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Appraisal of the Relevant Laws, Health Care Policies, and Legal and Institutional Frameworks for the Health Care Support of Intimate Partner Violence Survivors in Nigeria

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ABSTRACT

Intimate Partner Violence (IPV) remains a significant public health and human rights issue in Nigeria, yet the adequacy of existing legal frameworks to support survivors is a critical but underexplored area. This article examines the extent to which Nigerian laws address the healthcare needs of IPV survivors, evaluating both statutory and policy provisions. Through a comprehensive analysis of relevant legislation, including the Violence Against Persons Prohibition Act (VAPP), the Child Rights Act, and various state-specific laws, alongside healthcare policies and protocols, this study assesses the effectiveness and gaps in the legal infrastructure. Findings indicate that while there are progressive laws aimed at preventing and addressing IPV, substantial gaps persist in their implementation, particularly regarding the integration of healthcare support services for survivors. The article highlights the need for a more coordinated approach that aligns legal provisions with healthcare practices, ensuring that IPV survivors receive comprehensive support. Recommendations are provided to strengthen the legal framework and enhance inter-sectoral collaboration to better meet the needs of survivors in Nigeria.

Keywords: Health care Support, IPV, Legal Framework, Survivors

INTRODUCTION

It has been previously established that the ability to identify at-risk individuals and reduce their likelihood of exposure to violence through methods like counselling and referral to suitable options while also attending to their medical needs is the focus of the healthcare provider in efforts to combat the menace of IPV and provide adequate care to IPV survivors. As a result, if the country truly intends to enable the healthcare sector to help IPV survivors in Nigeria, the role of legislation in doing so cannot be ignored due to the importance of their function and the degree of their influence. To achieve this, the system approach as discussed in earlier chapters of this study which is a method aimed at tackling the menace of IPV is key as its role centres on the obligation for HCPs to identify those who are experiencing violence and provide comprehensive health services to them (and their children); facilitate access to supportive services in other sectors that women who are experiencing violence need and want; contribute to preventing the recurrence of violence by: identifying early the women who are experiencing violence and their children, providing appropriate care and referrals, and addressing problems associated with violence such as harmful alcohol and substance use; incorporating messages about human rights violations, harmful health and other consequences related to violence against women, the need for appropriate and timely care, and prevention into health education and health promotion activities with clients and communities; document the magnitude of the problem, its causes and consequences, and advocate for coordinated multisectoral prevention and provision of effective responses[1]. Beyond the aforementioned, the system approach considers payment, health insurance, emergency management systems, and the work of regulatory bodies, as well as the role of the legislation in resolving these. To achieve these roles, the WHO made recommendations for the pathway towards the achievement of the healthcare support of IPV survivors which were stated in the earlier part of this study but for this section, these roles for the healthcare support of IPV survivors are grouped as follows, women(survivor)-centred, identification and taking care of survivors of intimate partner violence, training of

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healthcare providers on intimate partner violence and sexual violence, healthcare policy and provision, mandatory reporting of intimate partner violence vis-à-vis the role of the legislation in resolving these.
In other words, this section appraised the adequacy of relevant laws to ascertain their provision for the healthcare support of IPV survivors using the above-mentioned recommended pathways.

