) programme, funded by the European Union and implemented by the British Council, for the funds to carry out this research. We appreciate their interest in affirming the need for research to identify prevailing levels of reported cases of sexual and gender-based violence and institutional responses to such violence.

Charmaine Pereira
LACVAW Initiative

Contents

Acronyms and abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AMAC	Abuja Metropolitan Area Council
CIRDDOC	Civil Resource Development and Documentation Centre
CMI	Change Managers International
CSO	Civil Society Organisation
DHS	Demographic Health Survey
DNF	Dorothy Njamanze Foundation
DRAC	Disability Rights Advocacy Centre
EVA	Education as a Vaccine
FCT	Federal Capital Territory
FGM	Female Genital Mutilation
FIDA	International Federation of Women Lawyers
GBV	Gender-Based Violence
H/C	Health Centre
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
JWC	Juvenile Welfare Centre
KII	Key Informant Interview
LACVAW	Legislative Advocacy Coalition on Violence Against Women Initiative
NAPTIP	National Agency for the Prohibition of Trafficking in Persons
NAWOJ	Nigeria Association of Women Journalists
NBS	National Bureau of Statistics
NDHS	Nigeria Demographic and Health Survey
NSRP	Nigeria Stability and Reconciliation Programme
PSS	Psychosocial Support
RoLAC	Rule of Law and Anti-Corruption
SAFE	Sexual Assault Forensic Evidence
SARC	Sexual Assault Referral Centre
SGBV	Sexual and Gender-Based Violence
SPSS	Statistical Package for the Social Sciences
STI	Sexually Transmitted Infections
UN	United Nations
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
VAWG	Violence Against Women and Girls
V4C	Voices for Change
VAPP	Violence Against Persons (Prohibition)
VVF	Vesico-Vaginal Fistula
WFI	Women Friendly Initiative
WHO	World Health Organization
WRAPA	Women's Rights Advancement and Protection Alternative

Executive summary

The passage of the Violence Against Persons (Prohibition) (VAPP) Act in 2015, applicable only in the FCT at present, heralds the new challenge of implementation of the law. As with other parts of the country, the Federal Capital Territory (FCT) grapples with the difficulties of strengthening institutions to implement laws and policies in ways that will, at the very least, set in motion an appropriate response to sexual and gender-based violence (SGBV), if not its prevention.

This report covers Phase 1 of LACVAW's research, which has the following objectives:

1. To establish a baseline on the prevalence of reported cases of sexual and gender-based violence in the FCT over a 12-month period (between the 1st of December, 2018 and the 30th of November, 2019).
2. To review the services provided by response agencies addressing sexual and gender-based violence in the FCT and the extent to which these are informed by the provisions of the VAPP Act.

The main collection of data for the baseline began in January 2020 and was completed in early February 2020.

In addition to reviewing the institutional response to sexual and gender-based violence in the FCT, the report addresses survivors' efforts to report their experiences of sexual and gender-based violence and the reception they received from the institutions they approached. The institutions involved were health facilities, law enforcement, government agencies, courts, and civil society organisations that provide response services to survivors of SGBV. In selected Area Councils of the FCT, personnel from these agencies were asked about their awareness of the provisions of the VAPP Act, the incidents of SGBV that were reported to them, and the measures in place to provide survivor-friendly responses to sexual and gender-based violence. The research was carried out in four Area Councils (AMAC, Bwari, Gwagwalada, and Kuje Area Councils) out of the six in the FCT.

A major challenge in carrying out the research was the unwillingness of some institutional respondents to participate in the data collection effort. Attempts at data collection were treated with suspicion in some quarters and subjected to bureaucratic bottlenecks, despite the necessary authorisation being obtained from the FCT Administration. A considerable number of health facilities within the AMAC Area Council in particular, were reluctant to divulge anonymised data for the survey. These were mainly private health facilities and in some instances, public hospitals, which claimed that they had no records of SGBV cases or else refused outright to cooperate. We therefore had a disproportionate number of responses from health facilities in the most populated Area Councils, which is likely to affect the accuracy of the distribution of reported cases across Area Councils.

Victims underreport the violations they suffered for a number of reasons. Some of the most important were that response agencies ranged from unfriendly to humiliating in their approach. In addition to this, there is a lack of information on what to do and where to go when victims experience sexual and gender-based violence. The incestuous rape of minors is generally hidden due to the beliefs of caregivers and communities regarding the potential impact on families, should the case be reported.

Access to information about health facilities' responses to SGBV incidents was greatest in Gwagwalada, and lowest in AMAC. Only two out of the 21 health facilities surveyed across the four Area Councils reported having a special unit for SGBV response. None of the facilities had rape kits, nor had any of their personnel ever administered such a kit. Just under half (43%) of the health facilities have staff that had received specialized training on SGBV. Only 5 health facilities responded that they carry out medical forensics on victims of SGBV (but not with the full complement of a rape kit) in order to provide evidence for law enforcement. Only 1 health facility reported that their treatment of victims of SGBV was guided by the VAPP Act. Most agencies stated that their treatment was guided by medical rules and guidelines.

Law enforcement agencies reported receiving several cases of sexual and gender-based violence against female as well as male victims. The agencies also reported that the most prevalent types of cases were the rape of minors, wife battery, rape of adults, and the abuse of under-aged domestic workers. However, the numbers they provided point to gross underreporting of cases. In comparison with reports from other institutional actors, the law enforcement numbers suggest that even when SGBV cases are reported to these agencies, many are not documented by the receiving officers.

Most of the law enforcement institutions sampled were aware of, and prosecuted cases utilising the VAPP Act. However, a few still only referred to the Penal Code, the Children and Young Persons Act, and Police Regulations in their prosecution of sexual and gender-based violence. Most of the stations (75%) had a gender desk. Less than half of the stations affirmed that they had specially trained officers, or the capacity to gather forensic evidence. However, all stations except one reported having protocols for responding to SGBV cases, and functional referral pathways, particularly to and from CSOs, Hospitals, the co-ordinating body NAPTIP, Social Welfare Units, Shelters, and the Court.

The civil society organisations surveyed provide a range of services for survivors of SGBV. These include: legal services; shelter; accompaniment to police stations, health services, courts; counselling; and referral. However, their interventions tend to be basic, and generally focus on one or two forms of interventions. While some CSOs affirmed that they had response protocols, others indicated that they had not had training on ensuring a survivor-friendly approach to their service provision. All CSOs provide referral services to law enforcement agencies, such as the police and NSCDC, to NAPTIP, and to health facilities. In some instances, CSOs partnered with the FCT Social Welfare Department/ FCT SGBV Response Team, community leaders, and health care service providers. Most CSOs recorded an average of 5 cases per week with a maximum turnaround time of 72 hours.

The courts surveyed were Sharia, Magistrate, and High Courts. None of their staff reported having received any form of training for managing SGBV cases. While there were records of prosecuted cases of SGBV, no courts made reference to the VAPP Act. Only High Courts have jurisdiction to hear cases under the VAPP Act but access to data at the High Courts was particularly challenging, despite having authorisation protocols fulfilled.

Information gleaned from some government agencies suggested a high level of mismanagement by the police which often led to withdrawal from cases by frustrated victims. From the responses, it was clear that the failure to ensure a survivor-friendly judicial system fosters situations which victims find discouraging, leading to fatigue and loss of confidence in the system. Overall, the level of documentation and follow-through interventions is very poor. Despite this, it is apparent from the number of SGBV cases reported and documented, and the support services provided, that sexual and gender-based violence is rife in the FCT.

The various agencies, organisations and institutions surveyed were asked to estimate the costs of providing services to survivors. Across the different institutional arenas, the costs of such provision were said to range from N1,000 to N100,000, for each survivor. Challenges in providing services until cases were concluded were attributed to: lack of trust; 'lack of cooperation' on the part of victims; pressure from victim's families (and sometimes the families of perpetrators) to drop cases; bureaucratic bottlenecks, such as delays in receiving funds; lack of cooperation from medical staff; dynamics attributed to culture and religion; and social stigmatisation.

Most importantly, this baseline study underlined the poor awareness and understanding on the part of numerous officials of response agencies, of the following: the VAPP Act, the rights of the victims, and the implications of sexual and gender-based violence for the physical, mental, social and psychological wellbeing of victims/survivors. The baseline study also documented poor capacity as well as operating resources to either respond effectively or to offer appropriate support and referral pathways.

1

Introduction

Charmaine Pereira

The Violence Against Persons (Prohibition) Act was passed in 2015 after a 14-year period of struggle for its enactment. The process began in 2001 when the International Human Rights Law Group (known as the Law Group), based in Abuja, held a workshop bringing together several women's rights organisations and others working on different aspects of violence against women.

Following Nigeria's transition from military to civilian rule in 1999, groups such as WACOL (Women Aid Collective), CIRRDOC (Civil Resource Development and Documentation Centre), GADA (Gender and Development Action), and Project Alert had begun advocating for laws prohibiting particular aspects of violence against women. Their advocacy was successful in ensuring that State laws were ultimately enacted against harmful traditional practices, inheritance rights, and domestic violence.

The Law Group workshop concluded with the agreement to form a coalition that would amplify the voices of organisations addressing the varying forms of violence against women that could be found across the country and push for more comprehensive legislation prohibiting such violence. The coalition – Legislative Advocacy Coalition on Violence Against Women (LACVAW) – is comprised of women's rights organisations, human rights groups, religious groups and development agencies working on various aspects of women's human rights, particularly violence against women. LACVAW played a formative role in the drafting of the Violence Against Women (Prohibition) Bill, having engaged in legislative advocacy for its enactment since 2001.

The National Assembly decided that the title of the Bill should be changed to refer to 'Persons', rather than 'Women', in 2008. Most of the original provisions were retained in terms of content but key provisions on marital rape, child marriage and abortion were removed in the course of the legislative process. The law is only applicable in the Federal Capital Territory (FCT), not across the federation.

Overview of the Violence Against Persons (Prohibition) (VAPP) Act 2015

The VAPP Act aims to 'Eliminate violence in private and public life, prohibit all forms of violence against persons, and to provide maximum protection and effective remedies for victims and punishment of offenders.' The law addresses gaps in current laws on violence in private and public spaces; covers old and new forms of violence; and establishes institutional mechanisms to prohibit violence.

One of the key provisions is a more comprehensive definition of rape (S.1) than previously codified in law; this section is quoted below:

1. A person commits the offense of rape if –
    a. 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;
    b. The other person does not consent to the penetration;
    c. 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 or 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.

Other offences include physical injury, economic abuse, forced isolation, emotional, verbal and psychological abuse, harmful traditional practices, stalking, attacks with harmful substances, incest, and indecent exposure (S.6-26).

The duties of police at the scene of violence are specified (S.32). They include assisting the victim to file a complaint; arranging transport to an alternative residence; arranging transport to the nearest medical facility for the treatment of injuries, where necessary; explaining the victim's rights to protection against violence and the remedies available; explaining the victim's right

to lodge a criminal complaint; and accompanying the victim to their residence to collect personal belongings.

Institutional support for protection from further abuse takes the form of protection orders to limit the occurrence of further abuse in domestic/ intimate relationships. Applications for protection orders (S.28) may be made to the High Court by a number of persons. They include the complainant, a police officer, a protection officer, an accredited service provider, a counsellor, a health service provider, a social worker, or a teacher. Such provisions enable other persons and institutions to seek protection on behalf of abused persons.

The rights of survivors are specified in section 38. They include remedies such as comprehensive medical, psychological, social and legal assistance; the right to be informed of the availability of legal, health and social services and be readily afforded access to them; and the right to rehabilitation and re-integration programmes of the State. Survivors' rights also include the right not to be prohibited or restrained from reporting offences; and to be free from expulsion, disengagement, suspension or punishment by availing themselves of the Act's provisions.

The agency mandated with the responsibility of administering the Act's provisions and of collaborating with relevant stakeholders in implementation of the Act is the National Agency for the Prohibition of Trafficking in Persons (NAPTIP) (S.44). NAPTIP is also expected to appoint a co-ordinator for the prevention of domestic violence and report annually to the federal government on implementation of the Act (S.42).

Towards implementation of the VAPP Act

The passage of the Violence Against Persons (Prohibition) Act in 2015 signalled the end of one chapter and the beginning of another. For the VAPP Act to have meaning and to make a difference to the lives of survivors of violence, it is necessary to take implementation of the law seriously. But what would it take to actually implement the VAPP Act? Given the generalised tolerance of gender-based violence in the country and the equally generalised expectation that laws passed will not be implemented, never mind have funds appropriated for their effective implementation, one might well ask why there should be any expectation that activist efforts to push for implementation of the VAPP Act would even be heard by legislators or institutional stakeholders. This, however, is not a basis for not acting to try and change the status quo. What it means is that organised action is necessary to demand recognition of state responsibility for implementing a law that prohibits violence against persons. Financial and institutional as well as more intangible resources to enable implementation – trained personnel, functional institutions – are critical. Access to such resources rests on an acceptance on the part of legislators and institutional stakeholders that they should make funds available for the different actors and agencies that play a part in implementing the law. Sustained pressure from groups in civil society is necessary to promote government acceptance of such responsibility. This perspective lies at the heart of LACVAW's intervention project on effective implementation of the VAPP Act.

For implementation of the VAPP Act to make a difference to survivors in an intentional manner, it would be necessary for policy actors to have some sense of how many survivors there might be, experiencing what forms of violence under what conditions, and what remedies they would need. At the same time, knowledge of the character of institutional response, or lack of it, would be necessary to work out how existing, ineffective response needs to be transformed. Ultimately, effective implementation of the VAPP Act should have a bearing on impunity – the widespread institutional failure to address the harms wrought by perpetrators of SGBV and the conditions giving rise to acceptance of this situation.

At present, there is considerable anecdotal awareness of inappropriate state response but this has not been systematically documented in the FCT. There is also a glaring lack of knowledge concerning survivors. This lack makes it difficult to plan for the required investigation of violations, service provision – particularly remedies for survivors – and prosecution where necessary. It also means that effective monitoring of the reported prevalence of sexual and gender-based violence is barely possible. Without this knowledge, it is difficult to know how much the required services would cost or even to demand for the appropriate level of funding for implementation of the VAPP Act in the FCT.

For these reasons, LACVAW's intervention strategy for effective implementation of the VAPP Act begins with research. Phase I of the study, reported here, aimed to establish a baseline of previous cases of sexual and gender-based violence in the Federal Capital Territory (FCT) reported over the year beginning the 1st of December 2018 and ending, the 30th of November 2019. This was followed in Phase II by collecting information about ongoing cases of SGBV reported over a 9-month period (May 2020 to January 2021). Both phases of the research emphasise the responses to SGBV from duty bearers. LACVAW's research on gendered violence underpins its intervention strategy on implementation of the VAPP Act. The findings of both phases of the research – comprising the first component of LACVAW's intervention strategy – provide a template for estimating the minimal number of survivors of SGBV there might be in the FCT and the remedies they might need. This information has formed the basis for developing an estimated budget for a 3-year workplan to address implementation of the VAPP Act. This is the second component of LACVAW's intervention strategy. Building on this, LACVAW has carried out advocacy to push for the inclusion of such costs in the necessary ministerial and legislative budgets, with a view to amplifying demands to pursue the law's provisions for remedies and redress. Advocacy aimed at the larger society has also drawn attention to the ongoing state of sexual and gender-based violence in the FCT in order to support these demands.

The rest of this introduction aims to do two things. The shift in the focus of the law's prohibition from 'Violence Against Women' to 'Violence Against Persons' potentially masks the significance of past struggles against gendered violence and the concepts embedded in such efforts. The first objective, therefore, is to highlight these struggles and provide some conceptual clarification about what is involved in efforts to name gendered violence, and to provide 'data' i.e. to count cases of such violence. The second objective is to draw attention to the broader context shaping violence in general in Nigeria, before pointing to the gendered violence that is officially recognised as well as that which is not. When law enforcement agents are some of the key actors in perpetrating sexual and gender-based violence, this raises the very serious question of how impunity can possibly be curtailed.

Naming gendered violence

How gendered violence is named is reflective of both how it is understood as well as the role it can play in shaping actions taken on the basis of this understanding.

> …our linguistic choices are fundamentally conceptual … Our words shape the ways in which it is (not) possible to understand the issues at stake, the ways they are legislated against, measured and resourced and the responses which are deemed most urgent and appropriate.[1]

Today, concepts such as 'Violence Against Women' (VAW) and 'Sexual and Gender-based Violence' (SGBV) "have become prominent in national and international research and policy agendas".[2] It is worth pointing out that the phrase 'Violence Against Women', more recently 'Violence Against Women and Girls' (VAWG), became prominent as a result of longstanding and sustained decades of feminist organising against gendered violence. Since the 1980s, feminist analysis and activism addressing gendered violence has emphasised the critical importance of the perspectives of the women experiencing (or threatened by) such violence. Since women are not a homogenous group, being positioned differently in multiple structures of power, such as class, ethnicity, religion, sexuality, race, ability, generation, it is important to acknowledge that diverse groups of women will have varying levels of exposure to violence and therefore, different experiences.

LACVAW's original focus on a law prohibiting violence against *women* reflects the influence of feminist theory and practice, and women's organising at international and regional levels as well as the organising by women's rights groups within Nigeria. At the international level, it was women's mobilisation and organising over two decades which had culminated in the Global Tribunal on Violations of Women's Human Rights, held during the UN World Conference on Human Rights in Vienna in 1993. Women from 25 countries gave testimonies of their experiences of domestic violence, political persecution and violations of economic rights, leading to the landmark recognition of "women's rights as human rights".[3]

In the same year, the UN General Assembly adopted the Declaration on the Elimination of

Violence Against Women, defining violence against women as "a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men, and to the prevention of the full advancement of women".[4] Violence against women is seen as a subset of 'gender-based violence', constituting "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life" (article 1). Such acts could be carried out in the family, community or perpetrated or condoned by the State (article 2). Ultimately, violence against women comprises "one of the crucial social mechanisms by which women are forced into a subordinate position compared with men". [5]

The definition of gender-based violence was expanded in the 1995 Beijing Platform for Action (BPfA), to include violations of the rights of women in situations of armed conflict. Outlining a series of actions to address violence against women in several policy areas, the Beijing Platform for Action was agreed to by 189 governments and supported by CSOs in 180 countries.[6] Since then, the understanding of gender-based violence has expanded further: "The term originally described violence against women but is now widely understood to include violence targeting women, transgender persons, and men because of how they experience and express their genders and sexualities".[7]

Almost a decade after the Beijing Platform for Action, the Maputo Protocol[8] was adopted in Mozambique in 2003. The Maputo Protocol stands out as a regional instrument that focuses specifically on the conditions facing African women; it was developed by women's rights organisations in Africa and elsewhere, and driven by extensive lobbying of governments. The Protocol does not focus solely on legal matters but engages several other sectors – health, education, food security – as well as economic and social welfare rights.[9] Rather than the term 'gender-based violence', the Protocol uses the phrase 'violence against women' in a comprehensive manner:

> 'Violence against women' means all acts perpetrated against women which cause or could cause them physical, sexual, psychological, and economic harm, including the threat to take such acts; or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peacetime and during situations of armed conflicts or of war. (Article 1)

Apart from the wide-ranging understanding of 'violence against women', the Maputo Protocol makes it clear that *states are expected to take measures* to 'ensure the protection of every woman's right to respect for her dignity and protection of women from all forms of violence' (Article 2.1.b). The rights to life, integrity and security of the person (Article 4) mean that every woman is entitled to 'respect for her life and the integrity and security of her person. All forms of exploitation, cruel, inhuman or degrading punishment and treatment shall be prohibited' (Article 4.1). Moreover, states are expected to take 'legislative, administrative, social and economic measures as may be necessary to ensure the prevention, punishment and eradication of all forms of violence against women' (Article 4.2.b). The VAPP Act draws considerably from the Maputo Protocol, in its initial formulation of provisions prohibiting all forms of violence against women.

