'SHE DIDN'T GET JUSTICE': ANALYSING BARRIERS TO POST-RAPE MEDICO-LEGAL SERVICE PROVISION IN KENYA

by

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Abstract

Sexual and gender-based violence (SGBV) is a significant public health issue that affects millions of people around the world, especially women and girls. SGBV can have significant physical, mental, and social impacts, and victim/survivors rely on medico-legal professionals to provide medical care and pursue justice. Even though medico-legal services are essential for the wellbeing of victims, research indicates that service provision is lacking worldwide, but especially in East Africa, a region with higher-than-average rates of SGBV and significant resource constraints.

In this thesis I aim to explore the barriers faced both by rape survivors in accessing medico-legal services and medico-legal professionals in providing these services in urban and rural settings in Kenya. Further, I examine the lived experiences of my participants during the COVID-19 pandemic as well as during times of normalcy, while also situating the findings within a larger East-African context.

To begin my research and familiarise myself with medico-legal service provision in the East African context, I undertook a scoping literature review of 54 papers to synthesise the existing models of service provision in the region surrounding Kenya. I then conducted a prospective cross-sectional study on 541 case records held by the Wangu Kanja Foundation to evaluate patterns of violence in Kenya during the COVID-19 pandemic, research that was not in the original design of my PhD, but which emerged as a result of the ongoing worldwide pandemic. Following this study, I conducted a secondary data analysis on case records of 514 survivors engaged with the Wangu Kanja Foundation to evaluate patterns that might predict how far a victim moves through the case referral pathway in Kenya. Finally, I worked closely with my partner organisation to conduct my qualitative research.

The Wangu Kanja Foundation (WKF), which is based in Nairobi, Kenya, was a critical partner for this work, providing links to survivors on the ground, a library of data on

previous violence in Kenya, and networking opportunities that were crucial when interviewing medico-legal service providers for this work. Due to the COVID-19 pandemic, I had to significantly postpone my fieldwork and the plan for this research was altered to accommodate travel restrictions. I conducted online interviews with medico-legal service providers between January and October 2021 with five medical professionals and six legal professionals. During this time, two in-person focus group discussions were also conducted by members of the WKF using interview guides I designed and based on an online training I conducted with Kenyan facilitators to ensure that the focus group discussions were moderated appropriately. One focus group discussion had eight participants, and the other had nine. In April 2022 I was able to travel to three cities in Kenya, where I conducted three focus group discussions with survivors with the help of UK and Kenyan-based researchers, and a further 10 semi-structured interviews with professionals, five medical and five legal. Each focus group I conducted in person had ten participants. In exploring the potential reasons behind the challenges encountered by both providers and survivors attempting to access medico-legal services, I identified shared barriers, including financial constraints, insufficient understanding of correct procedures, sociocultural prejudices, and ineffective implementation of policies and guidelines.

Results indicated that barriers to post-rape medico-legal service provision were prominent, and that there was a sense of resignation amongst survivors concerning how their cases would (or would not) move through the case referral pathway. In my scoping review (Chapter 2), I found a dearth of literature on sexual violence policies in East Africa and highlighted a disproportionate focus on Kenya compared to the other countries in the region. In a prospective cross-sectional study (Chapter 3), I identified new patterns of violence that emerged during COVID-19, which have implications for safeguarding in case of future humanitarian crises, including the need for plans to protect children when guardians are

absent and schools are closed. My secondary data analysis (Chapter 4) revealed that certain case characteristics, such as the age of the survivor and the presence of forensic evidence, helped cases progress through each stage of the care-seeking process, yet ultimately very few cases advanced through to the sentencing phase. In the qualitative research presented in Chapters 5 and 6, I conducted an in-depth analysis of the lived experiences of survivors in accessing care, as well as the experiences of professionals in providing care. The research on providers appears before the research on survivors in this thesis to ensure that the survivors have the final say on this topic.

The findings revealed a consensus among both providers and survivors that financial barriers constitute the primary impediment, followed by the need for formal training for providers in caring for survivors. Notably, provider bias (i.e., disbelieving a victim's rape story because of her physical appearance) remains a significant issue, despite the implementation of interventions in Kenya several years prior to the commencement of my research. My thesis findings have implications for future research, policy, and practice, and provide evidence for how the Kenyan government and international non-governmental organisations (NGOs) can better respond to the needs of both the victims and the practitioners delivering post-sexual violence medico-legal services.

For Oma

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First, I must thank the sexual violence survivors who were so willing to participate in this research. I hope I did your stories justice, and I vow to continue using my position to lift your voices in any way possible. Second, I am eternally indebted to Wangu Kanja and the Wangu Kanja Foundation, who provided me with support and connections when I was not allowed to travel to Kenya, and whose knowledge and expertise helped keep all survivors safe while taking part in this research.

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Authorship Statement

The research presented in this thesis was undertaken by the author (SR) with guidance and support from supervisors Professor Heather Flowe (HF) and Professor Caroline Bradbury-Jones (CBJ).

This thesis contains primary and secondary data analysis of victim and provider data from Kenya (Chapters 3-6), which was collected for a project initially titled "Telling their stories: Sexual violence survivors' experience of reporting rape to first responders in Kenya." This research project was conceived by HF and Wangu Kanja (WK), with input from CBJ.

Specific contributions to each chapter are detailed below:

Chapter 1: Introduction → SR drafted the chapter, HF and CBJ reviewed and provided feedback for content and clarity.

Chapter 2: Scoping Review → The initial protocol, geographical area, and inclusion and exclusion criteria were developed by SR, with feedback from HF, and CBJ. SR refined the protocol and selection criteria, chose the databases, and developed a search strategy with input from HF and CBJ. SR drafted the chapter, and HF and CBJ reviewed and edited the chapter for publication.

Chapter 3: Prospective Cross-Sectional Study → SR, HF, James Rockey (JR), and Laura Stevens (LS) evaluated and cleaned the data for inclusion in this paper. SR drafted the manuscript, with input from LS and JR. All authors (SR, LS, JR, LS, JR, MC, WK, JC, DN, CK, and HF) reviewed and edited the chapter for content and clarity.

Chapter 4: Secondary Data Analysis → SR undertook the data analysis, with support from JR, LS, and HF. SR drafted the manuscript, which was then reviewed and edited for content and clarity by all authors (SR, JR, LS, MC, WK, HF).

Chapters 5 and 6: Qualitative victim and provider chapters → SR designed the interview protocol and guides with input from HF and CBJ. The interview guides were then shared with the WKF and edited iteratively until both teams were satisfied. SR collected data with assistance from LS, LF, and two gender defenders from the WKF. SR undertook the data analysis and coding. SR drafted both chapters, which were then reviewed and edited for content and clarity by HF and CBJ.

Chapter 7: Discussion and Conclusion → SR drafted the chapter, HF and CBJ reviewed and edited the chapter for content and clarity.

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Thesis Format

This thesis is presented in compliance with the University of Birmingham's Alternative Thesis Guidelines, which allows students to submit material as a part of their thesis that has already been published. Three chapters in this thesis have already been published in peer-reviewed journals (Chapters 2-4). These publications are as follows:

1. **Rockowitz, S.,** Flowe, H., & Bradbury-Jones, C. (2022). A Scoping Review on Sexual and Gender- Based Violence Medicolegal Service Provision in East Africa. *Trauma, Violence, & Abuse*, 15248380221134292. https://doi.org/10.1177/15248380221134292

2. **Rockowitz, S.**, Stevens, L. M., Rockey, J. C., Smith, L. L., Ritchie, J., Colloff, M. F., Kanja, W., Cotton, J., Njoroge, D., Kamau, C., & Flowe, H. D. (2021). Patterns of sexual violence against adults and children during the COVID-19 pandemic in Kenya: a prospective cross-sectional study. BMJ Open, 11(9), e048636. https://doi.org/10.1136/bmjopen-2021-04863

3. **Rockowitz, S.**, Rockey, J., Stevens, L. M., Colloff, M. F., Kanja, W., & Flowe, H. D. (2023). Evaluating Case Attrition along the Medico-Legal Case Referral Pathway for Sexual and Domestic Violence Survivors in Kenya: A Secondary Data Analysis. Victims & Offenders, 1-24. https://doi.org/10.1080/15564886.2023.2214

As per the Alternative Thesis Guidelines, the publications have not been included in the pagination of this thesis. Additionally, the references, tables, figures, and, in the case of Chapter 4, the appendices, are all self-contained within each chapter. Furthermore, due to the nature of the inclusion of published chapters there is some duplication, as each chapter provides background information that may overlap with other sections of this thesis.

List of Abbreviations and Acronyms

BMJ	British Medical Journal
DHS	Demographic and Health Survey
DV	Domestic Violence
FGM	Female Genital Mutilation
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
LMIC	Low and Middle-Income Country
NGO	Non-Governmental Organisation
OSC	One-Stop Centre
PRC	Post-Rape Care
PTSD	Post-Traumatic Stress Disorder
SGBV	Sexual and Gender-Based Violence
SHEPS	Sexual Health Education for Professionals Scale
STI	Sexually Transmitted Infection
SV	Sexual Violence
UNHCR	United Nations High Commissioner for Refugees
USAID	United States Agency for International Development
VAW	Violence Against Women
WHO	World Health Organisation
WKF	Wangu Kanja Foundation

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Chapter 1. Introduction

In this thesis, I present a comprehensive critique of the state of the literature on SGBV in Kenya, my findings from the novel research that I undertook on the obstacles encountered by victims of sexual violence in accessing care in Kenya, and the challenges faced by the medico-legal service professionals who provide this care. In this introductory chapter, I provide pertinent background information on the prevalence of sexual and gender-based violence (SGBV) in Kenya, situating it globally, and set out the aims, objectives, and rationale underpinning my research.

1.1 Definitions of types of violence

While conducting my research, I observed that various types of violence were often defined and categorised differently across the literature. This variation in terminology makes it challenging to determine the prevalence of specific types of SGBV, as what one organisation might classify as 'domestic violence', another might label as 'intimate partner violence', and so forth. To this end, it was important for me to explore the varying definitions of violence that are used in this thesis, and to explore how these terms are used in Kenya. I provide an overview of SGBV-related definitions in the following sections.

1.1.1 *Sexual and gender-based violence*

The overarching term used to describe all other forms of violence in this thesis is sexual and gender-based violence (SGBV), which is defined as ‘any harmful act of sexual, physical, psychological, mental, and emotional abuse that is perpetrated against a person’s will and that is based on socially ascribed (i.e., gender) differences between males and females’ (United Nations Office for the Coordination of Humanitarian Affairs, 2019). Other definitions of SGBV encompass violence arising from 'unequal power relationships,' describe it as 'a

weapon employed in wars and during periods of unrest and conflict,' and characterise it as being 'perpetrated, frequently in private settings, in every country globally during times of peace' (International Federation for Human Rights, 2020; United Nations High Commissioner for Refugees Israel, 2022). SGBV is often used as an umbrella term to encompass other forms of violence and is frequently used in reference to violence committed during humanitarian crises.

1.1.2 *Sexual violence*

Sexual violence (SV) is a type of violence that is often included in SGBV statistics, and is defined as:

‘any sexual act, attempt to obtain a sexual act, or other act directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object’ (World Health Organization, 2022b).

Interestingly, when reading about the definition of sexual violence from other resources, such as those affiliated with the United Nations, the top definitions that appear list sexual violence either in reference to sexual violence experienced during childhood or during times of conflict (United Nations [UN], 2022a; United Nations Peacekeeping). This indicates a lack of comprehensive sexual violence data on adults during peacetime, which is where much sexual violence around the world occurs.

1.1.3 *Intimate partner violence and domestic violence*

Intimate partner violence (IPV) refers to ‘behaviour within an intimate relationship that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours’ and applies to violence by ‘both current and former spouses or partners’ (World Health Organization, 2022a). It is also

defined as ‘abuse or aggression that occurs in a romantic relationship,’ including physical violence, sexual violence, stalking, and psychological aggression (Centers for Disease Control and Prevention, 2022). Domestic violence (DV) is often used interchangeably with IPV and is defined as ‘a pattern of behaviour in any relationship that is used to gain or maintain power and control over an intimate partner,’ including ‘physical, sexual, emotional, economic, or psychological actions or threats of actions’ (United Nations, 2022b).

1.1.4 *Victim versus survivor*

In scholarly discourse concerning individuals who have endured sexual violence, two terminologies frequently emerge: 'victim' and 'survivor'. Each term carries its own connotations and implications, and there are cogent arguments supporting the use of either (Hockett & Saucier, 2015; Pollino, 2021; Schwark & Bohner, 2019). My preference leans towards the term 'victim' because it does not place any pressure on the woman (or man) who was sexually violated to recover in a certain manner or within a certain time. According to Merriam-Webster, 'victim' is defined as 'one that is subjected to oppression, hardship, or mistreatment' or 'one that is acted on and usually adversely affected by a force or agent' ("Victim," 2022). This definition aptly characterises the experience of individuals who have been subjected to sexual violence, as they have undeniably endured mistreatment and adverse effects.

On the other hand, 'survivor' is defined as ‘to continue to function or prosper despite: withstand’ ("Survivor," 2022). While it is commendable that some individuals manage to rebuild their lives post-trauma, the term 'survivor' may inadvertently impose an expectation of resilience and recovery. This can be problematic as it may not encompass the diversity of experiences and outcomes among those affected by sexual violence. Some individuals may find it challenging to regain a sense of normalcy and labeling them as 'survivors' could

inadvertently create an undue burden or expectation. Moreover, it is imperative to critically examine societal perceptions regarding victimhood (Schwark & Bohner, 2019). There appears to be a prevailing notion that being labeled a 'victim' is inherently negative. However, it is crucial to recognise that sexual violence is an act inflicted upon an individual, rather than a consequence of their actions. The term 'victim' accurately reflects the involuntary nature of their experience. Thus, ultimately both 'victim' and 'survivor' have their merits, and the choice of words should respect the experiences and preferences of those who have endured sexual violence and should be used in a manner that is both accurate and devoid of judgement.

1.2 Consequences of violence

SGBV can lead to a multitude of consequences, including health problems, social and behavioural issues, and cognitive problems (García-Moreno et al., 2015; Gevers & Dartnall, 2014). For instance, health consequences of sexual violence can include mental and neurological disorders, health risk behaviours, and communicable diseases, and may also lead to subsequent perpetration of violence (World Health Organization, 2022b). Additionally, experiencing sexual violence may lead to feelings of guilt, fear, distrust, or isolation, and eventually PTSD which can include symptoms such as depression, flashbacks, and suicidal thoughts (The Survivors Trust, 2022). Consequences of IPV are similar to those of SV, and also include poor daily functioning, pregnancy termination, poor general health, subsequent violence victimisation, and attachment problems (World Health Organization, 2022a).

Equally significant as the consequences of violence are the potential repercussions of reporting such violence to the authorities. These repercussions, which I examine in greater depth later in the thesis, include social isolation, financial insecurity, and stigmatisation (Rockowitz et al., 2022).

1.3 Violence rates around the world and in Kenya

One of the difficulties associated with the varying definitions of types of violence is the lack of unambiguous prevalence data, which is further exacerbated by resource restrictions that may prevent countries from gathering accurate data regardless of which definitions they are using. The WHO notes that there is a lifetime prevalence of sexual violence of 27% in the African region, 11% in the region of the Americas, 12% in the Eastern Mediterranean region, 12% in the European region, 19% in the South-East Asia region, and 6% in the Western Pacific region, and while it does not specify whether these statistics are specifically referring to sexual violence against women or just in general, it does note that the global lifetime prevalence of sexual violence perpetrated by a non-partner is 6% (World Health Organization, 2022b).

The rates for intimate partner violence are notably higher, with studies showing a 35% lifetime prevalence of physical IPV in the African region, 30% in the region of the Americas and the Eastern Mediterranean region, 25% in the European region, 31% in South-East Asia, and 18% in the Western pacific (World Health Organization, 2022a). Sexual IPV rates are lower, with prevalence being 27%, 15%, 12%, 15%, 22%, and 8%, accordingly (World Health Organization, 2022a).

Regardless of the type of violence, the African region often has some of the highest rates around the world (World Health Organization, 2021). When looking at violence against women (VAW) in general, the African region has a 33% prevalence while Europe and other high-income countries have a prevalence of 22% (World Health Organization, 2021). Possible reasons for higher rates of VAW in low- and middle-income countries (LMICs) include the frequent occurrence of sexual violence during times of conflict, which frequently occur in LMICs; patriarchal societies that are reinforced by discriminatory laws that undermine women; and female economic inequality (Heise et al., 1994; Jahan, 2018).

In analysing violence data specific to Kenya, the official data source I used was the Demographic and Health Survey from 2014. There were a few notable problems with how the data was collected, namely that not all types of violence were included in the questionnaire, thus leading to a potential underestimation of the prevalence of violence. Regardless, the DHS found that 45% of women aged 15-49 had experienced physical violence at least once since age 15, most often perpetrated by a husband, and 39% of ever-married women aged 15-49 had experienced either physical or sexual IPV (Ministry of Health Kenya et al., 2015). For sexual violence alone, 14% of women aged 15-49 in Kenya had ever experienced it, while 8% had experienced SV in the 12 months prior to the survey administration (Ministry of Health Kenya et al., 2015). I explore patterns of violence in Kenya during COVID-19 in Chapter 3.

1.4 Medico-legal systems and SGBV

Due to SGBV's previously mentioned potential physical and mental consequences, it is important that victim/survivors can access healthcare services. Health service responses may include psychosocial support, referral to other specialists within health systems, and general medical treatment (Sikder et al., 2021). Additionally, sexually transmitted infections (STIs), HIV/AIDS, and pregnancy all may result from an instance of sexual violence, which all require specialised and varied treatment, often long-term (Dhakal et al., 2014; Dunkle et al., 2004).

When evaluating health service responses to SGBV, it may be helpful to evaluate the health system in general, as it is often a conglomerate of various providers, resources, and regulations that must work together to respond to the consequences of violence (Colombini et al., 2022). Health systems for women facing the effects of violence are tasked with providing supportive care, which includes preventing the recurrence of violence, addressing associated

problems, and mitigating the consequences of said violence (García-Moreno et al., 2015). Health systems may also be tasked with preventing violence, documenting violence to identify patterns, and liaising with other sectors to enforce change (García-Moreno et al., 2015).

A major part of health systems is the providers, who are the point of contact between victims and the health system. Although providers' roles are significant in the identification of violence, response to disclosure, and provision of clinical care through to referral to other providers, in many countries, especially on the African continent, doctors, nurses, and other medical professionals receive no routine training on the provision of sexual violence services and consequently feel ill-prepared to offer care to victim/survivors (García-Moreno et al., 2015; Keesbury & Thompson, 2010). Furthermore, where health system protocols do exist to address SGBV, there is often a lack of uniform health policy and clinical guidance to address other forms of violence, such as economic or emotional violence (Sikder et al., 2021).

Regardless of training, a service provider will be unable to adequately help their patients without the proper infrastructure or materials. Some examples of larger infrastructure that may be needed to treat the problems associated with SGBV include furniture (for exams), private rooms or screens to create privacy, and areas for patients to wait to be seen (Sikder et al., 2021). Additionally, informational materials, medical instruments (i.e., speculums and swabs), lab testing supplies (i.e., swabs, test tubes, HIV test kits) and medicine are all needed for proper treatment of the consequences of SGBV (Ajema et al., 2009; Keesbury & Thompson, 2010; Sikder et al., 2021). Around the world, these materials are often in short supply (Keesbury & Thompson, 2010; Sikder et al., 2021).

The health system's significance, besides the treatment of the victim, is that it contributes to medico-legal documentation of violence, which can be used when prosecuting a perpetrator. Many countries have procedures that necessitate the provision of medical

evidence of an act of violence before the case can move through to the legal system, yet providers are often not trained in proper documentation techniques or the materials needed by the legal system are simply not available (Ajema et al., 2009; Keesbury & Thompson, 2010; Kilonzo et al., 2008; N. Kilonzo et al., 2009). Forms required by the police may include information about forensic evidence, such as genital and non-genital injuries, the presence of fluids, or the presence of pubic hair, but, as mentioned above, limited medical supplies make this evidence difficult to gather even if the providers are trained properly.

1.5 Global and national initiatives regarding medico-legal service provision

1.5.1 *Global human rights treaties and initiatives*

There are a number of international rights agreements that have been signed in recent decades with specific reference to violence against women. Perhaps the most influential of these agreements is the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which was adopted by the United Nations in 1979 and an optional protocol to which was adopted in 1999 (Office of the United Nations High Commissioner for Human Rights; Bott, Morrison, & Ellsberg, 2005). As of 2016, 189 countries around the world had ratified CEDAW (UN Women, 2016). This convention focuses on SGBV-related issues such as sex trafficking, sexual violence as a tactic of war, and forced marriage, while also including articles about health care and equality before the law (UN Women, 2016). While there are examples around the world of court rulings and legal reforms that were implemented with explicit reference to CEDAW, for example Ukraine amending their national legislation to include revisions on the definition of rape and Vietnam ideintifying human and financial resources to be used to implement measures to ensure gender equality, it must also be noted that many countries who have signed or ratified CEDAW have failed to enforce their laws or bring their legislation into compliance with the Convention (Bott,

Morrison, & Ellsberg, 2005; McPhedran et al., 2000, UN Women, 2019).

Another prominent initiative in the field is the Murad Code, which is a global voluntary code of conduct which aims to build and support better practice surrounding survivors of systematic and conflict sexual violence (2023). This code came from a United Kingdom-based initiative that worked with Nadia Murad and the Institute for International Criminal Investigations (IICI) to create a code which would uphold international standards for crime recording with a focus on survivor-centred care (Foreign & Commonwealth Office, 2020). The Code was deisgned to be applied by human rights investigators, activists, criminal investigators, journalists, researchers, and more, and applies to both the direct and indirect gathering of information either from or about sexual violence survivors in any form (2023). The overarching principles of the code are to understand that survivors are individuals, to respect survivor control and autonomy, to be responsible and have integrity, and to be sure that the work adds value or else it should not be done (2023). Because the Code is relatively new (it was finalised in 2022), it is difficult to tell what, if any, affects it has had on new research or work concerning sexual violence victims.

A third, yet no less important, global human rights instrument that relates to SGBV is the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, otherwise known as the Maputo Protocol (2003). The Maputo Protocol extensively details human rights for women, including those in the civil, political, economic, and sociocultral spheres (2003). It notes, for example, that states must protoect asylum seeking women against all forms of violence, including rape, that victims of harmful practices should be provided adequate health and legal support, and that medical abortionds should be authorised in the case of sexual assault or incest, or where the heath of the mother or foetus is at risk (2003). As with CEDAW, the Maputo Protocol has yielded mixed results. A positive consequence of the Maputo Protocol is that many countries in Africa have removed user fees

for maternal health services at health facilities owned by the government, which has in turn increased access to maternal health care and reduced maternal deaths (McKinnon et al., 2015). Additionally, a case involving the rape of a 13-year-old girl in Ethiopia that initially resulted in the perpetrator and his accomplices being released from prison because of the 'marry your rapist' law was eventually overturned after the African Commission on Human and Peoples' Rights found that the girl's rights to liberty, life, and security were being violated under the Maputo Protocol (Equality Now, 2021). Finally, and most importantly for my research, the Maputo Protocol was used in a 2020 case that found the Government of Kenya liable for failing to investigate and prosecute cases of SGBV that occurred during the eruption of post-election violence in 2007 (Equality Now, 2021). The High Court of Kenya found that the government had violated multiple human rights instruments, including the Maputo Protocol, and the government ultimately had to comepnsate some of the survivors who had brought their cases to court (Equality Now, 2021).

1.5.2 *Non-governmental organisation guidelines*

In a less official yet no less important place are guidelines from international non-governmental organisations, such as the World Health Organization and the United Nations. While these guidelines have no regulatory or legal power, they provide empirical evidence and clear steps for how countries should adapt their medical and legal systems to care for the needs of SGBV survivors. One such example is the WHO's 'Guidelines for medico-legal care for victims of sexual violence,' which was created in 2003 to address the gap between the health and legal service needs of sexual violence victim/survivors with the existing level of health and legal services provided (WHO, 2003). These guidelines aim to provide health care workers with the necessary knowledge and skills for them to manage cases with victims of sexual violence, standards for health and forensic service provision for victims of sexual

violence, and guidance on establishing new health and forensic services for victims of sexual violence (WHO, 2003). The guidelines provide clear definitions on types of violence, provide step-by-step instructions on collecting forensic specimens, and offer many more useful instructions and bits of information. Coupled with this resource is a more recent publication from the WHO, 'Stregthening the medico-legal response to sexual violence' (2015). This publication is a toolkit focused at addressing key knowledge gaps amongst practitioners within and between sectors, while also supporting service provision and coordination in settings with limited resources (WHO, 2015). It offers information on a variety of topics, including elements of the initial investigation of an allegation of sexual assault, managing health issues that result from sexual assault, and how to collect and manage medico-legal evidence in sexual violence cases (WHO, 2015). The WHO, United Nations Population Fund (UNFPA), and United Nations High Commissioner for Refugees (UNHCR) also have a joint publication entitled 'Clinical management of rape and intimate partner violence survivors: Developing protocols for use in humanitarian settings' (WHO, UNFPA, & UNHCR, 2020). These guidelines offer much of the same resources as the previous two, with a more specific focus on humanitarian emergencies rather than everyday instances of SGBV.

The United Nations has similar resources, such as 'The handbook for United Nations field missions on preventing and responding to conflict-related sexual violence' (2020). As with the previous resource, this handbook focuses specifically on sexual violence during times of conflict, and is intended to be used as a practical guide to support the implementation of the conflict-related sexual violence mandate by the UN. Within the handbook are definitions of key concepts related to conflict-related sexual violence, explanations of what the responsibilities are of civilians, members of the military, and police in these situations, and guidelines on reorting on conflict-related sexual vioence, among other topics (United Nations, 2020).

1.5.3 *Local policies*

The main policies that pertain to sexual violence in Kenya are in the Sexual Offences Act, which was first instituted in 2006 but revised in 2012 (National Council for Law Reporting, 2012). This Act was Kenya's first law that sought to comprehensively tackle sexual violence throughout the country by instituting sentences for crimes of a sexual nature that had not existed in previous legislation (Centre for Rights Education and Awareness, Cradle-The Children Foundation, Association of Media Women in Kenya, & The Education Centre for Democracy in Women, n.d.). These sentences include life imprisonment for defilement of a child less than 11 years old, 20 years imprisonment for a child 12-15 years old, 15 years imprisonment for a child 16-18, and a minimum sentence of ten years for anyone taking part in early child marriages or FGM, among others (CREAW, Cradle-The Children Foundation, AMWIK, & ECWD, n.d.). The Act also stipulates that victims of sexual offences should be able to access treatment in any public hospital or institution and that DNA tests can be ordered to match specimens collected during the gathering of forensic evidence (National Council for Law Reporting, 2012). As will become evident later in this thesis, these policies are not being enforced properly.

1.6 Justification for research

1.6.1 *Focus on barriers to care in Kenya*

There is an extensive body of literature pointing to the high rates of sexual and gender-based violence in Kenya (*Defining Gender Based Violence*, 2020; Nduku Kilonzo et al., 2009; Maternowska et al., 2009; Ministry of Health Kenya et al., 2015). Additionally, there is extensive research noting that post-SGBV medical and legal services for victim/survivors are limited (Ajema et al., 2009; Temmerman et al., 2018; Temmerman et al., 2009). Despite this,

there is limited research on the actual day-to-day barriers being faced both by victim/survivors in accessing care and by medico-legal professionals in providing care. The studies that have been conducted on specific interventions to increase post-SGBV service provision, such as by the implementation of a one-stop centre (OSC), focus on barriers faced regarding a specific programme being implemented rather than by everyday survivors attempting to access help from already-existing services (Temmerman et al., 2018; Temmerman et al., 2009). Given that it is reasonable to assume that the average Kenyan sexual violence victim will not have access to services that are part of a research project/intervention, I identified a need for further investigation of barriers to accessing and providing care for both service users and service providers.

1.6.2 *Focus on the medico-legal pathway*

The case referral pathway is significant in a victim's pursuit of medical attention and eventual justice. There are certain steps that must be followed in a certain order to ensure that the appropriate documentation is taken to be used as evidence if/when the cases proceed to court (see Figure 1). The medico-legal pathway is also a major point of focus for international aid organisations conducting research on sexual violence, though its function is often evaluated more than a victim's ability to access care (RTI International, 2015; World Health Organization, 2003, 2015)

For the purpose of this research, I defined medico-legal professionals as including health facility managers, doctors, nurses, emergency room physicians and nurses, mental health professionals, and general practitioners on the medical side and lawyers, paralegals, police officers, and judges on the legal side, in compliance with guidelines from the WHO (World Health Organization, 2003). Human rights defenders, known as gender defenders in this research context, are also an integral part of the medico-legal pathway, as they are often a

victim's first contact outside of family or friends after a sexual violence incident. Gender defenders are trusted members of the community, who have often experienced sexual violence themselves, and can refer new victims to appropriate services as needed. They are similar to community health workers in that they create a bridge between community services, health providers, and communities that may face difficulties in accessing these services, but they are not health professionals themselves (World Health Organization, 2018).

Figure 1. The journey of a survivor through the medico-legal pathway in Kenya

1.6.3 *The Wangu Kanja Foundation*

My partner organisation for this research was the Wangu Kanja Foundation (WKF), a Kenya-based NGO that focuses on connecting survivors to medical, legal, and psychological help after a sexual violence incident. The WKF was started by Wangu Kanja after she experienced

sexual violence during a carjacking incident in Nairobi in 2002. It has since expanded to have gender defenders in each of the 47 counties throughout the country to provide on-the-ground help to victims, built an app (SV_CaseStudy) to help report new incidents of sexual violence, created advocacy programmes, and also runs a programme to help survivors achieve financial freedom, among others.

1.7 Thesis aims, objectives, and structure

1.7.1 *Aims*

My research within this thesis aimed to (i) understand Kenya's approaches to post-rape service provision in comparison to approaches taken to address the same issues throughout the surrounding East African region, (ii) understand how the COVID-19 pandemic affected patterns of violence in Kenya, and (iii) investigate qualitative and quantitative findings about progression through the case referral pathway in Kenya.

1.7.2 *Objectives*

1) To evaluate and summarise existing service provision practices for victim/survivors of sexual and gender-based violence throughout the East African region.

2) To describe victim/survivor experiences in accessing care after a sexual violence incident in Kenya.

3) To describe medical and legal service provider perspectives on barriers to service provision for sexual violence victim/survivors in Kenya.

4) To explore possible correlates of victim/survivor characteristics and the stage reached in the case referral pathway for sexual violence victim/survivors in Kenya.

1.7.3 *Structure*

In this introductory chapter I have introduced the thesis topic as well as its aims and objectives, defined and described varying forms of sexual violence, provided an overview of the state of violence in Kenya, forms of post-rape medical and legal service provision, and the case referral pathway. I have also explained why the research in this thesis focused on victims of sexual and gender-based violence and described the Wangu Kanja Foundation, the partner organisation that made this research possible. The rest of the thesis is organised as follows.

Chapter 2 presents my scoping literature review on sexual and gender-based violence medico-legal service provision in East Africa. In this paper, I summarised the existing literature on the research topic and compared Kenya's approaches to those of its surrounding countries. This paper was published in Trauma, Violence, & Abuse in 2022.

Chapter 3 presents my prospective cross-sectional study on patterns of sexual violence perpetrated against adults and children in Kenya during the COVID-19 pandemic. In it, I used a quantitative between-group prospective research design to analyse data collected from adult sexual violence survivors and the guardians of defilement survivors. This paper was published in BMJ Open in 2021.

Chapter 4 presents my secondary data analysis of SGBV case attrition based on data from sexual violence survivors who sought services from the non-profit Wangu Kanja Foundation (WKF) between 2016-2020. In it, I used the sequential logit model to evaluate the correlates of survivors and their cases through the medical-legal pathway. This paper was published in Victims & Offenders in 2023.

Chapter 5 presents my qualitative study in which I used Framework Analysis to analyse medico-legal professionals' experiences of providing (or attempting to provide) care for victim/survivors of sexual violence. I analysed semi-structured interviews that I conducted with doctors, lawyers, police officials, and mental health professionals in Nairobi,

Kiambu, and Kitui in Kenya.

Chapter 6 presents my qualitative study in which I used Framework Analysis to analyse victim/survivor experiences of accessing (or attempting to access) medico-legal services in Kenya post-sexual violence incident. It contains analysis of focus group discussions that I conducted with victim/survivors in Nairobi, Kiambu, and Kitui in Kenya.

In Chapter 7 I discuss the main findings of this thesis alone and within larger-scale sexual and gender-based violence research. I also examine the strengths and limitations of my research, suggest further research, and draw final conclusions.

References

Ajema, C., Rogena, E., Muchela, H., Buluma, B., & Kilonzo, N. (2009). *Standards requried in maintaing the chain of evidence in the context of post rape care services: Findings of a study conducted in Kenya*.

Bott, S., Morrison, A., & Ellsberg, M. (2005). *Preventing and Responding to Gender-Based Violence in Middle and Low-Income Countries: A Global Review and Analysis*. Policy Research Working Paper; No. 3618. World Bank. http://hdl.handle.net/10986/8210

Centers for Disease Control and Prevention. (2022). *What is intimate partner violence?* US Department of Health and Human Services. Retrieved 14 November from https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html

Colombini, M., Mayhew, S. H., García-Moreno, C., d'Oliveira, A. F., Feder, G., & Bacchus, L. J. (2022, 2022/11/28). Improving health system readiness to address violence against women and girls: a conceptual framework. *BMC Health Services Research, 22*(1), 1429. https://doi.org/10.1186/s12913-022-08826-1

Defining Gender Based Violence. (2020). Gender Violence Recovery Centre,. Retrieved 16 November from https://gvrc.or.ke/facts-about-gbv/

Dhakal, L., Berg-Beckhoff, G., & Aro, A. R. (2014). Intimate partner violence (physical and sexual) and sexually transmitted infection: results from Nepal Demographic Health Survey 2011. *International Journal of Women's Health, 6*, 75-82.

Dunkle, K. L., Jewkes, R. K., Brown, H. C., Gray, G. E., McIntryre, J. A., & Harlow, S. D. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *The Lancet, 363*(9419), 1415-1421.

Equality Now. (2021). *9 Ways The Maputo Protocol Has Protected And Promoted The Rights Of Women And Girls Across Africa*. Equality Now,. Retrieved 19 December from https://equalitynow.org/news_and_insights/9_ways_maputo_protocol/

Foreign & Commonwealth Office. (2020). *UK launches landmark draft 'Murad Code' to support survivors of conflict-related sexual violence as COVID-19 pandemic increases suffering* [Press Release]. https://www.gov.uk/government/news/uk-launches-landmark-draft-murad-code-to-support-survivors-of-conflict-related-sexual-violence-as-covid-19-pandemic-increases-suffering

García-Moreno, C., Hegarty, K., d'Oliveira, A. F. L., Koziol-McLain, J., Colombini, M., & Feder, G. (2015). The health-systems response to violence against women. *The Lancet, 385*(9977), 1567-1579. https://doi.org/10.1016/S0140-6736(14)61837-7

Gevers, A., & Dartnall, E. (2014). The role of mental health in primary prevention of sexual and gender-based violence. *Global Health Action, 7*, 24741. https://doi.org/10.3402/gha.v7.24741

Heise, L. L., Raikes, A., Watts, C. H., & Zwi, A. B. (1994, 1994/11/01/). Violence against women: A neglected public health issue in less developed countries. *Social Science & Medicine, 39*(9), 1165-1179. https://doi.org/https://doi.org/10.1016/0277-9536(94)90349-2

Hockett, J. M., & Saucier, D. A. (2015, 2015/11/01/). A systematic literature review of "rape victims" versus "rape survivors": Implications for theory, research, and practice. *Aggression and Violent Behavior, 25*, 1-14. https://doi.org/https://doi.org/10.1016/j.avb.2015.07.003

Jahan, S. (2018, 15 November). Violence against women, a cause and consequence of inequality. https://www.undp.org/blog/violence-against-women-cause-and-consequence-inequality

Keesbury, J., & Thompson, J. (2010). *A step-by-step guide to strengthening sexual violence services in public health facilities: lessons and tools from sexual violence services in Africa*.

Kilonzo, N., Ndung'u, N., Nthamburi, N., Ajema, C., Taegtmeyer, M., Theobald, S., & Tolhurst, R. (2009, Nov). Sexual violence legislation in sub-Saharan Africa: the need for strengthened medico-legal linkages. *Reproductive Health Matters, 17*(34), 10-19, Article Pii s0968-8080(09)34485-7. https://doi.org/10.1016/s0968-8080(09)34485-7

Kilonzo, N., Taegtmeyer, M., Molyneux, C., Kibaru, J., Kimonji, V., & Theobald, S. (2008, Feb). Engendering health sector responses to sexual violence and HIV in Kenya: Results of a qualitative study. *Aids Care-Psychological and Socio-Medical Aspects of Aids/Hiv, 20*(2), 188-190. https://doi.org/10.1080/09540120701473849

Kilonzo, N., Theobald, S. J., Nyamato, E., Ajema, C., Muchela, H., Kibaru, J., Rogena, E., & Taegtmeyer, M. (2009). Delivering post-rape care services: Kenya's experience in developing integrated services [Short Survey]. *Bulletin of the World Health Organization, 87*(7), 555-559. https://doi.org/10.2471/BLT.08.052340

Maternowska, C., Keesbury, J., & Kilonzo, N. (2009). *Sexual violence: setting the research agenda for Kenya*.

McKinnon, B., Harper, S., Kaufman, J. S., & Bergevin, Y. (2015). Removing user fees for facility-based delivery services: a difference-in-differences evaluation from ten sub-Saharan African countries. *Health Policy and Planning, 30*(4), 432-441. https://doi.org/10.1093/heapol/czu027

McPhedran, M., Bazilli, S., Erickson, M., & Byrnes, A. (2000). *The first CEDAW impact study: Convention on the Elimination of All Forms of Discrimination Against Women. Final report*. York University.

Ministry of Health Kenya, Kenya National Bureau of Statistics, National Aids Control Council, Kenya Medical Research Institute, & National Council for Population Development. (2015). *Kenya Demographic and Health Survey, 2014*.

National Council for Law Reprting. (2012). *Sexual Offences Act.*

Office of the United Nations High Commissioner for Human Rights. *Introduction to the Committee: Committee on the Elimination of Discrimination Against Women*. United Nations. https://www.ohchr.org/en/treaty-bodies/cedaw/introduction-committee

Pollino, M. A. (2021). Turning points from victim to survivor: an examination of sexual violence narratives. *Feminist Media Studies*, 1-16. https://doi.org/10.1080/14680777.2021.2006260

Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol). (2003). http://www.achpr.org/instruments/women-protocol/

RTI International. (2015). *Evaluation of the UNTF-Funded Training and Technical Assistance Program in Kenya and DRC*. R. International.

Schwark, S., & Bohner, G. (2019). Sexual Violence—"Victim" or "Survivor": News Images Affect Explicit and Implicit Judgments of Blame. *Violence Against Women, 25*(12), 1491-1509. https://doi.org/10.1177/1077801218820202

Sikder, S. S., Ghoshal, R., Bhate-Deosthali, P., Jaishwal, C., & Roy, N. (2021, 2021/10/10). Mapping the health systems response to violence against women: key learnings from five LMIC settings (2015–2020). *BMC Women's Health, 21*(1), 360. https://doi.org/10.1186/s12905-021-01499-8

Temmerman, M., Emilomo, O., Griffins, M., Iqbal, K., Mary, T., Kishor, N. M., Lou, D., Markus, M., & Peter, G. (2018). The gender-based violence and recovery centre at Coast Provincial General Hospital, Mombasa, Kenya: An integrated care model for survivors of sexual violence. *PLoS Medicine, 16*(8), e1002886. https://doi.org/10.1371/journal.pmed.1002886

Temmerman, M., Maternowska, C., & Othigo, M. J. (2009, Sep). Organising referral and health care for survivors of sexual violence; an example from Mombasa, Kenya. *Tropical Medicine & International Health, 14*, 20-20. <Go to ISI>://WOS:000269264000057

The Global Code of Conduct for Gathering and Using Information about Systematic and Conflict-Related Sexual Violence. (2023). Retrieved from https://www.muradcode.com/murad-code

The Survivors Trust. (2022). *The effects of sexual violence*. The Survivors Trust,. Retrieved 14 November from https://www.thesurvivorstrust.org/the-effects-of-sexual-violence-how-to-support-a-survivor

United Nations. (2020). *The Handbook for United Nations Field Missions on Preventing and Responding to Conflict-Related Sexual Violence*.

United Nations. (2022a). *Sexual Violence*. UNICEF. Retrieved 14 November from https://data.unicef.org/topic/child-protection/violence/sexual-violence/

United Nations. (2022b). *What is domestic abuse?* United Nations,. Retrieved 14 November from https://www.un.org/en/coronavirus/what-is-domestic-abuse

United Nations Office for the Coordination of Humanitarian Affairs. (2019). *Sexual and gender-based violence: the time to act is now*. OCHA. https://www.unocha.org/story/sexual-and-gender-based-violence-time-act-now

United Nations Peacekeeping. *Conflict-Related Sexual Violence*. United Nations. Retrieved 14 November from https://peacekeeping.un.org/en/conflict-related-sexual-violence

United Nations Women. (2016). *Convention on the elimination of all forms of discrimination against women (CEDAW) for youth*. UN Women.

United Nations Women. (2019). *CEDAW-based legal review: Brief guide*. UN Women.

World Health Organization. (2003). *Guidelines for medico-legal care of victims of sexual violence*. https://apps.who.int/iris/handle/10665/42788

World Health Organization. (2015). *Strengthening the medico-legal response to sexual violence*. WHO. http://apps.who.int/iris/bitstream/handle/10665/197498/WHO_RHR_15.24_eng.pdf?sequence=1

World Health Organization. (2018). *WHO guideline on health policy and system support to optimize community health worker programmes*.

World Health Organization. (2021). *Violence against women prevalence estimates, 2018: global, regional, and national prevalence estimates for intimate partner violence against women and girls and global and regional prevalence estimates for non-partner sexual violence against women*.

World Health Organization. (2022a). *Intimate Partner Violence*. World Health Organization, . Retrieved 14 November from https://apps.who.int/violence-info/intimate-partner-violence/

World Health Organization. (2022b). *Sexual Violence*. World Health Organization, . Retrieved 14 November from https://apps.who.int/violence-info/sexual-violence/

World Health Organization, United Nations Population Fund, & United Nations High Commissioner for Refugees. (2020). *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*.

Chapter 2. A Scoping Review on Sexual And Gender-Based Violence Medicolegal Service Provision In East Africa

Given the notable challenges in accessing medico-legal services for SGBV survivors in Kenya (Ajema et al., 2011; Gatuguta et al., 2018; Kilonzo et al., 2003), I wanted to evaluate post-SGBV service provision throughout the East African region to provide better context for future literary and experiential studies of Kenya. While studies existed on the countries individually, little work existed that compared the countries to their neighbours. Therefore, I, along with my co-authors, conducted a scoping review with the aims of evaluating existing service provision practices throughout the region, understanding if/how provider bias may impact service provision, and how existing practice compared to national policies or internationally agreed human rights treaties. Throughout this review, and others (see Rockowitz et al., 2023), it became apparent that Kenya is the most heavily studied country in the region, perhaps owing to relative political stability and ease of access for Western researchers. This made it difficult to truly compare findings throughout the region, as Kenya was the focus of more than a third of included studies, while other countries, such as Seychelles and Mauritius, did not appear once. Despite this, 54 papers were included in this study and evaluated using Arksey and O’Malley’s methodological framework in addition to Bradbury-Jones et al.’s PAGER framework (Arksey & O'Malley, 2005; Bradbury-Jones et al., 2021).

References

Ajema, C., Mukoma, W., Kilonzo, N., Bwire, B., & Otwombe, K. (2011, May). Challenges experienced by service providers in the delivery of medico-legal services to survivors of sexual violence in Kenya. J Forensic Leg Med, 18(4), 162-166. https://doi.org/10.1016/j.jflm.2011.02.004

Arksey, H., & O'Malley, L. (2005, 2005/02/01). Scoping studies: towards a methodological framework. International Journal of Social Research Methodology, 8(1), 19-32. https://doi.org/10.1080/1364557032000119616

Bradbury-Jones, C., Aveyard, H., Herber, O., Isham, L., Taylor, J., & O'Malley, L. (2021, 03/18). Scoping reviews: the PAGER framework for improving the quality of reporting. International Journal of Social Research Methodology, 1-14. https://doi.org/10.1080/13645579.2021.1899596

Gatuguta, A., Merrill, K. G., Colombini, M., Soremekun, S., Seeley, J., Mwanzo, I., & Devries, K. (2018, Jun 19). Missed treatment opportunities and barriers to comprehensive treatment for sexual violence survivors in Kenya: a mixed methods study. BMC Public Health, 18(1), 769. https://doi.org/10.1186/s12889-018-5681-5

Kilonzo, N., Molyneux, S., Taegtmeyer, M., & Theobald, S. (2003). Post rape services in Kenya: a situation analysis. LVCT.

This chapter presents the findings of a scoping review that has been published in *Trauma, Violence, & Abuse as:*

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Supplemental material from this publication can be found in Appendix 1.

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A Scoping Review on Sexual and Gender-Based Violence Medicolegal Service Provision in East Africa

Sarah Rockowitz[1], Heather Flowe[1], and Caroline Bradbury-Jones[1]

Abstract

Sexual and gender-based violence (SGBV) is a leading cause of physical, emotional, and psychosocial problems around the world, with many countries in East Africa having rates above the global average. Despite the high prevalence in the region, service provision for post-SGBV care is often poorly funded, difficult to access, or simply nonexistent. This review reports the findings of a scoping review of literature from East Africa. The goals of this research were to evaluate existing service provision practices throughout the region, understand how provider bias may affect service provision, and compare existing practices to national policies and internationally agreed human rights treaties. This review identified 54 academic papers and reports through a search of electronic databases and grey literature sources, and four main themes emerged: (1) current models of service provision are inadequate to address the medical and psychosocial needs of survivors; (2) countries are not providing sufficient funding for services; (3) further research is needed into how to incorporate SGBV care into existing health systems and align with international human rights treaties; and (4) there is limited research in many countries in East Africa. The findings are likely to be of use to policy makers, nongovernmental organizations, and service providers working in the medical, legal, and justice systems.

Keywords

sexual and gender-based violence, East Africa, policy, service provision, scoping review, rape, sexual violence

Introduction

Sexual and gender-based violence (SGBV) encompasses several types of violent behavior perpetrated against the will of victims (including women, girls, men, boys, and LGBTQI+ people) that can lead to serious bodily harm or even death (ICRC, 2022; Médecins Sans Frontieres [MSF], 2021). Gender-based violence (GBV) refers to harmful acts directed against a person based on their gender (UNHCR, 2021b). Harmful acts include emotional, psychological, and physical abuse, as well as sexual violence (SV). While SGBV can be perpetrated by and against anyone, perpetrators are primarily men, and victims are largely women and girls (UNHCR, 2021a, 2021b; WHO, 2021b). For example, worldwide, 35% of women have experienced at least one form of SGBV, such as intimate partner violence (IPV) or non-partner SV, and 15 million girls have experienced forced sex (The World Bank, 2019; UN, 2021).

This paper focuses on SGBV in East Africa, one of the UN regions with the highest rates of lifetime SGBV in the world (WHO, 2021b). SGBV is a significant contributor to morbidity and mortality in East Africa (Amenu & Hiko, 2014) and is a major obstacle to achieving Sustainable Development Goal 5, which concerns achieving gender equality in all its forms. Around the world, including in East Africa, SGBV can cause lasting physical health consequences, such as injuries and sexually transmitted infections, mental health impacts, such as depression and anxiety, and social consequences, such as stigma and social rejection (WHO, 2021a). Injuries from SGBV can include stab wounds, fractures, vaginal fistulas, and bleeding, and victims may become pregnant (MSF, 2021). Furthermore, female SV victims are twice as likely to have an abortion across their lifespan than their counterparts (MSF, 2021). In many countries that have the highest rates of SGBV worldwide, abortion is illegal, and women frequently seek out unsafe procedures that can cause infections or even death (MSF, 2021). Against this backdrop of human suffering in East Africa, there is an urgent need to synthesize research on SGBV in this region.

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Toward this end, we conducted a scoping review of the literature on SGBV medical and legal service provision practices in East Africa. Our goals in conducting the review were to: (1) describe SGBV service provision throughout the region; (2) understand how provider bias may affect service provision; and (3) compare existing practices to national policies and internationally agreed human rights treaties that outline the medical and/or legal services that SGBV survivors are entitled to receive. The review analyzed papers that focused on peacetime SGBV.[1] This allows for determining the level of services that survivors receive in the absence of conflict, wherein service disruption may not be entirely, if at all, under state control. In the sections that follow, we provide an overview of policy and treaties concerning SGBV, the types of services SGBV survivors may be entitled to receive, and research on service delivery in East Africa, as well as outline considerations that arise in the care of the large populations of refugees in the region.

SGBV Survivors' Rights to Medicolegal Service Provision

The WHO (2015) report on strengthening the medical and legal response to SGBV highlights the importance of involving multiple sectors, including the police, forensic medicine, health and social service agencies, and the judiciary. Moreover, typical steps along the medical and legal service provision pathway include gathering evidence and documenting the crime, addressing a victim's medical needs, referring victims to the police, carrying out a foren- sic medical exam, and connecting victims to sustained psychosocial support services. The report lays out the key principles of best practice service provision: prioritizing victims' physical and emotional safety, keeping informa- tion confidential, ensuring that victims are not discrimi- nated against by agencies and organizations, and respecting the victims' rights and wishes (WHO, 2015). However, SGBV survivors are frequently stigmatized and face gender bias from providers on the pathway, which may discourage help seeking (WHO, 2015).

Policies in East African countries on SGBV service provision are scarce, as explained later in this review, while existing policies outlining services that survivors should receive may not be actioned or enforced (Ajema et al., 2011). To counter this, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, otherwise known as the Maputo Protocol, was written. The Maputo Protocol covers SGBV at length, including female genital mutilation (FGM) and underage marriage as well as stigma and bias against SGBV victims (African Union, 2003). Signatories vow to enforce change through policy action or administrative decision making. However, while multiple countries in the East African region are signatories to international human rights and global health treaties regarding SGBV-related service provision, like the Maputo Protocol, there are reports that survivors in these countries still find it difficult or impossible to access services (Rockowitz et al., 2021b).

Refugee Service Provision

Countries in East Africa host large refugee populations, which further complicates SGBV medical and legal service provision. People living in emergency and humanitarian contexts are at a high risk of SGBV, including FGM, socioeconomic abuse, and denial of reproductive health choices (Muuo et al., 2020). Humanitarian emergencies also make the delivery of adequate care for SGBV survivors difficult and increase the vulnerability of survivors to future victimization (Muuo et al., 2020). This is partially because refugees may be offered services within camps from external organizations with foreign staff, such as the UN, rather than medical or legal professionals from the country they are seeking refuge in. This camp context may not be an indicator of the status of wider service provision throughout the country, but this population nevertheless makes up a percentage of East African residents and we felt it was important to explore their experience in care-seeking. Additionally, even when refugees are living outside of camps, they face unique barriers to healthcare that their local neighbors do not experience, such as discrepancies in cost of healthcare between refugees and locals, and documentation requirements for treatment (Jemutai et al., 2021). Papers that include the experiences of refugees were included in the review given these considerations.

