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Original Article

Factors Affecting Utilization of Healthcare and Legal Services by Domestic Violence Survivors in Kibra Sub-County, Nairobi City County, Kenya

Pamela Karimi[1], Prof. Grace Wamue-Ngare, PhD[1] & Dr. Grace Okongo Bonareri, PhD[1]*

[1] Kenyatta University, P. O. Box 43844-00100, Nairobi, Kenya.
[*] Correspondence ORCID ID: https://orcid.org/0000-0002-0687-6180; Email karimipamela27@gmail.com

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ABSTRACT

Domestic violence is a criminal offense and a violation of fundamental human rights as provided in the Kenya Penal Code, the Sexual offences Act 2006, and the Constitution 2010 among other legal frameworks at the international, regional, and national level. Given the profound health impact and the link between abuse severity and the well-being of the survivors over time, coupled with the need to enhance protection and legal support, healthcare and legal services are critical in domestic violence management. Using Public enforcement of law theory, this paper posits that government agents for instance healthcare providers, chiefs, police, and prosecutors can detect and sanction violators of law, thereby preventing and responding to domestic violence crimes. The theory further argues that survivors hold primary information and can only provide it if they perceive the justice system as helpful. Legal and healthcare service providers are essential in assisting domestic violence survivors because of their complementary roles. Using a mixed methods descriptive survey design, this paper highlights factors that affect utilization of healthcare and legal services by domestic violence survivors in Kibra Sub-County, Nairobi City County, Kenya.

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INTRODUCTION

Domestic violence (DV) is one of the prominent forms of Gender Based Violence (GBV) and results in physical and psychological harm or suffering to the victims. It includes acts that inflict physical, sexual, or psychological harm or suffering, threats of such acts, coercion and other deprivations of liberty occurring within the home, typically involving the violent abuse of a spouse or partner. Domestic violence is defined along the lines of sexual orientation; hence it can occur in same-sex or heterosexual relationships (United Nations High Commissioner for Refugees 2011).

Although under-reported, domestic violence is prevalent in Kenya. The Kenya Domestic Household Survey (KDHS) 2014 indicates that 38% of women and 9% of men aged 15–49 reported physical violence, and 14% of women and 4% of men reported having experienced sexual violence committed by a spouse/partner. In 2017, 784 cases of rape, 3487 cases of defilement, 287 cases of incest, 107 cases of sodomy, and 245 cases of indecent assault were reported (Kenya Crime and Safety Report, 2017). Although domestic violence affects both men and women, women and girls are disproportionately burdened. According to Crime Research Centre 2020, 71/% of the cases reported between January and June 2020, the victims were females, and the main perpetrators were youthful males aged between 18-33 years who were in a family or intimate partner relationship. It is challenging to estimate the actual incidence of domestic violence because it is a hidden and invisible problem. Consequently, it goes on largely unrecognized, unreported, and unpunished, and therefore, continues unabated.

Existing service delivery models largely serve emergency rape or sexual assault needs and overlook care for more chronic forms of violence, such as domestic violence. One-stop centres, which have become increasingly popular in East and Southern Africa, including in Kenya, rarely provide the complete range of medico-legal and psychosocial services, and are not considered financially sustainable given that 90% of such centres depend on external donor funding (HECTA Consulting, 2016).

Effective management of domestic violence require that adequate referral systems are in place, which can be a challenge for resource-constrained contexts. In view of this, synergy through a coordinated approach by healthcare and legal service providers is important in enhancing effective service delivery.

This paper assesses factors that affect utilization of healthcare and legal services by domestic violence survivors in Kibra sub-county.

METHODS AND MATERIALS

The study used a descriptive mixed-methods survey approach. The study area was purposefully selected due to various reasons. It is an area with very high crime rates with frequent reports of electoral related violence, gender-based violence, and child defilement. It is also largely an informal settlement

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characterized by low-income population. This is related to capacity to access healthcare and legal services given many other needs households are required to meet for their livelihoods.

The target population comprised survivors of DV residing in Kibra Sub-County who had sought legal and healthcare services.

Domestic violence survivors were selected through simple random sampling. Their data was obtained from Kenya Health Information Software (KHIS) between 2018 and 2020. This sampling method was ideal as it allowed each survivor. According to (KHIS), the number of survivors accessing health services within Kibra Sub County was 218 in 2018,234 in 2019, and 93 in the first six months of 2020; thus, the total number of survivors accessed through KHIS was 545. These numbers only account for a small portion of the far more cases that go unreported and investigated. Moreover, there exist different reporting avenues that are not always linked to KHIS, hence leaving a huge chunk of data undocumented in KHIS.

According to Mugenda and Mugenda (2013), when the study population is less than 10 000, a sample size of between 10% and 30% is a good representation of the target population, and hence 10% is adequate for analysis. Therefore, 54 survivors (545 x 0.1) were considered sufficient for this study.

Key informants were purposively selected from health facilities, police stations, court, and local administration office where survivors sought services. Respondents included both men and women totalling 61.

Triangulation of the findings from qualitative and quantitative methods enriched the study and enabled the researcher to detect dishonesty, guesswork, and ignorance among the respondents. Interview schedules and questionnaires were used to collect data, ensuring cross-examining findings.

The study achieved a high level of reliability by retesting the research instruments during the pilot study. The researcher ensured that questions were designed and presented in the simplest way possible to ensure consistency in the responses. We did not do Cronbach's alpha test for reliability because the tools were not geared to test internal consistency.

Data was collected using self-administered questionnaires and interview guides. In addition, Key informant interviews were conducted with clinicians/doctors, police officers, office of the director of public prosecution and chiefs. Secondary sources were also used. Observation helped to identify non-verbal communication such as body language and tone variation resulting from the emotions of the respondents. All the data collected were adequately checked for completeness, and were analysed both qualitatively and quantitatively.