More recent terminology has involved referring to both 'sexual' and 'gender-based violence' in conjunction (SGBV). This has surfaced in the context of armed conflict, which is increasingly marked by horrendous acts of sexual violence. The UN High Commissioner for Refugees, in their Updated Strategy on Action Against Sexual and Gender-based Violence, points out that:

> Although the terms gender-based violence (GBV) and sexual and gender-based violence (SGBV) are often used interchangeably, UNHCR consciously uses the latter to emphasise the urgency of protection interventions that address the criminal character and disruptive consequences of sexual violence for victims/survivors and their families.[10]

It should be emphasised, however, that the widespread occurrence of sexual violence is not specific to situations of armed conflict. There are continuities between sexual and gender-based

violence manifested in violent conflicts, and the violence which *predates* such conflict, in times of 'peace'.[11] The UN Secretary General's annual report on sexual violence shows that many of the countries marked by political violence and thought to be at high risk of SGBV crimes are countries with higher than average levels of gender inequality. Specific systemic features of gender inequality are highlighted: "restricted physical integrity, discriminatory family codes, son bias, restricted civil liberties, and restricted resources and entitlements".[12]

The fact that the final wording of the VAPP Act's title rests on the prohibition of violence against *persons* has not only meant a change in reference point, in terms of the target of violence, but has also signalled changes in the language used to refer to gendered violence. The greater visibility of sexual violence in society and in media reports in recent years has no doubt prompted the broader use of the term 'SGBV' amongst women's rights organisations and practitioners working in the field. This has also informed the framing of LACVAW's research in its project on implementation of the VAPP Act.

Counting gendered violence

Whilst LACVAW's research aims to provide an estimate of the prevalence of *reported* cases of sexual and gender-based violence in the FCT, this is done in full recognition that the actual extent of SGBV is largely under-reported. There are several reasons for this, such as stigma, fear of a backlash and exposure to further violence, as well as a lack of trust in the institutions that are supposed to prohibit and prevent such violence from occurring in the first place.

A wide spectrum of people positioned across several hierarchies and structures of power – gender, class, ethnicity, religion, dis/ability, sexual orientation, generation – will be affected differently by SGBV. Those who very often become targets of sexual and gender-based violence are the people, predominantly women but not always, who are more vulnerable within the various hierarchies. They include people who are not economically independent, people who are dependent on public transport, those living in houses without effective security, those living in crime-ridden or conflict-prone areas. This is not to discount the existence of sexual and gender-based violence among the wealthy and powerful strata of society. However, accounts of these experiences of violence are less likely to surface, given the greater capacity of those involved to prevent such exposure and to deal with the aftermath of the violence.

Studies of the prevalence of SGBV generally emphasise the need for 'data' on such violence, the latter being defined by the *numbers* of cases identified in such studies. When President Thabo Mbeki demanded to know just "how much rape" there was in South Africa in 1999, the question was difficult to assess since reported cases generally represent "the tip of an iceberg of sexual coercion".[13] Beyond this, however, the issue had become politically fraught and controversial in the wake of a report attributed to Interpol (without any evidence for the claim) which purported to describe South Africa as "the rape capital of the world".[14] Such a statement glosses over the fact that legal definitions of sexual and gender-based violence differ from one country to another, as do ways of counting and keeping records of such violations. International comparisons are thus unlikely to be accurate.[15]

It is necessary to qualify what the 'data' i.e. the numbers and statistics obtained from research on the prevalence of SGBV, can and cannot tell us. Firstly, numbers and statistics in themselves do not convey incontrovertible 'evidence' about the *extent* of sexual and gender-based violence. Apart from the under-reporting alluded to earlier, there is the question of how the numbers are produced. Much depends on the assumptions embedded in the questions themselves, the responses to questions as well as the interpretations that may be made of what is actually counted.

Secondly, numbers as they are understood in an everyday sense[16] tend to be used as if each unit counted is equivalent to the next i.e. one plus one equals two. But we know that individual cases of SGBV are each distinct – no single experience of violence is equivalent to any other and no two cases of SGBV are therefore 'equal'. The pain and destabilisation caused by sexual and gender-based violence cannot be reduced to numbers.

So any time we examine the numbers and wish to compare different sets of numbers, this raises the question of *reference* – what can the numbers ultimately be said to refer to, or represent? It is necessary to take a critical approach to numerical

data, recognising that the information they provide is necessarily partial – numbers cannot convey the whole picture.

This does not mean, however, that quantitative studies and numerical data *cannot* be useful. What it does mean is that the numbers need to be *interpreted*; they have potentially more than one meaning but these meanings are neither fixed nor necessarily inherent in their numerical character. Whilst numerical information is important for planning and programming by policy actors, this is more often due to the meanings attached to numbers – greater objectivity and reliability – when making decisions about the allocation of resources.

Ultimately, however, numbers should *not* be treated as more important or more useful than any other kind of information. Numbers cannot be seen as a substitute for narratives or other forms of qualitative information nor should quantitative analyses be seen as superior to the nuanced analyses possible with in-depth qualitative studies. What the numbers do is paint a different kind of picture.
This brings us to the question of violence in general in Nigeria, and the varied contours of gendered violence in this broader context.

A violent state, a violent society ...

As a former colony, Nigeria has undergone the violence of colonial conquest followed by the militarisation inherent in decades of military rule. This has had destructive effects on men as well as women but in different ways. Colonial governments undermined women's power and influence where it existed,[17] whilst advancing gender ideologies that justified women's withdrawal from public economic activities and their restriction to domestic arenas.[18] The overall effect was to increase many women's economic dependence on men whilst eroding their opportunities to shape the new political and economic order. This was exacerbated under military rule. Moreover, the generalised violence against citizens that characterised military rule reinforced authoritarian tendencies in families, communities, and institutions, including those of the state.

Today, violence is endemic in Nigeria. Between January and December 2019, at least 3,188 people were killed in violent episodes. Most of these were due to banditry (1,075), followed by violent conflicts arising from the activities of insurgent groups such as Boko Haram and Islamic State's West Africa Province (ISWAP) (702 deaths). More than 10% (481) of the total number of deaths were of state security agents. Electoral violence, it should be noted, has resulted in almost as many killings as those resulting from insurgency (605).[19]

Whilst men and women can be victims as well as perpetrators of violence, the violence targeted at women is different in key respects from that targeted at men.

> Men are more likely to be killed or injured in wars or youth- and gang-related violence than women, and they are more likely to be killed or physically assaulted on the street by a stranger. Men are also more likely to be the perpetrators of violence, regardless of the sex of the victim. In contrast, women are more likely to be physically assaulted or murdered by someone they know, often a family member or intimate partner. They are also at greater risk of being sexually assaulted or exploited, either in childhood, adolescence, or as adults.[20]

Official records point to nearly one third (31%) of women and girls in Nigeria, aged 15-49 years, experiencing physical violence. The level of physical violence is markedly higher than that recorded for sexual violence, which is 9% of women and girls within the same age range. More than a third of women who have ever been married (36%) have experienced physical, sexual or emotional violence on the part of their spouse.[21] Women and girls continue to undergo the practice of female genital mutilation (FGM), although this is the case for a considerably lower proportion of girls between 15-19 years (12.3%) compared to older women aged 45-49 years (27.6%).[22] In 2015, most trafficking in persons was of those aged 16-25 years, of which 87.5% were women.[23]

Societal tolerance of violence against women and girls is pervasive. Many women accept that a husband may legitimately beat his wife under certain circumstances. The 2018 Nigeria Demographic and Health Survey (NDHS) found that between 25.6% and 29.8% of women and girls aged 15-49 years agreed that wife beating was acceptable in at least one of the following situations: if the wife burns the food, argues

with her husband, goes out without telling him, neglects the children, or refuses to have sex with her husband. Reports of acceptance were more than twice as high among women and girls in rural areas relative to those in urban spaces (37.9% and 16.3%, respectively). Across zones, the highest level of acceptance of wife beating was in the North East where there is an ongoing insurgency (45.2%); the lowest was in the South West (6.8%).[24]

Whilst particular forms and targets of gendered violence are recognised in official records, others are more likely to be overlooked. Women and girls with disabilities face considerable levels of sexual, physical and emotional abuse. Acts of deliberate restriction of their mobility are often not acknowledged as acts of violence. The physical, financial and emotional dependence of women and girls with disabilities on their carers exacerbates their vulnerability to violence. Most are also impoverished as a result of their disability, which leaves them even more open to abuse. The extent to which institutional carers violate those in their care is also not fully recognised.[25]
Gender nonconforming persons – those whose expressions of gender (e.g. dress, behaviour, and the like) and sexual orientation do not conform to what is expected of 'a proper man' or 'a proper woman' – have been consistently vilified since the passage of the Same Sex Marriage (Prohibition) Act in 2013. Targeted violence against gender nonconforming persons has been carried out not only by state actors but non-state actors as well, taking the form of mob violence in some instances as well as rape and physical and sexual assault. The Initiative for Equal Rights (TIERs) has been documenting human rights violations targeted at gender nonconforming persons since 2013. Those whose sexualities are considered 'deviant', such as gay men and transgender women, experience considerable violence at the hands of the police, the very agency that is supposed to ensure the security of the public.[26] Those who are violated by the police have no option of reporting such violence to the same law enforcement personnel, regardless of the existence of the VAPP Act. This strengthens the impunity exercised by law enforcement agents, a dire situation for the society as a whole.

Between April and May 2019, state sponsored violence against women and girls was particularly blatant in Abuja. Members of the Federal Capital Territory (FCT) Ministerial Joint Task Force (JTF) rounded up over a hundred women in raids on nightclubs in Abuja as well as in violent, random swoops on women who happened to be in public spaces after 6 p.m. Women were pursued not only in nightclubs but in public spaces of all kinds, whether on the streets, in front of supermarkets, walking in their neighbourhoods, even inside their cars. They were arrested for their mode of dressing, particularly if they were considered to be 'scantily clad'. Gun-toting military men and police officers descended on the women and shoved them violently into vans, before arraigning them before mobile courts run under the auspices of the Abuja Environmental Protection Board (AEPB). Several women caught up in these ambushes have testified to being raped.[27] The violence has provoked street protests and considerable anger on social media. Police harassment in the form of round-ups of women has also taken place elsewhere in Nigeria - Lagos, Ekiti and Cross River.

Anti-violence legal activism

In the last two decades, considerable efforts across Africa have been devoted to legal activism aimed at instituting laws that challenge unjust sexist practices and protect women and girls from violence. Women's rights organisations have been central to such efforts, as was the case for example in Ghana.[28] Ghana's process of getting the Domestic Violence law enacted in 2007 has been described as "long and arduous, fraught with contestations over the place of domestic violence legislation in an African context".[29]

Of the 15 countries in the West African sub-region, five have passed laws prohibiting either domestic violence or gender-based violence. They are: Sierra Leone (2007), Ghana (2007), São Tomé and Príncipe (2008), Cabo Verde (2011) and Nigeria (2015). In only four of these countries does the state support anti-violence programming – Cabo Verde, São Tomé and Príncipe, Sierra Leone and to some extent, Nigeria. The rest rely on civil society organisations to run anti-violence programmes.[30]

In general, the laws addressing gendered violence are not effectively implemented. This is due to the lack of political will, weak institutional capacity, and resistance to laws prohibiting violence against women and girls, which is generally cast as a private, family matter. Patriarchal interpretations of social norms, tradition, and religion exacerbate the poor response by state officials.[31] What this

highlights is that a state-centred focus alone – on laws and policies as instruments for countering violence against women and girls – is not enough. Efforts to prohibit violence against women and girls need to be supported by the larger society as well as local communities for such efforts to be effective. This is even more significant when it comes to prevention of gendered violence.

Phase I of LACVAW's research on SGBV in the FCT

This Baseline report begins by highlighting key elements of sexual and gender-based violence in the context of the Federal Capital Territory before outlining the research methodology. It proceeds by presenting the perspectives of survivors on their efforts to seek help or report their experiences of SGBV. This is followed by a consideration of reports of SGBV to institutions with mandated responsibilities under the VAPP Act, the responses by these various institutions, in terms of treating victims' injuries, enforcing the law on the prohibition of violence, and providing remedies for survivors. Sources of information were hospitals and health centres, the police, government response institutions, such as social welfare centres as well as the coordinating body, NAPTIP, and the courts. Additional sources were civil society organisations that provided services for survivors – psychosocial support, advocacy on their behalf, accompaniment to police stations, legal aid, and so on. The report concludes by emphasising the principles underlying an alternative approach to sexual and gender-based violence which prioritises survivors, and points to specific actions required in order to move towards effective implementation of the VAPP Act.

Endnotes

1 Boyle, K. 2019. "What's in a Name? Theorising the Inter-relationships of Gender and Violence", *Feminist Theory* 20 (1), 19-36. Page 20.

2 Frazer, E. and Hutchings, K. 2019. "The feminist politics of naming violence", F*eminist Theory* 0 (0), 1.18.

3 Joachim, J. 2003. "Framing Issues and Seizing Opportunities: The UN, NGOs and Women's Rights", *International Studies Quarterly* 47, 247-274. https://academic.oup.com/isq/article/47/2/247/2963241

4 United Nations, 1993. 48/104: Declaration on the Elimination of Violence Against Women (A/RES/48/104)

5 *Ibid.*

6 United Nations, 1996. The Beijing Declaration and the Platform for Action: Fourth World Conference on Women: Beijing, China: 4-15 September, 1995. (DPI/1766/Wom), paras. 114-116.

7 TIERs, 2019. *2019 Human Rights Violation Report: Based on Real or Perceived Sexual Orientation or Gender Identity in Nigeria.* Lagos: The Initiative for Equal Rights. https://theinitiativeforequalrights.org/wp-content/uploads/2019/12/2019-Human-Rights-Violations-Reports-Based-on-SOGI.pdf

8 Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa. Maputo, 2003. https://www.achpr.org/legalinstruments/detail?id=37

9 AWID Interview with Faiza Jama Mohamed. 2003. "African Women's Organizing For The Ratification And Implementation Of The Maputo Protocol." https://www.soawr.org/blog/african-women%E2%80%99s-organizing-ratification-and-implementation-maputo-protocol

10 UNHCR. 2011. Action Against Sexual and Gender Based Violence: An Updated Strategy. United Nations High Commissioner for Refugees, Division of International Protection. https://cms.emergency.unhcr.org/documents/11982/51689/UNHCR%2C+Action+Against+%20Sexual+and+Genderbased+Violence.+An+Updated+Strategy%2C+2011/4f9d2a1c-280e-4ac8-a832-1a789de63d46

11 Mama, A. and Okazawa-Rey, M. 2012. "Militarism, Conflict and Women's Activism in the Global Era: Challenges and Prospects for Women in Three West African Contexts." *Feminist Review* 101: 97-123.

12 Davies, S. and True, J. 2015. "Reframing conflict-related sexual and gender-based violence: bringing gender analysis back in", *Security Dialogue*, 1-18. https://www.researchgate.net/profile/Jacqui-True/publication/283452135_Reframing_conflict-related_sexual_and_gender-based_violence_Bringing_gender_analysis_back_in/links/563fceef08ae8d65c01511fe/Reframing-conflict-related-sexual-and-gender-based-violence-Bringing-gender-analysis-back-in.pdf Page 9.

13 Jewkes, R. and Abrahams, N. 2002. "The epidemiology of rape and sexual coercion in South Africa", *Social Science & Medicine* 55: 7, 1231-1244. https://www.sciencedirect.com/science/article/abs/pii/S0277953601002428

14 Wilkinson, K. 2014. "Why it's wrong to call South Africa – or any country – the world's

‘rape capital’.” Africa Check, 28 January. https://africacheck.org/fact-checks/reports/why-its-wrong-call-south-africa-or-any-country-worlds-rape-capital

15 Lancaster, L. 2021. “Debunked and flawed ‘statistics’ about rape in South Africa posted on Facebook”. Africa Check, 23 April. https://africacheck.org/fact-checks/fbchecks/debunked-and-flawed-statistics-about-rape-south-africa-posted-facebook

16 As distinct from the ways in which they can be used in statistics.

17 Amadiume, I. 1987. *Male Daughters, Female Husbands: Gender and Sex in an African Society*. London: Zed Books.

18 Pereira, C. 2005. “Domesticating Women? Gender, Religion and the State in Nigeria under Colonial and Military Rule”, *African Identities*, 3 (1), 69-94.

19 Global Rights. 2020. ‘Mass Atrocities Casualties Tracking Report 2019’. Abuja: Global Rights. https://www.globalrights.org/ng/mass-atrocities-casualties-tracking-report-2019/

20 Ellsberg, M. and Loise, L. 2005 *Researching Violence Against Women: A Practical Guide for Researchers and Activists*. WHO, PATH. Page 10.

21 NPC and ICF. 2019. *Nigeria Demographic and Health Survey 2018*. Abuja, Nigeria, and Rockville, Maryland, USA: National Population Commission (NPC) and ICF. https://dhsprogram.com/pubs/pdf/FR359/FR359.pdf

22 UNICEF. 2019. Statistical Profile on Female Genital Mutilation. Division of Data, Research and Policy, New York. Data.unicef.org

23 NBS, 2017. *Statistical Report on Women and Men in Nigeria.* National Bureau of Statistics. Issued February, 2018.

24 NPC and ICF. 2019. *Nigeria Demographic and Health Survey 2018*. Abuja, Nigeria, and Rockville, Maryland, USA: National Population Commission (NPC) and ICF. https://dhsprogram.com/pubs/pdf/FR359/FR359.pdf

25 cbm/DRAC. 2018. “Fallen Through the Cracks: A Baseline Study on the Knowledge, Attitude and Perception of the General Population on Violence Against Women and Girls with Disabilities in the FCT and Mararaba, Nasarawa State, Nigeria. Abuja: Disability Rights Advocacy Centre. https://dhsprogram.com/pubs/pdf/FR359/FR359.pdf

26 TIERs, 2019. *2019 Human Rights Violation Report: Based on Real or Perceived Sexual Orientation or Gender Identity in Nigeria.* Lagos: The Initiative for Equal Rights. https://theinitiativeforequalrights.org/wp-content/uploads/2019/12/2019-Human-Rights-Violations-Reports-Based-on-SOGI.pdf

27 Pereira, C. 2019. “Abuja: Routinely Raping Women At Night and Still Offering A Safe Space By Day?” https://opinion.premiumtimesng.com/2019/06/02/abuja-routinely-raping-women-at-night-and-still-offering-a-safe-space-by-day-by-charmaine-pereira/

28 Adomako Ampofo, A. 2008. “Collective Activism: The Domestic Violence Bill becoming Law in Ghana”, *African and Asian Studies*, 7, 395-421.