Present Study

In sum, this paper reviews the range of SGBV research activity on East Africa that has taken place, and identifies knowledge gaps, which is one of the key pillars of a scoping review (Levac et al., 2010; Munn et al., 2018). Our aim is to stimulate research that addresses critical knowledge gaps by highlighting topics and countries where research has been most lacking. Furthermore, this review evaluates whether practice models are compliant with national policies and international treaties. The review also considers what is known about the impact of services on victim health and well-being and highlights barriers in accessing and delivering medical and legal services. To examine provider bias, the review captures research whether beliefs about gender equality (e.g., believing that a husband has the right to abuse his wife, or that SV is to be expected in society) on the part of practitioners affects quality of care.

Method

We followed the steps outlined by Arksey and O'Malley (2005) and advanced by Levac et al. (2010), including identifying the research question, finding relevant studies,

selecting studies, charting the data, and synthesizing and reporting the results (Levac et al., 2010).

Research Questions and Study Purpose

We originally sought to review research on service provision as well as existing regulations and policies surrounding SGBV medical and legal services in East Africa (Rockowitz et al., 2021a); however, subsequent literature searches returned few academic papers on SGBV regulations and policies in East Africa countries. Per recommendations of Levac et al.(2010), to envision the intended outcome of the study while also considering the feasibility of the research, we modified our original research questions and focused solely on service provision in the region rather than service provision and policy. As a result, the following questions guided our scoping review:

Question 1: What SGBV medical and legal service provision practices are there across East Africa?
Question 2: To what extent are current service provision models compliant with internationally agreed public health treaties?
Question 3: How do duty bearers' personal beliefs and practices affect survivors' experiences in accessing care?
Question 4: What are existing gaps in the literature and what further research needs to be done?

Search Strategy

Our search strategy included conducting title, abstract, and keyword searchers of the PubMed, SCOPUS, CINAHL Plus, and Web of Science databases. The Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) diagram was used to record the number of arti- cles included along each step of the search process (Page et al., 2021).

Our review included literature on East African countries published between 2000 and 2020. This timeframe was chosen so that more recent policy and international health treaty agreements could be analyzed. Due to a lack of resources and translation skills, only papers in English were included in this review. Our search terms were chains created to allow for variations in terminology and phrases related to SGBV. These included "rape" + "East Africa," "rape" + "East Africa" + "law," "rape" + "East Africa" + "policy," and "rape" + "East Africa" + "health." We also used the terms "sexual assault" and "sexual violence" in place of "rape," and we expanded "East Africa" when possible in the data- base to include "Burundi," "Comoros," "Djibouti," "Eritrea," "Ethiopia," "Kenya," "Madagascar," "Malawi," "Mauritius," "Mayotte," "Mozambique," "Reunion," "Rwanda," "Seychelles," "Somalia," "South Sudan," "Tanzania," "Uganda," "Zambia," and "Zimbabwe." We largely followed the UN' geoscheme, which lists all the above countries, except South Sudan, as being in the East African region (Mendelson et al., 2014). As South Sudan is included in the East African Community, we included in our analysis (EAC Partner States, 2021). We conducted a grey literature search to find reports from nongovernmental organizations (NGOs) and other local organizations that worked with SGBV survivors.

Study Selection

Initial database searches yielded 14,230 academic articles, with an additional 124 results coming from other sources, such as grey literature and "cited by" searches. After these lists were combined and we removed duplicates using Endnote X9. This left us with 3,685 results to be screened by title and abstract. There are a few reasons why there were so many articles. Firstly, we were searching for research related to 20 countries, which yielded many results, and the use of the term "rape" yielded many irrelevant papers about "rapeseed" or "oilseed rape."

A key element of a scoping review is that the researchers should engage with each step in the process in an iterative and reflexive way to comprehensively search the literature (Arksey & O'Malley, 2005). Levac et al. (2010) further noted that the research team should use an iterative approach to choosing studies and extracting data. To this end, the first author did the initial title and abstract screening, yielding 257 results. Articles and research documents were excluded if they were about countries other than those in East Africa, if they were about East African diaspora populations living elsewhere, if they were about preventing SV rather than working with survivors post-incident, if they were about agriculture as mentioned above, and others. After the initial review was conducted by the first author, titles and abstracts were uploaded onto the online systematic review program *Rayyan* (https://www.rayyan.ai), which facilitates collaboration when identifying articles for a review paper. The first author tagged articles with a green label for inclusion and a red label for exclusion, while also adding additional customizable tags such as "medical," and "legal." Afterwards, the link was shared with the co-authors, and they repeated the process. Any articles that were tagged differently by the co-authors were then discussed by the team to determine the final set of papers.

Additionally, many papers that appeared in the searches were specifically about abortion services or HIV medication provision; while SGBV was mentioned in these papers as a possible reason why these services may be needed, the authors determined that they should be excluded because they were not principally about SGBV. Following this process, as well as a full-text review by the first author, 54 papers were included in the final sample (see Figure 1 for the PRISMA diagram).

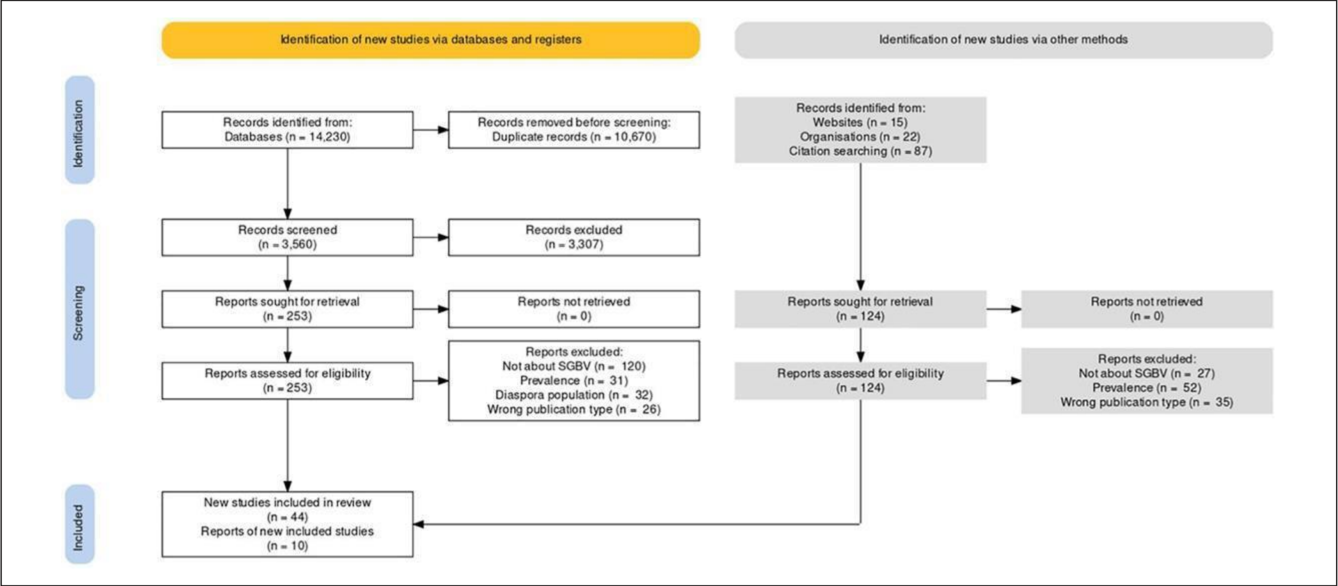

Figure 1. Preferred Reporting and Identification for Systematic reviews and Meta-Analyses flow diagram.

Data Charting

The researchers developed a data charting form using Microsoft Excel 2021. To facilitate data analysis and follow charting recommendations (Arksey & O'Malley, 2005), the charting form gathered information regarding the author, publication year and type (academic or grey literature), country, study design, study setting (refugee camp, health center, district, etc.), key findings, and the paper's conclusion.

Results

Sample Characteristics, Study Design, and Study Setting

All academic articles (*n* = 44) and grey literature (*n* = 10) in the final sample were published between 2001 and 2020. Details of the breakdown of countries included can be found in Supplemental Table 1. Although 20 countries were included in the search, most countries did not appear in the findings, while others had a relatively high number of publications (Supplemental Table 1). Kenya was the country with the most publications, with 22 (35.5%) academic papers or reports focused on the Kenyan context alone and one paper focused on Kenya and Ethiopia together. The country with the next highest number of dedicated studies was Uganda, with 10 papers (16.1%), followed by Tanzania, and Zimbabwe with four each (6.5%). Two pieces of literature, one a journal article and one report from USAID, focused on the continent rather than specific countries.

In most cases, the studies were based on qualitative research methods, primarily through in-depth interviews or focus group discussions. As many papers also included document and record analysis from health centers, cross-sectional prospective methods were also commonly used. More information about study setting and methodology can be found in Supplemental Table 1.

Medical and Legal Service Provision Across East Africa

The results are organized by type of SGBV. The terminology used to describe types of SGBV had differing operational definitions across papers. For instance, sometimes the term "sexual assault" was defined to include acts of penile-vaginal penetration (rape), while in other papers, it was not defined specifically but instead used interchangeably with the terms "rape" and "sexual violence" (e.g., Lakew, 2001). Given the lack of clarity and inconsistencies across the literature, we were unable to operationally define and code violence type and had to rely on the terminology used in the papers.

Rape

Rape was the form of SGBV studied the most (see Supplemental Table 1). Unlike IPV, which can have differing definitions depending on the source, rape is more consistently defined, perhaps because all the countries included in this review legally define rape. For instance, the National Guidelines on Management of Sexual Violence in Kenya define rape as "An act done which causes penetration of one person's genital organs with the genital organs of another without their consent or where the consent is obtained by force, threats or intimidation of any kind" (Ministry of Public Health & Sanitation and Ministry of Medical Services, 2009). Tanzania's government defines rape as when "a male person. . .has sexual intercourse with a girl or woman under

circumstances falling under any of the following descriptions:" including forcibly having sex with a non-wife or ex-wife due to use of force, obtaining consent when the woman is of unsound mind, and others (Tanzania, 1998). Throughout other countries in East Africa, rape is similarly defined. Penetration of often a requirement, and some countries still state that women can be raped by men, but men cannot be raped by women.

Most of the studies focused on rape were conducted in Kenya. Most papers used qualitative methods, primarily interviews, although some of the papers either solely or additionally performed document analysis, including retrospective record reviews from an adult rape clinic (Kufa et al., 2019). Of the 11 rape papers, all except one discussed service provision, and only two discussed interventions. The first intervention paper designed and implemented a training program for healthcare workers in Tanzania to improve the quality of care they offered rape survivors, and the second designed a post-rape care algorithm in Kenya to be implemented at selected government health facilities (Abeid et al., 2015; Kilonzo et al., 2009).

Papers focusing on rape collected information on medical and legal service provision from multiple sources. Some researchers interviewed providers, such as health practitioners or police officers (Ajema et al., 2009; Munala et al., 2018). Others interviewed survivors and those who care for them, or simply just community members who are aware of rape in their immediate surroundings (Kilonzo et al., 2003, 2009). Across all studies, there was minimal (if any) discussion of existing policies concerning service provision, except at times to say that there were none. As a result, a common theme across all papers was that their findings should be used for policy recommendations. These included formal training of healthcare workers, expanded abortion services, and the creation of a formal strategy for the provision of post-rape services (Abeid et al., 2015; Ajema et al., 2009; Casey et al., 2015; Kilonzo et al., 2003).

Despite these findings, it is important to note that research on rape was found for only five of the 20 countries that are in East Africa, and these were largely on Kenya. Additionally, little attention was paid to sociocultural factors that may have affected service provision or a victim's decision to seek out services in the first place. For example, victim care may be affected by the religious alignment between victim and provider, or the victim preferring traditional health and justice practices (Odero et al., 2014).

Intimate Partner Violence

IPV was the second most frequently occurring type of violence found in the included papers. It was variously defined, such as "a form of interpersonal violence by a spouse or life partner" (e.g., Shumba et al., 2017) "violence committed against a woman by her current or former spouse or boyfriend" (e.g., Horn, 2010), "violence committed in a present or past relationship." (e.g., Manuel et al., 2019). The primary data collection method for understanding medical and legal service provision for IPV survivors was qualitative interviewing, although two studies distributed surveys to medical students, nurses, and midwives (Ambikile et al., 2021; Manuel et al., 2019).

Two of the papers focused on mental healthcare needs of IPV victims, and these were specifically on screening processes and service provision (Ambikile et al., 2021; Chepuka et al., 2014). The remaining papers focused on screening for, responding to, or training for working with IPV cases more generally (Horn, 2010; Maina, 2009; Maina & Majeke, 2008; Manuel et al., 2019; Nguyen et al., 2016; Odero et al., 2014; Shumba et al., 2017; Undie et al., 2016). Unlike rape, there were no interventions studied in the IPV papers. Of the nine IPV papers, six focused on the providers' perspectives, with all providers in these papers described as working in the medical field, not in the legal or justice fields. The other three papers sampled survivor and non-survivor refugees, survivors, or men and women in general.

Several studies cited a lack of knowledge and relevant skills as potential reasons for inadequate service provision. This was often attributed to a lack of targeted trainings, staff shortages, and lacking protocols for case management (Ambikile et al., 2021; Odero et al., 2014; Undie et al., 2016). Additionally, several papers noted the additional challenges associated with treating the mental health impacts of IPV, whether due to societal pressures to resolve issues, poor training of service providers, or a lack of linkages to mental health services (Ambikile et al., 2021; Chepuka et al., 2014; Odero et al., 2014).

Sexual Assault

Sexual assault (SA) was the third most common type of SGBV studied. Unlike other topics, which mention the type of SGBV in the titles of the papers without any qualification, two papers in this group, one in Uganda and one in Ethiopia, refer to "alleged" SA in the titles of their papers (Lakew, 2001; Ononge et al., 2005). Interestingly, all papers that studied populations in Ethiopia focused on SA.

As with other topics, SA is defined rather fluidly. One paper defined SA as "any genital, oral, or anal penetration by a part of the accused's body or by an object using force or without the victim's consent," (Ononge et al., 2005). Another defined SA as "rape, attempted rape, sexual abuse and sexual exploitation," and yet another as "all non-consenting sexual activity from fondling to penetration" (Amenu & Hiko, 2014; Krolikowski & Koyfman, 2012).

Six of the nine SA papers analyzed medical and legal service provision for SA victims. More than half of the SA papers used quantitative approaches, reviewing records or other data as the primary data source. This enabled the researchers to analyze more data: for instance, a study on a SA center in Western Kenya analyzed 321 charts of SA

survivors and another analyzed 474 medical affidavits from a hospital in Zimbabwe (Ranney et al., 2011; Tapesana et al., 2017).

None of the SA papers about medical and legal service provision mentioned policy, either by the government or hospitals, that may pertain to the treatment of SA victims. Whether this means they were nonexistent is unclear, although it seems consistent with findings for other types of SGBV. Additionally, research concerning medical and legal service provision for SA victims was found for only four countries in East Africa, indicating a dearth of research both on SA in general and on service provision for said victims. This may be indicative of the "umbrella" of SGBV that many types of violence fall under or perhaps a reflection of the direction SGBV research has taken in recent years.

Sexual Violence

Seven papers in this review focused on SV. Definitions of SV were unique in that there was less of a focus on defining the act itself and more of a focus on noting what the societal and public health implications of SV are. For example, it was referred to as "a serious societal problem that creates significant challenges to local communities" and "a serious global health problem with significant physical, psychological, and social consequences" (Ajema et al., 2011; Gatuguta et al., 2018). While all included SV papers focused on service provision in some regard, only three focused on barriers. Two others focused on the perspectives of the providers, which is unique compared to other types of violence, and one was a report from USAID on strengthening service provision. The three service provision papers were all descriptive studies that used primarily qualitative methodologies.

The three SV papers that strictly covered medical and legal service provision were based in Kenya (2) and Uganda (1). Both Kenya papers used qualitative interviews with service providers to collect data, although one also compared health records from a hospital with data from the Demographic and Health Survey (DHS) (Gatuguta et al., 2018). Both Kenya papers mentioned the importance of proper forensic evidence collection to help victims pursue justice, which makes them unique from many of the other papers included in this study that have less of a focus on the legal aspect of service provision. As with previous types of violence, there was little mention of existing policy concerning service provision.

The paper based in Uganda is somewhat unique in this review in that it pulls data from an existing longitudinal study that the researchers had worked on previously. The WAYS Study, which focused on war-affected youth in Northern Uganda, was started in 2002 and targeted toward youth who had been targeted by the Lord's Resistance Army (Amone-P'Olak et al., 2018). While the study pri- marily focused on the prevalence of post-traumatic stress disorder in the research population, there was also an assessment of the availability of mental health services. This paper was also distinctive in that a significant portion is dedicated to understanding the meaning of mental illness among the target population, a focus on cultural competency that has seldom been seen in previously included papers.

Sexual and Gender-Based Violence

Six papers on SGBV were included in this review. Four of the papers studied SGBV in humanitarian settings, primarily with South Sudanese refugees, and all were based in Uganda (Liebling et al., 2020a, 2020b). This may be because SGBV is an all-encompassing term that can cover many other types of violence, and because it is more commonly associated with humanitarian efforts than other terms, such as SV or IPV (Liebling et al., 2020a). Due to this context, SGBV was often not explicitly defined but rather was explained as a "weapon of conflict" and "a growing problem in humanitar- ian settings" (Liebling et al., 2020a, 2020b; Odwe et al., 2018). Four of the papers focused on service provision, either health alone or health and justice, one on perceptions of vio- lence as well as service provision, and the final paper focused on help-seeking.

Most of the service provision papers for SGBV explicitly mentioned both health and justice service provision, perhaps because of the focus on refugees and the involvement of international aid organizations in their care. As a result of the involvement of the justice aspect of service provision, bribery and corruption appeared multiple times throughout the included papers (Liebling et al., 2020a, 2020b; McCleary-Sills et al., 2013). An interesting component when evaluating these papers that is not included in many of the others is the involvement of international actors, such as the UNHCR (UNHCR) and Médecins Sans Frontieres (MSF). This means that the systems being evaluated are not necessarily on the country-level alone, but instead reflect collaborations between local governments and international actors and human rights officials. It is therefore difficult to ascertain how much responsibility individual countries take for service provision and how much they outsource to international aid organizations.

Gender-Based Violence

Five papers covered GBV, four of which researched GBV in humanitarian settings. As a result, GBV was often defined in relation to conflict. For example, one paper noted that "GBV has been committed against civilians and soldiers as a means of warfare," while another noted that "emergency and humanitarian situations expose individuals, particularly women and girls, to a heightened risk for GBV" (Kawaguchi, 2018; Muuo et al., 2020).

All but one of the included papers were academic articles, with the final being a report from a Japanese aid organization (Kawaguchi, 2018). All papers focused on service provision,

although one was on reproductive health services more generally rather than specifically GBV (Whelan & Blogg, 2007). All papers but one focused on existing structures for service provision, and the final analyzed a dataset from a purpose created GBV and recovery center in Mombasa (Temmerman et al., 2019). The primary data sources across all studies were female refugee GBV victims, although a few studies also interviewed providers.

A few common themes appeared throughout the included papers. Financial constraints, either at the health facility level or the aid organization level, were seen as a common barrier to adequate service provision (Henttonen et al., 2008; Kawaguchi, 2018; Whelan & Blogg, 2007). Stigma was noted in most papers as a reason for underreporting of GBV and one of the barriers to accessing care (Henttonen et al., 2008; Kawaguchi, 2018; Muuo et al., 2020; Temmerman et al., 2019), though little was said about what could be done to address this problem.

Violence Against Women

Three papers examined violence against women (VAW). Two were academic articles, one was a report, and all covered medical and legal service provision (Amnesty International, 2010; Dennis et al., 2019; Vyas, 2019). Uganda, Tanzania, and Zambia were all represented once, making this one of the few topics where Kenya was not the primary area of work. Another unique aspect of this pool of research is that primarily quantitative methods were used. One paper analyzed data from Tanzania's DHS, and other used signal functions to identify the availability of clinics that were able to provide VAW services (Dennis et al., 2019; Vyas, 2019). The final paper conducted qualitative interviews with victims, NGOs, government officials, and international aid organizations to ascertain their experiences in providing and accessing care (Amnesty International, 2010).

Both quantitative studies found that distance was a limiting factor for accessing post-VAW services. Researchers in Zambia discovered that the median distance to a comprehensive care facility was 5.9 km and that quality of care was often poor, owing to limited resources or poorly trained staff (Dennis et al., 2019). Researchers in Tanzania similarly found that abused women had to travel on average 3.8 km to their nearest health facility, although the quality and comprehension of care offered was not assessed (Vyas, 2019).

Interpersonal Violence, Domestic Violence, and Collective Sexual Violence

These three forms of violence occurred only once each in the literature search. All three papers included were academic articles and used qualitative methods. One such paper covered interpersonal violence (IPEV), which is used as an umbrella term to include community violence, IPV, SV, and more (Decker et al., 2018). This paper (Schober et al., 2016) was based in Zambia, while the studies on domestic violence (DV) (Githui et al., 2018) and collective SV, which refers to nonconsensual sexual activity by a group of individuals or single individual that is driven by social movement goals (Ten Bensel & Sample, 2017; Zraly et al., 2011) were based in Kenya and Rwanda, respectively. Because only one paper was found for each violence type, the quality of research throughout the region more generally could not be assessed. Githui et al. focused on barriers to screening pregnant women for DV, Zraly et al. focused on providing mental healthcare for genocide survivors, and Schober et al. applied an intervention to an emergency room to improve care outcomes for IPEV victims. Participants of the three studies include medical and social service professionals, members of refugee support groups, and nurses, indicating once again that there is very little focus on the legal aspect of service provision throughout the region.

Service Provision Models and International Health Treaties

Types of service provision were varied, and included emergency center care, access to emergency contraception (EC) post-SA, and mental health care services (Amone-P'Olak et al., 2018; Kassa et al., 2009; Krolikowski & Koyfman, 2012; Maina, 2009). While most articles focused on provision of medical services, including mental healthcare, a few also focused on access to legal and judicial services (Liebling et al., 2020a, 2020b; Muganyizi et al., 2011; Odero et al., 2014).

The most consistent form of service provision offered was EC, typically in the form of oral contraceptive pills and often in tandem with post-exposure prophylaxis for HIV (Amenu & Hiko, 2014; Amnesty International, 2010; Dennis et al., 2019; Gatuguta et al., 2018; Kilonzo et al., 2003; Kilonzo & Taegtmeyer, 2005; Krolikowski & Koyfman, 2012; Muganyizi et al., 2011; Ononge et al., 2005; Tapesana et al., 2017; Temmerman et al., 2019). Although EC was included in the most basic of service packages, and was offered the most frequently, as with most other services in this region, resource constraints limited availability. Furthermore, a survivor was not eligible for EC if they presented outside of the 72-hour window in which it would still be effective (Ononge et al., 2005). Additionally, a lack of knowledge on behalf of some survivors led them to refuse EC even when they were offered it. Research in Zimbabwe found that 20% of clients who were eligible for EC did not take it, perhaps due to a lack of education and sensitisation, and research in Ethiopia similarly found that a lack of knowledge about EC in society was a barrier to providing adequate health services to victims of SA (Harrison et al., 2017; Kassa et al., 2009).

Another factor that was a significant predictor of the type of service provision a survivor would receive was the tier of health facility to which they had access. Tiers and levels of health facilities vary significantly within countries, with

some countries (such as Kenya) having as many as six tiers of health facilities (Gatuguta et al., 2018). Laboratory services were no exception; district health facilities in Kenya were found to be unable to analyze all components of forensic medical exam samples, while other health facilities lacked speculums and rape kits (Ajema et al., 2011; Gatuguta et al., 2018). This point was emphasized by Dennis and colleagues, who found that signal function domains, defined as three domains of SV response services (core services, immediate care, and delayed and follow-up care) varied greatly by level of health facility (2019). When surveying hospitals, the most advanced facility level, only 50% were able to offer all three signal functions, and less than 1% of health centers and 0% of health posts were able to offer all three signal functions (Dennis et al., 2019). Tanzania had similar breakdowns in service availability by facility level, with health dispensaries being able to provide the most basic of services and district designated hospitals or referral hospitals able to provide more comprehensive GBV services (McCleary-Sills et al., 2013). Similar disparities between services offered at health facility level were found in Uganda and South Sudan (Casey et al., 2015; Liebling et al., 2020a, 2020b).

This study initially sought to compare existing service provision models with international treaties that the countries had signed and/or ratified, but there was no mention of this in any of the papers included in the study. Additionally, since there is little policy literature, it is difficult to tell if the countries have changed their laws in response to the treaties they signed. Regardless, it is possible to compare what we learned about existing practices with public health treaties, such as the Maputo Protocol and the SDGs. For instance, the Maputo Protocol instructs state parties to establish mechanisms for the rehabilitation of victims of SGBV, yet previous findings have shown that services are often scarce, inaccessible due to financial or infrastructural constraints, and lacking the involvement of legal professionals (African Union, 2003; Ajema et al., 2011; Gatuguta et al., 2018). The Maputo Protocol also states that there should be a focus on eliminating cultural beliefs and stereotypes that "exacerbate the persistent and tolerance of violence against women," yet our research shows that these beliefs are still pervasive and having strong impacts on victims' care (African Union, 2003; Ferdowsian et al., 2018; Munala et al., 2018). SDG 5, which also focuses on eliminating violence against women and girls, states there should be universal access to sexual and reproductive health services (UN, 2021). As with the Maputo Protocol, our research indicates that this is simply not the case for people living in countries in East Africa.

Providers' Personal Beliefs

Nine papers in this review studied the personal beliefs of service providers. All the papers were academic articles and, as seems to be the overall trend with research in East Africa, most of the research took place in Kenya. Of the 20 countries included in East Africa, only Kenya, Malawi, Ethiopia, Tanzania, and Mozambique were represented in this area of research. Qualitative methodology was used in all studies, primarily qualitative interviews, or self-administered surveys. Some studies evaluated the providers' perceptions of the victims themselves, while others examined how the providers viewed or understood their responsibilities in providing care for SGBV victims. IPV was the most common type of violence included in these studies, followed by SV, rape, and SA. This is an interesting finding, as rape was the most common type of violence studied overall yet occurred only once in this topic area.

Two of the studies on the topic of duty bearers included NGO-organized trainings aimed at service providers to improve their "capacity to provide services to SV survivors" and to "improve the clinical care of SA survivors in diverse low resource settings" (Ferdowsian et al., 2018; Smith et al., 2013). One study evaluated beliefs pre- and post-intervention, and the other evaluated the effect of multiple variables on participant responses during the early stages of the intervention. All other studies in this group were descriptive. Attitudes, beliefs, knowledge, and confidence were some of the factors being evaluated in both studies, and pre- and post-intervention responses were measured with self-administered questionnaires.

Of the nine papers, the majority focused on the healthcare providers' views on how they cared for the victims, although three focused more on how the providers viewed the victims and how their opinions of the victims affected their care provision. All nine papers interviewed providers of varying types, be it medical students, nurses, midwives, or doctors, and one paper based in Kenya also interviewed legal and law enforcement professionals. The focus on healthcare professionals in this theme is reflective of the pattern seen throughout the review, wherein very little attention was paid to service providers other than those in the medical field.

Victim blaming was a pervasive theme throughout this group of articles, whether perpetrated by the service providers themselves or simply observed by them. Perhaps the most glaring example of provider bias came from a study in Nairobi, which found that providers felt they could tell when a survivor was not being genuine but was instead trying to access free reproductive health services, particularly because of being a commercial sex worker and being too ashamed to say so (Munala et al., 2018). One provider interviewed in the study noted "Not every client is genuine. Someone will find something happens and because now they are scared of the pregnancy they will tend to create a story" while another said, "Ok people are not being truthful; others know that you provide services for free" (Munala et al., 2018). Other research in Kenya evaluating attitudes toward SV survivors across different professional sectors found that law enforcement professionals were the most likely to feel that survivors should feel ashamed (19%), followed by legal professionals (13%) and healthcare professionals (5%) (Ferdowsian et al.,

2018). In a humanitarian context, lying about SA was seen as a way of qualifying for resettlement. One nurse in Ethiopia believed that women "don't come with medical problems they come for referral. They like to be referred. It is spoken or rumored that they will get a chance of getting resettlement" (Smith et al., 2013). Despite the training initiated during the intervention, there were not significant improvements post-intervention in the 68% of HCPs in Ethiopia who agreed that "people often make accusations about SA that are not true" or the 35% of healthcare providers who agreed with the opinion "if a woman's husband forces her to have sex, it does not count as sexual assault" because of cultural beliefs about a man's rights concerning his wife (Zraly et al., 2011).

Providers also felt that societal views of SGBV impacted their ability to provide services, both in how feelings of shame often prevented survivors from coming forward, which they understood from discussions with community members, and in how survivor-family interactions played out while in health centers. Providers additionally found that the potential financial consequences of reporting rape often dissuaded survivors from coming forward, especially when the perpetrator was the primary wage earner (Munala et al., 2020; Nguyen et al., 2016). Healthcare workers felt that their capabilities were limited by the societal views of violence, observing that often they would try to help but the community's ideals surrounding keeping families together and simply paying off the perpetrator made it difficult for them to do their jobs. One counseling psychologist described how she could do little more than try to make sure her clients were medically safe, as her abilities to help her clients who settled out of court were limited and the survivors had to continue living in the presence of their attacker(s) in their daily life after reparations had been arranged between families, potentially causing re-traumatization (Munala et al., 2020).

Gaps in the Literature

While Arksey and O'Malley's framework was key in executing most steps of this scoping review, the PAGER (pattern, advances, gaps, evidence for practice, and research recommendations) framework was referenced when identifying and addressing the gaps in the literature. This framework supplements Arksey and O'Malley's previous work and emphasizes that the identified gaps be contextualized and written for the target audience. With this in mind, a few notable gaps in the literature were found (Bradbury-Jones et al., 2021). A group notably absent from this review were men and boys, although this is largely to be expected because of the stigma attached to male victims of SV and the fact that significantly fewer men are victimized than women. Additionally, survivors who identified as genders beyond strictly male and female were not mentioned in the papers included in this review. It was not always clear whether the researchers excluded these other victims intentionally or whether they simply did not come forward to participate. Future research should examine service provision plans to determine whether and how providers adapt treatment depending on the gender of the survivor. Additionally, studies did not examine the type of psychosocial services offered to survivors. Research on this topic would further our understanding of how survivors' wellbeing is managed once they leave a health facility. Many papers mentioned women were often afraid to leave their spouses because of financial insecurity or societal pressures, and research regarding possible solutions for this, such as economic assistance or relocation, was largely absent from this literature.

Although this scoping review initially sought to examine medical and legal service provision, it became immediately clear that there is significantly less research on the legal/justice side of SGBV care than on the medical side. Of the 54 papers included in this review, 11 interviewed legal professionals, including police and justice organizations. These 11 papers covered only five of the 20 countries in East Africa, indicating there is a significant gap in knowledge about most countries in the region. It is important to conduct research on the legal aspect of post-SGBV service provision, especially because, while medical services may offer physical wellness to the survivors, pursuing justice and prosecuting the perpetrators may provide a sense of closure and security, as well as prevent the perpetrators from committing future similar crimes.

This review initially sought to evaluate existing medical and legal service provision practices throughout East Africa as they relate to country and region-wide policies; however, policy was scarcely mentioned throughout the literature. Without this insight, it made it difficult to know if the medical and legal practices were occurring as such because of a lack of guidance, because that is how the country's government or hospital's board instructed, or because of resource constraints. Additionally, the lack of policy inclusion made it difficult to compare country-wide medical and legal service guidelines with internationally agreed treaties, which was another original plan of this review which ended up not being feasible.

Discussion

This scoping literature review of 54 papers about SGBV in East Africa identified key themes surrounding both types of violence commonly seen in the region and common approaches to service provision. Many types of violence were identified as being pervasive throughout the region, and while rape was the most common type of violence in the selected literature, the interchangeable nature with which researchers and aid organizations use different definitions of violence mean that this finding is not necessarily reflective of which type of violence is the most prevalent in East Africa. Papers discussing rape made up 20% of the sample, followed by IPV (18%) and SA (17%).

Ten types of violence emerged from the literature. Although a type of violence was often specified in the title,

authors frequently switched between terms when explaining their research, further exacerbating the issue with finding clear, violence-specific data and contributing to poor data quality. This makes it difficult to compare similar statistics across countries and can complicate case building as the laws in countries may only pertain to some types of violence and not others. It is, however, an interesting finding that similar behaviors are being defined differently, perhaps pointing to political reasons why one phrase is preferred over another. Rape, for instance, is clearly defined in many countries' constitutions, whereas other terms, such as IPEV, are not mentioned once. In acknowledging the potential reasons why certain terms may be used more than others, we felt it was appropriate to organize this paper by the frequency of the term used in the papers included in this review. Rape, SV, and SGBV were often woven throughout a paper when describing the same study, although technically speaking, each of those terms has a different definition according to lawmakers, NGOs, and human rights organizations (Harrison et al., 2017; Liebling et al., 2020a, 2020b; Munala et al., 2018). SGBV and SV could perhaps be thought of as umbrella terms, however this should be better clarified in the papers for ease of understanding if certain types of violence make a victim more likely to seek and receive care and how resources are allocated.

Societal views of women were seen as a common cause of the violence itself and of the reluctance among survivors to seek help (Gatuguta et al., 2018; Kilonzo et al., 2003; Munala et al., 2020; Shumba et al., 2017). Patriarchal communities were explained as a common cause of violence throughout the region, although perhaps because the papers were not about preventing violence but rather addressing the side effects of it little was said about what could be done to address the patriarchal ideologies that made SGBV acceptable (Amnesty International, 2010; Kilonzo et al., 2003; Liebling et al., 2020a, 2020b; Manuel et al., 2019; McCleary-Sills et al., 2013; Munala et al., 2020; Odero et al., 2014; Tapesana et al., 2017). Patriarchal systems were also seen as the reason why many women did not seek help, but instead stayed in abusive relationships owing to ideas about what sort of behavior is to be expected in a marriage, as well as fears about financial insecurity and potential homelessness if one were to report her husband to the authorities (Fiske & Shackel, 2015; Kilonzo et al., 2003; McCleary-Sills et al., 2013).

A lack of human, material, and financial resources contributed to the difficulties in service provision felt by survivors and providers alike. Limited funding for supplies meant that, although providers often knew what should be included in a rape kit and what sort of treatment survivors should have access to, they simply did not have the resources to give to each survivor (Ajema et al., 2009; Dennis et al., 2019; Henttonen et al., 2008). A common approach to evaluate the quality of post-SGBV service provision was whether certain supplies were available in a post-rape/SGBV kit, or the elements of SGBV survivor medical management plans. The most common supplies deemed necessary to provide adequate care were EC, HIV tests and prophylaxis, speculums, and other materials needed for forensic exams (Dennis et al., 2019; Krolikowski & Koyfman, 2012; McCleary-Sills et al., 2013; Temmerman et al., 2019). While the possession of these materials is promising, their presence in a health facility does not mean that they are being utilized correctly, if at all. Resource constraints may mean that while some materials do exist, not all victims who present are deemed worthy of their use. Researchers also examined whether survivors were referred to psychological, psychosocial, and legal services to evaluate whether a given service provision package was comprehensive (Buard et al., 2013; Chepuka et al., 2014; Dennis et al., 2019; Gatuguta et al., 2018; Harrison et al., 2017; Kilonzo et al., 2009; Liebling et al., 2020a, 2020b; Liebling et al., 2019; Ononge et al., 2005; Ranney et al., 2011; Sithole et al., 2018; Tapesana et al., 2017).

Determining approaches to SGBV service provision throughout the region of East Africa was difficult, as some countries were studied far more than others. Kenya, for example, featured in 23 papers, whereas smaller countries, such as Burundi, Comoros, Djibouti, and Madagascar, were not mentioned once. Additionally, some countries in East Africa were mentioned mainly in the context of refugees that had come from that country to other countries in search of humanitarian aid, like refugees from Somalia and South Sudan in refugee camps in Kenya and Uganda (Amnesty International, 2010; Horn, 2010; Kawaguchi, 2018; Liebling et al., 2020a, 2020b; Muuo et al., 2020; Whelan & Blogg, 2007). Our review found that resource constraints and the failure of countries to follow WHO guidance were the most common themes that cut across the research studies on post-SGBV service provision in East Africa, although other issues, such as inconsistent provider training and provider bias, were also significant barriers to adequate service provision (Ajema et al., 2011; Ambikile et al., 2021; Amnesty International, 2010; Dennis et al., 2019; Gatuguta et al., 2018; Henttonen et al., 2008; Muganyizi et al., 2011; Nguyen et al., 2016; Odwe et al., 2018; Tapesana et al., 2017; Whelan & Blogg, 2007; Zraly et al., 2011).

Limitations

One limitation of the literature is the dearth of information about policies in each country. Although policy evaluation was to be included in this review according to the original protocol, it was so scarce in the literature that it had to be removed from the review altogether. Because there is such limited information on this topic, it is difficult to tell how each country's service provision compares to what "should" be happening, and what the possible policy implications might be. By not mentioning national policies as a criterion to evaluate service delivery, and similarly by neglecting to mention human rights treaties as a means of measuring the ethics of service provision, there is little official guidance to compare the practices to, WHO guidelines for post-SGBV

service provision were mentioned many times; however, these are not legally binding, whereas national policies would be. Additionally, there was little information provided about the health systems in each country, such as how the levels of care were divided or whether the country had nationalized health services, as well as the socioeconomic status of participants. Information on both facts could have helped provide a more comprehensive picture of why ser- vices are being accessed in the manner they are, especially regarding a victim's socioeconomic status compared to their country's health system. The researchers expanding on the types of services offered at private versus public institutions could have clarified equality of care, although most survi- vors surveyed accessed public institutions.

Conclusion

SGBV is a widespread human rights violation that is especially prevalent in the East African region. Research has found that current models and methods of service provision are leaving survivors with significant medical and psychosocial needs, and that countries are not providing adequate funding for services. Given the tremendous impact SGBV has on society, there is a need for further research into how to better incorporate SGBV into existing health systems and how to align the national policies of countries with international human rights treaties and WHO recommendations. Researchers should also account for the limited research that exists in some of the smaller countries to ensure that no SGBV survivors get left behind.

Summary of Critical Findings

- Limited financial and human resources were a major cause of inadequate service provision. Many providers did not receive appropriate training to work with SGBV survivors, and hospitals and health centers were also lacking appropriate supplies for forensic medical exams, such as speculums and rape kits.
- There is limited information available comparing existing practices to each country's health system, policies, or internation ally agreed human rights treaties.
- There is an extreme disparity in which countries receive the most international atte ntion and funding for research. Kenya was the focus of more than one-third of all included studies, while other countries, such as Seychelles, Comoros, and Mauritius, were not in any of the included papers.

Implications for Research

- Future studies are needed that focus on under-researched countries to ensure that all survivors in East Africa have equitable access to adequate service provision practices.
- Given that provider bias was found to be an issue significantly impacting a survivor's willingness to seek care, effective training interventions should be implemented across major health centers throughout the region.
- Research evaluating current government expenditures should be conducted to determine whether there is room in the existing budget to divert resources to SGBV service provision.

Implications for Practice and Policy

- SGBV service providers need to be adequately trained on proper evidence collection techniques, survivor -centered care, and how to overcome their preconceived notions and biases of survivors.
- Policymakers should incorporate human and financial resource needs into their policies. In addition, funding needs to be increased from national budgets to ensure that these services are included as part of the existing health system.
- Service provision practices must be designed to include delivery to rural and refugee populations that may not have access to high-level medical centers.

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Supplemental Material

Supplemental material for this article is available online.

Note

1. Notably, given the political, social, and economic volatility of the region, some of the papers discussed caring for survivors not only during peacetime, but during humanitarian crises as well.

References

Abeid, M., Muganyizi, P., Mpembeni, R., Darj, E., & Axemo, P. (2015). A community-based intervention for improving health-seeking behavior among sexual violence survivors: A controlled before and after design study in rural Tanzania. *Global Health Action*, *8*(1), 28608. https://doi.org/10.3402/gha.v8.28608

African Union. (2003). *Protocol to the African charter on human and peoples' rights on the rights of women in Africa*. African Union.

Ajema, C., Mukoma, W., Kilonzo, N., Bwire, B., & Otwombe, K. (2011). Challenges experienced by service providers in the delivery of medicolegal services to survivors of sexual violence in Kenya. *Journal of Forensic and Legal Medicine*, *18*(4), 162–166. https://doi.org/10.1016/j.jflm.2011.02.004

Ajema, C., Rogena, E., Muchela, H., Buluma, B., & Kilonzo, N. (2009). *Standards requried in maintaining the chain of evidence in the context of post rape care services: Findings of a study conducted in Kenya*. Liverpool VCT, Care & Treatment, the Division of Reproductive Health, and the Population Council.

Ambikile, J. S., Leshabari, S., & Ohnishi, M. (2021). Nurses' and midwives' awareness of intimate partner violence-related mental healthcare and associated factors in Tanzania. *Health & Social Care in the Community*, *29*(4), 947–956. https://doi.org/10.1111/hsc.13129

Amenu, D., & Hiko, D. (2014). Sexual assault: Pattern and related complications among cases managed in Jimma University Specialized Hospital. *Ethiopian Journal of Health Science*, *24*(1), 3–14. https://doi.org/10.4314/ejhs.v24i1.1

Amnesty International. (2010). *"I can't afford justice": Violence against women in Uganda continues unchecked and unpunished*. Amnesty International.

Amone-P'Olak, K., Elklit, A., & Dokkedahl, S. B. (2018). PTSD, mental illness, and care among survivors of sexual violence in Northern Uganda: Findings from the WAYS study. *Psychology Trauma*, *10*(3), 282–289. https://doi.org/10.1037/tra0000295

Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology*, *8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Bradbury-Jones, C., Aveyard, H., Herber, O. R., Isham, L., Taylor, J., & O'Malley, L. (2021). Scoping reviews: The PAGER framework for improving the quality of reporting. *International Journal of Social Research Methodology*, *25*(1), 1–14. https://doi.org/10.1080/13645579.2021.1899596

Buard, V., Van den Bergh, R., Tayler-Smith, K., Godia, P., Sobry, A., Kosgei, R. J., Szumilin, E., Harries, A. D., & Pujades-Rodriguez, M. (2013). Characteristics, medical management and outcomes of survivors of sexual gender-based violence, Nairobi, Kenya. *Public Health Action*, *3*(2), 109–112. https://doi.org/10.5588/pha.13.0012

Casey, S. E., Chynoweth, S. K., Cornier, N., Gallagher, M. C., & Wheeler, E. E. (2015). Progress and gaps in reproductive health services in three humanitarian settings: Mixed-methods case studies. *Conflict and Health*, *9*(Suppl 1), S3. https://doi.org/10.1186/1752-1505-9-s1-s3

Chepuka, L., Taegtmeyer, M., Chorwe-Sungani, G., Mambulasa, J., Chirwa, E., & Tolhurst, R. (2014). Perceptions of the men- tal health impact of intimate partner violence and health ser- vice responses in Malawi. *Global Health Action*, *7*(1), 24816. https://doi.org/10.3402/gha.v7.24816

Decker, M. R., Wilcox, H. C., Holliday, C. N., & Webster, D. W. (2018). An integrated public health approach to interpersonal violence and suicide prevention and response. *Public Health Reports*, *133*(1_suppl), 65S–79S. https://doi.org/10.1177/0033354918800019

Dennis, M. L., Owolabi, O. O., Cresswell, J. A., Chelwa, N., Colombini, M., Vwalika, B., Mbizvo, M. T., & Campbell, O. M. R. (2019). A new approach to assess the capability of health facilities to provide clinical care for sexual violence against women: A pilot study. *Health Policy and Planning*, *34*(2), 92–101. https://doi.org/10.1093/heapol/czy106

EAC Partner States. (2021). *About EAC*. https://www.eac.int/eac-partner-states

Ferdowsian, H., Kelly, S., Burner, M., Anastario, M., Gohlke, G., Mishori, R., McHale, T., & Naimer, K. (2018). Attitudes toward sexual violence survivors: Differences across professional sectors in Kenya and the Democratic Republic of the Congo. *Journal of Interpersonal Violence*, *33*(24), 3732–3748. https://doi.org/10.1177/0886260516639257

Fiske, L., & Shackel, R. (2015). Gender, poverty and violence: Transitional justice responses to converging processes of domination of women in eastern DRC, northern Uganda and Kenya. *Women's Studies International Forum*, *51*(4), 110–117. https://doi.org/10.1016/j.wsif.2014.11.008

Gatuguta, A., Merrill, K. G., Colombini, M., Soremekun, S., Seeley, J., Mwanzo, I., & Devries, K. (2018). Missed treatment opportunities and barriers to comprehensive treatment for sexual violence survivors in Kenya: A mixed methods study. *BMC Public Health*, *18*(1), 769. https://doi.org/10.1186/s12889-018-5681-5

Githui, S. N., Chege, M., Wagoro, M. C., & Mwaura, J. (2018). Barriers to screening pregnant women for domestic violence: A cross-sectional study. *Journal of Community and Public Health Nursing*, *4*(1), 207. https://doi.org/10.4172/2471-9846.1000207

Harrison, R. E., Pearson, L., Vere, M., Chonzi, P., Hove, B. T., Mabaya, S., Chigwamba, M., Nhamburo, J., Gura, J., Vandeborne, A., Simons, S., Lagrou, D., De Plecker, E., & Van den Bergh, R. (2017). Care requirements for clients who present after rape and clients who presented after consensual sex as a minor at a clinic in Harare, Zimbabwe, from 2011 to 2014. *PLoS One*, *12*(9), e0184634. https://doi.org/10.1371/journal.pone.0184634

Henttonen, M., Watts, C., Roberts, B., Kaducu, F., & Borchert, M. (2008). Health services for survivors of gender-based violence in northern Uganda: Aqualitative study. *Reproductive Health Matters*, *16*(31), 122–131. https://doi.org/10.1016/s0968-8080(08)31353-6

Horn, R. (2010). Responses to intimate partner violence in Kakuma refugee camp: Refugee interactions with agency systems. *Social Science & Medicine*, *70*(1), 160–168. https://doi.org/10.1016/j.socscimed.2009.09.036

International Committee of the Red Cross. (2022). 'That Never Happens Here' Sexual and gender-based violence against men, boys, and/including LGBTIQ+ persons in humanitarian settings. International Committee of the Red Cross.

Jemutai, J., Muraya, K., Chi, P. C., & Mulupi, S. (2021). A situation analysis of access to refugee health services in Kenya: Gaps and recommendations a literature review [Research Paper]. Centre for Health Economics, Alcuin College, University of York, York, UK.

Kassa, M., Hiwot, Y. G., & Abdella, A. (2009). Barriers to accessing emergency contraception by victims of sexual assault in Addis Ababa, Ethiopia. *Ethiopian Journal of Reproductive Health*, *3*(1), 24–30.

Kawaguchi, C. (2018). *The help-seeking pathways and barriers: Case of south sudanese refugees in Uganda* (Field Research Report). Peace and Development, JICA Research Institute.

Kilonzo, N., Molyneux, S., Taegtmeyer, M., & Theobald, S. (2003). *Post rape services in Kenya: A situation analysis*. Liverpool VCT and CARE Kenya.

Kilonzo, N., & Taegtmeyer, M. (2005). *Comprehensive post-rape care services in resource-poor settings: Lessons learnt from Kenya*. Liverpool VCT and CARE Kenya.

Kilonzo, N., Theobald, S. J., Nyamato, E., Ajema, C., Muchela, H., Kibaru, J., Rogena, E., & Taegtmeyer, M. (2009). Delivering post-rape care services: Kenya's experience in developing integrated services. *Bulletin of the World Health Organisation*, *87*(7), 555–559. https://doi.org/10.2471/blt.08.052340

Krolikowski, A. M., & Koyfman, A. (2012). Emergency Centre care for sexual assault victims. *African Journal of Emergency Medicine*, *2*(1), 24–30. https://doi.org/10.1016/j.afjem.2011.12.005

Kufa, K., Magure, T., Shambira, G., Gombe, N. T., Juru, T. P., Nsubuga, P., Borok, M., Iliff, V., Mushambi, T., & Tshimanga, M. (2019). Utilisation of medical services and outcomes at adult rape clinic at Parirenyatwa Group of Hospitals, Zimbabwe. *African Journal of Reproductive Health*, *23*(4), 99–107. https://doi.org/10.29063/ajrh2019/v23i4.12

Lakew, Z. (2001). Alleged cases of sexual assault reported to two Addis Ababa hospitals. *East African Medical Journal*, *78*(2), 80–83. https://doi.org/10.4314/eamj.v78i2.9093

Levac, D., Colquhoun, H., & O'Brien, K. K. (2010). Scoping studies: Advancing the methodology. *Implementation Science*, *5*(1), 69. https://doi.org/10.1186/1748-5908-5-69

Liebling, H. J, Barrett, H. R., & Artz, L. (2020a). South sudanese refugee survivors of sexual and gender-based violence and torture: Health and justice service responses in northern Uganda. *International Journal of Environment Research Public Health*, *17*(5), 1685. https://doi.org/10.3390/ijerph17051685

Liebling, H. J., Barrett, H. R., & Artz, L. (2020b). Sexual and gender-based violence and torture experiences of Sudanese refugees in northern Uganda: Health and justice responses. *International Journal of Migration, Health and Social Care*, *16*(4), 389–414. https://doi.org/10.1108/IJMHSC-10-2019-0081

Maina, G. M. (2009). Emergency medical response to intimate partner violence in Kenya. *Nursing Standard*, *23*(21), 35–39. https://doi.org/10.7748/ns2009.01.23.21.35.c6766

Maina, G., & Majeke, S. (2008). Intimate partner violence in Kenya: Expanding healthcare roles. *Nursing Standard*, *22*(35), 35–39. https://doi.org/10.7748/ns2008.05.22.35.35.c6533

Manuel, B., Roelens, K., Tiago, A., Keygnaert, I., & Valcke, M. (2019). Gaps in medical students' competencies to deal with intimate partner violence in key Mozambican medical schools. *Frontiers in Public Health*, *7*, 204. https://doi.org/10.3389/fpubh.2019.00204

McCleary-Sills, J., Namy, S., Nyoni, J., Rweyemamu, D., Steven, E., & Salvatory, A. (2013). *Help-seeking pathways and barriers for survivors of gender-based violence in Tanzania: Results from a study in Dar es Salaam, Mbeya, and Iringa Regions*. EngenderHealth/CHAMPION.

Mendelson, M., Han, P. V., Vincent, P., von Sonnenburg, F., Cramer, J. P., Loutan, L., Kain, K. C., Parola, P., Hagmann, S., Gkrania-klotsas, E., Sotir, M., & Schlagenhauf, P. (2014). Regional variation in travel-related illness acquired in Africa, March 1997-May 2011. *Emerging Infectious Diseases*, *20*(4), 532–541. https://doi.org/10.3201/eid2004.131128

Ministry of Public Health & Sanitation and Ministry of Medical Services. (2009). National guidelines on management of sexual violence in Kenya. Ministry of Public Health & Sanitation and Ministry of Medical Services.

