Scholars Journal of Medical Case Reports
Abbreviated Key Title: Sch J Med Case Rep
ISSN 2347-9507 (Print) | ISSN 2347-6559 (Online)
Journal homepage: https://saspublishers.com

OPEN ACCESS

Gynecology and Obstetrics

Sexual and Gender-Based Violence at the << One Stop Center Care Unit >> The Referral Health Centre In Commune V of the District of Bamako, Mali

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DOI: 10.36347/sjmcr.2023.v11i03.004 | **Received:** 16.01.2023 | **Accepted:** 24.02.2023 | **Published:** 04.03.2023

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Abstract **Original Research Article**

Summary: ***Introduction*:** Sexual violence is an all-encompassing term that refers to "any sexual act, attempt to obtain a sexual act, comment or advance of a sexual nature directed against a person's sexuality using coercion" according to the WHO. ***Objective*:** Study sexual violence based on gender at the level of the care unit << One Stop Center >> the Reference Health Center of Commune V of the District of Bamako. ***Materials and Methods*:** This was a descriptive and analytical cross-sectional retrospective study from January 1, 2019 to December 31, 2020. We included in this study, all survivors of sexual violence at least 10 years old admitted to the "One Stop Center" care unit of the Reference Health Center of Commune V of the District of Bamako. ***Results*:** The prevalence of sexual violence was 54.62% in relation to all cases of gender-based violence and 3.36% in relation to all gynaecological emergencies. The age group less than or equal to 19 years accounted for 54.18% of survivors, 69.68% of survivors were single. In 39.95% of the cases the incident took place in the home of the alleged perpetrator of the sexual assault. The survivors had presented a state of fear and panic in 23.92% of cases. Penetration was << penis-vagina >> in 37.1% of survivors. Survivors received psychiatric assistance in 12.87% of cases. ***Conclusion*:** Sexual violence is relatively common in our care unit << One Stop Center >>. They had constituted the majority of cases of gender-based violence. The care was holistic.

Keywords: Violence; Sexual; Based; Gender; << One Stop Center >>.

INTRODUCTION

The phrase "gender-based violence" (GBV) also known as "gender-specific violence" is a generic term describing harmful acts committed against someone's will based on differences due to societal precepts related to gender [1]. According to the United Nations, violence against women is "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 deprivation of liberty, whether occurring in public or private life" [2]. Sexual violence is an all-encompassing term that refers to "any sexual act, attempt to obtain a sexual act, comment or advance of a sexual nature directed against a person's sexuality using coercion" (World Health Organization) [3]. The French Penal Code defines "rape as any act of sexual penetration of any kind whatsoever, committed on the person of another person by violence, coercion or surprise" [4]. This is recognized worldwide as a violation of fundamental human rights. A growing body of research has highlighted the health, intergenerational and demographic consequences of this type of violence (United Nations 2006). Estimates of the prevalence of sexual abuse range from 23.2% in high-income countries and from 24.6% in the Western Pacific region to 37.7% in the South-East Asia region [3]. In the sub-region, more particularly in Dakar (Senegal) a

frequency of 2% was reported [6]. In Mali, according to EDS VI (2018) [7], 33% of women who had experienced sexual or physical violence at any time had been injured. In the last 12 months, this percentage has risen to 41%. According to the same source, among women who have experienced physical or sexual violence, 68 per cent have never sought help and have never told anyone, 12 per cent have never sought help but have told someone about it and only 19 per cent have sought help to end the situation. Despite an imposing regulatory and legislative framework, it must be recognized that the phenomenon is gaining in scale and seriousness. Thus, with the help of technical and financial partners, a unit for the holistic management of gender-based violence (GBV), including sexual violence, was created in June 2017 at the Commune V Reference Health Center and called <<One Stop Center>>, one of whose essential missions is the rehabilitation of women victims of these atrocities. We initiated this work in order to take stock of the holistic care of these women in distress.