29 Darkwah, A. and Prah, M. 2016. “Beyond Domestic Violence Laws: Women’s Experiences and Perceptions of Protection Services in Ghana” CEGENSA (Centre for Gender Studies and Advocacy), University of Ghana. http://ella.practicalaction.org/wp-content/uploads/2016/07/REP_CEGENSA-_Beyond-Domestic-Violence-Laws.pdf

30 *Ibid.*

31 *Ibid.*

2

Sexual and gender-based violence in the FCT

The Context

Nigeria is Africa's most populous country and has the seventh largest population in the world, with an estimated 193 million people in 2016. Of these, 49.2 percent are women and 50.8 percent men.[1] The country has one of the largest youth bulges in the world - 41.8 percent of its population is between 0-14 years and most of the population (70.7%) is under 30.[2]

Nigeria has more than 10 million out-of-school children,[3] and only 59.3 percent of young women are literate compared to 70.9 percent of young men.[4] Just over 50 percent of the population is multi-dimensionally poor.[5] General living conditions and health care are inadequate and although public basic education is free, it is of substandard quality.

Nigeria is a highly patriarchal and religious society, and patriarchal practices are embedded in the manifestation of its two dominant religions.[6] At the broadest levels, widely held ideas about masculinity and femininity are powerful dimensions of gender inequality and violence against women in all its forms.[7] The social constructs that privilege men over women, confer a higher social value on men, reinforcing a culture of sexual and gender-based violence.[8]

The country has been beset by violent conflicts which have resulted in the monumental loss of lives and property across its six geopolitical zones. Since 2010, more than 150,000 persons have been killed in an escalating field of mass atrocities for which there has hardly been any redress.

The political geography and patterns of atrocities, as well as the impunity for them, have expanded considerably. The nation's threshold of violence has grown over time, as evident from these theatres of conflict and reports of individual violence.[9] With the proliferating levels of conflict across the country, an increasing level of sexual and gender-based violence is apparent in society.

Federal Capital Territory

The Federal Capital Territory (FCT) is the seat of Nigeria's capital, Abuja. Located at the heart of the country, the FCT is bordered by the states of Niger to the west and north, Kaduna to the northeast, Nasarawa to the east and south, and Kogi to the southwest. The FCT has a landmass of approximately 7,315 km^2. The territory is made up of six area councils, namely: Abaji, Abuja, Bwari, Gwagwalada, Kuje, Kwali. There is no current, accurate census in Nigeria; the projected population of Abuja in 2020 is over 3 million. Ranging between 3,278,000 and 3,564,100,[10] this points to a 5.91% increase from 2019.[11] The FCT is largely cosmopolitan, with some peri-urban and rural concentrations at Abaji, Bwari, Kuje and Gwagwalada area councils. Abuja, as the capital city, is a cultural and religious melting pot that is truly representative of Nigeria.

FCT	3,564,100
Abaji	148,600
Abuja Municipal Area Council	1,967,500
Bwari	581,100
Gwagwalada	402,000
Kuje	246,400
Kwali	218,400

Population by gender: 47.9% female, 52.1% male.[12]

Sexual and gender-based violence in Nigeria

Sexual and gender-based violence (SGBV) refers to "any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. It includes physical, emotional or psychological and sexual violence, and denial of resources or access to services. Violence includes threats of violence and coercion. SGBV inflicts harm on women, girls, men and boys"[13], but its predominant victims are women and girls, and its perpetrators are mainly men. Globally, the prevalence of SGBV varies; however, roughly 35% of all women and girls have suffered some form of SGBV[14], with adolescents being the most vulnerable[15].

Sexual and gender-based violence is endemic in Nigeria – 1 in every 4 girls and 1 in every 10 boys will have suffered some form of sexual violence before they turn 18. Worse still, less than 5% of them receive any form of support.[16] Approximately 80 million Nigerian women and girls are victims of sexual and gender-based violence in Nigeria.[17] The most common types include: domestic violence, child/forced marriage, a spectrum of sexual abuse, including rape, sexual assault, sexual harassment, sex trafficking, female genital mutilation.

With these forms of violence are the attendant consequences that have an impact on the rights and health of victims as well as the wider society. A number of victims who escape death become maimed for life, suffering physical and mental disabilities, including post-traumatic stress disorder. Survivors are often unable to work and this has an impact on family incomes and national GDPs. Less often spoken about are the tremendous psychological impacts that these forms of violence have on the children for whom the victims are primary caregivers.

Most forms of sexual and gender-based violence are integral to the patriarchal constructs evident in the state and society. Hence, the political will to prevent such violence is often missing. Despite Nigeria's ratification of the UN Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) in 1979, the government has done very little to reduce the prevalence of SGBV in the country. The failure to protect half of the country's population from such forms of violence can be attributed to several factors:

Patriarchy: The pecking order of Nigerian society places men at the top of the power pyramid, followed by hierarchies of economic status and age. As in most other parts of the world, there exist strong cultural patriarchal nuances in which men (who are often the perpetrators of these crimes) can 'do no wrong'. This often leads to victim-blaming and re-victimisation of those violated. In acts of self-preservation, victims and their families often embrace the culture of silence.

Acts of SGBV are frequently treated as 'private' matters since women are assumed to 'belong' to their husbands, or fathers, or other male figures in their lives. Patriarchal norms support practices in which women are treated as 'chattels', paid for through bride price. In these transactions, it is implied that women's sexuality is for the exclusive pleasure of their husbands or male partners, who in a sense own them, and that consequently, women have a duty to protect their virginity/ sexuality and be chaste.

In this line of thinking, a woman who 'allows' herself to be raped, has failed to fight to protect her sexual purity and should therefore be punished. An often expressed sentiment by some religious and traditional leaders in the course of conducting this research was that victims of sexual violence were as guilty as perpetrators and ought to be punished for "allowing themselves to be raped". They justified their assertions by referring to the scriptures or their understanding of morality.

Impunity: Nigeria's greatest governance challenge is impunity.[18] The widespread culture of impunity often results in laws being broken without consequences. Within institutional contexts of patriarchal practice, impunity for sexual and gender-based violence becomes even more entrenched.

Inadequate laws: Laws governing sexual and gender-based violence are outdated in most parts of the country, making prosecution of these crimes difficult. This adds to the challenges of inadequate institutional capacity. A few states are taking steps to remedy this, however, such as Lagos state with its Prohibition Against Domestic Violence Law of 2007[19] and the Criminal Laws of Lagos[20]. These laws have provisions against various forms of violence against vulnerable persons, including sexual violence. In 2015, the Violence Against Persons Prohibition (VAPP) Act was enacted, currently applicable only in the Federal Capital Territory. Other states that

have taken the initiative to update their laws, modelling them (to varying degrees) on the VAPP Act, include Anambra, Benue, Ebonyi, Edo, Ekiti, Enugu, Kaduna, Oyo, and Osun states.

Weak institutions: Nigeria has failed to build up essential capacity for dealing with sexual and gender-based violence. The personnel of most response institutions do not have the necessary skills and resources to respond appropriately to the challenge. There is also a generalised lack of data for planning and programmatic purposes. The general apathy to collecting and analysing data in government agencies, even when faced with abuses as obviously pervasive as sexual and gender-based violence, is problematic for designing preventive interventions.

Initiatives addressing sexual and gender-based violence in Nigeria

There have been many interventions across Nigeria to address sexual and gender-based violence. These have been initiated by state actors, civil society actors, and development partners, in consonance with, as well as independent of the laws referred to above. Most of them have failed, however, to address the gaps in providing survivor-friendly responses to sexual violence. An important exception is the Mirabel Centre, the first sexual assault referral centre (SARC) which was opened in Lagos as a pilot project in July 2013, with the support of the British Council. The aim is to provide 'holistic and high quality medical and psychosocial services to survivors of sexual assault and rape'.[21] A response model grew from this initiative, resulting in a civil society/ government coordinated response in Lagos state, known as the Domestic and Sexual Violence Response Team (DSVRT). The DSVRT is a collection of medical, law enforcement, civil society service providers and government agencies that respond as a group to the various needs of domestic and sexual violence survivors. The Mirabel Centre provides emergency medical assistance, counselling, psychological and psychosocial support, and information about legal services.

The lessons and success of the first SARC are being replicated with centres established across Nigeria in the following states: Adamawa, Akwa-Ibom, Anambra, Borno, Enugu, Jigawa, Kaduna, Kano, Lagos, Niger, and Yobe. The centres have responded in this period to more than 10,000 clients over a period of 6 years.[22] There have also been several initiatives by CSOs to train security forces across the country on ensuring survivor-friendly response to victims of sexual and gender-based violence. In addition, thousands of community advocacy outreach efforts and media infomercials have sought to educate Nigerians on SGBV and available response resources. In spite of these strides, the institutional response to sexual and gender-based violence is still considered inadequate across Nigeria. Apart from sexual violence, there is a gap in responding to other forms of gendered violence. For instance, most states do not have shelters for victims of domestic and other kinds of SGBV. They also do not have basic response protocols that will ensure strong response coordination among various first line response agencies responsible for addressing such crimes.

Institutional responses to sexual and gender-based violence in the FCT

As in other parts of Nigeria, the FCT has been beset by sexual and gender-based violence. While there are no cumulative data on the types or frequency of such violence in this part of the country, the media has been replete with several cases, particularly of sexual violence. In one such report, officials of the FCT Administration Social Development Secretariat declared that they were 'overwhelmed' by SGBV cases, particularly rape and incest, and were 'inundated with cases of domestic violence against minors and teenagers'. According to Dr. Agnes Hart, Director, Gender Matters, the Secretariat received an average of one case per day.[23]

There have been several efforts to mitigate sexual and gender-based violence in the FCT, on the part of the FCT Administration as well as civil society organisations. The FCT Sexual and Gender-Based Violence Response Team was inaugurated by the FCT Minister in 2017, with representatives from civil society agencies, and designated state institutions, such as the ministries of health, education, and women affairs, constituting its membership.

Endnotes

1 NBS. 2018. 2017: *Statistical Report on Women and Men in Nigeria.* National Bureau of Statistics.

2 Nigeria Data Portal. 'Nigeria Population by Age and Sex – Population by Age Groups'. https://nigeria.opendataforafrica.org/htmbyze/nigeria-population-by-age-and-sex

3 UNESCO and UNICEF. 2010. Global Initiative on Out-of-School Children. *Nigeria Country Study - Conducted within the Conceptual and Methodology Framework (CMF).* http://uis.unesco.org/sites/default/files/documents/out-of-school-children-nigeria-country-study-education-2012-en.pdf

4 NBS and UNICEF, 2018. *Multiple Indicator Cluster Survey 2016-17.* https://www.unicef.org/nigeria/media/1406/file/Nigeria-MICS-2016-17.pdf.pdf

5 UNDP Nigeria. 2019. "MPI – More Nigerians are mutidimensionally poor than a decade before 2017", 10 July. https://www.ng.undp.org/content/nigeria/en/home/presscenter/pressreleases/2019/new-data-challenges-traditional-notions-of-rich-and-poor-.html

6 Dogo S.A. 2014. "The Nigerian Patriarchy: When and How", *Cultural and Religious Studies* 2 (5), 263-275. http://www.davidpublisher.org/Public/uploads/Contribute/554883203bc54.pdf

7 Ibid.

8 Ibid.

9 Global Rights. 2020. 'Mass Atrocities Casualties Tracking Report 2019'. Abuja: Global Rights. https://www.globalrights.org/ng/mass-atrocities-casualties-tracking-report-2019/

10 City Population. 2020. 'Federal Capital Territory'. http://www.citypopulation.de/php/nigeria-admin.php?adm1id=NGA015

11 Macrotrends. 2020. 'Abuja, Nigeria Metro Area Population 1950-2021'. https://www.macrotrends.net/cities/21976/abuja/population

12 City Population. 2020. 'Federal Capital Territory'.

13 UNHCR Emergency Handbook. 'Sexual and gender-based violence prevention and response – 1. Overview'. https://emergency.unhcr.org/entry/51693/sexual-and-gender-based-violence-sgbv-prevention-and-response

14 Lancet Editorial. 2015. "Violence against women and girls: how far have we come?" *The Lancet* 386 (10008): 2029. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)01029-6/fulltext

15 Zhang, X., Myers, S., Yang, H., Li, Y., Li, J., Luo, W. and Luchters, S. 2016. "Prevalence and correlates of sexual and gender-based violence against Chinese adolescent women who are involved in commercial sex: a cross-sectional study," BMJ Open 6 (12): e013409. https://pubmed.ncbi.nlm.nih.gov/27993907/

16 National Population Commission of Nigeria, UNICEF Nigeria, and the US Centres for Disease Control and Prevention. 2016. *Violence Against Children in Nigeria: Findings from a National Survey, 2014.* Abuja, Nigeria: UNICEF. p.32. https://www.unicef.org/nigeria/media/1586/file/Nigeria-violence-against-children-national-survey.pdf.pdf

17 Barde J. 2016. "Gender-Based Domestic Violence: Examining The Adequacy of The Legal Regime In Nigeria", Proceedings of the 86th IIER International Conference, Johannesburg, South Africa, 9-10 November. http://www.worldresearchlibrary.org/up_proc/pdf/539-14806777511-4.pdf

18 Vanguard News. 2013. "Impunity, not corruption is Nigeria`s biggest problem – Sanusi." 29 March. https://www.vanguardngr.com/2013/03/impunity-not-corruption-is-nigerias-biggest-problem-sanusi/

19 The Prohibition Against Domestic Violence Law of Lagos, State Law No 15, 2007.

20 Chapter 16, 17, 21, 24, 25.

21 Mirabel Centre'. https://mirabelcentre.org/#

22 Okpe, M. 2019. "60% of rape survivors in Nigeria are children 0-14yrs." *Global Sentinel*, 6 December. https://globalsentinelng.com/2019/12/06/sarc-60-of-rape-survivors-in-nigeria-are-children-0-14yrs/

23 Elemue A. et al. 2018. "We are Overwhelmed by Rape, Incest Cases – FCTA Family members, clergy top abuse list". *The Abuja Inquirer*, 11 November. https://www.theabujainquirer.com/?page=3329&get=We_are_overwhelmed_by_rape_incest_cases_%E2%80%93_FCTA_Family_members_clergy_top_abuse_list_3329

3

Research methodology

Phase 1 of LACVAW's research, reported here, has two main objectives:

- To establish a baseline on the prevalence of reported cases of sexual and gender-based violence in the FCT over a 12-month period.
- To review the services provided by response agencies addressing sexual and gender-based violence in the FCT and the extent to which these are informed by the provisions of the VAPP Act.

Once ethical approval for the research was obtained from the FCT, researchers approached response agencies in selected area councils in the Federal Capital Territory to seek information about cases of sexual and gender-based violence that had been reported to them over the previous 12 months (i.e. between the 1st of December, 2018 and the 30th of November, 2019).

Four of the six area councils in the FCT were selected for the research – two urban and two rural councils: AMAC, Bwari, Gwagwalada and Kuje. The main collection of data for the baseline began in January 2020 and was completed in early February 2020.

The research for the baseline study employed the collection and analysis of primary data on SGBV obtained through institutional surveys in the area councils and interviews with various stakeholders. Questionnaires were administered for the institutional surveys and were analysed using quantitative methods. Key informant interviews were held with survivors and other stakeholders in the area councils. Respondents had the purposes of the research explained to them and were assured that the information they gave would be confidential and anonymised.

Desk reviews of secondary data from country-specific and global literature on gender-based violence were also carried out. They covered news publications, peer-reviewed journal articles, and government policy documents. Census data and NDHS data were also reviewed.

Sampling frame

Due to the differences in services offered by each response institution, a triangulation of sampling strategies for each institution and research methods was used. In each of the four area councils, questionnaires were administered to key personnel in five types of response institution – health services, law enforcement, government response agencies, courts, and civil society organisations. Simple random sampling was used to identify SGBV response institutions in health, law enforcement, courts, and government response sectors. Purposive sampling was used to identify relevant CSOs, map resources, including funding, and obtain qualitative data from the institutions visited. Key informant interviews were carried out in selected institutions in each of the five sectors.

Institutional surveys

Questionnaires were developed and used to obtain data from sampled respondents. The sample comprised 21 health facilities, 8 law enforcement agencies, 5 government response agencies, 6 civil society organisations, and 6 courts. In the health, law enforcement, and government response sectors, 15 to 20 questionnaires were distributed to each institution. For courts and CSOs, around 10 questionnaires were distributed to each institution/organisation.

Most questionnaires were completed in-person at the site of the response institution/organisation. Response rates were around 30% in law enforcement (roughly 40 completed questionnaires were collected from a total of around 120 questionnaires) and similarly, the courts had a response rate of around 30% (around 18 completed questionnaires were retrieved from about 60 questionnaires in total). For health facilities, the response rate was around 35% (an estimated 147 completed questionnaires were retrieved from a total of around 420 altogether). Government response institutions also had a response rate of around 35% (roughly 30 completed questionnaires were collected from a total of around 85 questionnaires). For CSOs, the response rate was around 40% (about 24 completed questionnaires were collected from the 60 or so that were distributed).

Each institution/organisation was asked about cases of sexual and gender-based violence reported during the 12-month period between the 1st of December, 2018 and the 30th of November, 2019 and the services offered in response. The sections comprising each questionnaire are outlined below; details may be found in Appendix 1.

Health facility
Areas of questioning covered: demographics; most reported types of SGBV; types of services offered; cost of treatment and who pays; availability of medical forensic examination; application of the VAPP Act; availability of referral pathway; challenges encountered in providing services.

Law enforcement (Police and Civil Defence)
Areas of questioning covered: number of SGBV incidents reported; most reported types of SGBV; whether services are guided by the provisions of the VAPP Act, and if yes, in what ways and if not, why; other laws apart from the VAPP Act guiding practice; type of services offered to victims; special desk/unit to address SGBV issues; officers specifically trained to offer services to survivors of SGBV; capacity for gathering forensic evidence; availability of protocol and compliance responding to victims of SGBV; accompaniment of victims to health facilities; estimated average cost range for managing a case; existence of a referral system; challenges encountered in handling SGBV cases.

Government response agencies
Areas of questioning covered: demographics; support services offered; usual time range for attending to survivor's complaint; accompaniment to support services and what type; major constraints in providing services to SGBV victims; factors hindering provision of effective and optimal services to victims; other services mandated by the agency to offer survivors of sexual violence but currently unable to provide; budgetary allocation for SGBV cases.

Civil society organisations
Areas of questioning covered: number of reported SGBV cases; types of reported cases; availability and use of response protocol; availability of staff trained to handle cases of SGBV; existence of a referral system; major constraints in rendering SGBV services; funding sources for services provided.

Court system
Areas of questioning covered: type of relief provided to victims; availability of special fast track courts for matters charged under the VAPP Act, as mandated by law; whether SGBV cases are heard before a limited audience in court; the use and compliance of a protocol for protective orders; existence of a referral system; whether the court accepts evidence from private hospitals; problems encountered while administering justice for victims; factors hindering effective services to victims.