Médecins Sans Frontieres. (2021). *Sexual and gender-based violence*. Issues & crises. https://msf.org.uk/issues/sexual-and-gender-based-violence

Muganyizi, P. S., Nyström, L., Axemo, P., & Emmelin, M. (2011). Managing in the contemporary world: Rape vic- tims' and supporters' experiences of barriers within the police and the health care system in Tanzania. *Journal of Interpersonal Violence*, *26*(16), 3187–3209. https://doi.org/10.1177/0886260510393006

Munala, L., Welle, E., & Hohenshell, E. (2020). "If you report your dad, how are you going to survive": Health practitio- ner perspectives on quality of care for survivors of sexual violence and the challenge of family interference. *Journal of Interpersonal Violence*, *37*(7–8), NP5294–NP5316. https://doi.org/10.1177/0886260520959622

Munala, L., Welle, E., Hohenshell, E., & Okunna, N. (2018). "She is NOT a genuine client": Exploring health practitioner's mistrust of rape survivors in Nairobi, Kenya. *International Quarterly of Community Health Education*, *38*(4), 217–224. https://doi.org/10.1177/0272684x18781790

Munn, Z., Peters, M. D. J., Stern, C., Tufanaru, C., McArthur, A., & Aromataris, E. (2018). Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC Medical Research Methodology*, *18*(1), 143. https://doi.org/10.1186/s12874-018-0611-x

Muuo, S., Muthuri, S. K., Mutua, M. K., McAlpine, A., Bacchus, L. J., Ogego, H., Bangha, M., Hossain, M., & Izugbara, C. (2020). Barriers and facilitators to care-seeking among survivors of gender-based violence in the Dadaab refugee complex. *Sexual and Reproductive Health Matters*, *28*(1), 1722404. https://doi.org/10.1080/26410397.2020.1722404

Nguyen, Q.-U. P., Flynn, N., Kitua, M., Muthumbi, E. M., Mutonga, D. M., Rajab, J., & Miller, E. (2016). The health care sector response to intimate partner violence in Kenya: Exploring health care providers' perceptions of care for victims. *Violence and Victims*, *31*(5), 888–900. https://doi.org/10.1891/0886-6708.VV-D-13-00146

Odero, M., Hatcher, A. M., Bryant, C., Onono, M., Romito, P., Bukusi, E. A., & Turan, J. M. (2014). Responses to and resources for intimate partner violence: Qualitative findings from women, men, and service providers in rural Kenya. *Journal of Interpersonal Violence*, *29*(5), 783–805. https://doi.org/10.1177/0886260513505706

Odwe, G., Undie, C.-C., & Obare, F. (2018). Attitudes towards help-seeking for sexual and gender-based violence in humanitarian settings: The case of Rwamwanja refugee settlement scheme in Uganda. *BMC International Health & Human Rights*, *18*(1),15. https://doi.org/10.1186/s12914-018-0154-6

Ononge, S., Wandabwa, J., Kiondo, P., & Busingye, R. (2005). Clinical presentation and management of alleged sexually assaulted females at Mulago hospital, Kampala, Uganda. *African Health Sciences*, *5*(1), 50–54.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M.,

Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., . . .Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ*, *372*, n71. https://doi.org/10.1136/bmj n71

Ranney, M. L., Rennert-May, E., Spitzer, R., Chitai, M. A., Mamlin, S. E., & Mabeya, H. (2011). A novel ED-based sexual assault centre in western Kenya: Description of patients and analysis of treatment patterns. *Emergency Medicine Journal*, *28*(11), 927–931. https://doi.org/10.1136/emj.2010.096412

Rockowitz, S., Flowe, H. D., & Bradbury-Jones, C. (2021a). Post-rape medicolegal service provision and policy in East Africa: A scoping review protocol. *Systematic Reviews*, *10*(1), 63. https://doi.org/10.1186/s13643-021-01613-9

Rockowitz, S., Kanja, W., and Flowe, H. D. (2021b). Challenging social norms and legal responses to rape and sexual violence: Insights from a practice–research partnership in Kenya. In C. Bradbury-Jones & L. Isham (Eds.), *Understanding gen- der-based violence* (pp. 99–112). Springer.

Schober, M., Mtonga, R., Valenti, M., & Hametner, S. (2016). Improving care for victims of violence in resource-poor settings such as Lusaka, Zambia: Results of a low-budget intervention. *Injury Prevention*, *22*(2), 144–148. https://doi.org/10.1136/injuryprev-2014-041386

Shumba, C. S., Mathibe-Neke, J., & Dolamo, B. L. (2017). The health needs of women with experiences of intimate partner violence living in urban slums in Kampala, Uganda. *Africa Journal of Nursing and Midwifery*, *19*(1), 1–14. https://doi.org/10.25159/2520-5293/826

Sithole, Z., Gombe, N. T., Juru, T., Chonzi, P., Shambira, G., Nsubuga, P., & Tshimanga, M. (2018). Evaluation of sexual and gender-based violence program in Harare City, Zimbabwe, 2016: A descriptive cross-sectional study. *Pan African Medical Journal*, *31*, 200. https://doi.org/10.11604/pamj.2018.31.200.14791

Smith, J. R., Ho, L. S., Langston, A., Mankani, N., Shivshanker, A., & Perera, D. (2013). Clinical care for sexual assault sur- vivors multimedia training: A mixed-methods study of effect on healthcare providers' attitudes, knowledge, confidence, and practice in humanitarian settings. *Conflict and Health*, *7*(1), 14. https://doi.org/10.1186/1752-1505-7-14

Tanzania Act No. 4 of 1998, Sexual Offences Special Provisions Act (1998)

Tapesana, S., Chirundu, D., Shambira, G., Gombe, N. T., Juru, T. P., & Mufuta, T. (2017). Clinical care given to victims of sexual assault at Kadoma General Hospital, Zimbabwe: A secondary data analysis, 2016. *BMC Infectious Diseases*, *17*, 602. https://doi.org/10.1186/s12879-017-2702-4

Temmerman, M., Ogbe, E., Manguro, G., Khandwalla, I., Thiongo, M., Mandaliya, K. N., Dierick, L., MacGill, M., & Gichangi, P. (2019). The gender-based violence and recovery centre at Coast Provincial General Hospital, Mombasa, Kenya: An integrated care model for survivors of sexual violence. *PLoS Medicine*, *16*(8), e1002886. https://doi.org/10.1371/journal.pmed.1002886

Ten Bensel, T., & Sample, L. L. (2017). Collective sexual vio- lence in Bosnia and Sierra Leone: A comparative case study analysis. *International Journal of Offender Therapy and Comparative Criminology*, *61*(10), 1075–1098 https://doi.org/10.1177/0306624X15609704

The World Bank. (2019). *Gender-based violence (violence against women and girls)*. Social Sustainability and Inclusion.

UN. (2021). *Achieve gender equality and empower all women and girls*. Sustainable Development. https://sdgs.un.org/goals/goal5

Undie, C., Maternowska, M. C., Mak'anyengo, M., & Askew, I. (2016). Is routine screening for intimate partner violence feasible in public health care settings in Kenya? *Journal of Interpersonal Violence*, *31*(2), 282–301. https://doi.org/10.1177/0886260514555724

UNHCR. (2021a). *Gender-based violence*. Protection. https://www.unhcr.org/uk/gender-based-violence.html

UNHCR. (2021b). Sexual and gender-based violence (SGBV) prevention and response. UNHCR.

Vyas, S. (2019). Violence against women in tanzania and its association with health-care utilisation and out-of-pocket payments: An analysis of the 2015 Tanzania demographic and health survey. *The East African Health Research Journal*, *3*(2), 125–133. https://doi.org/10.24248/eahrj-d-19-00012

Whelan, A., & Blogg, J. (2007). 'Halfway people': Refugee views of reproductive health services. *Global Public Health*, *2*(4), 373–394. https://doi.org/10.1080/17441690701267048

WHO. (2015). *Strengthening the medical and legal response to sexual violence*. https://www.who.int/publications/i/item/WHO-RHR-15.24

WHO. (2021a). *Gender-based violence in health emergencies.* Health Cluster.

WHO. (2021b). *Violence against women prevalence estimates, 2018: Global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women*. WHO.

Zraly, M., Rubin-Smith, J., & Betancourt, T. (2011). Primary mental health care for survivors of collective sexual violence in Rwanda. *Glob Public Health*, *6*(3), 257–270. https://doi.org/10.1080/17441692.2010.493165

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Caroline Bradbury-Jones, PhD, is a registered nurse and holds the post of Professor of Gender-Based Violence in the College of Medical and Dental Sciences at the University of Birmingham, UK. She leads a research program on risk, abuse, and violence. Her principal research interest is violence against women and children, and she has a particular interest in exploring new ways to investigate gender-based violence.

Chapter 3. Patterns Of Sexual Violence Against Adults And Children During The Covid-19 Pandemic In Kenya: A Prospective Cross-Sectional Study

During the pandemic, researchers worldwide began to recognise the effects that lockdown policies were having on men, women, and children, but especially women and children who were forced to stay inside with abusers to abide with their countries' lockdown regulations (Bradbury-Jones & Isham, 2020; Mittal & Singh, 2020; UNFPA, 2020). Kenya had especially harsh lockdown policies, which were heavily enforced by the police and caused serious physical injury and even death in some instances (Human Rights Watch, 2020).

In this cross-sectional study, I evaluated records held by human rights defenders who were associated with the Wangu Kanja Foundation and who were tasked with connecting victim/survivors to essential services during the pandemic. Sexual violence in this study was defined as 'any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting,' as per the World Health Organization (2022). I performed a logistic regression to identify which offence characteristics were significantly different between adult and child victim/survivors. The findings discussed are of relevance both in the Kenyan context and for humanitarian crises around the world.

References

Bradbury-Jones, C., & Isham, L. (2020). The pandemic paradox: The consequences of COVID-19 on domestic violence. Journal of Clinical Nursing, 29(13-14), 2047-2049. https://doi.org/10.1111/jocn.15296

Human Rights Watch. (2020). Kenya: Police Brutality During Curfew. Human Rights Watch. https://www.hrw.org/news/2020/04/22/kenya-police-brutality-during-curfew

Mittal, S., & Singh, T. (2020, 2020-September-08). Gender-Based Violence During COVID-19 Pandemic: A Mini-Review [Mini Review]. Frontiers in Global Women's Health, 1(4). https://doi.org/10.3389/fgwh.2020.00004

UNFPA. (2020). Millions more cases of violence, child marriage, female genital mutilation, unintended pregnancy expected due to the COVID-19 pandemic. https://www.unfpa.org/news/millions-more-cases-violence-child-marriage-female-genital-mutilation-unintended-pregnancies

World Health Organization. (2022). *Sexual Violence*. World Health Organization. Retrieved 14 November from https://apps.who.int/violence-info/sexual-violence/

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Patterns of sexual violence against adults and children during the COVID-19 pandemic in Kenya: a prospective cross-sectional study

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ABSTRACT

Objectives This study examined patterns of sexual violence against adults and children in Kenya during the COVID-19 pandemic to inform sexual violence prevention, protection, and response efforts.

Design A prospective cross-sectional research design was used with data collected from March to August 2020.

Setting Kenya.

Participants 317 adults, 224 children.

Main measures Perpetrator and survivor demographic data, characteristics of the assault.

Results Bivariate analyses found that children were more likely than adults to be attacked during daytime (59% vs 44%, $p<0.001$) by a single perpetrator rather than multiple perpetrators (31% vs 13%, $p<0.001$) in a private as opposed to a public location (66% vs 45%, $p<0.001$) and by someone known to the child (76% vs 58%, $p<0.001$). Children were violated most often by neighbours (29%) and family members (20%), whereas adults were equally likely to be attacked by strangers (41%) and persons known to them (59%). These variables were entered as predictors into a logistic regression model that significantly predicted the age group of the survivor, $\chi^2(5, n=541)=53.3$, $p<0.001$.

Conclusions Patterns of sexual violence against adult and child survivors during the COVID-19 pandemic are different, suggesting age-related measures are needed in national emergency plans to adequately address sexual violence during the pandemic and for future humanitarian crises.

Strengths and limitations of this study

- This study was conducted in partnership with frontline, human rights defenders, survivor-led organisations/networks and social justice centres using a prospective study design, which enabled the systematic and rapid study of sexual violence in Kenya during the pandemic, even though there were considerable physical distancing measures in place.
- The data provide detailed information about survivors and perpetrators, including where and when incidents occurred, which enabled us to compare patterns of sexual violence in adults and children.
- The sample comprised individuals who were seeking help in accessing vital services; therefore, inferences about patterns nationally in Kenya cannot be made because the data may not be representative.
- Information about whether patterns of sexual violence are changing during the pandemic remains unknown because sexual violence is under-reported and also more difficult to report and document during emergencies/humanitarian situations/pandemics, and there is a need for real-time data collection systems that gather and analyse detailed, longitudinal information about sexual violence especially in resource-limited countries like Kenya, where service and response infrastructure are not as robust.

INTRODUCTION

This study focuses on Kenya, a country that has a long history of sexual and gender-based violence (SGBV), which is exacerbated during times of national crisis, such as during election periods.[1] While SGBV affects women, men and children, it disproportionately affects women and girls, with one in three women having faced SGBV in their lifetimes worldwide.[2] Previous conflicts and disasters have led to increased gender inequality, gender- based violence and other human rights violations, owing to disruptions in response (medical), protection and legal services.[3] The arrival of COVID-19 in Kenya in early March 2020 marked the start of another national crisis, with more than 56 000 confirmed cases as of November 2020.[3–5] In late March, Pres- ident Kenyatta issued a nationwide curfew, with all non-essential travel banned between 19:00 and 05:00. Schools and non-essential businesses had to close, and travel in and out of the country was heavily restricted.[4 5] These measures have been extended and modified multiple times, and by November 2020, the

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number of people who could gather in groups was still limited. Schools were also still closed, but universities opened, and air travel restrictions were lifted.[6] While the measures have undoubtedly curbed the spread of the disease, they seemed to be compromising the safety and well-being of citizens. In particular, there have been widespread reports of increases in domestic and sexual violence during the COVID-19 crisis.[5 6]

Around the world, humanitarian crises, such as natural disasters, conflict and disease outbreaks, are associated with changing patterns of sexual violence.[7–9] After the 2010 earthquake in Haiti, for example, the odds of an adolescent girl in Haiti being sexually abused increased by 41%.[9] Increased sexual violence occurs during conflicts, notably in Rwanda, Kosovo and the Democratic Republic of the Congo (DRC). These crimes are espe- cially prevalent against women and children, and attacks by multiple perpetrators are common. In the DRC, for example, nearly 76% of women surveyed had experiences of rape that were consistent with the attack being used as a weapon of war, and 69% of women reported expe- riencing gang rape, with these incidents typically being perpetuated by three perpetrators on average.[10] These findings are consistent with research conducted in the Central African Republic, Libya and Mali, which found that multiple perpetrator rape was commonly reported by survivors.[11]

SGBV increases during disease outbreaks, with studies reporting increases in Sierra Leone, Liberia and Guinea during the Ebola outbreaks in West Africa in 2014–2016, and especially high increases in teenage pregnancies were reported in Sierra Leone.[12 13] Similarly, Zika and cholera outbreaks have been linked with increased inci- dence of domestic violence, and reductions in funding for and access to public health services.[14] Physical distancing measures implemented during pandemics are also thought to be responsible for changing patterns and increases in violence. For instance, lockdowns and curfews mean that people must remain indoors with abusers and are unable to access outside assistance because police and vital services are unavailable, and abusers can act with impunity.[15 16]

More research on SGBV during times of compounding crises is needed, however. SGBV is highly stigmatised, which leads to under-reporting, especially in resource-limited countries that have high levels of gender inequality. Further, it is difficult to assess whether patterns and rates of SGBV are changing during times of crisis, owing to the unavailability of nationally representative data and a lack of up-to-date and recurring data collection, as well as a lack of data harmonisation, which would allow for exam- ining SGBV trends in relation to humanitarian crises, and inform effective prevention, protection, and responses.

During the ongoing COVID-19 outbreak, several months of lockdown measures, economic challenges, health concerns and changing global relations have increased concerns of a heightened risk of SGBV. This violence during lockdown is being considered a shadow pandemic with the United Nations Population Fund estimating an additional 31 million cases of SGBV world-wide following 6 months of isolation.[16 17] Governments in some countries have had to create or supply alternate housing for people fleeing abusive situations, as was the case in Italy and France, with hotels being used as safe houses.[16] Social isolation policies have distinct impacts on children as well. Adolescent girls' absence from school, coupled with the lack of alternative safe spaces or shelters, has been associated with increased vulnera- bility to sexual violence from family members and others, including guardians, neighbours, and other community members.[18] As seen during the Ebola crisis, the closure of schools was associated with increased sexual violence against girls and boys, child pregnancies, and child marriage.[19]

This study prospectively investigated patterns of sexual violence perpetrated against adults and children in Kenya during the COVID-19 pandemic. We analysed data from interviews with adult survivors and the guardians of child survivors conducted by human rights defenders and members of the social justice centres during the pandemic. We focus on sexual violence because it has received less attention during the pandemic compared with physical violence. Further, research to date has not compared patterns of violence for adults and children. Doing so is critical because social isolation measures may differentially affect people in relation to age, and different measures may need to be put in place depending on the age group to prevent and respond to SGBV during COVID-19.

Based on the literature reviewed above, we predicted that there would be a greater number of women and girls violated compared with men and boys. Additionally, we anticipated there would be age-related differences in the types of locations in which sexual violence is occurring. Owing to school closures, and a lack of alternative safe spaces, we predicted that children would be at a greater risk than adults during the day, and in private compared with public locations. We also compared the incidence of multiple versus single perpetrator attacks to better understand the nature of the violence occurring in rela- tion to age. To our knowledge, no previous research has compared adults and children regarding the preva- lence of violations committed by multiple perpetrators in Kenya. Hence, no age group predictions were made concerning multiple perpetrators.

METHOD

Design

A quantitative between-group prospective research design was used. The criterion variable was age group (child or adult survivor). The predictor variables included the offence characteristics displayed in table 1, which also summarises how the variables were operationalised.

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Table 1 Descriptions of how predictor variables were coded and operationalised

Variable	Definition
Female survivor	Whether the survivor was female (coded as 1) as opposed to male (coded as 0).
Male perpetrator	Whether the perpetrator was male (coded as 1) as opposed to female (coded as 0).
Daytime attack	Whether the attack occurred in daytime (06:00–17:59; coded as 1) as opposed to at night (18:00–05:59; coded as 0).
Private or public location	Whether the attack occurred in a private home (coded as 1) as opposed to a public location where the violation could have been witnessed or interrupted by a member of the public (coded as 0).
Private location type	Private locations were further subdivided into victim residence (coded as 1 for victim residence, 0 for any other location public or private); perpetrator residence (coded as 1 for perpetrator residence, 0 for any other location public or private); or other residence (coded as 1 for other residence, 0 for any other location public or private).
Multiple perpetrator	Whether the attack was perpetrated by more than one perpetrator (coded as 1) as opposed to a singular perpetrator (coded as 0).
Known or stranger perpetrator	Whether the attack was perpetrated by someone known to the survivor (coded as 1) or a stranger (coded as 0).
Perpetrator relationship type	Perpetrator relationship type was subdivided into neighbour (coded as 1 for neighbour, 0 for any other relationship type); stranger (coded as 1 for stranger, 0 for any other relationship type); family member (coded as 1 for family member, 0 for any other relationship type); acquaintance/friend (coded as 1 for acquaintance/friend, 0 for any other relationship type); spouse/husband/boyfriend (coded as 1 for spouse/husband/boyfriend, 0 for any other relationship type); authority figure (coded as 1 for authority figure, 0 for any other relationship type); or other (coded as 1 for other, 0 for any other relationship type).

Participants

Participants (n=787) were survivors of sexual violence. All were residents of Kenya, living in 23 counties and had contacted human rights defenders for assistance in obtaining vital services in the aftermath of sexual violence during the COVID-19 pandemic between March and August 2020. The human rights defenders interviewed the survivors (or their legal guardians if they were under 18) about the offence on intake. The interview protocol was informed by the WHO's ethical principles for research on SGBV and safety protocols developed by the human rights defenders for conducting their work with survivors. The survivors were aged between 7 months and 72 years (M=21.3; SD=9.4 years).

Survivors were categorised into two age groups. Following definitions provided by the WHO, the child group included survivors aged 17 years and younger, whereas the adult group included survivors aged 18 years and older.[1]

After excluding cases with missing data on the predictor variables, the final sample consisted of 224 survivors in the child group and 317 in the adult group. The participants in the final sample for the child group ranged in age from 8 months to 17 years (M=12.6, SD=3.9), 83% were girls and 93% were perpetrated against by men, and for the adult group, participants ranged in age from 18 to 72 (M=27.1, SD=8.1) years, 92% were women and 96% were perpetrated against by men.

Materials

The data were obtained from records held by the human rights defenders who were assisting survivors in accessing vital services during the pandemic. They interviewed survivors about the incident and recorded information about the case on their standard intake form (online supplemental file 1). They recorded the date, time and location of the incident, and gave a free text description summarising the incident. The form also had specific items to document the number of perpetrators, the rela- tionship between the survivor and perpetrator(s), the location of the attack and the age and gender of the survivor and perpetrator. Additionally, while not analysed in the current paper, any services (eg, police, medical, safe house) the survivor had accessed were also recorded.

Procedure

Each intake form was read by two members of the research team to create the data set. They coded the data using the criteria outlined in table 1. If there were missing data on the form, the team read the incident summary and attempted to complete the missing information.

Ethics

The confidentiality of the data was maintained by the research team, and safety precautions were taken to minimise any risks that might cause physical harm to participants of this study. Data collection involved qual- itative interviews only, and participants were offered psychological services after interview. The Kenyan Data Protection Act (2019) was adhered to in the conduct of this research study.[20] Special attention was paid to Part IV of the Act, which notes that personal data should be processed with special attention to the privacy of the data subject, data should only be collected for specified and

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legitimate purposes and that the data subject has a right to know how their data are used.[20] The data belong to the Wangu Kanja Foundation and the Sexual Violence Survivors' Network in Kenya, and permission to use the data was obtained from these organisations to conduct the analyses.

Patient and public involvement

We relied heavily on input from civil society grass-roots organisations who work on the frontlines to assist survivors in accessing vital services in the aftermath of sexual violence, including the Wangu Kanja Foundation and the Sexual Violence Survivors' Network in Kenya. These organisations codeveloped the research questions, the study design including the data collection instruments. They also conducted participant recruitment, data collec- tion and assisted with manuscript preparation. Their experience and knowledge with sexual violence in Kenya informed every aspect of the project. Their reputation within the Kenyan communities enabled survivors to disclose the incidents that occurred. The Wangu Kanja Foundation and human rights defenders would also be integral in disseminating the research findings to their networks and relevant stakeholders.

Statistical analysis

As our main analysis, we used logistic regression with age group as the dependent variable to determine which offence characteristics significantly differentiated the child and adult groups. The child age group was coded as 1 in the analysis, whereas the adult age group was coded as 0. While our data contain detailed information about each attack, we restrict our analysis to a limited number of binary variables in table 1 as predictors. This is because there is a risk of a statistical common support problem if we use a finer grained analysis. For example, while we have detailed data on where survivors were attacked, or their relationship with the perpetrator, we could not exploit this as few in the child group were attacked going to work, or by their spouse or partner. To avoid this diffi- culty, we used the coarser coding of relationship, known versus stranger perpetrator and whether the attack took place in a public place or in private. This ensured that there were sufficient numbers of both children and adults in all categories. We then supplemented this analysis by tabulating the finer coding in tables 2 and 3.

We conducted preliminary analyses to identify which variables to enter into the model using Pearson's χ^2 tests for association. This allowed for testing whether the association between age group and each of the dichotomous variables was statistically significant. Only the variables that were significantly associated with age group were entered into the logistic regression model. To control for type 1 errors, Bonferroni corrections were applied to the 0.05 alpha level (adjusted alpha=0.008, with six vari- ables). The strength of the relationship between the indi- vidual offence characteristics was assessed using Cramer's V, which measures the magnitude of the relationship between two categorical variables.[21] Values that fall between 0.41 and 0.60 were interpreted as large, whereas values that fall between 0.20 and 0.40 were interpreted as moderate in magnitude. Values smaller than 0.20 were regarded as associations small in magnitude. All analyses were conducted using SPSS V.26.

Our data are freely available at: https://osfio/b9dzp/.

Table 2 Distribution of perpetrator relationship to survivor within age group

	Child n=224 (%)	Adult n=317 (%)
Neighbour	29	6
Stranger	25	41
Family member	20	5
Other	12	16
Acquaintance/friend	11	12
Spouse/husband/boyfriend	3	15
Authority figure	2	6

RESULTS

Bivariate (χ^2) analysis indicates that children compared with adults were less likely to be female and less likely to be attacked by multiple perpetrators (table 4). Regard- less, both child and adult victims were overwhelmingly female; 83% and 92%, respectively. Children were also more likely to be attacked in a private location by a known perpetrator and were more likely to be attacked in the daytime. The associations between age and private loca- tion, and age and multiple perpetrators were moderately large, whereas the strength of the other associations, while statistically significant, was small in magnitude.

In the logistic regression model, the variables that were statistically significant from the bivariate analysis (χ^2 results) were entered as predictors (ie, female survivor, daytime attack, private vs public location, multiple perpetrators and known vs stranger perpetrator), and the dependent variable was age group. The results are shown in table 5. The overall model was statistically significant, $\chi^2(5, n=541)=53.3$, $p<0.001$. According to Nagelkerke's R^2, 13% of the variability in age group was accounted

Table 3 Distribution of attack location within age group

	Child n=224 (%)	Adult n=317 (%)
Perpetrator's house	41	20
Public	28	48
Survivor's house	23	23
Other house	7	6
Survivor/perpetrator's house	1	3

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Table 4 Comparisons between characteristics of sexual violence against children versus adults: bivariate analysis

Variable	Child n=224 (%)	Adult n=317 (%)	Pearson's χ^2	P value	Cramer's V
Female victim	83	92	11.41	0.001	0.145
Male perpetrator	92	94	1.17	0.279	0.047
Daytime attack	59	44	13.18	<0.001	0.156
Private versus public location	66	45	21.55	<0.001	0.2
Multiple perpetrators	13	31	24.2	<0.001	0.212
Known versus stranger perpetrator	76	58	17.86	<0.001	0.182

for by the predictors in the model. Child compared with adult survivors were 1.61 times more likely to be attacked during the day, and 1.72 times more likely to be attacked in private as opposed to in public. Child compared with adult survivors were also significantly less likely (OR=0.458) to be female, and less likely (OR=0.528) to be attacked by multiple perpetrators.

Tables 2 and 3 present a more detailed descriptive analysis of the child and adult cases on the relationship between the perpetrator and the victim, and the loca- tions in which the attacks took place. As can be seen, age group was significantly associated with the relation- ship between the perpetrator and the survivor, $\chi^2(7, n=541)=107.84$, $p<0.001$. Children were most often victi- mised by neighbours, followed by strangers, and family members, whereas adults were most often victimised by strangers, followed by other types of perpetrators (customer, community member, friend of a friend), and spouses. Age group was also significantly associated with attack location, $\chi^2(4, n=541)=35.59$, $p<0.001$. Children were most often attacked at the perpetrator's house (41% of the cases), whereas adults were most often attacked in public locations (48% of cases).

DISCUSSION

Summary of key findings

We compared patterns of sexual violence committed against adults and children in Kenya during the COVID-19 pandemic. The data arose from interviews conducted by human rights defenders with survivors and describe the experiences of 541 survivors. We found that the children in our sample were on average 4 years younger compared with national surveys of children in Kenya.[22 23] Further, compared with adults, children were more likely to be attacked during the day, in private as opposed to public locations, by lone perpetrators and by neighbours. In what follows, we discuss our findings in relation to existing research and draw implications for policy.

Table 5 Outputs of logistic regression by predictor variable

	df	Estimate	SE	Wald χ^2	P value
Female victim	1	−0.782	0.29	7.3	0.007
Daytime attack	1	0.474	0.19	6.5	0.011
Private versus public location	1	0.543	0.21	6.96	0.008
Multiple perpetrators	1	−0.638	0.27	5.77	0.016
Known versus stranger perpetrator	1	0.295	0.34	1.6	0.21

Comparisons to current literature

There were significant numbers of children in our sample, which is unsurprising, as approximately half of gender-based violence (GBV) survivors are children during humanitarian crises. However, the children in our sample were 12 years old on average, which is 4 years younger than the nationally representative samples taken before the pandemic.[22 23] Our sample was not nationally representative due to time and resource constraints, and it must also be noted that this violence was occurring within a particular crisis and the consequences of other crises may be different. However, it is still notable that the child survivors in our sample were younger than previous national samples have indicated. A recent study in Kenya noted that survivors who are being seen in medical settings during the pandemic appear to be younger compared with before the pandemic, speculating this is due to school closures during the pandemic.[24] Although SGBV, such as domestic violence, has been linked to cases of domestic homicide in Kenya, there were no mortalities captured in our study sample.[25]

We also found that children were 1.61 times more likely than adults to be attacked during the day. This could be attributed to the way that children and adults were spending their time during the pandemic. Because schools were closed, and there was no provision of any alternative safe spaces, children may have been often left alone or under the care or supervision of neighbours or community members, which may have made them more vulnerable to attack in some instances. Children were more likely to be attacked in private as compared with public locations. Adults in our sample were about equally likely to be attacked during the day as at night. Further, in keeping with previous research, significantly more adults

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were violated by multiple perpetrators in one attack compared with children.[26]

The proportion of boys in the child group was larger than the proportion of men in the adult group. This may reflect differential rates of victimisation for men compared with boys, as boys are more vulnerable to assault than men due to their age. Another possible reason is that sexual violence against men compared with boys is disclosed less often. The legal definition of rape in Kenya, like many countries, requires 'vaginal penetration', which reinforces sociocultural notions that men cannot be sexu- ally victimised.[27] Further, the tendency for people to believe that the victimisation of men is harmless, coupled with self-blame, and fear on the part of victims that their community and family will react negatively towards them, discourages men from seeking help, and reporting sexual offences to the police.[28]

The children in our sample were more likely to be violated by someone they knew than a stranger. For adults, perpetrators were most likely to be strangers, followed by neighbours and community members, and spouses. The most common perpetrators for children were neigh- bours, followed by strangers and family members. Adults were violated by strangers more frequently because they were often attacked when the opportunity struck, such as while walking to or from work, whereas children were violated by neighbours when they were left under their supervision due to school closures and their parents' job requirements.[29] Children were attacked by neigh- bours and in the perpetrators' houses at higher rates than adults. Although both groups were more likely to be violated by someone they knew as opposed to a stranger, and in both groups more than half of the perpetrators were known to the survivor, there is a high proportion of strangers compared with known assailants in both age groups. There were several instances in our data set in which neighbours invited children to use a computer or access the Internet, and then assaulted them once they were inside the neighbour's residence.

Strengths and limitations

This research was conducted in partnership with front- line, survivor-led organisations using a prospective study design, which are key strengths. This enabled us to study sexual violence systematically and rapidly in Kenya during the pandemic, even though there were considerable physical distancing measures in place. Further, our data are unusually rich. The data provide detailed information about survivors and perpetrators, where and when the incidents occurred, which allowed for studying patterns of sexual violence. There are also several limitations of our study to note. First, the sample comprised individuals who were seeking help in accessing vital services. Hence, inferences about patterns nationally in Kenya cannot be made because the data may not be representative. Further, our data do not provide information about overall sexual violence trends in our study setting. Like many countries around the world, sexual violence is under-reported, and detailed, longitudinal information about sexual violence incidents is lacking. Consequently, researchers struggle to make inferences about whether patterns of violence are changing during COVID-19.[30] For example, the Demo- graphic and Health Survey in Kenya, which is a nationally representative survey of adults conducted every 5 years, does not gather in-depth information about violations. For example, it does not collect information about the time of day (or night) the attack occurred, if there were multiple perpetrators involved in the attack and if the attack took place in a public or private location. Similarly, the national Violence Against Children Survey in Kenya, conducted in 2010 and 2019, does not gather in-depth information. We also had to rely on secondhand accounts from guardians of sexual violence against children, owing to a lack of trained personnel and adequate resources in Kenya for interviewing children. Some children were too young to be interviewed, with the youngest victim being just 7 months old. Finally, our model better accounted for patterns of violence against adults compared with chil- dren. This is because some of the factors we analysed were more applicable to adults than children (eg, employment, romantic relationships, being alone in public).

Recommendations and conclusion

We urge policymakers to ensure that government COVID-19 emergency management and recovery plan- ning adequately addresses SGBV and that minimising the risk of additional SGBV risk is integrated into national crisis policies. In particular, the results above suggest this should include the provision of adequate alternative safe spaces and shelters when schools are closed. Further, many communities have voluntarily organised neighbour- hood watch groups that are focused on security issues, and these should be explicitly expanded and supported to monitor and prevent SGBV. Community leaders have also said that there is a need for more social halls— community facilities for holding meetings, which would enable screening educational films, and other social activ- ities. These structures can be a safe space for children and can be built using constituency development funds, which each member of parliament in Kenya receives to undertake projects that will address the urgent needs of their constituents.

Our results indicate the importance of high-quality and timely data in understanding and thus combating SGBV. We thus recommend governments invest in real- time data collection and analysis systems to capture the evolving distribution of SGBV and to allow for the study of regional trends. Data collection would allow authori- ties to identify crime hotspots and violations being perpe- trated by serial offenders, and to monitor the accessibility of vital services to help ensure that survivors have support. This information is crucial in designing effective inter- ventions. For example, by knowing the location and time of attacks, there can be more vigilance and awareness of SGBV against children. Additionally, this information can be used to provide further education about SGBV against

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children and can highlight signs to look out for of abuse. These interventions can be low cost, with communities mobilised to create such activities with the help of university students, local non-governmental organizations (NGOs), neighbourhood teachers and religious organisations. Police patrols and community initiatives could also be planned for times at which SGBV rates peak to deter attacks and apprehend offenders. Further, the installation of street lighting might deter perpetrators from attacking women and children. Another suggestion is to establish a national sexual offender register in Kenya that would warn communities about high-risk offenders. The collection of real-time data can also inform educational programmes that sensitise parents and children about community risks. These efforts must be survivor-centred, involving survivors in the implementation and evaluation of the systems.

More generally, the results in this paper highlight the latent risk of SGBV, particularly for women and girls. While its manifestation currently waxes and wanes dependent on the context, meaningful reductions in violence will require changing the narrative such that SGBV is understood to be a crime, a gross violation of human rights, and that its pre-eminent importance as a determi- nant of physical, emotional and mental health is reflected in national and county budgets. Funding for program- ming, interventions and research should be included.

High rates of SGBV also necessitate adequate protec- tion for the needs of survivors. To this end, the national government has approved the use of the National Government Affirmative Fund to facilitate the establishment of safe spaces/shelters in all 47 counties to ensure survivors' safety and security is safe guarded. However, advocacy is required to ensure the funds are directed appropriately.

The implementation of emergency referral pathways that enable survivors to access comprehensive care and support services should be enacted by the government. Curfews and other social distancing regulations need to include SGBV response mechanisms to ensure the continued availability and accessibility of services for survivors. Further, the medicolegal response to SGBV can be strengthened by expediting restraining orders and prosecutions, and by establishing 'one-stop' centres to allow survivors to access essential services, and authorities to collect evidence, all in one location. This would also facilitate the preservation of evidence and protection of survivors to facilitate access to justice.

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REFERENCES

1 Odhiambo A. *"They Were Men in Uniform" Sexual Violence Against Women and Girls in Kenya's 2017 Elections USA*. Human Rights Watch, 2017.
2 World Health Organization. Violence against women who.int: World Health Organization, 2021. Available: https://www.who.int/news-room/fact-sheets/detail/violence-against-women
3 Ministry of Health. First case of coronavirus disease confirmed in Kenya: Ministry of health, 2020. Available: https://www.health.go.ke/first-case-of-coronavirus-disease-confirmed-in-kenya/#:~:text=The%20Ministry%20of%20Health%20has,in%20China%20in%20December%202019
4 Ritchie H, Ortiz-Ospina E, Beltekian D. Kenya: coronavirus pandemic country profile ourworldindata.org: ourworldindata.org, 2020. Available: https://ourworldindata.org/coronavirus/country/Kenya
5 Flowe H, Rockowitz S, Rockey J. *Sexual and other forms of violence during the COVID-19 pandemic emergency in Kenya*. The University of Birmingham, 2020.
6 Bearak M, Ombuor R. *Kenya's coronavirus curfew begins with wave of police crackdowns*. The Washington Post, 2020.
7 Marsh M, Purdin S, Navani S. Addressing sexual violence in humanitarian emergencies. *Glob Public Health* 2006;1:133–46.
8 Dara Kay C, Ragnhild N. Sexual violence in armed conflict: introducing the SVAC dataset, 1989–2009. *J Peace Res* 2014;51:418–28.
9 Sloand E, Killion C, Yarandi H, *et al*. Experiences of violence and abuse among internally displaced adolescent girls following a natural disaster. *J Adv Nurs* 2017;73:3200–8.
10 Harvard Humanitarian Initiative, Open Society Institute. *Characterizing sexual violence in the Democratic Republic of the Congo: profiles of violence, community responses, and implications for the protection of women*. Cambridge, MA: Harvard University, 2009.
11 Guterres A. *Conflict related sexual violence: report of the United Nations Secretary General*. United Nations, 2019.
12 O'Brien M, Tolosa MX. The effect of the 2014 West Africa Ebola virus disease epidemic on multi-level violence against women. *Int J Hum Rights Healthc* 2016;9:151–60.
13 Schwartz DA, Anoko JN, Abramowitz SA. *Pregnant in the time of Ebola women and their children in the 2013-2015 West African epidemic*. Cham: Springer International Publishing, 2019.

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14 Chandan JS, Taylor J, Bradbury-Jones C, *et al*. COVID-19: a public health approach to manage domestic violence is needed. *Lancet Public Health* 2020;5:e309.
15 Mittal S, Singh T. Gender-Based violence during COVID-19 pandemic: a mini-review. *Front Glob Womens Health* 2020;1.
16 Bradbury-Jones C, Isham L. The pandemic paradox: the consequences of COVID-19 on domestic violence. *J Clin Nurs* 2020;29:2047–9.
17 UNFPA. Millions more cases of violence, child marriage, female genital mutilation, unintended pregnancy expected due to the COVID-19 pandemic, 2020. Available: https://www.unfpa.org/news/millions-more-cases-violence-child-marriage-female-genital-mutilation-unintended-pregnancies
18 Onyango M, Resnick K, Davis A. Gender-Based violence among adolescent girls and young women: a neglected consequence of the West African Ebola outbreak: medical, anthropological, and public health perspectives 2019:121–32.
19 Giannini S, Albrectsen AB. *Covid-19 school closures around the world will hit girls hardest unesco.org: UNESCO*, 2020.
20 The Data Protection Act, 24, 2019. Available: http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/2019/TheDataProtectionAct__No24of2019.pdf
21 McHugh ML. The chi-square test of independence. *Biochem Med* 2013;23:143–9.
22 Kenya Ministry of Health, Kenya National Bureau of Statistics, National AIDS Control Council, Kenya Medical Research Institute, National Council for Population and Development. *Kenya demographic and health survey, 2014*. Kenya, 2015.
23 Ministry of Labour and Social Protection Kenya. *Violence against children in Kenya: findings from a national survey, 2019*. Kenya, 2019.
24 Johnson K, Green L, Volpellier M, *et al*. The impact of COVID-19 on services for people affected by sexual and gender-based violence. *Int J Gynaecol Obstet* 2020;150:285–7.
25 Mungai C. *Domestic violence in Kenya: stop blaming women*. Cambridge, MA: Nieman Foundation, 2019.
26 Edinburgh L, Pape-Blabolil J, Harpin SB, *et al*. Multiple perpetrator rape among girls evaluated at a hospital-based child advocacy center: seven years of reviewed cases. *Child Abuse Negl* 2014;38:1540–51.
27 Bullock CM, Beckson M, Mace B. Male victims of sexual assault: phenomenology, psychology, physiology. *J Am Acad Psychiatry Law* 2011;39:197–205.
28 Hlavka HR. Speaking of stigma and the silence of shame: young men and sexual victimization. *Men and Masculinities* 2017;20:482–505.
29 Simba H, Ngcobo S. Are Pandemics Gender Neutral? Women's Health and COVID-19. *Frontiers in Global Women's Health* 2020;1.
30 Chelangat N, Kipyego E, Kimani S. *Trapped within a lockdown: understanding sexual and gender-based violence during the Covid-19 period*. Nairobi: Professional Criminologists Association of Kenya, 2020.

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Chapter 4. Evaluating Case Attrition Along The Medico-Legal Case Referral Pathway For Sexual And Domestic Violence Survivors In Kenya: A Secondary Data Analysis

Understanding the case referral pathway in Kenya was a crucial aspect of evaluating barriers to post-rape medico-legal service provision, with the pathway outlining the proper steps (in the eyes of Kenyan officials) in receiving care. Despite the case referral pathway, it was not always clear to victims in what order they should visit service providers to both receive appropriate physical and mental health care and complete the proper paperwork needed to document a case and pursue justice. Work in other settings had demonstrated correlates between offence and victim characteristics and progression through the medico-legal system after a sexual violence event (Artz & Smythe, 2007; Lea et al., 2016; Pattavina et al., 2021). However, similar work had not been done in Kenya. Although there was research about how few victims' cases reach prosecution, work identifying possible predictive factors of this outcome had not been done before (Shadle, 2010).

In the secondary data analysis reported in this chapter I used a quantitative cross-sectional research design to identify correlates of victims and their cases through the case-referral pathway. Sexual violence in this study was defined as 'any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting,' as per the World Health Organization, and domestic violence was defined as violence by a current or former intimate partner, including physical, sexual, or emotional abuse (Garcia-Moreno et al., 2005; 2022). The sequential logit model was used to model the progress of a case as a series of distinct choices made by the victim rather than a selection from a list of outcomes, including seeking medical attention and seeking help from the police. It evaluated the dataset both as a whole

and separately as domestic violence only or sexual violence only.

References

Artz, L., & Smythe, D. (2007). Case attrition in rape cases: a comparative analysis. South African Journal of Criminal Justice, 20, 158-181.

Garcia-Moreno, C., Jansen, H. A. F. M., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Initial results on prevalence, health outcomes, and women's responses* W. Press. https://apps.who.int/iris/handle/10665/43309

Lea, S. J., Callaghan, L., Grafton, I., Falcone, M. A., & Shaw, S. (2016). Attrition and Rape Case Characteristics: A Profile and Comparison of Female Sex Workers and Non-Sex Workers. Journal of Interpersonal Violence, 31(12), 2175-2195. https://doi.org/10.1177/0886260515573575

Pattavina, A., Morabito, M. S., & Williams, L. M. (2021). Pathways to Sexual Assault Case Attrition: Culture, Context, and Case Clearance. Victims & Offenders, 16(8), 1061-1076. https://doi.org/10.1080/15564886.2021.1970661

Shadle, B. (2010). Sexual Offences in Kenya Courts 1960s-2008.

World Health Organization. (2022). *Sexual Violence*. World Health Organization. Retrieved 14 November from https://apps.who.int/violence-info/sexual-violence/

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Evaluating Case Attrition along the Medico-Legal Case Referral Pathway for Sexual and Domestic Violence Survivors in Kenya: A Secondary Data Analysis

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ABSTRACT

Case attrition along the medico-legal referral pathway for sexual and domestic violence survivors has drawn attention worldwide. Despite much research about the prevalence of sexual and domestic violence in Kenya, little is known about factors impacting progress through the medico-legal referral pathway. To address this research gap, we ana- lyzed data from the Wangu Kanja Foundation, based in Nairobi, to test which key case characteristics have explanatory power in predicting case progression. We used a sequential logit model to evaluate case progression as a series of distinct choices. Our analysis revealed that age of the survivor was the strongest predictor for all steps of the pathway, and that the presence of forensic evidence was also asso- ciated with increased odds of moving through each step. These find- ings reflect cultural ideas about what legitimizes a case of sexual or domestic violence and can be used to inform policy targeted at strengthening the case referral pathway in Kenya.

KEYWORDS

Kenya; sexual violence; domestic violence; case attrition

Introduction

In Kenya, as elsewhere, sexual violence (SV) and domestic violence (DV) affect the lives of people of all ages, particularly those of women and girls (Garcia-Moreno et al., 2005). Close to 41% of women in Kenya have experienced DV and/or SV at least once in their lifetime, with nearly 26% report having experienced it within the previous 12 months (Ministry of Health Kenya et al., 2015). For comparison, 25% of women in the United States and 30% of women in England and Wales have experienced lifetime DV and/or SV (Office for National Statistics [ONS], 2022; Truman et al., 2014).

Women and girls in Kenya are also at risk of SV from a young age. A third of females and nearly a fifth of males in Kenya experience childhood (i.e., age <18) SV according to the most recent population-based survey (UNICEF et al., 2012). For females, 18% have experi- enced SV by the age of 13, 39% by the ages of 14–15, and 43% by the ages of 16–17 years (UNICEF et al., 2012). Additionally, 24.3% of female survey respondents stated that they had experienced sexual intercourse against their will prior to the age of 18.

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Despite these high rates of SV and DV, there is very little research on case adjudication in Kenya. What is known about SV and DV in Kenya originates largely from work seeking to measure prevalence using the Demographic and Health Survey (DHS). The DHS asks women if they have experienced violence using a modified version of the Conflict Tactics Scale, which lists some types of violence but excludes others, an approach that often underestimates the actual prevalence of violence (Ministry of Health Kenya et al., 2015).

To prevent and protect people from SV, Kenya passed The Sexual Offences Act in 2006. It defines acts that constitute sexual offences and sets minimum sentences. Nevertheless, sexual and gender-based violence (SGBV) convictions are rare in Kenya and the country has relatively high rates of SV and DV (Shadle, 2010; UN Women, 2016). The current research is the first to systematically study SV and DV case attrition along the medico-legal case referral pathway in Kenya, wherein cases reported by victim-survivors to the authorities are recorded and proceed from medical facilities to the police station, then the prosecutor's office, and finally to the court system. To our knowledge, only two other studies have investigated case attrition in Africa (both in South Africa, (Artz & Smythe, 2007; Machisa et al., 2022). It is not altogether surprising that there is little research on SV and DV case attrition in Kenya. Research on this topic requires case-level data that are linked across multiple agencies. Data of this nature are typically unavailable in low-income countries.

Our analysis of SV and DV case attrition is based on data from SV survivors who sought services from the non-profit Wangu Kanja Foundation (WKF), a Kenyan NGO, between 2016–2020. The WKF supports adult and child survivors along the medico-legal case referral pathway, which in Kenya includes medical services, security services, and official justice via the police and courts.

The WKF dataset allowed us to analyze case attrition along the medico-legal case referral pathway among SV and DV survivors. In Kenya, cases proceed along the pathway in a stepwise fashion and in a predetermined order (i.e., the survivor must first obtain a medical report before reporting the crime to the police, and so forth). Thus, the data structure allows us to use sequential logit models to study case attrition (Buis, 2017). We studied case attrition across the pathway as a function of key case characteristics, such offense type, demographic information about the victim and perpetrator, and information about evidence in the case (i.e., DNA, clothing, weapon used) to test which have explanatory power in predicting case progression. The outcome variables tested included whether medical services were accessed, whether the case was reported to the police, whether the case proceeded to the prosecutors' office, and whether the cases went to court. Sequential logit models were chosen because they allow for evaluating the effect of an explanatory variable (in this case engagement with steps along the case referral pathway) with the outcome (e.g., the case being reported to the police; Buis, 2017). Each interaction with a different step along the case referral pathway can be thought of as a transition to the next step, which means, for example, that to reach step three, the survivor must first have passed through steps one and two. The approach also allowed us to evaluate which case factors (e.g., evidence, relationship between the victim and perpetrator) influence each transition along the case referral pathway (Pattavina et al., 2021). By identifying which steps of the pathway are reached and what case factors are most likely to lead a victim through each step, targeted interventions can be designed and implemented at crucial points along the pathway.

Case attrition

Case attrition, which refers to the cases which are lost or dropped from the criminal justice process, is a problem that has been seen in sexual violence cases for decades (Gregory & Lees, 1996). In the 1980s, research showed that a high proportion of rape and sexual assault cases reported in the United Kingdom were categorized by the police as “no-crimes” and were not recorded as offenses, with similar research across multiple American cities finding that sexual assault complaints were often categorized by police as “unfounded,” meaning that the case was not regarded as constituting a crime (Gregory & Lees, 1996; Kerstetter, 1990; Spohn & Tellis, 2012). Additionally, the few cases that did proceed to court largely ended up either in a conviction for a less serious offence or in acquittal (Gregory & Lees, 1996; Hohl & Stanko, 2015; Smith & Skinner, 2017). While limited research on the decision to prosecute rape cases has been conducted in Kenya, research conducted elsewhere has found that there are a few factors that predict the filing of charges against a perpetrator. These include the presence of injuries to the victim, the use of a weapon during the assault, evidence that calls into question the victim’s moral character, and a timely report by the victim (Beichner & Spohn, 2005). Additionally, women who are perceived to have engaged in “risk-taking” behavior, such as hitchhiking, walking alone at night, being in a bar alone, or using alcohol or drugs are less likely to be seen as genuine victims, and thus are less likely to have their cases prosecuted (Spohn & Holleran, 2001).

Prior work has found that sexual violence cases are less likely to move through the case referral pathway from reporting to prosecution and then conviction than other types of offenses, often due to a combination of legal factors and extra-legal factors, with legal factors including whether the sexual assault charge is one of a number of charges and with extra- legal factors including perceived victim cooperation (Hester & Lilley, 2017; Lovell et al., 2021). Previous research has also revealed that a combination of factors can predict attrition at various points along the care-seeking pathway, including victim characteristics, the location or duration of the offense, and evidence of the attack (Lea et al., 2016). The relationship between the victim and offender and the perceived vulnerability of the victim have also been found to increase attrition in sexual violence cases, with cases involving intimate partners being treated differently by the criminal justice system than cases invol- ving strangers or acquaintances (Hester & Lilley, 2017; Kerstetter, 1990; Spohn & Tellis, 2012). Case attrition can also occur due to the desires of the victims to no longer formally pursue the case, perhaps due to the perceived mental health burden of the process or threats from the perpetrator, although accurate numbers on this may be hard to determine due to a lack of clarity about whether the individuals themselves wanted to drop the case or whether they felt pressured to do so by police or others around them (Lea et al., 2003; Murphy et al., 2014). Additionally, other factors that predict case progression include the victim’s character and details about the offense that are consistent with rape myths, which are beliefs about rape that serve to discredit the victim’s claims, such as a woman’s revealing clothing being the reason she was assaulted, and are deeply entrenched in society (Murphy- Oikonen et al., 2022; Thelan & Meadows, 2022). Rape myth acceptance on the part of criminal justice practitioners, including the jurors selected for rape cases, has been asso- ciated with case attrition in upper-income (e.g., the US and the UK) as well as lower-income countries (Artz & Smythe, 2007; Leverick, 2020; Temkin et al., 2016; Withers et al., 2019).

There is considerable case attrition in Kenya, owing in part to the complex case referral pathway that is often challenging for victim-survivors to navigate. The Kenyan health system relies on the Division of Reproductive Health to provide policy and capacity development for SV cases; however, Kenya's integrated approach to primary care, which aims to treat patients holistically rather than through specialization, is under-developed, making it difficult for survivors of SV to access the vital post-assault services they typically require (Kilonzo, Theobald, et al., 2009). These include forensic medical exams, pregnancy tests, and HIV prophylaxis, as well as legal assistance.

Facilities that offer post-rape services frequently lack proper protocols and confidential spaces for SGBV survivors to receive treatment, and there are poor reporting and procedural requirements. As a result, survivors are often evaluated improperly (i.e., in a manner that is inconsistent with government forensic protocols) and given insufficient counselling (Kilonzo, Theobald, et al., 2009). Additionally, survivors often face financial barriers, such as being asked to pay to print medical or legal forms, or for drugs and other services in public institutions (Kilonzo, Theobald, et al., 2009). There are also poor community structures for long-term follow-up with survivors. The infrastructure at health facilities for comprehensive SV services is inadequate and thus forensic evidence is collected improperly, and the linkage between the medical and legal sectors is weak (Temmerman et al., 2018). For instance, if medical professionals do not use an official government form to record their clinical notes, the information cannot be used as evidence in court (Kilonzo, Ndung'u, et al., 2009).