RESULTS AND DISCUSSIONS

Before discussing factors that affect utilization of healthcare and legal services by domestic violence survivors in Kibra, the study analysed their demographic characteristics.

Demographic Information

Gender

Previous studies show that while both genders are affected by domestic violence, women and girls are more vulnerable. According to KDHS (2014), 38% of women and 9% of men aged 15–49 reported physical violence, 14% of women 4% of men committed by a spouse or romantic partner. It was therefore, necessary to consider the survivors gender to determine who was more affected or otherwise reported such violations. 33 of the respondents were females constituting (86.8%) and five males (13.2%). This implies that more women than men were affected or rather reported violence. This is corroborated by KDHS (2014) data highlighted earlier.

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Age Distribution

Age was also considered because it is related to individual knowledge on reporting, health-seeking behaviour, and decisions to leave an abusive relationship. This varied across several cohorts. Findings indicated that the middle-aged (31-40) and younger (18-30) population were the highest proportions among the respondents reporting domestic violence at 39.5% and 31.6% respectively. About a fifth of the respondents (21%) were aged 41-50 and those 51 and above were 7.9%. It is evident from these findings that, younger population are more likely than their older counterparts to report domestic violence.

Marital Status

Marital status of respondents was considered important, with the assumption that there is a relationship between one's marital status and reporting domestic violence due to factors such autonomy and dependence on the abuser for sustenance.

Results showed that majority (34.2%) of the respondents were single, (23.7%) separated, (18.4%) widowed, and (13.2%) divorced. The findings also indicated that (7.9%) of the respondents were married, while (2.6%) did not disclose their status. This reality simply reflects the fact that single people are less limited by social and cultural standards and can disclose the abuse they experience. Most married women do not disclose abuse because they feel pressure from their families to maintain the "family image," but some do not speak up because they are dependent on the abuser This can be corroborated with findings from a study conducted by NHCR (2017) that found out that accepting abuse as a "private matter" frequently discourages others from getting involved and stops girls and young women from reporting it.

Education Levels

Education is linked to self-awareness and the ability to promptly seek services when the violation of rights happens and, in this case, domestic violence, a criminal offense in Kenya. The World Bank (2004) has also emphasized the significance of education in promoting gender equality, noting that low levels, particularly among women, severely impede development in most Sub-Saharan countries, including Kenya. At the individual level, for instance, education is viewed as the ultimate liberator that gives a person the power to make decisions regarding their own lives and those of others (World Bank, 2004).

Results from the study showed that, 31.6% of the respondents had attained secondary education, 23.7% primary, 21% post-secondary education, 18.4% had no formal education, while only 5.3% had tertiary education. The respondent's education showed that most survivors were secondary schooled, thus considered to know their rights and able to report violence. On the contrary, the relatively small proportion with lower education or no education could indicate that this group had accepted violence for one reason or another or were less aware of avenues for seeking help.

Occupation

Studies have shown that a survivor's access to and utilization of existing healthcare and legal services is influenced by several factors. These include the ability to afford legal services, medical expenses, and transport costs (United Nations Population Fund, 2008).

Findings indicated that the highest percentage of the respondents (39.5%) were casual laborers, 21% were unemployed, 18.5% were small business owners and, (15.8%) were employed in the private sector. Government employees were 2.6% and 2.6% did not disclose. Most respondents were involved in some form of economic activity supporting their livelihoods. Observably, these were temporary

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menial jobs. It is important to mention that survivors are commonly faced with the challenges of choosing whether to seek healthcare and legal services at the expense of basic needs in the household. Consequently, many of them suffer in silence as they cannot afford the services.

Utilization of Healthcare and Legal Services by Domestic Violence Survivors

The study explored five factors that affected the willingness and ability of domestic violence survivors to report violence and gain access to the services they require. These factors are; accessibility, affordability, timeliness, levels of awareness, and gender responsiveness.

Accessibility was defined by geographical distance, availability of infrastructure, resources, and human capacity. Affordability was measured by costing some of the services vis-a-vis average daily earnings of the domestic violence survivors. Timeliness was determined by the amount of time a survivor took to navigate the referral systems from reporting of the incident to conviction of the offence. Levels of awareness were defined by; first, survivors' awareness of healthcare and legal services and secondly, service providers' awareness of existing protocols and guidelines for addressing domestic violence from a policy level. Finally, gender responsiveness was defined by how equitable services were to both male and female survivors. Each of these factors are discussed below.

Accessibility of Services

This was looked at in three ways; distance from home/scene of the crime to the nearest health facility or police station, availability of necessary infrastructure, and human capacity at the facilities.

Average Distance from Home to a Health/ Legal Facility

The study found out that 7.9% of survivors covered between 500 m to 1 km from their home to the nearest health/legal facility, 44.7% covered 1-3 km, 31.6% 3.5 km, and 15.8% over 5 km. Most of respondents did not express distance as a major challenge because of a variety of means of transport available to them including motorbike/'boda-boda'. However, it is worth noting, the time burden and opportunity costs associated with delays in accessing services, medical examinations, filing fees, and expenses for witnesses (UNFPA 2008).

The direct costs of accessing services, such as transport costs and time foregone in productive activities, indicate an enormous social and economic burden to the survivors, their families, and society.

Availability of Infrastructure, Resources, and Human Capacity

All interviewed service providers noted a lack of adequate resources. Hospitals missed adequate ambulances for emergencies and referrals to other facilities, and police also noted shortages, including insufficient funds for daily office operations. A key informant noted;

> *"We lack funds for investigations. Physical follow-ups on cases are hindered by a lack of money for fuel and supplies, collection of forensic evidence and the provision of counselling throughout the process is also affected"* (KII, Police Officer, Kibra).

The study found that, service providers lacked adequate office equipment and supplies, with needs ranging from computers for data entry and sharing to missing essential supplies for collection (GBV kits) and submission of forensic evidence (such as envelopes to preserve and submit physical evidence). A healthcare worker intimated;

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> *"Even some major health facilities are struggling with inadequate equipment and supplies to collect, store and transfer forensic evidence, or to provide primary care"* (KII, health officer, Kibra).