MATERIALS AND METHODS

This was a descriptive retrospective study for analytical purposes that took place at the << One Stop Center care unit >> the Reference Health Center of Commune V of the District of Bamako from 1 January 2020 to 31 December 2022. Our study focused on all women, girls and girls received and cared for at the "One Stop Center" unit of the Reference Health Center of Commune V of the District of Bamako. We included in this study all survivors of sexual violence who were at least 10 years old admitted to the One Stop Center care unit during the study period. We excluded in this study, all women, girls and girls victims of other forms of gender-based violence such as: forced marriage, physical violence, verbal violence, psychological violence and all other forms of violence . We conducted a comprehensive sampling of all cases of sexual violence. The sample size corresponded to the number of cases of sexual violence recorded at the unit level of the One Stop Center during the study period. The data collection was based on the documentary analysis of the different recording media of information on survivors., Access to this data from the "One Stop Center " care unit allowed us to have the list of survivors of sexual violence who have used our services. Data were extracted from survivors' medical records and the admission log at the One Stop Center care unit. Data processing and analysis were done using Epi-info7 software. The odds ratio (OR) was calculated and presented with its limits within the 95% confidence interval (95% CI) and the significance level was set at $p<0.05$. Confidentiality and anonymity were respected. The files of the care unit << One Stop Center >> are filed in a safe and secure place and access is only possible with the authorization of the coordinator and this after the acceptance of a formalized request. The variables studied were sex, age, perpetrators, occupation, marital status, type of violence, type of sexual contact, number of accused, place of events, origin, reason for consultation, injuries caused, mode of admission, care.

RESULTS

During the study period we collected 13176 gynecological emergencies including 811 cases of gender-based violence, a frequency of 15%. The number of sexual and gender-based violence was 443, a frequency of 54.62% in relation to all gender-based violence and 3.36% in relation to all gynaecological emergencies. In our series the age group less than or equal to 19 years had represented 54.18%, that of 20 to 34 years had represented 24.6% and that greater than or equal to 35 years 21.22%. The average age of survivors was 28 years ± 4 with extremes of 13 and 57 years. Nulligestes had represented 49.20%, primigestes 28.20%, paucigestes 11.96% and multigestures 10.64%. Nulliparous represented 89.65%, primiparous 18.74%, pauciparous 9.71% and multiparous 12.68%. In our study 36.34% of survivors were students, 23.7% were housekeepers, 7.16% were housewives, 19.64% were saleswomen and 3.16% were civil servants. In our series 69.68% of survivors were single, 25.10% were married, 4.10% were widows and 1.12% were divorced. The survivors were in school in 50.79% of cases and not in school in 41.21% of cases. School survivors had primary education in 50% of cases, secondary level in 38.70% of cases and higher in 11.30% of cases. The survivors were accompanied by a judicial police officer in 70.40% of cases, a relative in 11783%, the boyfriend in 7.67% of cases and by female grouping agent in 4.10% of cases. In our series 49.43% of survivors had a first aid card at admission, 23.92% had a requisition and 26.65% had no documents.

Table I: Distribution of survivors by nature of penetration

Nature of sexual penetration	Actual	Percentage
Penis-vagina	**201**	**37,1**
Penis-anus	17	21,54
Penis-vagina-anus	79	14,54
Penis-mouth-vagina	146	26,82
Total	**443**	**100**

