FEMALE SURVIVORS OF SEXUAL VIOLENCE: CULTURAL AND SOCIO-ECONOMIC FACTORS THAT INFLUENCE FIRST VISITS TO THE SGBV CLINICS AT KENYATTA NATIONAL HOSPITAL.

By: JANETROSE WAMBUI KAMAU (H56/69308/2011)

A THESIS DISSERTATION IN PARTIAL FULFILLMENT FOR THE AWARD OF THE DEGREE OF MASTERS OF SCIENCE IN CLINICAL PSYCHOLOGY

THE UNIVERSITY OF NAIROBI

DEPARTMENT OF PSYCHIATRY

2016

DECLARATION

I, Janet Rose Kamau declare that this dissertation is my own original work carried out in fulfillment of the requirement for the award of the degree of Masters of Science in Clinical Psychology at The University of Nairobi. I further declare that this dissertation has not been submitted for the award of any other degree or to any other university.

Signature: ……. Date: ……

INVESTIGATOR: KAMAU JANETROSE WAMBUI

CELL: 0726200517

EMAIL:wjanetrose@gmail.com

SUPERVISORS' APPROVAL

This dissertation has been submitted for examination with our approval as The University supervisors.

1. DR. MUTHONI MATHAI

   M.B.Ch.B, M.Med. PSYCHIATRY,

   PhD UNIVERSITY OF NAIROBI.

   SENIOR LECTURER, DEPARTMENT OF PSYCHIATRY,

   COLLEGE OF HEALTH SCIENCES, THE UNIVESITY OF NAIROBI.

   Signature: ……

   Date: ……

2. DR. ANNE OBONDO

   M.B.Ch.B, M.Med PSYCHIATRY,

   PhD UNIVERSITY OF NAIROBI.

   SENIOR LECTURER, DEPARTMENT OF PSYCHIATRY,

   COLLEGE OF HEALTH SCIENCES, THE UNIVESITY OF NAIROBI.

   Signature: ……

   Date: ……

3. DR. MARGARET MAKANYENGO

   M.B.Ch.B, M.Med PSYCHIATRY

   KENYATTA NATIONAL HOSPITAL, NAIROBI, KENYA

   Signature: ……

   Date: ……

COLLABORATING INSTITUTIONS

I. Kenyatta National Hospital

II. University of Washington

DEDICATION

This work has been dedicated to my beloved parents, David and Grace Kamau, my lovely husband James Kamau and my son Brian Kamau for their love, support, patience, encouragement, understanding and their prayers.

Thank you all.

ACKNOWLEDGEMENT

This research and dissertation was possible through the assistance of a great number of people who provided; advice, support and encouragement. I acknowledge the following:

My parents; David and Grace Kamau for their support especially financially, love, care, and believing in me. Thank you to my loving husband James Kamau for his patience, tolerance, encouragement and believing in me even when I did not believe in myself. To my loving son, Brian Ugi Kamau for all the patience he had with me. Special thanks to my three supervisors: Dr Muthoni Mathai, Dr Anne Obondo and Dr Margret Makanyengo for all their support and guidance. To all my participants who contributed a lot to my study. Finally, I would like to thank the department of psychiatry and MEPI for all the support they have given me.

ABBREVIATIONS AND ACRONYMS

KNH..... Kenyatta National Hospital

SGBV.....Sexual Gender Based Violence

GBV..... Gender Based Violence

KDHS.....Kenya Demographic Health Survey

GBVRC……. Gender Based Violence Recovery Centre

ART……Antiretroviral Therapy

SOA…… Sexual Offences Act

IRB…….Independent Review Board

ERC……...Ethics Research Committee

SPSS……. Statistical package for The Social Sciences

DSM-IV-TR …… Diagnostic and Statistical Manual for Diagnosis of Mental Illnesses 4th Edition

KNBS ……. Kenya National Bureau of Statistics

PEP ……Post Exposure Prophylaxis

HIV …….Human Immune-deficiency

DEFINITION OF OPERATIONAL TERMS

Sexual Violence: any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work.

Gender Based Violence: any act of violence against women that is likely to result or may result in sexual, physical or mental harm to women. These includes such acts as; arbitrary deprivation of liberty or coercion, whether occurring on private life or in public.

Culture: the cumulative deposit of knowledge, beliefs, attitudes, religion, spatial relations, experience, values, meanings, hierarchies, notions of time, roles, concepts of the universe, and material objects and possessions acquired by a group of people in the course of generations through individual and group striving.

Socio-Economic Status: an economic and sociological measure of a person's or a family's economic and social position in relation to others, based on income, education, and occupation.

TABLE OF CONTENTS

List of Tables

ABSTRACT

Sexual violence against women is a health problem that is well recognized globally. The situation is very wide spread In Kenya. It has been estimated that women from all social and ethnic groups are raped and sexually assaulted everyday in the country. The Kenya police report pointed out that 876 cases of rape were reported, 1, 984 defilement cases, 182 incest cases and 191 sodomy cases. (Kenya Police, 2003) Also, according to Kenya DHS 2003, 16% of women in Kenya reported that they have ever been abused sexually and 13% among those reported having been sexually abused in the last year.

The study focused on examining the women survivors of sexual violence and the cultural and socio-economic factors that influence first visits to sexual gender based violence clinics at Kenyatta National Hospital. The research question looked at whether there is a relationship between cultural, socio-economic factors and visits to SGBV clinics after sexual violence.

The study population included all urban women survivors of sexual violence from different social economic background, while the sampling frame was every sexual violence woman survivor who was coming for follow up. The study area was Kenyatta National Hospital. The study used a cross-sectional retrospective quantitative and problem centered qualitative approach. In the case of the cross-sectional retrospective data collection, a random sampling method was used to select participants, and every patient's file had an equal chance of being selected. A sample size of 164 files was used in the study.Specific guidelines tailored to determine whether cultural and socio-economic factors influence first visits to sexual gender based violence clinics following sexual violence were used for qualitative data collection. The researcher got a list of SGBV women survivors who are on follow up from the patient support

center at KNH, purposively select 25 patients who delayed to visit the SGBV clinic, i.e., went after 72 hours following sexual violence, then called them and requested them to come on a specific day for the problem centered interview.

The researcher first explained to the patients what the study was about and after getting their consent, the interviews took place. Quantitative data was analyzed using SPSS version18, it was then presented using frequency tables and in narratives, while the qualitative data was transcribed, coded into themes using NVIVO and then content analysis was done.

Results: The data indicated that out the 156 survivors whose files were used only 40 (25.6%) reported to the KNH SGBV clinic within 72 hours, the majority 116(74.4%) reported after 72 hours and therefore could not receive the necessary after rape services. From the in depth interviews the following reasons were given for late reporting to the SGBV clinic: ignorance, lack of money, relationship with the perpetrator, circumstances surrounding the incidence, fear of stigma, self-blame, religious influence and advice given by the person shared with.

Discussion:The study found that, the majority (60%) of the SGBV survivors reported late (72 hours after sexual abuse) to the SGBV clinic in Kenyatta. This is comparable to a study done at Mulago hospital in Kampala Uganda. 2005 where the majority (57%) reported to the emergency gynecological ward after 72 hours following sexual violence.