Virtually all the facilities included in the study were missing crucial infrastructure; healthcare facilities lacked sufficient facilities and rooms to ensure privacy and quality care for different cases. Police stations also often lacked sufficient rooms for privacy and domestic violence-specific services, and adequate cells for custody. As a result of their shortcomings, survivors were unable to get comprehensive services. Additionally, inadequate service infrastructure and resources, such as staff shortages, resulted in shortened or restricted operating hours for facilities, with night-time operations in particular suffering; A respondent explained;

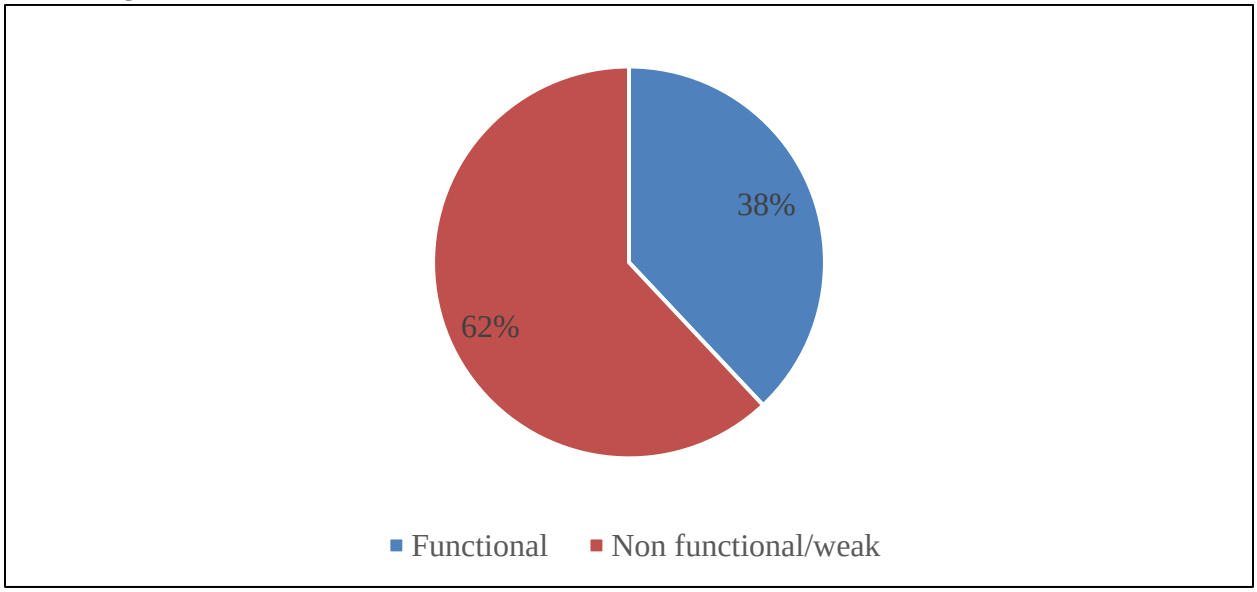
> *"Violence mostly happens at night, and there is no means of transport…"* (KII, health facility manager, Kibra).

Related to this, inadequate support for medical practitioners compelled them to work without nurses and records officers, which led to multitasking resulting in medical practitioners conducting administrative and various operational duties. This most often results in a lack of consistency in handling these cases. A health care worker noted;

> *"Some of the challenges affecting us in support for survivors of gender-based violence are inadequate personnel including support staff leading to burnouts"* (KII, health officer, Kibra).

Against this backdrop, there are several issues where respondents felt that progress had been made over the last few years. For example, access to GBV services is being facilitated by referral structures among the health care system, and police gender desks for reporting are available at the sub-county level. Data in Figure 1 explains the scenario.

Figure 1: Perceptions by domestic violence survivors about the functionality of referral systems in the management of domestic violence cases



While some respondents (38%) assessed referral structures to be functional, most (62%) said there is a weak or a lack of an organized referral network structure, with many services appearing 'scattered'

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and uncoordinated. For example, there are several entry points to initially report and obtain access to referrals for and services, but there does not seem to be a consistent structure. In this regard, a healthcare service provider indicated that;

> *"In this area, Community health volunteers (CHVs) and chiefs are often the first point of contact for domestic violence issues; although cases are also first reported to the local police or area advisory council, then escalated to different stakeholders, such as village elders, the police, or peace committee who then individually or together decide which hospital a client should be taken to, and who will undertake the follow-up"* (KII, health officer, Kibra).

The study noted that the referral pathways in place are complex and hard to navigate by survivors. This can be observed in different understandings of what the structure is supposed to be like. Many potential ways of reporting and then requiring different referrals, and a widespread perception that the process can be laborious and circular. Some accounts of clients getting 'lost' or failing to keep track of clients while navigating different systems of service provision.

Secondly, the requirement for survivors who report domestic violence to obtain a P3 form is not clear among the community members in Kibra. They are permitted by law to seek treatment at any nearby facility that provides GBV services without first making a police report (National Guidelines on Management of Sexual Violence [NGMSV], 2014). However, a widespread belief in the community is that the survivor should report to the police to obtain a P3 before receiving medical care. This is proving difficult given tedious referral pathways in pursuit of legal help. More so, survivors have reportedly faced, for example, offensive comments that limit their willingness to approach the police.

In view of the above, several key areas could be improved, both in terms of filling gaps and improving existing services. The key factors hampering accessibility of services are related to a lack of staff, inadequate resources, infrastructure, and poor coordination amongst service providers.

Affordability

Poverty and inability to pay for services are serious barriers to reporting violence and utilization of healthcare and legal services. This in turn, affects survivors' health outcomes and freedom to live free from violence. This is particularly the case for low-income people who often face trade-offs between seeking services and other essential items, and women who are often financially dependent on their husbands/significant other.