Additionally, the law requires that medical evidence is presented in court by an "expert witness"; however, medical professionals providing care to survivors are often not deemed to be experts by the courts (Kilonzo, Ndung'u, et al., 2009). Moreover, cases of rape or other forms of SV, usually in provinces outside of Nairobi, against both children and adults, are settled out of court through clan elders, which often results in a lack of medical treatment and justice for survivors (Mwangi et al., 2009; Wangamati et al., 2019). All these factors, along with corruption and low rates of reporting to the authorities, as well as financial, material, and infrastructural resource barriers, both for survivors and providers, contribute to few successful prosecutions in Kenya (Lekakeny, 2015; Wangamati et al., 2019).

Some previous research has shown that case characteristics have a significant effect on case outcomes. One such characteristic is the relationship between the victim and the perpetrator, with stranger rape often being taken more seriously than acquaintance rape, and the prior relationship between the defendant and the victim affecting the prosecutor's decision as to whether to file charges (Spohn & Horney, 1993). Conversely, other research has shown that the most prominent factors relating to decisions made by police, prosecutors, and jurors, are legally relevant factors. For instance, the victim's ability to identify the suspect, the use of a weapon, promptness of reporting, and the age of the victim have all been associated with case attrition in the Global North (LaFree, 1989). In the Kenyan context, case characteristics, such as long delays between the crime and attending a health facility, the relationship between the perpetrator and survivor, and number of perpetrators, have been identified as important details when determining whether a case will be processed (Anastario et al., 2014).

Data and methods

The data for this study were recorded from the case records of 514 survivors who were assisted by the Wangu Kanja Foundation between the years of 2016–2020, inclusive. The

WKF is a non-profit organization founded in 2005 in Nairobi by Wangu Kanja, a rape survivor. The WKF aids survivors in accessing post-rape care services. In addition to its work in supporting survivors in the aftermath of SV and DV, the WKF advocates for initiatives pertaining to SGBV prevention, protection, and response throughout Kenya. The WKF collaborates with the Survivors of Sexual Violence in Kenya Network, which works to build survivor self-agency, amplify survivors' voices across the country to address all forms of SV, and restore survivors' dignity post-violation (Wangu Kanja Foundation, 2016). The WKF dataset is the most comprehensive dataset on SV and DV in Kenya (Ji et al., 2022). The dataset was gathered by the WKF over a four-year period, and it links case outcomes with the survivor's account of the offense and other information about the offense from police and medical reports.

Gender defenders, survivors of SV and DV who provide support to victims and are trained by the WKF, interviewed survivors about their SV and DV ordeal. They gathered information including the time, date, and location of the incident, as well as information about the offense, including demographics of both the victim and perpetrator, the number of perpetrators committing the offense, the relationship between survivor and perpetrator, what (if any) post-assault services the survivor accessed, and what (if any) forensic evidence was available to criminal investigators, such as evidence of physical injury to the survivor, or biological specimens, such as semen or hair.

There were multiple ways that survivors could access support from the WKF. This included those walking into the WKF headquarters in Nairobi, using an SMS text platform, or using the foundation's own mobile phone application, then called MobApp. Due to data availability, we focus on walk-ins only. Our data included 277 participants who were adults and 237 who were children, as defined by Kenya's defilement law, which states that a person under 18 years of age is a child (Sexual Offences Act, 2006).

After further reviewing the data and excluding 111 cases for which the data were incomplete, we were left with 212 adults and 194 children for our statistical analysis. Table 1 provides descriptive statistics of the variables used in our analysis for combined sexual and domestic violence cases. Descriptive statistics for each type of violence can be found in appendix 1. We were interested in two outcome measures. First, whether the case was reported to the police. Second, whether the case proceeded to court. The case proceeding to court is the final procedural outcome for all cases progressing through the case referral system, with the final decision then being whether the perpetrator was sentenced. Our selection of variables captures details about the location of the attack, categorized as either public or private, whether the survivor knew the perpetrator at the time of the attack, if the survivor was a child, if there was forensic evidence present at the time of the medical examination, the survivor's age, and if the survivor was a female. An important feature of our data is that the mean age is 20, in line with previous research indicating that significant proportions of both females and males in Kenya experience sexual violence before the age of 18 (UNICEF et al., 2012). Figures in the appendix indicate the distribution of ages in our data and makes clear that a substantial proportion of survivors in our sample are adolescents. The analyses were performed on the full sample (i.e., all case types considered together in the same model), as well as separately on each case type (i.e., SV and DV cases were analyzed in different models).

Table 1. Descriptive statistics.

		Cases at risk of passing each transition											
		No Medical Attention		Police		Prosecutor		Court		Convicted		All	
		n	%	n	%	n	%	n	%	n	%	n	%
Sexual Violence	No	38/48	79%	57/113	50%	56/91	62%	34/86	40%	15/68	22%	200/406	49%
	Yes	10/48	21%	56/113	50%	35/91	38%	52/86	60%	53/68	78%	206/406	51%
Attack Happened in Public	No	45/50	90%	82/113	73%	77/91	85%	58/86	67%	58/68	85%	320/408	78%
	Yes	5/50	10%	31/113	27%	14/91	15%	28/86	33%	10/68	15%	88/408	22%
Survivor Knows Perpetrator	No	2/48	4%	24/113	21%	5/91	5%	16/86	19%	13/68	19%	60/406	15%
	Yes	46/48	96%	89/113	79%	86/91	95%	70/86	81%	55/68	81%	346/406	85%
Child Survivor	No	38/48	79%	62/113	55%	54/91	59%	42/86	49%	16/68	24%	212/406	52%
	Yes	10/48	21%	51/113	45%	37/91	41%	44/86	51%	52/68	76%	194/406	48%
Forensic Evidence	No	47/48	94%	101/113	89%	80/91	88%	66/86	77%	55/68	81%	349/408	86%
	Yes	3/50	6%	12/113	11%	11/91	12%	20/86	23%	13/68	19%	59/408	14%
Female Survivor	No	4/48	8%	13/113	12%	9/91	10%	8/86	9%	15/68	22%	49/406	12%
	Yes	44/48	92%	100/113	88%	82/91	90%	78/86	91%	53/68	78%	357/406	88%
Survivor's Age	Mean SD	24	8	20	9	20	9	21	10	17	10	20	10

Analytic approach

This secondary data analysis used a quantitative cross-sectional research design. The out- come variable for this analysis was how far the case progressed through the case referral pathway. We studied this for all crimes, and separately for DV and SV. Predictor variables used in this analysis include characteristics of both the victims and perpetrators, such as whether the victim was a child, age, relationship, and gender. It also included key eviden- tiary factors, namely the presence or absence of physical injury, and whether post-assault care services were accessed. These services include connection to medical services, counsel- ing, psychosocial support, and support reporting the case to the police. All variables other than age, which is continuous, are binary.

Procedure

The data were collected via face-to-face interviews between the Gender Defenders and the survivors using a standardized data collection sheet. Information provided on the forms was read and coded by fellow researchers, and whenever missing data were discovered, the Wangu Kanja Foundation was contacted to attempt to complete the dataset, although this was often not possible owing to a lack of information in the case file.

Ethics

The secondary data used in this study was the property of the Wangu Kanja Foundation and the Survivors of Sexual Violence in Kenya Network. These organizations provided us with permission to analyze their data and all work adhered to the Kenyan Data Protection Act. The research was also approved by the STEM Ethics Committee at the University of Birmingham. None of the participants were placed at an increased risk of harm because of their participation.

The WKF provided the survivors who reported to them the opportunity to contact support services post-interview if required.

Figure 1 maps the case referral pathway for the full sample. At the first transition, the decision is made by the survivor to seek medical attention (coded as 1 = yes and 0 = no). Nearly the entire sample made it to this stage, the effects of which are explained later in the paper. After seeking medical help, survivors may choose to seek assistance from the police. This decision is made by the survivor, although they cannot progress to this stage until they have received medical attention and procured the appropriate forms that the police require to officially record the case. At the next stage, prosecutors might decide to file charges, which is the third stage in the case referral pathway, but this often depends on case characteristics, which are explained below. The final stage of the referral pathway, reflected in purple in Figure 1, is the case proceeding to court. Although cases may proceed to court, many do not continue to the sentencing phase due to issues with the required medicolegal officials not being able to attend court and endless delays causing already traumatized survivors to lose confidence in the formal legal process. Cases that make it to this stage have the potential to move on to sentencing, although the diagram shows that few cases progress to this point.

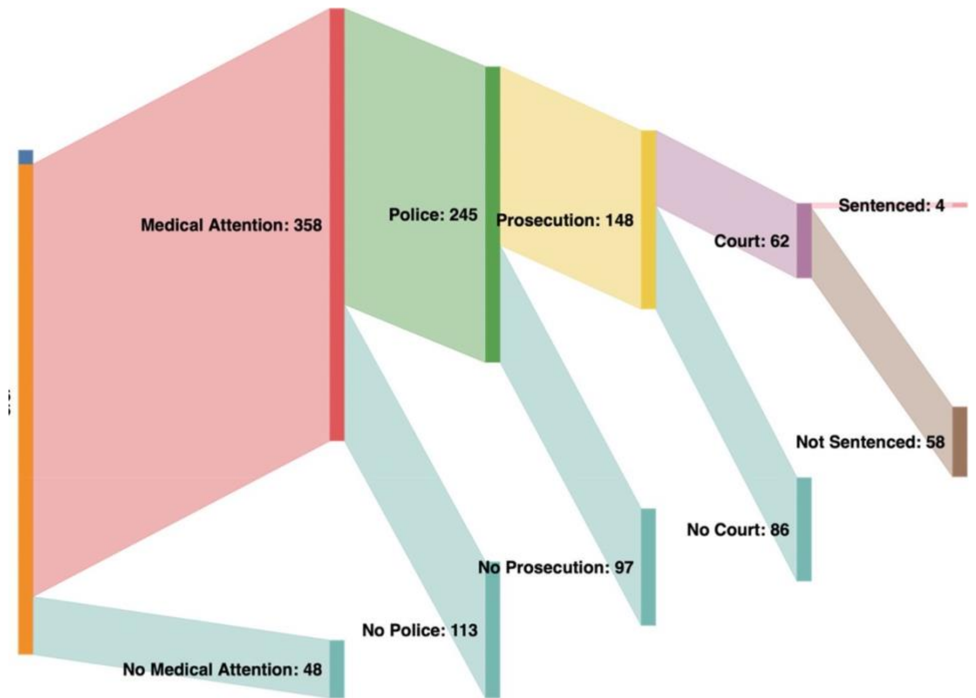

Figure 1. Sexual and domestic violence case referral pathway.

Our research objective was to analyze these data to identify the factors associated with attrition from the case referral pathway. Our data contain the proportion of survivors by crime type who accessed medical, police, and judicial services. We used sequential logit models to study case attrition along the case referral pathway, which dictates that survivors should be referred from medical services to the police and then to judicial services.

Results

Figure 1 presents frequency data on case progression (top row) and attrition (bottom row) along the pathway. The key property of the medico-legal pathway, as evidenced in Figure 1, is that it is ordered. Survivors must first attend medical care before proceeding to the police, and a prosecutor will not take up a case until the survivor has visited both medical and police officials and obtained the proper documents. Likewise, the decision to prosecute the perpetrator of the attack occurs before the case proceeds to court and after the police decide to charge the accused with the crime. The number of cases that progress to the stage versus those that fail at the stage are depicted. As can be seen, case attrition increases across the pathway when moving from left to right as evidenced by the decreasing size of the shaded areas in the top row of Figure 1.

We used a sequential logit model to evaluate the correlates of survivors' and the progression of their cases along the medical-legal pathway (Fullerton, 2009; Maddala, 1983; Mare, 1980). This model is appropriate because it models case progression as a series of distinct choices, whereas multinomial or nested logit models do not. For example,

multinomial and nested logit models would categorize cases based on their final disposition (i.e., conviction, acquittal, dismissal). However, the complexity of the legal process and the many distinct choices made by different actors at different stages of the process that influence the final case outcome would not be captured if these modelling approaches were used. The decisions in help-seeking are made at different

times given different information and are also made by different people. While the survivor decides to seek medical support and report the rape to the police, subsequent choices regarding how the case moves through the system are made by the police, public prosecutors, and the court. Further, we did not conduct multiple logistic regression analysis as it does not analyze case progression as a series of multiple distinct stages. In sum, sequential logit modelling allows for greater nuance in studying the challenges that survivors face along the medical-legal pathway. It provides a more accurate representation of the reality of the legal process and thereby allows the examination of the factors that impact case progression at each stage. By using this approach, we can better understand the challenges that survivors face. The stages we analyzed are provided in Figure 1 and Table 1. Very few cases led to a conviction; therefore, we do not include this stage in our statistical analysis.

Estimation of a sequential logit model amounts to jointly estimating a separate logit model for each node of the decision tree, noting that the coefficients should be identical if we estimate the models separately, but that estimating them jointly facilitates the decom- position exercise that is reported below (Buis, 2017). In particular, the coefficient estimates reported in Figures 2–4 will be identical. The advantage of the sequential logit procedure is that it allows the computation of the quantities, such as the gain, reported in Table 2 and discussed below.

Thus, we write the estimated probability of survivor i receiving medical treatment p_{i1} as:

$$Pr(Medical = 1 \mid X_1, \cdots, X_k) = \widehat{p_{1i}} = \Lambda(\lambda_{0,Medical} + \sum_{k=1}^{K} \lambda_{k,Medical} X_{ki})$$

Where $\Lambda(\cdot) = \frac{exp(\cdot)}{1+exp(\cdot)}$ is the logistic function and $x_1, \cdots, x_K$ are covariates describing key features of the case such as the survivor's age and $\widehat{\lambda_{k,Medical}}$ are the associated regression coefficient estimates. Likewise, the probabilities of "success" for survivor i and their case at subsequent nodes are given as follows:

$$Pr(Police_i = 1 \mid X_1, \cdots, X_k) = \widehat{p_{2i}} = \Lambda(\widehat{\lambda_{0Police}} + \sum_{k=1}^{K} \widehat{\lambda_{k,Police}} X_{ki}) \text{ if } Medical_i = 1$$

$$Pr(Legal = 1 \mid X_1, \cdots, X_k) = \widehat{p_{3i}} = \Lambda(\hat{\lambda}_{0Legal} + \sum_{k=1}^{K} \widehat{\lambda_{k,Legal}} X_{ki}) \text{ if } Medical_i = 1, Police_i = 1$$

$$Pr(Court = 1 \mid X_1, \cdots, X_k) = \widehat{p_{4i}} = \Lambda(\hat{\lambda}_{0Court} + \sum_{k=1}^{K} \widehat{\lambda_{k,Court}} X_{ki}) \text{ if } Medical_i = 1, Police_i = 1, Court_i = 1$$

The results of this analysis are displayed in Figure 2. The circles display the average marginal effects associated with each of the covariates while the narrow (and wide) horizontal line displays the 95% (and 99%) confidence interval of the average marginal effect (Wooldridge, 2010). These average marginal effects can be interpreted as the change in the probability of the outcome variable. Thus, an average marginal effect of 0.05 suggests that the outcome is 5% more likely, and so forth. For convenience, we also report the results numerically in Table A1 in the appendix.

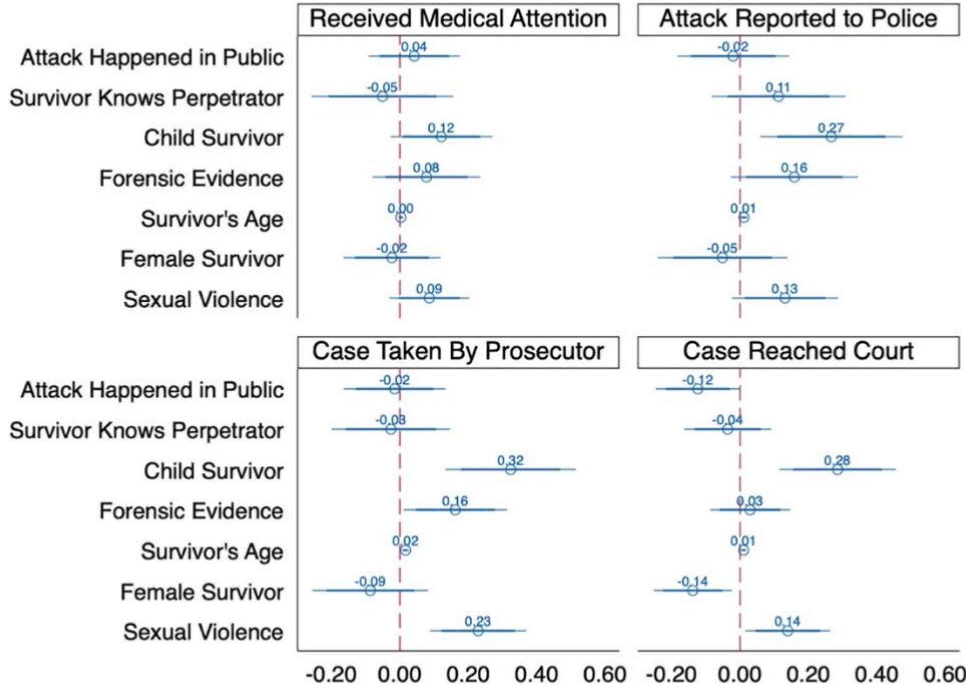

Figure 2. Sequential logit estimates (all cases).

Looking first at the upper left panel of Figure 2 we can see that there are two statistically significant correlates of whether a survivor received medical attention. Survivors of SV were around 9% [ME = 0.09, p = .058] more likely to receive medical attention than DV survivors. Child survivors were also 12% more likely to receive medical attention [ME = 0.12, p = .035]. The lack of precise estimates for these, and particularly for the other correlates, may reflect the high proportion of survivors in our sample who received medical attention (89%) and thus there was a limited amount of variation.[1]

The results plotted in the upper right panel, for whether survivors report to the police, are more precise, perhaps because only 60% of all cases lead to a police report. Note that now our sample is different, it is now only those who received medical attention. This will be true for subsequent stages discussed below, the sample will only be those who progressed

Table 2. Estimated weights for each stage of the medical-legal pathway, and their determinants.

	Medical	Police	Prosecutor	Court
Weight (W_k)	0.183	0.357	0.203	0.089
	(0.0312)	(0.021)	(0.013)	(0.008)
Gain (ΔE_k)	2.27	1.84	1.36	1
	(0.061)	(0.057)	(0.05)	
Proportion Affected	1	0.912	0.63	0.387
		(0.017)	(0.026)	(0.027)
Discrimination (p_i)	0.912	0.691	0.615	0.359
	(0.017)	(0.025)	(0.035)	(0.05)

at the previous stage. As with the receipt of medical care, violence against children [ME = 0.27, $p < .001$]and SV [ME = 0.13, $p = .029$]] were both more likely to lead to a police report. The results also suggest that older survivors are also more likely to contact the police, with an additional year of age found to increase the chance of reporting by 1% [ME = 0.01, $p =$
.006]. For clarity, in Figure 2 we report the estimated effect for an increase in five years of age. Note, given we also included a variable for whether the victim is a child in the model, the results suggest an older adult (or an older child) is more likely to make a police report. Perhaps, as might be expected, the availability of physical evidence is also positively correlated with contacting the police, [ME = 0.16, $p =. 027$].

The bottom left panel plots the results for whether, following a police report, a prosecutor decides to file charges. This happens in around 60% of such cases making it to this stage (or 36% of all attacks in our data). The results are like those for the decision to file a police report, but again more precise. We can see that SV compared to DV, and attacks against children compared to adults, are 23% [ME = 0.23, $p < .001$] and 33% [ME = 0.33, $p <$
.001] more likely to lead to prosecution. The availability of forensic evidence is also again important, with cases with evidence being 16% [ME = 0.16, $p = .006$] more likely to be prosecuted. The effect of survivor age is now larger, with a survivor who is two years older being 3% more likely to have their case prosecuted [ME = 0.016, $p < .001$]. It is not statistically significant at conventional levels (i.e., $p < .05$), but as can be seen in Figure 2, the results also hint that female compared to male survivors are less likely to have their case prosecuted, other things being equal.

The final, bottom right, panel plot results for whether the case proceeds to court. Again, we see that children [ME = 0.28, $p < .001$], survivors of SV [ME = 0.14, $p = .004$] and older survivors [ME = 0.01, p < .001] are more likely to see their cases come to court. However, other results are interestingly different at this stage compared to earlier stages. Firstly, evidence is no longer an important factor [ME = 0.29, $p = .517$]. This is not because all cases at this stage have it, indeed only 20% do. Instead, this likely reflects other, unmeasured, aspects of these cases. We also see that women are 14% less likely to have their cases tried in court [ME = −0.14, $p = .002$], and that assaults in public are 12% less likely to go to court [ME = −0.12, $p = .010$]. This may reflect that the survivor is less likely to know the perpetrator. Taken together, this suggests that assaults on young women in public places are much less likely to come to court, whereas SV against boys is much more likely to do so. So far, we have established which factors predict a survivor's case moving to the next stage of the pathway. But, given that only a small percentage of cases make it to court, and only 1% of our sample leads to a conviction it is useful to analyze which stages lead to case attrition. Such an analysis can not only help us understand better the reality of SV and DV in Kenya, but also potentially inform policy. Buis (2017) shows that if we are willing to assign numerical values to each node of the tree above then we can define the expected outcome for survivor $E[L_i]$, as:

$$E[Li] = (1 - p_{1i})\, l_{Medicine} + p_{1i}(1 - p_{2i}) l_{Police} + p_{1i}p_{2i}(1 - p_{3i}) l_{Legal} + p_{1i}p_{2i}p_{3i}\, l_{Court}$$

Where here we treat each step symmetrically such that $l_{Medicine}$ ¼ $l_{Police} - l_{Medicine}$ ¼ $l_{Legal} - l_{Police}$ ¼ $l_{Court} - l_{Legal}$ ¼ 1. That is, we are not choosing to weight some steps of the pathway as being more important than others.[2]

I.E., $l_{Medicine}$ ¼ 1; l_{Police} ¼ 2; l_{Legal} ¼ 3; l_{Court} ¼ 4

Then the impact of each explanatory variable on the overall outcome is given by the product of the estimated regression coefficient for that variable at each stage, $\lambda_{k;Police}$ with a weight $W_{i;Police}$ Where the weight is the product of the (predicted) proportion of survivors whose case will reaches that node, the discrimination of the node, and the difference in expected outcome of those who pass and those who do not. Thus, a given stage of the process will have a higher weight if it affects more survivors; the outcome is more varied (a stage at which almost every case continues or every case ends will do little to predict the overall outcome); and the difference in outcome between those cases that pass that stage and those that do not is larger (e.g., a stage matters less if almost every case that passes it fails at the next stage, and matters more if almost every case that passes it then is likely to lead to conviction, say). (See Eq 3. of Buis (2017) for a formal statement.)

Table 2 displays the estimated weights for each stage of the medical-legal pathway, and their determinants. The results suggest that the stage with the greatest weight is the decision to go to the police, which has weight 0.357 reflecting that this stage is reached by a large share of cases, but that only around ⅕ go on to be prosecuted, and that the expected outcome of those that do go to the police is relatively large at 1.8 stages further on average. This interpretation of this finding depends on why more cases do not go to the police.

If cases are not taken to the police due to a lack of resources, such as lack of trained SGBV professionals and/or inadequate evidence collection resources, then this suggests that addressing this resource issue could lead to a large increase in the number of cases prosecuted. On the other hand, if it is the case that survivors decide about whether to report their assault to the police based on knowledge (perhaps supplied by WKF) as to whether the case will be likely to be prosecuted, then this would suggest that the necessary policy response is to change police or prosecutor behavior. Or indeed, if prosecutor behavior reflects their knowledge of likely court outcomes, then activity should be focused there.

That the decision to prosecute has a weight of 0.2 and the decision to receive medical attention has a weight of 0.18 suggests that the importance of the decision to go to the police does not just reflect what may happen subsequently, and likewise the decision to receive medical attention does not just anticipate the police's behavior. This implies that efforts to address bias cannot focus on just one stage. That the court stage is less important reflects not that it is unimportant *per se*, but rather the fact that almost no cases successfully lead to a conviction.

The subtlety of this point can be understood by analyzing further the weight of the medical attention node. Its weight reflects a balance between the fact that it discriminates few cases – over 90% of people receive medical attention – on one hand, and the fact that on the other if they do, then they on average will go 2.27 stages further in the process.

So far, we have combined and analyzed SV and DV cases together to maximize the statistical power of the available sample. However, there may be important differences in the determinants of case progression between the two crimes. To understand these differences, we analyzed the data separately and present the results for each in turn.

Sexual violence only

Figure 3, Table A2 and Table A4 report results now restricting our sample only to SV cases. Looking first at the results in the top left panel for whether survivors received medical attention, we see that none of the estimated coefficients are statistically significant, and all are close to zero. This likely reflects the fact that 95% of all SV survivors received medical attention, meaning there is relatively little variation to explain.

Looking now at the results for whether the survivor filed a police report in the top right panel, the estimates are still relatively noisy; but the coefficients are nevertheless informa- tive. We see that an attack that happened in a public place is 15% [ME = −0.15 p = .034] less likely to lead to a police report. One explanation for this is that given the police have little forensic and investigative resources, survivors are less likely to file a report about an assault by a stranger given the low chance of a perpetrator being identified. The coefficients on child survivor and forensic evidence are not significant; but the estimated coefficients are relatively large at 19% and 13%, respectively, and suggestive of an increased probability of filing police reports in such cases [ME = 0.19, *p* = .11 and ME = 0.13, *p* = .145, respectively]. Interestingly, the results are quite different for whether prosecutors take up a case as shown in the bottom left panel. Unlike the decision to report an attack to the police, whether the assault happened in public is not important. But child survivor and forensic evidence are associated with large, 42% and 20% respectively, and precisely estimated coefficients [ME = 0.42, p < .001; ME = 0.20, p = .020]. Victim age is now, like the pooled sample, significant, and suggests that a survivor who was five years older is 9.23% more likely to have their case taken by the prosecutor [ME = 0.018 p = .022].

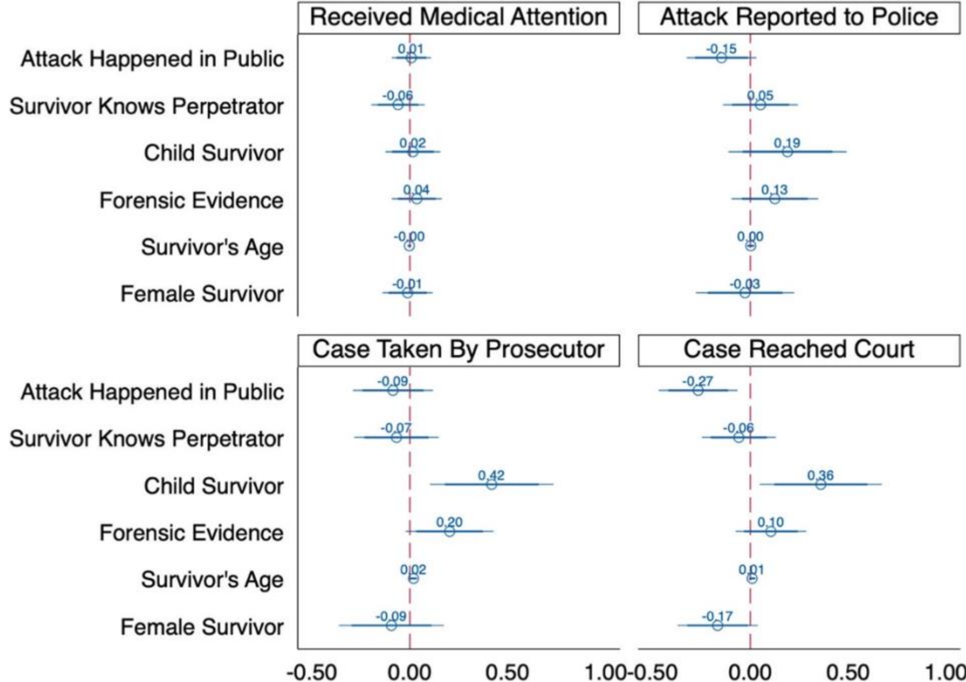

Figure 3. Sequential logit estimates (sexual violence cases).

The pattern of coefficients changes again for whether a case comes to court in the bottom right panel. Cases that involve SV in a public place are 27% less likely to come to court. While cases in which the survivor is female are 17% less likely to do so. Cases in which the survivor was a child are 37% more likely to come to court. These results suggest that the cases which reach trial are far from a representative sample and are much more likely to involve (male) children.

Domestic violence only

We now consider the results focusing on DV cases, which are reported in Figure 4 (and Table A3 and A5). As for SV cases, the results are again somewhat noisy; but the results in the top left panel suggest that child survivors are about 21% more likely to receive medical attention. [ME = 0.21, p = .068] The results for whether a report is filed with the police (top right panel) are interesting, as they show that attacks in public are 20% more likely to lead to a police report than those in private [ME = 0.21, p = .047]. Older survivors are also more likely to file a police report, with a five-year age increase associated with a 7.4% increase in the probability of filing a report [ME = 0.015, p = .003]. Again, as shown in the bottom left panel, age and whether the survivor is a child predict whether the prosecutor takes forward the case [ME = 0.013, p < .001 and ME = 0.19, p = .066, respectively]. Gender and location are not found to be important. The same is true for whether a case comes to trial shown in the bottom right panel, although in common with the results above, the evidence is

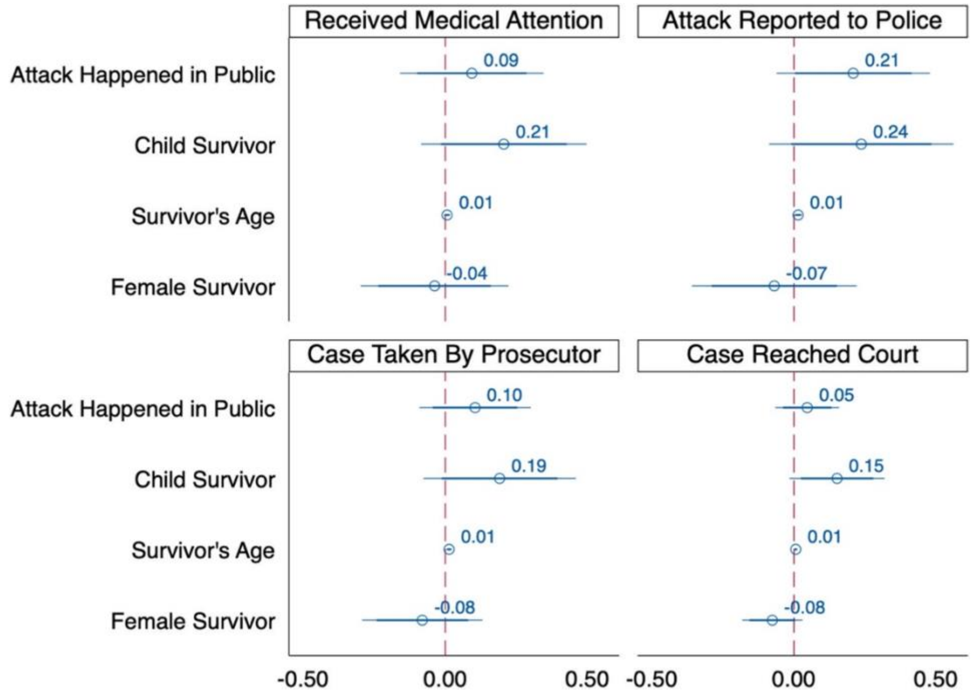

Figure 4. Sequential logit estimates (domestic violence cases).

suggestive that female survivors are 8% less likely to see their case come to court, given a prosecutor has taken it up [ME = −0.076, p = .065].

Discussion

Our results show that there are numerous correlates of case progression through the medical-legal pathway in Kenya. These correlates differ based on the step in the pathway and the type of violence being examined, though there are correlates that are significant for multiple steps, no matter which type of violence is being studied.

Age, or whether the survivor was an adult or child, was a significant correlate for both SV and DV, and it was the strongest predictor for all steps of the pathway. Across all types of violence, age was found to be significant for receiving medical attention, reporting to the police, a prosecutor taking up the case, and the case proceeding to court when the types of violence are combined. For DV, age was associated with whether prosecutors took up the case and whether the case proceeded to court. For SV cases, age was associated with whether the survivor received medical attention, whether a prosecutor took up the case, and whether the case proceeded to court. The role of age in the survivor’s ability to access services and other support might be explained by differences in societal views of violence in relation to age. Children may be less likely to experience the same amount of stigma faced by adult survivors when reporting SV. Further, patriarchal views that serve to normalize abuse against a spouse or partner may be less likely to extend to children. Concerns about repercussions from the abuser may prevent some people from reporting violence against either themselves or their children; however, once a case against a child is brought into the system, it is far more likely to reach each step than a case against an adult.

When evaluating correlates for both types of violence combined in one model, SV was significant for the survivor receiving medical attention, reporting to the police, having their case taken up by the prosecutor, and having their case proceed to court. This means that for both types of violence combined, SV and the survivor being a child are significant correlates for all four steps along the case referral pathway. Additionally, older survivors are more likely to report their cases to the police and for their cases to proceed to court, while the presence of forensic evidence makes cases more likely to be prosecuted. Some possible explanations for this are that DV was most frequently perpetrated in our dataset against adults by a spouse or partner (80%), whereas SV against adults in our data set was most often perpetrated by strangers (43%) followed by acquaintances or friends (16%). Therefore, a survivor of SV would be more willing to report their case than a survivor of DV for the aforementioned reasons; namely, reporting a spouse might have dire financial consequences for one’s family. Older survivors may be more willing to report their cases to the police and for their cases to proceed to court because they have more community support and may be less financially reliant on others.

When evaluating SV separately from DV, our analysis was able to identify some correlates to case progression. There were no significant correlates of whether a survivor received medical attention, likely because the great majority of SV survivors did so. Public SV attacks are less likely to lead to a police report, perhaps because these were often perpetrated by someone unknown to the survivor, and hence, who could not be identified by the police. The survivor being a child and the presence of forensic evidence were correlated with an increased likelihood of the case being taken up by prosecutors, and for

SV cases progressing to court, with the survivor being a child making the case 37% more likely to progress to this stage. This may reflect an idea in Kenya that defilement is a serious crime that deserves punishment, whereas rape is not, in line with the previously discussed ideas concerning the social acceptability of crime against a child. Additionally, without evidence, cases are unlikely to move through the case referral pathway, indicating that the victim's testimony alone is not considered substantial evidence when pursuing a case (Rockowitz, forthcoming).

In evaluating solely DV cases, the findings differed slightly from SV cases. Child survivors were once again more likely to receive medical attention than their adult counter- parts. Public attacks and those involving older adult victims were more likely to lead to a police report, and older adults and children were more likely to have their cases taken up by prosecutors and for their case to proceed to trial. One possible explanation for this is that most DV cases are perpetrated by someone known to the victim, and this, might support the charges. Further, cases occurring in public may also be more likely to have bystanders to corroborate the survivors' account, and research has found that cases where witnesses are present are more likely to progress through to prosecution (Bechtel et al., 2012). Further research is needed to assess this possibility. DV cases may have more witnesses than SV cases, as SV cases often occur in more private locations. DV cases also have less evidence, as SV may leave bodily fluids and ripped clothes that DV would not. Because evidence is a strong correlate of case progression, in the combined model SV is still a significant correlate for each step of the case referral pathway.

The law in Kenya is supposed to apply to all citizens of DV and SV equally, regardless of their age, their gender, or where the violence occurred (National Council for Law Reporting, 2009). Our data reveals, however, that SV and DV survivors who are children are far more likely to make it to every stage of the medical-legal pathway than adults, that SV survivors are more likely than DV survivors to make to every stage of the pathway, and that being an older adult also helps cases move through the medical-legal pathway. It is also important to note that while certain factors increase one's likelihood of moving through the pathway all the way to court, which is the final step, still only 15% of the cases studied made it to court and only 1% resulted in a conviction. This means that while certain factors may help cases move further along the pathway, conviction is still extremely unlikely. This may be due to cases falling out of the system either due to the wishes of the survivor to end what is often a multi-year process where the survivor is burdened by administrative issues, or where the survivor is subject to bribery by the perpetrator or his family, or simply because judges and juries in Kenya often side with the perpetrator rather than the complainant.

The factors identified in this study that result in case attrition are also likely associated with ideologies embedded in rape myths and patriarchal cultures that are pervasive throughout Kenya. Rape myths are beliefs about rape's "causes, context, consequences, perpetrators, victims, and their interaction" that are used to reject, lessen the significance of, or justify SV that men commit against women and shift the blame onto the victim rather than the perpetrator (Temkin et al., 2016; Zinzow et al., 2022). Rape myths are beliefs that operate outside conscious awareness that hold victims accountable for rape rather than perpetrators. Rape myths are often tied to victim blaming, which contributes to poor handling of rape cases, post-traumatic stress in rape survivors and can impede their recovery (Suarez & Gadalla, 2010). Rape myths also play a significant role in how SV cases are treated as they move through the medico-legal pathway, with providers often

subconsciously adjusting their treatment of a victim based on foregone conclusions related to clothing, alcohol consumption, or previous behavior (Temkin et al., 2016). Future research should work with prosecutors to train them to identify rape myths in the court- room and gender defenders to assess the impact of rape myths on a victim's willingness to come forward.

Although rape myths are often studied in high-income contexts, they are pervasive around the world. In Western Kenya, research has found that five of the seven standard rape myth categories emerged in focus group discussions without prompting. These categories included that rape is a deviant event, that it was an accident because men are not able to control their sexual urges, and that the women were lying about being raped (Tavrow et al., 2013). With these in mind, it is perhaps clearer why there is such a focus on the presence of evidence for a case to be believable. If the standard opinion is that a woman is lying, the presence of evidence helps prove otherwise. For DV, beliefs about the husband's alleged manliness or control may influence their violence perpetration, with men with lower self-esteem being more likely to be violent towards their spouse than men with higher self- esteem (Goodman, 2018). Knowing how important these ideologies are to the perpetration of violence, investigation of SV and DV cases should also include interviews with the perpetrators about these ideas, perhaps providing information that evidence (or the lack thereof) may not.

The results of this study can help to inform policy makers who are evaluating ways to strengthen the medico-legal case referral pathway in Kenya. We had a select dataset to work with of survivors who had interacted with the WKF, limiting the representa- tiveness of our sample. Survivors who had assistance from the WKF are more likely to succeed than survivors navigating the system on their own, so our results are probably more positive than they would have been from a more general sample. However, due to our limited data it is unclear how survivors being helped by a similar organization would fare in their progression through the case referral pathway. Similar work should be conducted on a larger, more diverse sample to evaluate how these factors may affect survivors moving through the system without external assistance. Future research should also investigate how these findings apply to assaults of those beyond the gender binary, and how the factors included in the analysis may have affected a survivor's willingness to accept a bribe to stop pursuing the case based on their perceptions of which case details are most beneficial to their case moving through the entire pathway.

Conclusion

With the known physical, mental, and social consequences of SV and DV, organizations such as the Wangu Kanja Foundation, in Kenya and beyond, provide important support through connecting their clients to medical and legal services. Despite efforts by the WKF, still very few survivors make it through the case referral pathway, and more needs to be done by the Kenyan government to ensure that all survivors are given equitable access to services and justice. It is also clear from the results that children are far more likely to make it to every step of the pathway than adults, and that for both adults and children, certain factors, such as SV versus DV and the presence of forensic evidence, increase the odds of moving along the case referral pathway. Survivors of sexual and

physical violence should have equal access to medical, legal, and justice services regard- less of their age, or the location of the attack. Work must be done in Kenya, as elsewhere, to strengthen the case referral pathway so that survivors of SV and DV are awarded equal access to services. This can be done in two key ways: firstly, by eliminating blockages on the case referral pathway so that more cases progress to court and conviction. Secondly, by improving equality of progression rates along the case referral pathway so that all survivors of SV and DV are afforded equal access to services.

Notes

1. We tested for multicollinearity using a Variance Inflation Test. The maximum score was 3.21, with a mean of 1.78, comfortably below the conventional benchmark of 10.
2. If one had evidence on how survivors valued the different steps of the pathway then this assumption could – in principle – be relaxed, but we are aware of no such evidence.

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References

Anastario, M. P., Adhiambo Onyango, M., Nyanyuki, J., Naimer, K., Muthoga, R., Sirkin, S., Barrick, K., van Hasselt, M., Aruasa, W., Kibet, C., & Omollo, G. (2014). Time series analysis of sexual assault case characteristics and the 2007-2008 period of post-election violence in Kenya. *PLoS ONE*, *9*(8), e106443. https://doi.org/10.1371/journal.pone.0106443

Artz, L., & Smythe, D. (2007). Case attrition in rape cases: A comparative analysis. *South African Journal of Criminal Justice*, *20*, 158–181. https://journals.co.za/doi/epdf/10.10520/EJC52915

Bechtel, K. A., Alarid, L. F., Holsinger, A., & Holsinger, K. (2012, April 1). Predictors of domestic violence prosecution in a state court. *Victims & Offenders*, *7*(2), 143–160. https://doi.org/10.1080/ 15564886.2012.657289

Beichner, D., & Spohn, C. (2005). Prosecutorial charging decisions in sexual assault cases: Examining the impact of a specialized prosecution unit. *Criminal Justice Policy Review*, *16*(4), 461–498. https:// doi.org/10.1177/0887403405277195

Buis, M. L. (2017). Not all transitions are equal: The relationship between effects on passing steps in a sequential process and effects on the final outcome. *Sociological Methods & Research*, *46*(3), 649–680. https://doi.org/10.1177/0049124115591014

Fullerton, A. S. (2009). A conceptual framework for ordered logistic regression models. *Sociological Methods & Research*, *38*(2), 306–347. https://doi.org/10.1177/0049124109346162

Garcia-Moreno, C., Jansen, H. A. F. M., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO multi-country study on women's health and domestic violence against women: Initial results on prevalence, health outcomes, and women's responses*. W. Press. https://apps.who.int/iris/handle/10665/43309

Goodman, M. (2018). *Domestic violence and social status: A Kenyan case study*. The Conversation Trust UK Limited. https://theconversation.com/domestic-violence-and-social-status-a-kenyan- case-study-105746

Gregory, J., & Lees, S. (1996). Attrition in rape and sexual assault cases. *The British Journal of Criminology*, *36*(1), 1–17. https://doi.org/10.1093/oxfordjournals.bjc.a014060

Hester, M., & Lilley, S.-J. (2017, June 1). Rape investigation and attrition in acquaintance, domestic violence and historical rape cases. *Journal of Investigative Psychology and Offender Profiling*, *14* (2), 175–188. https://doi.org/10.1002/jip.1469

Hohl, K., & Stanko, E. A. (2015). Complaints of rape and the criminal justice system: Fresh evidence on the attrition problem in England and Wales. *European Journal of Criminology*, *12*(3), 324–341. https://doi.org/10.1177/1477370815571949

Ji, Z., Rockowitz, S., Flowe, H. D., Stevens, L. M., Kanja, W., & Davies, K. (2022). Reflections on increasing the value of data on sexual violence incidents against children to better prevent and respond to sexual offending in Kenya. *Societies*, *12*(3), 89. https://doi.org/10.3390/soc12030089

Kerstetter, W. A. (1990). Gateway to justice: Police and prosecutorial response to sexual assaults against women. *The Journal of Criminal Law and Criminology*, *81*(2), 267. https://doi.org/10.2307/ 1143908

Kilonzo, N., Ndung'u, N., Nthamburi, N., Ajema, C., Taegtmeyer, M., Theobald, S., & Tolhurst, R. (2009, January 1). Sexual violence legislation in sub-Saharan Africa: The need for strengthened medico-legal linkages. *Reproductive Health Matters*, *17* (34), 10–19. https://doi.org/10.1016/S0968-8080(09)34485-7

Kilonzo, N., Theobald, S. J., Nyamato, E., Ajema, C., Muchela, H., Kibaru, J., Rogena, E., & Taegtmeyer, M. (2009, July). Delivering post-rape care services: Kenya's experience in developing integrated services. *Bulletin of the World Health Organization*, *87*(7), 555–559. https://doi.org/10. 2471/blt.08.052340

LaFree, G. (1989). Rape and criminal justice: The social construction of sexual assault.

Lea, S. J., Callaghan, L., Grafton, I., Falcone, M. A., & Shaw, S. (2016). Attrition and rape case characteristics: A profile and comparison of female sex workers and non-sex workers. *Journal of Interpersonal Violence*, *31*(12), 2175–2195. https://doi.org/10.1177/0886260515573575

Lea, S. J., Lanvers, U., & Shaw, S. (2003). Attrition in rape cases. Developing a profile and identifying relevant factors. *The British Journal of Criminology*, *43*(3), 583–599. https://doi.org/10.1093/bjc/43. 3.583

Lekakeny, R. (2015). *The elusive justice for women: A critical analysis of rape law and practice in Kenya*. University of Cape Town.

Leverick, F. (2020). What do we know about rape myths and juror decision making? *The International Journal of Evidence & Proof*, *24*(3), 255–279. https://doi.org/10.1177/ 1365712720923157

Lovell, R., Overman, L., Huang, D., & Flannery, D. J. (2021, June 1). The bureaucratic burden of identifying your rapist and remaining "cooperative": What the sexual assault kit initiative tells us

about sexual assault case attrition and outcomes. *AMerican Journal of Criminal Justice*, *46*(3), 528–553. https://doi.org/10.1007/s12103-020-09573-x
Machisa, M., Jina, R., Labuschagne, G., Vetten, L., Loots, L., & Jewkes, R. (2022). Factors associated with rape case attrition in the South African criminal justice system: A national cross-sectional study. *The British Journal of Criminology*. https://doi.org/10.1093/bjc/azac044
Maddala, G. S. (1983). *Limited-dependent and qualitative variables in econometrics*. Cambridge University Press. https://doi.org/10.1017/CBO9780511810176
Mare, R. D. (1980). Social background and school continuation decisions. *Journal of the American Statistical Association*, *75*(370), 295–305. https://doi.org/10.2307/2287448
Ministry of Health Kenya, Kenya National Bureau of Statistics, National Aids Control Council, Kenya Medical Research Institute, & National Council for Population Development. (2015). *Kenya demographic and health survey, 2014*.
Murphy, S. B., Edwards, K. M., Bennett, S., Bibeau, S. J., & Sichelstiel, J. (2014). Police reporting practices for sexual assault cases in which "the victim does not wish to pursue charges." *Journal of Interpersonal Violence*, *29*(1), 144–156. https://doi.org/10.1177/0886260513504648
Murphy-Oikonen, J., Chambers, L., Miller, A., & McQueen, K. (2022). Sexual assault case attrition: The voices of survivors. *SAGE Open*, *12*(4), 215824402211446. https://doi.org/10.1177/21582440221144612
Mwangi, G. K., Jaldesa, G. W., & Sheikh, M. (2009). An assessment of sexual and gender based violence in Wajir district, North Eastern Kenya.
Office for National Statistics. (2022). Domestic abuse in England and Wales overview.
Pattavina, A., Morabito, M. S., & Williams, L. M. (2021). Pathways to sexual assault case attrition: Culture, context, and case clearance. *Victims & Offenders*, *16*(8), 1061–1076. https://doi.org/10. 1080/15564886.2021.1970661
Rockowitz, S. (Forthcoming). University of Birmingham.
The Sexual Offences Act. (2006).
Shadle, B. (2010). Sexual offences in Kenya courts 1960s-2008.
Smith, O., & Skinner, T. (2017). How rape myths are used and challenged in rape and sexual assault trials. *Social & Legal Studies*, *26*(4), 441–466. https://doi.org/10.1177/0964663916680130
Spohn, C., & Holleran, D. (2001). Prosecuting sexual assault: A comparison of charging decisions in sexual assault cases involving strangers, acquaintances, and intimate partners. *Justice Quarterly*, *18* (3), 651–688. https://doi.org/10.1080/07418820100095051
Spohn, C., & Horney, J. (1993). Rape law reform and the effect of victim characteristics on case processing. *Journal of Quantitative Criminology*, *9*(4), 383–409. https://doi.org/10.1007/BF01064110
Spohn, C., & Tellis, K. (2012, February 1). The criminal justice system's response to sexual violence.
Violence Against Women, *18*(2), 169–192. https://doi.org/10.1177/1077801212440020
Suarez, E., & Gadalla, T. M. (2010, November). Stop blaming the victim: A meta-analysis on rape myths. *Journal of Interpersonal Violence*, *25* (11), 2010–2035. https://doi.org/10.1177/0886260509354503
Tavrow, P., Withers, M., Obbuyi, A., Omollo, V., & Wu, E. (2013, July). Rape myth attitudes in rural Kenya: Toward the development of a culturally relevant attitude scale and "blame index." *Journal of Interpersonal Violence*, *28* (10), 2156–2178. https://doi.org/10.1177/0886260512471086
Temkin, J., Gray, J. M., & Barrett, J. (2016). Different functions of rape myth use in court: Findings from a trial observation study. *Feminist Criminology*, *13*(2), 205–226. https://doi.org/10.1177/ 1557085116661627
Temmerman, M., Emilomo, O., Griffins, M., Iqbal, K., Mary, T., Kishor, N. M., Lou, D., Markus, M., & Peter, G. (2018). The gender-based violence and recovery centre at coast provincial general hospital, Mombasa, Kenya: An integrated care model for survivors of sexual violence. *PLoS Medicine*, *16*(8), e1002886. https://doi.org/10.1371/journal.pmed.1002886
Thelan, A. R., & Meadows, E. A. (2022). The Illinois rape myth acceptance scale—subtle version: Using an adapted measure to understand the declining rates of rape myth acceptance. *Journal of Interpersonal Violence*, *37*(19–20), NP17807–NP17833. https://doi.org/10.1177/08862605211030013

Truman, J. L., & Morgan, R. E., & United States. Bureau of Justice Statistics. (2014). Nonfatal domestic violence, 2003-2012 [text]. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

UNICEF, Division of Violence Prevention, National Center for Injury Prevention and Control, US Centers for Disease Control and Prevention, & Kenya National Bureau of Statistics. (2012). Violence against children in Kenya: Findings from a 2010 national survey. Summary report on the prevalence of sexual, physical, and emotional violence, context of sexual violence, and health and behavioral consequences of violence experienced in childhood.

UN Women. (2016). *Prevalence data on different forms of violence against women*. https://evaw-global
-database.unwomen.org/en/countries/africa/kenya

Wangamati, C. K., Sundby, J., Izgubara, C., Nyambedha, E. O., & Prince, R. J. (2019). Challenges in supporting survivors of child sexual abuse in Kenya: A qualitative study of government and non-governmental organizations [article]. *Journal of Interpersonal Violence*. https://doi.org/10. 1177/0886260519846864

Wangu Kanja Foundation. (2016). *Survivors network*. Retrieved December 12, from https://wangu kanjafoundation.org/?page_id=1005

Withers, M., Minkin, E., & Kyle, A. (2019). *Rape myth acceptance leads to victim-blaming*. Psychology Today. Retrieved November 20.

Wooldridge, J. M. (2010). *Econometric analysis of cross section and panel data*. The MIT Press. http:// www.jstor.org/stable/j.ctt5hhcfr

Zinzow, H. M., Littleton, H., Muscari, E., & Sall, K. (2022, August 18). Barriers to formal help-seeking following sexual violence: Review from within an ecological systems framework. *Victims & Offenders*, *17*(6), 893–918. https://doi.org/10.1080/15564886.2021.1978023

Appendix

Table A1. Logit regression of whole sample.