Key informant interviews

Key informant interviews were held with victims/survivors, and personnel from health institutions, law enforcement, government response agencies, civil society organisations, and courts (see Appendices 2 and 3 for the questions and respondents, respectively).

Victims/survivors: It was only possible to carry out six key informant interviews with victims/survivors. Five were drawn from AMAC and the sixth, from Bwari area council. The victims/survivors had been recommended by personnel from response agencies covered in the institutional surveys. All interviewees were female; there were five adults and one minor.

Each victim/survivor was interviewed individually in a private office, except for one, a minor, who was accompanied by her mother. The mother also provided information. The purpose of the research was explained to each interviewee and they were assured of anonymity if they so desired. The interview began by first asking them to speak freely of their experience, before following on with the interview questions. Depending on the responses given, additional questions were sometimes asked. At the end, victims/survivors were informed of services that might be useful to them moving forward.

Health institutions, law enforcement and government response agencies
Five interviews were carried out with supervisory staff at health facilities; four interviews with officers in charge at law enforcement agencies; and three interviews with the officers receiving complaints, and one director, at government response institutions. Efforts were made to interview relevant personnel from NAPTIP and the FCT SGBV Response Team but these were not successful.

Respondents from health facilities, law enforcement and government response agencies were asked about the average number of SGBV cases that were reported to them weekly; the most commonly reported types of cases; the procedures followed when cases of sexual and gender-based violence were reported to them;

the challenges they faced in providing services to victims of such violence; and their relations with other response institutions in the FCT.

Civil society organisations:
Five respondents with managerial responsibilities and one programme manager were interviewed. Respondents were asked about the greatest challenges they faced in providing services to victims of sexual and gender-based violence; the procedures followed when people came to their organisations with a view to reporting cases of SGBV; the relations with other response institutions in the FCT; whether their organisation was a member of the FCT SGBV Response Team and if so, how it functioned and their role within the Team; their sources of funding; and whether their core organisational focus was SGBV.

Courts:
Four key informant interviews were carried out with court registrars. Respondents were asked about the average number of SGBV cases that were reported to them weekly/monthly; the types of cases most commonly reported; the length of time it took to conclude cases; whether judges made orders as prescribed by the VAPP Act; and the most commonly faced challenges.

Data analysis and documentation

The study utilised descriptive statistics to analyse the survey data. The statistical package for social scientists (SPSS) version 20 and STATA version 12 were used to analyse the quantitative data. Descriptive statistics included frequencies, cross tabulations and comparisons of means. The results of the analyses are tabulated and some presented in charts, where appropriate.

Qualitative data were analysed using content analysis. This was useful for contextualising nuances and helped in interpreting the survey data.

Methodology Workshop

A one-day Methodology Meeting at the start of the project brought together all researchers as well as project team members engaging in other components of LACVAW's intervention strategy on the VAPP Act (see Appendix 4). This included those working on: setting up the website; communications and advocacy; and on an estimated budget for implementation, based on analyses of the reports of sexual and gender-based violence that were to be generated from the research. LACVAW members within the FCT who engage in research were also invited to attend. The discussions covered the methodology for the two phases of the research i.e. the baseline and subsequent data collection.

The objectives of the meeting were:

1. To discuss the overall approach to LACVAW's research and the methods to be used.
2. To explore the power relations involved in sexual and gender-based violence.
3. To examine existing protocols developed for SGBV response agencies.
4. To discuss ethics in research on sexual and gender-based violence.

As indicated earlier, the research on the baseline would involve collating reports of SGBV already compiled by duty bearers, service providers, media and third parties over the previous 12 months. The process would involve finding out what information was recorded, what information was omitted, and what needed to be done to strengthen survivor-centred responses. Phase 2 of the research would involve data collection of ongoing cases for 6 months. The information sought in this second phase would cover forms of violence reported, contexts in which violence took place, information about perpetrators, information about survivors, and about service providers' and duty bearers' responses.

Discussion during the workshop centred on what forms of violence get reported, what it would be possible to collect data on, which agencies were addressing sexual and gender-based violence, and what forms of justice were ultimately realised. Across the Area Councils, SGBV cases were generally addressed at the level of traditional or religious leaders, rather than being reported to the police. In cases of rape, many communities asserted that they had their own laws. The question of whether there were any benefits to alternative dispute resolution (ADR) was debated. It was pointed out that service providers in many Sexual Assault Referral Centres (SARCs) were actively setting them up as ADR centres, contrary to their original purpose. From the point of view of communications and advocacy targeting the public, the point was made that what mattered

Legislative Advocacy Coalition on Violence Against Women (LACVAW)

Methodology Meeting

Conference Hall, Education as a Vaccine (EVA), 9th December 2019

Intervention Strategy for the Effective Implementation of the VAPP Act (2015)

9.30 a.m.	Registration
10.00 a.m.	Welcome remarks – EVA
10.10 a.m.	Introductions
10.30 a.m.	Presentation of the Project
	Charmaine Pereira
	Participants' expectations and concerns
	Discussion
11.00a.m.	Tea break
11.20 a.m.	The Gender Politics of Violence
	Charmaine Pereira
	Discussion
12 noon	Sexual and Gender-Based Violence Response Tool Pack
	Abiodun Baiyewu
	Discussion
1.00 p.m.	Lunch
2.00 p.m.	Reviewing reports and records of SGBV in the FCT
	Charmaine Pereira
	Discussion
2.45 p.m.	Field work in four LGAs of the FCT
	Abiodun Baiyewu
	Discussion
3.30 p.m.	Ethics in data collection on SGBV
	Charmaine Pereira
	Discussion
4.15 p.m	Concluding comments
	Charmaine Pereira

was the kind of information that would allow one to tell a story. The central message was important in providing targeted information.

The weaknesses of state institutions with mandated responsibilities for implementing the VAPP Act was discussed. Stronger institutions were necessary to end impunity and hold duty bearers accountable. The question of how to make institutions operate standards that would apply across the board was raised. This was implicated in the critical task of co-ordinating responses across institutions and sectors.

The difficulty in receiving accurate reports of sexual and gender-based violence from people with disabilities was emphasised. For the deaf community, it was proposed that interpreters could be selected from the Association for Sign Language, as a way of rectifying such exclusion. Representatives from the Disability Rights Advocacy Centre pointed out, however, that sign language interpreters often do not use the correct signs for 'violence'. Many interpreters had a tendency to 'take over' the discussion. It was important that this tendency should be minimised. In cases where the protector is the perpetrator and shame surrounds incidents of violence such as incest, an informal network of people living in the locality was often the only available access to information.

Ethical considerations in carrying out the research

Given the sensitive nature of information about sexual and gender-based violence as well as the risks to survivors of publicising such experiences, the research followed the requirement of upholding strong ethical standards. The ethical principles that guided the research were based on respect for the autonomy, rights and dignity of survivors. This entailed seeking informed consent for interviews with survivors, respecting their privacy when carrying out the interviews, and ensuring anonymity and confidentiality of all information gathered from survivors directly as well as indirectly, from the various response agencies. Information capable of identifying survivors was not collected.

Limitations of the Study

This study should not be viewed as a comprehensive study of the prevalence of sexual and gender-based violence in the FCT. Instead, it should be treated as an estimate of the prevalence of reported cases of SGBV. As observed in the Introduction, sexual and gender-based violence is generally under-reported in most contexts and the same is no doubt the case here.

The unwillingness of relevant stakeholders (particularly healthcare facilities) to participate in the survey had a negative impact on the sampling spread of agencies covered in some area councils.

4

Victims'/survivors' perspectives

In this report, we use the term 'victim' to refer to someone who is currently being harmed or injured due to sexual and gender-based violence, and is thus in imminent danger. We use the term 'survivor' to refer to a person who has previously experienced harm or injury as a result of sexual and gender-based violence but is no longer in imminent danger. Survivors of SGBV in the FCT were often unwilling to identify as having once been victims. Many victims, especially victims of sexual violence, expressed shame and confusion in relation to their ordeals.

Most victims had little or no faith in the workings of the justice system. Of the few who had sought justice, most felt let down by the response system. Many respondents felt that law enforcement agents were (or would be) biased against them, and that nothing would come of their cases as their violators were more influential than they were.

Respondents alleged 'interferences' by politically exposed persons (the police also mentioned cases being frustrated due to 'orders' from above); that perpetrators and their families also frustrate their attempts at getting justice by bribing law enforcement agents and their own community leaders. The latter would then seek to mediate the rape or domestic violence suffered. Victims had also expressed the view that they felt more confident when they had CSOs supporting them through the process of seeking justice or help at health facilities.

The interviews with victims pointed to weakness in the capacity of law enforcement agents to respond holistically to cases, by providing the necessary services. Some victims reported a level of empathy on the part of the police, while others reported that the police were hostile and failed to render assistance. In one instance, a woman who had suffered domestic violence reported that officers, rather than arrest her former husband who had assaulted and wounded her, bullied her instead. They accused her of not being 'submissive' after receiving bribes from her then-husband and advised her to go home, beg for forgiveness, and 'settle' with her husband. Another woman stated that police protected the man who raped her 4-year-old daughter; other than documentation of the case, she received no service from the police.

On a positive note, a different victim reported not only being accompanied to the hospital by the police, but that the initial payment for her treatment was covered by the officer who accompanied her because she could not afford it.

A common approach by the police and community heads to 'resolving' SGBV crimes is mediation. In one instance, a respondent stated that the police bullied her into mediation over the rape that her daughter had suffered. In this case, the perpetrator was made to pay for the medical expenses at a pharmacy and was subsequently released without a charge being brought against him.

Some women who had suffered domestic violence also stated that they were bullied into mediation, whereas they would have preferred to press charges against their spouse. One victim disclosed that she was bullied into 'apologising' to her husband in spite of the physical injuries she had sustained when he beat her up.

A rape victim reported being bullied by her parents into dropping her case since her father had threatened to disown her. He had spat on her and threatened to curse her after disowning her, while her mother had demanded that she returned "the breastmilk with which she fed her". At 19, she would have become homeless had she not agreed. On the work front, her boss had initially empathised with her but was displeased with her constant visits to the police station and had told her that she could no longer take further time off to pursue the case.

A number of respondents were emboldened to report their experiences of SGBV to law enforcement agencies due to: information they had gleaned from the media; community outreach efforts by CSOs; or their sense of outrage at what they suffered.

Many victims of sexual and gender-based violence did not report to law enforcement for a variety of reasons:

1. They would not be believed by law enforcement that the sexual violence they suffered was not consensual. Some felt they were not taken seriously in their first visit and did not return.
2. They were afraid their violators would do them even more harm after reporting, especially where the latter lived close by.
3. They had been bullied or shamed by

their families and communities into not reporting, and had been blamed for the violence that they suffered.
4. They did not want their families to know what had happened to them. And in some cases, the incestuous rape of minors was considered a taboo and in order to 'protect' the family, the violence was kept a secret.
5. They could not afford the cost of seeking help from health facilities and law enforcement at the same time.
6. They were afraid that their abusive husbands would get arrested, and they might get thrown out of their homes as a consequence, with nowhere to go, and that they might lose their children in the process.
7. They were deeply affected by the trauma and just wanted to put it behind them and assume a normal life.

Victims who sought to gain access to services from government response agencies pointed to a number of problems, particularly the lack of shelters. There are only two public women's shelters for the entire population of the FCT. There were mixed responses regarding the survivor-friendliness of the services of the FCT SGBV Response Team.

While some survivors rated the staff as being very resourceful and helpful, others said that they were bullied and further victimised by staff at the secretariat. The attitudes of some personnel at these response agencies robbed survivors of their dignity, and was a deterrent to them in pursuing their case. As a result, they abandoned their search for support.

Some victims also stated that they did not visit the hospital because they considered treatment at these facilities expensive and time consuming. Embarrassment was another reason they did not seek medical assistance. Instead, they sought first aid at patent medicine stores and pharmacies, or self-medicated, or did nothing at all. Most sexual violence victims had no idea what post exposure prophylaxis treatment was, or the urgent need to get such treatment, particularly to prevent unwanted pregnancies, HIV and Hepatitis B.

The agencies most frequently mentioned as spaces where victims sought help were local CSOs and activists, and the Social Welfare Department where the secretariat of the FCT SGBV Response Team is situated.

Most respondents stated that their cases were eventually abandoned - due to frustration and/or a lack of evidence – or were being mediated. Two cases were ongoing in court.

5

Health facility response institutions

Distribution of health facilities by ownership and type

Overall, there are more private hospitals than public health facilities found across the FCT, particularly in AMAC. However, there was an almost equal spread of public and private health facilities among those in the sample, with slightly more government owned facilities represented since they were more responsive to the survey. A number of private hospitals declined to participate in the survey, denying that they provide services concerning sexual and gender-based violence to patients.

Public health facilities, on the other hand, are often the preferred source of medical help for survivors of sexual violence who intend to report their case subsequently to the police. (This is in the context of Nigerian courts generally giving greater credence to reports issued by government owned hospitals). The sample comprised a total of 21 health facilities: 11 government owned and 10 privately owned. Disaggregated by type, there were 19 primary health care centres, 1 secondary health care, and 1 tertiary health institution.

Figure 5.1: Health Facility by ownership

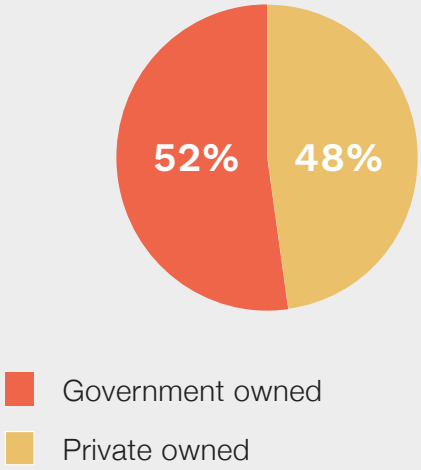


Figure 5.2: Health Facility by type

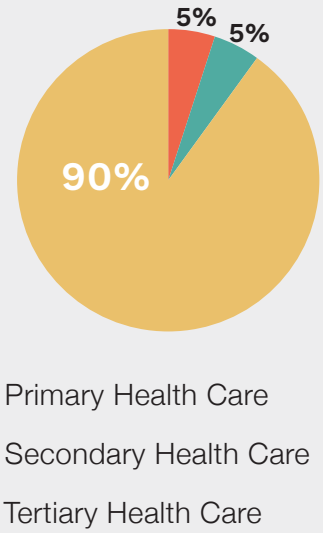


Figure 5.3: Health Facility in each Area Council %

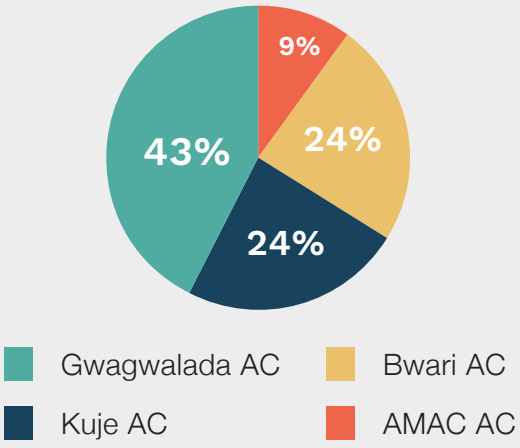


Table 5.1: H/F in each Area Council per Area Council

Health Facility	
Gwagwalada AC	9
Kuje AC	5
Bwari AC	5
AMAC AC	2
Total	21

Reports of sexual and gender-based violence to health facilities

Of the health facilities in our sample, 76% reported receiving cases of sexual and gender-based violence in the past year. All the public health facilities had received cases whereas some of the private health facilities stated that they had no records of SGBV related cases. In total, 121 cases of SGBV were reported to the 21 health facilities surveyed.

The overwhelming majority of SGBV cases reported to the health facilities – 98% - were perpetrated against women; 2% were against men.

The highest number of reported cases of SGBV was recorded in Bwari Area Council where 2 health facilities recorded a combined total of 50 cases. The Primary Health Care Centre, Mpape, and Primary Health Care Centre, Kubwa, both in Bwari Area Council, recorded the first and third highest numbers of reported cases in the surveyed facilities in the FCT. The University of Abuja Teaching Hospital, in Gwagwalada, was ranked second highest with 26 reported cases.

Of the 4 health facilities with the highest numbers of SGBV cases, 2 are in Bwari, 1 in Kuje, and 1 in Gwagwalada Area Council. The three most reported types of SGBV are:

- Rape
- Domestic violence
- Child abuse (physical violence, maltreatment of domestic servants, street hawking).

Figure 5.4: H/F receiving SGBV cases (%)

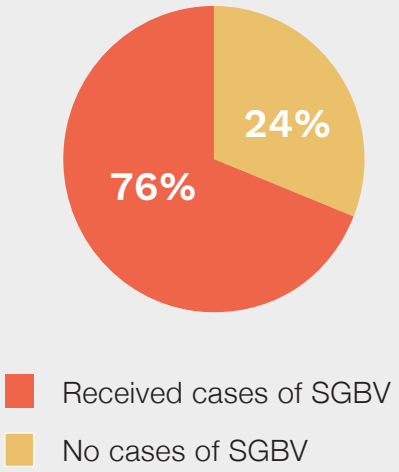


Figure 5.5: Cases reported to H/F

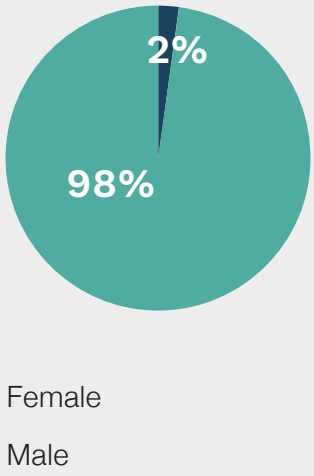


Table 5.2: H/F receiving SGBV cases (no.)