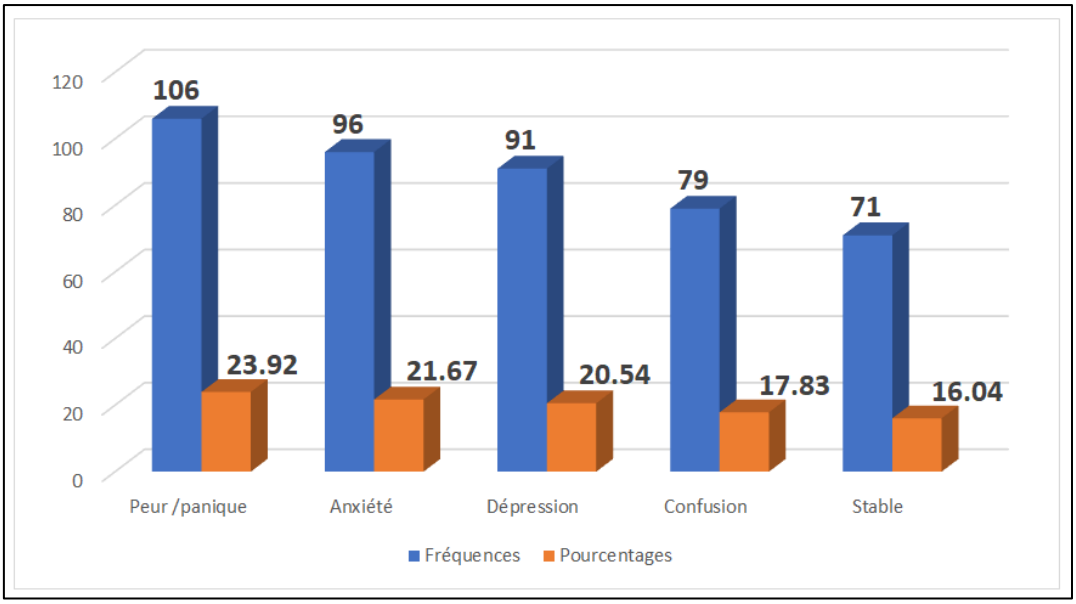

Figure 1: Distribution of survivors by psychological state at admission

Chez 98% of survivors there was penetration with ejaculation against 2% without ejaculation. Survivors had consulted within 72 hours after the assault in 75.85% of cases and in 24.15% after 72 hours. Consultation times ranged from 1 day to 43 days with an average of 11.77 days. In 51.24% the number of accused was 1 and in 48.76% it was greater than or equal to 2 with extremes of 1 to 7 and an average of 2.35. The assault took place in 39.95% at the home of the alleged perpetrator, in 21.90% at the home of the survivor, in 14.22% at school, in 13.09% in a house under construction, in 7.90% in a bus station and in 2.94% at the market. In our series, 9% of survivors had done intimate grooming before the consultation compared to 91% who had not done any toilet. In 47% of cases the perpetrator(s) were known to the survivor versus 53% or the accused(s) were not known to the survivor. The clothes and/or underwear of the survivor were present at the time of the consultation in 26.63% of cases and absent in 73.37%. The assault took place in 49.42% between 1 and 5 a.m., in 41.10% between 7 and 12 a.m. and in 9.48% between 6 and 6 p.m. In our series the alleged perpetrator of the assault had no connection to the survivor in 30.04%, he was a classmate in 19.64%, a family member in 8.80%, a neighborhood neighbor in 7% and ex-husband/boyfriend in 6.09%. The alleged perpetrator of the assault was a pupil/student in 15.28%, a member of the armed or security forces in 4.97%, a shopkeeper in 16.39%, a public transport driver in 10.49% and the occupation of the accused was unknown in 52.87% of cases.

Table II: Distribution of survivors by presence or absence of physical violence

Traces of physical violence	Actual	Percentage
Torn clothes (A)	118	26,63
Scratch lesions (B)	78	17,60
Bruise (C)	61	13,76
A + B	58	13,09
No	**128**	**28,92**
Total	**443**	**100**

In our series 23% of survivors had genito-lesions.

Table III: Distribution of survivors by nature of genital lesions found by survivors by context of the course of events

Nature of lesions	Actual	Percentage
Vaginal tears	47	10 ,60
Recent hymenal tears	39	8,80
Vulvar tears + scrapes	17	3,83
Old hymenal lesions	**340**	**76 ,77**
Total	443	100

In Our series the survivors were assaulted by surprise in 55.98%, by coercion in 23.25% and by violence 20.77%. The accused had used a firearm in 52% of cases, a knife in 25.4% of cases, an iron stick in

22.6% of cases and physical force in 53.33% of cases. Survivors were hospitalized in 13% of cases. Of the hospitalized survivors, 19% were in psychiatry.