Law and Healthcare Support of IPV Survivors

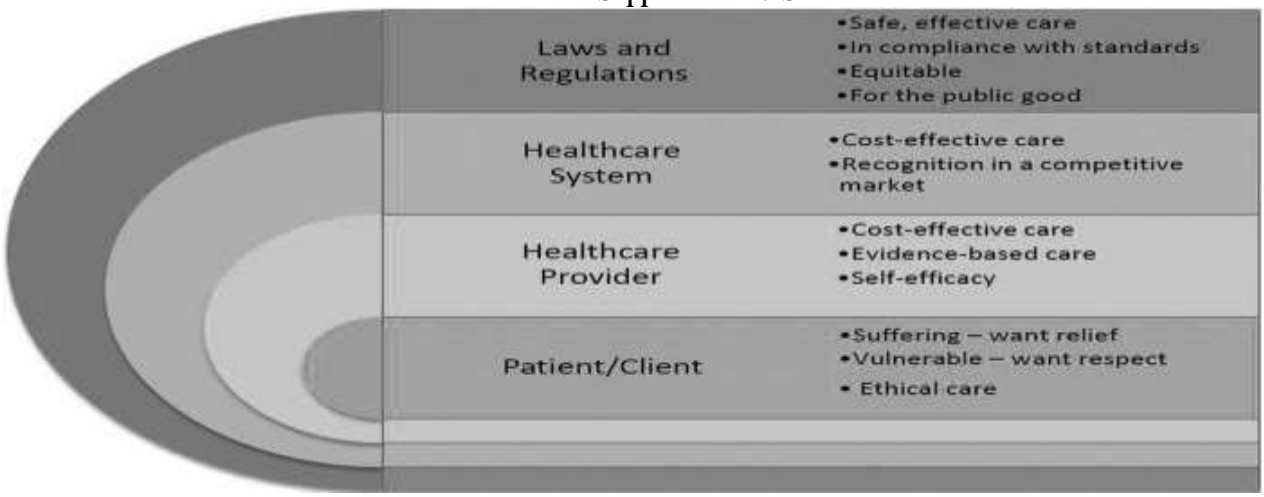

Figure 1: Systems considerations in IPV screening

Within the healthcare delivery system, then, what are the best practices for addressing IPV to provide effective intervention and help prevent further harm? The above diagram highlights the multiple levels to consider when implementing IPV screening and counseling interventions, as providers, the healthcare system, and regulatory goals and constraints need to align with one another and with patients' needs and desires. What is at stake varies at each level for different stakeholders. Implementation of IPV screening and counseling requires an integrated response within a healthcare delivery system with buy-in from clients and health professionals to health system leaders and policymakers. Individuals exposed to IPV may seek care in multiple healthcare settings; each setting needs to have the capacity and motivation to identify, support, and connect patients to services. Such a systems-based approach emphasizes not only health provider education but also policies, protocols, and institutional supports within the healthcare delivery system to facilitate the implementation of routine IPV screening and counseling and connection to advocacy services[2]. Simultaneously, a systems-based approach highlights the need for cross-sector collaboration and community partnerships. Staff and clinicians within the healthcare delivery system can be connected to community and victim advocacy service providers who can support patients exposed to IPV, and those relationships can be incentivized and encouraged. Practice-based evidence and research on systems-based interventions underscore the extent to which integration of IPV assessment into routine care can be accelerated with various tools. Monitoring and tracking improvements for patients and healthcare providers should be part of systems-based practice changes, such that continuous quality improvement and ongoing performance evaluation among staff are expected[3].

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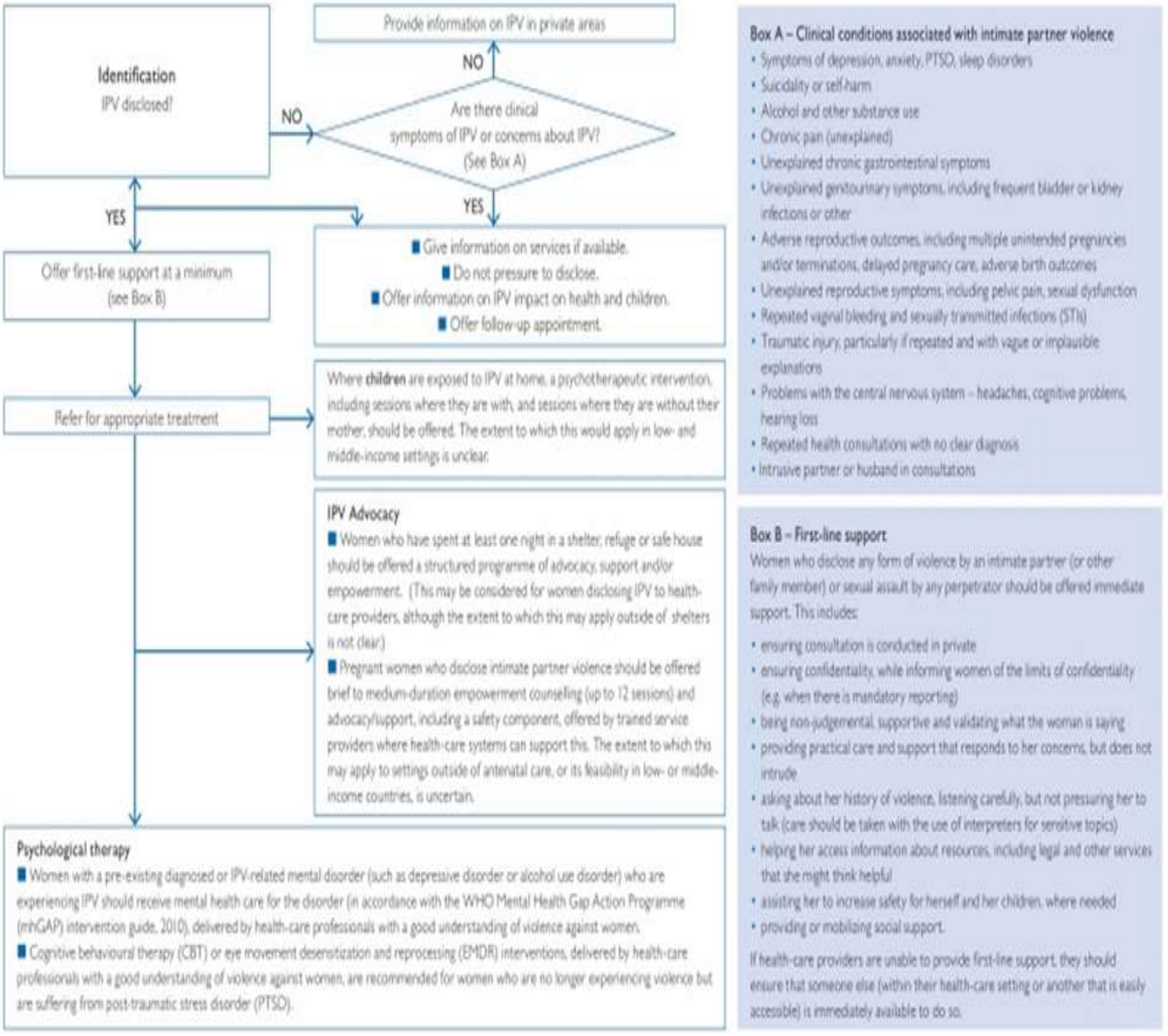