Health facilities receiving incidents of SGBV	
Received cases of SGBV	16
Received no case of SGBV	5
Total number of health facilities surveyed	21

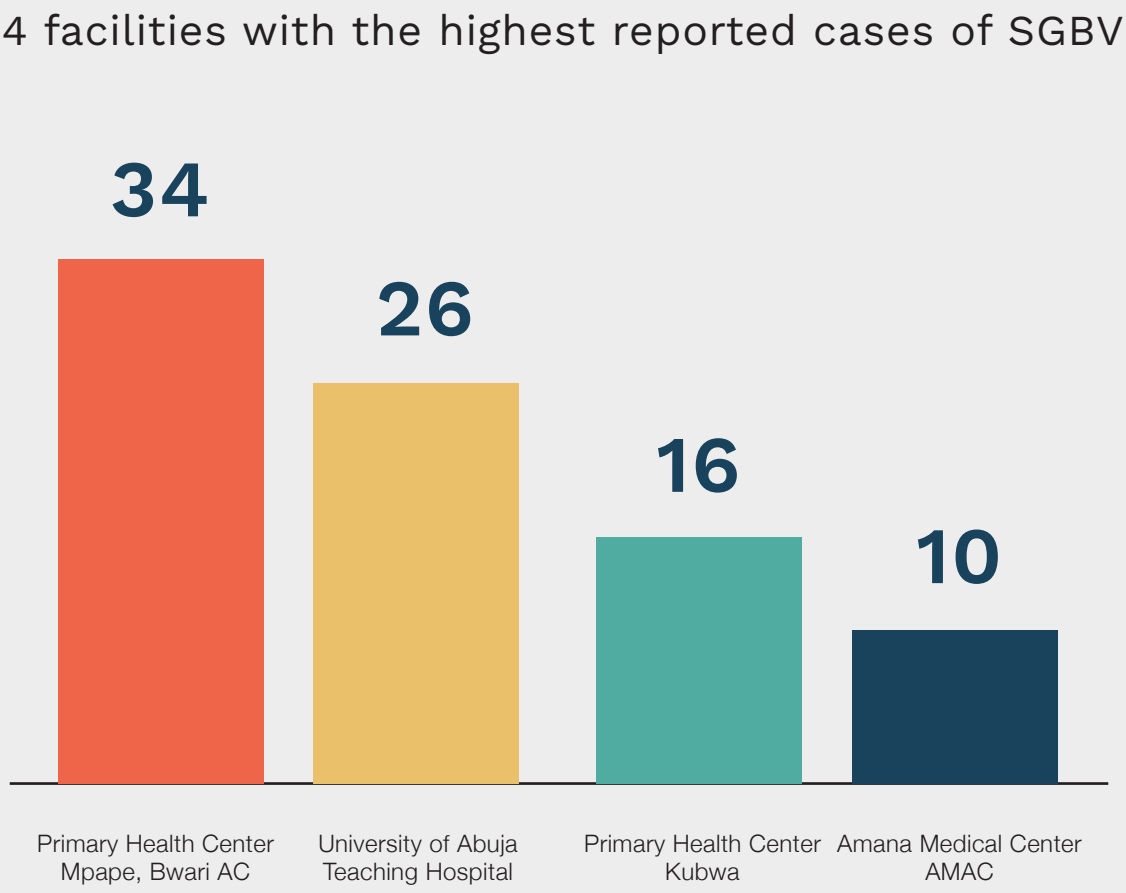
Table 5.3: Sex-disaggregated cases

Male	3
Female	118
Total	121

Table 5.4: Total number of H/F and reported cases in each Area Council

Area Council	No. of H/F surveyed	No. of H/F reporting SGBV cases	Total no. of SGBV cases
Bwari AC	5	2	50
Gwagwalada AC	9	8	47
AMAC	2	2	15
Kuje AC	5	4	9
Total number of SGBV cases reported			121

Figure 5.7: H/F with highest numbers of reported cases



SGBV Services provided by Health Facilities

Most health facilities stated that their treatment of victims of sexual and gender-based violence is guided by medical rules and guidelines. Amana Hospital in AMAC affirmed that they were guided by the VAPP Act in the treatment of SGBV patients.

Seventy-six percent (16 out of 21) of the health facilities surveyed provide some form of SGBV response service. Of the 16 facilities that provide SGBV services, 15 affirmed round the clock (24 hours) response. Only 10% (2 of the 21 health facilities) reported having a special unit for SGBV. The 2 facilities with special units are located in Kuje Area Council and AMAC. Just under half - 43% - of the health facilities (9 out of 21) affirmed the availability of staff that had received specialised training on providing SGBV response.

Only 5 of the 21 health facilities surveyed carry out SGBV medical forensics on victims, to aid investigations. Seventy-one percent (15 of the 16 health facilities that provide SGBV response care) indicated that their protocol included the administration of Post Exposure Prophylaxis treatment (PEP) to victims of SGBV.

Figure 5.8: Special units for SGBV

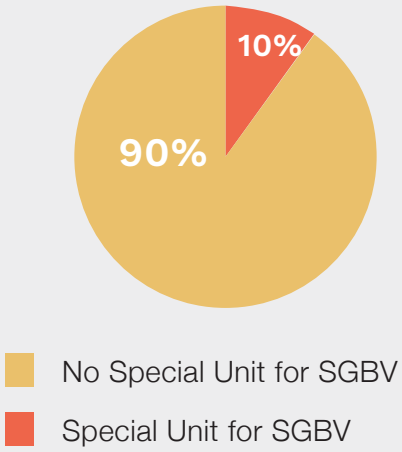
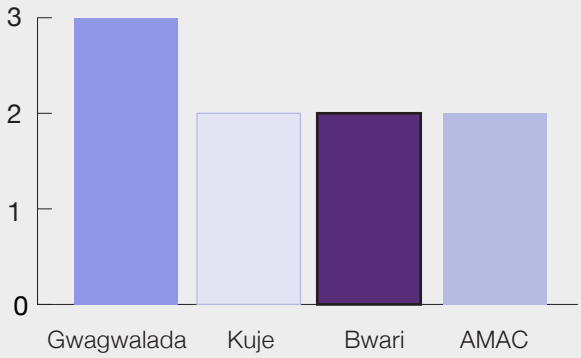


Figure 5.9: No. of H/F with specially trained staff



Number of Health Facilities with Specially Trained Staff by Area Council

Table 5.5: Services provided by H/F in each Area Council

Area Council	Number of Health Facilities Per Service in Each Area Council					
	Medical Exam	Medical Forensics Investigation	Treatment	Counselling	Referral	Psycho-Social Support
Gwagwalada	8	8	8	6	8	6
Kuje	4	1	4	3	1	0
Bwari	2	1	2	2	3	1
AMAC	1	0	2	2	2	1

Costs associated with SGBV Services

Two health facilities in Gwagwalada reported providing free PEP services. Other health facilities in the Area Council put the cost of PEP at between N1,000 and N4,000. In Kuje, one facility provided free PEP service while 2 others estimated the cost to be between N1,000 to N5,000. In Bwari, while PEP was free at one facility, it cost about N4,000 in the others.

In addition to the cost of providing PEP, there is the cost of treating SGBV-related injuries and complications. This was difficult for the facilities to determine, as they pointed out that it was contingent on the type and extent of the injury that the patient presented. The average treatment cost in Gwagwalada ranges from N1,000 to N10,000. Treatment costs in Kuje were estimated to be between N1,000 and N5,000. In Bwari, treatment costs were said to be in the range of N1,500 to N2,500. Respondents in AMAC facilities did not respond to the question of the cost of PEP or treatment at their hospitals.

Whether the victim gets treatment is often determinant on who is willing or able to bear the cost of such treatment. The three groups in (order of frequency) that pay for services rendered were:

- Victims
- Family of victims
- Whoever brings the victims

Challenges in Providing Survivor-Friendly SGBV Healthcare Response Services

Most health care facilities stated that funding was the major impediment that they encountered in providing survivor-friendly response to victims of SGBV. According to them, some victims were unable to cover the cost of treatment, and the health facilities' budgets did not allow them to accommodate free services. In addition, they note that most victims do not complete their course of treatment before they stop visiting the health facility.

Health personnel also cited interference by members of a victim's family, and the fear on the part of health personnel themselves of being victimised for helping victims. For example, a doctor at a private hospital in AMAC Area Council stated that staff were likely to record injuries from sexual violence as simply 'trauma' because they did not want to go through the rigours of appearing as witnesses in rape or domestic violence cases and being embarrassed by lawyers in the course of cross-examination. This was quite apart from the question of health personnel spending valuable time in court.

None of the facilities surveyed had rape kits or had ever utilised them in their treatment of victims. Otherwise referred to as a sexual assault kit, or a sexual assault forensic evidence (SAFE) kit, this is a package of items used by medical personnel for gathering and preserving physical evidence following an allegation of sexual assault. The evidence collected from the victim can aid the criminal rape investigation and the prosecution of a suspected assailant.

Some of the other factors that health personnel considered as hindering them from providing survivor-friendly access to treatment include:

- Lack of other supplies, apart from SAFE kits, and equipment.
- Epileptic power supply.
- Police - interference, uncooperative, and lacking in adequate training.
- Victims not cooperating due to fear of stigmatisation and possible backlash.
- Psychological/ mental health issues in victims.

Referring victims to support services

Amana Hospital within AMAC Area Council has internal reference mechanisms for medical forensics and psychotherapy. For primary health care centres, referrals are done to secondary health facilities (general hospitals). Wuse General Hospital reported a referral to 'Spotlight', alluding to the shelter renovated by the EU Spotlight Project. Roughly half the health facilities – 11 out of 21 – refer victims to other non-medical agencies.

6

Law enforcement response institutions (Police and Civil Defence)

The findings presented below are based on responses obtained from the field, which established the current situation, the reported prevalence of SGBV in the FCT, and the services provided.

Police and Civil Defence agencies and locations

Data were elicited from police stations in all 4 area councils, and a Nigeria Security and Civil Defence Corps (NSCDC) station located within AMAC. Within the timeframe of the survey (December 1, 2018 to November 30, 2019), the Police documented a combined total of 38 cases reported to them, comprising 36 female and 2 male victims.

The police station with the highest number of cases documented was the Asokoro Divisional Headquarters, with 18 cases. NSCDC documented 27 cases reported to them: 22 female, and 5 male. More cases, therefore, tended to be reported to the Police than the NSCDC. From interviews with victims, however, we learned that the Police sometimes failed to formally document and investigate all cases brought to them. Under-reporting of SGBV cases to law enforcement was apparent from the records of the 8 law enforcement stations captured within this survey.

It is important to note that non-state security agents (in particular community vigilante groups) also receive complaints from victims in communities. Most of these incidents do not appear to go through formal law enforcement processes.

SGBV cases reported to law enforcement

The table below provides a summary of the number of cases treated by each of the law enforcement stations that participated in the study, disaggregated by sex and the predominant type of abuse reported.

Table 6.1: Cases reported to each law enforcement agency surveyed

Law enforcement agency	Location	Total no. of SGBV cases	Male	Female	Predominant type of SGBV
Zone B Police station	Gwagwalada	7	1	6	Child abuse, rape, wife battery.
Zone A Police station	Gwagwalada	4	0	4	Child abuse, rape.
Kuje Police station	Kuje	2	0	2	Child abuse, rape.
Bwari division	Bwari	4	1	3	Child abuse, rape.
NSCDC	AMAC	27	5	22	Wife battery, child labour, sexual abuse.
Asokoro Div Police HQ	Asokoro	18	0	18	Rape
Maitama Police station	Maitama	0	0	0	N/A
Wuse Police station	Wuse	3	0	3	Sexual abuse, domestic violence, child abuse.
Total		65	7	58	

Use of the VAPP Act

Most stations affirmed that they utilised the VAPP Act in charging SGBV cases. In addition to the VAPP Act, they also utilised the Penal Code, and the Children and Young Persons' Act. According to the Asokoro Divisional Police Headquarters, their protocol for dealing with these cases was derived from 'Police Regulations'.

Capacity of police stations to handle cases of SGBV

Six of the eight police stations in the survey said they have a gender desk tasked with responding to SGBV cases. All but one of these had a department within the Gender Unit that was designated a Juvenile Welfare Centre (JWC). Only three stations said they had officers specially trained in providing SGBV response. The Bwari Divisional HQ stated that its personnel had general training on SGBV, but that they had no specialised officer.

All the other stations that had specialised officers also stated that their other personnel had received some general form of training on SGBV. Only the stations at Bwari and Maitama said they have forensic capacity to gather evidence. They all however admitted that they did not have forensic labs, equipment or storage, thus limiting their capacity to efficiently prosecute related cases.

SGBV services provided by the stations

With the exception of Wuse and Gwagwalada, all of the law enforcement stations surveyed stated that they provide essential SGBV response services, including protection, prosecution, referral, and counselling. Interestingly, Maitama Police station said that it neither offered prosecution nor referral services, while Gwagwalada did not provide counselling services and did not make referrals to support services other than health facilities.

All of the stations (except Maitama) stated that they make client referrals to hospitals, NAPTIP, Social Welfare (particularly for child welfare services), and CSOs. In spite of their claims to providing all of these services, law enforcement agencies indicated that they lack the capacity to adequately respond to the SGBV cases in their vicinity.

All of the law enforcement stations, with the exception of Wuse Police station, affirmed that they had an internal protocol for dealing with SGBV cases.

Costs associated with SGBV services

The law enforcement stations estimated the current cost of their handling of cases to range from N1,000 to N50,000. Officers were of the view that the inclusion of forensic laboratories and state of the art equipment might increase the cost of their services but would ensure greater efficiency. They were, however, not able to estimate the cost of their suggested interventions.

Table 6.2: Response on reference to VAPP Act/other laws as applicable

Law enforcement agency	Services guided by VAPP Act?	What other law?
Zone B Police Station	Yes	No Response
Zone A Police Station Gwagwalada	Yes	Penal Code
Kuje Police Station	Yes, sometimes	Penal Code
Bwari Division	Yes	N/A
NSCDC	Yes	No Response
Asokoro Div Police HQ	Yes	Police regulations concerning the offences
Maitama Police Station	N/A	N/A
Wuse Police Station	Yes	Children and Young Persons Act

Table 6.3: Capacity of police stations to handle cases of SGBV.

Law enforcement agency	SGBV desk	Special desk named	Specially trained officers	General training	Capacity to gather evidence	If No/ Somewhat, why?
Zone B Police Station	No	NA	No	Sometimes	No	NA
Zone A Police Station Gwagwalada	Yes	JWC	Yes	Yes	No	Proper storage needed
Kuje Police Station	No	NA	No	Sometimes	No	Storage required
Bwari Division	Yes	JWC	No	Yes	Yes	NA
NSCDC	Yes	Anti-Human Trafficking and Illegal Migration Unit, GBV Unit	Sometimes	Sometimes	Somewhat	No equipment yet
Asokoro DIV Police HQ	Yes	JWC	Yes	Yes	No	No lab equipment
Maitama Police Station	Yes	JWC	Yes	Yes	Yes	
Wuse Police Station	Yes	JWC	Yes		No	No equipment yet

Table 6.4: Services provided by law enforcement

Law enforcement agency	Protection	Prosecution	Referral	Counselling
Zone B Police Station	Yes	Yes	Yes	Yes
Zone A Police Station Gwagwalada	Yes	Yes	Yes	No
Kuje Police Station	Yes	Yes	Yes	Yes
Bwari Division	Yes	Yes	Yes	Yes
NSCDC	Yes	Yes	Yes	Yes
Asokoro DIV Police HQ	Yes	Yes	Yes	Yes
Maitama Police Station	Yes	No	No	Yes
Wuse Police Station	No	Yes	Yes	Yes

Table 6.5: Availability of SGBV protocol

Law enforcement agency	Is there a protocol for SGBV?
Zone B Police Station	Yes
Zone A Police Station Gwagwalada	Yes
Kuje Police Station	Yes
Bwari Division	Yes
NSCDC	Yes
Asokoro Div. Police HQ	Yes
Maitama Police Station	Yes
Wuse Police Station	No

Table 6.6: Law enforcement institutions' estimated cost per case

Law enforcement agency	Estimated cost
Zone B Police Station	N1,000 – N50,000
Zone A Police Station Gwagwalada	N1,000 – N10,000
Kuje Police Station	N1,000 – N10,000
Bwari Division	No Response
NSCDC	N10,000 – N15,000
Asokoro DIV Police HQ	No Response
Maitama Police Station	No Response
Wuse Police Station	No Response

Table 6.7: Challenges impeding effective SGBV service delivery

Law enforcement agency	Problems in providing services
Zone B Police Station	Lack of victims' co-operation No logistics
Zone A Police station Gwagwalada	Delay No logistics for follow up
Kuje Police station	Family interference Lack of funds Inadequate logistics
Bwari Division	None
Civil Defence	Lack of finance Lack of co-operation from medical staff Staff mobility Victims' fear of stigmatisation
Asokoro Div. Police HQ	Lack of transport Insufficient personnel Low morale
Maitama Police Station	No response
Wuse Police Station	Financial challenges No refreshment for children to allow them to open up Uncomfortable office Lack of financial assistance in case of any health challenges

Challenges in providing effective SGBV response services

Apart from the station at Bwari which stated that it was not experiencing any hindrance in offering response services to SGBV victims, and the nonresponse of a station at Maitama, all of the respondents indicated that finance/funding was a major issue.

Many officers complained of having to personally fund the treatment of victims. They said that the inadequate level of equipping of their station meant that sometimes, they did not have implements as simple as paper for taking statements, fuel to transport themselves to crime scenes to investigate, take victims to the health facilities, make phone calls or attend court hearings.

They noted that indigent victims were also less likely to pursue their cases because they could not afford the expenses related to following up at the station and court attendance. They also stated that most victims could not take time off their jobs to track their cases diligently.

Other challenges that law enforcement officers noted include: occasional lack of cooperation from health facilities' personnel, victims' fear of stigmatisation stops them from reporting or from following up on the case. They pointed to the interference by families and religious leaders, and in some cases, 'orders from above' to step off certain cases. They considered their stations generally unconducive for the quality of service expected of them.

Referral services

In general, law enforcement agencies made referrals to both health services and support services. Only the Zone A Police Station in Gwagwalada did not make referrals to support services. In all instances, health agencies made referrals to police stations.

Table 6.8: Responses on referral services

Law enforcement agency	Referrals to health services?	Health institutions refer to the station?	Referral to support services?	Which support services often referred to?
Zone B Police Station	Yes	Yes	Yes	Hospital
Zone A Police Station Gwagwalada	Yes	Yes	No	Hospital
Kuje Police Station	Yes	Yes	Yes	NGO, NAPTIP
Bwari Division	Yes	Yes	Yes	Social Welfare, Court
Civil Defence	Yes	Yes	Yes	National Hospital, Garki Hospital
Asokoro DIV Police HQ	Yes	Yes	Yes	Hospital and Trauma Centre
Maitama Police Station	Yes	Yes	Yes	NAPTIP, NGO
Wuse Police Station	Yes	Yes	Yes	Social Welfare for Shelter for Children

7

Government response institutions

The survey sought to elicit data from critical government institutions involved in the prevention of, and response to, SGBV. The institutions that participated in the survey were:

- Women Juvenile Welfare Centre, Gwagwalada.
- Social Welfare Centre, Gwagwalada.
- Social Welfare Centre, Kuje.
- NAPTIP, AMAC.
- FCT SGBVRT, AMAC.

Reports of SGBV cases to government institutions

The institutions above recorded a combined total of 313 cases of SGBV; 231 were female and 82 males. The FCT SGBV Response Team recorded an average of 20 new cases per week, making them the agency with the highest number of reported cases of sexual and gender-based violence. They also appeared to have received a higher number of cases than the combined total of the health facilities and the law enforcement agencies. Their numbers raise questions because they do not align with the numbers of cases reported to the first line response agencies – health and law enforcement. As the coordinating agency for SGBV response in the FCT, it is expected that the SGBV Response Team would refer all cases to the appropriate institutions, in particular, health facilities and law enforcement. Therefore, assuming their numbers were indeed accurate, their larger number of reported cases indicates that their referral processes were defective. Government agencies, however, appear to be satisfied with the level of coordination and the referral system that they had in place.

Going by the number of cases of sexual and gender-based violence that staff from government agencies dealt with on a weekly basis (see Table 7.2), one would expect the total number of SGBV cases to be much higher than the figures presented in Table 7.1, which refer to the number of cases documented in the institution's records. The considerable difference between these figures points to victims of SGBV that have not been followed up after first reporting their cases. Whether this was because the case was subsequently withdrawn, or was referred elsewhere, or for some other reason, such details should be entered into a fully functional documentation system.