Table IV: Distribution of survivors according to the result of the routine assessment carried out a**tthe level of the "One Stop Center" care *unit***

Results of the routine check-up	Positive	Negative
Pregnancy test (n=443)	1(0,23)	(99,77%)
HIV testing (n=443)	1(0,23%)	(99,77%)
ABS Ag (n= 443)	73(1, 6%)	(98,4%)
Syphilis serology (n= 443)	00 (0%)	100

In our series the vaginal swab with susceptibility testing was positive in 4.06% of survivors and negative in 95.94%, cytobacteriological examination with susceptibility testing was positive in 8.35% and negative in 91.65% and sperm testing was positive in 2.48% and negative in 97.52%. A pelvic ultrasound was performed in 25.05% of survivors and objectified pregnancy in 0.23% of cases. Ultrasound was requested in 51.47% of survivors but not performed and it was not requested in 23.47%. Survivors had benefited from the morning-after pill in 17% of cases for pregnancy prevention compared to 83% who did not. In our series 12.42% of survivors had received hemostatic suturing of lesions, 9.25% had a simple antiseptic dressing, 52.82% had antibiotic treatment, 54.62% had antibiotic and anti-inflammatory treatment and 78.33% had no treatment. Survivors received security assistance in 13% of cases, psychiatric assistance in 12.87% of cases, psycho-social assistance in 71.14% of cases and legal assistance in 36.10% of cases.

Table IV: Relationship between age of survivors and time to consultation

Age	Consultation period		p	GOLD	IC
	≤72hours	>72 hours			
	E(%)	E(%)			
≤ 19 years	**235(69,94)**	**5(4,67)**	0,00	**47,40**	**[17,95-136,41]**
20-34 years	56(16,67)	53(49,53)	0,00	0,20	[0,12-0,34]
≥35 years	45(13,39)	49(45,80)	0,00	0,18	[0,11-0,31]
Total	**336(100)**	**107(100)**			

Survivors under 20 years of age were most likely to consult within the first 72 hours after surgery with a statistically significant difference (OR=47.40).

Table V: Relationship between survivors' occupations and time frame

Profession of the survivor	Consultation period		p	GOLD	IC
	≤72hours	>72 hours			
	E (%)	E (%)			
Students	152(51,52)	9(6,00)	0,00	16,6	[7,8-36,3]
Domestic helpers	52(17,63)	53(35,33)	0,00	0,39	[0,24-0,63]
Housewives	40(13,56)	36(24,00)	0,00	0,50	[0,29-0,85]
Vendors	42(14,24)	45(30,00)	0,00	0,39	[0,23-0,64]
Officials	9(3,05)	7(4,67)	0,38	0,64	[0,2-1,96]

The majority of survivors consulted within the first 72 hours were students with a statistically significant difference (OR=16.6).

Table VI: **Relationship between survivors' marital status and time to consultation**

Profession of the survivor	Consultation period		p	GOLD	IC
	≤72hours	>72 hours			
	E(%)	E(%			
Married	58(18,01)	53(43,80)	0,00	0,28	[0,17- 0,46]
Widows	8(2,48)	10(8,26)	0,00	0,28	[0,10-0,80]
Divorced	5(1,55)	0(0,00)	-	-	-
Single	**251(77,95)**	**58(47,93)**	**0,00**	**3,84**	**[2,41 ; 6,13]**

Single survivors were most likely to see in the first 72 hours after being made with a significant difference (OR=3.84).

Table VII: **Relationship between the concept of survivor education and the time frame for consultation**

Concept of instruction	Consultation period		p	GOLD	IC
	≤72hours	>72 hours			
	E(%)	E(%			
Yes	**199(65,03)**	**26(18,98)**	**0,00**	**16,6**	**[7,8-36,3]**
No	107(34,97)	111(81,02)	0,00	0,39	[0,24-0,63]
Total	**306(100)**	**137(100)**			

Being educated increased survivors' chance of seeing them within the first 72 hours of the incident by 7.94 times (OR=7.94).

Table VIII: Relationship between survivors' consultation time and the notion of intimate grooming

Intimate toilet	Consultation period		p	GOLD	IC
	≤72hours	>72 hours			
	E(%)	E(%			
Yes	**193(91,5)**	**143(86,1)**	**0,09**	**1,72**	**[0,86-3,48]**
No	18(8,50)	23(13,9)	0,09	0,5	[0,29 -1,17]
Total	**211(100)**	**166(100)**			

A consultation time greater than 72 hours multiplied by 1.72 the risk of intimate grooming before consulting (OR = 1.72).