Affordability was defined by looking at respondents' average monthly earnings vis-a-vis the cost of services. It should be noted that there seems to be a lack of clarity and information around which services should be provided for free, which explains differing accounts of users and providers. Apart from P3 [1] and emergency contraception, which are both free for survivors of sexual violence (National Guidelines Ministry of Health, 2014a), no documentation has been found that provides information on what costs to expect for which kind of service.

This study used the costing study of GBV survivors by National Gender and Equality Commission [NGEC] (2016) which estimates the average cost of medical-related expenses per survivor and family amounted to KES 16,464; reporting the incident to the chief and community structures costs KES 3,111; reporting to police cost KES 3,756.

[1] A P3 form is a document issued by the police in case of an injury is used to request for medical examination by a Medical Officer of Health, in order to determine the nature and extent of the bodily injury sustained by a complainant(s) in assault cases

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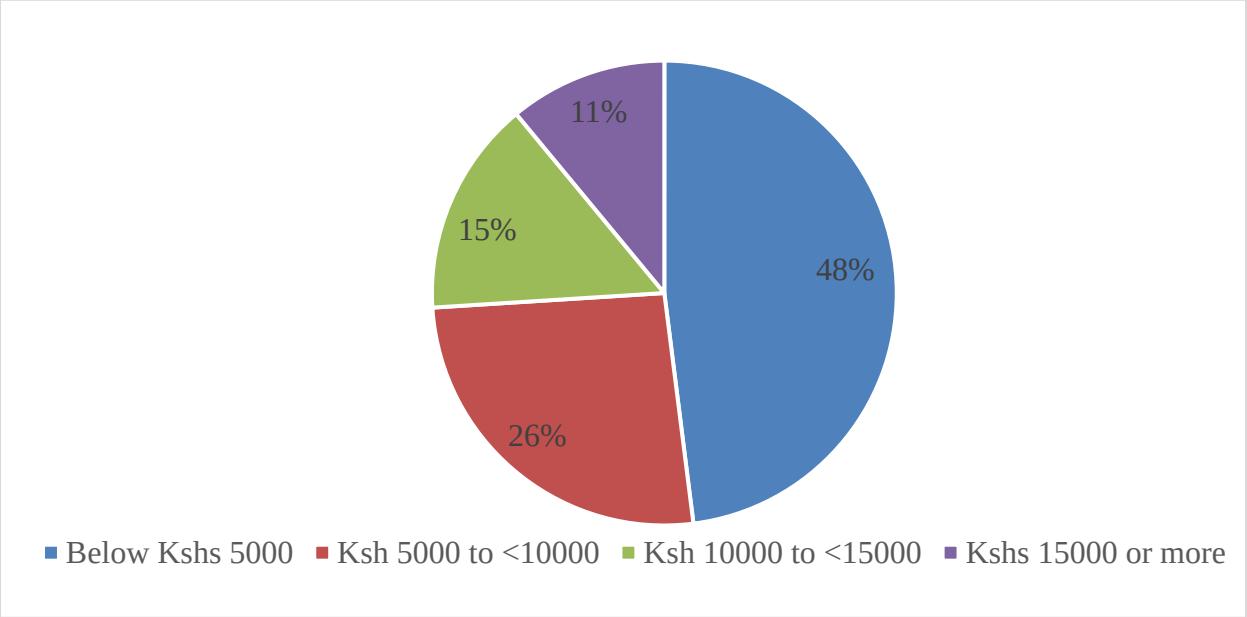
Productivity loss from serious injuries amounted to KES 223,476; productivity loss from minor injuries was KES 18,623; and productivity loss from premature mortality from GBV amounted to KES 5,840,664. The weighted cost of GBV incidents per survivor and family was estimated at KES 24,797 annually. It is worth noting that these costs could have gone higher over the years, further impoverishing survivors and their families. Cognizant of the economic status of the respondents, as observed earlier on the respondents' occupation, where a majority (39.5%) were casual laborers and (21%) unemployed/without any source of income, utilization of health and legal services could be negatively impacted. Average earnings of survivors are shown in *Figure 2* below.

Figure 2: Average monthly income among DV survivors in Kibra



48% of domestic violence survivors monthly earnings on average was below KES 5,000. 26% KES 5,000-10,000, 15% KES 10,000-15,000 and 11% earn income above KES 15,000 per month. Given that majority (48%) of the domestic violence survivors in Kibra earn less than 5000 per month, it is not sufficient to cater to their household expenditure and support them in case of a domestic violence incident. As noted earlier, the weighted annual cost of a GBV incidents is Kshs 24,797 per family (~2066 which, is equivalent to USD 20 per month), a cost over a third of their monthly income. The cost is prohibitive for them accessing the needed services.

Noteworthy is the fact that, in case of rape or defilement, prevention of unwanted pregnancies and emergency treatment for STI's and HIV is time bound, generally within 72 hours (NGMSV, 2014), and therefore inability of a survivor to seek timely medical attention for one reason or another could be detrimental to their health.

On the other hand, the cost of legal services was prohibitive for the survivors. A key informant, for example, noted that cases took too long to finalize because of numerous adjournment requests that the courts allowed making them incur more cost to cater for several travels to the courts, and other cases were dismissed due to lack of evidence;

> *"The expenses associated with the numerous visits to court are prohibitive for survivors and witnesses. It becomes expensive to conclude the cases for survivors who sometimes must pay their witnesses to get to court. This may result*

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> *in witnesses not attending to give evidence, thus contributing to cases being dismissed"* (KII, prosecutor, Kibera law courts, Kibra).

Additionally, there is a lack of clarity and consistency in the charging of fees. For example, survivors are charged up to 1000 Kenyan Shillings for the filing of legal forms (P3[2]) forms at the police or hospital;

> *"I was asked for KES 1000 fees at the hospital for examination"* (Domestic violence Survivor, Kibra).

