Sexual Violence: Setting the Research Agenda for Kenya

November 2009

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January 2009

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Sexual Violence in Kenya

The true extent of sexual violence in accordance to the WHO definition is unknown, though varied studies highlight its pervasiveness. The WHO multi-country study[1] on women's health and domestic violence against women, provides the first comparative data across the world and included three African countries: Namibia (the capital), Tanzania (a rural and urban setting) and Ethiopia (a rural setting). According to the WHO multi-country study, between 16% and 59% women from Africa had ever experienced sexual violence from intimate partners. Younger women (<15years) were more likely to report force at first sex (between 18% and 43%). Other studies shows high levels of sexual violence in-country but data is scant. Data from demographic health surveys are limited by a general tendency to under-report.

Sexual violence: '*any physical, psychological or sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances against a person's sexuality using coercion by any person regardless of their relationship with the victim, in any setting, including but not limited to home and work*'
(Krug *et al,* 2002).

No nationally representative data on sexual violence existed until the 2003 Kenya Demographic and Health Survey[2]. In this survey 29% women reported experiencing sexual violence in the year preceding the survey, and the highest proportion is among women aged 20–29 years. Published literature reporting gender based, and particularly sexual violence in Kenya is limited. A survey of domestic violence in Kenya by the Federa-

Kate Holt 2008

tion of Kenya Women Lawyers[3] showed that 51% of women visiting four antenatal clinics in Nairobi reported having been victims of violence at some point in their lives, 65% from their husbands and 22% from strangers. In a study of 324 HIV positive women in Kenya, 19% had experienced violence from their partner[4]. Evidence suggests that adolescent sexual activity is not consensual as is often assumed. A study of 10,000 female secondary school pupils in 1993 found that 24% of the sexually active girls reported experiencing forced sex on their first encounter[5]. There is *"growing evidence that a large share of new cases of HIV infection is due to gender-based violence in homes, schools, the workplace and other social spheres. Not all young people have sex because they want to. In a nationwide study of women 12 – 24 years old, 25% said they lost their virginity because they had been forced*[6]. In a study on contraceptive use among high school students, 9% reported not using a method at last intercourse because they had been forced to have sex[7]. A countrywide study showed that pressure starts at an early age, with 29 per cent of girls and 20 per cent of boys aged 13 years and below reporting one or more episodes of sexual harassment[8].

Kenya's Policy and Legislative Response

The Government has cited sexual violence as an issue of concern in various policy and strategic documents in Kenya: the National Population Advocacy and IEC strategy for Sustainable Development 1996 – 2010[9], the Mainstreaming Gender into the Kenya National HIV/AIDS strategic plan 2000 – 2005[10], The Kenya National HIV/AIDS Strategic Plan II

(KNASPII) 2005 – 2010[11]. Kenya's committment to addressing sexual violence is gaining regional and international recognition. Prevention of sexual violence through legislation, awareness raising and advocacy as well as provision of post sexual violence services in health care, legal representation and rehabilitation has become key.

Policy and legislative framework: The Sexual Offences Act 2006 provided legislation for sexual violence crimes in Kenya. A Sexual Offences Act Implementation Taskforce was set up to provide guidance on multi-disciplinary collaboration in the implementation of the Act and provide a regulatory framework to guide the legislative context. In 2007 the Division of Reproductive Health (DRH) in the Ministry of Health (MoH) constituted and mandated a national post rape care committee. The Reproductive Health policy makes explicit reference to sexual violence.

National standards and protocols: Kenya has National Guidelines on the Medical Management of Sexual violence that sets standards for care. A post-rape care committee is mandated to develop a regulatory framework to scale-up plan quality services including a national monitoring and evaluation system.

Multi-disciplinary collaboration: In addition to the Government convened taskforce, framework, civil society partnerships on issues of sexual violence operate under the 'Komesha Unajisi' (Kiswahili words for stop rape) Network formed in March 2003. The network advocates for social, legislative and policy changes with regard to sexual violence.


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Why Does Kenya Need a Research Agenda?

Kenya like many sub-Saharan African countries experiences the impact of sexual violence in service delivery. However, there exist no population-based surveys to demonstrate or understand the magnitude of the problem and there are few studies on service delivery in the health, justice or community sectors. Advocacy for systematic and consistent engagement, articulation of comprehensive responses and financing for interventions are constrained due to the lack of new knowledge that is methodologically rigorous and sound.

Challenges to research in sexual violence in Kenya

There exists a lack of consistency in study methods, study designs, and analyses of results in sexual violence studies that makes comparison across specific geographical contexts different. Kenya has 42 communities with varied understandings of sexual violence that make research problematic (Kilonzo 2008). The taboo nature of sexual violence and the varied societal responses makes it even more difficult to estimate baseline information though epidemiological data collected in several centres.