Table IX: **Relationship between the number of accused persons and the need for psychiatric assistance**

Need for psychiatric assistance	Number of accused		p	GOLD	IC
	1	≥2			
	E(%)	E(%			
Yes	**7(3,4)**	**50(20,8)**	**0,00**	**7,37**	**[3,12 - 18,27]**
No	196(96,6)	190(79,2)	0,00	0,14	[0,05-0,32]
Total	**203(100)**	**240(100)**			

The need for psychiatric assistance increased 7.37 times if the number of accused was greater than or equal to 2 (OR=7.37).

Table X: Relationship between the number of accused and the presence of genital lesions

Presence of genital-lesions	Number of accused		p	GOLD	IC
	1	≥2			
	E(%)	E(%			
Yes	100(44,05)	127(58,80)	0,001	0,55	[0,37- 0,82]
No	127(55,95)	89(41,20)	0,001	0,81	[0,22-1,69]
Total	**227(100)**	**216(100)**			

There was no statistically significant relationship between the presence of genito-lesions and the number of accused (OR=0.55).

Table XI: Relationship between the occupation of survivors and the number of accused persons

Profession of the survivor	Number of accused		p	GOLD	IC
	1	≥2			
	E(%)	E(%			
Students	65(35,91)	96(51,61)	0,002	0,53	[0,34 - 0,82]
Domestic helpers	45(24,86)	60(32,26)	0,11	0,69	[0,43 - 1,12]
Vendors	**62(34,25)**	**25(13,44)**	**0,000**	**3,36**	**[1,93 -5,85]**
Officials	9(4,97)	5(2,69)	0,25	0,89	[0,57 -1,64]
Total	**181(100)**	**186(100)**			

The profession of saleswoman multiplied by 3.36 the risk of being a victim of several accused