This inconsistency leads to a lack of accountability on the service provider's side, while breeding corrupt practices and imposing an enormous economic burden on the survivors.

The study noted, that fear of economic insecurity was a factor that inhibited reporting of domestic violence in the study area. Women financially dependent on their husbands often fear the potential social or economic consequences of reporting their husbands to authorities, including being left without financial support. It appears that perpetrators are aware of this risk, as violence in these scenarios is often more severe;

> *"Those who have low income, or the poor are the ones who experience most violence because the perpetrator is mostly the breadwinner"* (KII, police officer, Kibra).

They also fear that one's husbands would go to jail. A sub-county level prosecutor in Kibra outlined how even when women seek services for domestic violence cases, they want to limit the severity of legal consequences for their husbands. When they understand the full repercussions of reporting, they proceed to ask for reconciliation rather than wanting an arrest.

This may be due to a fear of losing the family's primary income sources, children losing access to their father, or a generalized fear of the legal system and what happens once someone has been arrested and jailed.

It is important to underscore that management of domestic violence depends mainly on adequate and functional referral systems. The study observed that costs associated with accessing different services within the referral system were quite restrictive to the survivors.

A key informant elaborated;

> *"Referral of survivors from pro-bono to health to legal or police services pose a challenge – once fees are involved (i.e., transitioning from free government-provided services to those services incurring a fee), clients often drop out of the system due to lack of funds"* (KII, prosecutor Kibera law courts, Kibra).

From the above discussion, it is evident that the respondent's income level determines the affordability of domestic violence-related healthcare and legal services in Kibra sub-county.

It is important to note that development partners provide more than 90% of the funding for GBV services (NGEC, 2016). This raises the risk of placing an undue reliance on donor funding, which may be insufficient or inconsistent.

Timeliness

Findings on the length of time it took for respondents to access services at the police station reveal that 27.5% of respondents were seen within 10 and 30 minutes, 37.5% within an hour, and 35% for longer than an hour. According to the national

[2] A P3 form is a document issued by the police in case of an injury is used to request for medical examination by a Medical Officer of Health, in order to determine the nature and extent of the bodily injury sustained by a complainant(s) in assault cases

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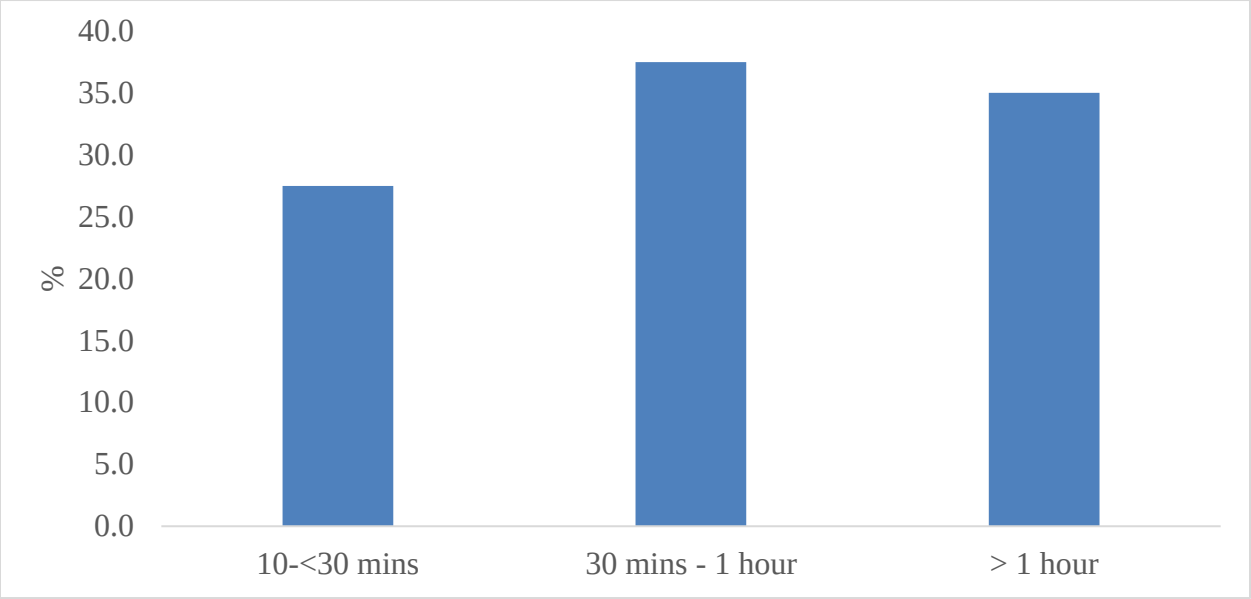
police service delivery charter (2015), any reported case should be addressed within the first 15 minutes.

Figure 3: Average time taken to access service by the domestic violence survivor at a legal facility



Our findings show that most of the respondents received services after waiting for over half an hour, contrary to what the service charter stipulates. The more time the respondents waited before they were served, the more they became dissatisfied with the operations at the police station. a domestic violence survivor in Kibra lamented that;

> *"When I went to report the abuse, I was told to wait as the officers handled a group of suspects who were brought in having been arrested taking illicit brew. I waited from 10:00 a.m. up to noon. I was told to come at 2.00 p.m. because the officer in charge had been summoned to court. My statements were taken at 3.00 p.m., I and had to come and follow up on the case the following day. I was so disappointed..."* (Domestic violence Survivor, Kibra).

The likelihood of collecting evidence decreases with time. For instance, National Police Service Standard Operating Procedures for Prevention and Response to Gender-Based Violence stipulates that the specimen should be collected within 24 hours after the assault.