	Whole Sample			
	(1) MEDICAL	(2) POLICE	(3) LEGA L	(4) COURTCASE
Public Attack	0.0421	−0.0203	−0.0152	−0.124***
	(0.052)	(0.052)	(0.058)	(0.048)
Survivor Knew P	−0.0509	0.113	−0.0264	−0.0361
	(0.080)	(0.076)	(0.067)	(0.049)
Child Survivor	0.121**	0.267***	0.324***	0.285***
	(0.058)	(0.081)	(0.074)	(0.066)
Forensic Evid.	0.0777	0.159**	0.162***	0.0293
	(0.061)	(0.072)	(0.059)	(0.045)
Survivor's Age	0.00280	0.0113***	0.0166***	0.0106***
	(0.003)	(0.004)	(0.004)	(0.003)
Female Survivor	−0.0232	−0.0516	−0.0864	−0.138***
	(0.055)	(0.074)	(0.066)	(0.044)
Sexual Violence	0.0861*	0.131**	0.229***	0.139***
	(0.045)	(0.060)	(0.055)	(0.048)
Observations	405	405	405	405

Table A2. Sequential logit estimates of sexual violence only.

	Sexual Violence Cases			
	(1) MEDICA L	(2) POLIC E	(3) LEGA L	(4) COURTCAS E
Public Attack	0.00761	−0.147**	−0.0863	−0.267***
	(0.039)	(0.069)	(0.080)	(0.078)
Survivor Knew P	−0.0604	0.0520	−0.0683	−0.0590
	(0.053)	(0.074)	(0.084)	(0.073)
Child Survivor	0.0154	0.189	0.418***	0.360***
	(0.054)	(0.117)	(0.122)	(0.121)
Forensic Evid.	0.0357	0.125	0.203**	0.105
	(0.049)	(0.086)	(0.087)	(0.070)
Survivor's Age	−0.00260	0.00189	0.0185**	0.00935
	(0.004)	(0.008)	(0.008)	(0.007)
Female Survivor	−0.0113	−0.0270	−0.0940	−0.167**
	(0.050)	(0.097)	(0.104)	(0.080)
Observations	205	205	205	205

Table A3. Sequential logit estimates of domestic violence only.

	Sexual Violence Cases			
	(1) MEDICAL	(2) POLICE	(3) LEGAL	(4) COURTCASE
Public Attack	0.0934	0.209**	0.105	0.0467
	(0.098)	(0.105)	(0.076)	(0.043)
Child Survivor	0.206*	0.237*	0.191*	0.152**
	(0.113)	(0.126)	(0.104)	(0.065)
Survivor's Age	0.00618	0.0148***	0.0133***	0.00644***
	(0.004)	(0.005)	(0.004)	(0.002)
Female Survivor	−0.0377	−0.0692	−0.0811	−0.0761*
	(0.101)	(0.112)	(0.082)	(0.041)
Observations	200	200	200	200

Table A4. Cases at risk of passing each transition for sexual violence only.

		No Medical Attention		Police		Prosecutor		Court		Convicted		All	
		n	%	n	%	n	%	n	%	n	%	n	%
Attack Happened in Public	No	8/10	80%	30/56	54%	29/35	83%	31/52	60%	47/53	89%	145/206	70%
	Yes	2/10	20%	26/56	46%	6/35	17%	21/52	40%	6/53	11%	61/206	30%
Survivors Knows Perpetrator	No	1/10	10%	23/56	41%	4/35	11%	16/52	31%	12/53	23%	56/206	27%
	Yes	9/10	90%	33/56	59%	31/35	89%	36/52	69%	41/53	77%	150/206	73%
Child Survivor	No	4/10	40%	18/56	32%	8/35	23%	13/52	25%	5/53	9%	48/206	23%
	Yes	6/10	60%	38/56	68%	27/35	77%	39/52	75%	48/53	91%	158/206	77%
Forensic Evidence	No	9/10	90%	48/56	86%	31/35	89%	40/52	77%	40/53	75%	168/206	82%
	Yes	1/10	10%	8/56	14%	4/35	11%	12/52	23%	13/53	25%	38/206	18%
Female Survivor	No	1/10	10%	7/56	12%	3/35	9%	4/52	8%	10/53	19%	25/206	12%
	Yes	9/10	90%	49/56	88%	32/35	91%	48/52	92%	43/53	81%	181/206	88%
Survivor's Age	Mean SD	18	7	16	7	14	7	16	7	14	5	15	7

Table A5. Cases at risk of passing each transition for domestic violence only.

		No Medical Attention		Police		Prosecutor		Court		Convicted		All	
		n	%	n	%	n	%	n	%	n	%	n	%
Attack Happened in Public	No	35/38	92%	52/57	91%	48/56	86%	27/34	79%	11/15	73%	173/200	86%
	Yes	3/38	8%	5/57	9%	8/56	14%	7/34	21%	4/15	27%	27/200	14%
Survivors Knows Perpetrator	No	1/38	3%	1/57	2%	1/56	2%	0/34	0%	1/15	7%	4/200	2%
	Yes	37/38	97%	56/57	98%	55/56	98%	34/34	100%	14/15	93%	196/200	98%
Child Survivor	No	34/38	89%	44/57	77%	46/56	82%	29/34	85%	11/15	73%	164/200	82%
	Yes	4/38	11%	13/57	23%	10/56	18%	5/34	15%	4/15	27%	36/200	18%
Forensic Evidence	No	36/38	95%	53/57	93%	49/56	88%	26/34	76%	15/15	100%	179/200	90%
	Yes	2/38	5%	4/57	7%	7/56	12%	8/34	24%	0/15	0%	21/200	10%
Female Survivor	No	3/38	8%	6/57	11%	6/56	11%	4/34	12%	5/15	33%	24/200	12%
	Yes	35/38	92%	51/57	89%	50/56	89%	30/34	88%	10/15	67%	176/200	88%
Survivor's Age	Mean SD	25	8	23	10	25	8	28	10	29	15	25	10

Chapter 5. Provider perspectives on barriers to medico-legal service provision to sexual violence survivors in Kenya

Extensive research, including the scoping review in Chapter 2, has shown that sexual violence survivors face a myriad of barriers when accessing medico-legal services post-incident in Kenya, yet little research exists to examine the providers' perspectives on why these barriers are present (Gatuguta et al., 2018; Kilonzo et al., 2003; Kilonzo et al., 2008; Kilonzo et al., 2009; Maina, 2009; Maina & Majeke, 2008; Oronje, 2013). Given this paucity of research, I set out to determine what factors the medico-legal providers themselves felt were limiting their ability to provide adequate care. To do this, I worked with the Wangu Kanja Foundation to find medico-legal professionals in both rural and urban areas in Kenya to take part in my research. Due to COVID restrictions, I initially conducted these interviews online, and then in-person when I was able to travel to Kenya. In total I conducted in-depth interviews with 10 medical professionals and 11 legal professionals, including police officers working at a gender desk, doctors, lawyers, and counsellors. I used Framework Analysis to analyse these interviews and found that financial barriers and a lack of training were noted as common obstacles to service provision, and that provider bias was present, particularly among the legal professionals. In this research, I have provided an important opportunity to expand the understanding of barriers to medico-legal service access and provision in Kenya, as well as insights that can be used to inform future policy and practice. This chapter on providers appears before the chapter on survivors not to privilege the voice of the providers, but rather to ensure that the victims have the final say on the matter.

5.1 Introduction

The provision of medico-legal services for a victim of sexual violence is one of the key aspects that may contribute to survivor healing and overall wellbeing (Du Mont & White,

2007; World Health Organization, 2003). Additionally, without the providers associated with this care it is impossible for justice to be found (Du Mont & White, 2007). In Kenya, where over 11 million women have experienced sexual violence as either children and/or adults, providers are faced with the momentous task of helping victims to seek justice and providing medical and mental health services for victims in a country where sexual violence is thought of as a societal norm (Bridgewater, 2016; National Gender and Equality Commission, 2014).

There is a substantial body of literature about what sort of medico-legal services to which victims of sexual violence should have access in countries around the world (Kilonzo et al., 2009; Ministry of Health & Family Welfare Government of India, 2014; World Health Organization, 2003, 2015; World Health Organization & United Nations High Commissioner for Refugees, 2002). This is especially important as studies have shown that women who have been abused use more medical care than women who have not been abused (World Health Organization, 2003). Additionally, when health workers interact with victims of sexual violence, they serve a pivotal role both in recognizing and responding to individual cases of sexual violence formally and in acknowledging the legitimacy of a victim's experience (World Health Organization, 2003).

An act of sexual violence can cause a multitude of both temporary and lasting physical and mental consequences (Garcia-Moreno et al., 2005). Immediately after a rape or other sexual assault, the victim may experience bruising, cuts, swelling, ligature marks, or other anogenital trauma, all of which may require urgent medical attention (World Health Organization, 2003). Psychologically, immediately after an act of violence a victim may experience suicidal ideation, depression, anxiety, and increased substance use or abuse (World Health Organization, 2003). More lasting physical consequences of sexual violence can include an unwanted pregnancy, infertility, urinary tract infections, and unsafe abortions, while psychological effects may include fatigue, sleep disturbances, chronic headaches, and

post-traumatic stress disorder (World Health Organization, 2003). Though this list is of course not all-encompassing, it indicates the extensive array of physical and mental issues that medical providers should be able to address when a victim of sexual violence presents for care.

The provision of medical services for victims of sexual violence is instrumental in their eventual physical and mental recovery, but so too are their interactions with the legal system (Kilonzo et al., 2009; Patricia et al., 2021). In 2006, Kenya created the Sexual Offences Act, which clearly defined different types of sexual violence and outlined what the appropriate legal repercussions are (Kenya, 2006). While it is difficult to get accurate numbers of how many cases in Kenya reach prosecution, research on police reports in 2006 and 2007 showed that just 3,518 and 3,667 charges were filed with the criminal justice system out of a population of 35 million, a presentation rate of 0.001% (Kilonzo et al., 2009). Other research has found that, of the cases that are prosecuted in court, only about 25% lead to convictions (Ajema et al., 2009). Possible explanations for this can be seen in my secondary data analysis in Chapter 4. There is also little possibility of DNA matching in Kenya, as where the technology does exist there are often extensive backlogs which mean that evidence is not evaluated in a timely manner (Kilonzo et al., 2009).

The legal aspects of service provision rely heavily on the competency of medical professionals, as they are the ones tasked with recording the signs of sexual violence that may be used as evidence in court (World Health Organization, 2003). In Kenya, evidence is documented via the P3 form, which is a document that includes information about how the victim's clothing looked upon presentation to the medical centre, details of any injuries sustained during the attack, and information about any weapons used (Kenya Police Service, 2023). The P3 form can be seen in Appendix 3.1. There is also the post rape care (PRC) form, which is to be used in conjunction with the P3 form to guide the completion of the P3

evaluation (Ajema et al., 2009). This form can be seen in Appendix 3.2. Both forms must be taken from the health facilities to the police, often by the survivors themselves, for a case to be taken up by the legal system. An example of a form that accompanies the other forms to the police can be found in Appendix 3.3. Once the process has been initiated, legal professionals are then tasked with maintaining the evidence that had been collected by health care workers, collecting witness statements, and progressing the case through the criminal justice system (Ajema et al., 2009).

For adequate services to be provided, medico-legal professionals must be given proper training about how to manage sexual violence cases. While guidelines for training exist around the world, in practice medical professionals are frequently given inadequate training during medical school and their employers do little to bolster their knowledge base before having them interact with victim/survivors, both in Kenya and elsewhere worldwide (Manuel et al., 2019, 2020; World Health Organization, 2003, 2015). This is even more relevant when discussing male or child victims of sexual violence, whom medical professionals feel ill-equipped to examine forensically due to anatomical differences (Ajema et al., 2011). Providers' attitudes towards, and treatment of, the victims is a key aspect of service provision, but of critical importance is the collection of forensic evidence. Due to the nature of how sexual violence cases are treated by the legal system in Kenya, without forensic evidence cases are far less likely to progress through the case referral pathway (see Chapter 4). Despite this, research has shown that healthcare workers who provide care to victim/survivors are often lacking proper training in forensic evidence collection and storage, thus causing a case's progression to stop prematurely (Ajema et al., 2009; World Health Organization, 2003). Additionally, although Kenya implemented the Sexual Offences Act in 2006, providers have still been found to use incorrect terms when describing sexual violence on official documentation, thus making it difficult for the prosecution when a victim's

testimony does not match the details documented by the medico-legal professionals (Ajema et al., 2011).

In addition to training, the provision of appropriate supplies is crucial in service provision for sexual violence victims (Du Mont & White, 2007). While rape kit components may vary, the World Health Organization notes that health facilities should minimally have a couch, swabs, needles and tubes for blood collection, speculums, pregnancy kits, a sharps container, glass slides to examine samples under a microscope, and gloves to adequately provide services to sexual violence victim/survivors (Ajema et al., 2011; Kilonzo & Taegtmeyer, 2005). Despite these guidelines, and those of the Kenyan National Guidelines on the Management of Sexual Violence, health care workers in Kenya have noted that they may be lacking certain supplies that prevent them from collecting sufficient evidence, such as speculums, and that their facilities are ill-equipped to examine blood or urine samples, making it impossible to meet the standards laid out by the WHO's guidelines (Ajema et al., 2011). Besides limitations from the medical side, police officers have also been found to have inadequate knowledge on the proper storage and transportation techniques needed to maintain forensic samples (Ajema et al., 2011).

Many of the previous studies conducted in Kenya that interviewed medico-legal professionals have been part of larger interventions and have targeted specific facilities (see Temmerman et al., 2018). While the original design for my study was to conduct qualitative interviews in Kenya, analyse them, and then return to Kenya to discuss our findings with the original interviewees, COVID restrictions meant that only one data collection trip was possible, thus limiting the methodological approach taken. Despite this, my unique working relationship with the Wangu Kanja Foundation meant that medico-legal professionals who worked in smaller institutions were accessible, thus enabling my research to engage with individuals that had not been included in previous research in the area.

5.2 Methodology

5.2.1 *Participants and recruitment*

During the lockdown in Kenya, participants were recruited for online interviews via an information sheet that I wrote and distributed to the Wangu Kanja Foundation. The participants also helped recruitment by sharing information about the study with their coworkers. Since there were no established instruments for interviewing medical and legal service providers in such a specific context, I co-designed the interview guides with assistance from both of my supervisors and the leads at the WKF. In creating each interview guide, I drew from existing research that had taken place in a similar context and consultations with the WKF (Kilonzo et al., 2003; Ajema et al., 2011; Ferdowsian et al., 2018). The surveys were designed at first by myself and my supervisors, then we sent it to Wangu Kanja for her feedback on which questions she felt were most relevant for the given context. After an iterative process, the final interview guide was designed. Based on my previous training and experience with qualitative interviews during my two master's degrees, I conducted Zoom interviews with six legal professionals and five medical professionals from several legal and medical institutions within Nairobi, including lawyers who worked at various NGOs and clinical officers from numerous health centres. Participants were sent an electronic consent form to sign and return before the start of the interview, and I also recorded verbal consent before each interview began. Interviews conducted over Zoom were recorded for later analysis. All of the interviews with providers were conducted in English, and only the interviews with the police officers in Kitui required translational help at certain times throughout the questioning, which was provided by trained interviewers from the WKF.

Once lockdown had lifted in both Kenya and the UK, I arranged in-person interviews. Participants were recruited from health clinics, legal and government offices, and police

stations within the Nairobi, Kitui, and Kiambu areas with the help of gender defenders from the Wangu Kanja Foundation. I interviewed medical professionals at county-level health centres in all three locations, police officers at a district police station in Kitui, and legal professionals from district courts in Nairobi and Kiambu. Recruitment involved the dispersion of an information sheet that I had created via the Wangu Kanja Foundation within their network of professionals (Appendix 3.4). Professionals then circulated information about the study within their professional networks. Additionally, I left a few days open at the end of my time in Kenya to allow for interviewing participants who were recruited during my visits to the medico-legal institutions via word-of-mouth networking.

In total, I interviewed five medical professionals and five legal professionals while on the ground in Kenya and five medical professionals and six legal professionals over Zoom, totaling 21 interviewees over 17 interviews. This included police officers who worked at a gender desk, which is a special desk within police stations that has been established to receive, investigate, and refer cases to other stakeholders, such as health providers, NGOs, psycho-social support providers, and the courts. Other professionals I interviewed included lawyers, physicians, and mental health professionals. In total, I interviewed three female medical professionals and six female legal professionals.

In order to ensure the emotional safety of all professionals taking part in my research, I informed them at the start of each interview that they were able to pause or stop the interview at any time and would not face any repercussions. I also informed them that, if necessary, I could connect them to counselors at the Wangu Kanja Foundation for a debriefing session. Some of the providers I spoke to also mentioned debriefing sessions they regularly held with their colleagues as an option if needed.

5.2.2 *Materials*

I conducted a semi-structured interview with all of the medico-legal professionals on an individual basis, apart from two legal professionals who joined a Zoom call together when I was conducting the interviews online, two doctors who I interviewed together in Kitui because one was training under the other, and gender desk officials (three in total) who I interviewed together in Kitui due to time constraints. All interviews with medico-legal professionals conducted in-person were held at the interviewee's office and were audio-recorded with a digital voice recorder. At the start of each interview, I collected information from the interviewees about what their position entailed and what their working environment was like. During the rest of the interview I asked open-ended questions, which included questions about training received to facilitate care, barriers faced in providing services, and ideas about how to improve the process of service provision. These open-ended questions left space to discuss issues brought up by the participants as well as survivors from the same region who had been interviewed previously. The interview guide for these interviews can be found in Appendix 3.5.

5.2.3 *Procedure*

Ethical approval for the study was obtained from the University of Birmingham's ethical review board and written in compliance with the university's code of practice for research. Additionally, due the international nature of this research, ethics was required in Kenya as well. I thus obtained ethical approval from United States International University Africa's institutional review board (Appendix 3.6). Prior to each interview, I either emailed participant information sheets and consent forms to each participant if the interviews were being conducted over Zoom or distributed them in-person before the start of each interview. These information sheets can be found in Appendix 3.4. Consent was collected via signed forms and verbal consent on audio recordings. Interviews were collected either over Zoom (n = 11)

or in-person (n = 10). I conducted all of the Zoom interviews and in-person interviews myself with the assistance of a member of the Wangu Kanja Foundation for translational purposes for the in-country interviews. The mean interview length for medical professionals was 32 minutes (range: 19 – 47) and the mean for legal professionals was 52 minutes (range 34 – 67).

5.2.4 *Reflexivity*

When conducting research, reflexivity can be thought of as the process by which a researcher engages in ongoing self-awareness and self-appraisal to identify how their identity may impact the design, methods, and analysis of a project (Basit, 2013; Dowling, 2006). Reflexivity is not to be confused with reflection, which is instead a process by which there is an objective and somewhat removed thought process at more of a fixed time than reflexivity, which is more subjective and ambiguous (Finlay, 2002). Reflexivity enables the subjectivity that has often been criticised for its role in qualitative research to instead become an opportunity to bring trustworthiness and integrity into qualitative research methods (Denzin & Lincoln, 2017; Dodgson, 2019, Finlay, 2002).

The process of reflexivity occurs multiple times across a research project and in multiple ways. For instance, reflexivity can be undertaken on a personal, interpersonal, methodological, or contextual level (Olmos-Vega et al., 2023). Personal reflexivity involves reflection and clarification on expectation, assumptions, and reactions to any contexts, participants, or data that may occur in the research (Olmos-Vega et al., 2023; Walsh, 2003). In this instance, it required me to ask myself how my unique perspectives may be influencing the research, for instance how my views about Kenya's apparent attitude towards sexual violence survivors, coupled with assumptions about emotional detachment within the medical and legal professions, led me to believe that many providers would appear apathetic towards

the plights of their patients/clients (Crivatu et al., 2023). While at times some providers did seem quite emotionally detached from the topic at hand, at other times some were expressing how distraught they felt at not having the resources or training to be able to help sexual violence victims who came to them for care. This caused me to think further about where my assumptions had come from, and to make sure that I asked questions in further interviews as sensitively as possible.

The next type of reflexivity is interpersonal reflexivity, which involves how the relationships surrounding the research project may affect the context, people involved, or results (Olmos-Vega et al., 2023; Walsh, 2003). While a significant portion of this is the relationship between researchers and participants, for me the most important interpersonal relationship in this research was often that between me and the head of my partner NGO who was helping me to organise my work, as well as a few employees of the organisation. In the years preceding my trip to Kenya, and possibly exacerbated by the COVID pandemic, I felt increasingly ignored and neglected by a team who was supposed to be facilitating my research. Repeated missed meetings and unanswered emails left me wondering what my place, and my research's place, was within the organisation, and left me fearful in the lead-up to my visit to Kenya that nothing would be organised and I would be unable to collect data. I had to firstly consider the power dynamic between myself and my partner organisation, and then any power dynamics between my partners and any participants, to anticipate how they might influence my interactions with my participants. I took extreme care to go into every interview without holding resentment towards the previous few years of struggles and lapses in communication it took to get to this point and believe that I was successful and acknowledging any power dynamics and proceeding appropriately.

Another type of reflexivity is methodological reflexivity, in which researchers consider any nuances and potential impacts of their methodological decisions (Olmos-Vega

et al., 2023; Walsh, 2003). This includes analysing the meaning of methodological decisions and ensuring that they are both ethical and rigorous (Olmos-Vega et al., 2023; Walsh, 2003). For me, methodological reflexivity took two forms. Firstly, I chose to not assign a strict theory to my work but rather to use a descriptive approach, which I felt would be best suited to my research goals after multiple literature reviews and discussions with our partners in Kenya. The main implication of this, of course, is that some may consider my work atheoretical, however I feel I have addressed these concerns in the next section. Secondly, COVID meant that I was unable to conduct research in-country, and also severely impacted the intended methods of my study. Using reflexivity, I was able to critically appraise what I felt were the most important aims of my study and adjust my methods accordingly, which in this case meant foregoing an entire stage of my study due to time constraints and instead focusing on one stage of data collection, which I began over Zoom due to COVID-related travel restrictions.

The final type of reflexivity is contextual reflexivity, which involves contextualising a particular project based on the culture and historical context in which it takes place (Olmos-Vega et al., 2023; Walsh, 2003). Contextual reflexivity also involves understanding how research influence the field in which it takes place in both intended and unintended ways (Smith, 1994; Reid et al., 2018; Olmos-Vega et al., 2023). In order for research to be ethical, it should positively impact the context in which it takes place (Olmos-Vega et al., 2023). For me, in considering how context may be influencing the participants involved, I was cognisant of being clear with my participants about what I was researching and how I was hoping to use their findings to improve policy in Kenya. I was aware that many people in similar contexts feel that Western researchers swoop in, extract information, and then are never heard from again. I ensured my participants that all of my findings would be shared with the WKF, who has worked for years on informing policy in Kenya, and that I would gladly share my

findings with them should they wish to use them to appeal for more SGBV-specific training. Additionally, due to extensive reading I did prior to data collection, as well as previous experience working within the East African context, I was able to anticipate some responses I got to my questions that seemed otherwise unsavoury, for instance those in sections 5.3.1 and 5.3.5. I was able to critically evaluate my feelings about those responses while also situating them in a wider cultural context, which allowed me to remain neutral during the interviews and not reflect to my participants how I felt about their responses.

5.2.5 *Data analysis strategy*

All English portions of the audio recordings of the interviews conducted were transcribed verbatim by a professional, and I checked translations that took place during the interviews with the Kenyan research assistants prior to departing the country. I approached my research following a descriptive lens, as inspired by Sandelowski's multiple works detailing this methodology, which enabled me to explore elements that might affect the professionals' ability to provide care to the victims and analyse their lived experiences (Asemani et al., 2014; Sandelowski, 2000, 2010). Qualitative description is a method that is often used when the researcher seeks to describe the phenomena encountered in their research and to provide clear descriptions of experiences and perceptions on behalf of research participants (Doyle et al., 2020; Sandelowski, 2000). In using this method, I was able to understand the data as it was presented to me, while still interpreting it based on both my previous readings and research and any preconceived notions I may have had about the phenomenon I was studying (Sandelowski 2000, 2010). Again, I was not seeking to generate theory, but rather to explore a phenomenon. In this case, I was looking to explore what factors might affect a medical or legal provider's ability to give care to sexual violence victims in Kenya. While some have stated that qualitative descriptive research is largely atheoretical, other researchers have noted

that this approach instead allows for the researcher to consider to what extent theory may inform the study (Doyle et al., 2020; Kahlke, 2014). Furthermore, a review of qualitative studies to analyse their use of theory found that many qualitative studies in health, medicine, and social science journals did not specify a theory, and while the authors initially stated that they felt that theory was an integral part of any qualitative research, an updated review from the same team reported that in fact over-reliance on theory may stifle reasoning and, of especial importance to my research, that imposing Global North theories on the Global South may perpetuate the marginalisation of Global South ideologies (Bradbury-Jones et al., 2014, 2022; Guzman-Valenzuela & Barnett, 2019). For these reasons, I am confident that although my work was not strictly theoretical, it was still strong methodologically.

I analysed provider interviews using the Framework Method, which is often used for semi-structured interview transcripts and was especially useful in this case because the data all covered similar topics and issues and was thus able to be categorised (Gale et al., 2013; Spencer & Ritchie, 1994). For this analysis, I used five key stages of the Framework Method: transcription, familiarisation with the interview, coding, charting the data, and interpreting the data (Gale et al., 2013). In analysing these interviews, I also used an inductive thematic approach, which enabled me to find themes in the data itself rather than trying to match themes to a pre-existing coding frame (Braun & Clarke, 2006).

Once the transcription of the data was completed by a hired professional, I focused on familiarizing myself with the data by listening to each interview recording multiple times whilst comparing the audio against the transcripts to ensure that no information was being missed. Once this was complete, I began coding the interviews using NVivo 12. This process entailed further familiarisation with the data and open coding where I used NVivo to highlight and label each transcript while creating a list of codes. This list of codes and resulting themes came entirely from the data and I analysed them all by hand. I also created

cases for each participant, wherein each case was their gender and whether they were a medical or legal professional, such as 'F, MP.' This allowed me to evaluate my themes both within and across interviews. Once the coding was complete, I organised the codes manually by writing them on notecards and clustering them until I found appropriate themes. After the themes were compiled, I created a framework matrix to insert quotes from the participants for further mapping and interpretation of the data (Gale et al., 2013). I analysed all of the provider transcripts before analysing any of the survivor transcripts as I wanted to form a complete idea of one side's perspectives of the situation before engaging with the other side. Furthermore, I was the sole analyst of this data due to time constraints, however if I had had more time or were to go back and do this study again, I would be sure to have at least one of my supervisors review my data in hopes of potentially identifying new codes and/or themes.

5.3 Results

When I was analysing the data from provider interviews, I identified five main themes: professional journey, operating outside of the norm, case details and procedure, limiting factors, and personal reflections. Each of these themes contained lower-level categories for further specification.

5.3.1 *Theme 1: Professional journey*

This theme covered the medico-legal professionals' journeys to their current jobs, including what motivated them to work with sexual and gender-based violence survivors, what the origin of their role was, and what training they received or felt they should have received for their current position. An interesting finding I noted in this theme was that while some professionals had chosen to work in this field because they noticed problems in their community, i.e.,

Many women were affected with a lot of violence, children were displaced, property was

destroyed, and we realised, being that we are the heart of the community, we are in a position to give legal advice to the most affected with the post-election violence. (LP1)

other professionals were working in their specific role because they had been assigned to do so, namely some of the police officers working at a gender desk in a rural town east of Nairobi. When asked how employees were chosen to be assigned to the gender desk, the lead officer replied:

Yeah. It is us who deploy who's supposed to work. It's up to me, we can deploy someone else here. It's at the discretion of us. (LP7)

When I asked what criteria he used to select employees who would be a good fit to the role, he said:

Just a feminine. If we wake up in a bad mood we can remove her from this position. It depends on how she performs. (LP7)

Training (or lack of training) received was a theme that occurred in all of my interviews with professionals. Given the professions I included in this study, relatively high levels of education were mentioned as a necessity for the role by every interviewee; yet, whether the medico-legal professionals had received formal training to work with SGBV survivors varied across professionals. Some interviewees had a special unit in university, medical school, or law school, although the perceived efficacy of the training received was mixed, and many providers sought further training elsewhere:

Yes, I did receive the training when I trained as a paralegal. But I enhance that training from other organisations that are providing SGBV related interventions (LP2)

Yeah, when we were being trained on sexual violence cases, there is a unit that you are trained on handling gender violence cases or, sexual gender-based violence. And also, we received training here and there from other organisations. (LP1)

It wasn't so much in our training. Sarah: Okay. Male: It wasn't so much in our training. Sexual and gender-based violence wasn't so much in our training it's something that we figure out on the ground/ (MP2)

Most professionals I interviewed had received training on the job, either through their

employers or through NGOs who had organised training nearby:

> *Well, we have very many on job training sensitisations about violence, but we've also gone through the ones that our Ministry of Health accredited ones, the ones we get from, the area leadership, especially the county governments. (MP5)*
>
> *The training that is being offered by my employer now, sometimes we do training on psychosocial support related to survivors, mental health related to survivors, and sometimes we even attend forensic evidence or sample collecting. (MP6)*

Finally, some of the professionals I interviewed received no formal training, and all of their knowledge about how to handle SGBV cases came from work experience:

> *But, to answer you specifically, no, I have not received specific training, so, it's something that I've had to learn on the go and something that I've had to learn. (LP5)*
>
> *Not really. The, the hospital does not, they do not, commonly take people for any SRH training, basically you learn it on job from your colleagues or from the supervisors on how to handle these clients, how to examine them, how to fill the forms, how to fill the registers, things like that. Yeah. (MP4)*

5.3.2 *Theme 2: Operating outside of the norm*

Multiple providers described to me steps either taken by them or taken by SGBV survivors that were outside of normal operating procedure. This included offering services pro bono and the acknowledgement that survivors were often pursuing justice informally. For some, this was through giving extra time to the survivors they were trying to help:

> *She is supposed to wake up at that moment and take the victim to the hospital. There is a lot of commitment. You must volunteer, you put the needs of the victim on yourself. It is working hard. Some of the others will tell them, come back tomorrow. (LP7)*
>
> *Sometimes she's even call me, they'll even call me at night. "[Interviewee name], are you at this place and this, is it possible to make to this police station we're having trouble?" (LP8)*

Others described working pro bono on some cases, while also acknowledging that victims would often not receive justice unless they had financial means to help move their cases through the system.

Most of these things we do on a pro bono basis voluntary, and you find that you also have your own work, probably employed somewhere, you really need to work, and they may not get that representation. (LP8)

You'll quickly realise in the course of your research that in the Kenyan legal system cases are barely concluded very quickly unless they involve politicians, or a large amount of money. (LP3)

Professionals were also very aware that many survivors chose to handle the matter outside of the formal medico-legal system, and at times would drop cases that the providers had been handling.

Reporting can be done but follow up and the arresting perpetrators is a problem, because sometimes you find that, some of the clients and their relatives sometimes prefer to settle these issues in the home setting, out of court. (MP4)

Sometimes, even if you take the perpetrator to court, and the family, poor family, they agree outside the court, now it is somehow difficult to get justice. It's not even about the court process. (LP7)

5.3.3 *Theme 3: Case details and procedures*

When I asked the professionals about what their service provision looked like day-to-day, multiple providers discussed the presence (or absence) of forensic evidence and discussed statistics about how many cases proceeded through the pathway. Interestingly, the descriptions of how many survivors moved through the pathway were in sharp contrast to my secondary data analysis, which can be found in Chapter 4, perhaps indicating a lack of knowledge about what happened to the survivors once they moved forward to the next step of care seeking. Descriptions of both the statistics of survivors moving through the pathway and the presence of forensic evidence included the following:

If the age of 0 to 18 under Kenyan law. All cases go to court. In terms of evidence threshold, sometimes if we get the forensic evidence at the right time, and the victim cooperates with the legal system, 90% go through for conviction. (LP7)

Yes. In majority of cases, it's just the oral testimony and the medical/legal documents. But those forensic, determinations, you'll highly, and in a few cases they're there, but in many

cases they're not. Actually, in the majority of cases, there is no forensic evidence. (LP6)

When I asked questions about the process of service provision, many providers had knowledge of what the appropriate pathway for service provision should be and confirmed that they were trying their best to facilitate progress for their clients.

> *So, I would say if a survivor comes to us, either through our offices or through the phone on the toll-free line and tell us they're survivors; first thing would be to ask whether they've received medical support, because that is key. And so, the next response will be based on where they are at. If they say that they've not been able to receive such, we're able to refer them to several locations where those rape care services are provided for free. (LP3)*

> *Once, in most cases we receive calls when the case is already at a police station, and then, when we receive cases, we help the victim to pursue health first, you know, like going to the hospital, getting better, being done. And then, now from there, we pursue that the case to be extended to a court of law, whenever we realise that there is sufficient evidence. (LP1)*

> *You counsel them, there is, my speciality, they go for HIV testing room, where the counsellor is situated; so, they go through counselling. Then the next, what you do, you just maybe, you may get them, you tested them for HIV. (MP1)*

5.3.4 *Theme 4: Limiting factors*

Like the findings from the scoping literature review presented in Chapter 2, and as I will explore from the survivors' perspectives in the next chapter, there were many limiting factors that precluded the providers from offering adequate care to the survivors, due in part to financial and other resource barriers, as well as logistical problems experienced by the victims that made the job of the providers especially difficult. A legal professional working at an NGO expressed frustrations to me about what services were available for survivors:

> *So, psychosocial support, so far, at least the experience we've had, in Kenya, we don't have free psychosocial support to the extent of healing. (LP3)*

> *And something to notice that, not all survivors can access government hospitals, because the government hospitals are either the major level five hospitals or level four hospitals, but a survivor who's living in a certain rural area, the nearest is a clinic that they would access. But even with governments hospitals, they still face challenges. (LP3)*

Numerous officials I interviewed also spoke of a support fund available to victims, technically as part of the Victim Protection Act of 2014, although none of the victims I spoke to were aware of this fund. Furthermore, the few providers I spoke to who were aware of this fund noted that they had not had a single patient/client successfully access it.

There were also observations from some professionals that a lack of sensitisation amongst the public about the legal process involved in sexual violence cases resulted in a lack of evidence, making their jobs especially difficult.

> *The only challenge we have in that front is that, there is no sensitisation, and what the victims want to do initially is just get rid of what they would call that really, and like want to wash up and get rid of the clothes and all that, which is technically getting rid of the evidence. (LP3)*
>
> *One, I would say there's a problem with, again, like I said, the reporting patterns of, the clients or the victims of violence that most of them do not like directly, visit at facilities and especially if they do, they might not do it immediately, so, they might have come maybe having a change of clothing or taken a bath or maybe after a few days since the events occurred. (MP5)*

Logistical problems that occurred also made service provision difficult. These included court processes that may lead to re-traumatisation for survivors, as well as delays or errors from other professionals along the pathway that made my interviewees' jobs nearly impossible.

> *So, sometimes the survivor facing their perpetrator face-to-face can cause a reaction that may result in them collapsing or fainting, and this has happened in court several times. So, witness boxes are nonexistent, so, it has to take a lawyer to really follow-up with the court and argue that we need something, in this case, that a survivor shouldn't face the perpetrator face-to-face. (LP3)*
>
> *Yeah. Like recently we had a defilement case; a 12-year child was defiled by a neighbour, and, when the father of the child reported the matter to a police station, then the kid was taken to hospital and everything was okay. Every evidence, every, the results showed that the child was defiled; so, it was for the police to arrest this man, you know, so, that they can take him to court, (to the) judges. But they delayed arresting this man he fled. (LP1)*
>
> *And most of the sexual violence has come from low-income people, which normally didn't have the money to access the high-end facilities or services. So, for the few who can assess the services, they do not have enough service providers to attend to them. (MP2)*

Besides financial barriers, other resource constraints were a major obstacle in service

provision. This included the shifting of responsibilities due to restructuring and limited infrastructure.

> *When the NGO was around--the services were 24/7 and we had nurses and clinicians specifically for those services. Now, as you can see, I'm still same person providing the services seeing the patient at times, with other certain duties. (MP2)*
>
> *First, our legal system is a bit complicated. You'll find that we do not have enough courts, so, you only have one main court and the others are mobile courts. (LP8)*
> *But a place like this one, I know that this is not a good setup for counseling, first and foremost, it's not a good setup, sometimes I even struggle because I have to sit next to, near them, because the arrangement is not basically for counseling, it's just an office. (MP7)*

5.3.5 *Theme 5: Personal reflections*

In talking to the providers, I learned about what they thought of their colleagues, what they thought of their clients, and what sort of support they felt their clients needed. Legal professionals made disparaging remarks primarily about the police to me, some also made negative comments about medical professionals as well.

> *Police officers have been a big problem for us…as a result of police officers in action, we have lost a case in court, because they failed to conduct an accused person's assessment properly. (LP3)*
>
> *I think one of something maybe I didn't mention, police officers barely know their rules, sadly. Unlike western countries where police officers support you through the process, in Kenya has been that police officers hinder access to justice. (LP3)*
>
> *Most of the time, the perpetrators, sometimes you'll see the family members who are wealthy in their family, they have money, So, what'll happen, they'll just go to the police station, see who's in charge of the station. Then once they get the bribe, they will stop reporting the case. (MP3)*
>
> *Another area where we get a challenge is the medical, because if the medical, as an expert, if the medical process or medical evidence is not tightened…the legal law officer or the advocate of the perpetrator will ask. (LP2)*

While not as prevalent as some of the other themes I found in the data analysis, I still encountered victim blaming and bias against victims multiple times throughout the interviews. Included in this bias were ideas of how a victim should be acting after

experiencing a traumatic event:

> *In fact, the problem is with sex workers, they tend to report it as sexual violence, if maybe they've had an argument with, say someone and then they have intercourse, but they don't get paid. (MP5)*
>
> *For example if you say a child has been defiled and the child is playful or happy, they don't go hand in hand. Or an adult because sometimes we get somebody above 18 who has been defiled then they are here, their mood is good, they are not moody and they are saying maybe it was agreed to do that, so the mood plays a part. (MP2)*
>
> *Again, the survivors sometimes they frustrate us also, because sometimes you get the adolescents, the perpetrators are their boyfriend, they don't want them to get arrested. So, instead of helping us, they help the perpetrator to run away. (MP3)*

Another significant reflection from the providers was about the strain of the job, and what might be done to help them. While dealing with all sexual violence cases was found to be affecting for the providers, professionals who worked with children told me that they found their work to be especially taxing, especially those with their own children of a similar age as the victims.

> *So, many times, yes, it affects you because you also think the people that you know, or people that might be at risk, and there's not much you can do to protect them. Yeah. (MP5)*
>
> *The father has been sexually abusing her, that is incest, and so, it really affects that, me on how can I, as a father to my daughter, you know, do such a thing. (LP2)*
>
> *Sarah, as a person, it affects me because of that trauma, it's really traumatic. As a father, it affects me because I see some of these survivors who are the same age as my daughters, you know, you find a case of a mother, somebody who's like a mother and, you know, anybody of the age of your mother is your mother, or your cousin; so, it's a bit traumatizing. (LP4)*
>
> *If you get like a five-year-old girl defiled by like a seventy-year-old man, sometimes you feel disturbed, because us also, we are parents, you can imagine the kids you have at home, the same thing happening to them, it really affect us. (MP3)*

Some of the providers I spoke to were fortunate to have support from their employers or educators, but others were unable to get help themselves due to financial obstacles on behalf of their employer.

Right now, we don't have support services because, that is why we thought of bringing in a counselor, but because we currently don't have funding it's very hard to find counselors and, the psychosocial people who can journey with us the trauma of sexual survivors' experience. (LP1)

Yeah, we have internally as an organisation, because I work, we work directly with survivors. We also are able to receive psychosocial support, like myself, I've been to counseling with the support of the organisation. So, the organisation caters for such things, but it's tough. (LP3)

Yeah. You know, we usually, you know, if there was, I'm not sure there's could be a psychologist, specifically offering counseling services to healthcare workers who go through these kinds of traumatizing events, or, but for now, I wouldn't say there are such. (MP4)

5.4 Discussion

5.4.1 *Main findings*

In this study, I sought to learn about the barriers faced by medico-legal professionals in providing services to sexual violence survivors in both urban and rural areas of Kenya. There were a few noteworthy findings, including the steps that led the interviewees to their current roles, the blatant frustration that some providers have with those in other fields, and the disparate statistics provided by the interviewees compared with our findings in other studies, most notably the secondary data analysis in Chapter 4. Conversely, some findings were expected as I had read about them in other similar work conducted in Kenya previously, notably the presence of financial and resource constraints as well as provider bias (Ajema et al., 2011; Ferdowsian et al., 2018; Gatuguta et al., 2018; Munala et al., 2018).

One of the most notable results from this study came from my interviews with the gender desk officers, where the head officer essentially told me that his only criteria for his employees was that they were women and that he did not care how they felt about the job, he could keep them in that position until he felt like changing it. He even acknowledged that he had 'forced these ladies to be here' because no one else was willing to work at the gender desk. In addition to being literally forced into these positions, the gender desk officials had

also been thrown into their jobs with little to no formal training, an issue that was found throughout my interviews with professionals from all sectors, including doctors, counselors, lawyers, and judges. Although the lack of formal trainings was pervasive in my data, especially as a part of medical or law school, many providers stated that they had personally sought out additional training to strengthen their skills, or that NGOs had come into their workplaces to offer bespoke sessions on sensitivity, evidence collection, and multisectoral collaboration. This training was also often offered by researchers hoping to conduct pre- and post-intervention evaluations, the results of which have been mixed (Ajema et al., 2011; Albezreh et al., 2022).

While previous research has explored victims' problems with their providers, my research was unique in that the providers often spoke about issues they had when working with providers from other sectors (Ferdowsian et al., 2018; Munala et al., 2018). Police officers were spoken poorly about by lawyers, doctors, and counselors, providing corroboration to some of the issues often faced by victims, such as poor inter-sectoral communication, willingness to take bribes from the families of perpetrators, and resource constraints (Ajema et al., 2009; Kilonzo et al., 2003). Some providers described to me how police officers took their time to arrest suspected perpetrators to the point where they had time to flee the county, took bribes to stop the case from progressing any further through the case referral pathway, and were constantly offering excuses as to why their job was not being done properly. While some of the interviewees chalked this poor performance up to inadequate training, some were bolder in stating that it seemed like the police simply did not care about the victims or doing their jobs properly.

Regarding the statistics of cases who progress through the pathway, my findings highlighted a major gap in knowledge on behalf of the providers. For example, one of the providers I interviewed in this study, the head of the gender desk mentioned previously,

stated that 90% of defilement cases go through to conviction. A medical professional I interviewed stated that he thought 50% of cases made it through the case referral pathway to the end, and another provider, this time a lawyer, said that he thought that 10% of cases made it through to conviction. While this number is more realistic, it is still highly inaccurate, as my secondary data analysis found that fewer than 1% of cases reach the sentencing phase of the pathway. Though the sample from the WKF may not be representative of the rates in all of Kenya, they are still striking, though not so different than the 1.1% of rape cases in the United States that get referred to a prosecutor or the 1% of cases in the UK that result in a charge (not necessarily a conviction) in the same year in the United Kingdom (RAINN, 2019; *Rape and sexual assault statistics*, 2023; Van Dam, 2018). It was difficult to distinguish whether these inaccuracies were due to a lack of available data on case progression, inflated statistics being fed back to the providers, or simply misguided ideas about what happened to cases after they were passed on to the next step of care seeking.

As with previous research, there were quite a few instances of victim blaming and bias present in my interviews with both medical and legal professionals, although, as found previously, bias was more prevalent amongst legal providers than medical providers (Ferdowsian et al., 2018; Munala et al., 2018). During my interviews, multiple providers said that the behaviour of the victim might indicate if they were being truthful about the assault, and that certain behaviours would not go together with having been sexually assaulted, thus indicating that the survivor was lying. These opinions may be explained by the prevalence of rape myths in Kenyan society and could potentially be handled via intensive trainings (Tavrow et al., 2013). As mentioned previously, however, many of these professionals go through their entire education and many years of professional work before encountering a formal training process.

5.4.2 *Strengths and limitations*

My study was unique in that professionals from multiple roles within the medico-legal fields were interviewed to learn about their attitudes about their jobs and what barriers they faced daily. By using qualitative methodology, I identified a number of key findings that are likely to be relevant in similar contexts elsewhere, thus making these findings widely applicable and informative for future research. These findings will be transferrable to other similarly-resourced contexts, as evidenced by the frequency of themes that occurred in my scoping review throughout multiple countries in East Africa (Rockowitz, Flowe, & Bradbury-Jones, 2022). Furthermore, my descriptions of the types of providers interviewed for this research and the settings in which this research took place make it possible for similar work to be conducted elsewhere. My interviews with professionals across different professions within the field yielded unique findings about barriers faced at multiple stages of the case referral pathway, and helped shed light on what steps can be taken in the future to ensure that providers are given the best tools and knowledge possible to provide improved care for SGBV survivors. By interviewing professionals in both urban and rural areas, study credibility was strengthened, and data saturation was achieved. Because I was able to interview all professionals in English, I am not concerned about any information being lost in translation, a minor concern of mine regarding my victim interviews.

The lack of inclusion of tribal leaders/community elders was a limitation of this study, as they play a crucial, albeit informal, role in connecting survivors to, if not providing, certain services. Considering the frequency with which the interviewed medico-legal professionals mentioned informal care seeking, such as 'kangaroo courts,' interviewing this population would have provided me with valuable insight into other service provision models that exist in Kenya. However, due to the pandemic and thus a severely shortened fieldwork timeline, it was simply not possible for me to include this population in my research. I also would have

liked to interview professionals from private health facilities to see how their ability to provide care may have differed from those in government hospitals, but again, my shortened timeline made it difficult to include participants from so many locations. Another potential limiting factor of this work was the cross-cultural nature of the research, which may have caused participants to feel constrained in their responses, though this was hopefully mitigated by the presence of a local representative of the Wangu Kanja Foundation with me in my interviews. Finally, there may have been issues with social desirability bias, and interviewees may have altered their responses to appear more socially aware, yet the boldness with which some interviewees proclaimed their distrust of survivors, coupled with the recurrence of themes indicating data saturation from both medical and legal professionals, suggested that this was minimally impactful (Bergen & Labonté, 2020).

5.4.3 *Recommendations for policy, practice, and future research*

Given the findings from my research, there is a pressing need to implement policies and practices that can help prepare medical and legal professionals to address the needs of sexual violence victims in Kenya. Although my research did not evaluate the health and legal systems' overall functioning in relation to sexual violence service provision, but rather the experiences of professionals within the health and legal systems, addressing issues at the system level would address some of the issues I identified in my research.

There exists a robust body of research that has explored health system readiness to sexual violence service provision around the world, both in high- and low-income countries, which has noted that the main roles of health systems include identifying violence, referral to legal and other support services, providing long-term mental health support, and more (Garcia-Moreno et al., 2015; Sikder et al., 2021; Colombini et al., 2022). Health system strengthening approaches include training sessions for professionals, streamlined referral

pathways, and resource allocation to better suit the needs of sexual violence victims (Garcia-Moreno et al., 2015; Hudspeth et al., 2022). While many of these recommendations would certainly help bolster Kenya's health system, one of the major issues that I found during my research was a lack of appropriate education. This finding has also been noted in Mozambique and Tanzania (Manuel et al., 2019, 2020; Ross et al., 2018; Rosser et al., 2022). This issue can at times be addressed within the health and legal systems, as some of my participants did note that their employers brought in outside experts for ad-hoc training sessions, however many of my participants also noted that they wished they had had more sexual violence-specific training while in medical or law school.

One way to address this gap in knowledge would be to require relevant classes be integrated into the formal curricula at all accredited medical and law schools in Kenya. These courses should be taught by dedicated teachers who are experts in sexual violence, rather than by professors who are teaching the bare minimum on the topic simply to say that it has been done. Additionally, lessons addressing sexual violence should not occur over a short period of time, but rather across the duration of one's medical or legal education, so that professional skills can be applied to the needs of sexual violence victims as they develop. These courses should also be co-produced with sexual violence survivors, such as the gender defenders from the Wangu Kanja Foundation, so that the coursework can be designed based on lived experience.

There is also a notable need for improved working relationships between sectors, as reflected by multiple comments from professionals in all fields disparaging other professionals. Existing research on improving multisectoral collaboration has found that engaging nongovernmental stakeholders, civil society organisations, academia, and the private sector is a potentially effective way to create sustained change (Rasanathan et al., 2017; Albezreh et al., 2022). By working within existing structures collaboratively, rather

than having a single group working to champion change, negotiation, flexibility, and communication can be prioritised (Nicholls, Raman, & Girdwood, 2012; Rasanathan et al., 2017). Tools created by international non-governmental organisations already exist to increase multisectoral collaboration, such as one by the Prevention Institute aimed at preventing interpersonal violence through multisectoral collaboration and another by USAID aimed at improving health policy design through multisectoral coordination (Health Policy Project, 2014; Violence Prevention Alliance 2020). Although neither of these tools are specifically aimed at increasing collaboration between medico-legal professionals in treating sexual violence victims, their recommendations, such as developing a shared language for sectors to communicate with each other, identifying shared outcomes, and supporting multisectoral working group meetings, can all be applied to the Kenyan context (Health Policy Project, 2014; Violence Prevention Alliance 2020).

Future research on the barriers faced by medico-legal professionals when providing care to sexual violence victims in Kenya should focus on refining and developing resources that professionals from each sector would find useful in their everyday roles. My research identified a lack of knowledge or appropriate training experienced by professionals in both sectors, and these resources may be able to address some of the gaps that are being experienced as a result of poor (or nonexistent) education. Future research may also involve a co-design process between service users and service providers to establish a practice model that victims find more acceptable. Many victims spoke of poor treatment by professionals that deterred them from seeking help, and a co-design process guided by trauma and gender-informed care approaches may be a way to help address some of these issues, especially those surrounding provider bias.

5.5 Conclusion

My study addressed a gap in the literature on barriers felt by medico-legal professionals in providing care to SGBV survivors, as well as the impact of the profession on the providers' personal well-being. The themes I identified in my interviews correlated with previous findings in similar work, although my work examined the lived experiences of professionals in both rural and urban areas in Kenya more thoroughly than had been done previously. I found that critical barriers experienced by providers appeared to be limited financial and infrastructural resources, inadequate training, and distrust of professionals in other sectors. Future research should focus on enhanced training programmes that include professionals from multiple sectors, to ensure that the next generation of providers is both being trained on proper case management skills and fostering more multisectoral collaboration and trust, which is the only way to ensure that survivors in Kenya get adequate care while moving through the case referral pathway.

References

Ajema, C., Mukoma, W., Kilonzo, N., Bwire, B., & Otwombe, K. (2011, May). Challenges experienced by service providers in the delivery of medico-legal services to survivors of sexual violence in Kenya. *Journal of Forensic Legal Medicine, 18*(4), 162-166. https://doi.org/10.1016/j.jflm.2011.02.004

Ajema, C., Rogena, E., Muchela, H., Buluma, B., & Kilonzo, N. (2009). *Standards requried in maintaing the chain of evidence in the context of post rape care services: Findings of a study conducted in Kenya*.

Albezreh, S., Anastario, M., Ulibarrí, B. J., Naimer, K., Johnson, K., McHale, T., Mishori, R., Macias-Konstantopoulos, W. L., Olson, R., & Nelson, B. D. (2022). Multiyear, Multisectoral Training Program in Kenya to Enhance Medical–Legal Processes in Response to Sexual and Gender-Based Violence. *Violence Against Women, 28*(14), 3311-3330. https://doi.org/10.1177/10778012221099984

Asemani, O., Iman, M. T., Moattari, M., Tabei, S. Z., Sharif, F., & Khayyer, M. (2014). An exploratory study on the elements that might affect medical students' and residents' responsibility during clinical training. *Journal of Medical Ethics and History of Medicine, 7*, 8.