Figure 2: Care pathway for intimate partner violence (IPV = intimate partner violence)

Women(survivor)-centred

The WHO model pathway for women-centered care is summarised in the above diagram.

Research has shown that the statistics of women survivors of IPV are more than that of males. The HB Model of the sociological theory posits that there is a need for lawmakers to have an understanding of people's reluctancy to speak out and receive help, in the African context, women are seen as the keepers of the home and society has made the African woman solely responsible for either the success or failure of the marriage, while the male ego will make it difficult for them to admit being abused by the wives at home for fear of being tagged a weak man. This factor must be borne in mind while making laws to aid the healthcare support of IPV survivors[4]. As stated earlier, women who are survivors of IPV go through not only physical implications but also psychological ones. A typical IPV survivor is a woman who has undergone multi-facet stress and where such reaches out to access healthcare support, stress should not be part of or underlay the support. A situation where the multisectoral

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interventions are cumbersome to access either due to the gruesome procedures or geographical location is not sensitive to the particular needs of the woman. The healthcare multiple responses must acknowledge empowerment, agency, and meeting survivors' practical needs which includes advocacy and better integration within the healthcare setting. A woman may need more than one intervention and a cumbersome procedure and where the location is far from one another will most likely frustrate and discourage the desire to reach out for healthcare support, hence there is a need to reprogram and rearrange the healthcare settings through healthcare legal framework and policy to be able to accommodate women-centered care in creating multisectoral interventions for IPV survivors[5].

Identification and Taking Care of Survivors of Intimate Partner Violence

There must be legislation on how to identify/ screen for IPV survivors. Whether every patient who comes to use the healthcare facilities should be screened for suspected cases? If it is based on suspicion, what are the signs that should raise suspicion? Different signs can raise suspicion of IPV, this also differs from jurisdiction to jurisdiction, hence each jurisdiction needs to be explicit on what would constitute IPV in their jurisdiction so that the HCP would know what exactly to look out for, also it has to be written before it can be a generally accepted concept to avoid confusion and individual perception.in taking care of the identified survivor, VAPPA as adopted by different states defined different forms of IPV but did not state the signs that can indicate IPV. This is necessary because the Sociological theory using the HB Model explained different reasons establishing that IPV survivors in this study may not be willing to reach out for help and therefore, the government must enact laws and guidelines to identify and help them. VAPPA would be the best law to go beyond just definitions of different forms of IPV but also state lists of signs that may suggest the patient is going through abuse[6]. VAPPA and NHA need to create guidelines on the interventions for taking care of the survivors. As discussed earlier, the needs of each survivor differ from one another, while some may require minor treatment of physical injury, some may need long-term continuous treatment, major surgical operations, shelter, therapy, etc. The NHA relying on the provisions of the Maputo Protocol, African Charter, CEDAW, ICESCR, etc coupled with the judicial decisions in Nigeria that have established the right to health in Nigeria has to enjoin all states to implement their duty to provide and ensure that all the facilities needed to take care of the survivors are made available and accessible notwithstanding the geographical location of the survivor and this includes the grassroots[7]. The provision of NHA on manpower must be adhered to, contrary to the NHA 14 working days, maximum industrial strike, there are incessant long-term strike actions, the provision of appropriate distribution of HCPs, provisions of strategies for recruiting and retaining HCPs has been replaced with massive brain drain[8].