Conversely, the time spent (often in days) in accessing justice is inhibitory to survivors and their families. For instance, the process of obtaining prosecution documents (P3[3] and PRC[4] forms) and having them filled after examination by a medical practitioner sometimes contributes to affected survivors losing the motivation to pursue justice (Shako and Kalsi, 2019). The delay is attributed to the complex referral pathways that include various visits to the hospital, police, prosecution, and court visits. These visits are physically and financially draining and often lead to lethargy, resulting in

[3] A P3 form is a document issued by the police in case of an injury is used to request for medical examination by a Medical Officer of Health, in order to determine the nature and extent of the bodily injury sustained by a complainant(s) in assault cases

[4] Post-rape care form is a Ministry of Health Register (MOH 363) used for documentation of and presentation of data on post rape services offered by the health facility

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survivors dropping out of the cases, and foregoing justice.

On the approximate time taken by the survivors to be served at a health facility they attended is shown in the table below.

Table 1: Proximate time taken by a survivor to be served by a clinician at a health facility (in minutes)

Time in minutes	Count (N=38)	Proportion (%)
<15 minutes	0	0
15-30 minutes	1	2.6
31-60 minutes	34	89.5
Over 60 minutes	3	7.9

Most of the respondents (89.5%) waited between 30-60 minutes to be served at a health facility they attended, and about 7.9% waited for over 1 hour. While the health care providers may have made efforts to serve them promptly, there may be several factors affecting service delivery impacting negatively on the survivors' well-being.

Consistent staffing appears to be a challenge. Health facilities often lack an adequate number of nurses, and professionally trained GBV counselling staff, as observed earlier. This leads to a long waiting time before receiving treatment. A key informant echoed;

> *"We lack enough doctors and healthcare professionals causing overcrowding due to slow patient attendance rate. In this case, the survivor is likely to wait for some time before being attended to"* (KII, health officer, Kibra).

The nature and quality of the evidence are also dependent on the timing within which the survivor seeks help. The need to have the evidence collected within 72 hours from the time of the sexual violence incident, the collection of such evidence at the first point of contact, and the preservation of such evidence is critical. However, as noted earlier, some health institutions have no capacity to collect and preserve such evidence. Where the evidence is collected, its preservation is compromised due to storage.

National guidelines on the management of sexual violence (2014) stipulate that evidence should be collected within 72 hours following the assault, Still, upon the survivor arriving at the facility, the case should be treated as an emergency (Ministry Of Health [MOH], 2014).

Levels of Awareness

The study established that awareness and knowledge of healthcare and legal services were at different levels, as discussed in the subsequent sections.

Awareness about Where to Seek Services

The table below shows proportions of the different places/avenues where survivors sort help.

Table 2: Proportions of the different places/avenues where survivors sort help

What did you do about it?	n (%)
Reported to the police	23 (61%)
Sought medical care at a healthcare facility	38 (100%)
Reported to the chief	28 (74%)
Told a friend/neighbour	13 (34%)

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Table 2 indicates that all the respondents interviewed sought help from at least one of the avenues, but there are those that sort help from multiple avenues. 23 (61%) reported to the police, 38 (100%) sought medical care from a healthcare facility, 28 (74%) to the chief, and 13 (34%) disclosed to a friend or neighbour. The 100% of respondents sought medical services were because they were purposively sampled from the health facilities. Findings indicate that generally, survivors were aware of formal reporting avenues.

Further, the study observed that there exist gaps in information sharing. There is a lot of duplication in terms of mitigation on domestic violence programs. Actors target the same participants with similar information leaving massive chunk of the population unattended/unreached. The study was also informed that many cases of domestic violence go unreported. The reasons given include; low levels of trust towards officers entrusted with gender issues and lack of action by the law enforcement agencies, corruption, issues of delayed or lack of justice to survivors, ignorance, and some families opting to settle such cases in-house (out of court) and the stigma associated with cases of domestic violence. A health worker, while commenting on reasons as to why most domestic violence cases go unreported, mentioned that;

> *"…. there are so many cases that go unreported here in Kibra. Sometimes we hear from people and move in to understand the issues. At times, when it is too late already. The other day we learned of a 13-year-old girl who was undergoing defiled – had been going for too long - by a neighbour, opened to her teacher who followed up and shared with her parents. Upon learning of the issues, the parents quickly rushed and negotiated with the neighbour and informally settled the case without following the right process…"* (KII, health officer, Kibra).

The study findings revealed a lack of knowledge by domestic violence survivors about the 72-hour window stipulated in the National guidelines on the management of sexual violence (2014) for reporting sexual violence. This limited survivors' ability to receive immediate medical care, thus exposing them to STI's and unplanned pregnancies. Moreover, survivors had little knowledge of preservation of evidence which greatly affected evidentiary material for further documentation and the presentation in court.

Awareness of Existing Protocols for Addressing Domestic Violence

Awareness of policies and legal frameworks coupled with implementation is key to quality service delivery. A case in point is the Protection Against Domestic Violence Act of 2015. Besides, capacity building of service providers to handle domestic violence, particularly in healthcare and legal sectors, is critical.

There are many efforts related to raising GBV capacity amongst service providers in the study area. Hospital staff had generally been trained on various aspects of GBV between 2017-2019, including domestic violence, sexual assault, and psychosocial support. A few police officers had received police-specific domestic violence and sexual assault training;

> *"All staff have received a five-day training on clinical management of GBV, existing policies, referral, and reporting pathways, (by the National AIDS & STI Control Programme (NASCOP). An LVCT facility provides training to data clerks within the sub-county to report GBV data on the Kenya Health and Information System (KHIS)"* (KII, health facility manager, Kibra).

Furthermore, a key informant also outlined how protocol dictates that domestic violence cases are treated as an emergency;

> *"Clients are treated separately from others and are taken to a secure room where they are*

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> *examined and counselled alone and receive differentiated treatment based on the violence experienced. It should be noted, however, that at other facilities, domestic violence survivors must wait in line like other patients to receive treatment and screening. no infrastructure is specifically available for these cases"* (KII, health officer, Kibra).