Apart from the Social Welfare Centre, Gwagwalada, all of the other agencies listed provide response and prevention services for victims of SGBV. The most common forms of SGBV reported were:

- Rape
- Domestic violence
- Abandonment

The National Human Rights Commission announced that it had launched a portal (https://report.nhrc.gov.ng/) for reporting and collating data on sexual and gender-based violence.

Table 7.1: Number of SGBV cases reported to government institutions

Government institutions	Total number of SGBV cases	Number of female victims	Number of male victims
Women Juvenile Welfare Centre	2	2	0
Social Welfare Centre, Gwagwalada	0	0	0
Social Welfare Centre, Kuje	20	20	0
NAPTIP in Wuse, AMAC	91	29	62
FCT SGBVRT	200	180	20
Total	313	231	82

Table 7.2: Government response agencies' estimated cases reported per week

Government response agency	Estimated no. of SGBV cases per week
Women Juvenile Welfare Centre	-
Social Welfare Centre, Gwagwalada	0
Social Welfare Centre, Kuje	3
NAPTIP, AMAC	8
FCT SGBVRT	20

Table 7.3: Support services provided by government institutions

Services provided	Women Juvenile Welfare Centre	Social Welfare Centre, Kuje	NAPTIP, AMAC	FCT SGBVRT, AMAC
Health care	Yes	No	Yes	No
Legal	Yes	No	Yes	No
Shelter	Yes	No	Yes	Yes
Police accompaniment	Yes	No	Yes	Yes
Court accompaniment	Yes	No	Yes	Yes
Health services accompaniment	Yes	Yes	Yes	Yes
Counselling	No	Yes	Yes	Yes
Referral	Yes	No	Yes	Yes
Psychosocial support	Yes	No	Yes	Yes
Economic support	No		Yes	Yes

Table 7.4: Availability of SGBV protocol and trained staff

Government institution	Availability of SGBV protocol	SGBV trained staff
Women Juvenile Welfare Centre	Yes	Yes
Social Welfare Centre, Gwagwalada	No response	No
Social Welfare Centre, Kuje	Yes	Yes
NAPTIP, AMAC	Yes	Yes
FCT SGBV Response Team	No response	Yes

Support services provided

Government agencies provide a wide range of support services but the effectiveness of these services is doubtful, as pointed out by victims and CSOs that have tried to gain access to them. The shelter at Kurudu, renovated through a grant by the Spotlight Project of the European Union, is able to accommodate just four women at a time.

The NAPTIP shelter, on the other hand, was always stretched beyond capacity. In some instances, NAPTIP placed minors who had been abused, in the same facilities as international sex trafficking survivors. Some child victims are sent temporarily to orphanages for shelter. The only recorded private shelters are run by WOTCLEF, a CSO in AMAC Area Council, and the defunct WRAPA shelter at Karu, on the outskirts of Abuja.

Protocol for SGBV and trained SGBV staff

For most of the government agencies, SGBV response protocols guide their services, and with the exception of the Social Welfare Centre at Gwagwalada, all government response agencies affirmed that they had staff trained in SGBV response. They pointed out, however, that there were frequent transfers of staff to other locations, just at the point when they were gaining traction on results.

Estimated cost of SGBV response services by government institutions

Responding institutions affirmed the lack of dedicated funding for government agencies to provide response or prevention services to SGBV victims and residents of the FCT. However, they estimate the cost of their services to each victim to range between N1,000 and N5,000. NAPTIP provided a ballpark estimate of N100,000 per month.

Challenges to government agencies in providing effective SGBV services

The responses by government agencies to the question of the challenges they experienced in providing survivor-centred responses to victims of sexual violence resonates with those indicated by law enforcement and health care facilities. At the top of the list was the lack of finance, followed by lack of 'cooperation' by victims, a poor referral network, inadequate skills and number of personnel, a weak judicial system, police interference, interference by religious and traditional institutions, family pressure and undue influence to drop cases, lack of housing/shelter for victims, and logistical constraints.

Other challenges include a lack of skills to circumvent depression and PTSD in victims, the bureaucratic slowness in the release of funds which resulted in delayed responses, and lack of a contingency fund for indigent victims.

When prioritising what was needed for effective response, government institutions advocated for more shelters for victims of SGBV, especially survivors of domestic violence, and a subvention for the upkeep of survivors while at the shelter.

They also prioritised the following as the core needs of their clients:

- Funding for improved communication with support services
- Finance for self-care
- Empowerment and reintegration
- Medical treatment, including psychosocial support
- Family support, counselling, and psychosocial support
- Shelter and educational support

Referral system

As mentioned earlier, government agencies seem to be satisfied that they have a workable system of referrals. Records of their referrals were, however, unavailable for the study.

Other organisations and agencies that are targets of referrals, according to respondents, are:

- FCT Social Welfare Department
- Ministry of Women Affairs and Social Development
- NDE
- SMEDAN
- Ministry of Education
- Police
- Health care providers
- CSOs
- NAPTIP
- SOS Children Village
- Social welfare centres

Table 7.5: Estimated cost of providing SGBV services by government institutions

Government institution	Estimated cost of service
Women Juvenile Welfare Centre	₦1,000 – ₦5,000
Social Welfare Centre, Gwagwalada	No response
Social Welfare Centre, Kuje	₦500 – ₦5,000
NAPTIP, Wuse, AMAC	₦100,000 per month
FCT SGBV Response Team	No response

Table 7.6: Referral pathways used by government response agencies

Government agency	Does the agency refer victims to health facilities?	Does the agency refer victims to police stations?	Does the agency refer victims to Social Welfare?	Does the agency refer victims to Social Services?
Women Juvenile Welfare Centre	Yes	Yes	Yes	Yes
Social Welfare Centre, Gwagwalada	No response	No response	No response	No response
Social Welfare Centre, Kuje	Sometimes	Sometimes	NA	Yes
NAPTIP, AMAC	Yes	Yes	Yes	Yes
FCT SGBVRT	Yes	Yes	Yes	Yes

Table 7.7: Referrals received by government response agencies

Government agency	Do other institutions send referrals?	Which institutions?
Women Juvenile Welfare Centre	Yes	Police, Social Welfare, Community leaders
Social Welfare Centre in Gwagwalada	No response	No response
Social Welfare Centre in Kuje	Yes	Police, Court
NAPTIP in Wuse, AMAC	Yes	Police, Social welfare, NHRC, community leaders, CSOs
FCT SGBVRT	Yes	Police, health, social welfare, community leaders, NAPTIP, CSOs.

Budgetary allocations

Of the government agencies surveyed, only the FCT SGBVFCT said that they received an allocation from government for the provision of services. They stated that the funds are not released on time, however, making it difficult to provide timely and quality services.

8

Civil society organisations

Civil society organisations are engaged in both prevention and response services regarding sexual and gender-based violence. Most CSO respondents, however, stated that they work on prevention and case reporting advocacy campaigns, leaving very few engaged in actual response services. Most CSOs could not take up the additional expense of direct response services due to funding gaps and inadequate staffing. Nevertheless, they viewed their interventions as important due to their catalytic impact on prevention and the uptake of SGBV support services.

CSOs that engaged in advocacy only, around prevention and reporting, include:

- Education as a Vaccine
- Global Rights
- Partners West Africa

Respondents stated that their organisations used a variety of activities and tools to achieve their objectives. The activities and tools included:

1. Community advocacy visits which often led to cases being reported to them, and which the CSOs subsequently referred further to appropriate organisations and agencies.
2. Hosting infomercials and radio drama series.
3. Training response agencies, particularly the police.
4. Social media engagements.
5. Hosting of an information and reporting website:
   Global Rights hosts www.rapeisacrime.org

SGBV cases reported to CSOs

Five of the six CSOs surveyed reported that they provide SGBV response services. Altogether, they provided SGBV services to 786 children, adolescent, and adult victims of sexual and gender-based violence. SOAR Initiative and Eagle Hope for Mother and Child Care Foundation are largely focused on providing services to minors, Dorothy Njemanze Foundation tends to provide both, while Women Friendly Initiative and WRAPA focus on adolescents and adults.

Table 8.1: CSOs - Location and number of cases

CSO	Location	Number of SGBV cases
Dorothy Njemanze Foundation	AMAC	453
Eagle Hope for Mother and Child Care Foundation	Gwagwalada Area Council	3
SOS Children's Home	Gwagwalada Area Council	0
SOAR Initiative	AMAC	15
Women Friendly Initiative	Kuje Area Council	15
WRAPA	Wuse 2, AMAC	300
Total		786

Service mapping by CSOs

Estimated number of cases per week

Here too, the number of cases of sexual and gender-based violence that staff estimated that they dealt with on a weekly basis (Table 8.2) is at variance with the total number of SGBV cases actually documented (Table 8.1), the latter being considerably lower than expected from the estimated weekly figures. This points to a general problem of cases not being tracked and a weak culture of documentation that needs to be strengthened.

Table 8.3. summarises the support services provided by each CSO that participated in the survey. Only one CSO provided health services – Women Friendly Initiative – and only one provided legal support – WRAPA. Four of the six CSOs accompanied survivors to the police and to health agencies. Most CSOs also provided psychosocial support. None of the organisations was in a position to provide either a shelter, just yet, or economic support.

The use of a standard protocol and trained staff

While Eagle Hope for Mother and Child Care Foundation, SOAR Initiative, and Women Friendly Initiative reported having a standard protocol for the provision of SGBV services, WRAPA and DNF did not have standard protocols and dealt with cases on a needs-related basis.

Eagle Hope for Mother and Child Care Foundation did not have staff trained in SGBV response, whereas SOAR Initiative, WRAPA and Women Friendly Initiative had trained staff. DNF did not have specially trained staff; however, the organisation is staffed and led by SGBV survivors.

Apps

Civil society actors reported using communications technology in their response to cases of sexual and gender-based violence, through the development of a number of reporting and response apps. For instance, Global Rights had developed two apps: "Rape Is a Crime", and "The Whistle". The "No More" (https://nomore.org/) and the "Kobo Collect" apps are also hosted by civil society organisations. There appear to be several apps in use, which most stakeholders consider to be a positive development. As some respondents pointed out, the apps provide more avenues for reporting and responding to sexual and gender-based violence.

Costs and needs

CSOs stated that the range in cost of their services was dependent on the gravity of the issues which they confronted in each case; therefore, costs varied from case to case. DNF gave the range in costs of treating a survivor of domestic violence as N15,000 to N50,000; for a victim of sexual violence, costs incurred could be between N10,000 and N12,000.

These costs are exclusive of the costs of logistics associated with actual support. WRAPA estimated that it cost the organisation between N50,000 and N100,000 to provide support to clients. However, the cost of following through in each case – aiding clients through the response agencies and the courts – proved their biggest challenge. The hidden cost of having to make funds available to response agencies to address perpetrators and take them to the police station was also cited.

Alongside the direct cost of responding to victims, CSO respondents also pointed out that the cost of logistics and basic staffing was prohibitive, and that very few donors were willing to fund administrative costs.

Challenges in providing effective SGBV services

The organisations described SGBV response service provision as highly challenging and cited certain factors that made their work even more difficult. These include:

- Lack of funds
- Understaffing and high staff turnover
- Parents who were in denial of their children's abuse
- Family interference and spousal threats
- Interference by cultural and religious leaders
- Delays in reporting cases
- Police interference and frustration of cases
- Lack of skills to deal with cases of SGBV
- Economic inducement of law enforcement agents by perpetrators

A common difficulty voiced by respondents was that referral pathways for SGBV cases in the FCT are not very clear, and interagency rivalries are apparent and inimical to the provision of appropriate

Table 8.2: Estimated cases per week

CSO	Estimated cases per week
Dorothy Njamanze Foundation	6-12
Eagle Hope for Mother and Child Care Foundation	1
SOAR Initiative	5-6
Women Friendly Initiative	2
WRAPA	5

Table 8.3: Support services provided by each CSO

Services provided	Dorothy Njamanze Foundation	Eagle Hope for Mother and Child Care Foundation	SOAR Initiative	SOS Children's Home	Women Friendly Initiative	WRAPA
Health care	No	No	No	No	Yes	No
Legal	No	No	No	No	No	Yes
Shelter	No	No	No	No	No	No
Police accompaniment	Yes	Yes	Yes	No	Yes	Yes
Court accompaniment	Yes	No	Yes	No	No	Yes
Health services accompaniment	Yes	Yes	Yes	No	Yes	No
Counselling	Yes	No	Yes	No	Yes	Yes
Referral	Yes	Yes	Yes	No	Yes	Yes
Psychosocial Support	Yes	Yes	Yes	No	Yes	No
Economic support	No	No	No	No	No	No

The turnaround time for responding to reported cases of SGBV is shown below:

Table 8.4: Turnaround time

CSO	Turnaround time
Dorothy Njamanze Foundation	24 hours
Eagle Hope for Mother and Child Care Foundation	24 hours
SOAR Initiative	24 hours
Women Friendly Initiative	24 hours
WRAPA	72 hours

and effective SGBV service. For example, although the FCT SGBV Response Team had a WhatsApp group, some CSOs were excluded from the group. Moreover, not all CSOs providing SGBV response services were represented on the SGBV Response Team. Some CSOs were unaware of the exact activities of the SGBV Response Team. In addition, the roles of the Ministry of Women Affairs and the FCT Social Department, relative to one another, were not clear to all CSOs.

In spite of these hitches, CSO respondents reported that when they accompanied survivors through the maze of response institutions, survivors were more likely to follow through with their cases and get better responses from law enforcement agencies.

For most of the CSOs interviewed, their funding was sourced from donor agencies, and occasional private donors. Epileptic donor priorities made long term programming difficult. In addition, most donors did not want to commit funds to service provision and were more likely to focus on advocacy, which costs less in terms of reach.

Respondents all noted that the absence of public shelters to which survivors could be referred was a huge challenge in carrying out their work. The lack of shelters has resulted in several cases being dropped because survivors were often afraid of being re-victimised if they returned to the environment in which they were being abused.

The ownership and situation of the 2-bedroom shelter at Kurudu was unclear and none of the CSOs had access to it, to apply for survivors to be temporarily sheltered there. Respondents noted that NAPTIP had a shelter, but that it was overstretched and most of the survivors they worked with were not considered a priority for admission into NAPTIP's shelter.

Organisations that provide services to child victims were also uncomfortable with the idea of children referred to NAPTIP being sheltered alongside adult victims of sex trafficking. WRAPA has a private shelter at Karu, on the outskirts of Abuja. However, it was not functional at the time this study was being carried out, due to the high cost of maintenance. WRAPA was instead using its resources to complete a new shelter at Utako, within AMAC.

DNF pointed out that they had logistical challenges in reaching victims, particularly in cases of domestic violence when it was necessary to use a vehicle to pick up victims and sometimes, their children and property. DNF could not afford to buy their own vehicle and so had to hire a utility van on many occasions, delaying their ability to respond on time.

Most respondents noted the importance of data to their work and admitted to having limited capacity to organise, manage and disseminate data effectively.

Referral mechanisms

All of the organisations affirmed that they provided referral services to law enforcement agencies, in particular, the police and NSCDC. CSOs also referred SGBV cases to NAPTIP, the Social Welfare department, community leaders, and health facilities. CSOs found health facilities to be highly receptive.

Referral networks appeared loose, however. Although the FCT SGBV Response Team was supposed to be coordinating institutional responses to ease referrals, CSO respondents observed that their staff often encountered challenges with referrals and client accompaniments, especially at certain police stations. On a positive note, however, respondents mentioned that the Police Clinic at Area 1, AMAC, was quite receptive and often assisted in getting SGBV cases prioritised.

Most CSOs also found NAPTIP to be very cooperative. However, some were of the view that NAPTIP needed to step up to its coordination role as prescribed by the VAPP Act, and suggested that its role could be strengthened through the adoption of an inter-agency response services protocol. Global Rights had designed a prototype[1] which four of the CSOs stated that they were aware of, but which was never utilised on a general level by the FCT SGBV Response Team.

All the CSOs providing response services affirmed that first line government response agencies and other CSOs, schools, and community leaders referred SGBV cases to them.

What Works

While civil society actors appear largely frustrated with the limitations that their services contend with, they are also happy to say that there are positive trends which can be amplified. According to respondents, community outreach efforts have a positive impact, particularly if the outreach is conducted in local languages. They indicated that activities such as rallies, physical outreach efforts to local communities and schools, and outreach efforts on the radio always resulted in an upsurge in cases. For instance, SOAR Initiative reported receiving 365 cases in a single month after an outreach initiative to a community. DNF also reported increased reporting of not less than 30 a week, after the release of each of their SGBV explainer edutainment outputs.

Respondents noted that engagements with male community gatekeepers and the facilitation of male champions and advocates against SGBV also appeared to have a positive impact on community attitudes and inclinations. Training community-based paralegals, especially those able to speak local languages, to provide onsite legal first aid to victims also appears to increase the number of reported cases. As noted earlier, community vigilantes often intervene in issues of domestic and sexual violence in communities. Fostering their reorientation to provide legal first aid and facilitate reporting to the police will be of help to survivors.

Endnote

1 Global Rights. 2017. *Sexual & Gender-Based Violence Response Tool-Pack: SGBV Protocols, Matrices & Tool-Kit*. Abuja: Global Rights.

9

Court system

Table 9.1: Courts and number of SGBV cases managed

Area Council	Number of courts	Type of courts	Number of SGBV cases
Gwagwalada	2	1 Magistrate court	3
		1 Sharia court	2
Kuje AC	2	1 Magistrate court	1
		1 Sharia court	1
Bwari AC	1	Customary court	0
AMAC	1	Magistrate court	0

Table 9.2: Use of special fast track Courts

Court	Limited audience in Court	Reasons
High Court, Gwagwalada	Sometimes	If a victim/survivor is a minor. Cases are heard in judges' chambers
Sharia Court, Gwagwalada	Yes	For privacy and protection of victims
Sharia Court of Appeal, Kuje	Sometimes	For purposes of privacy
Magistrate Court, Kubwa	Optional	Optional

Six courts participated in the survey. However, only four of the six had managed and prosecuted cases of sexual and gender-based violence. The magistrate and customary courts in Bwari and AMAC, respectively, had not heard cases of SGBV. The distribution of the courts per area council and hierarchy in the judicial system is summarised in Table 9.1.

Adjudication based on the Violence Against Persons (Prohibition) (VAPP) Act

Since the administration of the VAPP Act is vested only in the High Court, the lower courts were limited to guidance by the Penal Code, and Sharia law at the Sharia court of Kuje and Gwagwalada, respectively. The High Courts at Gwagwalada and Kuje were, however, able to charge crimes of sexual and gender-based violence using the provisions of the VAPP Act and provisions of the Penal Code.

There are no special fast track procedures for SGBV cases at the Courts, as mandated by the law under the VAPP Act. This was reportedly due to the lack of administrative structures to accommodate fast track procedures. However, respondents from each of the courts informed us that SGBV cases are heard before a limited audience, in certain instances.