Also, the law must protect the expectations of the survivors to ensure that they get relief from their sufferings, that they are respected, and are given ethical care. VAPPA, NHA, and the NHIS need to regulate and make provisions for safe and effective care by providing guidelines for what is the accepted best practice and ensuring it is complied with by the healthcare system, to ensure cost-effective care, the healthcare system must be regulated to ensure that both private and public hospitals give cost-effective care. The legislative plans for the law have the interest of both the survivor and children as indicated in the case of *Anaishaly* Anaishaly was adjudicated neglected and committed to the commissioner's custody on February 24, 2015. Thereafter, the department referred both respondents to various rehabilitative services to facilitate their reunification with Anaishaly. In 2015, the mother completed an intimate partner violence course, substance abuse treatment, and parenting education course. In the said case, both the survivor and her daughter were admitted into different shelters with the daughter taken into the shelter promptly and at different intervals as the need arose. One of the major challenges of an IPV survivor is finding an appropriate emergency shelter while arranging and instituting legal actions against the abuser. And this must be looked into by VAPPA, the CRC has given the state responsibility for the health of the children too, therefore it will be in the best interest of the child and the survivor if every state in Nigeria updates their VAPP and VAW laws to accommodate the provision of shelter, one-stop-shop, and all programs to make integration of the IPV survivors easier, just like the VAPP law, Imo state. This is very important so that when an HCP identifies an IPV survivor he knows where exactly to refer such and the place of referral is prepared to take and attend to the survivor[9].

As observed in this case and many more like it, there was a protection order and emergency protection which can even be obtained by simply calling a responding police officer on the phone. Mrs. A has been having serious issues with her husband and recently he has been issuing threats to take the children away from her, on one of her frequent visits to the healthcare centre for treatment of the injuries she sustained from her husband's attacks, she opened up to the HCP and requested for legal advice and was told she needed to leave the house with her children first to be safe. Then came the problem, where should she go?[10] There have to be concise legal provisions in the VAPP and VAW laws for the safety planning of survivors after they have been identified in the healthcare setting as to where exactly they can go, VAPP and VAW laws of every state in Nigeria need to not only provide for this but create awareness for the entire society. Some needs may require urgent and emergency actions and the law must make clear provisions for this. The NHA included women as one of the vulnerable groups that should be

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qualified for free medical care as beneficiaries of the VGF fund but the NHIS streamlined the category to include only pregnant women, and IPV survivors considering the health implications of IPV on them which makes them use the health care facilities more than those who do not experience should be enough to qualify them to added to the vulnerable person group[11].

Healthcare Policy

Practice and Policy must be Drafted and Implemented for:

i. VAPP and VAW laws just like the Imo state need to provide Integrated health and advocacy service delivery to support identification and interventions, use of electronic health record (EHR) tools, and cross-sector partnerships.
ii. VAPP and VAW laws need to make laws to ensure continuous or periodical staff and clinician training ineffective, client-centred IPV assessment that connects patients to support and services regardless of the disclosure; training can improve knowledge, preparedness, and confidence of HCPs to conduct routine enquiry and support women during the perinatal period, Training can assist HCPs to recognise signs of DV, ask women about what would be helpful to them, and address perceived organisational barriers to routine inquiry. Practice guidelines and clear referral pathways following DV disclosure need to be implemented to support gains made through training[12].
i. The Medical and Dental Practitioners Act, The Nursing and Midwifery (Registration etc.) Act, The National Health Act 2014, and the Pharmacy Act can include training on health care support of IPV survivors in the curriculum as part of the requirements for becoming an HCP in Nigeria. This will reduce the shortage of manpower in the health care settings thereby enabling an HCP to spend more quality time with the IPV survivor. And also, to prepare the healthcare students for healthcare support of IPV survivors[13].
ii. supporting the enhancement of electronic health records (EHRs) to prompt appropriate clinical care for IPV and facilitate capturing more detailed and standardized IPV data;
iii. integrating IPV care into the quality and meaningful use measures. The implementation of Research directions by the NHA which include studies across various health settings and populations, development of quality measures and patient-centered outcomes, and tests of multilevel approaches to improve the uptake and consistent implementation of evidence-informed IPV screening and counseling guidelines

Training of HCPs on IPV and Sexual Violence on Documentation

Osinachi the late popular gospel singer was reported to have died in the hospital after being in a coma for 5 days, she died on the 8th of April 2022 after which there were testimonies of the fact that she was being abused severally by her husband and it was the kick he gave her in the chest that sent her into coma contrary to the claim that she died of throat cancer. the husband was arrested two clear days after her death, on 10th April 2022 at the instance of the late Osinachi's brother. The question is how come the HCPs under whose care she was for 5days did not see any sign of the abuse on her, which treatment were they giving her without investigating the cause of her illness, and if the test revealed the impact on the chest as claimed, how come they were silent for 5days and it was the brother who took action 2days after her death? The problem here is even though Osinachi is dead if the HCPs did not manage their records well, there is every possibility of the husband going scot-free once there is no medical evidence to link him to her death and that will be a gross medico-legal injustice against the late Osinachi, unfortunately, there is no law which would guide them or make it an obligation for them to act in an IPV related case or make them accountable[14].