The availability of GBV services generally seems to be improving, with interviewed health service providers noting they could provide full medical examinations, Post Exposure Prophylaxis (PEP), emergency contraception and, STI prophylaxis, usually free for domestic violence survivors. furthermore, post-rape care legal documentation has been made free (legal notice 133 sexual offenses medical treatment regulation 2012). However, not all respondents seemed aware of this, and it is not enforced everywhere. This is a milestone implemented to reduce barriers for those survivors of violence who cannot afford legal fees.

Nevertheless, facilities' ability to collect forensic evidence, allow uncontaminated storage and transport, and pass evidence to the police varied significantly, affecting the usefulness of the legal documentation.

In this regard, many stakeholders still need capacity building on management of domestic violence and how it pertains to their specific roles. For instance, local administrators, e.g., chiefs and assistant chiefs, who are often the first point of contact with domestic violence survivors, lacked comprehensive and systematic training on handling domestic violence and gender-based violence cases.

The gaps in training result in concerns around the ability of recently hired staff that had not been sufficiently trained to perform their role. This applies particularly to health staff collecting forensic evidence and filling in legal forms. Given the high demand for these services by domestic violence survivors, this could then result in errors with far-reaching consequences.

It has also been noted that for a long time, the aspect of domestic violence has been treated as a normal assault, not giving the survivor the special care, they require. These include; addressing long-term trauma, effects on cycles of violence, and sometimes the legal attention foregone.

In view of the above, key areas that could be improved are inconsistent awareness about domestic violence response and implementation of protocols and guidelines.

Gender Responsiveness

Gender-responsive institutions and systems reduce barriers to access and utilization of services while reducing inequalities in service delivery.

The figure below represents respondents' opinions on how gender inequality/equality affected their health outcomes in the event of domestic violence, including on reporting.

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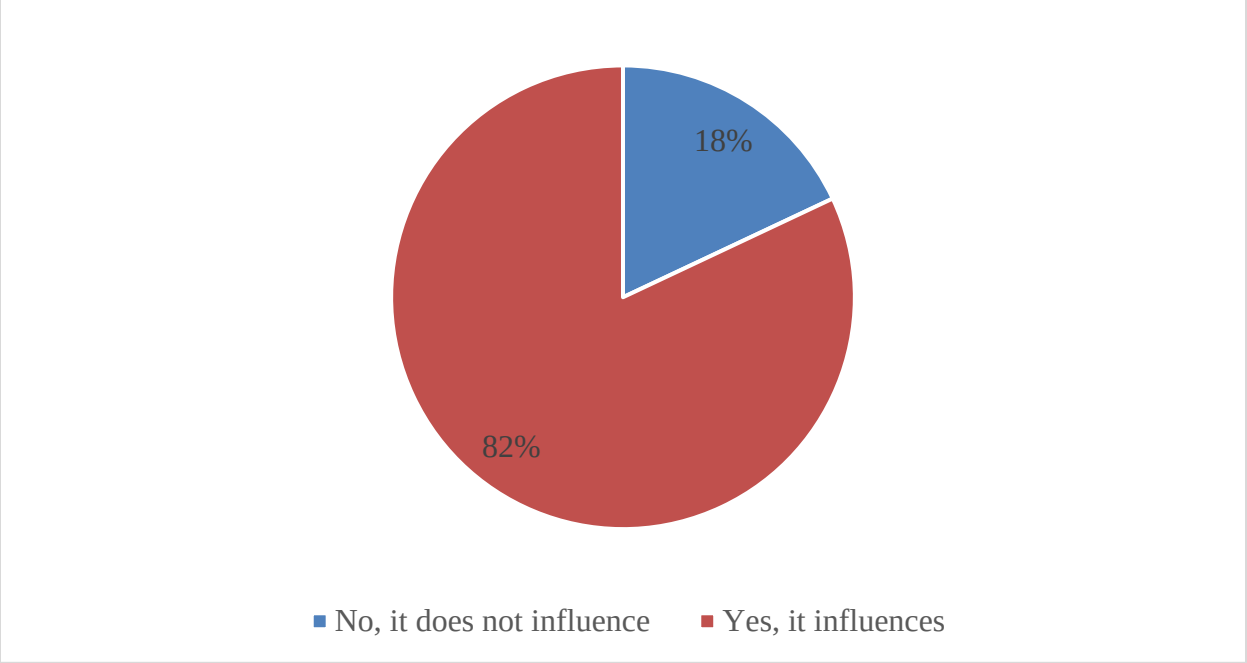
Figure 4: Perception of whether gender inequality influences reporting of domestic violence cases



82% of the respondents highlighted that gender inequality influenced reporting of domestic violence, whereas 18% had a contrary opinion. While domestic violence affected both men and women, reporting of the same was different between the two genders. Cases of incest and defilement, involving boys, were said to be underreported and under-addressed. The study learned that many of these cases especially involving close relatives, were mostly negotiated within the community. Women were said not to report cases involving their husbands to save their families from breaking up. Men were also said to suffer in silence, mostly due to stigma. Cases involving husband battery were reported to be widespread in society but were not taken and addressed seriously. A domestic violence survivor mentioned that;

> *"…men suffer in silence… majority cannot openly report their wives rather they lie to have been attacked by criminals to avoid the shame, stigma or being seen as weak..."* (Domestic violence survivor, Kibra).

It was also noted that many survivors would love to have a service provider of the same gender to communicate their problem, perhaps due to stigma and lack of trust when an opposite gender is involved. A male survivor mentioned that;

> *"To the police, if you go to report as a man that your woman is beating you, they will not take you seriously. They can even laugh at you and fail to help"* (Domestic violence Survivor, Kibra).

The study assessed whether men and women were equally accessing healthcare and legal services. *Figure 5* presents the findings.