The research findings showed that when a woman is raped by her husband or a close relative, she is more unlikely to report to the hospital because they think that their husbands has the right to have sex with her even when she is not interested. On the same, women raped close relatives did not report because incest is a taboo in many ethnic groups in Kenya and therefore they feared r of

bringing shame to the family. This is comparable to a study done at Mulago hospital in Kampala Uganda, (Samuel Ononge et.al, 2005)

Some participants were not able to report to the hospital on time due to long distances and lack of transport. Experiences of female survivors of sexual violence in eastern Democratic Republic of the Congo study (JT Kelly et.al) concluded the same.

Conclusion:Sexual Gender based violence is still a major problem in our society today and many women who experience it do not know what they are required to do when they are abused.

CHAPTER ONE

INTRODUCTION/BACKGROUND

The World Health Organization defines sexual violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work".

Sexual violence is a very wide spread problem globally. A National telephone Survey which was conducted in the USA 2001-2003 indicates that 1 in every 59 adult, that is, 978 000 men and 2.7 million women had experienced forced sexual activity within the one year preceding the survey. The survey also indicates that 1 among 15 adults in the USA had been sexually violated in their lifetime. (Basile, Kathleen C.; Chen, Jieru; Black, Michele C.; Saltzman, Linda E, 2007)

The survivors of sexual violence are left shocked and traumatized in a way that their status in the community is undermined. They are also left to face a lot of consequences resulting from the sexual violence. Evidence shows that sexual violence is a major ill health cause among girls and women, as it can lead to disabilities and even death. It also causes physical and mental illnesses. (Krug et al, 2002). Sexual violence may also lead to unwanted pregnancies and unsafe abortions, infections in the reproductive tract (Campbell and self, 2004). Sexual violence acts as a high contributor to the spread of HIV/AIDs and other sexually transmitted infections, this can be explained by the studies carried out in Peru, China, Uganda and USA which found out that, women and girls are less likely to use condoms after being sexually violated hence high rate of infections (Gazmararian et al., 1995)(McPhail, 2002).

Survivors of sexual violence are also subjected to stress, depression as well as personality disorders. They also manifest very high levels of somatic and anxiety disorders. Sexual violence can also result to post traumatic stress disorder, low self-esteem, eating disorders and dissociative disorders. The psychological effects negatively affect the survivor by paralyzing them and restrain their self-determination (Ms. Radika Coomaraswamy, (1995)).

In South Africa, it has been indicated by the DHS that 10% of girls aged between 15-19 years were persuaded or forced to have sex (S.A DHS, 1998).

WHO, 2005 reported that 59% of ever partnered women have experience sexual violence by their partners. The WHO, 2005 report also indicates that 31% of ever-partnered women in Tanzania have ever had sexual violence experience.

In Kenya, 876 cases of rape were reported by the Kenya police report (2007). 1,984 defilement cases, 182 incest cases and 191 sodomy cases were also reported by the Kenya police. The Kenya DHS 2003 also reported that 16% of Kenyan women reported having been abused sexually and 13% of Kenyan women reported having been sexually abused in the last year.

The sexual Offences Act was passed in 2006; it was considered a main step in addressing the major forms of Gender based violence. On 21st July 2006, the act came into force. Before the enactment of the Act sexual violence could not have been adequately dealt with by the law. The Act has improved the laws against sexual offences by adding the number of offences which were previously not covered by the Kenyan law, these include; male rape, sexual assault, gang rape, sexual purpose child trafficking, sexual exploitation, interference with evidence, cultural or religious sexual involvement and HIV infection to others knowingly. It also defines the sexual offences and widens their scope. It insists on sentences that are deterrent and punitive, the age of

consent according to the Act is above 12 years, it seeks to protect vulnerable witnesses, regulates proper investigations, focuses on supervision and treatment of sexual offenders and also confers extra-territorial jurisdiction over offences committed outside Kenya by Kenyan citizens (Sexual offences act, 2006).

It is crucial for sexual violence survivors to seek medical assistance immediately (within 72 hours) following sexual violence; this is because medical management is very essential in reducing the adverse effects of physical and sexual violence. Management services for SGBV survivors available within 72 hours include; pregnancy prevention, prevention of sexually transmitted infections (post exposure prophylaxis), management of physical injuries, (which can also be used as evidence to prosecute the perpetrator), hepatitis B prevention and psychosocial care and support.

STATEMENT OF THE PROBLEM

Sexual violence is a major problem in Kenya. It is very wide spread and is most common among women from low socio-economic status. The KNH-GBVRC service report for 2007 –Sept 2011 brought out the fact that, female gender is the most vulnerable when it comes to sexual violence making up for 84% of the 2010 new reported cases. 16% of women in Kenya reported that they have ever been abused sexually and among them 13% reported that it happened within the last year (Kenya DHS, 2003). Kenya DHS, (2008-2009) reported that one in five Kenyan women (21%) has experience sexual violence.

According to another GBVRC-KNH report (2010), 548 gender based violence survivors were either attended at the Patient support centre, casualty or the youth centre which is a 28.04% increase from the previous year which had a total number of 428 survivors. The report also shows that the majority of the survivors are female, amounting to 1,533 representing 87.95% of the total population of survivors in 2006- 2010 December. This puts the ratio of male: female as 1:7. In the year 2010 alone, female survivors totalled up to 471 which is, 85.95% of all the survivors attended to, among these 471 survivors, were 335 (71.13%) new survivors while the rest 28.87% were going for follow up after the first visit to the clinic.

A report by KDHS (2008-2009) indicates that the possibility of sexual or physical violence experience increased with women's age and is affected by their culture, education as well as socio-economic status, the factors which may also contribute to limited or delayed visits to SGBV clinics after sexual violence. The report also indicates that the perpetrator was often someone well known to the women. Strangers accounted for 6% only while those who reported sexual violence by current husbands or partners accounted for 37%. 16% was by a former or

current boyfriend while 13% was by a former partner or husband. This is an indication that sexual violence is a big problem in Kenya.

Sexual violence is also a wide spread problem in Africa in general. South African DHS (1998) data indicates that 10% of women aged between15-19 were persuaded or forced to involuntary sexual intercourse. According to WHO, (2005), 59% of women in Rural Ethiopia reported having ever been sexually assaulted. In addition, 31% of Tanzania women reported having ever experienced sexual violence (WHO, 2005).

It is very important for Sexual violence survivors to visit an SGBV clinic within 72 hours after being sexually violated so that they can be helped to reduce the effects of the sexual violence by; reducing the chances of getting sexually transmitted infections including HIV, pregnancy prevention, management of physical injuries as well as counselling. They are also helped to gather the evidence needed to prosecute the perpetrator and provided with a medical report to present to the police.

Despite the importance, high percentages of sexual violence women survivors do not seek medical help within 72 hours after sexual violence. It is against this background that this study intends to investigate the cultural and socio-economic factors contributing to the delay in visits to SGBV clinics.

CHAPTER TWO

LITERATURE REVIEW

Sexual violence against women can be considered as a major problem in to public health, it results to serious physical injuries, both long and short term consequences which include pregnancy complications and mental illness (WHO, 1998).Sexual gender based violence has continued to be recognized globally over the past 10 years, however due to its sensitivity it is almost under-reported. All the same, the data that is available on the subject suggests that, women continue to experience (S) GBV and living with the consequences in millions all over the world (Zimmerman and Watts, 2002).