The state must come up with a legislative mode of documentation of HCP while attending to IPV survivors. This is because the survivor or her legal representative can submit medical documentation as evidence to access a range of protective relief (such as a restraining order). or to support claims of abuse, to be qualified for special status or exemptions in obtaining certain privileges attached to survivors of IPV like public housing, welfare, health and life insurance, victim compensation, and immigration relief and in resolving landlord-tenant disputes[1]. Documentation needs to be well written and strong enough to be admissible in evidence in a law court. Also, medical documentation can corroborate police data where such police reports may vary in quality and completeness. It is more reliable considering the proximity of the time of occurrence and the time of recording the information in the hospital, one can safely conclude that the information given at that time can be relatively correct as the survivor's memory of the event will still be fresh and the possibility of twisting facts with that frame of mind and at that short period is slim[15].

Medical records can contain photographs taken in the course of the examination, record images of injuries which would have faded before trial, a variety of information useful in legal proceedings, Body maps which can document the extent and location of injuries and information about the emotional impact of the abuse among others. Nevertheless, the way the information is recorded can affect its admissibility. For instance, a statement about the

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injury in which the patient is identified as the source of information is more likely to be accepted as evidence in legal proceedings. Even poor handwriting on written records can affect their admissibility. This explains the need for clear and concise legislative provisions for salient issues that surrounds medical documentation some of which are discussed below:

a. Regarding the obligation of the HCP and the expected roles to be played, there must be clear as to whether screening and documentation are an obligation, whether it would attract sanction for default and the precise sanction. In *State v Porter***,** the SANE nurse was a trained specialist who was very clear about her duties, according to her, in seeming domestic violence cases, "It is her job to ensure the safety of all her patients, hence her habit to ensure that they are living in safe environments[16]." She went further to acknowledge that her duty was to "investigate" a victim's injuries related to what they report happened and to "ensure accurate representation of their injuries as it relates to measurements and level of seriousness to enable the patient to pursue a case in court and have appropriate justice." and consequences of careless or non-documentation.
b. Admissibility of such documentation in evidence was tendered by the HCP in court, will they amount to hearsay or corroboration what is the stand of the law on medical treatment or diagnosis hearsay exception? In *State v Burke*[17], a patient who was being treated for a sexual assault made remarks to a sexual assault nurse examiner during a medical and forensic examination. We believe that, in these circumstances, the primary goal of nearly all of the comments were to guide medical care rather than to serve as an out-of-court replacement for trial testimony. As a result, their admission did not violate the Sixth Amendment because the statements were not testimonial. It was held that the trial court did not abuse its discretion in allowing those remarks to the admissibility under the hearsay exception for statements made for medical diagnosis or treatment, but the trial judge erred in accepting one statement describing the assailant, but that the error was harmless. The legislative needs to have a stand on this as not all statements by a victim to a medical professional are admissible under this hearsay exception see State v. Williams[18], and in another case, State v. Perry, Wash a boy met a girl on Snapchat, offered to bring her food, did not enter her house but lured her into the car he brought and raped her in the car, on getting to the hospital she explained her experience to the nurse during the trial, Perry expressed his objection to the testimony of the SANE nurse, on the ground that ER 803(a)(4) was not applicable because the girl's purpose in speaking with the nurse was not for medical treatment. The trial court however determined that although her statements to the nurse were in part to collect evidence, such statements were also necessary for medical treatment. The jury convicted Perry of all charged counts.[19].
c. To what extent can the HCP act on the results of their clinical investigation of the survivor where she was unconscious and later dies? how strong are the interests of the spouse and relative of the survivor on this decision, is their consent compulsory or needed? In *Boermeester v Carry*[20], it was held that prosecution could continue even without the consent of the survivor of the violence. Also, in *State v Porter*[21], the accused was convicted on the testimony of the HCP who attended and documented her investigation on the survivor, despite the non-participation of the survivor in the trial. This would create a big problem in Nigeria considering the Nigerian criminal system which places the onus of proof on the prosecution and the victim of crime is the prosecution witness (PW) and state's witness. There should be a consideration and legal provision in the VAPP and VAW laws for instances where the PW becomes a hostile witness and where the survivor is incapacitated to give consent.