Research on service delivery is challenged by limited resources in Kenya. Post rape care services (where available) are provided in a context of competing resources, poor infrastructure, low staff morale, rudimentary training, lack of procedures and protocols and in-availability of confidential spaces for treatment[12,13]. Health

worker attitudes as part of societal attitudes often impact negatively on quality of service delivery. Models for providing care for sexual violence survivors in the health sector are largely from developed countries. This, building evidence is however constrained.

Where evidence is developed, the problematic nature of ensuring research utilization and translating both research and policy into practice is challenged by complexities and context-specific nature of interventions, variability of methods, problems in generalizing study findings across health settings and cultural diversities.

The Research Agenda

This research agenda is the result of a stakeholders' meeting held in Nairobi on June 11-12, 2008 that identified, developed, and prioritized areas for research on sexual violence in Kenya. The meeting was convened by the Population Council, Liverpool VCT, Care & Treatment (LVCT), and the International Centre of Reproductive Health, Kenya (ICRHK).

Kenya's research agenda is premised on the need to generate evidence required to impact on policy formulation and services strengthening. Knowledge gaps that form the basis of five key research areas identified include the need to:

1. Understand the nature, contexts and prevalence of sexual violence.

2. Document and evaluate prevention initiatives from national to grassroots and spanning legislation, advocacy and community interventions to identify replicable and scalable interventions

3. Research innovative ways to improve access to, uptake and delivery of quality sexual violence care, treatment and rehabilitation services for men and women in Kenya.

4. Improve knowledge on sexual violence focusing on priority populations with higher risk and vulnerability towards sexual violence.

I Understanding the nature, contexts and prevalence of sexual violence

Given the lack of population based data on sexual violence, policy engagement in prevention, care and rehabilitation is challenging. In addition to epidemiological and prevalence data required, there is need for improving current knowledge on forms, prevalence, contexts of sexual violence. A range of forms of gender based violence cited in Kenya's grey literature such as intimate partner violence, trafficking, forced sex work and incest there remains limited knowledge on the manifestations, risk factors and vulnerabilities and characteristics to better inform interventions.

Rationale for further research: There is a lack of population based data on sexual violence. Knowledge on prevalence, forms, contexts, expressions and responses is lacking. The *conceptual understanding* of the individual, community and structural drivers of perpetration and victimization in Kenya, the impact on social, political and economic aspects of livelihoods, societal responses and their impact on prevention, care and treatment interventions is diverse among stakeholders engaged in responses.

***Priority research questions*:**

1. What is the prevalence of sexual violence in Kenya?

It is difficult to compare most international prevalence data on violence because different methods have been used to obtain them. Researchers face two major challenges in obtaining accurate prevalence data: how to define "abuse" and how to determine the study population. A further complication is that surveys measure the number of survivors willing to disclose abuse rather than actual numbers abused. This can bias prevalence data often prone to under reporting.

2. What are the perceptions of sexual violence in Kenyan communities and how do these affect responses?

    a. What definitions of sexual violence exist? What acts are considered sexual violence? To whom and how are they responded to?
    b. What cultural norms exist in various areas in Kenya? How do they impact on sexual violence perpetration and victimization?

Notes: Research on cultural norms takes researchers into the nuances of definitions of violence. An etic (externally derived definition) facilitates comparisons across different groups of survivors over an emic (relying on survivors definitions of abuse) approach that is subjective as it is based on survivors perceptions of violence. Complementing these two approaches may be optimal as it allows comparisons across settings and to other women's perceptions of their experience.

Possible study designs: Population-based surveys; ethnographic studies; longitudinal behavioural designs.

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II Documenting and evaluating prevention initiatives

The source and prevention of gender-based violence, in large part, rests within communities. However, often communities are forgotten or ignored in responding to sexual violence. A range of prevention interventions have been undertaken in Kenya. Prevention efforts span national interventions by the Sexual Offences Act Implementation Taskforce that aims to impact on justice and therefore enhance prevention, the development of the gender based violence framework by the National Commission on Gender and Development and efforts of the Justice, Order and Law Reform Sector. A range of grassroots prevention interventions led by the civil society includes advocacy and community interventions. Data demonstrates that community interventions are most successful where they aim to be tranformatory, utilize community knowledge and resources and harness community capacities for socal change. These are long-term, heavy investment processes.