Basit, T. N. (2013, 2013/09/01). Ethics, reflexivity and access in educational research: issues in intergenerational investigation. *Research Papers in Education, 28*(4), 506-517. https://doi.org/10.1080/02671522.2012.689318

Bergen, N., & Labonté, R. (2020). "Everything Is Perfect, and We Have No Problems": Detecting and Limiting Social Desirability Bias in Qualitative Research. *Qualitative Health Research, 30*(5), 783-792. https://doi.org/10.1177/1049732319889354

Bradbury-Jones, C., Taylor, J., & Herber, O. (2014, 2014/11/01/). How theory is used and articulated in qualitative research: Development of a new typology. *Social Science & Medicine, 120*, 135-141. https://doi.org/https://doi.org/10.1016/j.socscimed.2014.09.014

Bradbury-Jones, C., Herber, O. R., Miller, R., & Taylor, J. (2022, 2022/12/01/). Improving the visibility and description of theory in qualitative research: The QUANTUM typology. *SSM - Qualitative Research in Health, 2*, 100030. https://doi.org/https://doi.org/10.1016/j.ssmqr.2021.100030

Braun, V., & Clarke, V. (2006, 2006/01/01). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Bridgewater, G. (2016, Feb). Physical and sexual violence against children in Kenya within a cultural context. *Community Practitioner, 89*(2), 30-34.

Colombini, M., Mayhew, S. H., García-Moreno, C., d'Oliveira, A. F., Feder, G., & Bacchus, L. J. (2022). Improving health system readiness to address violence against women and girls: a conceptual framework. *BMC Health Services Research, 22*(1), 1429. https://doi.org/10.1186/

Crivatu, I. M., Horvath, M. A. H., & Massey, K. (2023). The Impacts of Working With Victims of Sexual Violence: A Rapid Evidence Assessment. *Trauma, Violence, & Abuse, 24*(1), 56-71. https://doi.org/10.1177/15248380211016024

Denzin, N. K., & Lincoln, Y. S. (2017). *The SAGE Handbook of Qualitative Research*. SAGE Publications.

Dodgson, J. E. (2019). Reflexivity in Qualitative Research. *Journal of Human Lactation, 35*(2), 220-222. https://doi.org/10.1177/0890334419830990

Dowling, M. (2006). Approaches to reflexivity in qualitative research. *Nurse Reearcher, 13*(3), 7-21. https://doi.org/10.7748/nr2006.04.13.3.7.c5975

Doyle, L., McCabe, C., Keogh, B., Brady, A., & McCann, M. (2020, Aug). An overview of the qualitative descriptive design within nursing research. *Journal of Research in Nursing, 25*(5), 443-455. https://doi.org/10.1177/1744987119880234

Du Mont, J., & White, D. (2007). *The uses and impacts of medico-legal evidence in sexual assault cases: a global review*. WHO Press.

End Violence Against Children, Prevention Institute, & Violence Prevention Alliance. (2020). Violence Prevention through Multisectoral Collaboration: An International Version of the Collaboration Multiplier Tool to Prevent Interpersonal Violence. https://www.who.int/publications/m/item/violence-prevention-through-multisectoral-collaboration

Ferdowsian, H., Kelly, S., Burner, M., Anastario, M., Gohlke, G., Mishori, R., McHale, T., & Naimer, K. (2018, Dec). Attitudes Toward Sexual Violence Survivors: Differences Across Professional Sectors in Kenya and the Democratic Republic of the Congo. *Journal of Interpersonal Violence, 33*(24), 3732-3748. https://doi.org/10.1177/0886260516639257

Finlay, L. (2002). "Outing" the Researcher: The Provenance, Process, and Practice of Reflexivity. *Qualitative Health Research, 12*(4), 531-545. https://doi.org/10.1177/104973202129120052

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013, 2013/09/18). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology, 13*(1), 117. https://doi.org/10.1186/1471-2288-13-117

Garcia-Moreno, C., Jansen, H. A. F. M., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Initial results on prevalence, health outcomes, and women's responses* W. Press. https://apps.who.int/iris/handle/10665/43309

García-Moreno, C., Hegarty, K., d'Oliveira, A. F. L., Koziol-McLain, J., Colombini, M., & Feder, G. (2015). The health-systems response to violence against women. *The Lancet, 385*(9977), 1567-1579. https://doi.org/10.1016/S0140-6736(14)61837-7

Gatuguta, A., Merrill, K. G., Colombini, M., Soremekun, S., Seeley, J., Mwanzo, I., & Devries, K. (2018, Jun 19). Missed treatment opportunities and barriers to comprehensive treatment for sexual violence survivors in Kenya: a mixed methods study. *BMC Public Health, 18*(1), 769. https://doi.org/10.1186/s12889-018-5681-5

Guzmán-Valenzuela, C., & Barnett, R. (2019). Patterns of theory use in qualitative research in higher education studies in Latin America: a geopolitical interpretation. *International Journal of Qualitative Studies in Education, 32*(5), 477-492. https://doi.org/10.1080/09518398.2019.1597213

Health Policy Project. (2014). Capacity Development Resource Guide: Multisectoral Coordination. Washington, DC: Futures Group, Health Policy Project.

Kenya Police Service. (2023). *The Kenya Police Medical Examination Report*. Kenya Police Service, Retrieved from https://www.kenyapolice.go.ke/downloads/category/4-police-forms.html

Kilonzo, N., Molyneux, S., Taegtmeyer, M., & Theobald, S. (2003). *Post rape services in Kenya: a situation analysis*. LVCT.

Kilonzo, N., Ndung'u, N., Nthamburi, N., Ajema, C., Taegtmeyer, M., Theobald, S., & Tolhurst, R. (2009, Nov). Sexual violence legislation in sub-Saharan Africa: the need for strengthened medico-legal linkages. *Reproductive Health Matters, 17*(34), 10-19, Article Pii s0968-8080(09)34485-7. https://doi.org/10.1016/s0968-8080(09)34485-7

Kilonzo, N., & Taegtmeyer, M. (2005). *Comprehensive post-rape care services in resource-poor settings: lessons learnt from Kenya*. L. a. C. Kenya.

Kilonzo, N., Taegtmeyer, M., Molyneux, C., Kibaru, J., Kimonji, V., & Theobald, S. (2008, Feb). Engendering health sector responses to sexual violence and HIV in Kenya: results of a qualitative study. *AIDS Care, 20*(2), 188-190. https://doi.org/10.1080/09540120701473849

Kilonzo, N., Theobald, S. J., Nyamato, E., Ajema, C., Muchela, H., Kibaru, J., Rogena, E., & Taegtmeyer, M. (2009). Delivering post-rape care services: Kenya's experience in developing integrated services [Short Survey]. *Bulletin of the World Health Organization, 87*(7), 555-559. https://doi.org/10.2471/BLT.08.052340

Lederle, M., Tempes, J., & Bitzer, E. M. (2021, May 5). Application of Andersen's behavioural model of health services use: a scoping review with a focus on qualitative health services research. *BMJ Open, 11*(5), e045018. https://doi.org/10.1136/bmjopen-2020-045018

Maina, G. (2009). Emergency medical response to intimate partner violence in Kenya. *Nursing Standard, 23*(21), 35-39. https://doi.org/10.7748/ns2009.01.23.21.35.c6766

Maina, G., & Majeke, S. (2008). Intimate partner violence in Kenya: expanding healthcare roles. *Nursing Standard, 22*(35), 35-39. https://doi.org/10.7748/ns2008.05.22.35.35.c6533

Manuel, B., Roelens, K., Tiago, A., Keygnaert, I., & Valcke, M. (2019). Gaps in Medical Students' Competencies to Deal With Intimate Partner Violence in Key Mozambican Medical Schools [Article]. *Frontiers in Public Health, 7*, Article 204. https://doi.org/10.3389/fpubh.2019.00204

Manuel, B., Roelens, K., Tiago, A., Keygnaert, I., & Valcke, M. (2020, Jan). Medical Curricula on Intimate Partner Violence in Mozambique. *Acta Medica Portuguesa, 33*(1), 22-30. https://doi.org/10.20344/amp.12049

Ministry of Health & Family Welfare Government of India. (2014). *Guidelines & Protocols: Medico-legal care for survivors/victims of sexual violence* Government of India.

Munala, Welle, E., Hohenshell, E., & Okunna, N. (2018, Jul). "She Is NOT a Genuine Client": Exploring Health Practitioner's Mistrust of Rape Survivors in Nairobi, Kenya. *Community Health Equity Research & Policy, 38*(4), 217-224. https://doi.org/10.1177/0272684x18781790

National Gender and Equality Commission. (2014). *National Monitoring and Evaluation Framework towards the Prevention of and Response to Sexual and Gender Based Violence in Kenya*.

Nicholls, R, Raman, S and Girdwood. (2012). Can inter-sectoral collaboration improve adolescent sexual and reproductive health? Health, media and education partnerships in developing countries, Human Resources for Health Knowledge Hub, University of New South Wales, Sydney

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2023, 2023/03/04). A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Medical Teacher, 45*(3), 241-251. https://doi.org/10.1080/0142159X.2022.2057287

Oronje, R. N. (2013, Nov). The Kenyan national response to internationally agreed sexual and reproductive health and rights goals: a case study of three policies. *Reproductive Health Matters, 21*(42), 151-160. https://doi.org/10.1016/s0968-8080(13)42749-0

Patricia, M. A., Roger Campdepadrós-Cullell, Concepció Fuentes-Pumarola, & Elena Mut-Montalvà. (2021). ‘I think I will need help’: A systematic review of who facilitates the recovery from gender-based violence and how they do so. *Health Expectations, 24*(1), 1-7. https://doi.org/10.1111/hex.13157

RAINN. (2019). *The Criminal Justice System: Stastistics*. RAINN. https://www.rainn.org/statistics/criminal-justice-system

Rape and sexual assault statistics. (2023). Rape Crisis England & Wales.

Rasanathan, K., Bennett, S., Atkins, V., Beschel, R., Carrasquilla, G., Charles, J., Dasgupta, R., Emerson, K., Glandon, D., Kanchanachitra, C., Kingsley, P., Matheson, D., Mbabu, R. M., Mwansambo, C., Myers, M., Paul, J., Jr., Radebe, T., Smith, J., Solar, O., Soucat, A., Ssennyonjo, A., Wismar, M., & Zaidi, S. (2017). Governing multisectoral action for

health in low- and middle-income countries. *PLoS Medicine, 14*(4), e1002285. https://doi.org/10.1371/journal.pmed.1002285

Reid, A. M., Brown, J. M., Smith, J. M., Cope, A. C., & Jamieson, S. (2018, Apr). Ethical dilemmas and reflexivity in qualitative research. *Perspectives on Medical Education, 7*(2), 69-75. https://doi.org/10.1007/s40037-018-0412-2

Rockowitz, S., Flowe, H., & Bradbury-Jones, C. (2022). A Scoping Review on Sexual and Gender-Based Violence Medicolegal Service Provision in East Africa. *Trauma, Violence, & Abuse*, 15248380221134292. https://doi.org/10.1177/15248380221134292

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing and Health, 23*(4), 334-340. https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing and Health, 33*(1), 77-84. https://doi.org/10.1002/nur.20362

Sexual Offences Act, (2006).

Sikder, S. S., Ghoshal, R., Bhate-Deosthali, P., Jaishwal, C., & Roy, N. (2021). Mapping the health systems response to violence against women: key learnings from five LMIC settings (2015–2020). *BMC Women's Health, 21*(1), 360. https://doi.org/10.1186/s12905-021-01499-8

Smith, J. A. (1994). Towards reflexive practice: Engaging participants as co-researchers or co-analysts in psychological inquiry. *Journal of Community & Applied Social Psychology, 4*(4), 253-260. https://doi.org/https://doi.org/10.1002/casp.2450040405

Spencer, L., & Ritchie, J. (1994). Qualitative data analysis for applied policy research. In *Analyzing Qualitative Data* (pp. 187-208). Routledge. https://doi.org/10.4324/9780203413081-14

Tavrow, P., Withers, M., Obbuyi, A., Omollo, V., & Wu, E. (2013, Jul). Rape myth attitudes in rural Kenya: toward the development of a culturally relevant attitude scale and "blame index". *Journal of Interpersonal Violence, 28*(10), 2156-2178. https://doi.org/10.1177/0886260512471086

Temmerman, M., Ogbe, E., Manguro, G., Khandwalla, I., Thiongo, M., Mandaliya, K. N., Dierick, L., MacGill, M., & Gichangi, P. (2019, Aug). The gender-based violence and recovery centre at Coast Provincial General Hospital, Mombasa, Kenya: An integrated care model for survivors of sexual violence. *PLoS Medicine, 16*(8), e1002886. https://doi.org/10.1371/journal.pmed.1002886

Van Dam, A. (2018). Less than 1% of rapes lead to felony convictions. At least 89% of victims face emotional and physical consequences. *The Washington Post*. https://www.washingtonpost.com/business/2018/10/06/less-than-percent-rapes-lead-felony-convictions-least-percent-victims-face-emotional-physical-consequences/

Walsh, R. (2003). The methods of reflexivity. *The Humanistic Psychologist, 31*(4), 51–66. https://doi.org/10.1080/08873267.2003.9986934

World Health Organization. (2003). *Guidelines for medico-legal care of victims of sexual violence*. https://apps.who.int/iris/handle/10665/42788

World Health Organization. (2015). *Strengthening the medico-legal response to sexual violence*. WHO. http://apps.who.int/iris/bitstream/handle/10665/197498/WHO_RHR_15.24_eng.pdf?sequence=1

World Health Organization, & United Nations High Commissioner for Refugees. (2002). *Clinical Management of Survivors of Rape: A guide to the development of protocols for use in refugee and internally displaced person situations* World Health Organization & United Nations High Commissioner for Refugees.

Chapter 6. Sexual violence survivor perspectives on barriers to medico-legal service access in Kenya

Consequences of sexual violence can include physical injuries, mental health and behavioural issues, sexual and reproductive health concerns, and chronic disease (World Health Organization, 2014). In Kenya, a country where more than 11 million women have experienced physical or sexual violence at least once in their lives, this has led to serious issues both for the victim/survivors themselves and for the health and legal systems tasked with managing these cases (National Gender and Equality Commission, 2014). Although survivor interactions with the medico-legal system in Kenya have been researched previously, I found no research comparing the experiences of the survivors to the experiences of the providers. Additionally, there exists a dearth of research on the everyday experience of a victim in interacting with the medico-legal system. Instead, most research focuses on the experiences of survivors engaged with certain interventions or initiatives. In this study, I set out to gain further understanding of the average experience of a Kenyan sexual violence victim when accessing medico-legal services, with the intention of later comparing these findings to those from the provider interviews. Through conducting focus group discussions in both urban and rural areas in Kenya, I found that financial barriers, infrastructural barriers, and cruelty from providers were significant issues faced by victims when seeking medico-legal services. These findings, in addition to the findings from the provider chapter, can be used to inform future training programmes for medico-legal providers in Kenya as well as policies centred around more trauma-informed and survivor centric care.

6.1 Introduction

Sexual violence is one of the world's most prevalent human rights abuses and non-

communicable diseases (Garcia-Moreno et al., 2005; Tulchinsky & Varavikova, 2014). Sexual violence is defined as any sexual act or attempt to obtain a sexual act, acts to traffic, unwanted sexual comments or advances, or acts directed against a person's sexuality using coercive tactics regardless of their relationship to the victim and in any setting, including personal and professional (World Health Organization/London School of Hygiene and Tropical Medicine, 2010). Ubiquitous negative beliefs about women, including rape myths and other harmful stereotypes, can be found around the world and both cause and sustain poor responses to sexual violence by communities, societies, families, and individuals, which enable cycles of violence to continue through the generations (Kalra & Bhugra, 2013).

In Kenya, over 11 million women have experienced sexual violence as children and/or adults (National Gender and Equality Commission, 2014). Research has shown that nearly 41% of women in Kenya have experienced physical and/or sexual intimate partner violence at least once in their lifetime, and that nearly 26% reported having experienced it within the 12 months preceding data collection (Ministry of Health et al., 2015). Research in low- and middle-income countries has found that young adult women aged 20-24 have a higher risk of violence than older women, with adolescent girls aged 15-19 showing a comparable risk to the young adults (Decker et al., 2015). In Kenya, 18% of females experience their first incident of sexual violence prior to 13 years of age, 39% between the ages of 14-15, and 43% between 16-17 years old (UNICEF et al., 2012). This violence often occurs in tandem with physical and emotional violence (UNICEF et al., 2012). Additionally, in up to 42% of cases, a young girl's sexual debut in Kenya is due to coercion, be it via force, flattery, persistence, or threats (Moore et al., 2012). There are multiple notable reasons for the pervasiveness of sexual violence in Kenyan society, including the fact that Kenyan society often resolves conflict through violence, women are viewed as inferior due to patriarchal views, and that violence is seen as means of social control (Bridgewater, 2016).

In addition to the health risks associated with sexual violence discussed in the previous chapter, research has also shown that women in Kenya and around the world who suffer violence are more than 1.40 times more likely to give birth prematurely, 1.52 times more likely to acquire HIV/AIDS, and 4.54 times more likely to die as a result of suicide (Garcia-Moreno et al., 2013). Victims also face possible death or disability arising from physical injury, chronic diseases, mental health conditions, and substance abuse issues (Garcia-Moreno et al., 2013). In addition to the physical and mental consequences of sexual violence, victims are often shamed by their loved ones and excluded from their social circles, leading to isolation and the possible exacerbation of existing mental health problems (Kennedy & Prock, 2018).

Kenya's Sexual Offences Act of 2006 defines rape as an unlawful and intentional act 'which causes penetration with his or her genital organs; the other person does not consent to the penetration; or the consent is obtained by force or by means of threats or intimidation of any kind' (National Council for Law Reporting, 2009). Upon a survivor reporting rape or other sexual violence to the authorities, several stages of documentation and medico-legal evidence collection will commence before the case can proceed to court, as explained further in Chapter 4. If a victim presents to a police station, their testimony will be taken by an officer at a gender desk. When survivors report to hospitals or other medical clinics, the health practitioner will carry out the forensic medical examination, which includes filling out the PRC and P3 forms (Wangamati et al., 2016). While this process is supposed to be free for victims, previous research has found that victims have been asked to provide money for gloves for the medical examination or to pay to print the post rape care (PRC) forms, a financial obstacle which often prevents victims from seeking help (Wangamati et al., 2016). Sexual violence victims may disclose their incident through several avenues, including to community health volunteers, religious leaders, family members, and human rights

defenders, depending on their socioeconomic status, geographic location, and the wider cultural context that surrounds them (Odero et al., 2014).

In an effort to improve the handling of sexual violence cases, Kenya's government created the *National Guidelines on Management of Sexual Violence in Kenya* (Ministry of Public Health and Sanitation & Ministry of Public Services, 2009). These guidelines were last updated in 2014 and were created to provide guidance on how to manage sexual violence from clinical, justice, and societal approaches. Despite the creation of these guidelines, societal perspectives on sexual violence and women's health in Kenya persist (Rockowitz, Kanja, & Flowe, 2021; Wangamati, 2018). Although the guidelines allow for abortion in the event of pregnancy due to rape, many health providers still refuse to provide abortions to minors who have been violated and to adults unless there is a clear risk to the mother (Wangamati et al., 2020). In addition to the national guidelines, there is also the Victim Protection Trust Fund, which was established to provide financial assistance to victims of post-election violence (National Council for Law Reporting, 2019).

Much of the research involving sexual violence victims in Kenya is in relation to a specific intervention or initiative, such as a one-stop centre (OSC) or a training programme involving medico-legal professionals (Temmerman et al., 2009; Temmerman et al., 2019; Wangamati et al., 2020). My research differs in that the intention is to understand the experience of the average survivor who interacted with Kenya's existing medico-legal system to see how everyday operations are enabling or preventing a victim's access to services. However, the involvement of the Wangu Kanja Foundation does mean that the survivors interviewed may have different experiences compared to victims in the general population. On the one hand, this group of survivors may have had more supportive interactions with medico-legal providers than is typical for survivors in Kenya because of the support they received from the WKF. On the other hand, many of the survivors I interviewed had begun

interacting with the medico-legal system prior to their engagement with the Wangu Kanja Foundation, and they may have sought services from the WKF because they were not receiving adequate support from the medico-legal providers they were encountering. All things considered, caution is warranted in generalizing from the experiences reported by survivors in this chapter.

6.2 Methodology

6.2.1 *Participants and recruitment*

As with the providers, I recruited some victims for focus group discussions to be conducted on the ground in Kenya while the UK was still in lockdown. Focus group discussions were chosen for the victim group for multiple reasons. Firstly, I wanted my interviewees to be as comfortable as possible and was assured by my research assistants from the WKF that my interviewees would be most comfortable sitting amongst women (or men) that they already knew and had endured similar difficulties. Additionally, focus groups were chosen because they enabled the participants to hear other people's responses and add commentary as they chose, perhaps bringing up points they may not have thought of otherwise (Robinson, 1999). Focus groups give participants the opportunity to generate their own questions towards their peers, which occurred multiple times throughout each focus group and yielded information I might not have received otherwise (Kitzinger, 2005). Additionally, previous research on focus groups has found that critical comments appear more frequently in group discussions than individual interviews, and the nature of my research meant that I wanted the participants to be as honest and critical about the medico-legal system as possible (Kitzinger, 2005; Watts & Ebbutt, 1987). One potential disadvantage of focus groups is that the themes that emerge may reflect shared experiences of the majority rather than individual experiences, however the research assistants and I attempted to mitigate this by emphasizing that we wanted to hear

about everyone's experiences, even if they thought they were unique to her or him alone (Acocella, 2012; Stasser et al., 1995).

To recruit for the focus group discussions, I provided the Wangu Kanja Foundation with an information sheet that was distributed to survivors who were associated with the Wangu Kanja Foundation via gender defenders who offer support groups. This information sheet and consent form can be found in Appendix 4.1. The participants also aided in recruitment by spreading information about the study to their friends or family members who also met the inclusion criteria. Two focus group discussions were conducted by a trained member of the Wangu Kanja Foundation in Nairobi using a questionnaire that I had designed. These focus groups were audio and video recorded and safely transferred to me for analysis.

Once lockdown had lifted in both Kenya and the UK, I arranged three in-person focus group discussions. Participants were recruited in the same manner as previously, and I conducted the discussions with the assistance of translators from the Wangu Kanja Foundation and my research team who had gone with me to Kenya from the UK. We conducted these focus group discussions in Nairobi, Kitui, and Kiambu at locations chosen by the gender defenders with groups ranging from 8 to 10 and participants ranging in age from 18 to 56. In total, 47 victim/survivors were interviewed for this study.

In order to manage the emotional safety of the participants, it was made clear at both the beginning and end of all focus group discussions that counselors from the Wangu Kanja Foundation were available for assistance should it be needed. Additionally, participants were informed that they could leave the focus group discussions at any time and that there would not be any consequences. Due to the existing relationships between the gender defenders who helped organise and facilitate the focus group discussions and the participants, there were open lines of communication throughout the entire process to ensure the wellbeing of participants. In order to manage the safety of the researchers, debriefing sessions were held at

the end of each day of interviewing. Additionally, I as the lead researcher made it clear that if any of my colleagues felt unable to continue conducting the research they would be able to discontinue the interviewing process and would be connected with appropriate mental health services either at the university or their host organisation. I am also a co-founder of an international community of practice for researcher resilience for postgraduate researchers, and made our resources available to my colleagues,

6.2.2 *Materials*

The focus group discussion consisted of open-ended questions, including those about barriers to accessing different types of services after an incident of sexual violence. As with the interview guides for the providers, these questions were designed at first by myself and my supervisors, then sent to Wangu Kanja for her feedback on which questions she felt were most relevant for the given context. The questions for the victims differed from the questions for the providers, however, in that these questions were also designed with Andersen's behavioural model of health services use in mind. This meant that the questions were sure to evaluate the need intended use, actual use, and disabling and enabling factors of the health and legal services being accessed in Kenya (Andersen, 1995; Lederle et al., 2021). Furthermore, the questions were sure to address any contextual characteristics or individual characteristics that may have affected a victim's interactions with the Kenyan health system (Lederle et al., 2021). After an iterative process, the final interview guide was designed. These open-ended questions left space for the participants to raise their own issues and for some discussion between the survivors and the gender defenders about their experiences. The interview guide can be found in Appendix 4.2.

Focus group discussions were conducted with all survivors involved in this study either by UK-based researchers or affiliates of the Wangu Kanja Foundation. Although I was

informed prior to my visit that English fluency would be sufficient amongst interview participants that I could conduct the FGDs on my own, it quickly became apparent that this was not the case. As a result, I enlisted the help of counselors or gender defenders who had been trained by the WKF in qualitative interviewing techniques to assist me with my interviews. I discussed with my colleagues how best to conduct the FGDs given that a translator was now needed, and we determined that I would ask the questions, we would allow time for a discussion, and then the information would be summarised for me before a new question was asked. While relying on summary translation made me concerned about missing crucial information, I felt it was preferable to interrupting flowing conversations with a group discussing an incredibly difficult topic. I hope to have mitigated this potential loss of information by listening through the recordings with my colleagues prior to departing Kenya to cover any material that may have been missed by the live translation. At the start of each focus group, I or my colleagues distributed consent forms that were then explained verbatim in Swahili by employees of the Wangu Kanja Foundation or gender defenders helping facilitate the discussions. Each participant signed a consent form which was then returned to me, and I then set audio recorders in multiple spots around the room to ensure everyone's voice was being captured.

6.2.3 *Procedure*

Ethical approval for the study was obtained from the University of Birmingham's ethical review board and written in compliance with the university's code of practice for research. Additionally, due the international nature of this research, ethics was required in Kenya as well. I obtained ethical approval from United States International University Africa's institutional review board in Kenya. Evidence of ethical approval can be found in Appendix 3.6. Prior to each focus group discussion, I distributed participant information sheets and

consent forms around the room. Consent was collected via signed forms, and all participants agreed to the use of an audio recorder before the focus group discussions began. The mean focus group discussion length was 79 minutes (range 69-93). Participants were given phone credit for participating.

6.2.4 *Reflexivity*

In section 5.2.4 I explained in-depth what reflexivity means to me, and provided examples for how I incorporated personal, interpersonal, methodological, and contextual reflexivity into my research with medical and legal professionals. I also used these reflexive practices in my research with sexual violence victims. On a personal level, the main reflexive action I took was constantly checking in with myself and with my team about how continually hearing stories related to sexual violence may have been impacting our mental health. However, since my research did not ask about the sexual violence itself, but rather the care that was sought as a result of said violence, the interviews with the victims were more frustrating in nature than they were traumatising. I felt myself getting increasingly frustrated hearing about the barriers my participants had faced at every step of the journey, and could not help but sympathise with their struggles. Because I was largely accompanied by a gender defender who was familiar with each participant, I was also able to see how frustrated and angry they were about not being able to facilitate better care for their clients. I was able to analyse how I was feeling and use these emotions to guide my practice, in this case my interviewing techniques, and also debriefed with my team at the end of every day and made sure that my research assistants felt comfortable continuing their work. On the interpersonal level, my reflexivity was largely the same as I mentioned in section 5.2.4. I was extremely discontented with my interactions (or lack thereof) with my NGO partner and wondered if their poor engagement skills with me mirrored their engagement with clients. This left me concerned about how

much help my participants had actually gotten from the WKF, although I did not feel comfortable asking both due to the presence of gender defenders who worked for the WKF and because that was not the goal of my research. Another way I engaged with interpersonal reflexivity was to reflect upon how power dynamics between myself, a white Western researcher and my participants, Kenyan women (and one man) who had faced extreme hardship, might influence my interactions during data collection. I tried my best to make sure that my participants felt comfortable with me and believe that the presence of known gender defenders serving as translators helped bridge the gap between us.

Methodologically, my reflexivity was also similar to that mentioned in the provider chapter. One difference, however, was that while I was able to interview providers over Zoom, I realised that I did not feel comfortable doing the same with victim/survivors as I could not guarantee that they were alone, away from their perpetrators, and able to access mental health support if needed after our interview. As a result, I changed my methods to include FGDs conducted by trained interviewers while travel was prohibited, which were then audio recorded and sent to me for analysis. I believe this was the ethical choice, as it helped me ensure the safety of my participants, however due to quality control issues with the audio recording and file transfer the data are not as rich as I had hoped. Finally, on a contextual level, it was important that I be aware of how the cultural context of Kenya, a largely patriarchal society, might influence my work. One of the ways in which this contextual reflexivity occurred was the iterative process in which I designed my research questions. Although I designed them initially, as further detailed in section 6.2.2, they also went through an iterative process in which the head of our partner organisation, as well as trained counselors and gender defenders, offered feedback to ensure that the questions were culturally competent. We then took their feedback into account, redesigned the questions as needed, and repeated the process until both sides were satisfied with the questionnaires.

6.2.5 *Data analysis strategy*

As with the provider chapter, all English portions of the audio recordings were transcribed verbatim by a professional, and I checked translations with my Kenyan research assistants prior to departing the country. Again, as with the provider chapter, I approached this research through a descriptive lens, which I have described at length in section 5.2.5. I analysed the victim focus group discussions using the Framework Method, which was useful in that the data all covered similar topics and was thus able to be categorised (Gale et al., 2013; Rabiee, 2004; Spencer & Ritchie, 1994). Although focus group discussion analysis often requires more in-depth analysis of participants' in-group interactions, perhaps due to the topic at hand, or the presence of a cross-cultural researcher, there was minimal in-group discussion and participants tended to respond solely to the translator asking the questions rather than to their groupmates. Again, as with the provider chapter, I used an inductive thematic approach to analyse the data so that I could find themes within the data itself rather than matching themes to a pre-existing coding framework (Braun & Clarke, 2006). Thematic analysis was especially useful for this data set because it allowed me to analyse the perspectives of multiple research participants to identify similarities and differences while also summarising key features of all of the focus groups overall (Nowell et al., 2017).

Once the data had been transcribed by a hired professional, I focused on data familiarisation by listening to each focus group discussion multiple times whilst comparing the audio to the transcripts to make sure that all participants' responses were included. Once I had completed the data familiarisation process, I began coding the focus group discussions using NVivo 12. This process included further familiarisation with the data and open coding where I used NVivo to highlight and label each transcript while creating a novel list of codes. This list of codes came entirely from the data and was all analysed by hand. Once this

process was complete, I organised the codes manually by writing them on notecards and clustering them until I found overarching themes. Once the themes were organised, I created a framework matrix to insert quotes from the participants for further mapping and interpretation (Gale et al., 2013). The survivor interviews were analysed after the provider interviews so I could have a more complete picture of the providers' perspectives before analysing the survivors' perspectives. Due to the nature of the transcripts, cases were not created for the focus group discussions because it was difficult to track all of the participants as there would often be a brief conversation between multiple participants in Swahili that would then get translated to me once the conversation had ended. As with the provider chapter, I again wish that I had had more time to allow for at least one of my supervisors to code some transcripts so we could compare and discuss our themes. Once the themes had been identified from the survivor transcripts, I again sat with my notecards, this time from both providers and survivors, and looked for overlapping content. This analysis resulted in a Venn Diagram of overlapping themes which is discussed in section 7.2.5.

6.3 Results

While I was analysing the focus group discussion transcripts, I identified seven main themes: no care seeking, obstacles and barriers, operating outside of the norm, care seeking process, reasons for seeking care, future talk, and interactions with professionals. Each of these themes contained lower-level categories for further specification and analysis.

6.3.1 *Theme 1: No care seeking*

In this theme I have described the reasons that victims did not seek medical or legal help after their sexual violence incident, which included advice from their family or community members against pursuing the case, having internalised feelings of shame that prevented them

from publicizing their case, and more general reasons for not seeking out medical or legal care. In one instance, a woman was warned against reporting because of how it might affect her marriage:

> *The sister told her, you know, if you go to report, your husband will find out. (FG3)*

Another woman whose daughter was assaulted was told to relocate rather than report due to safety concerns, causing her to move her family rather than pursue any further justice:

> *So, someone advised the mom because the daughter was in dangerous groups, take her to upcountry. (FG3)*

A more common theme amongst the participants that I identified was the shame of being outed as a sexual violence victim, which often deterred them from pursuing help of any sort, especially if they were pregnant as a result of the rape:

> *I fear that stigma with me, that's one. Two, I feared my child, because I have only one child, to know that I was raped. (FG1)*
>
> *She says she took time before going to the hospital because she didn't want people to know about what had happened, and also, she didn't want people to know that she's expectant out of rape. (FG1)*
>
> *So, she said, fear of being stigmatised, like, "If I go there what will they think of me?" "What will they think?" (FG4)*

Besides the fear of being stigmatised, survivors also explained to me that they did not seek legal help because they did not see the point, had heard it was a negative experience, or because they had more pressing concerns, such as the welfare of their child:

> *After that they advised her to go to the police station. But she said she didn't go because she was raped at night and also she didn't know the perpetrators so she didn't see the need to go to the hospital. (FG3)*
>
> *She says, although she did not go to report, the reason why she didn't go to report was because of what she had heard from people who go through at the police stations. She says, maybe she would have gone there and would have been told, especially from the male police officers. Maybe you are dressed badly, that's why those people raped you or*

maybe they will tell you that you are the one that showed them interest. (FG3)

Okay, she says she didn't go to legal services because first the perpetrator beat her child up. And then, now went ahead to rape her. So, the first thing that struck her mind was to go check her daughter. Yeah, to take the child to the hospital, a boy. So, she first went to the hospital. She didn't think about going to seek legal services. (FG2)

Finally, some survivors did not seek help because they feared repercussions, either because they had been threatened directly or had heard about what would happen to them should they pursue their cases further:

She says she didn't report at first because she was threatened by the perpetrators that they will kill her. (FG1)

They don't pursue because they knew the perpetrators in the community, they had raped many women. So, they told her don't pursue them because they would come back and rape you again or kill you. (FG3)

But I'm also thinking, some of these police officers tend to threaten. They will track you or something, I don't know. (FG3)

6.3.2 *Theme 2: Obstacles and barriers*

This theme explores the obstacles and barriers that survivors perceived that made it difficult for them to access care. I found this theme multiple times in every focus group discussion and split it into three smaller categories: issues with the legal process, logistical barriers, and financial barriers or being asked for a bribe. Issues with the legal process were numerous, including poor organisation and the indefinite postponements of the case:

She says even in the court they were abused, because they went and then their name was not called on the date that they knew they were supposed to go. So, they went and they were abused. (FG1)

She says that this happened in 2018 and since then the case is still going on. But still the case is being prolonged because the perpetrator always has excuses. Sometimes he says he is sick. That he didn't read the proceedings and things. So, with those kind of excuses, the case is dragging. So, now they have another hearing. (FG2)

There was also the ever-present issue of resource constraints, which had been documented heavily in previous research and explored further in both my scoping review and provider

chapters (Undie et al., 2016; Wesson et al., 2015). A typical resource constraint experienced by the survivors in this study were limited supplies at health centres when they sought out medical care:

> *I think in a scenario maybe when somebody is taken to a facility, that they don't do, they don't have a lab, you know they are so small, small facilities. (FG1)*

There were also issues with infrastructural barriers, including transportation issues and limited operating hours of sexual violence clinics:

> *So, from where the incident happened to where the police station is, it is very far and she didn’t have the transport. (FG3)*
>
> *No. Okay. She is saying that you cannot get help, especially from the hospitals, you cannot get treatment the same day that there are specific days, for example, Tuesday and Thursdays when you can get help. So, for example, if your case was on Monday, you are not treated until Tuesday. (FG3)*

The most common barrier faced by survivors in accessing care, and one that has appeared consistently in previous literature on SGBV service provision in LMICs, is financial. This included both the cost of care itself and the bribes being asked for by medico-legal professionals to provide care.

> *She went to the hospital and when she came back, they told her, now that they can help her, do you have 500-schillings, money. And when she said she’s just a casual labourer, she doesn’t have money. (FG3)*
>
> *She says, the major problem is about its corruption. You must have a bribe to get help. They will not ask for it directly. But they look for ways to ask for it. (FG3)*
>
> *So, she said, for her it's the transport, like the lack of money, like you see for her, she was saying, “Would with the little that you have, would you choose to get transport to go to hospital or would you feed your kids,” so, it’s a dilemma. So, you end up, because of lack of money, you end up choosing to fulfil your wellbeing, I guess. (FG4)*
>
> *They're like, give us money, say for the, the police car doesn't have petrol, so, you have to fuel the car; you have to give us something small. (FG4)*

A final barrier faced by the survivors I interviewed was COVID, and the restrictions and

limited resources that occurred as a result:

> *And then, also, just when COVID had started, some hospitals were restricting. Like you'd be told you are not coming to the hospital. And also, the police station. And all that. You didn't just walk in like you used to. So, you would find that it became so difficult. (FG3)*

> *So, she is saying, it was hard, because one divided attention, like you'd go talking to a doctor, he's, you know, with someone else and something, and then also there were few, there were few doctors who were available for such cases, because all their attention was now. Yeah. (FG4)*

6.3.3 *Theme 3: Operating outside of the norm*

As with the provider chapter, there were multiple occasions where survivors mentioned events to me that had occurred outside of the typical case referral pathway. These included actions taken by the survivors, such as learning how to play the corrupt system and settling their issues in 'kangaroo court,' and actions taken by the perpetrators that rendered the survivors' cases null. Nepotism and connections were used to ensure that a survivor got taken care of properly:

> *Her dad, before he passed, he was an Army solider. So, when the mom went to the police station, she told the police and said, take good care of her, she's one, she's like your child. (FG3)*

Additionally, full awareness of the bribability of the medico-legal professionals meant that well-resourced survivors took full advantage of the situation to help move their cases along.

> *After the incident I went to the hospital, so you know if you have money it helps, so we went. (FG2)*

Kangaroo courts, informal justice systems often run by community leaders or tribal elders, were also referenced as a means to justice (Wangamati et al., 2016).

> *There is what we call the kangaroo court. So, people advise you like, these rape cases, most of the time, they say they're not operated in the court of law but at home. (FG1)*

6.3.4 *Theme 4: Care seeking process*

During the focus group discussions, I asked participants about what the actual process of care seeking looked like to them. This was important in both ascertaining if the case referral pathway as outlined in Chapter 4 was being followed and in finding out how this process affected the wellbeing of the participants. After I asked what steps a survivor went through after being violated, participants stated:

> *Okay, for me, first of all, I didn't go to the hospital. So, I have to seek help first because I didn't know where to start from or what to do next. So, I didn't have any idea of going to the hospital or doing whatever, but first of all, I tried to seek help online, therefore, I found a number to send a help form. (FG4)*
>
> *So, for me, I was referred to the doctor directly, so, I went, I didn't pass through the reception, so, again, the reception is where you get a lot of (words) from the doctors; so, I went through the doctor direct. (FG4)*

Participants also discussed with me at what point along the case referral pathway their journey had ended. For some, it was due to interference from medical or legal professionals:

> *Actually, the judge. The judge was the one who said, if there was no witness, this evidence form is blank, we can dismiss the case. (FG2)*

Other participants were frank about their negative experiences, both regarding how they were treated personally and how their cases progressed.

> *For example, the gender desk there was harsh treatment, abuse, corruption, everything. It is so hard to get good services. So, so hard. (FG2)*
>
> *She says-- She says, for her, she hopes that the case can be redone and she gets her justice. She did not get justice. She said at the time she told herself she would just let it go. But it's too hard. She is unable to do that. (FG2)*
>
> *She said, once they got to the hospital, they just left her at the reception. They did not follow up with coming to attend to her or anything. So, when the nurses came they started abusing her. You have blood all around you why are you sitting here? And she felt the rejection and felt the shame and condemnation. So, she left the hospital feeling worse than she did when she got there. (FG3)*

Although I encountered many instances of negative interactions with the medico-legal

system, survivors were also eager to share the positives, especially how the care they received helped them in their long-term recovery:

So, for now, we can't complain about the gender desk, we have good people, qualified and we are happy about them. Yes. (FG1)

She is saying that she was expecting-- She had hoped that when they go, they would be able to find out if the child was okay, no infections, no pregnancy. And they went and they were well tested and found out that she is okay. (FG2)

So, after the guiding and counseling, now she's able to work, she's no longer isolated, because she had a lot of fear and anxiety. (FG1)

6.3.5 *Theme 5: Reasons for seeking care*

In addition to learning about what the survivors experienced when seeking medico-legal care, it was also important to me to discover what motivated them to seek help in the first place. This was especially important because many sought help despite hearing about others' negative experiences and having very little faith in the Kenyan justice system. The most obvious reason for seeking help was acute health issues stemming from the assault:

Until the time I started bleeding so much, I could not even stand; standing the blood could just flow on the floor/wall; then I just felt this is too much. (FG1)

She went because she noticed that her daughter had been badly injured with the way that she was walking. She was uncomfortable, so she went because she wanted her daughter to be checked. Yeah. (FG2)

Chronic health issues were also of concern, especially relating to HIV and unwanted pregnancies.

I thought that person maybe had another chronic disease, and that HIV and so other, because even my private parts, it was even, I can't tell there was an irritation, which I couldn't even identify, what sort of it. (FG1)

So, when she went to the hospital, she found out she was pregnant and she was also having an STI, which she says she battles still today, but she seeks medical care. (FG1) Infections that could have been contracted or because of pregnancy, so she wanted to go and get help and know her status. (FG3)

So, she wanted to know her HIV status. So, whether or not she contracted HIV because she has children. (FG4)

Finally, some survivors told me that they had sought help for mental health reasons. A handful of survivors were distressed from the events, others wanted to better themselves, and some were suicidal and desperate for help.

I was to go to the hospital because I was mentally affected, so, I had to see a counselor for eight months; it took me eight months, for me to recover to accept myself. Yeah. (FG1)

I had to be counselled because I didn't want to survive anymore. (FG1)

And I thought that this certain pattern of behaviour that I have was apparently because of the trauma. So, I needed to sort that out. I cannot get into relationships. It keeps being a barrier for me for any relationship. (FG2)

So, she really wanted counseling and just someone to like, to be able to accept herself, because, after the incident, I mean, she just needed someone to talk to. (FG4)

6.3.6 *Theme 6: Interactions with professionals*

While I have explored the interactions with professionals a bit in previous themes, especially when recounting negative experiences, in this theme I went more in-depth to see how survivors were treated when accessing care. Some survivors were verbally harassed and subjected to victim blaming by the police and medical professionals:

So, when the nurses came they started abusing her. You have blood all around you why are you sitting here? And she felt the rejection and felt the shame and condemnation. So, she left the hospital feeling worse than she did when she got there. (FG4)

So, she's saying, it was a horrible experience, she didn't like it. So, the doctors and the nurses there were just really judgemental, they kept asking, 'How would you, big old lady, get raped, like, what were you doing?'(FG4)

The gender desks that survivors had visited had mixed reviews. Some found the gender desk officers to be horrible to deal with, and others found them to be helpful:

For example, the gender desk there was harsh treatment, abuse, corruption, everything. It is so hard to get good services. So, so hard. (FG2)

Most police stations have gender defence. But not all of them are functional. Most of them are just there by name, no action will be taken. (FG3)

So, now with the gender desk, now, everything is okay, they're attending nicely, they even take you to the hospital themselves. (FG1)

A few survivors expressed to me that they had received help with care seeking, although this primarily came in the form of help from non-governmental organisations rather than the providers themselves:

But the other time we had a workshop with Wangu, she told us that you can file a civil case while you are ongoing, you are taking, you are still having that case which has been violated. If you have reported the case and the case is in the court, you can file for a civil case, whereby you can be compensated with something. (FG1)

But I heard MSF was helping, if you call MSF, the ambulance would come for you and you'd get help during curfew. (FG3)

6.3.7 *Theme 7: Proposed solutions*

The final theme emerging from my focus groups with victims was proposed solutions, in which the survivors mentioned ideas they had on how to improve medico-legal service provision in Kenya. A common recommendation to me was increased training, which providers themselves expressed interest in:

Okay. She says she thinks the service providers should be trained more and more, so that they know the kind of people they'll be dealing with; the sexual supervisors, yes, and how to deal with them. (FG1)

In school where they are being trained, while the doctors, they're in doctor class, they should also be educated. (FG1)

Other victims proposed ways for themselves to get involved, so that the people providing care or at least connecting others to care had first-hand knowledge of what it was like to be a sexual violence victim in Kenya:

So, you'll find there's somebody who has been raped, and is a survivor, the doctor, maybe the doctor was not raped, but you were a survivor there. You know, you find her, your job, she tells you I was raped, I get the courage and now I'm working here like a role

model. (FG1)

Why don't we have those people, the ones who have been raped like me, who are sexual survivors like me. If those people can sit in gender desk, they have other experience, the feeling they felt, that one could be better about their dissemination and the awareness. (FG1)

6.4 Discussion

6.4.1 *Main findings*

In this study, I aimed to learn about the barriers that sexual violence victims faced when accessing medico-legal services in both urban and rural areas of Kenya. Many of my findings echoed previous research conducted in the same area, such as the prevalence of financial and logistical barriers and the influence of shame and stigma on one's decision to seek care (Ajema et al., 2011; Kilonzo et al., 2003; Temmerman et al., 2019). However, I also discovered a few noteworthy findings, namely how cruelly some survivors were treated by medico-legal professionals and what factors might cause a survivor to stop pursuing their case further.

One of the most notable findings from my study was the level of cruelty present when survivors were seeking care. One survivor was asked by medical professionals why anyone would rape her because she was so fat, a male participant was asked by the police why anyone would rape a man, and a woman was yelled at by nurses for getting blood on the chairs in the waiting room of the hospital while she was waiting for care. While I had read before that survivors were experiencing bias or stigma from their providers, I was unprepared for the blatant abuse that was being directed towards them when they were trying to get help for their injuries (Temmerman et al., 2019). Whilst these findings were disturbing, they were not necessarily surprising. In the previous chapter, I discussed my findings concerning provider bias, and it follows logically that if providers were being honest about their feelings towards victims the victims were feeling shamed as a result.

Though previous research has explored the barriers faced by victims in accessing medico-legal services post-sexual violation, my research was unique in that I investigated further the obstacles faced and how these may affect a victim's journey through the case referral pathway (Gatuguta et al., 2018; Muuo et al., 2020). One victim's case made it all the way to court, a stage which many cases do not reach. However, despite her progress her pursuit of justice was impeded because the court had mismanaged the paperwork and had not prepared for her case on the date it had assigned to her. While multiple other survivors noted the obstacles they faced in getting care, some also described to me which resources they had found most useful, namely external NGOs or gender defenders who helped them navigate the extremely unclear medico-legal process. Without these volunteer organisations stepping in, the barriers experienced by the victims in this study would have likely been more detrimental to their post-violation wellbeing.

My findings from this study were also interesting when compared to my findings from the previous chapter, in which I analysed interview data from the providers. Many victims noted that medico-legal professionals did not seem to have adequate training to do their roles, a point which was stated numerous times by the professionals themselves. Additionally, victims discussed times when they had experienced bias or stigma from providers, and, though I was initially thinking I would not hear any from the providers due to social desirability bias, it in fact occurred multiple times in my interviews (Bergen & Labonté, 2020). A diagram of overlapping themes from both sets of interviews can be seen in the discussion.

6.4.2 *Strengths and limitations*

My study was novel in that I asked more in-depth questions of survivors than are typically found in similar studies. Additionally, my findings from survivors were able to be compared

to findings from providers to examine both sides of medico-legal service provision in Kenya. By using focus group discussions, bolstered by the presence of gender defenders known to the victims prior to the research, victims were able to be candid with me about their experiences and see that their fellow community members had been through similar ordeals. Additionally, victims could propose ideas that might help future victims, such as including previous victims on the staff of medico-legal service providers. By interviewing victims across a wide range of ages, including both males and females in the focus groups, and having participants with a wide range of time since assault, study credibility was strengthened, and data saturation was achieved. Furthermore, because I interviewed a range of respondents from both rural and urban areas and with access to different tiers of health facility, these findings may be transferable to research conducted with sexual violence victims in similar settings.

One limitation of my research was that Kenyan victims of sexual violence are an already heavily researched population, limiting the possibility of completely novel findings. As has been discussed in Chapters 1 and 2, Kenya is the most researched country in East Africa, and has been for many years, meaning that it was at times difficult for me to think of interview questions that had not been asked before. A more unique angle to this research could have been taken had the pandemic not occurred, thus giving me more time to do more sociological research and learn more about how the survivors' religious or tribal affiliations may have affected their choices in care seeking. Additionally, although I initially intended to collect characteristics of the participants, inconsistent collection of these details between myself and my research assistants, especially when the interviews were conducted in Kenya and the videos were sent to me for analysis, meant that I did not have characteristics collected for each participant and thus could not further analyse my findings by age, tribal affiliation, employment status, etc. Additionally, as with the provider chapter, there may have been

issues with social desirability bias, and interviewees may have altered their responses to focus more on the negative, since it was clear that my research was more focused on what had gone wrong rather than what had gone right. However, the presence of trusted gender defenders who had often accompanied the interviewees through the care seeking process may have mitigated this, as they were able to point out interactions with the medico-legal system that the survivors may have forgotten. Finally, although I double-checked the translations of the interviews with my colleagues prior to departing Kenya, I still fear that summary translation instead of verbatim translation may mean that I missed some crucial information.

6.4.3 *Recommendations for policy, practice, and future research*

As with my recommendations in the provider chapter, one of my recommendations for the survivors is also improved multisectoral collaboration. Survivors recounted numerous occasions to me in which the process of care seeking was unclear to them. Previous research has found that increased multisectoral collaboration can benefit both the providers and the users of a service, and that multisectoral approaches to care provision can help prevent further revictimisation, reduce provider bias, and reinforce trust between providers and clients (Horga & Nicoara, 2015; Albezreh et al., 2022). Research on multisectoral collaboration elsewhere has also found that these efforts improved forensic documentation and court processes for sexual violence victims (Keesbury & Askew, 2010).

I also believe that there need to be better resources widely available to the public so that they are aware of what to do in case they need to seek care post-sexual assault. Many of the participants in my research said that they were simply unaware of what the proper avenues were for care-seeking, and that they were not sure who they could ask to find out where to start. One way that this can be done is through community sensitisation via community health workers, an approach which has been trialed previously and found to be a

good method of information sharing (International Federation of Red Cross and Red Crescent Societies, 2021). Using community health workers is a viable approach for this because they are often already trusted within their local communities, and small sessions can be held so that participants feel comfortable to ask questions if needed.

Future research about barriers to post-rape medico-legal service provision for victims in Kenya should first compare the experiences of victims who have assistance from external organisations from the beginning of the care-seeking process, such as the WKF, with victims who attempt to go through the entire journey themselves. Because much of the research that exists in this field is about specific interventions to address these issues rather than the lived experiences of victims outside of interventions, this research can provide an update to the current situation of care seeking in Kenya (Rockowitz, Flowe, & Bradbury-Jones, 2022). Additionally, the use of mobile technology for connecting sexual violence survivors to services should be explored further. There has been some research to date about MediCapt, an app created by Physicians for Human Rights that helps facilitate the collection of forensic data relating to an incident of sexual violence. While findings have been largely positive, more research should be done to assess the true acceptability and feasibility of using mobile technology both for the survivors to report an incident and for the providers to gather data on an incident (Physicians for Human Rights, 2019).

6.5 Conclusion

My study has furthered the literature on barriers felt by sexual violence survivors in Kenya when accessing medico-legal care. The themes found in the focus group discussions echoed previous research findings, although this research expanded on the barriers experienced by the victims. I also compared them to findings from medico-legal professionals to explore both the provision and access sides of service provision in Kenya. Obstacles to accessing care faced by victims were primarily financial and logistical in nature, such as being asked for

bribes from the police, not having access to a well-equipped health centre, or not being able to afford the transportation costs to visit medico-legal professionals repeatedly. Future research should focus on bringing together providers and victims so they can each hear the other group's respective experiences and work together at proposing solutions.