Mandatory Reporting

Mandatory reporting laws in the United States impose a legally enforceable obligation on those who have contact with vulnerable populations to report suspected or verified mistreatment or abuse to state and municipal authorities. While the groups covered by these laws differ by state, they typically include children, the disabled, and the elderly. Abuse between intimate partners is also a reportable offence in some states. Neglect, and physical, sexual, emotional, and financial abuse, are usually covered by these statutes. Childcare providers, pastors, coaches, counsellors, healthcare providers, police enforcement, principals, and teachers are among those required to report, however, the list varies by state. They are also required to report the mistreatment of vulnerable patients. HCPs have an important ethical and legal role in identifying and reporting abuse in children and other vulnerable populations (including intimate partner violence survivors) to their appropriate state agencies[22].

Different jurisdictions have diverse opinions on the mandatory report of suspected or identified intimate partner violence in a healthcare setting. while some believe it should be encouraged some, believe that it conflicts with the confidentiality right of the survivor. The command theory as discussed in the early part of this study is to the extent that the HCP should have an obligation to report abuse with or without the consent of the IPV survivor, VAPP and VAW laws gave third parties including HCPs the power to apply for a protection order for the IPV survivors against the abuser however this power is subject to the written consent of the IPV survivor. PADVL on

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the hand lowers this condition to include where it is obvious that the consent is being withheld because of fear. PADVL provides for mandatory reporting for sexual violation of a child. Anyone who has knowledge of the sexual violation of a child and refuses to report attracts prescribed sanction. Therefore, this study believes that all the states' laws under study do not support mandatory reporting of IPV except PADVL and considering the laws guiding the rights and obligations of doctors and patient relationship, it will be an infringement on the right of a patient to deny care if the HCP should provide intervention for IPV survivor without a corresponding legal covering and guideline for such HCP not to offend the right to deny care of the patient[23].

The Right to Refuse Medical Care

The need to obtain the consent of the patient before any medical treatment and the necessity to respect his right to refuse such medical treatment stems from the fact that in medical parlance, every touching of the patient is potentially a battery on that patient and makes the medical practitioner susceptible to some liability. The classic expression of this principle of autonomy is that of Cardozo J in *Schloendorff v Society of New York Hospital*[24] wherein the learned law lord stated thus: Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who operates without his patient's consent commits an assault, for which he is liable in damages….The opinion of the HCP that the patient is treated is in the best interest of the patient notwithstanding the lack of consent is not a defense for the HCP for infringing on the right to reject care of a patient see *Natanson v Kline*[25], *Sidaway v Board of Governors, Bethlehem Royal Hospital*[26]. In *Bouvia v. Superior Court (Glenchur)*[27], which extended the concept of medical treatment to include nourishment and the right of a woman who rejected the use of a feeding tube despite her malnourishment was upheld. The right to refuse medical treatment is thus constant and does not lie within the competence of the medical practitioner to decide. Once the patient was competent while being presented with the decision and in making the decision which he did, the court should not interfere even though his decision might be considered unwise, foolish, or ridiculous.

In Nigeria, the right of patients to deny care is deeply rooted and recognised by Nigerian laws. The Supreme Court in the case of *Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo*[28] affirmed the rights of patients to reject medical treatment and held that the right of a patient to consent to medical treatment must be respected. Patients' right to refuse care is legally covered by the provisions of the Universal Declaration of Human Rights which is embedded in Chapter IV of the Nigerian Constitution. Section 34 of the Constitution provides that "every individual is entitled to respect for the dignity of his person Section 23 of the National Health Act and that of the Consumer Protection Council (now Federal Competition and Consumer Protection Commission) introduced a patient's bill of rights for the health sector which outlines certain fundamental rights of patients including the rights that amplify patient's rights to decline care, subject to prevailing law and upon full disclosure of the consequences of such a decision as well as the right to relevant information in a language and manner the patient understands, including diagnosis, treatment, other procedures and possible outcomes.

Justification for Judicial Intrusion

However, with the increasing awareness about domestic violence as a healthcare issue, attention has turned to how healthcare providers can best assist their patients through routine assessment, documentation, intervention, and referral. Still, many of the available educational and training resources often emphasize the role of the health care provider as a mandated reporter considering the frequent contact between the duo, and they are often at significant risk for further, more severe injury if there is no intervention[29]. Also, the courts in The Court of Appeal of Nigeria stated as in *Esabunor v Faweya*[30], while citing the Supreme Court of Nigeria decision in *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo*[31] that overriding decisions on medical treatment on religious grounds to be taken on the grounds of public interest or recognised interest of others, such as dependent minor children, are to be taken by the courts. The implication of this is that the right to refuse medical treatment was never absolute. Medical decisions involve several interests including the constitutionally protected right of the individual, the state's interest in public health, safety, and welfare of society; and the interest of the state in maintaining the ethical integrity of the medical profession, this has been seen balanced by the Courts in some scenarios as the case of *Esabunor v Faweya*[32]. The state interests that would constitute the justification for judicial intrusion into the right of a patient to refuse medical treatment include preservation of life, protection of third-party interests, and maintaining the ethical integrity of the medical profession.