Studies suggest that mostly women face violence perpetrated by their husbands or intimate male partners. A global review on over 50 surveys which were population based, that was done in the last 16 years reported that; 10%-60% of women aged 18 years and above have ever been physically abused by their intimate male partners (Heise, L., M. Ellsberg, and M. Gottemoeller. et al,., 1999). Research has also shown that mostly physical violence is usually accompanied by sexual violence in half of the cases (WHO, 2002).

WHO (2002), Gordon & Crehan (2000) and Jensen & Otoo-Oyortey (1999) suggests that the real extent of sexual violence is not known even though the available data shows that one in three – five women may possibly have a sexual violence experience in their life time. There is a very high concern that sexual violence is a high risk factor that contributes to high vulnerability of women in particular to contracting HIV/AIDs (UNAIDS, 2002). Sexual violence is related to other consequences which include; unintended pregnancies that bring about unsafe abortions, gynecological complications, physical injuries, permanent disabilities, sexual dysfunction, vulnerability to risky sexual behavior and high risks to sexually transmitted infections and PTSD.

A research on gender based violence showed a high risk of existing sexual and physical violence among younger women mainly those aged 15-19(WHO, 2005& Krug et al, 2002) reported that separated or divorced women report higher prevalence of all kinds of violence. In addition, drugs and alcohol consumption and previous sexual abuse experience is also linked to adulthood sexual violence.

A study which was carried out in Kenya and Tanzania on child sexual abuse reported that, most research done on child abuse in both countries is unpublished. The study also reported that very little data exists on sexual abuse in children in Tanzania. However, child abuse may be on the increase as many AIDs sufferers rape children in an attempt to "cleanse themselves". Poverty, tradition systems for child care, foreign influences and girls' lower position in the society are also implicated. In Kenya, the study found out that first sexual experience happens at a very young age for both children and adolescents. There is also a high degree of trickery, forced and material exchange sexual relationships (Lalor K, 2004).

The life time prevalence of gender based violence in Kenya has been estimated to be 39% (KDHS, 2008/2009). A recent study carried out by FIDA reveals that Gender based violence and intimate partner violence is on the rise, indicating 74.5% of participants from the Coast, Nyanza, Nairobi and western provinces revealing that they have ever been physically abused. Western province reported the highest incidences of domestic violence.

A study was carried out in Kisumu, Kenya to measure the forced sex prevalence and the associated factors. The data was drawn from a cross sectional population based survey. The study found out that there was a 13% forced sex prevalence in women and 4.5% in men. It also suggests that in women, forced sex was related to transactional sex, many life time partners, high

economic status and having secondary education and post-secondary education. There were no factors found to be directly associated with forced sex in men. According to this study, in majority of the cases, intimate partners were the perpetrators, (62.1%) of men abused their partners. (Adudans MK, Montandon M, Kwena et, al, 2011).

This study is focusing on the influence of cultural and socio-economic factors on visits to SGBV clinics for women survivors of sexual violence. There are a few studies that have been carried out indicating these factors and their influence on visits to SGBV clinics after sexual violence globally; however, some of the few studies are discussed below.

SOCIO-ECONOMIC FACTORS

Global Health 2005 research, found that some of the reasons for not seeking medical health include, poverty and lack of education. These two may also contribute to sexual gender based violence survivors patients to delay in seeking medical help. These is because, they may not know what they are expected to do (ignorance/ lack of knowledge) or if they do, they may not have enough money to get to the hospital which may be very far from their residences.

Studies show that women are more vulnerable to both physical and sexual violence due to their sexuality. These results to rape, female genital mutilation, domestic violence, women trafficking and forced prostitution. This is because they are related to a man or because they belong to a social group. Women violence can be used as a means of humiliation towards a certain group in times of ethnic strife or armed conflict. In family settings, women are vulnerable to violence in forms of; sexual abuse, battering, incest and marital rape. Women of low socio-economic status are shown to be more vulnerable to sexual slavery and sexual harassment. Such women are usually employed as low paid labor and as bonded labor globally. A study done in relation to

wife battering indicated that economic equality is a major factor in preventing women violence. The study also shows men being in control of the knowledge systems. These include; culture, science, religion and language, where women have been excluded from the creating symbolic systems enterprises. This lack of control not only allows them to be sexual violence victims but also to be part of legitimizing women violence. Also, women have been denied access to knowledge by being refused education in many parts of the world, lack of knowledge contributes to violence against women (Ms. Radika Coomaraswamy, 1995).

Studies show that there is a relationship between socio-economic status which include education & poverty and sexual violence and the influence to SGBV clinics visits. The literature by Health and violence World report (Krug et al., 2002) holds that there is a relationship between high female education levels and high risk of sexual violence, as sited by South African and Zimbabwean studies. The authors' reasoning is that empowerment in women goes hand in hand with going against the norms and this provokes men to become violent in order to regain control (Jewkes, et.al, 2002). However, this is only to certain point as on a higher note, women empowerment protects women from both physical and sexual violence (Jewkes et al., 2002).

According to a study which was conducted in Botswana, Tanzania and Uganda showed that economic factors such as transport and costs related to clinic attendance for ART were major obstacles to clinic attendance and treatment adherence. (Nachega JB, Knowlton AR, Deluca A, et al. , 2006).

A study that was carried out to examine the relationship between education level and gender based violence among women going for HIV test in both rural and urban areas in Kenya. The study suggests that almost half of gender based violence sexual (45%), emotional (45%), and

physical (46%) occurred amongst women aged 15-29. In addition women from urban areas who had secondary or college/university level of education were less likely to experience physical violence by 26% as compared to those with primary education. This was 175 less likely among those from rural areas. There was a surprising finding suggesting that women from rural areas with lower than primary level education were 35% less likely to have been sexually violated in comparison to those who had a primary education. The findings show the extent of sexual, emotional and physical violence among formerly married and married women in Kenya (Abuya BA, Onsomu EO, Moore D et. al, 2012).

The Kenyatta National Hospital (Sexual) Gender based violence recovery center strategic plan (2012-2017) looks at some of the cultural and socio-economic factors that influences low rate of health seeking behavior for SGBV survivors. The economic factors they looked at include; low income levels where most people at risk of sexual violence earn very low wages/salaries such that they are not able to access health care on time since the SGBV centers are located very far from their area of residence. Another economic factor is disparities of income between genders. Due to poverty levels, low income earners are not able to have health insurance coverage. In such a case they may not seek health care in fear of they may not be able to cover the hospital bills. Other socio-economic factors that may have not been covered include; lack of education, people with low levels of education may not know the importance of seeking health care within 72 hours after sexual violence. Low women empowerment is another factor brought out by the Kenyatta National Hospital (Sexual) Gender based violence recovery center strategic plan (2012-2017). Women may not know their rights and women survivors of sexual violence may not know that it is their right to receive post rape medical care for free in public hospitals. Lack of empowerment reflects means lack of control over resources e.g. personal property, land as well

as wages (United Nations General Assembly (UN-GA), 2006). This lack of power manifests lack of access to health facilities and support institutions.

CULTURL FACTORS

Cultural factors are major factors that influence visits to the SGBV clinics for sexual violence survivors. A study done by Liver Pool VCT and Care Kenya on post rape services in Kenya indicated that culture has high influence on both causes and outcomes of sexual gender based violence. One of the research findings indicated that, most participants felt aired the view that there was no rape in marriage. If most cultures believe the same, then women will shy away from seeking medical help after sexual violence by her husband or a partner.