References

Acocella, I. (2012, 2012/06/01). The focus groups in social research: advantages and disadvantages. *Quality & Quantity, 46*(4), 1125-1136. https://doi.org/10.1007/s11135-011-9600-4

Ajema, C., Mukoma, W., Kilonzo, N., Bwire, B., & Otwombe, K. (2011, May). Challenges experienced by service providers in the delivery of medico-legal services to survivors of sexual violence in Kenya. *Journal of Forensic and Legal Medicine, 18*(4), 162-166. https://doi.org/10.1016/j.jflm.2011.02.004

Albezreh, S., Anastario, M., Ulibarrí, B. J., Naimer, K., Johnson, K., McHale, T., Mishori, R., Macias-Konstantopoulos, W. L., Olson, R., & Nelson, B. D. (2022). Multiyear, Multisectoral Training Program in Kenya to Enhance Medical–Legal Processes in Response to Sexual and Gender-Based Violence. *Violence Against Women, 28*(14), 3311-3330. https://doi.org/10.1177/10778012221099984

Andersen, R. M. (1995). Revisiting the Behavioral Model and Access to Medical Care: Does it Matter? *Journal of Health and Social Behavior, 36*(1), 1-10. https://doi.org/10.2307/2137284

Bergen, N., & Labonté, R. (2020). "Everything Is Perfect, and We Have No Problems": Detecting and Limiting Social Desirability Bias in Qualitative Research. *Qualitative Health Research, 30*(5), 783-792. https://doi.org/10.1177/1049732319889354

Braun, V., & Clarke, V. (2006, 2006/01/01). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Bridgewater, G. (2016). Physical and sexual violence against children in Kenya within a cultural context: The Journal of the Health Visitors' Association. *Community Practitioner, 89*(2), 30-34. https://search.proquest.com/docview/1764193720?accountid=8630

https://birminghamprimo.hosted.exlibrisgroup.com/openurl/44BIR/44BIR_Services?genre=article&issn=14622815&title=Physical+and+sexual+violence+against+children+in+Kenya+within+a+cultural+context&volume=89&issue=2&date=2016&atitle=Physical+and+sexual+violence+against+children+in+Kenya+within+a+cultural+context%3A+The+Journal+of+the+Health+Visitors%27+Association&spage=30&sid=ProQ%3Ahealthcompleteshell&author=Bridgewater

Decker, M. R., Latimore, A. D., Yasutake, S., Haviland, M., Ahmed, S., Blum, R. W., Sonenstein, F., & Astone, N. M. (2015). Gender-based violence against adolescent and young adult women in low- and middle-income countries [Article]. *Journal of Adolescent Health, 56*(2), 188-196. https://doi.org/10.1016/j.jadohealth.2014.09.003

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013, 2013/09/18). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology, 13*(1), 117. https://doi.org/10.1186/1471-2288-13-117

Garcia-Moreno, C., Jansen, H. A. F. M., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Initial results on prevalence, health outcomes, and women's responses* W. Press. https://apps.who.int/iris/handle/10665/43309

Garcia-Moreno, C., Pallitto, C., Devries, K., Stockl, H., Watts, C., & Abrahams, N. (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and nonpartner sexual violence*. WHO.

Gatuguta, A., Merrill, K. G., Colombini, M., Soremekun, S., Seeley, J., Mwanzo, I., & Devries, K. (2018, Jun 19). Missed treatment opportunities and barriers to comprehensive treatment for sexual violence survivors in Kenya: a mixed methods study. *BMC Public Health, 18*(1), 769. https://doi.org/10.1186/s12889-018-5681-5

Horga, I., & Nicoara, B. (2015). Multi-sectoral response to GBV: an effective and coordinated way to protect and empower GBV victims/survivors. In: UNFPA EECARO.

International Federation of Red Cross and Red Crescent Societies, Kenya Red Cross, Norwegian Red Cross, & International Committee of the Red Cross. (2021). Sexual and gender-based violence: Good practices from Kenya. IFRC.

Kalra, G., & Bhugra, D. (2013, Jul). Sexual violence against women: Understanding cross-cultural intersections. *Indian Journal of Psychiatry, 55*(3), 244-249. https://doi.org/10.4103/0019-5545.117139

Keesbury J., Askew I. (2010). *Comprehensive responses to gender-based violence in low resource settings: Lessons learned from implementation*. Population Council.

Kennedy, A. C., & Prock, K. A. (2018). I Still Feel Like I Am Not Normal: A Review of the Role of Stigma and Stigmatization Among Female Survivors of Child Sexual Abuse, Sexual Assault, and Intimate Partner Violence. *Trauma, Violence, & Abuse, 19*(5), 512-527. https://doi.org/10.1177/1524838016673601

Kilonzo, N., Molyneux, S., Taegtmeyer, M., & Theobald, S. (2003). *Post rape services in Kenya: a situation analysis*. LVCT.

Kitzinger, J. (2005). Focus group research: using group dynamics. *Qualitative research in health care, 56*, 70.

Lederle, M., Tempes, J., & Bitzer, E. M. (2021, May 5). Application of Andersen's behavioural model of health services use: a scoping review with a focus on qualitative health services research. *BMJ Open, 11*(5), e045018. https://doi.org/10.1136/bmjopen-2020-045018

Ministry of Health, Kenya National Bureau of Statistics, National Aids Control Council, Kenya Medical Research Institute, National Council for Population and Development, & The DHS Program. (2015). *Kenya Demographic and Health Survey 2014*.

Ministry of Public Health & Sanitation and Ministry of Medical Services. (2009). National guidelines on management of sexual violence in Kenya. Ministry of Public Health & Sanitation and Ministry of Medical Services.

Moore, A. M., Madise, N., & Awusabo-Asare, K. (2012, Oct). Unwanted sexual experiences among young men in four sub-Saharan African countries: prevalence and context. *Culture, Health, & Sexuality, 14*(9), 1021-1035. https://doi.org/10.1080/13691058.2012.713119

Muuo, S., Muthuri, S. K., Mutua, M. K., McAlpine, A., Bacchus, L. J., Ogego, H., Bangha, M., Hossain, M., & Izugbara, C. (2020). Barriers and facilitators to care-seeking among survivors of gender-based violence in the Dadaab refugee complex [Article]. *Sexual and Reproductive Health Matters, 28*(1), Article 1722404. https://doi.org/10.1080/26410397.2020.1722404

The Sexual Offences Act, (2009).

National Gender and Equality Commission. (2014). *National Monitoring and Evaluation Framework towards the Prevention of and Response to Sexual and Gender Based Violence in Kenya*.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017, 2017/12/01). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods, 16*(1), 1609406917733847. https://doi.org/10.1177/1609406917733847

Odero, M., Hatcher, A. M., Bryant, C., Onono, M., Romito, P., Bukusi, E. A., & Turan, J. M. (2014). Responses to and Resources for Intimate Partner Violence: Qualitative Findings From Women, Men, and Service Providers in Rural Kenya. *Journal of Interpersonal Violence, 29*(5), 783-805. https://doi.org/10.1177/0886260513505706

Physicians for Human Rights. (2019). Using MediCapt to document medical evidence of sexual violence in kenya: perspectives from the end users. PHR.

Rabiee, F. (2004). Focus-group interview and data analysis. *Proceedings of the Nutrition Society, 63*(4), 655-660. https://doi.org/10.1079/PNS2004399

Robinson, N. (1999, 1999/04/01). The use of focus group methodology — with selected examples from sexual health research [https://doi.org/10.1046/j.1365-2648.1999.00966.x]. *Journal of Advanced Nursing, 29*(4), 905-913. https://doi.org/https://doi.org/10.1046/j.1365-2648.1999.00966.x

Rockowitz, S., Kanja, W., & Flowe, H. D. (2021). Challenging Social Norms and Legal Responses to Rape and Sexual Violence: Insights from a Practice–Research Partnership in Kenya. In C. Bradbury-Jones & L. Isham (Eds.), *Understanding Gender-Based Violence: An Essential Textbook for Nurses, Healthcare Professionals and Social Workers* (pp. 99-112). Springer International Publishing. https://doi.org/10.1007/978-3-030-65006-3_7

Rockowitz, S., Flowe, H., & Bradbury-Jones, C. (2022). A Scoping Review on Sexual and Gender-Based Violence Medicolegal Service Provision in East Africa. *Trauma, Violence, & Abuse*, 15248380221134292. https://doi.org/10.1177/15248380221134292

Spencer, L., & Ritchie, J. (1994). Qualitative data analysis for applied policy research. In *Analyzing Qualitative Data* (pp. 187-208). Routledge. https://doi.org/10.4324/9780203413081-14

Stasser, G., Stewart, D. D., & Wittenbaum, G. M. (1995, 1995/05/01/). Expert Roles and Information Exchange during Discussion: The Importance of Knowing Who Knows What. *Journal of Experimental Social Psychology, 31*(3), 244-265. https://doi.org/https://doi.org/10.1006/jesp.1995.1012

Temmerman, M., Maternowska, C., & Othigo, M. J. (2009, Sep). Organising referral and health care for survivors of sexual violence; an example from Mombasa, Kenya. *Tropical Medicine & International Health, 14*, 20-20. <Go to ISI>://WOS:000269264000057

Temmerman, M., Ogbe, E., Manguro, G., Khandwalla, I., Thiongo, M., Mandaliya, K. N., Dierick, L., MacGill, M., & Gichangi, P. (2019, Aug). The gender-based violence and recovery centre at Coast Provincial General Hospital, Mombasa, Kenya: An integrated care model for survivors of sexual violence. *PLoS Medicine, 16*(8), e1002886. https://doi.org/10.1371/journal.pmed.1002886

Tulchinsky, T. H., & Varavikova, E. A. (2014). *The New Public Health*. Elsevier Science. https://books.google.co.uk/books?id=giuNmgEACAAJ

Undie, C., Maternowska, M. C., Mak'anyengo, M., & Askew, I. (2016). Is Routine Screening for Intimate Partner Violence Feasible in Public Health Care Settings in Kenya? *Journal of Interpersonal Violence, 31*(2), 282-301. https://doi.org/10.1177/0886260514555724

UNICEF, Division of Violence Prevention, National Center for Injury Prevention and Control, US Centers for Disease Control and Prevention, & Kenya National Bureau of Statistics. (2012). *Violence against Children in Kenya: Findings from a 2010 National Survey. Summary Report on the Prevalece of Sexual, Physical, and Emotional Violence, Context of Sexual Violence, and Health and Behavioeral Consequences of Violence Experienced in Childhood* UNICEF.

Wangamati, C. K. (2018). Why attitudes towards sexual violence in Kenya need a major refresh. *The Conversation*.

Wangamati, C. K., Gele, A. A., & Sundby, J. (2020). Post Rape Care Provision to Minors in Kenya: An Assessment of Health Providers' Knowledge, Attitudes, and Practices [Article]. *Journal of Interpersonal Violence, 35*(5-6), 1415-1441. https://doi.org/10.1177/0886260517696863

Wangamati, C. K., Thorsen, V. C., Gele, A. A., & Sundby, J. (2016). Postrape care services to minors in Kenya: are the services healing or hurting survivors? *International Journal of Womens Health, 8*, 249-259. https://doi.org/10.2147/ijwh.S108316

Watts, M., & Ebbutt, D. (1987). More Than the Sum of the Parts: Research Methods in Group Interviewing. *British Educational Research Journal, 13*(1), 25-34. http://www.jstor.org/stable/1501227

Wesson, H. K., Stevens, K. A., Bachani, A. M., Mogere, S., Akungah, D., Nyamari, J., Masasabi Wekesa, J., & Hyder, A. A. (2015). Trauma systems in Kenya: a qualitative analysis at the district level. *Qualitative Health Research, 25*(5), 589-599.

World Health Organization. (2014). *Global Status Report on Violence Prevention*. World Health Organization, United Nations Office on Drugs and Crime, & United Nations Development Programme.

World Health Organization/London School of Hygiene and Tropical Medicine. (2010). *Preventing intimate partner and sexual violence against women: taking action and generating evidence*.

Chapter 7. Discussion and Conclusion

7.1 Introduction

In this thesis I sought to answer two main research questions. First, what are the barriers faced by sexual violence victims when accessing medico-legal care in Kenya? Secondly, what are the barriers faced by medico-legal professionals when providing care to said victims in Kenya?

Throughout the research I conducted for this PhD, I found that existing models of service provision in Kenya were leaving survivors with lasting physical and mental health issues, preventing their access to justice, and inhibiting the ability of providers to adequately care for their patients/clients. These issues were evidenced by the scant number of survivors whose cases proceed to court, the pervasive mental health issues found throughout the study population, and the frustrations expressed to me by medico-legal providers when reflecting on the numerous barriers they faced when providing (or attempting to provide) care. In analysing this situation from both the perspective of the care-seekers and the caregivers, I have provided a comprehensive view of the current state of SGBV service provision in Kenya.

7.2 Summary of main findings

Two major themes emerged from my scoping review in Chapter 2 that I then evaluated in my empirical research. First, I identified numerous barriers faced by both parties, namely financial, logistical, and infrastructural. Second, I analysed the process that survivors went through when progressing through the case referral pathway. In this section I will first provide an overview of the findings, followed by a more in-depth synthesis and then a discussion of the findings within the existing literature.

7.2.1 *Assessment of existing research regarding sexual and gender-based violence service provision in East Africa*

At the start of this PhD work, it became clear to me that there was existing research on interventions to address these problems but that this literature required updating, especially considering the larger geopolitical context. As a result, I conducted a scoping review to evaluate existing research and theory regarding the state of medico-legal service provision for survivors of sexual and gender-based violence in East Africa. Although my research for the rest of this PhD was focused solely on Kenya, my literature review included all of East Africa to understand how countries in similar geopolitical situations were addressing similar issues. By ascertaining how neighbouring countries, and countries who had signed the same human rights treaties, were managing the treatment of sexual violence cases, I was able to evaluate subsequent empirical findings about Kenya in a broader context and compare strengths and weaknesses across the region.

In my review, I found that research on this topic and in this region was heavily focused on Kenya, with more than a third of all papers included on the review focusing either on Kenya alone or Kenya with one or two other countries. There are a few possible explanations for this finding. Firstly, Kenya is relatively safe compared to other countries in East Africa, such as Somalia or South Sudan. Secondly, Kenya has a high English fluency compared to the rest of the continent (Nairobi is the city with the highest English fluency in Africa), making it an obvious choice for Western researchers (Education First, 2022). This suggests that going forward, more efforts should be made to build the capacity of local researchers so that future research is not as reliant on foreign academics or English-speaking locals, especially in times of political instability. Additionally, government investment should work towards enhancing local data collection systems, particularly in the under-researched countries where an influx of foreign researchers is less likely.

Regarding other barriers identified in the review, I found financial and infrastructural barriers to service provision mentioned in relation to every country, and I also noted stigma from providers as another common theme found throughout the region. I confirmed and explored these issues further in qualitative interviews with survivors and providers (Chapters 5 and 6). These findings were likely to be related to a consistent lack of both financial investment and health systems strengthening throughout the region, indicating a lack of prioritisation of sexual violence services by governing bodies and a persistent culture of victim-blaming causing stigmatisation throughout the care seeking process.

Although my research question initially sought to identify existing country and regional policies that might affect service provision, the complete dearth of papers on this topic made the question unanswerable within the scope of this review. Thus, it was impossible for me to know how existing practices compared to what was supposed to be happening as laid out by governing bodies or international human rights treaties. This suggested either a lack of interest in comparing policy to practice amongst the researchers focusing on East Africa or, more likely, a lack of available and relevant policy documents throughout the region.

My review also highlighted an issue which was prevalent in all other readings done for my PhD, which is that there was a lack of consistency in which terms were used to describe different forms of sexual violence. As noted in my introduction (Chapter 1) and scoping review (Chapter 2), I found that many authors used terms like sexual violence, domestic violence, and intimate partner violence interchangeably. This made it difficult for me to compare data as it was impossible to know what form of violence was being measured. This indicated a need for uniformity when describing violence, especially by large organisations such as the WHO or the UN, whose data is being used around the world and whose definitions are being used to guide global research. The inconsistent used of

terminology related to various forms of sexual and gender-based violence may have reflected cultural practices, i.e., any violence that happens within a relationship does not count as anything other than intimate partner violence, or a lack of clarity by researchers about what acts of violence fall under which terms. Even throughout this entire PhD I struggled similarly when categorizing violence and lacked a resource to reference when seeking clarification. In order for this problem to be remedied in future research, oft-cited resources, such as UN and WHO reports, as well as demographic and health surveys from around the world, must explicitly define how they are using each term and how their data might be comparable to that from another resource.

7.2.2 *Financial factors affecting service access and provision*

Regarding financial barriers, my qualitative interview data from both survivors and providers (Chapters 5 and 6), as well as previous literature reviews (including Chapter 2 and Rockowitz et al., 2023), indicated to me that financial barriers were a common issue faced by both parties. For victim/survivors, financial barriers occurred at multiple points (Henttonen et al., 2008; Kawaguchi, 2018). First, in the form of everyday costs, such as paying for the bus. Second, in the form of more official (although technically not allowed per Kenyan law) costs, such as paying for gloves for a medical exam, and third, in the form of coercive costs, such as being asked for bribes by medical or legal professionals for services to be provided.

These findings were not novel, and in fact had been seen in similar work conducted in Kenya for many years, as evidenced in my scoping review (Rockowitz, Flowe, & Bradbury-Jones, 2022). Financial barriers faced by victims were noted throughout East Africa in Chapter 2, as a reason why some survivors may have disengaged with the case referral pathway in Chapter 4, and even further in Chapter 6. Although the support fund was mentioned by providers, survivors had no knowledge of it and thus it was not a viable option

for reducing the financial barriers faced in accessing services. The pervasiveness of this issue across multiple research projects for this PhD indicated to me how widespread it was throughout the Kenyan population, and how significant of an obstacle it was for survivors from all backgrounds.

Regarding the financial barriers faced by medico-legal professionals, I reported in Chapter 5 that some noted that they were unable to provide the standard of care they desired due to financial constraints of the institutions or organisations they worked for. My interviews with legal professionals revealed that some worked cases pro bono to help the victims access justice, although the providers also told me that this put significant strain on them and was an uncommon occurrence due to already being at capacity with their existing cases. Conversely, other professionals had observed that others in their field were willing to take bribes from perpetrators' families to make a case end, an unfortunate but common finding according to multiple literature reviews I conducted (including Chapter 2 and Rockowitz et al., 2023) and qualitative interviews (Chapters 5 and 6). My findings reflected a major gap in the Kenyan health system that was forcing professionals to sacrifice their income and mental health to help their clients. Furthermore, the pervasiveness of bribery, especially in the legal system, indicated to me that professionals were not being trained and monitored adequately to ensure that their actions aligned with the intended goals of the organisation.

The prevalence of financial issues and the apparent acceptance of this barrier, even with the establishment of the Victim Protection Act, was a glaring reflection on the Kenyan government's limited engagement with sexual violence survivors. This was especially concerning to me considering Kenya has both signed and ratified the Maputo Protocol, which explicitly states that countries should ensure the right to health of women, especially health concerns arising from violence (*Protocol to the African Charter on Human and People's*

Rights on the Rights of Women in Africa (Maputo Protocol Text), 2003). Additional research is needed to better understand Kenya's intentions in signing the Maputo Protocol. For instance, did Kenya sign because of true aims of improving care for sexual violence cases, because they did not want to seem like the outlier in their region, or did they sign with correct intentions but inadequate resources to work more concretely towards the goals outlined in the Protocol? These findings will help inform the execution and feasibility of future endeavors, such as the Murad Code and future Sustainable Development Goals.

Regarding possible solutions to these barriers, there were extremely limited ideas from my literature reviews and qualitative interviews on how to remedy this issue. Although some of the interviewees mentioned to me that they had heard politicians say they would work on sexual violence during their campaigns and then failed to act once they were in office, the financial barriers faced by survivors did not seem to be a talking point. Additionally, neither the interviews I conducted nor the many papers I read on the subject had any substantial ideas on how these barriers could be addressed for either party. One potential solution to address all barriers that did come up in my literature searches was the use of mobile technology to help with the reporting and documentation of sexual violence cases. One such example was MediCapt, an app created by Physicians for Human Rights that was designed to help document forensic evidence of sexual violence, and another was SV_CaseStudy, an app being piloted by the Wangu Kanja Foundation that helps preserve memory evidence over time by allowing survivors to report and document their cases immediately after they have occurred (Mishori et al., 2017; Naimer et al., 2017; Stevens et al., 2022). Because the apps were freely available to anyone with a smartphone, previously stated financial barriers that prevented the survivors from reporting their cases in a timely manner were no longer relevant. Furthermore, survivors also did not have to engage with providers who may not treat them respectfully so soon after experiencing a traumatic

incident. Further work on removing these financial barriers, as well as the others listed below, will need to be undertaken, but the Murad Code, which works to create better practice around investigating and documenting systemic and conflict-related sexual violence, has provided a strong set of guidelines to improve further practice (*Murad Code Project*, 2022).

7.2.3 *Logistical and infrastructural barriers faced by survivors and providers*

Regarding logistical and infrastructural barriers faced by survivors and providers, I identified the following as obstructing either service provision or access based on my qualitative interviews (Chapters 5 and 6): limited supplies (i.e. gloves for medical exams, speculums), transportation issues (bus journey is too far to health centre), logistical barriers (childcare, limiting operating hours of clinics) and knowledge (lack of training for providers, not knowing where to access help for survivors). A significant factor I identified in my qualitative interviews with medico-legal providers in Chapter 5 was a dearth of training on how to handle sexual violence cases during either medical or law school. Most providers told me that they had lacked formal courses on sexual violence while training for their current positions and observed that without external NGOs offering tailored training packages, they would be forced to provide care with an inadequate knowledge base.

7.2.4 *Progression through the case referral pathway*

After conducting the scoping literature review to learn about the existing situation regarding medico-legal service provision in Kenya and throughout East Africa, and after learning more background information when exploring other areas of research (i.e. the COVID-19 work in Chapter 3), it became apparent to me that there was no information on how many survivors were progressing to each stage of the case referral pathway and what factors were relevant in their journeys. Based on these findings, I decided that information collected by the Wangu

Kanja Foundation could be used to explore this question further. As a result, I conducted a secondary data analysis using case data from 406 survivors in Kenya who had sought help from the Wangu Kanja Foundation (Chapter 4).

My results indicated that nearly all survivors accessed medical care, and that the numbers declined significantly with each subsequent step, resulting in less than 1% of the sample reaching the sentencing phase of the pathway (Rockowitz et al., 2023a). I found that child survivors were more likely than adults to progress through every step of the pathway, and the presence of forensic evidence also increased one's odds of moving forward to the next step of care seeking (Rockowitz et al., 2023a). In interviews with victims (Chapter 6), they noted multiple times how hard it was to get their case through to the next phase of care seeking. Issues such as court disorganisation, emotional trauma from prolonging a case, and bribes were all cited as reasons that may prevent them from pursuing a case. Importantly, I found that the police stage was the most crucial step in the pathway. This indicated the importance of allocating sufficient resources towards the collection of forensic evidence and emphasised the importance of educating survivors about what to do (or not do) after an incidence of sexual violence to preserve evidence, such as not showering and not washing the clothes that were worn during the incident.

Qualitative interviews that I conducted with providers and victims also indicated that provider bias and shame/stigma were issues faced at all stages of the case referral pathway. While more direct quotes can be found from my qualitative interviews in Chapters 5 and 6, examples of such issues included one provider asking a survivor why anyone would want to rape her due to her body size, another scolding a victim waiting to be seen at a hospital for bleeding on the chair, and yet another asking a male victim why someone would want to rape a man. These findings aligned with research found in Kenya and throughout East Africa in my scoping review, in which I found that provider bias was a major deterrent of care seeking

for survivors. Further work is needed to determine the best approaches to ameliorate the cultural biases present among the providers. However, the stated lack of formal training present for all medico-legal professionals offers a promising opportunity to address these issues while also increasing the providers' capacity to offer more comprehensive services.

7.2.5 *Overlapping themes between survivors and providers*

In analysing the data from my research, I identified themes that were shared between the survivors and the providers: operating outside of the norm, obstacles and barriers, and procedure. There were also themes that were unique to each group: providers mentioned professional journeys and discussed personal reflections while survivors spoke about why they did not seek care, what their reasons were for seeking care, proposed solutions, and their interactions with professionals. These themes can be seen in Figure 2.

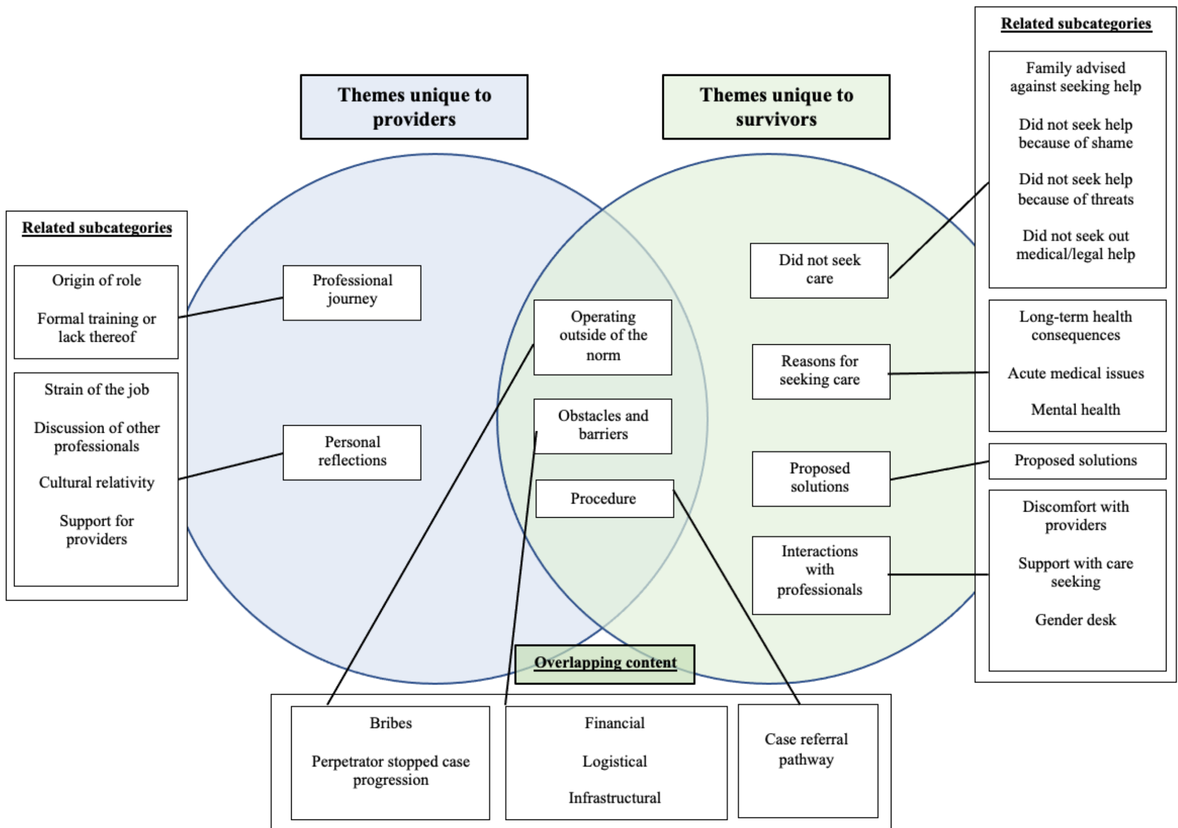

Figure 2. Venn Diagram of Overlapping Codes Between Provider and Survivor Interviews

The first shared theme, ‘operating outside of the norm,’ included mentions of bribes and of the perpetrator stopping case progression. Victims noted that they had been asked by medico-legal professionals for money in order to receive care, with a survivor in one focus group discussion noting ‘You must have a bribe to get help. They will not ask for it directly. But they look for ways to ask for it.’ Similarly, a medical professional told me that perpetrators will go to the police station, see who is in charge, and then give them a bribe so they stop reporting the case. Other professionals mentioned witnessing colleagues in their field take bribes from perpetrators’ families to make a case go in their favour. That both providers and victims are willing to discuss this bribery so freely evidences what a common occurrence it is, and even professionals do not seem to be attempting to hide these practices from their colleagues. There were also discussions from both providers and survivors about perpetrators delaying or stopping case progression through means other than bribery. One victim, for example, explained to me that the perpetrator in her case always makes up excuses to the court for why he cannot appear, including being ill or having not read the proceedings. A provider noted that a perpetrator in one of their cases skipped town and evaded arrest, causing the case to be delayed indefinitely. Both the providers and victims expressed great frustration at the perpetrators’ ability to delay cases, however both sides also seemed resigned to the fact that little could be done to address these problems.

The second overlapping theme between providers and survivors was ‘obstacles and barriers,’ which included the subthemes ‘financial,’ ‘logistical,’ and ‘infrastructural.’ Financial barriers were the most commonly mentioned obstacle mentioned by both providers and survivors, and also appeared many times in my literature reviews when preparing for this research (Ajema et al., 2011; Gatuguta et al., 2018). Providers mentioned financial barriers in relation to their own issues, i.e., in regard to having all of the materials needed for exams, but also in acknowledgement of their clients’ struggles, i.e., ‘most of the sexual violence has

come from low-income people, which normally didn't have the money to access high-end facilities or services.' Victims discussed financial barriers in regard to being asked to pay fees at health centres and having the money for transportation to medical or legal professionals and noted that they had to think about if they should spend the little money they have on transportation to the hospital or on feeding their children, with fulfilling personal wellbeing often being a preferable choice. Logistical and infrastructural barriers were also mentioned by both providers and survivors, though these have been explained in more detail in section 7.2.3.

The third overlapping theme I identified in my research related to procedure, which was primarily in relation to the case referral pathway. Providers spoke of the presence (or absence) of forensic evidence and what it meant for a case's odds of progressing, and also shared with me their ideas about how many cases progress through each step of the pathway. I was struck by the disconnect between the provider's ideas about case progression in comparison to the actual statistics, which I analyse in Chapter 4. Police officers told me that all defilement cases made it to court, but this was simply not true. Conversely, the victims I interviewed spoke about their care-seeking process in length, often starting with seeking medical care and ending their process due to interference from medical or legal professionals.

The overlap of themes between my two study populations was an interesting finding, as it indicated to me that both sides were experiencing similar issues, and some participants were even aware of their counterparts' struggles. Moving forward, these overlapping themes could be a good basis for a codesigned project working towards new policies and practices that can be implemented in Kenya.

7.3 Strengths and limitations

While sexual violence in Kenya has been heavily researched, and interventions to aid in

service provision have been evaluated, there remains an absence of literature on barriers to accessing and providing these services as assessed from both the seeking and providing sides of the case referral pathway. Therefore, the research I have summarised in this thesis has provided a unique angle from which to evaluate medico-legal service provision for sexual violence in Kenya, as well as important findings that have contributed to the existing body of work. Additionally, my research reported in this thesis used a range of reporting guidelines, such as the PRISMA guidelines outlined in Chapter 2, and both qualitative and quantitative research methods, including a scoping literature review, logistic regression, a sequential logit model, and both in-depth interviews and focus group discussions. By using this variety of methods, the quality of my research was strengthened in that a broader range and complexity of findings from both providers and survivors could be explored. Additionally, my approach helped bolster the reliability and validity of the findings and conclusions drawn from the research. The findings from my PhD research have thus far been disseminated in a variety of ways, including two conference presentations, five invited talks, and nine peer-reviewed publications.

My scoping review presented a comprehensive summary of existing forms of medico-legal service provision for sexual and gender-based violence throughout East Africa, which not only helped me understand the scope of existing research throughout the region but also helped provide a geopolitical context to situate my Kenyan findings. The breadth of my review was wide-ranging, covering a total of 20 countries included in either the United Nations geoscheme for East Africa or the East African Community's description of included countries (*EAC Partner States*, 2022; Mendelson et al., 2014). It also included research published over a 20-year span, from 2000 to 2020. The search strategy was discussed among the research team and included papers were decided on in an iterative and reflexive way as specified by both Arksey and O'Malley's and Levac et al.'s scoping review guidelines

(Arksey & O'Malley, 2005; Levac et al., 2010). One limitation of my review was that despite efforts during the literature search, multiple countries in East Africa did not have any relevant publications that could be included in the review, thus slightly limiting the scope of the findings. Without papers on these countries, it was difficult for me to comprehensively situate Kenya in its full East African context and compare service provision practices to those of its geographically and developmentally adjacent neighbours. Learning about methods of service provision that may be working in similar contexts would have been useful for me to address the gaps identified in Kenya, especially in regard to cultural beliefs that affected interactions between survivors and providers, and also how similarly resourced countries were managing their health systems to aid sexual violence survivors. Additionally, although my scoping review was initially designed to include information about how each country's practices compared to their existing sexual violence policies, the literature on policy was so scant that the research question had to be dropped from the review. This is an important issue for future research, and work going forward should include policy as a reference guide to contextualise findings and promote systemic change. Furthermore, comparing policy to practice will provide a measure of how seriously countries are working towards the Sustainable Development Goals and abiding to the guidance laid out in the Maputo Protocol (*Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, 2003;* UN, 2023)

Regarding Chapters 3 and 4, in which I report primarily on the use of quantitative methods, I engaged with local volunteers with the Wangu Kanja Foundation, otherwise known as 'gender defenders,' who were known in their communities and helped undertake data collection. By using trained gender defenders, I helped ensure that all participating survivors were treated with the utmost respect, as gender defenders are specially trained in working with sexual violence survivors and know how to ask questions in a way that avoids

or minimises re-traumatisation. Additionally, the far-reaching networks of the volunteers and gender defenders helped ensure that my data came from a variety of survivors, including those of varying socioeconomic statuses and from both rural and urban areas. My prospective cross-sectional study in Chapter 3 provided a valuable opportunity to compare sexual violence patterns during the COVID-19 pandemic to data previously collected by demographic and health surveys. Additionally, the format of the questionnaires being collected by the Wangu Kanja Foundation meant that the analysis included more in-depth information about survivors and perpetrators than is typically collected. For my secondary data analysis in Chapter 4, the rich data from the Wangu Kanja Foundation meant that attrition along the case referral pathway in Kenya could be studied for the first time, and my use of multiple statistical methods strengthened the validity of the results. A limitation across both studies was the generalisability of the findings. Because my data came from victims who had been connected to the Wangu Kanja Foundation, they may have had a different experience in care-seeking than the average Kenyan victim. This was because the Wangu Kanja Foundation helped connect them to resources they may not have found otherwise. As a result, my findings may not be representative of the general population of sexual violence survivors in Kenya. Because the Kenyan government does not collect as detailed information about a survivor's care seeking journey post-assault, it was difficult for me to know how the experiences of the survivors in our sample may have compared to the general Kenyan public, and if there were any case characteristics that made our survivors more likely to connect to the WKF than others. For instance, it was unclear if survivors sought out help from the WKF because they had especially bad cases, if they knew other survivors who had also connected to the WKF, or if the gender defenders working for the WKF did such a proficient job at canvasing their local communities that the survivors had known about the foundation's services before they even needed them. This might also reflect geographical differences, as

although the WKF had gender defenders in all 47 counties in Kenya, it is not known if they were spread evenly throughout urban and rural areas in each county and how far a survivor in each county might have had to travel to connect with their county's gender defender versus a government health centre. Additionally, as sexual violence is underreported in Kenya as across the rest of the world, and since longitudinal information about sexual violence is lacking, my findings from Chapter 3 could not be used to determine if patterns of violence had changed during COVID-19.

I helped ensure data saturation by conducting focus group discussions and in-depth interviews with both groups of participants in three separate Kenyan settings. Another benefit of my approach was that it also made sure that the lived experiences of both groups of participants were heard. My interview questions for both participant groups were designed based on Andersen's behavioural model of healthcare utilisation that contribute to victims' interactions with the medico-legal system and can be found in Appendix 4.2. (Andersen, 1995; Lederle et al., 2021). In using this framework, I designed the questions with a focus on contextual characteristics, individual characteristics, and desired outcomes (Andersen, 1995). Additionally, because I interviewed participants from multiple cities/towns in Kenya, and professionals from a variety of healthcare centres, courts, and police stations, the scope and generalisability of the findings from my research has been broadened. Participants in both groups represented a wide range of ages and were comprised of both men and women, helping provide experiences from a variety of perspectives, although there were far fewer male interviewees in the survivor groups than females, and no survivors shared any information about being part of the LGBTQI+ community, thus limiting the scope of my findings for the victim/survivor group. Additionally, as with all cross-cultural research, there may have been social desirability bias present, although this was hopefully mitigated by the presence of gender defenders known by the victims in each focus group discussion and

private interviewing locations (Bergen & Labonté, 2020).

7.4 Conclusion

My findings explored in this thesis have made an important contribution to the existing body of work surrounding medico-legal services for sexual violence victims in Kenya and throughout East Africa.

Although there existed a substantial body of literature on sexual and gender-based violence in East Africa prior to the research described in my PhD, my scoping review described advanced this literature in that it highlighted the disparity in countries being researched. Although there are 20 countries in the East African region, Kenya accounted for more than a third of all studies included in my review, and many countries were not found once in any of the databases, even before the application of the inclusion and exclusion criteria. Existing research partnerships do make it easier to start new projects, however these existing partnerships do not justify the complete dearth of research funding and focus being given towards other countries. Another significant contribution to come from my scoping review was the apparent interchangeability of terms used to describe various forms of sexual and gender-based violence. By using terms interchangeably, and without providing proper definitions to aid the reader in knowing what type of violence was actually being studied, it was difficult for me to ascertain what types of violence were being targeted by the various interventions mentioned in the study, and to compare efficacy rates across contexts. Not being able to properly compare findings made it challenging for me to ascertain if certain service provision models were more effective at providing care for some forms of violence versus others, and thus limited my ability to recommend future targeted interventions.

My analysis of emerging data from sexual violence survivors in Kenya during COVID-19 lockdowns allowed for a unique comparison to be made of existing demographic

patterns of victims to those occurring during a very specific period of crisis. Crisis-related SGBV research to date in Kenya had focused on post-election violence, and that research largely failed to investigate patterns of violence but rather focused on prevalence. In finding that children experiencing violence during COVID-19 were younger than the previously reported national average, and that the details of the assaults against adults were different than in non-COVID times, my research identified a unique pattern of violence that might emerge in future humanitarian crises in Kenya. This finding offers researchers and policy makers the chance to work preemptively to ensure that future situations do not cause similar patterns of violence.

Most studies in the field of sexual violence in Kenya have focused primarily on two aspects of sexual and gender-based violence: preventing it or treating it. By focusing on either end of the spectrum, and ignoring the middle, past research has failed to note the numerous obstacles faced by survivors when accessing help for anything besides the medical consequences of their assault. This has contributed to a complete dearth of knowledge on how a survivor moves from one step to the next when seeking care, as well as the financial, logistic, and cultural factors that were present throughout the process. My research presented in Chapter 4 was the first investigation of case attrition from the referral pathway in Kenya. My research has added to the extremely limited literature that researches attrition along the care-seeking pathway around the world, particularly in low and middle-income countries. My study established a quantitative framework for identifying predictors of attrition based on case variables and added a completely new dimension to the existing body of research on medico-legal service provision for sexual violence victims in Kenya. My results suggested that, while there were a few case characteristics that might increase a victim's odds of moving forward to the next step of care seeking, the pathway was so fraught with logistical and financial barriers that even the most 'ideal' of cases, i.e. a child survivor of sexual

violence with forensic evidence, was unlikely to make it to the prosecution stage of the case referral pathway, let alone sentencing. Perhaps my most significant finding from this research was the weighting of each stage of the pathway, which revealed that the stage with the most weight in determining case progression was the decision to go to the police. While a large share of cases made it to the police stage, only around 20% of cases moved on to the next step, which was prosecution. This indicated to me that a resource issue might be contributing to further handling of cases, that survivors were perhaps hesitant to engage with the police based on hearing about others' experiences, or that survivors were not confident that pursuing their cases any further would lead in positive results and thus decided to stop their engagement with the case referral pathway altogether.

Previous research to date on sexual violence care seeking in Kenya has largely focused on the opinions of the survivors alone. If the opinions of the providers were sought, the research focused on identifying bias amongst the providers rather than understanding how they felt about their roles in providing care to sexual violence victim/survivors. This focus on the experiences of the victims without offering any explanatory power to the providers thus limited the applicability of the findings because they could only hypothesise why the survivors were experiencing things as they were. By examining both the access and provision sides of sexual violence services in Kenya, I was able to highlight the lived experiences of both parties. My findings from the qualitative chapters in this thesis provided a unique perspective to this field, comparing the obstacles faced by the survivors to the barriers experienced by the providers. My approach proved useful in expanding knowledge about why certain issues were being identified both consistently by the survivors interviewed for this research and in similar work conducted in Kenya previously. It also illuminated serious issues with the existing training protocols (or lack thereof) for medico-legal professionals who work with sexual violence victims.

7.5 Future research

The findings I have discussed within this thesis have added a new perspective to the existing body of research about sexual violence in Kenya, particularly with a focus on medico-legal service access and provision. Considering the global relevance of sexual violence research, especially since Sustainable Development Goal 5 focuses on achieving gender equality and Goal 16 focuses on providing access to justice for all, there is an impetus for future researchers to expand on these ideas and focus on developing tangible solutions to improve access to healthcare and justice for all sexual violence survivors (United Nations, 2023). Throughout the course of my PhD, I identified a few notable areas for future research as potentially being able to help improve the access to and provision of medico-legal services for sexual violence survivors.

7.5.1 *Improved training for service providers and health system changes*

Professionals from every field I interviewed for this project noted a distinct absence of training on working with sexual violence cases during their schooling for their current professions, and many noted this lack of knowledge as a serious hindrance on their ability to provide adequate services (Chapter 5). While my studies in this thesis did not extensively investigate what the professionals' sexual violence education consisted of during medical school, nursing school, law school, or police training, there is some prior literature that exists to support the claims that these topics were either not mentioned at all during their schooling process or were not focused on sufficiently (Manuel et al., 2019, 2020; Ross et al., 2018; Rosser et al., 2022). For a new curriculum to be designed, research would need to be conducted to evaluate the current education being provided, perhaps using the Sexual Health Education for Professionals Scale (SHEPS), which can be used to assess knowledge and

attitudes among health care providers about matters pertaining to sexual health, including violence (Ross et al., 2018). Once these assessments have been carried out, participatory research with professionals from each field can be used to design and iteratively test future curricula, building on similar work conducted by Albezreh et al. (2022). Given the cultural and religious norms that are relevant throughout Kenya, especially pertaining to patriarchal violence, these educational programmes must be designed with cultural competency in mind (Deliz et al., 2020; Kariuki & Jansen van Rensburg, 2022).

Furthermore, training should involve clear descriptions of the professionals' roles and responsibilities. Research has indicated that ambiguous roles may negatively affect sexual violence victims due to poor service implementation within health centres, and that clearly defined roles as a result of training can lead to increased cooperation between staff (Bacchus et al., 2021; d'Oliveira et al., 2022). In addition to clearly defining roles for staff within health and legal centres, there is a need for organisational commitment on a higher level within the institutions. Medical or legal professionals in management positions should receive training about how to properly engage with their staff, and they should be given explicit decision-making authority to legitimise their roles within their institutions (Bacchus et al., 2021). While in managerial positions, it is important that the professionals show political will in furthering knowledge surrounding sexual violence service provision, so staff working under them will understand its importance (Colombini et al., 2022). This may also help implement future programmes, as the managers will feel that they are able to facilitate change due to their position within their organisation (Bacchus et al., 2023). The training also must be designed to work within Kenya's current case referral mechanism, so providers are able to offer services that are feasible given the existing system, which is often fraught with corruption and other barriers (Chapters 2, 4, 5, and 6).

7.5.2 *Rape myth awareness/bias monitoring*

Over the duration of this PhD research, it became abundantly clear to me that, as elsewhere around the world, rape myths and bias from providers were severely impacting a survivor's willingness to engage with the medico-legal system. Within Kenya, as I noted in Chapter 2, prior research found that providers felt they could tell if a victim/survivor was being truthful based on their behaviour. Professionals from different sectors often felt differently about victims, with law enforcement professionals being the most likely to feel that victims should feel ashamed of their sexual violence incident, followed by legal professionals and healthcare professionals (Ferdowsian et al., 2018; Munala et al., 2018). These findings were supported in Chapter 6, where one survivor told me that a medical professional could not believe anyone would have raped her because she was overweight, and in Chapter 5, where legal professionals told me that they could often tell if a survivor was being truthful based on their mood. Given the extremely high rates at which survivors drop out of the case referral pathway, as I analysed in Chapter 4, it is crucial that they feel supported when accessing medical or legal care. There is a need for future research to evaluate how these opinions may be monitored and how to mitigate against the impact on delivery of care, especially as they relate to the service quality, the willingness of survivors to engage with the medico-legal system, and training of future medico-legal professionals.

7.5.3 *Investigation of the benefits of engaging with an NGO versus accessing care independently*

Whilst the findings of my research mentioned in previous chapters is illuminating, and helpful in informing future policy, it is somewhat limited in its applicability because data came from a slightly advantaged group of victims, those who had previously liaised with the Wangu Kanja Foundation. Given that the goal should be improving future medico-legal

service provision for all, comparative work should be conducted to evaluate how participants in my studies experienced the case referral pathway in comparison to Kenyan sexual violence victims accessing care without any external support. The major other NGO mentioned by victims in assisting with their care was Médecins Sans Frontières (MSF), so future investigations should compare their journeys with MSF versus the Wangu Kanja Foundation and compare those findings to the general public to see which shortcomings were or were not being addressed by the help of an external NGO. While finding victims to engage with who are not associated with the Wangu Kanja Foundation may be difficult, as there are no existing prior connections, it is crucial to accurately examine the current stand of medico-legal service provision throughout the country.

7.5.4 *National policies versus existing models of service provision*

Although my scoping review initially sought to identify how current practices of post-rape medico-legal service provision may or may not align with existing national policies, there was a dearth of research on the topic that made further evaluation impossible. Given that most of the countries I included in the scoping review had both signed and ratified the Maputo Protocol, I would have liked to be able to compare existing policies to the goals outlined in the charter, especially given that the charter has been in place for nearly 20 years (*Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol Text)*, 2003). Additionally, comparing existing policies to existing practices may have given me insight into what areas the countries' governments determined should be focused on versus what was being enforced, identifying areas for future research and gaps in the policies that may be contributing to the issues with service access and provision.

7.6 Policy and Practice Recommendations

In order for any of these changes to be implemented, new policy and practice must be put into place. It is important that any policy related to sexual violence be created with a strong gender lens, considering the different experiences and vulnerabilities of service users and service providers based on certain intersectionalities (Hegarty, Andrews, & Tarzia, 2022; Bacchus et al., 2023). Although Kenya already has policies relating to sexual violence, most notably the Sexual Offences Act, the policies within the act are poorly implemented and are often used as talking points during election campaigns and then never mentioned again.

Given my findings about the lack of clarity surrounding the case referral pathway in Kenya, policies should be created that more clearly outline the roles and responsibilities of the health and legal sectors in providing services for sexual violence victims. As it exists currently, different tiers of health systems offer different levels of service, and it is largely unclear to service users where they should go to access medical and legal care. Care for sexual violence victims can be integrated into existing health services rather than attempting to divert already limited funds into creating new one-stop centres, and these health care approaches should be designed with gender and human rights perspectives in mind to account for any power inequalities that may have led to the violence in the first place and my influence survivor-provider interactions (World Health Organization, 2013; Bacchus et al., 2023).

Given the context of Kenya, where many civilians live in poverty, it is critical that services that are supposed to be free are in fact provided free of charge. Although there is a trust fund for victims in Kenya, most of my participants had never heard of this, and the money was intended to be used more by victims of violence relating to the post-election riots of 2007 than everyday sexual violence victims. Ensuring the support of the government in providing medical and legal providers with sufficient funds and supplies to offer their

services for free, as intended, is crucial in minimising the amount of sexual violence victims who do not seek or receive help because they cannot afford to print out the forms needed to file an official report.

Finally, because there is still a deeply entrenched stigma surrounding sexual violence in Kenya, I believe that increasing community sensitisation can help increase the willingness of survivors to seek help while reducing provider stigma. Given how important religion is to many Kenyans, religious gatherings could be a good place for sensitisation activities to occur (Statista, 2019). Improved understanding about the realities of sexual violence in Kenyan society may help encourage victims to come forward and may also help providers make more gender and human rights-lens-informed decisions when providing care. Having religious leaders deliver these messages will help reduce stigma as they are well-regarded within their communities and considered trustworthy sources of information.

7.7 Final thoughts

Given the significant physical, emotional, and psychosocial consequences associated with sexual violence, and the worldwide emphasis on eradicating this violence, my research is timely and crucial for ameliorating the issues found in the access to and provision of sexual violence medico-legal care in Kenya. My research identified a crucial need for improved training for professionals, both on the process of service provision itself and how to identify and remediate bias, and identified cultural factors that may preclude survivors from seeking care in the first place. Future research is needed to identify what practices may be implemented to improve the process for both survivors and providers, and to ascertain what may motivate Kenya to institute and enforce more stringent policies given that signing and ratifying international treaties has been largely ineffective. Future research should also explore further how the reliance on international NGOs for service provision may influence

the Kenyan government's decision making in relation to improving service provision in the future, and how to plan for and prevent violence during future humanitarian crises, based on the patterns that were seen during COVID-19.

References

Ajema, C., Mukoma, W., Kilonzo, N., Bwire, B., & Otwombe, K. (2011, May). Challenges experienced by service providers in the delivery of medico-legal services to survivors of sexual violence in Kenya. *J Forensic Leg Med, 18*(4), 162-166. https://doi.org/10.1016/j.jflm.2011.02.004

Albezreh, S., Anastario, M., Ulibarrí, B. J., Naimer, K., Johnson, K., McHale, T., Mishori, R., Macias-Konstantopoulos, W. L., Olson, R., & Nelson, B. D. (2022, Nov). Multiyear, Multisectoral Training Program in Kenya to Enhance Medical-Legal Processes in Response to Sexual and Gender-Based Violence. *Violence Against Women, 28*(14), 3311-3330. https://doi.org/10.1177/10778012221099984

Andersen, R. M. (1995). Revisiting the Behavioral Model and Access to Medical Care: Does it Matter? *Journal of Health and Social Behavior, 36*(1), 1-10. https://doi.org/10.2307/2137284

Arksey, H., & O'Malley, L. (2005, 2005/02/01). Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology, 8*(1), 19-32. https://doi.org/10.1080/1364557032000119616

Bacchus, L. J., Alkaiyat, A., Shaheen, A., Alkhayyat, A. S., Owda, H., Halaseh, R., Jeries, I., Feder, G., Sandouka, R., & Colombini, M. (2021). Adaptive work in the primary health care response to domestic violence in occupied Palestinian territory: a qualitative evaluation using Extended Normalisation Process Theory. *BMC Family Practice, 22*(1), 3. https://doi.org/10.1186/s12875-020-01338-z

Bacchus, L. J., d'Oliveira, A. F. P. L., Pereira, S., Schraiber, L. B., Aguiar, J. M. d., Graglia, C. G. V., Bonin, R. G., Feder, G., & Colombini, M. (2023). An evidence-based primary health care intervention to address domestic violence against women in Brazil: a mixed method evaluation. *BMC Primary Care, 24*(1), 198. https://doi.org/10.1186/s12875-023-02150-1

Bergen, N., & Labonté, R. (2020). "Everything Is Perfect, and We Have No Problems": Detecting and Limiting Social Desirability Bias in Qualitative Research. *Qualitative Health Research, 30*(5), 783-792. https://doi.org/10.1177/1049732319889354

Colombini, M., Mayhew, S. H., García-Moreno, C., d'Oliveira, A. F., Feder, G., & Bacchus, L. J. (2022, 2022/11/28). Improving health system readiness to address violence against women and girls: a conceptual framework. *BMC Health Services Research, 22*(1), 1429. https://doi.org/10.1186/s12913-022-08826-1

d'Oliveira, A. F. P. L., Pereira, S., Bacchus, L. J., Feder, G., Schraiber, L. B., de Aguiar, J. M., Granusso Bonin, R., Guida Vieira Graglia, C., & Colombini, M. (2022). Are We Asking Too Much of the Health Sector? Exploring the Readiness of Brazilian Primary Healthcare to Respond to Domestic Violence Against Women. *International journal of health policy and management, 11*(7), 961-972. https://doi.org/10.34172/ijhpm.2020.237

Deliz, J. R., Fears, F. F., Jones, K. E., Tobat, J., Char, D., & Ross, W. R. (2020, Feb). Cultural Competency Interventions During Medical School: a Scoping Review and

Narrative Synthesis. *Journal of General Internal Medicine, 35*(2), 568-577. https://doi.org/10.1007/s11606-019-05417-5

EAC Partner States. (2022). EAC. Retrieved 2 September from https://www.eac.int/eac-partner-states

Education First. (2022). *EF English Proficiency Index: A Ranking of 111 Countries and Regions by English Skills*.