Preservation of Life

In most jurisdictions of the world, the primary purpose of government is the preservation of human life. This means that the state has an unambiguous interest in preserving the lives of those who desire to live. In line with this governmental obligation, apart from the assurance of the right to life in section 33, section 14(2)(b) of the Constitution of the Federal Republic of Nigeria[33] provides that the security and welfare of the people shall be the primary purpose of government. This means that the state's interest in preserving the lives of its citizens is commonly considered the most significant. Therefore, while fully recognising the right of a competent adult to refuse medical treatment, the court may, where the need arises i.e where the health and safety of society are under

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threat, make an order overriding the patient's autonomy to decide what happens to his body. In Nigeria, recent observation has shown that spousal homicide has become a regular feature in Nigerian newspapers and social media, and a majority of these murders involve couples or spouses who were legally and traditionally united in marriage as husband and wife.

Protection of Innocent Third Parties

Another instance that justifies judicial intrusion of the state interest is the protection of innocent third parties particularly when minor children are involved. If the court thinks that the refusal of medical care for an adult will bring irreparable damage to the welfare of the child, the court will override the right to refuse medical care of such an adult on the grounds of state interest. In *Holmes v Silver Cross Hosp of Joliet, III.*[34], the court held that while the state's interest in preserving an individual's life was not sufficient, by itself, to outweigh the individual's interest in the exercise of free choice, the resultant effect on minor children would be a factor that might have a critical effect on the outcome of the balancing process. see *Prince v Massachusetts*[35]; in the case of the *Application of the President & Directors of Georgetown College*[36], a court ordered a competent adult (twenty-five-year-old) and the mother of a seven-month-old-child to submit to a medical procedure of blood transfusion against her religious wish on grounds of the state's interest in the protection of innocent third parties, which in that case is the seven-month-old child. In the case of an IPV survivor, since it has been established that they are often at significant risk for further, more severe injury if there is no intervention the interest of the state in overriding the right to decline intervention of such a survivor will be would be on the ground of the state's obligation to preserve the survivor's life, the same way anyone who attempts to commit suicide would be held guilty of committing the crime of attempted suicide. The state is responsible for preserving the lives of her citizens and notwithstanding the right to life, no citizen is allowed the freedom to end their life at will, therefore where it is obvious to the HCP that the life of an IPV patient is at risk, the exercise of the right of such to decline treatment should be equated with attempted suicide and treated as such giving ground for mandatory reporting of such a patient by the HCP[37].

Also, studies have established that continuous exposure to a child has various long-term consequences on such a child, ranging from low social competence and emotional regulation levels which leads to aggressive behaviours, psychological distress; and few empathic skills; it also has long-term effects on the mental and physical health of the children, etc., Also Exposure of children to IPV in low and lower-middle -income countries is widespread; it is therefore recommended that prevention of this major public health exposure should be a priority[38].

Ethical Integrity of the Medical Profession

Another point of the state's interest based on which judicial intrusion may be justified is the maintenance of the ethical integrity of the medical profession. Although some courts may have shown some concern for protecting the interest of the medical profession, this cannot override a patient's right to refuse treatment. The state may have a valid interest in protecting doctors from civil or criminal liability by giving them free hands in the treatment and care of their patients, this has never been a valid ground to justify the judicial intrusion of the constitutional right to self-determination and bodily integrity of the patient to refuse medical treatment. This study however believes that in IPV cases the ethical integrity of the medical profession is under threat with the refusal of an IPV survivor rejecting health care support because every case of domestic violence is a potential murder case and early reporting is critical. She went further to state that everyone needed to become interested in ending domestic violence by reporting abusers so that survivors could be rescued before they were maimed or killed. As one of the institutions most likely to see these survivors, the medical community serves as the first line of detection and intervention· Therefore, the situation where HCPs have contact with IPV survivors, suspects or confirm IPV without reporting for whatever reasons and it leads to the killing of the survivor by the abuser is in the opinion of this paper a threat to the ethics of the medical profession is to save lives and not just look helplessly till lives are lost. The ability of HCPs to identify at-risk persons and limit their likelihood of exposure to violence through counselling and referral to appropriate options is critical for IPV survivors. In Nigeria, out of the 36% of the survivors of IPV, 29% of them suffer injuries. If the health care system in Nigeria provides a supportive environment for survivors to report and get support, there is a possibility of this 29% being supported and leaving about 7% to be identified and supported through other means since the majority would have been attended to and supported while presenting their injury at the hospital[39]. When the HCPs fail or neglect to ask about or document the issue of IPV which most likely led to the health challenge complained of by the IPV survivor, they go back into the abusive situation where they end up dead or killing the perpetrator[29]. These are avoidable deaths that could have been saved by enacting and implementing mandatory reporting laws for IPV by the HCPs.