10

Analytical overview

The research effort to establish a baseline of reported cases of sexual and gender-based violence in the FCT points to the critical need to strengthen the capacity for effective institutional response to SGBV. It might be expected that one of the requirements for establishing a baseline would be to have minimal variation in the numbers of SGBV cases reported to the various response agencies. Instead, the research has highlighted the wide variation in the numbers of actual cases reported to the different response agencies addressing sexual and gender-based violence in the FCT, with the totals ranging from 65 to 786, more than a tenfold difference.

It was possible to get gender-disaggregated figures for all reported cases of SGBV to the various response agencies but not for civil society organisations and courts. In all cases where the figures are disaggregated by gender, there are considerably more instances of females being violated than males.

SGBV grossly underreported

Both the primary and secondary data point to the fact that various forms of SGBV are prevalent and are grossly underreported crimes, in the FCT as in other parts of Nigeria. Current responses to the phenomenon are clearly inadequate. Some of the factors underlined by the baseline survey include:

1. **The culture of silence regarding SGBV in other parts of Nigeria resonated in the FCT.** Victims and their families spoke of being shamed into silence and into thinking they would not be believed because of the power imbalance between them and their perpetrators. As a result of their experiences of previously reported incidents of sexual and gender-based violence, they did not think that law enforcement would act on the information they were willing to provide.

2. **While most law enforcement agencies report that they have protocols for responding to sexual violence, it was apparent that their personnel often failed to adhere strictly to their protocol.** Rather, their responses to victims of sexual violence strongly reflect the pervasive patriarchal societal and religious norms. For instance, law enforcement officers often blamed victims of sexual violence, justifying the crime that they had suffered by referring to what they describe as 'promiscuous' or 'provocative' dressing. Community gatekeepers, including community chiefs, women leaders, and clerics also tended to agree with this. Victims and support CSOs also deplored the arbitrariness of police officers' responses when they had sought justice at the stations.

3. **The stigma attached to SGBV, particularly sexual violence, engenders the culture of silence and denial.** Respondents shared accounts of minors that had sought support, only later to have the case stalled by parents who denied that their wards were ever sexually abused.

Table 10.1: SGBV cases reported to the different response agencies

	Female	Male	Total
Health services	118	3	121
Law enforcement	58	7	65
Government response agencies	231	82	313
CSOs			786
Courts			7
Total number of reports of SGBV cases			1,292

4. Victims and their caregivers (particularly mothers) reported being harassed by the families of perpetrators, their own families, and even law enforcement, into dropping the case. They also described frequent court adjournment, and not understanding the workings and language of the courts, as deterrents in seeking justice.

5. Victims, caregivers, and community members attested that they often did not know the steps to take to seek redress. They cited examples of reporting to the police and then being asked to return periodically to the station with no arrest or investigations made.

6. A number of victims and response CSOs also expressed the view that law enforcement was biased against them. Moreover, their attackers often bribed the police, who then became hostile to them.

7. Response institutions stated that they were unable to afford the cost of treatment and the cost of seeking justice for victims. As a result, they generally become wary of taking on cases that they cannot handle.

8. Victims and caregivers stated that they did not realise the need for post-exposure prophylaxis treatment for sexual violence and so did not seek medical assistance.

9. Victims spoke of visiting pharmacists near them for treatment due to the prohibitive costs and long waiting periods at health institutions.

10. The support framework for survivor-friendly response to SGBV beyond first line responders is near non-existent. For instance, the lack of shelters to accommodate victims, and other protective measures prescribed by the VAPP Act, were recurring features throughout the study. In this context, victims are understandably reluctant to approach law enforcement, realising that they will be afforded minimum or no protection from the environment in which they are being abused, thus worsening their plight.

Poor understanding of SGBV and the VAPP Act

While most stakeholders agreed that the various manifestations of SGBV were 'bad', they tended to view them as moral wrongs which were often instigated by the victims themselves. Some respondents, including law enforcement agents, religious and community leaders spoke of women bringing intimate partner violence upon themselves because they 'were disrespectful to their husbands as "heads" of their homes'. They considered as noted above, that sexual violence was often provoked by 'indecent' dressing and 'seduction' by the victim. A few CSOs reported that they had attempted to counter these narratives through radio edutainment programmes and anti-SGBV advocacy outreach efforts to communities with high levels of such violence.

There was also a pervasive lack of knowledge of the VAPP Act. Most stakeholders did not know of the VAPP Act, and even when they had heard of it, they generally did not know its provisions or its workings. Given this general lack of knowledge of the provisions of the VAPP Act, most respondents had no idea of the survivor-centred nature of the VAPP Act, or the need to institutionalise the implementation of the reliefs it prescribes for victims of violence.

Interagency lapses

While not all victims of sexual and gender-based violence will be willing to press charges even in the most supportive systems, they must however, at the very least, prioritise seeking health care. This is especially necessary for sexual violence crimes, grievous bodily wounds, and psychosocial support. Most victims do not seek health care. Current data suggests that a lot of victims fall through the interagency loops and become unaccounted for. Most will visit one first line response agency (usually law enforcement or healthcare), and then not follow through in seeking an intervention at the other, even when referred.

Victims and CSOs ascribe this failure to follow through to 'survivor's fatigue', given the bureaucracy and mishandling they were subjected to, at the first first line agency they visited. Many victims complained about the length of time it took for them to gain access to care at health

facilities. This is particularly evident in the case of government health facilities whose reports tend to be better respected by the courts than private facilities, which are also often too expensive for victims. Victims also reported frustration with police stations which solicited bribes to work, or demanded payment for their services and the cost of investigations.

CSOs complained about being ostracised by agencies to which they accompanied victims to report SGBV crimes. They noted for example that NAPTIP often denied them access to their clients if they were admitted into the NAPTIP shelter. Similarly, police officers tended to treat them as meddlesome interlopers, and once they become hostile, some of the victims they referred to these stations lose confidence and drop off the case. While some first line response agencies appear to have built a working rapport, others struggle through cases, inadvertently re-victimizing clients.

The FCT SGBVRT secretariat should ordinarily be the response hub for the FCT. This works well on paper, but in reality, the member organisations of the response team are not as functionally connected as they should be. NAPTIP's coordination role as prescribed by the VAPP Act is also challenged, largely due to funding constraints.

Poor funding for SGBV interventions

SGBV interventions are generally poorly funded both by the government and donors. Response institutions all vented their frustration with the lack of finances, which was a major hindrance in their service delivery. Victims and their families also stated that they could not afford the cost of seeking justice. Very poor victims mentioned that they sometimes could not afford the cost of visiting the police station or courts to follow up, or even pay for medical treatment. Some victims and CSOs also hinted that they sometimes had to cover the cost of law enforcement's transportation to investigate crimes, or pay for paper for their statements and case files. A response institution stated that they were asked to pay a N50,000 access fee for their client to be sheltered at the WOTCLEF private shelter because the state shelters were overstretched. Since they could not afford the fee, the case unravelled.

The lack of funding, according to law enforcement agents, was the reason why they did not have forensic investigations capacity, or could not afford healthcare facilities to provide them with forensic evidence to aid investigations. A gap in dedicated budgetary allocations also means that it is difficult to prioritise institutional spending on SGBV, or train staff on survivor-friendly approaches to managing SGBV cases.

Benefits of community engagement

Increased community engagement has the potential to open up possibilities for further discussion about the need to take a stand against sexual and gender-based violence. The provision of basic information on what to do and where to seek help appears to make a considerable difference to community members' willingness to act accordingly. CSOs reported that they had regular spikes in the number of persons seeking services after community and media outreach efforts, and during school and public holidays. This observation was corroborated by law enforcement agents. The spike after outreach efforts suggests that attitudinal changes occurred due to these advocacy initiatives.

11

Conclusions

The need for interventions to address sexual and gender-based violence in the FCT

This Baseline Report has presented the findings from a study conducted across five key response institutions that provide SGBV response services across four of the six Area Councils of the FCT – AMAC, Bwari, Gwagwalada, and Kuje Area Councils.

The aim has been to establish the prevalence of reported cases of SGBV in the FCT over a period of one year (December 2018 – November 2019), to document the type of response and support services provided, and to indicate the estimated costs of such services. The institutions involved were health facilities, law enforcement, government agencies, courts, and civil society organisations that provide response services to survivors of SGBV.

The scope of information presented in this baseline report is limited due to several factors: the stigma and other factors which continue to inhibit the reporting of SGBV cases, the limited access to information at some institutions, and a very poor culture of documentation across the board.

The overall findings from the study lead us to the following conclusions:

- The tremendous variation in the numbers of cases reported to different SGBV response agencies and institutions points to the need for much greater co-ordination across sectors in responding to sexual and gender-based violence.
- A broader conceptual understanding of sexual and gender-based violence is important for staff of service institutions, alongside learning the implications for appropriate standards of practice.
- There is still a paucity of information on the causes and prevention of SGBV across the FCT, thereby perpetuating the dynamics fostering such violence and promoting impunity.
- There is very limited knowledge of the VAPP Act, its provisions and workings, as manifested from the inception of efforts to report sexual and gender-based violence, to the procedures involved in law enforcement. This restricted knowledge has considerable bearing on the poor uptake of the VAPP Act.
- The concept of a 'survivor-centred approach' to sexual violence response is still not prioritised in the reception and treatment of victims of SGBV in the FCT.
- While a workable interagency referral system exists, its framework is still rather weak. The relevant agencies are in need of a clearly defined interagency protocol that is survivor-friendly and provides a system as close as possible to a one-stop shop for response to sexual and gender-based violence in the FCT.
- Interagency rivalry and failure to adequately acknowledge the contributions of civil society actors is also hampering the effectiveness of the ecosystem for SGBV response in the FCT.
- The failure to allocate multi-agency funding to ensure an effective response to SGBV is detrimental to appropriate service delivery. A multi-stakeholder approach is lacking overall.
- There is a lack of a monitoring and evaluation framework for addressing sexual and gender-based violence.
- Failure to fund interventions against SGBV through the operation of the VAPP Act in the FCT is limiting the ability of response agencies to work towards prevention and promote a culture of zero tolerance of sexual and gender-based violence.

Programming to address SGBV in the FCT

Effective implementation of the VAPP Act requires intervention programmes specifically to address sexual and gender-based violence in the FCT. Such programming ought to be based on a number of critical needs:

A survivor-friendly approach

A survivor-centred approach means that:

- The survivor's wellbeing and safety are considered the highest priority;
- The survivor's right to self-determination is respected at all times and they are provided with all the information they need. They have the right to make decisions about their case, including whether to report the case to the police or not. If there are mandatory reporting laws, these are explained clearly to the survivor/victim so that they can make an

informed choice as to whether to proceed or not;

- The survivor is not stigmatised or discriminated against, regardless of religion, ethnicity, sexual orientation, gender identity, age, ethnic group, profession, or any other factor;
- The survivor's right to confidentiality is respected.

The overall approach needs to ensure that interventions are designed to prioritise the wellbeing of victims, and promote their transition from being victims to becoming survivors. This should be done in the context of implementation of the VAPP Act, bearing in mind its critical intent of ensuring survivor friendly interventions. For instance, S2(5) of the Act empowers a court to award appropriate compensation to a victim of physical injury in the circumstances they deem fit and S28 also empowers the court to issue a protection order. Section 28(3) also directs law enforcement to inform complainants of the remedies they have under the VAPP Act, if the complainant has no legal counsel. The rights of victims are enumerated in S38 which provides, among other things, that every victim of violence is entitled "to receive the necessary materials, comprehensive medical, psychological, social and legal assistance through governmental agencies or non-governmental agencies providing such assistance."

The VAPP Act in S41 also institutes the appointment of protection officers in each Area Council of the FCT. While resources might be a limiting factor in NAPTIP's ability to fulfil this mandate, community-based protection committees could be considered to serve in advisory and rapid response capacities.

Given their pivotal role in the movement from victimhood to *'survivorhood'*, the point-officers of each response institution need to be mapped and a network fostered. For instance, a mapping of gender desk officers at each police station is important in strengthening the network of responders, in particular, the FCT SGBVRT. An investment in provision of a network for psychosocial support and the embedding of psychologists in the interagency matrix is also an essential element in the shift towards survivorhood.

Interagency response

In order to fulfil the objective of being survivor friendly, SGBV programming must form the web of a safety net for victims. This can be done by ensuring that response agencies do not work in silos but instead, adopt strong intra- and interagency protocols for their response. Importantly, the establishment of Sexual Assault Referral Centres (SARCs) in all the area councils is necessary to provide one-stop centres for victims of sexual violence. The Lagos state SGBVRT provides a model which the FCT SGBVRT can emulate to ensure an effective synchrony of all response agencies and their entry points. As the coordinating agency, NAPTIP's capacity needs to be enhanced to draw up a workable roadmap for the FCT SGBVRT, and effectively manage its coordination functions.

Response institutions are also in need of an accountability matrix to ensure that victims do not fall into the cracks caused by the failure of response agents to deliver diligently on their mandates. Since the VAPP Act, in S38(2), calls for the sanctioning of the heads of institutions who do not take measures to ensure the implementation of the reliefs to which victims are entitled, it is necessary to ensure that all agencies of government are aware of this provision and educated about their duties. As a point of leverage, civil society could consider issuing a petition to NAPTIP on this matter or instituting a strategic litigation case for the enforcement of the section to create precedence regarding erring government actors.

There is also a need to mitigate the fissures in the trust relationships among law enforcement and government response agencies, on the one hand, and civil society actors, on the other. One of the ways will be to ensure that the importance and contributions of civil society responders are acknowledged, their operations integrated into the interagency protocols, and that they are granted credit in successful interventions. The provision of state subventions for their contributions may also be considered.

The protection of human rights defenders and civil society response agencies is imperative. There is a need to institutionalise their protection as envisaged under the VAPP Act.[1]

Behaviour change communication

Zero tolerance for SGBV starts with accurate information on the causes of sexual and gender-based violence, its prevention, and the prosecution of perpetrators. Awareness of SGBV crimes and the provisions of the VAPP Act, by a critical mass of people, is therefore essential. In order to create a paradigm shift in perceptions and attitudes towards SGBV, a strong behaviour change communication plan is essential, not just for those who seek to report cases of sexual and gender-based violence but also for those involved in enforcing the law. In particular, staff of first line response agencies are in need of specialised survivor-friendly SGBV response training. As civil society actors have shown, community outreach efforts, especially in local languages, are effective and should be utilised. Community champions and community based paralegals should also be trained and situated throughout the municipal areas of the FCT. Another advantage to mentoring community-based paralegals is the potential for sustainability – most will continue to serve their communities long after a funded intervention on their training.

Service delivery programming

Service delivery programmes are necessary for strengthening effective response to cases of sexual and gender-based violence. Such programmes are important in documenting information that is critical in providing court evidence and promoting the wellbeing of survivors. Essential areas that service delivery programmes need to focus on include the provision of rape kits, PEPs and other treatments for victims, strengthening forensic capacity for law enforcement, provision of temporary shelters for survivors, protection order modalities and other systemic structures to aid effective service delivery. Legal programmes should address the logistics of implementing the VAPP Act and promoting human rights norms.

Moreover, duty bearers should adopt a multi-sectoral approach and jointly advocate for budgetary allocations for effective service delivery and accountability in addressing sexual and gender-based violence.

Monitoring and Evaluating FCT SGBV Interventions

In order to ensure up-to-date and accurate data for informed decision making, especially in designing programmes, building budgeting tools, and providing information for policymakers, a robust M&E system is crucial for collating and harmonising data across response service institutions. There is a need to invest in a multi-sectoral M&E framework that utilises strong evaluation designs. This calls for intra-agency data exchange and subsequent tracking of indicators on a systematic and longitudinal basis. One approach for sustainable data collection would be to adopt a reporting mechanism that is linked to communities.

A strong point made by civil society actors in the course of this study was the need for SGBV response institutions to seek the technical expertise of the public health sector in the curation of data. CSO respondents pointed to the efficacy of the systems that public health personnel had developed over time. All response institutions, including organisations in civil society, will therefore need to acquire these much needed skills.

The creation of a data hub is imperative. Our recommendation would be to situate it at either the National Human Rights Commission (NHRC) or at NAPTIP. Alternatively, both agencies could be involved in running and co-ordinating the data hub.

It is important to state that whilst the organisation and management of data is costly, it is necessary for developing an appropriate framework for response and prevention of sexual and gender-based violence in the FCT. An effective working model could provide a potential reference point for other parts of the country.

Institutional implications

Law enforcement

There is a need to ensure a total reorientation towards the promotion of zero tolerance for sexual and gender-based violence, across the leadership and entire rank and file of law enforcement agencies. The training of all officers on survivor-friendly response to SGBV, the institutionalisation of a standard operations protocol, and an accountability matrix are also essential.

In addition, a reorganisation of the physical layout of police stations is imperative in order to provide safe spaces for victims. This means that every law enforcement station in the FCT needs to have a private interview room, and amenable spaces for minors pending their transfer to protection shelters.

Basic equipment needed for the effective discharge of law enforcement duties is also essential – the provision of police vehicles and their maintenance, stationery, computers and printers, and a subvention for interagency referrals. The latter includes the treatment and collection of evidence from victims at health facilities, telephone lines and other communications facilities. The establishment of a forensic laboratory to assist in the prosecution of crimes is also necessary.

The relationships between law enforcement and health facilities need to be strengthened to create a robust system for the protection and welfare of victims. The Police Hospital at Area 1, Garki of AMAC has been commended by both victims and CSO responders. It is suggested that perhaps the hospital can be upgraded to have a SARC annex within its complex. On a larger scale, a mapping of gender desk officers in law enforcement agencies as well as medical directors of health facilities should be conducted. Advocacy outreach initiatives to strengthen relationships among agencies across both sectors should be undertaken periodically.

Health facilities

A whole sector approach is needed when considering interventions for the health sector. Therefore, both public and private health facilities need to be conscripted to provide survivor-friendly response to sexual and gender-based violence. Although the VAPP Act only indirectly refers to health agencies in S38, which specifies the rights of victims of violence to receive comprehensive medical and psychological assistance, education on the VAPP Act and its provisions is essential for the health sector. Knowledge of the VAPP Act in this sector will facilitate appropriate referral of cases to relevant response agencies.

There is a need for a reorientation of health agency personnel too, in order for them to exhibit the highest duty of care in their response to victims of sexual and gender-based violence. In the case of minors, this means reporting to social welfare, or directly to the family unit of the Nigerian Police Force. The creation of a SARC within every major secondary public health facility in the FCT would contribute to the development of a multiagency approach. The entire staff of health facilities would need to be trained to provide survivor-friendly response to all victims without discrimination. As front line institutions, it is imperative that funding is allocated specially and adequately for the free treatment of SGBV cases, at least at every public health facility in the FCT.

Since a lot of victims seek treatment at patent medicine stores and pharmacies, these outlets should also be targeted for advocacy initiatives to promote the uptake of PEP treatment, provide directions on early reporting to law enforcement, and push for mandatory reporting of the violation of minors.

Court system

The VAPP Act provides specifically for the High Court to:

- Assign specific courts to fast track cases on VAPP-related offenses.
- Receive and grant applications for Protection Orders, which are effective throughout the country.
- Ensure that a hearing under the VAPP Act takes place before a limited audience.
- Court registrars and judges therefore need to be trained on the provisions of the Act, especially on the protocol for Protection Orders. The need to sensitise, train, and retrain on the VAPP Act is crucial, as is a more responsive judicial system for addressing cases of sexual and gender-based violence.