Ferdowsian, H., Kelly, S., Burner, M., Anastario, M., Gohlke, G., Mishori, R., McHale, T., & Naimer, K. (2018, Dec). Attitudes Toward Sexual Violence Survivors: Differences Across Professional Sectors in Kenya and the Democratic Republic of the Congo. *Journal of Interpersonal Violence, 33*(24), 3732-3748. https://doi.org/10.1177/0886260516639257

Gatuguta, A., Merrill, K. G., Colombini, M., Soremekun, S., Seeley, J., Mwanzo, I., & Devries, K. (2018). Missed treatment opportunities and barriers to comprehensive treatment for sexual violence survivors in Kenya: a mixed methods study. *BMC Public Health, 18*(1), 769. https://doi.org/10.1186/s12889-018-5681-5

Hegarty, K. L., Andrews, S., & Tarzia, L. (2022, Aug 1). Transforming health settings to address gender-based violence in Australia. *Med J Aust, 217*(3), 159-166. https://doi.org/10.5694/mja2.51638

Henttonen, M., Watts, C., Roberts, B., Kaducu, F., & Borchert, M. (2008). Health services for survivors of gender-based violence in northern Uganda: a qualitative study. *Reproductive Health Matters, 16*(31), 122-131. http://search.ebscohost.com/login.aspx?direct=true&db=jlh&AN=105547535&site=ehost-live

Kawaguchi, C. (2018). *The help-seeking pathways and barriers: Case of south sudanese refugees in Uganda* (Field Research Report). Peace and Development, JICA Research Institute.

Kariuki, L. W., & Jansen van Rensburg, S. K. (2022). Towards Dismantling Patriarchy in the Kibera Slum, Kenya: Narrative Accounts of Victims of Intimate Partner Violence. *International Annals of Criminology, 60*(1), 99-117. https://doi.org/10.1017/cri.2022.7

Lederle, M., Tempes, J., & Bitzer, E. M. (2021, May 5). Application of Andersen's behavioural model of health services use: a scoping review with a focus on qualitative health services research. *BMJ Open, 11*(5), e045018. https://doi.org/10.1136/bmjopen-2020-045018

Levac, D., Colquhoun, H., & O'Brien, K. K. (2010, 2010/09/20). Scoping studies: advancing the methodology. *Implementation Science, 5*(1), 69. https://doi.org/10.1186/1748-5908-5-69

Manuel, B., Roelens, K., Tiago, A., Keygnaert, I., & Valcke, M. (2019). Gaps in Medical Students' Competencies to Deal With Intimate Partner Violence in Key Mozambican

Medical Schools [Article]. *Frontiers in Public Health, 7*, Article 204. https://doi.org/10.3389/fpubh.2019.00204

Manuel, B., Roelens, K., Tiago, A., Keygnaert, I., & Valcke, M. (2020, Jan). Medical Curricula on Intimate Partner Violence in Mozambique. *Acta Medica Portuguesa, 33*(1), 22-30. https://doi.org/10.20344/amp.12049

Mendelson, M., Han, P. V., Vincent, P., von Sonnenburg, F., Cramer, J. P., Loutan, L., Kain, K. C., Parola, P., Hagmann, S., Gkrania-Klotsas, E., Sotir, M., & Schlagenhauf, P. (2014, Apr). Regional variation in travel-related illness acquired in Africa, March 1997-May 2011. *Emerging Infectious Diseases, 20*(4), 532-541. https://doi.org/10.3201/eid2004.131128

Mishori, R., Anastario, M., Naimer, K., Varanasi, S., Ferdowsian, H., Abel, D., & Chugh, K. (2017, Mar 24). mJustice: Preliminary Development of a Mobile App for Medical-Forensic Documentation of Sexual Violence in Low-Resource Environments and Conflict Zones. *Global Health: Science and Practice, 5*(1), 138-151. https://doi.org/10.9745/ghsp-d-16-00233

Munala, Welle, E., Hohenshell, E., & Okunna, N. (2018, Jul). "She Is NOT a Genuine Client": Exploring Health Practitioner's Mistrust of Rape Survivors in Nairobi, Kenya. *Community Health Equity Research & Policy, 38*(4), 217-224. https://doi.org/10.1177/0272684x18781790

Murad Code Project. (2022). https://www.muradcode.com/

Naimer, K., Brown, W., & Mishori, R. (2017). MediCapt in the Democratic Republic of the Congo: The Design, Development, and Deployment of Mobile Technology to Document Forensic Evidence of Sexual Violence. *Genocide Studies and Prevention, 11*(1), 25-35. https://doi.org/10.5038/1911-9933.11.1.1455

Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol Text). (2003). (achpr.org, Issue. http://www.achpr.org/instruments/women-protocol/

Rockowitz, S., Flowe, H., & Bradbury-Jones, C. (2022). A Scoping Review on Sexual and Gender-Based Violence Medicolegal Service Provision in East Africa. *Trauma, Violence, & Abuse*, 15248380221134292. https://doi.org/10.1177/15248380221134292

Rockowitz, S., Rockey, J., Stevens, L. M., Colloff, M. F., Kanja, W., & Flowe, H. D. (2023). Evaluating Case Attrition along the Medico-Legal Case Referral Pathway for Sexual and Domestic Violence Survivors in Kenya: A Secondary Data Analysis. *Victims & offenders*, 1-24. https://doi.org/10.1080/15564886.2023.2214550

Rockowitz, S., Wagner, K., Cooper, R., Stevens, L., Davies, K., Woodhams, J., Kanja, W., & Flowe, H. D. (2023). A Systematic Review of Criminal Justice Initiatives to Strengthen the Criminal Investigation and Prosecution of Sexual Violence in East Africa. *Trauma, Violence, & Abuse, 0*(0), 15248380231165694. https://doi.org/10.1177/15248380231165694

Ross, M. W., Leshabari, S., Rosser, B. R. S., Trent, M., Mgopa, L., Wadley, J., Kohli, N., & Agardh, A. (2018, 2018/04/01/). Evaluation of an assessment instrument for a sexual health curriculum for nurses and midwifery students in Tanzania: The sexual health education for professionals scale (SHEPS). *Applied Nursing Research, 40*, 152-156. https://doi.org/https://doi.org/10.1016/j.apnr.2018.01.005

Rosser, B., Mkoka, D., Rohloff, C., Mgopa, L., Ross, M., Lukumay, G., Mohammed, I., Massae, A., Mkonyi, E., Mushy, S., Mwakawanga, D., Kohli, N., Trent, M., Wadley, J., & Bonilla, Z. (2022). Tailoring a sexual health curriculum to the sexual health challenges seen by midwifery, nursing and medical providers and students in Tanzania. *African Journal of Primary Health Care & Family Medicine, 14*(1), 9 pages. doi:**https://doi.org/10.4102/phcfm.v14i1.3434**

Stevens, L. M., Reid, E., Kanja, W., Rockowitz, S., Davies, K., Dosanjh, S., Findel, B., & Flowe, H. D. (2022). The Kenyan Survivors of Sexual Violence Network: Preserving Memory Evidence with a Bespoke Mobile Application to Increase Access to Vital Services and Justice. *Societies, 12*(1).

United Nations. (2023). *The 17 Goals*. United Nations. https://sdgs.un.org/goals

World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. WHO. https://iris.who.int/bitstream/handle/10665/85240/9789241548595_eng.pdf?sequence=1

APPENDICES

Appendix 1. A Scoping Review on Sexual and Gender-Based Violence Medicolegal Service Provision in East Africa

Authors' names and publication year	Country	Setting	Methodology	Outcome being measured	Publication Type
Zraly, Rubin-Smith and Betancourt, 2010	Rwanda	Four districts in Butare area	Ethnographic work was conducted with two genocide-rape survivor associations and findings were used to inform semi-structured interview protocol with 57 members of the associations	Barriers to accessing the health care system and meeting mental health needs	Academic article
Githui, Chege, Wagoro and Mwaura, 2018	Kenya	National maternity hospital	Random sampling was used at a hospital in Kenya. 125 nurses took place in a cross-sectional study using a semi-structured questionnaire	Screening for DV in health care settings	Academic article
Muuo, Muthuri, Mutua, McAlpine, Bacchus, Ogego, Bangha, Hossain and Izugbara, 2020	Kenya	Dadaab refugee complex	Women who reported cases to response teams at GBV service centres were asked to participate in a quantitative survey and in-depth interviews. 209 participants were recruited for the survey and 34 for the qualitative interviews	Barriers and facilitators to accessing care for survivors in the Dadaab refugee complex	Academic article
Temmerman, Ogbe, Manguro, Khandwalla, Thiongo, Mandaliya,	Kenya	Coast Provincial General Hospital in Mombasa	Data was collected from a clinic over 11 years and 6,575 cases of SV survivors were analysed	Characteristics of centre attendees	Academic article

Dierick, MacGill and Gichangi, 2019					
Henttonen, Watts, Roberts, Kaducu and Borchert, 2008	Uganda	Gulu district	Health services available to GBV survivors were studied using semi-structured interviews with 26 experts on GBV and health providers	Availability of medical supplies and sufficiently trained staff	Academic article
Kawaguchi, 2018	Uganda	Six refugee settlement districts	Focus group discussions and individual interviews were conducted with 347 men and women who were South-Sudanese refugees or service providers	Refugee pathways in help-seeking and potential barriers	Field research report
Whelan and Blogg, 2007	Uganda	Refugee settings	Focus group discussions and field visits were conducted with refugee 379 participants at three refugee sites in Uganda	Factors that facilitate or hinder access to reproductive health services in refugee settings	Academic article
Schober, Mtonga, Valenti and Hametner, 2014	Zambia	Emergency room in Lusaka	174 patients presenting at the ER with IPEV were recruited for pre- and post-intervention quantitative cross-sectional studies	Victim understanding of available services for IPEV	Academic article
Horn, 2009	Kenya	Kakuma refugee camp	157 refugees were recruited from the refugee camp and qualitative data was collected via focus-group discussions	How refugees discuss how IPV is dealt with	Academic article
Maina, 2009	Kenya	Emergency department in western Kenya	One doctor, four clinical officers, and six nurses who had worked with patients who had experienced IPV were chosen and interviewed using in-depth interviewing techniques	Health professional responses to IPV victims in an emergency department setting	Academic article

Majeke, 2008	Kenya	Emergency department in western Kenya	One doctor, six nurses, and four clinical officers were selected to achieve theoretical sampling and participated in in-depth interviews	Perceptions of health professionals who work with IPV victims in emergency department settings	Academic article
Nguyen, Flynn, Kitua, Muthumbi, Mutonga, Rajab and Miller, 2016	Kenya	Health care centres in Nairobi, Kisii, Kibera, Makwenda, Nyamira, and Nyamusii	18 healthcare providers were recruited via word of mouth and email invitations sent to multiple health centre in Nairobi. They were invited to participate in face-to-face interviews	Health care provider responses to IPV in multiple clinical settings and the barriers they face in offering care	Academic article
Undie, Maternowska, Mak'anyengo and Askew, 2016	Kenya	Kenyatta National Hospital in Nairobi	Focus group discussions were conducted with providers at four sites within the hospital and in-depth interviews were carried out with clients from the clinics after screening for IPV in 1,210 clients		
Odero, Hatcher, Bryant, Onono, Romito, Bukusi and Turan, 2014	Kenya	Migori and Rongo districts in Nyanza Province	In-depth interviews and focus group discussions were conducted with 90 men and women including pregnant women, partners or male relatives of pregnant women, and service providers	Victim actions, available support services, and barriers to using available IPV resources	Academic article

Chepuka, Taegtmeyer, Chorwe-Sungani, Mambulasa, Chirwa and Tolhurst, 2014	Malawi	Blantyre, Mangochi, and Lilongwe districts	278 survivors, healthcare workers, community members, and key informants participated in in-depth interviews and focus group discussions. They were recruited to represent urban and rural areas and on the bases of age, sex, marital and parental status to create homogenous groups	Stakeholder perceptions towards the mental health impact of IPV	Academic article
Manuel, Roelens, Tiago, Keygnaert and Valcke, 2019	Mozambique	Five medical schools in Mozambique	378 third and sixth-year medical students participated in a survey after being randomly selected from each medical school	Medical students' perceived mastery of knowledge, skills, and attitudes to work with IPV victims	Academic article
Ambikile, Leshabari and Ohnishi, 2020	Tanzania	Health facilities in Mbeya region	662 nurses and midwives from all hospitals and health centres in the region participated in a cross-sectional self-administered survey	Nurse and midwife awareness of IPV-related mental health care	Academic article
Shumba, Dolamo and Mathibe-Neke, 2017	Uganda	Kabalagala area in Kampala	48 women with experiences of IPV were recruited from two slums in Uganda for a cross-sectional exploratory study using qualitative in-depth interviews	Health impacts of IPV in urban slums	Academic article
LVCT	Kenya	National maternity hospital	NA		Policy brief
Kilonzo, Molyneux, Taegtmeyer and Theobald, 2003	Kenya	Nairobi, Thika, and Malindi districts	Literature and secondary reviews, study visits, and qualitative and participatory research methodologies	Perceptions of and service provision for GBV	Report

Munala, Welle, Hohenshell and Okunna, 2018	Kenya	Eight post-rape care facilities in Nairobi	28 health practitioners, 16 female and 12 female, who had worked at the health facilities for at least six months and who were not in supervisory positions were qualitatively interviewed following a semi-structured interview protocol format	Health practitioner experiences and perspectives when providing services to female survivors of SV	Academic article
Ajema, Rogena, Muchela, Buluma and Kilonzo, 2009	Kenya	Two district hospitals and two police stations in Kenya	24 healthcare workers and police officers from hospital and police stations were interviewed with an in-depth interview guide by trained qualitative interviewers. Data was also collected from hospital records and analysed quantitatively	Current practices and gaps in collection and maintenance of evidence collected from rape survivors	Report
Kilonzo, Theobald, Nyamato, Ajema, Muchela, Kibaru, Rogena and Taegtmeyer, 2009	Kenya	Government health facilities in Thika, Milindi and Rachuonyo districts	A new standard of care was created and executed in selected districts in Kenya. During the study period 784 survivors were seen across the three sites.	Changes in standard of care for rape survivors	Report
Mukamana, Brysiewicz, Collins and Rosa, 2017	Rwanda	Kamonyi district, Southern Province	In-depth semi-structured interviews were administered to 12 female rape survivors of the genocide and 17 men and women who were not raped but lived in the same community	Theory of genocide rape trauma management	Academic article
Casey, Chynoweth, Cornier, Gallgher and Wheeler, 2015	South Sudan	Maban County	Nine health facilities were assessed for key aspects of clinical management of rape. Self-completed close-ended questionnaires were also given to 18 providers, and focus group discussions were conducted with 92 married and unmarried men and women	Availability, quality of, and barriers to reproductive health services in humanitarian settings	Academic article
Muganyizi, Nystrom, Axemo and Emmelin 2011	Tanzania	Temeke district in Dar es Salaam	In-depth interviews were conducted with 10 women who had been raped and 20 men and women who had supported women who had been raped	Experiences of raped women and supporters of raped women when seeking help	Academic article

Abeid, Muganyizi, Mpembeni, Darj and Axemo, 2016	Tanzania	Two districts in Morogo region	Cross-sectional surveys were administered to 151 health professionals at baseline and 169 in the final assessment to assess the change in key indicators from a training programme	Impact of training health professionals on rape management	Academic article
Harrison, Pearson, Vere, Chonzi, Hove, Mabaya, Chigwamba, Nhamburo, Gura, Vanderborne, Sions, Lagrou, De Plecker and Van den Bergh, 2017	Zimbabwe	SGBV clinic in Harare	A retrospective descriptive study of routine programmatic data collected at an SGBV clinic from 2011 to 2014 was analysed using chi-square tests and logistic regression. 3617 adolescent and adult cases were analysed	Care requirements for rape victims and minors who had consensual sex	Academic article
Kufa, Magure, Shambira, Gombe, Juru, Nsubuga, Borok, Iliff, Mushambi and Tshimanga, 2019	Zimbabwe	Adult Rape Clinic in Harare	A retrospective record review of data from 2343 cases from an adult rape clinic from 2009 to 2017 was analysed looking at age, sex, number of times the victim was assaulted, time taken to present to the clinic, and medical services offered	Gaps in service provision and areas for improvement at a rape clinic	Academic article
Buard, Van den Bergh, Tayler-Smith, Godia, Sobry, Kosgei, Szuilin, Harries and Pujades-Rodriguez, 2013	Kenya	Medecins Sans Frontieres Clinic for SGBV in Nairobi	A retrospective review of clinical records and the SGBV register was carried out at an MSF clinic in Nairobi. 866 records were analysed	Medical management and outcomes of survivors of SGBV	Academic article
Liebling, Barrett and Artz, 2020	Uganda	Refugee settlements in Northern Uganda	Focus group discussions and individual interviews were carried out with 37 key stakeholders such as international, government, non-government and civil society organisations and 61 refugee survivors of SGBV and torture	Health and justice service responses to needs of South Sudanese refugees	Academic article

Liebling, Barrett, Artz, Niyonkuru and Canoguru	Uganda	Refugee settlements in Northern Uganda	Focus group discussions and individual interviews were carried out with 93 men and women refugee survivors of SGBV or torture and 32 key stakeholder providers of health, justice, and support services	Impacts of SGBV on survivors living in Northern Ugandan refugee settlements	Working paper
Odwe, Undie and Obare, 2018	Uganda	Rwamwanja refugee settlement scheme in southwest Uganda	A cross-sectional survey aimed at collecting evidence to inform a community-based intervention to prevent SGBV was conducted from May to June 2016 with 601 heads of refugee households, 261 females and 340 males	Attitudes towards help-seeking for SGBV in humanitarian settings	Academic article
Sithole, Gombe, Juru, Chonzi, Shambira, Nsubuga and Tshimanga, 2018	Zimbabwe	Facilities that offer SGBV services in Harare City	A process-outcome evaluation using a logic model was conducted at eight SGBV sites with 27 nurses and eight other staff offering SGBV services	Performance of a SGBV programme	Academic article
McCleary-Sills, Namy, Nyoni, Rweyemamu, Salvatory and Steven, 2013	Tanzania	Dar es Salaam, Mbeya, and Iringa regions	Focus group discussions and individual interviews were conducted with 104 key informants including healthcare providers, police, ward leaders, and ministry representatives	Community perceptions of violence, availability of services, and gaps in service provision	Report
Krolikowski and Koyfman, 2012	Africa	NA	A review of treatment practices for SA survivors across multiple African countries was conducted	Quality of emergency centre care for SA victims	Academic article
Amenu and Hiko, 2014	Ethiopia	Jimma University Specialised Hospital	A cross-sectional descriptive study was conducted in a hospital to assess sexual assault patterns and related complications of 99 cases. A structured interview was administered to the patients and data was analysed using SPSS	Patterns and complications of SA cases	Academic article

Lakew, 2001	Ethiopia	Tikur Anbessa and St. Paul's hospitals in Addis Ababa	A cross-sectional descriptive study was carried out with a study population of 170 reported cases of alleged SA at two hospitals. Data was collected with a pre-designed questionnaire that collected demographic information of the victims, their relation to the offender, and the pattern of reporting		Academic article
Kassa, Hiwot and Abdella, 2009	Ethiopia	Addis Ababa	A quantitative survey was administered at all hospitals in the city using a standardised questionnaire and in-depth interviews were conducted with four police women who handle sexual assault cases at four police stations	Barriers to accessing emergency contraception for SA victims	Academic article
Muriuki, Kimani, Machuki, Kiarie and Roxby, 2017	Kenya	Gender-Based Violence Recovery Centre at Kenyatta National Hospital	Records were analysed of 385 patients who had visited the GBVRC between 2009 and 2012. A data abstraction questionnaire was used to collect information on age, sex, nationality, initiation of PEP, and outcomes post-PEP	Characteristics of survivors of SV	Academic article
Ranney, Rennert-May, Spitzer, Chitai, Mamlin and Mabeya, 2010	Kenya	Centre for Assault Recovery-Eldoret at a Kenya emergency department	A retrospective chart review was carried out of all sexual assault survivors who attended a sexual assault centre between 2007 to 2008. 321 survivors were seen, and their cases were analysed with simple descriptive statistics and t tests	Treatment patterns of patients of an SA recovery centre	Academic article
Smith, Ho, Langston, Mankani, Shivshanker and Perera, 2013	Kenya and Ethiopia	Dadaab refugee complex and two government operated hospitals in refugee camps in Ethiopia	A purposive sample was taken of 106 healthcare providers and they were surveyed before and after training to measure attitudes, knowledge, and confidence about sexual assault survivors. In-depth interviews were also conducted with 40 providers, and medical record audits were conducted in 35 health	Effect of a training programme for clinical care of SA victims	Academic article

			facilities before and after the intervention.		
Ononge, Wandabwa, Kiondo and Busingye, 2005	Uganda	Mulago hospital in Kampala	58 sexually assaulted females were recruited from an emergency ward and interviewed using a questionnaire with both open and close ended questions. The patients were also given physical examinations and referred to support services. Data was collected and entered using statistical methods.	Management of sexually assaulted females	Academic article
Tapesana, Chirundu, Shambira, Gombe, Juru and Mufuta, 2017	Zimbabwe	Kadoma General Hospital	A retrospective cross-sectional study based on secondary data analysis was used to analyse 474 medical affidavits from a hospital in Zimbabwe.	Quality of care offered to SA victims	Academic article
Keesbury and Thompson, 2010	Africa	NA	NA		Report
Gatuguta, Merrill, Colombini, Soremekun, Seeley, Mwanzo and Devries, 2018	Kenya	Level four hospital in Nakuru County and Level five hospital in Kiambu County	Hospital records of 543 survivors from two hospitals were compared with national data from the DHS and the VACS. Differences in characteristics of the survivors were analysed using chi-square tests. There were also six in-depth interviews carried out with healthcare providers.	Characteristics of survivors and barriers to treatment	Academic article
Kilonzo, Taegtmeyer, Molyneux, Kibaru, Kimonji and Theobald 2008	Kenya	Thika, Malindi, and Nairobi districts	16 focus group discussions with adult women, adolescent women, adult men, and adolescent men, and 34 individual key informant interviews with participants from healthcare facilities, counsellors, members of religious institutions, and legal advocates and police officers were conducted and analysed thematically.	Reasons for low uptake of SV services	Academic article

Ajema, Mukoma, Kilonzo, Bwire and Otwombe, 2011	Kenya	Government run health facilities in Nyanza, Eastern and Nairobi provinces	An operations research study was conducted in three government run health facilities purposefully chosen due to their collaboration with district police and their post-rape care services. In-depth interviews were conducted with 29 clinical officers, medical officers, nurses, and police.	Obstacles to handling forensic evidence for SV cases	Academic article
Ferdowsian, Kelly, Burner, Anastario, Gohlke, Mishori, McHale and Naimer, 2016	Kenya	Rift Valley region	181 Legal and medical professionals were invited to participate in a sexual violence training programme. Before the training began the participants completed a self-administered questionnaire about attitudes towards sexual violence survivors	Beliefs and attitudes of professionals who work with SV survivors	Academic article
Munala, Welle and Hohenshell, 2020	Kenya	Eight post-rape care facilities in Nairobi	28 health practitioners were interviewed, including clinical officers, nurses, trauma counselors, social workers, a reproductive health counselor, a pharmacy technician, and a testing counselor. The in-depth interviews used a semi-structured interview protocol format and questions were generated based on a literature review.	Experiences and perspectives of service providers who work with SV victims	Academic article
Amone-P'Olak, Elklit and Dokkedahl, 2017	Uganda	Five districts in Northern Uganda	181 female participants of the WAYS study were assessed to collect information on associations between sexual violence and PTSD. A 22-item questionnaire was used to ask about PTSD symptoms and a separate questionnaire was used to ask about the availability of mental health services.	Barriers to mental health care for survivors of SV	Academic article

Vyas, 2019	Tanzania	NA	Quantitative analysis of survey results from the 2015 Tanzania DHS was carried out to assess the association between violence and healthcare utilisation among 9,304 women	Health care utilisation rates of victims of VAW	Academic article
Amnesty International	Uganda	Women's crisis centres in Kampala	In-depth interviews were conducted with 105 interviewees including survivors of sexual violence, NGOs, governmental officials, and representatives from international organisations	Obstacles to seeking justice for victims of VAW	Report
Dennis, Owolabi, Cresswell, Chelwa, Colombini, Vwalika, Mbizvo and Campbell, 2019	Zambia	Central Province, Zambia	A health facility census was administered to 193 facilities. trained interviewers assessed each facility using a structured questionnaire that asked about general infrastructure, staffing, and capacity to perform clinical functions	Availability of clinical SV services	Academic article

Appendix 2. Patterns of Sexual Violence Against Adults and Children During the COVID-19 Pandemic in Kenya: A Prospective Cross-Sectional Study

Wangu Kanja Foundation (K)
P.O.Box 12608 – 00100
Nairobi, Kenya
Telephone No:
Email:

SURVIVORS DATA COLLECTION INTAKE SUMMARY FORM

1. Date of incident: ___________________________
2. Time of incident: ____________________
3. Age of survivor: ________________________________
4. Sex of survivor: __________________________
5. Location(s) of incident:
6. Survivor's house: Yes/No
7. Other's house: Yes/No
8. Place of Work: Yes/No/I don't know
9. Perpetrator's house: Yes/No/I don't know
10. On my way to work/On the road: Yes/No/I don't know
11. Other location (please describe) ________________________: Yes/No/I don't know
12. Name of the city/town/village where incident initially took place:
13. Brief description of incident: ____
____
____
____
____
____
____
____
____
____
____
____

Perpetrator's Information: -

1. Number of perpetrator(s): - ________Do you know the perpetrator(s):- ___________
2. If yes, how____
3. Estimate of perpetrator's age: ________________________________
4. Perpetrator's Sex: ___________________________

Post Incident Information: -

5. What action did the survivor take after the incident?
6. Seek medical attention: Yes/No

7. Seek counselling: Yes/No
8. Report to the police: Yes/No
9. Seek legal redress: Yes/No
10. Protection/Safe space/Shelter: Yes/No

If the survivor sought medical attention for the incident:

- **a.** Did you become HIV positive due to the incident: **Yes/No/I don't know**
- **b.** Did you get pregnant due to the incident? **Yes/No/I don't know**
- **c.** Did you contract any STI's due to the incident? **Yes/No/I don't know**
- **d.** Were you physically injured due to the incident **Yes/No/I don't know**

Was the survivor referred to the WKF? Yes/No → **If YES**: Client's Ref. No: ____________

Appendix 3. Provider perspectives on barriers to medico-legal service provision to sexual violence survivors in Kenya

3.1 P3 Form

THE KENYA POLICE P3
MEDICAL EXAMINATION REPORT

PART 1-*(To be completed by the Police Officer Requesting Examination)*

From……………………………………………..Ref…………………………
……………………………………………………..Date………………………..
To the.. Hospital/Dispensary
I have to request the favour of your examination of:-
Name……………………………………………..Age ....(If known)
Address……………………...........Date and Time of the alleged offence.......
……………………………………………………………………………………...
Sent to you/Hospital on the……………………20…..under escort of……………
….. and of your furnishing me with a report of the nature and extent of bodily injury sustained by him/her.
Date and time report to police…………………………………………………… Brief details of the alleged offence……………………………………………...
…………………………………………………………………………………………
……………………………………………… ………………………………………..
Name of Officer Commanding Station Signature of the Officer Commanding Station

PART 11-MEDICAL DETAILS -*(To be completed by Medical Officer or Practitioner carrying out examination)*

*(Please type **four** copies from the original manuscript)*

SECTION ''A''-THIS SECTION MUST BE COMPLETED IN ALL EXAMINATIONS

Medical Officer's Ref.NO…………………………………………………

1. State of clothing including presence of tears, stains (wet or dry) blood, etc.
   …………………………………………………………………………………
   ....……………………………………………………………………………..
   ………………………………………………………………………………….
2. General medical history (including details relevant to offence)……………………
   ……………………………………………………………………………………
   ……………………………………………………………………………………
3. Genaral physical examination (including general appearance, use of drugs or Alcohol and demeanour)
   ……………………………………………………………………………………

Document Printed from the Kenya Police Website. All laws apply

SECTION ''B''**- TO BE COMPLETED IN ALL CASES OF ASSAULT, INCLUDING SEXUAL ASSAULTS, AFTER THE COMPLETION OF SECTION ''A''**

1. Details of site, situation, shape and depth of injures sustained:-
   a) Head and neck……………………………………………………………………
   ……………………………………………………………………………………
   ……………………………………………………………………………………
   b) Thorax and Abdomen……………………………………………………………
   ……………………………………………………………………………………
   ……………………………………………………………………………………
   c) Upper limbs……………………………………………………………………
   ……………………………………………………………………………………
   ……………………………………………………………………………………
   d) Lower limbs ……………………………………………………………………
   ……………………………………………………………………………………
   ……………………………………………………………………………………
2. Approximate age of injuries (hours, days, weeks)………………………………………
……………………………………………………………………………………
3. Probable type of weapon(s) causing injury……………………………………………
……………………………………………………………………………………
4. Treatment, if any, received prior to examination…………………………………………
……………………………………………………………………………………
5. What were the immediate clinical results of the injury sustained and the assessed degree, i.e.''harm'', or'' grievous harm''.*

DEFINITIONS:-

''Harm'' Means any bodily hurt, disease or disorder whether permanent or temporary.

''Maim' means the destruction or permanent disabling of any external or organ, member or sense

''Grievous Harm'' Means any harm which amounts to maim, or endangers life, or seriously or permanently injures health, or which is likely so to injure health, or which extends to permanent disfigurement, or to any permanent, or serious injury to external or organ.

…………………………………………………… Name &
Signature of Medical Officer/Practitioner

Date…………………………………………….

Document printed from the Kenya Police Website. All laws apply

SECTION "C"-TO BE COMPLETED IN ALLEGED SEXUAL OFFENCES AFTER THE COMPLETION OF SECTIONS "A" AND "B"

1. Nature of offence.. Estimated age of person examined………………………………………………………………………
2. **FEMALE COMPLAINANT**
   a) Describe in detail the physical state of and any injuries to genitalia with special reference to labia majora, labia minora, vagina, cervix and conclusion…………………………………………………………………… …
   ……………………………………………………………………………………
   ……………………………………………………………………………………
   ……………………………………………………………………………………

   b) Note presence of discharge**,** blood or venereal infection, from genitalia or on body externally…………………………………………………………
   ……………………………………………………………………………………
   ……………………………………………………………………………………
   ....
3. **MALE COMPLAINANT**
   b) Describe in detail the physical state of and any injuries to genitalia…………………………………………………………………………
   ……………………………………………………………………………………
   ……………………………………………………………………………………
   ……………………………………………………………………………………
   ……………………………………………………………………………………

   c) Describe in detail injuries to anus…………………………………………..
   ……………………………………………………………………………………
   ……………………………………………………………………………………

   d) Note presence of discharge around anus, or/ on thighs, etc.; whether recent or of long standing...
   ....
   ....

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SECTION "D"

4. **MALE ACCUSED OF ANY SEXUAL OFFENCE**

a) Describe in detail the physical state of and any injuries to genitalia especially penis…………………………………………………………………………
…………………………………………………………………………………
…………………………………………………………………………………
…………………………………………………………………………………
…………………

b) Describe in detail any injuries around anus and whether recent or of long standing……………………………………………………………………………
…………………………………………………………………………………
…………………………………………………………………………………
…………………………………………………………………………………
…………………

5.Details of specimens or smears collected in examinations 2, 3 or 4 of section "C" including pubic hairs and vaginal hairs……………………………………..
………………………………………………………………………………………
……………………………………………………………………………………….

6. Any additional remarks by the doctor……………………………………………………....
………………………………………………………………………………………
…...…………………………………………………………………………………..
………………………………………………………………………………………

…………………………………………………………
Name & Signature of Medical Officer/Practitioner

Date…………………………………………………..

Document printed from the Kenya Police Website. All laws apply

3.2 PRC Form

POST RAPE CARE FORM (PRC) PART A

PRC FORM IS NOT FOR SALE

MOH 363

Ministry of Health National Rape Management Guidelines. Examination documentation form for survivors of rape/sexual violence (to be used as clinical notes to guide filling in of the P3 form)

PRC Post Rape Care Form

Date: Day | Month | Year — County Code — Sub-county Code — OP/IP No

Facility Name — MFL Code

Name(s) (Three Names) — Date of birth: Day | Month | Year — Male / Female

Contacts (Residence and Phone number) ______

Disabilities (Specify) ______ Marital Status (specify) ______

Orphaned vulnerable child (OVC) Yes / No — Citizenship ______

Date and time of Examination: Day | Month | Year | Hr | Min | AM/PM — Date and Time of Incident: Day | Month | Year | Hr | Min | AM/PM — No. of perpetrators

Alleged perpetrators: Male / Female — Estimated Age ______

Unknown / Known (specify the relationship) ______

Where incident occurred

Administrative location: County ______ Sub-county ______ Landmark ______

Chief complaints: Indicate what is observed ______

Indicate what is reported ______

Circumstances surrounding the incident (survivor account) remember to record penetration (how, where, what was used? Indication of struggle?)

Type of Sexual Violence: Oral / Vaginal / Anal / Other (specify) ______

Use of condom? Yes / No / Unknown

Incident already reported to police? No / Yes (indicate name of police station) ______

Date and time of report: Day | Month | Year | Hr | Min | AM/PM

Attended a health facility before this one? No / Yes (Indicate name of facility) ______ — Date: Day | Month | Year | Hr | Min | AM/PM

Were you treated? Yes / No

Were you given referral notes? Yes / No

Significant medical and/or surgical history

Comments: Indicate additional information provided by the client or observed by clinician

PHYSICAL EXAMINATION [indicates sites and nature of injuries bruises and marks outside the genitalia]

Please use the body map below to indicate injuries, inflammations, marks on various body parts of the surviver

BODY MAP

Anterior View — Posterior view — Comments

Female Genitalia

Male Genitalia

MOH 363

OB/GYN History	Parity	Contraception type	LMP	Known Pregnancy? Yes / No	Date of last consensual sexual intercourse
General Condition	BP	Pulse Rate	RR	Temp	Demeanor /Level of anxiety (calm, not calm)

FORENSIC

Did the survivor change clothes? Yes / No — State of clothes (stains, torn, color, where were the worn clothes taken)?

How were the clothes transported? a) Plastic Bag / b) Non Plastic Bag / c) Other (Give details) ______

Were the clothes handed to the police? Yes / No

Did the survivor go to the toilet? Long call? / Short call?

Did the survivor have a bath or clean themselves? No / Yes (Give details) ______

Did the survivor leave any marks on the perpetrator? No / Yes (Give details) ______

GENITAL EXAMINATION OF THE SURVIVOR-indicate discharges, inflammation, bleeding

Describe in detail the physical status

Physical injuries (mark in the body map) ______

Outer genitalia ______

Vagina ______

Hymen ______

Anus ______

Other significant orifices ______

Comments

Immediate Management	PEP 1st dose	ECP given	Stiching /surgical toilet done	STI treatment given
	No / Yes (No of tablets)	No / Yes	No / Yes(Comment)	No / Yes(Comment)

Any other treatment / Medication given /management?

Referrals to: Police Station / HIV Test / Laboratory / Legal / Trauma Counseling / Safe Shelter / OPD/CCC/HIV Clinic / Other (specify)

LABORATORY SAMPLES	Sample Type	Test	Please tick as is applicable: National government Lab	Health Facility Lab	Comments
	Outer Genital swab	Wet Prep Microscopy			
	Anal swab, Skin swab, Oral swab, Specify	DNA			
		Culture and sensitivity			
	High vaginal swab	Wet Prep Microscopy			
	Urine	Pregnancy Test			
		Microscopy			
		Drugs and alcohol			
		Other			
	Blood	Haemoglobin			
		HIV Test			
		SGPT/GOT			
		VDRL			
		DNA			
	Pubic Hair	DNA			
	Nail clippings	DNA			
	Foreign bodies	DNA			
	Other (specify)				

CHAIN OF CUSTODY

These /All / Some of the samples packed and issued (please specify)

By	Name of Examining Officer (Doctor/Nurse/Clinical officer)	Signature	Day / Month / Year
To	Police Officer's Name	Signature	Day / Month / Year

PSYCHOLOGICAL ASSESSMENT — Complete psychological assessment section in Part B

3.3 Makadara Medico-Legal Form

NAIROBI CITY COUNTY

MAKADARA HEALTH CENTRE
P.O Box :30108
MFL-13056

COUNTY HEALTH SERVICES

SGBV MEDICAL SUMMARY SHEET

(To be filled in duplicate, Based on the medical record)

Confidential document – covered by medical confidentiality

This is to certify that (Name)...D.O.B..living in

....

was examined at MAKADARA HEALTH CENTRE -SGBV Clinic on.......................................*(date)*
At .... *(Time)* at her/ his request.
Medical record attests the following:
....declared to have been a victim of sexual assault
on ....*(date) at(time of assault/violence)* ....

at (*place of assault)*..

by........................ (Number of perpetrator/s) known or unknown persons (Tick as appropriate).

During the consultation, *she/ He* stated that: (*Narration of the survivor)*

1

.... *(Patient's name)* presented the following signs:

Emotional:

On physical examination:

On genital examination: (*External genitalia, Vagina, Hymenal and anal examination*)

Tests performed (particularly samples taken):

Treatment Given:

Certificate drawn on *Date:* /....... /......... and handed personally to the person/Guardian of person involved for all legal purposes.

Examining health worker:

Health care provider's name : .... *Signature:*

Stamp

2

3.4 Provider information sheet and consent form

Study title: Analysing medicolegal approaches to rape survivorship and understanding psychological implications of care provision

You are being invited to take part in a research study by the researchers from the University of Birmingham in England. The study has been approved by the United States International University Africa. Before you decide to participate it is important for you to understand why the research is being done and what it will involve. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. The following is to explain details of the study:

1. What is the purpose of the study?

The purpose of the study is to find out more about how survivors of sexual violence in Kenya access medical and legal services. We are interested in interviewing medical and legal professionals.

2. Why have I been chosen?

You have been asked to participate because you provide medical or legal services to survivors of sexual violence. We are aiming to interview five service providers in each category.

3. Do I have to take part?

It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

4. What will happen to me if I take part?

If you agree to take part in this study, I will ask you to take part in the following activity:

1. If you agree to take part in this study a research team member will interview you.
2. This interview will be approximately 1 hour long.

3. If the interviewer asks any question that you do not feel comfortable answering you may decline to respond.

5. What are the possible disadvantages and risks of taking part?

There are no direct risks associated with being involved in this study.

6. What are the possible benefits of taking part?

If you decide to participate in this study you will play an active role in helping identify possible ways that changes can be made to help sexual violence survivors access care. By participating in this programme you will be helping to improve survivors' wellbeing with no financial cost to you.

7. Will my taking part in the study be kept confidential?

Yes. All information collected about you during the course of the research will be kept strictly confidential. Only people that are involved in this research will have access to your information. All information will be kept in a secure location.

8. What will happen if I don't want to carry on with the study?

You can decide to stop participating in the study at any time, even after we have interviewed you. If you withdraw from the study, you can decide whether you want us to destroy the questionnaire and the information you provided us, or whether you allow us to use these data.

9. What if something goes wrong?

If you have a concern about any aspect of this study, you should ask to speak to my supervisor who will try to answer your questions. If you wish to complain formally, or have any concerns about any aspect of the way you have been treated during the course of this study then you should immediately inform the Investigator ______.

The University of Birmingham holds insurance policies which apply to this study. If you experience harm or injury as a result of taking part in this study, you may be eligible to claim compensation.

10. What will happen to the samples and the results of the research study?

All the data from the interviews and observations will be analysed by researchers working with the University of Birmingham. These results will be used to develop policy recommendations that will be presented to the Kenyan government and NGOs working with survivors of sexual violence.

11. Contact Details

sxr1005@student.bham.ac.uk

You will be given a copy of the information sheet and a signed consent form to keep.

Thank you for considering taking the time to read this sheet.

Consent Form

By singing below, you are agreeing that (1) you have read and understood the Participant information sheet, (2) questions about your participation in this study have been answered and you are satisfied with this, (3) you are aware of any potential risks, (4) you are taking place in this study on a voluntary basis without coercion and you are able to leave the study at any point, and (5) the data will only be used for the purposes of this study, (6) you are only able to withdraw your data up to 10 weeks or the original data collection.

Participant Initials (Printed) *

____

Participant Signature *

____

Date

____

Name of Person Obtaining Consent (Printed)

____

Signature of person Obtaining Consent

____

3.5 Provider Interview Guide

Questions for legal professionals

Can you tell me about your experience working with survivors of sexual violence?
What sort of training did you receive about how to handle sensitive cases?
What has made it difficult for you to assist sexual violence survivors as they move through the legal system?
Can you describe the process you go through when working with a sexual violence survivor?
How do you feel about how the legal system currently handles sexual violence cases?
How does this process affect you?
What do you think is the best way for sexual violence survivors to access and move through the legal system?
Can you tell me about how COVID affected this process? (if relevant)

Questions for medical professionals

Can you tell me about your experience working with survivors of sexual violence?
What sort of training did you receive about how to handle sensitive cases?
What has made it difficult for you to assist sexual violence survivors as they move through the medical system?
Can you describe the process you go through when working with a sexual violence survivor?
How do you feel about how the medical system currently handles sexual violence cases?
How does this process affect you?
What do you think is the best way for sexual violence survivors to access and move through the medical system?
Can you tell me about how COVID affected this process? (if relevant)

Questions for Gender Defenders

Can you tell me about your experience working with survivors of sexual violence?
What sort of training did you receive about how to connect survivors to medical and legal resources?
What has made it difficult for you to assist sexual violence survivors as they move through the medical and legal systems?
Can you describe the process you go through when working with a sexual violence survivor?
How do you feel about how the medical system currently handles sexual violence cases?
How does this process affect you?
If you need help after helping a recent survivor, who do you go to?
What do you think is the best way for sexual violence survivors to access and move through the legal and medical systems?
Can you tell me about how COVID affected this process? (if relevant)

3.6 USIU Ethics

USIU-A/IRB/084-2021

USIU-A Institutional Review Board (IRB)

23rd March, 2021

SARAH ROCKOWITZ,
United States International University-Africa

Dear Sarah,

IRB-RESEARCH APPROVAL.

The USIU-A IRB has reviewed and granted an ethical approval for the research proposal titled **"Analyzing medicolegal approaches to rape survivorship and understanding psychological implications of care provision".**

The approval is for **twelve months** from the date of IRB. A continuing review application must be approved within this interval to avoid expiration of IRB approval and cessation of all research activities. A mid-term report and a final report must be provided to the IRB within the twelve months approval period. All records relating to the research (including signed consent forms) must be retained and available for audit for at least 3 years after the research has ended.

You are advised to follow the approved methodology and report to the IRB any serious, unexpected and related adverse events and potential unanticipated problems involving risks to subjects or others.

Should you or study participants have any queries regarding IRB's consideration of this project, please contact irb@usiu.ac.ke.

Sincerely,

Dr. Juliana Namada,
IRB chair
Tel:
Em

Appendix 4. Survivor

4.1 Survivor Information Sheet and Consent Form

Participant information Sheet and Consent Form - Study one

Project Title
Working Title: Analysing medicolegal approaches to rape survivorship and understanding psychological implications of care provision

Invitation

You are being invited to take part in a research study on gaining a better understanding of sexual violence survivors' experience of seeking services for **post-rape service** provision from providers (e.g., healthcare practitioners, community volunteers, the police) along the case referral pathway. This study will use focus groups and in-depth interviews, in which sexual violence survivors in Kenya discuss their experience of seeking medical care and other services for people who have been sexually violated. We may use the information we learn from the focus groups to develop interview guides to be used with groups of professionals. The outcome of this research is to better understand the experience of survivors when they seek care after a sexual violation.

As a survivor of sexual violence, you are being invited to join in a focus group or in-depth interview with other survivors to discuss the practice and experience of seeking care after a sexual assault. The discussion will mostly be conversational, about your experiences, though some questions or topics may be introduced by the researcher to steer the conversation to the relevant topic.

The focus group is expected to take a one hour and will be recorded on a voice recorder.

Participant Rights

Participation in this study in voluntary and if you decide to leave the study, you can do so at any time without having to give a reason. You have the right to omit or refuse to answer any question that is asked of you. You have the right to have any questions you have about the research

answered and if you have any questions before signing the consent form you may ask the researcher before the study begins.

Between the time of recording the focus group conversation and transcribing the data, we are not able to delete or remove your data alone as the whole focus group is recorded together. However, we will transcribe the recording within 2 weeks of the focus group. From this point onwards until 10 weeks after the focus group, if you choose to withdraw your participation, we will destroy your data and remove it from the transcripts.

Benefits and Risks

There are no known risks of this study. The benefit of this study is that it will inform policy and practitioners as to how better to provide care for rape survivors.

Confidentiality / Anonymity

The researchers involved in the study will be present (either physically or online via video calling) at the focus group or interview that you are attending, therefore you will not be completely anonymous to the researchers at this time. The focus group will be recorded on a voice recorder, and then transcribed. In this transcription, your personally identifiable information, such as your name (or any names discussed in the recording) will be changed for a unique participant ID number or a pseudonym. After transcription, the voice recording will be destroyed.

Once the data have been analysed, it will be stored for at least 10 years on the BEAR datastore, which is a secure central storage service provided University of Birmingham for research data.

Should you disclose something within the focus group that leads the researchers to believe that you or someone else is in serious risk of harm, the researchers have the responsibility to inform the relevant authority as a matter of good professional practice.

For Further Information

Researchers

Wangu Kanja, Founder and Director of the Wangu Kanja Foundation
Email:

Dorothy Njoroge, PhD, Assistant Prof of Communication USIU-A
Email:

Heather Flowe, PhD, Senior Lecturer in Forensic Psychology at the University of Birmingham
Email:

Melissa Colloff, PhD, Lecturer in Forensic Psychology at the University of Birmingham
Email:

Sarah Rockowitz, MSPH, MSc, PhD Student at the University of Birmingham
Email:

Consent Form

By signing below, you are agreeing that (1) you have read and understood the Participant information sheet, (2) questions about your participation in this study have been answered and you are satisfied with this, (3) you are aware of any potential risks, (4) you are taking place in this study on a voluntary basis without coercion and you are able to leave the study at any point, and (5) the data will only be used for the purposes of this study, (6) you are only able to withdraw your data up to 10 weeks or the original data collection.

Participant Initials (Printed) *

____

Participant Signature *

____

Date

____

Name of Person Obtaining Consent (Printed)

____

Signature of person Obtaining Consent

____

**Participants wishing to preserve levels of anonymity* <u>*may use only their initials*</u> *(from the British Psychological Society Guidelines for Minimal Standards of Ethical Approval in Psychological Research)*

4.2 Survivor Interview Guide

Questions for survivors	Andersen's	CIT
What motivated you to seek out healthcare?	Need Intended Use	Motivators
What were the main issues you wanted to be addressed when you were seeking healthcare?	Need Intended Use	Motivators
Can you tell me about an incident where you sought out healthcare after an unwanted sexual experience? - What happened? - Who did you see?	Actual use	Behaviour
How did you find the relationship between you and the providers while you were seeking out care? - Were you treated how you expected to be? - Did they refer you to appropriate services for care?	Actual Use	Consequences
How did the care you received compare to the care you were expecting to receive?	Actual Use	Consequences
What helped or would have helped you get the care you needed?	Enabling Factors	Context
What (if anything) made it difficult for you to receive the care you needed?	Disabling Factors	Context
How did this process affect you?		Consequences
In what ways did using healthcare services for your unwanted sexual experience make a difference to you? OR How would better care have made a difference to you?		Consequences
Can you tell me about how COVID affected this process? (if relevant)		

Appendix 5. COREQ (Consolidated criteria for Reporting Qualitative research) Checklist for Chapter 5

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	**26**
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	**26**
Occupation	3	What was their occupation at the time of the study?	**N/A**
Gender	4	Was the researcher male or female?	**N/A**
Experience and training	5	What experience or training did the researcher have?	**26**
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	**25**
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	**25**
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	**N/A**
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	**11**
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	**26**
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	**25**
Sample size	12	How many participants were in the study?	**26**
Non-participation	13	How many people refused to participate or dropped out? Reasons?	**N/A**
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	**27**
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	**28**
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	**28**
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot	**27**

		tested?	
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	**N/A**
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	**27**
Field notes	20	Were field notes made during and/or after the interview or focus group?	**N/A**
Duration	21	What was the duration of the inter views or focus group?	**28**
Data saturation	22	Was data saturation discussed?	**40**
Transcripts returned	23	Were transcripts returned to participants for comment and/or correction?	**N/A**
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many coders coded the data?	**29**
Description of the coding tree	25	Did authors provide a description of the coding tree?	**29**
Derivation of themes	26	Were themes identified in advance or derived from the data?	**29**
Software	27	What software, if applicable, was used to manage the data?	**28**
Participant checking	28	Did participants provide feedback on the findings?	**N/A**
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? E.g. participant number	**29**
Data and findings consistent	30	Was there consistency between the data presented and the findings?	**29**
Clarity of major themes	31	Were major themes clearly presented in the findings?	**29**
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	**N/A**

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Appendix 6. COREQ (Consolidated criteria for Reporting Qualitative research) Checklist for Chapter 6

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	**49**
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	**26**
Occupation	3	What was their occupation at the time of the study?	**N/A**
Gender	4	Was the researcher male or female?	**N/A**
Experience and training	5	What experience or training did the researcher have?	**26**
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	**25**
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	**49**
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	**49**
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	**51**
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	**50**
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	**50**
Sample size	12	How many participants were in the study?	**50**
Non-participation	13	How many people refused to participate or dropped out? Reasons?	**N/A**
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	**50**
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	**50**
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	**N/A**
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot	**50**

		tested?	
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	**N/A**
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	**51**
Field notes	20	Were field notes made during and/or after the interview or focus group?	**N/A**
Duration	21	What was the duration of the inter views or focus group?	**51**
Data saturation	22	Was data saturation discussed?	**62**
Transcripts returned	23	Were transcripts returned to participants for comment and/or correction?	**N/A**
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many coders coded the data?	**52**
Description of the coding tree	25	Did authors provide a description of the coding tree?	**52**
Derivation of themes	26	Were themes identified in advance or derived from the data?	**52**
Software	27	What software, if applicable, was used to manage the data?	**52**
Participant checking	28	Did participants provide feedback on the findings?	**N/A**
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? E.g. participant number	**53**
Data and findings consistent	30	Was there consistency between the data presented and the findings?	**53**
Clarity of major themes	31	Were major themes clearly presented in the findings?	**53**
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	**N/A**

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357