Another study by KDHS 2008-09 indicates that women who are of the opinion that a husband has a right to hit his wife and have a right to have sex with her whenever he feels like, believe themselves to be in low status. This kind of perception may act as an obstacle to health care access. The same study by Liver Pool VCT and Care Kenya on post rape services in Kenya indicated that, according to both men and women participants, women are responsible for sexual violence in relationships (non-marital relationships in particular) because they are in those relationships willingly.

Another factor that may influence first visits to SGBV clinics following sexual violence is stigma. According to the UNAIDS; 2005, people with sexual diversity worldwide have experienced stigmatization, cruelty and even denial in health facilities. If these people experience sexual violence, they may shy away from seeking medical help for the fear of stigmatization.

Sexual violence is especially stigmatizing in those cultures that have strong taboos and customs regarding sexuality and sex. A good example is a survivor who was a virgin prior to the abuse,

may be seen as damaged by the society and may suffer isolation, disowned by family and friends, prohibited from getting married, divorced or even get killed. (Alliance Factsheets, 2011).

Another study done in Zambia observed that sexual violence survivors are more interested in seeking social justice than seeking medical care. It also reports that one major reason for not reporting or seeking medical help is fear of stigma (Keesbury et al., 2006).

Age is yet another contributing factor that may influence visits to SGBV clinics following sexual violence. According to Keesbury et al., 2006; Radar 2006; Kilonzo and Taegtmeyer , 2005), adult women are less likely to seek medical help after sexual violence but they are more likely to report and seek medical help if children are raped. This reflects the widespread belief that, sexual; violence towards children is a crime as opposed to sexual violence towards adults.

In addition, religion highly influences visits to SGBV clinics for sexual violence victims. Where religion does not allow fornication, survivors may tend to shy away from seeking treatment after being sexu ally violated in fear of being punished for fornication. Under the Islamic law, rape is forbidden. (Mazhar, Uzma, 2002). Survivors of sexual violence are usually accused and severely punished for engaging in sexual intercourse outside marriage. In some of the 3rd world countries, "Local Sharia" courts often punish girls and women who are victims of rape by beating them using shoes and flogging. (How Sharia Law Punishes Raped Women. Aina.org. Retrieved on 2011-10-01.)

The government of Pakistan in 1979 adopted the "Zina" Ordinance so as to bring the penal code to accordance with the Islamic principles. Under the ordinance, women and girls who reported that they have been raped must be able to prove that it was forced sex (without consent) and those who fail to do so will be charged with fornication(Polk, Michael F., 1998).

CHAPTER THREE

SIGNIFICANCE /RATIONALE OF THE STUDY

There was little research that had been done and published on the relationship between cultural and socio economic factors that influence visits to the SGBV clinics for sexual violence women survivors in Kenya. However, the few that had been published in other countries showed that there was great influence.

The research study used its findings to provide information on the influence of cultural and socio-economic factors on delayed visits to SGBV clinics among sexual violence women survivors. The study stressed on the health risk factors that are associated with delayed visits to SGBV clinic after being sexually violated. The study also emphasized on the importance of seeking medical attention immediately (within 72 hours) after sexual violence and provided recommendations that could be used to reduce the influence of the cultural and socio-economic status on health seeking behavior of sexual violence survivors in Kenya.

The study was carried out to fill the gaps that address cultural and economic factors and their relationship to delayed visits to SGBV clinics. It enabled us to tackle these issues and encourage SGBV survivors to visit centers within 72 hours after sexual assault.

OBJECTIVES

Broad objective: Was to determine the cultural and socio- economic factors that influence first visits to sexual gender based violence clinics.

Specific objectives:

1. Was to determine the temporal pattern of reporting to the SGBV centre after sexual violence
2. Was to determine the influence of cultural factors delayed visits to SGBV clinics.
3. Was to determine the influence of socio-economic factors delayed visits to SGBV clinics.

STUDY DESIGN AND METHODOLOGY

Study Design: The study used a mixed design: cross-sectional retrospective quantitative and problem centered qualitative approach.

Study area description: The study was carried out in Kenyatta National Hospital in Nairobi, which is Kenya's largest teaching and referral public hospital with 1800 bed capacity. It has been operating since 1901 and has gradually expanded. KNH established a GBV recovery centre in 2006 which was launched on 29th May in 2008. This was after the recognition of a high rate of GBV and sexual violence survivors coming for treatment at the hospital. The GBVRC mission is to provide accessible and comprehensive quality care to SGBV survivors, to provide research and training, enhance advocacy and to participate in planning and policy making in relation to Gender Based violence issues. The major functions of the GBVRC include; psychosocial and medical services to the survivors, GBV advocacy, to improve care and support by networking with other actors of GBV, Medical-legal support and mentorship to students and health workers.

These aspects made the hospital a favorable area to carry out the research since it offers health services and support to the survivors' Sexual gender based violence. There were many patients who visited the hospital SGBV clinic between 2009-2011 who were ample for the required sample size.

Study population: The study population included all women aged 18 years and above who attended the GBVRC in KNH between the years 2009-2011.

Inclusion & Exclusion criteria: Inclusion criteria included SGBV survivors aged 18 years and above, who delayed to visit SGBV clinic after sexual violence and those who consented to

participate in the study. The exclusion criteria included; women under the age of 18 years, those in critical health condition and those who did not agree to participate in the study. The patients' files that did not have the date of reporting and/or the date assault were also eliminated.

Sample size determination and formula used

Sampling method: Hospital data- (patient files) of patients seen at the GBVC between 2009 and 2011 with a diagnosis of sexual abuse were used as a sampling frame. A random sampling method was used for cross-sectional retrospective interview to select a sample size of 164 participants. The sample size was calculated using Epi Power Calculations software. The formula used is: $n = z^2pq/d^2$(Cochran, 1977)

Where,

- n = sample size
- p = proportion of women who reported to KNH after 72 hours following sexual violence between 2009-2011is estimated at 1000
- q = 1-p
- d = absolute precision (confidence level of 5%)
- z = z score of 95% confidence level

Assuming that the number of women survivors who came to the SGBV clinic in 2009-2011 is estimated to be 1000, assuming that 15% of these women came within 72 hours after being sexually violated, with a 95% confidence and 5%precision the researcher randomly selected 164 patients' files. From these files, 6 were eliminated because they either did not have the date of assault or the date of reporting, while 2 files did not have the age. Therefore a total of 8 file were eliminated and hence a total of 156 files were used for the study.

From selected files 25 participants were selected purposively for qualitative problem centered interview. The sampling method considered the fact that there was a limited number of sexual gender based violence survivors visiting Kenyatta national Hospital. Due to this factor of limited patients, purposive sampling method was used. However out of the 25 patients purposively selected for the in depth interviews, 12 of them were eliminated because; 7 of the files did not have phone numbers and so the patients could not be contacted, when contacted, two of them could not make it for the interviews as they came from far, two patients became too emotional during the interviews and therefore could not go through with it, while one patient refused to give consent as she was not comfortable being recorded.

Criteria for selection for in-depth interviews

- Delayed visit beyond 72 hours
- Age- those above 18 years
- Marital status--- married/ divorce widowed
- Level of education
- Social economic status – low SES, Middle SES

To start off with 2 women were selected to ensure that each category had been covered- the numbers were increased to saturation and 13 women were interviewed.