Government response agencies

Beyond the first line institutions (law enforcement and healthcare), support agencies have to be adequately strengthened in order to respond effectively to cases of sexual and gender-based violence. For example, the failure to create safe spaces for victims of violence to be urgently protected is quite problematic and is one of the major reasons why some victims do not report. The establishment of dedicated shelters that are managed by Social Welfare departments of every Area Council should be strongly considered. The modalities for gaining access to shelter support for victims should also be clearly spelt out for other response institutions.

The coordination of SGBV response by the FCT SGBV Response Team should be carefully thought through and reoriented such that Team members are active in ensuring a seamless and failsafe referral system for victims. NAPTIP's powers under the Act suggest that it should coordinate state actors' response to violence. While this responsibility might appear to be usurped by the FCT SGBV Response Team, in practice, their roles are quite complementary. NAPTIP's role

is to coordinate state actors' responses. The mandate of the FCT SGBV Response Team, on the other hand, is to ensure coordination among both state and non-state actors in the response to sexual and gender-based violence.
Given the importance of its role therefore, NAPTIP should set up a Technical and Advisory Services Unit. This must be able to draw a pool of experts from government as well as outside, who are able to provide technical support to the various government ministries and departments. The role of the unit would be to conduct needs assessments and develop technical support plans with direction on how best to provide the required resources. It should also be charged with coordinating and managing a multi-sectoral M & E template for SGBV response in the FCT, which would also entail co-ordinating data collection.

Accounts of sexual and gender-based violence affecting girls and adolescents abound in the media. Within the FCT, many in that population are students at schools across the FCT. Child labourers, particularly domestic servants when they receive some form of education, are largely enrolled in public schools. Preventive outreach efforts and zero tolerance policies will need to be implemented across educational institutions to reduce these numbers. Public school teachers and authorities therefore need to be educated on the VAPP Act, and protocols developed for responding to violence against children. School authorities should also be considered for inclusion into the FCT SGBV Response Team.

The Local Council Administration should consider crafting edicts to create funded private foster systems for minors who have been abused. The aim would be to ensure that they are not further traumatised by their experiences at the hands of response agencies and do not remain in abusive environments in the course of the interventions on their case.

Civil society organisations

For an effective institutional response framework for responding to sexual and gender-based violence in the FCT, government must consider civil society as equal partners and engage with them as such. It is important to foster strong relationships with local SGBV-response CSOs as first line organisations that play a key role in supporting survivors. A register of CSOs that provide support services to victims of sexual and gender-based violence as well as advocacy organisations working on prevention should be updated regularly and their services included in the FCT SGBV Response Team.

Media

It is necessary to continue to engage the media on the need for a zero tolerance approach towards sexual and gender-based violence. There have been several initiatives to train the media on reporting such violence but these must be stepped up. Both traditional and electronic media should be engaged to become champions for zero tolerance of SGBV, and to act as ambassadors for survivor-friendly response information.

Edutainment is a powerful tool and should be deployed across mass media. The infusion of information on SGBV should also be fashioned into TV and radio dramas and popular soap operas. Regular public service announcements on the availability and types of response services available should also saturate the media.

The National Orientation Agency should also be engaged in the circulation of information on government's zero tolerance of SGBV and the institutional response to such violence.

Whole of Society Approach

Given the root causes of sexual and gender-based violence, a culture of zero tolerance of such violence and a survivor-centred approach cannot be achieved without a 'Whole of Society Approach' to addressing SGBV and operationalising the VAPP Act in the FCT. Therefore every segment of society across the FCT must be engaged in this campaign. Traditional and religious leadership need to be engaged and educated alongside all of the sectors referred to above, given their immense influence on people in their communities. It is also important given that a number of SGBV cases are reported directly to traditional and religious leaders and never make their way into official response institutions addressing sexual and gender-based violence. Trade associations, in particular market and transport associations, should also be engaged.

Endnote

1 See provisions on service providers in Part III of the VAPP Act (S39-S40).

12

Appendices

Appendix 1: Questionnaires

Tool 1

Government Response Agencies – Aggregate Form

Name of agency? _____

Type of agency? _____

What LGA/ Area of Abuja is it located? _____

What district is it located in /does it serve?

_____

Number of sexual and gender based violence (SGBV) incidents reported between December 1, 2018 to November 30, 2019:
Male ____ Female____ Total_____

In order of frequency, what are the 3 most reported types of SGBV at your institution

a._____ b. _____ c. _____

What types of support services do you offer? (Tick as applicable)

Services	Description
Healthcare	
Legal	
Shelter	
Accompaniment to Police	
Court accompaniment	
Health services accompaniment	
Counselling	
Referral	
Psychosocial Support	
Economic Support	
Other	

What is the usual time range within which you attend to survivor's complaint?

a) 24 hours [ ] b) 48 hours [ ] c) 72 hours [ ] d) Later [ ] e) unknown [ ]

Approximately how many cases do you handle on a weekly basis? _____

Do you have a protocol for responding to victims of SGBV? Yes ☐ No ☐ Sometimes ☐

Do you have staff. that are trained to offer services to SGBV victims? Yes ☐ No ☐

Do you refer /accompany victims to health facilities? Yes ☐ No ☐ Sometimes ☐

Do you refer /accompany victims to the police station? Yes ☐ No ☐ Sometimes ☐

Do you refer /accompany victims to social welfare dept? Yes ☐ No ☐ Sometimes ☐

Do you refer victims to other institutions/ support services? Yes ☐ No ☐ Sometimes ☐
If yes or sometimes, specify the institutions/ support services and referral process

_____

_____

_____

Do other institutions/ organisations refer victims to you? Yes ☐ No ☐ Sometimes ☐

If yes, or sometimes, which institutions:
Police☐ Health ☐ Social welfare ☐ NHRC ☐ Community leaders ☐
NAPTIP ☐ CSOs ☐ Govt. agencies ☐
(specify)_____

What is the estimated cost range for managing a case, on average? _____

Ranking the following from 1-5, what would you consider to be your major constraints in providing services to SGBV victims:

Finance: ____
Manpower ____
Skills ____
Referral network ____
Victims' cooperation ____

What other factors hinder you from rendering effective and optimal services to victims?

a) _____
b) _____
c) _____

What other services is your agency mandated to offer survivors of sexual violence but is currently unable to provide?

a) _____
b) _____

What would you consider to be the 3 greatest needs of your clients?

a) _____

b) _____

c) _____

What problems do you encounter while providing service to victims?

_____

_____

_____

Is there a budgetary allocation in your agency's budget for SGBV cases? Yes ☐ No ☐ Sometimes ☐

_____

Tool 2

CONFIDENTIAL

Health Service Provider - Aggregate Form

Name of health facility:

Type of health facility:

Location of health facility:

Number of sexual and gender based violence (SGBV) incidents reported between 1 December, 2018 to 30 November, 2019:

Male ____ Female____ Total_____

In order of frequency, what are the 3 most reported types of SGBV

1._____ 2. _____

3. _____

Comment: _____

SECTION A: HEALTH CARE INSTITUTION

1. Does your institution offer healthcare services to SGBV victims? Yes ☐ No ☐

2. (If yes to Question 1) what type of services do you offer to them?
   a) Medical examination ☐
   b) Medical forensic examination ☐
   c) Treatment ☐
   d) Counselling ☐
   e) Referral ☐
   f) Psychosocial support ☐

3. Do you offer 24 hours medical care service to victims SGBV? Yes ☐ No ☐

4. Do you have a special unit with the mandate of handling sexual violence cases? Yes ☐ No ☐

5. Do you have healthcare personnel – doctors, nurses, laboratory technicians, etc. that are trained to offer services to sexual violence victims? Yes ☐ No ☐

6. Does your institution administer Post Exposure Prophylaxis to victims? Yes ☐ No ☐

   If yes, how much do they cost? _____

   What is the estimate cost range for treatments averagely _____

   Who pays for the treatments? _____

7. Do you carry out medical forensic examinations that that can be used as evidence in investigation /court proceedings? Yes☐ No☐

8. Are your services guided by the provisions of the Violence Against Persons Prohibition Act? If yes, explain briefly in what ways and if not, why.

_____

_____

_____

9. What are the problems you encounter while treating victims?

_____

_____

_____

10. Do you refer victims to other institutions/ support services? Yes ☐ No ☐ Sometimes ☐

If yes, specify the institutions/ support services and referral process

_____

_____

_____

11. What are the factors hindering effective services to victims in your institution?

a) _____

b) _____

c) _____

Tool 3

Civil Society Organisations

1. Name of Organisation? _____
2. Type of Organisation? _____
3. What LGA/ Area of Abuja is it located? _____
4. What district is it located/serves? _____
5. Number of sexual and gender-based violence (SGBV) incidents reported between December 1,2018 to November 30, 2019:
   Male ____ Female____ Total_____
6. In order of frequency, what are the 3 most reported types of SGBV at your organisation

   a._____ b. _____

   c. _____
7. What types of support services do you offer? (Tick as applicable)

Services	Description
Healthcare	
Legal	
Shelter	
Accompaniment to Police	
Court accompaniment	
Health services accompaniment	
Counselling	
Referral	
Psychosocial Support	
Economic Support	
Other	

8. What is the usual time range within which you attend to survivor's complaint?
   a) 24 hours [ ] b) 48 hours [ ] c) 72 hours [ ]
9. Approximately how many cases do you handle on a weekly basis? _____

10. Do you have a protocol for responding to victims of SGBV? Yes ☐ No ☐ Sometimes ☐

11. Do you have staff. that are trained to offer services to SGBV victims? Yes ☐ No ☐

12. Do you refer /accompany victims to health facilities? Yes ☐ No ☐ Sometimes ☐

13. Do you refer /accompany victims to the police station? Yes ☐ No ☐ Sometimes ☐

14. Do you refer /accompany victims to social welfare dept? Yes ☐ No ☐ Sometimes ☐

15. Do you refer victims to other institutions/ support services? Yes ☐ No ☐ Sometimes ☐

    If yes or sometimes, specify the institutions/ support services and referral process

    a. _____

    b. _____

16. Do other victim support institutions/ organisations refer victims to you? Yes ☐ No ☐ Sometimes ☐

    If yes, or sometimes, which institutions:
    Police☐ | Health ☐ Social welfare ☐ NHRC ☐
    Community leaders ☐ NAPTIP ☐ CSOs ☐
    Govt. agencies. ☐ (specify)_____

17. What is an estimated cost range for managing a case averagely? _____

18. Ranking the following from 1-5, what would you consider to be your major constraints in providing services to SGBV victims:
    a. Finance: ____
    b. Manpower ____
    c. Skills ____
    d. Referral network ____
    e. Victims' cooperation ____

19. What other factors that hinder you from rendering effective and optimal services to victims?

    a) _____
    b) _____
    c) _____
    d) _____
    e) _____
    f) _____

20. What other services would you want to offer survivors of sexual violence?
    a) _____
    b) _____

21. What would you consider to be the 3 greatest needs of your clients?
    a) _____
    b) _____
    c) _____

22. What problems do you encounter while providing service to victims?

_____

_____

23. How is your support service funded?

_____

_____

Tool 4

CONFIDENTIAL

Law Enforcement Data Aggregate Form

Name of Law Enforcement Station:

Number of sexual and gender based violence (SGBV) incidents reported between December 1, 2018 to November 30, 2019:

Male ____ Female____ Total_____

In order of frequency, what are the 3 most reported types of SGBV

1._____ 2. _____

3. _____
Comment:
_____

Services

1. Are your services guided by the provisions of the Violence Against Persons Prohibition Act? If yes, explain briefly in what ways and if not, why.

_____

_____

_____

What other laws apart from the VAPP Act guide your services?

_____

_____

_____

2. What type of services do you offer to victims?
   a) Protection ☐
   b) Prosecution ☐
   c) Referral ☐
   d) Counselling ☐
   e) Others (please specify) ☐
   f) _____
   g) _____
   h) _____

3. Do you have a special desk/unit that handles SGBV issues? Yes ☐ No

   What is that special desk/unit called?_____

4. Do you have officers that are specifically trained to offer services to survivors of SGBV?
Yes ☐ No ☐ Sometimes ☐

5. Are your officers generally trained on Sexual Violence issues either while in Police College or as on-the-job training? Yes ☐ No ☐ Sometimes ☐

6. Do you consider that your station has the capacity for gathering forensic evidence Yes☐ No☐ Somewhat☐

7. If no, or somewhat, why?

_____

8. Do you have a protocol for responding to victims of SGBV? Yes ☐ No ☐ Sometimes ☐
If yes, do your officers comply with the protocol? Yes ☐ No ☐ Sometimes ☐

9. Do you refer /accompany victims to health facilities? Yes ☐ No ☐ Sometimes ☐

10. Do health institutions and other support services refer victims to you? Yes ☐ No ☐ Sometimes ☐

11. Do you refer victims to other institutions/ support services? Yes ☐ No ☐ Sometimes ☐
If yes, specify the institutions/ support services and referral process

_____
_____
_____

12. What is an estimated cost range for managing a case averagely?_____

13. What are the problems you encounter while providing service to victims?

_____

_____

_____

14. What are the factors hindering effective services to victims at your station?

a) _____
b) _____
c) _____

Tool 5

CONFIDENTIAL

Courts Data Aggregate Form

Name of Court and Location:

Number of sexual and gender based violence (SGBV) brought between December 1, 2018 to November 30, 2019:

Male ____ Female____ Total_____

In order of frequency, what are the 3 most reported types of SGBV brought before the court

1._____ 2. _____

3. _____

Comment: _____

Services

1. Are the crimes being charged using the provisions of the Violence Against Persons Prohibition Act? If yes, explain briefly in what ways and if not, why.

_____

_____

_____

What other laws apart from the VAPP Act guide your management of cases?

_____

_____

_____

2. What type of reliefs do you provide to victims?
   a) Protective orders ☐
   b) Prosecution of cases ☐
   c) Referral ☐
   d) Court mandated Counselling ☐
   e) Others (please specify) ☐
   f) _____
   g) _____
   h) _____

3. Are there specially trained judicial officers who manage SGBV cases?
   Yes ☐ No ☐ Sometimes ☐

4. If yes, what are their designations

_____

5. Do you have special fast track courts for matters charged under the VAPP as mandated by law
Yes ☐ No ☐ Somewhat ☐
If yes, what is that special court called

_____

If no, or somewhat, why?

_____

6. Are SGBV cases heard in before a limited audience in court? Yes ☐ No ☐ Sometimes ☐
If no, or somewhat, why/
how?_____
7. Do you use a protocol for protective orders? Yes ☐ No ☐ Sometimes ☐
If yes, do judicial officials comply with the protocol? Yes ☐ No ☐ Sometimes ☐

8. Do you refer victims to health facilities? Yes ☐ No ☐ Sometimes ☐

9. Does the court refer victims to social welfare/shelters/ other support services? Yes☐ No☐
Sometimes ☐

If yes, specify the institutions/ support services and referral process/ level of cooperation

_____
_____
_____

10. Does the court accept evidence from private hospitals? Yes ☐ No ☐ Sometimes ☐

If no/sometimes, why

_____

11. What are the problems you encounter while administering justice for victims?

_____

_____

_____

12. What other factors hinder effective services to victims in your court?

a) _____
b) _____
c) _____

Appendix 2: Key informant interviews - questions

Victims/survivors (and caregiver)

1. Did you report the attack to the police? Why?
2. Did you go to the hospital for treatment? Why?
3. Which other agency did you report to?
4. Were you satisfied with the attention you received at these institutions?
5. What was the outcome of your case?
6. What would have made your case better?

Health facilities, Law enforcement, and Government response agencies

1. On average, how many cases do you get in a week/ month?
2. What are the most commonly reported types of cases?
3. What have been your greatest challenges in providing services to victims of SGBV?
4. Can you walk me through what typically happens from the time a client walks in through your doors, or a case is reported to you, to when you consider the case closed.
5. How would you describe your relationship with other response institutions in the FCT?
6. Is there any other information that you think we might find useful?

Civil society organisations

1. What have been your greatest challenges in providing services to victims of SGBV?
2. Can you walk me through what typically happens from the time a client walks in through your doors or a case is reported to you, to when you consider the case closed.
3. How would you describe your relationship with other response institutions in the FCT?
4. Is your organisation a member of the FCT SGBVRT? What role do you play/ how does it function?
5. How do you fund your response activities?
6. Is SGBV the core focus of your organisation?

Courts

1. On average, how many cases are filed in a week/ month?
2. What are the most commonly reported types of cases?
3. On average, how long does it take to conclude cases?
4. Do the judges make orders as prescribed by the VAPP Act?
5. What are the most common challenges the courts face?
6. Is there any other information that you think we might find useful?

Appendix 3: Key informant interviews - respondents

Health institutions

Five interviews were carried out with staff of the following health institutions:

1. Primary Health Centre, Mpape, Area Council – Matron
2. Primary Health Centre, Kubwa, Bwari Area Council – Matron
3. Wuse General Hospital, AMAC – Matron
4. University of Abuja Teaching Hospital Gwagwalada Area Council – Matron
5. Amana Medical Centre, AMAC – Director

Law enforcement

The Officers in Charge at the following four law enforcement agencies were interviewed:

1. Asokoro (DIV) Police HQ
2. Zone A Police Station, Gwagwalada
3. Bwari Division
4. Kuje Police Station

Government response agencies:

Interviews were held with staff from the following three government response institutions:

1. Women Juvenile Welfare Centre - Director
2. Social Welfare Centre, Gwagwalada - Officer receiving complaints
3. Social Welfare Centre, Kuje - Officer receiving complaints

Efforts were made to interview relevant personnel from NAPTIP and the FCT SGBV Response Team but these were not successful.

Civil society organisations:

Staff from the following six CSOs were interviewed:

1. Dorothy Njemanze Foundation - ED
2. WRAPA - Programme Manager
3. Education as a Vaccine - ED
4. SOAR Foundation - ED
5. Stand to End Rape - ED
6. Rape is a Crime - Programme Officer

Courts:

Four key informant interviews were carried out with the Registrars of the two Magistrate and two Sharia courts in Gwagwalada and Kuje Area Councils.

Appendix 4: Methodology workshop participants

Held at the EVA Office, Abuja, 9 December 2019

S/N	Organisation	Project role
1.	Global Rights (ED)	Principal field researcher
2.	GR Consultant	Research assistant
3.	GR Consultant	Research assistant
4.	EVA (ED)	CSO
5.	EVA (Programme Manager)	CSO
6.	WRAPA (Programme Officer)	CSO
7.	CIRDDOC (Programme Officer)	CSO
8.	DRAC (Programme Officer)	CSO
9.	DRAC (Programme Manager)	CSO
10.	NAWOJ (Programme Officer)	CSO
11.	EIDS	Estimated budget component
12.	CC Consulting (ED)	Social advocacy communications
13.	CC Consulting	Social advocacy communications
14.	Techmax (ED)	Website development
15.	DN Foundation (Co-founder)	Social advocacy content development
16.	NIP	Rapporteur
17.	LACVAW	Coordinator
18.	LACVAW	Research co-ordinator
19.	LACVAW	Project officer
20.	LACVAW	Finance officer