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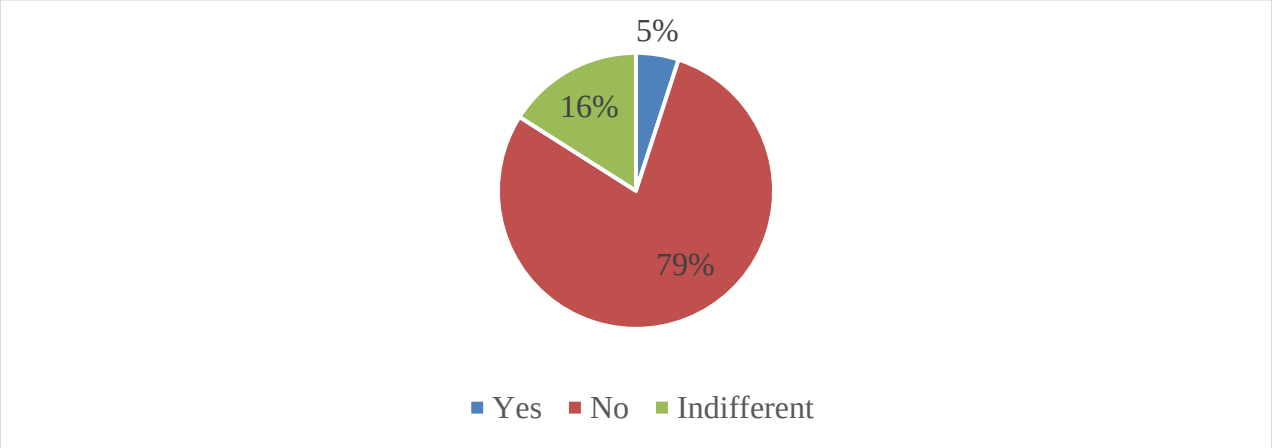
Figure 5: Perception on whether male and female domestic violence survivors are equally accessing healthcare services



79% of the respondents felt that men and women were not accessing services equally, 5% believed both genders accessed services equally and the remaining 16% were unsure. A male domestic violence survivor said that men were most likely to suffer poor health outcomes as they are less willing to wait in lines; hence, they do not receive the necessary services.

Additionally, it is perceived that many health programs are tailored and geared toward women, causing further disadvantages to them as they are less aware of issues that may affect them, leading to unequal resource distribution and subsequent service utilization.

The use of healthcare is predominantly left to women. Despite their presence, male domestic violence survivors are not making use of them. Varying views about why this was so: religion and culture were pointed out to influence their willingness to seek these services. Lack of the right information on what is available and stigma, especially while reporting at the police station, make them fear how service providers will respond. A survivor noted;

> *"All are supposed to access since anyone can be abused… those who are not accessing are boys and men since they fear that the community might discriminate them for what they are facing…. Also, most men do not like showing that they are weak"* (Domestic violence survivor, Kibra).

The study noted that existing GBV interventions, generally focused more on women and children's survivors. Men were said to have been left out even on empowerment programs. This neglect of men's suffering was contributing to depression, deterioration of mental health, and suicide. Such expressions include;

> *"Male gender feel that they are being side-lined by what they said women are being favoured looking at every health program that involves women and very few men e.g., the DREAMS Girls program"* (Domestic violence Survivor, Kibra).

In summation, the study posits that gender inequality does impact the utilization of healthcare and legal services for the various groups. Gender inequality leads to fear of discrimination making the affected persons not able to access services, moreover, the attitude of service providers towards different genders makes them shy away from accessing services; hence domestic violence interventions are treatment based as opposed to preventive.

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CONCLUSION

The study noted that despite the availability of healthcare and legal services, the level of utilization of the same by domestic violence survivors was hampered by various factors which included; accessibility, affordability, timeliness, levels of awareness, and gender responsiveness. These factors negatively impacted reporting and access to appropriate and quality care. This was attributed to a myriad of challenges related to structural weaknesses within the institutions as well as knowledge on the management of forensic evidence, by survivors and investigating officer (s), inadequate resources (human and financial), and requisite infrastructure.

The study acknowledges that strong and effective processes and structures are necessary for the operationalization of laws, policies, and plans for domestic violence prevention and response. Effective solutions must integrate long-term and economical domestic violence prevention methods with procedures that respond to the afflicted, offer protection, and guarantee that service providers are held accountable.

The study suggests that the distressing problem of domestic violence in the nation, and Kibra in particular, be addressed by a multi-agency approach using the national investigative, psychological, social, medical, forensic, and legal instruments.

Recommendations

To inform future efforts of domestic violence response services and prevention efforts across different service sectors, particularly healthcare and legal services, the study proposes the following recommendations:

- Address issues of delay in legal response: Legal responses to GBV remain slow and ultimately ineffective. The lack of financial support and protection services during the process leaves survivors economically vulnerable with little confidence that justice will be served. This leads to many survivors abandoning their cause or compromised and witnesses being fatigued or compromised The Police need to establish a department/unit devoted to GBV, within the police service.
- Address capacity gaps across GBV service providers. Continuous training of prosecutors, police officers, administration officers and judicial officers on various protection mechanisms for survivors; the survivors' rights before, during, and after the trial; use of medico-legal documentation including psychological evidence; training relating to new laws, policies, and regulations on sexual and gender-based violence is important.
- Enhance inter-agency collaboration. This in turn will help survivors navigate the GBV referral pathways with ease. The State Department for Gender should improve coordination between all GBV actors, particularly medical and legal sectors by strengthening County and Sub-County gender sector working groups.
- Harmonization of PRC[5] Forms and P3[6] forms. This will ease the logistics of moving from one place to the other, and having the documents handled by many people as this may compromise the content of the evidence captured in the two documents.

[5] Post rape care form is a Ministry of Health Register (MOH 363) used for documentation of and presentation of data on post rape services offered by the health facility

[6] A P3 form is a document issued by the police in case of an injury is used to request for medical examination by a Medical Officer of Health, in order to determine the nature and extent of the bodily injury sustained by a complainant(s) in assault cases

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