Recruitment: Recruitment took place in the patient support centre in KNH. The researcher obtained permission from the IRB, project supervisors and the site manager (medical superintendents and the head of departments at the site). The researcher got a list of SGBV women survivors who are on follow up from the patient support centre at KNH, purposively selected 25 patients who delayed to visit the SGBV clinic, i.e., visited the SGBV clinic after 72 hours following sexual violence, and then contacted the patients by telephone to invite them to come for the interview. The participants were informed the purpose of the study and were also made aware that participation was voluntary and they were allowed to withdraw when they want to. The researcher then interviewed 13 of them one by one after they had consented using specific guidelines that covered the socio demographic features, cultural and socio-economic factors that influence first visits to SGBV clinics after sexual violence. The interview took place in private rooms which were provided by the KNH patient support centre to ensure privacy and confidentiality. The researcher first explained to the participant what the research was about and these included the risks and benefits of the study. The participants were then provided with the consent form to read and then sign. After the interview, the researcher gave the participants incentives to cover the burdens that were imposed on the participants like; loss of income (the participant could have been working), in that case, lunch and transport was provided. Since the area of study was sensitive and may have re-traumatized the respondents, the researcher briefed the respondents at the end of the interview and the two who showed signs of trauma, were referred to the support centre for counseling. The participants were also assured of confidentiality during data collection and analysis.

The recruitment took place in April on specific days that the participants and the researcher had agreed on. It was conducted on week days during working hours (8am-4pm). The interviews

were expected to take a maximum of one hour for each patient since it was a qualitative study and the researcher was looking for detailed information from the participants (in-depth interviews).

Data collection instruments:

Qualitative data was collected using researcher designed question guidelines. These were used to collect data on cultural and socio economic factors which include; age, religion, date of assault, date of first reporting to SGBV clinic, tradition, social status, economic status , relationship with the perpetrator, circumstances that surrounded the incidence and marital status and whether they affect visits to SGBV clinics. The data was also recorded with the use of an audio recorder.

A data recording form was used to collect data from the patient's files in order to determine the temporal pattern of reporting to the SGBV centre after sexual violence. The form was used to record factors like; Age, Marriage status, Education, date of reporting /first stop and report to GBVC and date assault.

Data management and statistical analysis:

In order to ensure confidentiality and to avoid damage, data collected was kept under lock and key. In order to prevent any kind of linkage to the participants, the recording form which contained personal information that contained the participant's personal details like their contacts was kept separate, coded data was used on such details.

Data entry and analysis was done using Epi-Info version 7. For descriptive statistics, the means and proportions were determined while the odds ratio was used to assess measures of association. To test statistical significance, the Chi square was used with the p set at <0.05. To

determine independent factors, Multiple Logistic Regression was utilized. Data was analyzed using SPSS version18. The results were then presented using frequency tables, bar charts, pie charts and in narratives. Qualitative data was transcribed, then coded into themes using NVIVO, and then content analysis was done.

Dependent and Independent variables

Dependant variables-cultural and socio-economic factors

Independent variable- delayed visits to clinics for sexual gender based violence women survivors.

Study limitations

- Some of the client's files were missing some important information like; patients date of sexual violence, date when the survivor first reported to the hospital and the kind of services she received.
- Some files were missing phones numbers and some numbers were not going through.
- Some of the patients lived out of town and could not manage to come for the interview.
- Some did not want to be interviewed.
- Some of those clients contacted and agreed to participate but were still traumatized and could not talk.
- Some did not finish the interviews.
- one clients refused to be recorded
- Since the researcher was interviewing patients were on follow up, some could not recall all the details.

Study benefits

- Respondents who were found traumatized received free therapy and were referred to centers for follow up.
- Participants received psycho education in relation to sexual violence.
- The study findings will be used to help other women in the community by reducing the influence of the dependant factors.

ETHICAL CONSIDERATION

The proposal was first presented to the department of psychiatry in the University of Nairobi; it was then presented to the KNH/UON research body of Ethics. The researcher obtained a written consent from the Health Ministry in Nairobi since the study was carried out in a hospital setting. Consent from IRB, KNH ERC and KNH management was also obtained. The in charge of the SGBV clinic as well as the matron was also consulted and informed of the study so that the researcher could get the required support. The researcher had a consent form where each and every patient who was interviewed signed in agreement to participate to the study. This came after the researcher had explained the purpose of the study clearly to the participants. The study is to benefit women survivors of sexual gender based violence by emphasizing the importance of seeking medical care within 72 hours after sexual violence.

Given the sensitivity of sexual violence in the community, the purpose of the study was well explained to the participants. Informed consent from the participant was obtained at the beginning of the interview, where each participant was required to sign a consent paper. Respondents were given a right to withdraw from participating anytime they felt like. Also the participants were made aware that they would be asked questions that were personal in nature as

they would be exploring different aspects related to their sexual gender based violence experience. The statement would assure them that their answers would be completely confidential and will not be shared with other people. The benefit of informed consent was that, the participants were interviewed at their own will but there was a risk factor of bias since the participants were told in advance what the study was about.

In order to ensure confidentiality, the participants were interviewed in private rooms. They were not required to write their names on the question guideline sheet. The data collected was kept safe under lock and key to ensure that nobody else would get to look at them.

The study may have exposed trauma to some participants since they were revisiting the traumatic experience when being interviewed. Since the researcher is a trained clinical psychologist, debriefing was done and participants who still showed signs of trauma were referred for counseling in the KNH patient support centre. The participants were encouraged to continue attending the SGBV clinical for physical and psychological care.

CHAPTER FOUR

RESULTS

Quantitative & Qualitative findings

This study involved information from patient's 156 files and in-depth interviews from 13 respondents, who were sexual violence survivors that visited the KNH GBVRC between the years 2009-2011.

Quantitative Findings

Table 1: Study population description

	Mean	Median	Minimum	Maximum	Standard Deviation
Age	26	24	17	49	8
Characteristic		**Category**		**n**	**%**
Age group		18- 24 years		80	51.3%
		25 - 33 years		53	34.0%
		33 years and above		23	14.7%
Marital status		Single		100	64.5%
		Married		43	27.7%
		Separated		8	5.2%
		Widowed		4	2.6%
Religion		Protestant		115	79.9%
		Catholic		18	12.5%
		SDA		5	3.5%

	Muslim	6	4.2%
Education	No Schooling	3	2.3%
	Primary	55	43.0%
	Secondary	42	32.8%
	College	28	21.9%
Physical injuries	No	90	57.7%
	Yes	66	42.3%
Penetrative	No	10	6.4%
	Yes	146	93.6%
Type of penetration	N/A	10	6.4%
	Vaginal	131	84.0%
	Anal	7	4.5%
	Oral	0	0.0%
	More than One	8	5.1%
Relation to perpetrator	Father	5	3.3%
	Brother	2	1.3%
	Cousin	5	3.3%
	Known Non Relatives	53	34.9%
	Unknown	84	55.3%
	Husband	3	2.0%