However, according to the sociologist theory of the HB model, IPV mandatory reporting laws may lead to IPV survivors being more withdrawn due to certain reasons, therefore such reasons must be considered before enacting mandatory reporting laws on IPV and they discussed below:

a. Fear of criminal legal involvement

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b. Fear of child protective services involvement
c. Homelessness
d. Deportation
e. Fear of the Situation Worse
f. warnings by concerned people

This study, therefore, recommends the enacting and implementation of mandatory reporting of IPV, especially by the HCP but subject to the government taking the following steps:

a. Enhance the quality of medical care offered to domestic violence victims
b. Support the safety and autonomy of patients
c. Reduce the risk that patients will refrain from seeking cared
d. Ensure that domestic violence victims receive referrals to free and confidential services
e. Provide clear direction to healthcare providers and law enforcement on reporting requirements

CONCLUSION

From the foregoing, it will be safe to conclude that Nigeria has a lot of lacunas to fill in our legal system where the healthcare support of IPV survivors is concerned. Some of these lacunas include but are not limited to lack of provision for funding, emergency treatment, trained HCPs, awareness, distinct modalities of providing health care support, required facilities, etc. Our laws and policies are grossly inadequate and fall below the standard recommended by the WHO, wherein the WHO recommended that for the healthcare system to effectively support intimate partner violence and gender-based violence survivors, there should be Women(survivor)-centred care; Identification and care for survivors of intimate partner violence; Training of healthcare providers on intimate partner violence and sexual violence; Healthcare policy and provision; Mandatory reporting of intimate partner violence**.** To achieve this pathway in line with the universal basic health standard, there is a need for a legal framework to design and assign roles and responsibilities to all stakeholders, especially the health care providers.

RECOMMENDATION

1. Enhanced sustainable Legal Framework Integration by:

- Developing Comprehensive Legislation that requires the Formulation and implementation of laws that specifically mandate the integration of healthcare services within the legal framework for IPV. This should include provisions for accessible medical care, mental health support, and long-term rehabilitation for survivors.
- Harmonizing all the existing laws: The government should ensure coherence among national and state-level legislation to avoid discrepancies and gaps in the support system for IPV survivors.

2. Strengthening Implementation Mechanisms:

- Allocation of Resources: adequate funding and resources should be allocated to healthcare facilities and support services designated for IPV survivors. These resources are to be distributed equitably across different regions, particularly underserved areas.
- Consistent and continuous Training and Capacity Building: the government should make provision for continuous specialized training for all stakeholders including healthcare professionals, law enforcement officers, and legal practitioners on handling IPV cases and the associated legal and healthcare needs.

3. Improve Coordination Between Sectors:

- Establishing Multi-Sectoral Coordination Bodies: Create and empower multi-sectoral committees or bodies that facilitate collaboration between legal institutions, healthcare providers, and social services. These bodies should be tasked with overseeing and ensuring that survivors receive comprehensive support.
- Promoting and encouraging Community Engagement: community organizations and local stakeholders should be involved in the design and implementation of IPV support programs, while also ensuring that services are culturally sensitive and accessible.

4. Enhancement of Public Awareness and Education:

- Increase Awareness Campaigns: Launch national and local awareness campaigns to educate the public about IPV, available legal protections, and healthcare resources. Focus on reducing stigma and encouraging survivors to seek help.
- Educational Programs: Integrate IPV awareness and prevention education into school curricula and professional training programs to foster a more informed and supportive society.

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5. Monitoring and Evaluating Effectiveness:

- Establish Monitoring Mechanisms: there is a need to develop robust monitoring and evaluation systems to assess the effectiveness of IPV laws and healthcare services based on collated data on the number of survivors accessing services, the quality of care provided, and the legal outcomes.
- Regular Reviews and Updates: Conduct regular reviews of existing laws and healthcare policies to identify shortcomings and areas for improvement. The updates to legal and healthcare frameworks are to be evidence-based and responsive to emerging needs.

By implementing these recommendations, Nigeria can build a more effective and integrated support system for IPV survivors, ensuring that legal provisions are not only comprehensive but also practically accessible and beneficial to those in need.

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