***Rationale for further research*:** Many of these interventions are often undocumented and remain un-evaluated. They are undertaken in concentrated populations, often those identified by programmers as vulnerable or in specified geographical areas. Further, with the limited understanding of societal responses and the extent and nature of survivors needs these prevention efforts are not based on evidence. These factors mean that prevention interventions are not well understood in Kenya, are sporadic and therefore often un-coordinated, promising practices are not reviewed for replicability or scalability.

Priority research questions:

1. What advocacy messages and community interventions and approaches impact positively on a change in community attitudes towards intolerance for violence and increase service uptake?

    a. What messaging is required and how should messages be delivered?
    b. What are the most appropriate channels of communication?
    c. What the interventions work best with which sections of the community? How should they be structured?
    d. What are the minimum components in information and methodology for interventions?

Possible study designs: Participatory appraisals; Ethnographic studies; o peration research that evaluate interventions.

III Researching innovative ways to improve access to, uptake and delivery of quality sexual violence care, treatment and rehabilitation services

Health care services:

Access to, utilization and delivery of quality services requires multi-sectoral collaboration between communities, the legal sector and the health sector. In Kenya, three models for health care service delivery include: 'one-stop centres', semi-integrated gender violence recovery centres in public facilities that offer both health care and basic legal services and 'integrated' services that offer health services integrated into the operations of a public health facility. These models all serve specific geographic locations adequately. Health sector gains have been facilitated by the development of national


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service delivery guidelines, a standardized training curriculum and the implementation of a regulatory framework, with post rape care indicators as part of national reporting requirements.

***Rationale for further research*:** While service scale up is on-going in Kenya, there has been no evaluation of the one-stop models or the semi-integrated models. Scale up of the integrated services is also not yet evaluated and further complicated by the increasing numbers of primary referral facilities, many of which are up-graded health centres and lack the rudimentary facilities to offer comprehensive care. Actual on-the-ground translation of policy into practice has been challenging. There are fewer gains in the legal and social services. There is limited understanding of the predictors, variables and factors impacting on service access, uptake and utilization and delivery in the various models and across the different sectors. There is need to understand and document what models are promising and what is needed to make sexual violence interventions more effective, scalable, comprehensive and, ultimately sustainable.

Priority research questions:

1. What are the minimum standards, measures for and indicators of success of models for service delivery? experiences in service uptake and delivery?

    a. What are the experiences, gaps and successes in service uptake and delivery?
    b. What client, programme and system attributes impact on service uptake and quality of services delivered?
    c. What indicators for service access, utilization and quality of services are required in successful models of service delivery?

2. What is the optimal medical and counseling care, and follow-up mechanisms required to optimize on reproductive health outcomes and short and long-term HIV prevention, care and treatment in public health settings?

    a. What services are required for management of unwanted pregnancies and long-term reproductive health consequences?

    b. What is the baseline HIV risk among survivors? What information and services are required for PEP adherence and management survivor retention in the health system, and long-term HIV prevention?

***Possible study designs*:** Operational research testing service delivery models; exploratory studies on client and programme attributes; observational studies on reproductive health and HIV outcomes to inform services; evaluation studies of existing models.

Psycho-social care services:

For survivors of violence the psychological consequences of abuse and coercion can be even more serious than its physical effects. Across the world it has been shown that the experience of abuse can erode self-esteem and if untreated can trigger a variety of mental health problems including but not limited to anxiety, depression, phobias, post-traumatic stress disorder, alcohol and drug abuse and high risk sexual behaviors. Women and children respond to violence in different ways and understanding the immediate, medium and long term psychological effects of violence is essential.

***Rationale for further research*:** There has been limited research on the mental health outcomes of sexual violence for survivors and the consequences for their partners and families in Kenya. In the context of scale up of trauma support services, there is limited knowledge on the mental health and social needs and requirements of survivors, factors that impact on recovery and the long-term outcomes. This also means that these needs are unmet for survivors and that the justice system does not have the capacity or mechanisms to utilize psycho-social consequences to impact on justice outcomes.

***Priority research questions*:**

1. What are the mental health outcomes among survivors, their families and providers?
2. What are the optimal psycho-social interventions in frequency, time, type, and information required for survivors to respond to their mental, reproductive health, HIV and justice system outcomes?
    a. What psycho-social health services are required? What are the minimum standards necessary for these outcomes?
    b. How best can psycho-socail interventions respond to the sexual and reproductive health counseling and service needs (including abortion and post abortal care), HIV prevention and care among survivors?
    c. What models are required to effectively integrate psycho-social care and medical care for short and long-term treatment?

***Possible study designs*:** Longitudinal experimental studies among survivors that evaluate psycho-social interventions within facilities and home settings; longitudinal observational designs to study mental health outcomes; operational research that involves comparative intervention designs.