The table above shows the study population description; it shows that out the 156 files used for the study the majority 80 (51.3%) were aged between 18- 24 years, 53 (34.0%) were aged

between 24-33 years while the least 23(14.7%) were aged 34 years and above. On marital status, the majority 100 (64.5%) were single, 43(27.7%) were married, 8(5.2%) and the least 4(2.6%) were widowed. 115(79.9%) were protestants, 18 (12.5%) were Catholics, the SDAs were 5(3.5%) and 6 Muslims (4.2%). On education those with primary education were more than the rest at 55(43.0%), followed by those with secondary education at 42(32.8%), those with college education were 28(21.9%) and the least were those that had no formal education at 3(2.3%). The data showed that majority of the survivors 90(57.3%) suffered physical injuries during the incidence while 66(43.2) were not physically injured. Only 10(6.4%) of the survivors did not experience penetrative sexual abuse while the majority 146(93.6%) did. 131(84.0%) survivors experienced vaginal penetration, 7(4.5%) experienced anal penetration, 8(5.1%) experienced more than one kind of penetration while none of them experienced oral abuse alone. The data revealed that more than half of the survivors 84(55.3%) were perpetrated by unknown people, 53(34.9%) by known non relatives, 5(3.3%) by their fathers, 2(1.3%) by their brothers 5(3.3%) by their cousins and 3(2.0%) by their husbands.

Table 2(Temporal pattern of reporting)

Reporting			
		Frequency	Percent
	Within 3 days	40	25.6%
	Within 14 Days	47	30.2%
	Within 30 Days	24	15.3%
	Within 180 Days	22	14.2%
	After 180 Days	23	14.7%
	Total	156	100%
Reporting	Early	40	25.6%
	Late	116	74.4%

Table 2 shows the temporal reporting of the survivors to the KNH SGBV clinic.

The results indicate that less than half of the survivors 40(25.6%) are the only ones who reported to the KNH SGBV clinic on time i.e within 72 hours, 47(30.2%) reported within14 days after they were assaulted, 24(15.3%) reporting within 30 days, 22(14.2%) reported within 180 days while 23(14.7%) reported after 180 days. In conclusion, the majority 116(74.4%) reported late (after72 hours) and thus could not receive the after rape services and only 40 (25.6%) reported within 72 hours and received the services.

Table 3: Relationship between study population characteristics and late reporting (Bi variate analysis)

Characteristic	**Category**	**Early Reporting**					
		Early		**Late**			
		n	**%**	**n**	**%**	**Chi square**	**P value**
Age group	< 25 years	23	31.9%	49	68.1%	8.481	0.014
	25 - 34 years	11	22.4%	38	77.6%		
	35 years and above	0	0.0%	19	100.0%		
Marital status	Single	21	23.6%	68	76.4%	1.747	0.627
	Married	11	28.9%	27	71.1%		
	Separated	2	25.0%	6	75.0%		
	Widowed	0	0.0%	4	100.0%		
Religion	Protestant	24	23.3%	79	76.7%	0.667	0.881

	Catholic	5	31.2%	11	68.8%		
	SDA	1	25.0%	3	75.0%		
	Muslim	1	16.7%	5	83.3%		
Education	No Schooling	0	0.0%	3	100.0%	1.699	0.637
	Primary	13	26.5%	36	73.5%		
	Secondary	7	18.9%	30	81.1%		
	College	5	20.0%	20	80.0%		
Physical injuries	No	19	23.5%	62	76.5%	0.072	0.789
	Yes	15	25.4%	44	74.6%		
Penetrative	No	7	77.8%	2	22.2%	14.967	<0.0001
	Yes	27	20.6%	104	79.4%		
Type of penetration	N/A	5	55.6%	4	44.4%	7.021	0.071
	Vaginal	25	21.4%	92	78.6%		
	Anal	3	42.9%	4	57.1%		
	Oral	0	0.0%	0	0.0%		
	More than One	1	14.3%	6	85.7%		
Relation to perpetrator	Known including family members	21	35%	39	65%	10.291	0.067
	Unknown	11	14.5%	65	85.5%		

Table 3 shows the significance between the study population characteristic and late reporting. The table shows that there is a significance between early reporting and age because the p value is 0.014 however the results indicated that women aged 34 years and above are less likely to

report to the SGBV clinics within 72 hours after sexual abuse this is because all the women 19(100%) aged 34 years and above reported after 72 hours while women aged between 18 -24 years were more likely to report within 72 hours.

There is no significance between marital status and early reporting as p(0.627), however results indicate that widowed women 100% are more likely to report late followed by single women (76.4%), then those separated (75.0%) while the married women are more likely to report on time (71.1%).

The p value for religion is 0.881 showing that there is no significance between religion and early reporting. From the results, the Muslims 83.3% reported late and only 16.7% reported on time. Out of the 103 Protestants 23.3% reported early while the majority 76.7% reported late. 5(31.2%) Catholics reported on time while 11(68.8%) reported late. SDAs, 1(25.0%) reported early while 3(75.0%) reported late.

There p value for the relationship between education and early reporting is 0.637 hence no significance. The results indicated that survivors with more education are more likely to report late as all the 3(100%) reported late. For those with primary education 13(26.5%) reported early while 36(73.5%) reported late. 7 (18.9%) of those with secondary education reported early while the majority 36(73.5%) reported late. 5(20%) of survivors with college education reported early while 20(80.0%) reported late. There is no significance between physical injuries and early reporting as the p value is 0.789. 19 (23.5%)of survivors with no physical injuries reported early while, 62(76.5%) reported late on the other hand, 15(25.4%) of survivors who incurred physical injury reported early while the majority 44(74.4%) reported late. The P value 0.0001 shows that there is negative significance between early reporting and whether there was penetration or not. 7(77.8%) survivors who had experienced non penetrative abuse reported on time while 2(22.2%)

reported late. Only 15(25.4%) survivors who experienced penetrative abuse reported early while the majority 104(79.4%) reported late.

There is no significance between the type of penetration and early reporting as the p value is (0.071). The results further shows that 25(21.4%) survivors who experienced vaginal penetration reported early and 92(78.6%) reported late. 3(42.9%) of those who experienced anal abuse reported early while 4(57.1%) reported late. Those survivors who experienced more than one kind of penetration, 1(14.3%) reported on time while 6(85.7%) reported late.

The results indicate that there is a p value of 0.067% between early reporting and relation to the perpetrator thus no significance however only 21(35%) of survivors who were perpetrated by known perpetrators including family members reported early while 39(65%) reported late. 11(14.5%) of those perpetrated by unknown perpetrators reported early while 65(85.5%) reported late.

Table 4: Multivariate analysis

	Coefficient	**S.E. of coefficient**	**P value**	**OR**	**95% C.I. for OR**
Age Group	.718	.352	.041	2.051	1.029 - 4.087
Penetrative	2.200	.847	.009	9.026	1.716 - 47.459

The table further shows the multivariate analysis of significance between Age group, Penetration and early reporting.

QUALITATIVE FINDINGS

RAPE INCIDENCE

Whether or not a woman who has been sexually abused will visit the hospital or not within 72 hours after the incidence depends on the circumstances surrounding the incident. Sexual violence in itself is a traumatizing experience and some women tend to forget that they are supposed to go to the hospital even if they are aware of the importance of doing so. After a rape incidence, a woman gets confused and traumatized to the extent that she is so scared not to share with anybody what she went through.