DISCUSSION

During our study, we encountered some difficulties, especially in the literature search. Indeed, we found few authors who worked on the theme with statistical analysis. Therefore, judicial issues are not included in this work. During the study period, sexual violence accounted for 3.36% of gynaecological emergency consultations and 54.62% of all gender-based violence (GBV). Haidara T [8] had found in the same structure a frequency of 0.53% of gender-based violence on all admissions to gynecology. Djelia L in Senegal [9] had reported 10% of rape cases among all GBV. The average age of our survivors was 28 ± 4 years with extremes of 13 and 57 years. In our sample, 50.80% of survivors were educated; 36.34% were students, 69.68% were single, 49.20% were nulligestes and 58.69% were nulliparous. In some series reported in the literature, about 50% of survivors were students [5, 7, 17]. Thiam O in Dakar [6] had found 92.6 % cases of admissions by requisition. In our study, 70.40% of survivors were accompanied by a judicial police officer, 23.92% of whom were provided with a requisition. The majority of survivors who consulted on the same day were students with a statistically significant difference (OR=16.6). Survivors under 20 years of age were the most likely to consult on the same day of the incident with a statistically significant difference (OR=47.40). Single survivors also consulted on the same day with a significant difference (OR=3.84). Being educated increased the chance for survivors to consult on the same day of the incident by 7.94 times (OR=7.94). The profession of saleswoman increased the risk of being a victim of modus operandi sexual violence in groups of several accused by a factor of 3.36 times (OR=3.36). In our series the accused was a classmate in 16% of cases and a family member in 7.18% of cases. In addition, it was a stranger to the survivor in 61.15% of cases. Thiam O [6] reported that in 60.3% of cases , the alleged perpetrator had no connection with the victim; that he was in the family circle in 24.3%, a friend in 14.1% and a spiritual guide in 1.3% of cases. Traoré in Mali [10] and Cissé in Senegal [11] found similar results. In this work that we report, 55.98% of cases of sexual violence took place in a context of surprise, coercion in 2 3.25% of cases and violence in 20.17% of cases. Thus, 26.63% of the survivors had been received with torn clothes. Penetration into the vagina with ejaculation was encountered in 98% of cases. Several African authors had found similar results [6, 12, 13, 14]. We found 76.77% of old hymenal lesions. Recent hymenal tears were found in 8.80% of survivors, vaginal tears in 10.60% of survivors, and vulvar tears with scratches in 3.83% of survivors. Thiam O [6] in Senegal, had found 74.7% of hymenal lesions including 60% old and 25.3% of intact hymens. In France, 60% of victims of sexual violence had recent injuries due to a short consultation time of less than 48 hours [15]. In our series, 75.85% of survivors had consulted within 72 hours , 24.15% of cases had consulted after 72 hours and 90.74% of survivors had already done intimate grooming. In a Senegalese study, the authors reported 46.6% of cases of consultation within 72 hours [6]. In the same study, the authors also report that 70% of minors had consulted within 96 hours [6]. In our study we found no statistically significant relationship between the presence of genital lesions and the number of accused (OR=0.55). We also found that a consultation time greater than 72 hours multiplied by 1.72 the risk of intimate toileting before consulting (OR = 1.72). The determination of urinary βHCG was systematic and allowed us to diagnose a case of pregnancy confirmed by obstetric ultrasound. Routine HIV screening of survivors found a positive case who was put onantiretroviral treatment as a cure. Antiretrovirals had been given to all other survivors for preventive purposes. Thiam O and Cissé in Senegal [6, 11] reported 14.7% and 20% HIV-positive antiretroviral prophylaxis, respectively. Sperm were identified in the vaginal swab in 2.48% of survivors. Thiam O in Senegal [6] had reported one positive sperm test case out of a total of 21 cases. Authors such as Laudata A [15] and Boutin L [16] had reported up to 30% positive sperm search. This difference could be explained by the long consultation time with risk of the realization of the intimate toilet before the consultation, and also and especially the level of performance of the laboratories. The administration of the morning-after pill as part of emergency contraception (Norlevo) to prevent pregnancy was an attitude observed in 83% of survivors. Thiam O [6] in Senegal had reported 15% of victims of sexual assault who had benefited from emergency hormonal contraception based on Pregnon or Norlevo. We used antibiotics in 52.82% of cases. These were mainly beta-lactams, cyclins and imidazoles. Analgesics were used in 54.62% of survivors. Thiam O [6] reported antibiotic therapy in 7.4% of survivors. We performed haemostatic suturing of some bleeding lesions in 12.42% of survivors and simple dressing in 9.25% of survivors. Psychosocial support for survivors of sexual violence remains an essential part of holistic care. Psychological support from a psychologist is essential for survivors after such a tragedy. It is a necessary step in the care for the reconstitution and rehabilitation of survivors. In our work, 7.14% of survivors had received psychosocial assistance. Psychiatric care concerned 12.86% of survivors. We proceeded by listening attentively and showing empathy without judgment, which allowed us to establish an initial psychosocial diagnosis. During this stage of care, we assessed the survivor's needs, developed an action plan that we implemented until the survivor recovered. GANHI Eminka [18] reported no cases of psychological counselling. We have used the psychiatrist especially in cases of sexual violence with group modus operandi. Thus, the need for psychiatric assistance was multiplied by 7.37 if the number of accused was greater than or equal to 2 with an OR = 7.37. Security assistance was provided by the police, who were present at all times. It ensures the safety of survivors in their environment and at the level of the "

One Stop Center" care unit if they were hospitalized. It expedites requisitions and ensures their transmission to the competent judicial authorities. It involved all survivors in this study. This aspect of care remains the most complex and least solicited of all interventions in our context. Only 160 survivors out of 443 survivors had expressed a desire for the option of a judicial resolution. As announced in some studies [19], we believe that this low rate is explained by several elements including fear of reprisals, stigma that could result from judicial exposure, the fact of favoring amicable settlement and the absence of judicial culture in some countries, such as ours.

CONCLUSION

Sexual violence is relatively frequent in our care unit << One Stop Center >> the Reference Health Center of Commune V of the District of Bamako. They had constituted the majority of cases of gender-based violence. Adolescent girls were the most affected. . Care has been holistic in order to rebuild and rehabilitate survivors.

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