Legal and justice services

Efficient and timely referrals between entities within the criminal justice system including the police, prosecution and courts of law is required. Further, the nature of sexual violence requires multi-prong approach weaving through the justice system and health system. Medico-legal linkages are anchored on the chain of evidence which refers to the process of obtaining, preserving and conveying evidence through accountable tracking mechanisms from the health facility, through the police and finally as evidence admissible in court.

Rationale for further research: The sexual offences implementation act taskforce has developed rules and regulations for implementation of the Act. Attempts at multi-sectoral collaboration are primarily between the Division of Reproductive Heath in the Ministry of Public Health and Sanitation and the sexual offences act implementation taskforce. However, these still lack a clear operational and implementation framework. The role and impact of these rules and regulations, the proposed and currently utilized operational tools and guidance for investigation, prosecution and sentencing and for strengthened medico-legal linkages on the primary outcome of justice is unknown. The needs and experiences of survivors within the criminal justice system and the impact of these on ability to seek justice is unknown.

***Priority research questions*:**

1. What is the impact of the Sexual Offences Act implementation on justice?
    a. How effective are the SOA's mandatory minimums for increased reporting, perpetrator rehabilitation, and securing convictions?
    b. What evidence has optimal impact on convictions? How best should this evidence be delivered and by whom?
    c. How effective is the PRC1 Form in securing prosecutions?
2. What are survivors needs and experiences of survivors within the criminal justice system and the impact of these on ability to seek justice and future perpetration or victimization?

***Possible study designs*:** Record reviews within the medical and criminal justice system; formative studies among survivors and service providers (including police and medical) and their experiences with the legal system.

IV Improving knowledge on vulnerable and priority populations

On populations noted as especially vulnerable to sexual violence in Kenya is children. There is increased reporting and presentation of sexual violence among children in Kenya. Populations whose behavioural characteristics place them at increased risk of sexual violence such as sex workers and men who have sex with men also experience marginalization and stigma embedded in Kenya's legal frameworks and social contexts. Although increased reporting and evidence suggests sexual violence against men (Njue 2005 -220) exists and associations between male victimization and later life

perpetration have been made, there is limited knowledge about sexual violence against men in Kenya. People with disabilities are at more risk of sexual violence.

Rationale for further research: In Kenya there exists no nationally representative data on sexual violence against children or any vulnerable populations. The prevalence, forms and contexts of violence are not known with specific risk and vulnerability factors being poorly understood. Interventions are often focused on general populations with no cognizance of the specificities of increased vulnerabilities particularly among children. Where interventions have been initiated such as gender desks at police stations, these are sporadic, poorly staffed with in-consistent procedures. Service needs for child survivors in all sectors – community, legal, health and social services are poorly understood often being crafted out of adult services.

***Priority research questions*:**

1. What is the prevalence of sexual violence among children in Kenya?
    a. What factors impact on the vulnerability of children to sexual violence?
    b. What attitudes and specific societal responses exist towards child sexual violence?
2. What are the priorities for responding to short-term and long-term health, legal care, psychosocial needs and rehabilitation for child survivors?

***Possible study designs*:** Population-based surveys; community-wide participatory appraisals


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Building National Capacity for Research in Sexual Violence

A primary part of the research agenda is exploring opportunities for building national capacity for research on sexual violence, effective utilization of research for policy reforms and translation of research results into programming. This requires building strategic alliances among researchers and academics, politicians, technocrats, service providers, activists and effective coalition building through local, national, regional and international consortiums.

Building capacity requires finances. Kenya lacks literature on costs of sexual violence and cost effectiveness of any interventions – behavioural, social, legal, health care or rehabilitative. There are no available studies either published in peer-reviewed journals or as grey literature in Kenya on costs of sexual violence. A costing study by the Division of Reproductive Health focuses on costs for scaling up health care services within the integrated system and l ong-term sustainable funding for research as a basis for informing services is required.


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Conclusion

Setting a research agenda is a first important step towards documenting the extent of sexual violence in Kenya as a premise for evidence informed programming, policy reforms advocacy and resources mobilization. With effectively focused research it is hoped that Kenya will produce powerful synergies from partnerships between researchers and community members, service providers, policy makers and advocates. Undertaking a coherent research agenda and building capacity for on-going research will encourage inter-sectoral and multi-disciplinary collaboration with delivery of information in the principles of scientific inquiry. The challenge then, will be to coordinate the delivery of important evidence and scientific information among technocrats, programme planners and advocates to ultimately engineer effective social change in Kenya.


kate Holt 2009

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