> Resp1: *"I was from class, it was around four in the evening at around the resource centre and I was just walking. Two men then hijacked me and put me in a car, I do not know what happened after that. I found myself dumped in Uhuru Park at around six in the evening. I felt so confused I could not think straight it did not even occur to me that I am supposed to visit the hospital."*

> Resp2: "*After the incidence, I just sat there confused up until about 3am, there was nobody that I knew there. He was the only person; together with the manager are the only people that I knew. So I locked my room and just sat there until 3am, then I slept. I didn't wash or try cleaning myself. When the morning came, they waited for me to go for duty but I didn't, so the manager came and asked me why I was not reporting but I told him that I did not want the job. He tried inquiring the reason but I didn't tell him anything. He left me there and went to his office. I just sat there until about 11am when I showered and went to his office and told him to pay my wages as I wanted to go home."*

On the other hand, the circumstance of the sexual violence can also lead a victim to visit the hospital sooner. Sexual violence victims who are physically injured during the violence tend to visit the hospital sooner than those who are not injured. This is because even if they are scared and traumatized the physical injuries are more visible and need medical intervention. They also find it easier to report to the medical personnel that they are physically injured rather than reporting sexual violence.

> Resp3: "*I was on my way from the town centre when I was taken by force by some two men. What those men did to me is what made me go to hospital. When they released me, I went home, but they had also beaten me so much...after 2days when I saw that the wounds were not healing I decided to go to the hospital to seek help."*

PERSON REPORTED TO AND ADVICE GIVEN

Whether a sexual violence survivor reports to the hospital within 72 hours or not also depends on whether she told anybody immediately and the person she shared with. When a sexual violence survivor shares with someone immediately after the incident they are more likely to be advised to go to the hospital. However, most survivors who report late (after 72 hours) either do not share the incident with anyone or the person shared with is not aware of the importance of going to the hospital.

> RESP1: "*I did not have a phone at that time. The people who kidnapped me had even taken my phone, I went and someone helped me with a phone, two days later I replaced my line. That was the phone I was using for the time being. I called a woman who I knew worked in Kenyatta and she advised me to go to the hospital immediately."*

Resp2: *"I took a bath but I was also concerned that I was bleeding too. Even after three days, I was still bleeding, and some other discharges. So I went to see some woman who worked as Sunday school teacher. She came home and I told her everything without any fear. She then took me to hospital where I was given some drugs, some were oral while others were put down here (signaling the female genitalia)."*

The advice given to the first person the survivors shares with is also very important, this is because if she is advised not to tell anyone and keep it as a secret mostly likely she will follow the advice as she will think that is something to be ashamed of and will therefore not report to the police nor would she visit the hospital.

Resp1: "*I just kept quiet. Then I went to high school, when I was in form three, I dropped in my grades. One teacher used to ask me why I was not performing well, whether there was any problem at home. Then I told the teacher what was happening at home. We did not take any action, and he did not suggest any. He was initially shocked, but he told me not to share with anybody else, because if I say it to other people it would be shameful for me."*

IGNORANCE

As much as the ministry of health has tried to campaign for immediate medical assistance after sexual violence and making sure that free services are offered, most women are not aware of such services and even those who do still do not seek them on time because they think that they will be discriminated against by the medical personnel. Ignorance cause some sexual violence survivors to visit the SGBV centers when it is too late i.e. even years late as they only do so when someone advices them to do so. Some think that even if they visited and the hospital they

would not get ant help there. Some of the participants had gone up to high school while others had dropped out of school either in primary or secondary school mostly because of lack of school fees. On the other hand there was one participant who had gone up to college level and had studied hotel management but was still not aware that she was supposed to report to the hospital within72 hours after sexual abuse.

> Resp: "*I did not report to the hospital because I did not know that it was important to do so"*
>
> Resp2: "*The idea of going to the hospital never crossed my mind, not even for a moment did I think of going to the hospital*."

In addition to not reporting to the hospital on time, most sexual violence survivors do not report to the police due to ignorance. Even those who later go to the hospital most of them do not report to the police. The fear that the most police are men, contributes greatly in the survivors not reporting. Others just do not see the point of reporting because they do not know the perpetrator or do not want to be discriminated against because they put the perpetrator in prison.

> Resp3: "*I thought that if I reported, he would be arrested and people will say that I was the one who had made him arrested, so I didn't report"*
>
> Resp4: *I didn't report because you can only report a case when you know the culprits. So if I would have reported, how would I have identified them yet I didn't know them?"*

Relationship with the perpetrator

Incest is considered a taboo in most African societies, it is because of these taboos that whenever a woman is sexually abused by a member of her family, the family members tend to cover up the abuse or try to "solve" the issues within the family boundaries. Women who are abused by their family members rarely report to the hospital despite the risks involved like HIV and unwanted pregnancies because they do not want to break their family ties or bring "shame" to the family.

> Resp: "*I thought that if I went to the hospital or told my parents, I would break the family, that they will not live in harmony, and would they even understand me? What would they take me for? They would have told me not to speak of the incidence. Even later when I told my father, he just kept quiet, and told me that it was long ago and therefore not relevant."*

STIGMA

Most women who are sexually abused fail to report or tell anyone about it due to fear of stigma. They fear that if they share with anybody the person/ people they tell will view them in a different way. Some of these women view sexual abuse as something to be ashamed of. Sexual violence is associated with lack of morals as it is viewed as the woman's fault for either being out at night or claimed to have provoked the perpetrator by dressing too seductively. When the perpetrator is a family member the family tends to cover the story or 'solve' the case by discussing with other members of the family. All these are done to avoid stigma from people outside. Some parents also advice their daughters who have been sexually abused to remain quiet about it for they do not want to be associated with loose morals. Fear of stigma is one of the major reasons as to why many sexually abused women never report to the hospital on time.

RESP1: *"I did not want to report to the hospital or tell anyone because if people found out I thought they would start seeing me in a different way and would hate me."*

Self blame

Self blame is a major reason as to why many sexually abused women never report to the hospital on time. Many abused women tend to blame themselves for what happened to them, they tend to believe that it was their fault especially those abused by perpetrators well known to them because they think that if only they had not gone to the perpetrators home then it could have never happened. Also those who are abused while walking at night blame themselves and think that it was their fault for walking in the dark alone. This self blame prevents these women from sharing with anyone or even seeking medical help that they deserve.

> Resp: "*May be my mother would have taken me to the hospital but I was afraid to say, if I had told my mother, where I would say it happened from? I was supposed to come from school and go home, why did I go to his place? I took myself to his place. All that made me afraid to tell my mum."*
>
> Resp2: "*The doctors could not have understood. They have this notion that only children can be raped. They would have asked so many questions like, 'where were you coming from? Or, where were you going?' more so, I didn't have a husband, and I was coming from town. Then I was living far away from town. Put yourself in my shoes, when you have not been successful to get any job or money to feed your children, and as you walk home you are ambushed and raped, what can you do?"*
>
> Resp3: "*I blamed myself for allowing a man into my house, something that I had never done. I would never have allowed that man."*

Religious Influence

Religion is part of many people's life's, in Kenya, we have two major religious denominations; most people are either Christians or Muslims. Both religions discourage sex before marriage and in fact Muslims who are found not to be virgins when they are getting married are punished. In Christianity those sex before marriage is considered as a sin. Even though both religions condemn 'evil' doings including rape, women who are religious feel like they have gone against their religious beliefs when they are sexually abused because even though it was against their will, they still consider it as sex before marriage. These women are forced to keep it to themselves as they do not want to be condemned for having sex before marriage and regarded to as impure. In some religious cults like the "Akurinu" followers are not allowed to go to the hospital for any reason. Therefore, this contributes to not reporting to the hospital on time.

> Resp1: "*you know, I was a saved Christian and was a virgin and pure. So after I was raped I realized I was very filthy, I didn't even want to go to church or share with anybody. I didn't go to church for nearly a whole year*".
>
> Resp2: "*People from my church would have thought that I had engaged in fornication and would look at me differently and probably ban me from attending services. In my church, we are also not allowed to go to the hospital so either way there was no need of sharing with them."*

Lack of transport

Sexually abused women especially those who live in the villages where health facilities are kilometers away from their homes, fail to report to the hospital on time due to lack of transport. Those women who are aware that they are supposed to visit a health facility fail to do so due to

financial constraints. They are also not aware that services are offered for free and therefore fail to go in fear of being over charged.

> Resp1: "*I knew that I was supposed to go to the hospital but I did not have any money yet it is very expensive to go to the hospital."*
>
> Resp2: "*I went home, I thought of going to the hospital but my husband was away on a trip and I did not have money so I waited for him to come back three days later and that's when I told him and he took me to the hospital.*"

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This study was carried out to look at the influence of Cultural, socio-economic factors on first visit to the KNH SGBVRC clinic for SGBV women survivors.

The study found that, the majority (60%) of the SGBV survivors reported late (72 hours after sexual abuse) to the SGBV clinic in Kenyatta. Only 36.8% reported within 72hours, 6.7% reported within 14 days 5.5% reported within 30 days, 23.3% reported within 180 days and 23.9% reported after 180days. This is comparable to a study done at Mulago hospital in Kampala Uganda, (Samuel Ononge, Julius Wandabwa, Paul Kiondo and Robert Busingye, 2005 where the majority (57%) reported to the emergency gynecological ward after 72 hours following sexual violence.

Most survivors who reported to the health clinic within 72 hours did so because they were either injured, had vaginal discharge or were referred by the police. This is similar to a study by (L.H and J.F,2011).

Most (57%) of the survivors were abused by perpetrators who were unknown to them. This was different from other studies like the Mulago study where (79%) of the survivors had been abused by people well known to them. This however could have been have been a result of those raped during the post election violence in 2007-2008.

Stigma is one of the major reasons as to why some SGBV female survivors failed to report or reported late to the clinic because they did want to share their experience with anyone for fear that their families will find out. This is comparable to a study by Lauren Harris and Julie Freccero, 2011 which showed that SGBV survivors may be reluctant to report due to fear of stigma. This also applies to those survivors whose perpetrators were relatives, they did not report due to fear of stigma from family.

SGBV survivors experienced psychological issues like; shock, confusion, feeling of helplessness and self blame and were therefore not be able to seek medical help this is similar to the Sexual Violence & Accountability Project Working Paper Series, (L.H and J.F,2011)

SGBV survivors did not report the incidence to anyone because; they felt embarrassed and because they felt that nothing could be done. The study sexual gender-based violence and health facility needs assessment in Liberia, (WHO, 2005) had the same results.

Very few survivors were advised to seek medical services by the person they first reported to. These people got traumatized and shocked. This is in comparison to the study sexual gender-based violence and health facility needs assessment in Liberia, (WHO, 2005) which shows that only 23% were referred to the hospital.

Some Sexual Gender Based violence survivors lacked knowledge (ignorant) about the importance of going to the hospital within 72 hours and therefore went when it is too late.. This is comparative with the study; Sexual Violence & Accountability Project
Working Paper Series, (L.H and J.F,2011).

Some participants were not able to report to the hospital on time due to long distances and lack of transport. Experiences of female survivors of sexual violence in eastern Democratic Republic of the Congo study (JT Kelly et.al) concluded the same.

There is a relationship between poverty and late reporting to the SGBV clinics for survivors, this because, the survivors thought that that they would be charged a lot of money for the services and may not be able to cover the bills.The Kenyatta National Hospital (Sexual) Gender based violence recovery centre strategic plan (2012-2017) has the same findings.

Some survivors did not trust the health care workers in opening up to them about the rape incidence. The respondents said that the health workers lack confidentiality and are very insensitive. This is comparable to the study sexual gender-based violence and health facility needs assessment in Liberia, (WHO, 2005).

The research findings showed that when a woman is raped by her husband or a close relative, she is more unlikely to report to the hospital because they think that their husbands has the right to have sex with her even when she is not interested. On the same, women raped close relatives did not report because incest is a taboo in many ethnic groups in Kenya and therefore they feared r of bringing shame to the family. This is comparable to a study done at Mulago hospital in Kampala Uganda, (Samuel Onongeet.al, 2005)

CONCLUSION

The purpose of the study was to investigate: The cultural and socio-economic factors that influence first visits to the SGBV clinics for female survivors of sexual violence at Kenyatta national hospital.

These findings have shown that majority of sexual gender based violence survivors (74.4%) report late (after 72 hours) to the SGBV clinic in Kenyatta and therefore there is still a major problem that needs to be urgently addressed.

Education was found to be a significant factor in relation to late reporting for post rape care, this is because of those who reported within 72 hours, the majority 37% had only attained primary education while 28% had attained high school education and 15% at college level.

There is a relation between SGBV and late reporting to health facilities for SGBV survivors and employment. This is because more than half, 71% were unemployed while only 29% were employed at the time of reporting.

Cultural factors can lead to late reporting because, the cultural perception of rape makes the survivors fearful and feels stigmatized and therefore they do not seek medical services. Religion also contributes as both Muslim and Christian religions are against sex before marriage and hence survivors fear to disclose in fear or rejection and being referred to as a "sinner''.

Economic factors such as lack of education and low socio economic status highly contribute to late reporting to SGBV clinics. This is because some women did not have transport to go to the hospital while others had no knowledge of the importance of visiting the clinic.

Lack of knowledge on what to do after sexual abuse is also a major problem and need to be looked at.

RECOMMENDATIONS

1. Computerized file storage should be encouraged for easier access and standardization.
2. Strict measures should be taken to prevent SGBV
3. **Awareness Creation**: it is important to ensure that the public is aware of the importance of reporting to a health facility following sexual violence. It is also important to create awareness on what one should do in case of rape.
4. **Training for medical staff:** medical staff should be trainedhow to handle sexual gender based violence survivors. This will help to reduce stigmatization from medical personnel.
5. Further studies on reasons for late visits to SGBV clinics after sexual violence should be conducted.

Research Time Frame

Activity	Starting Time	Completion
Research Proposal Preparation	14th Jan 2013	9th March2013
Presentation and Approval of Proposal By Department of Psychiatry, UON	11th March2013	11th March2013
Submission of Proposals to Ethics Committee	5th April 2013	13th Oct 2013
Data Collection	1st Nov 2013	30th March 2014
Data Entry	1st May 2014	15th June 2014
Data Analysis	17th July 2014	8th Sept 2014
Research Write-up	1st Feb 2015	30th March
Results defense & Approval By Department of Psychiatry, UON	3rd July 2015	3rd July 2015
Complete Research Document	8rd July 2015	10th July 2015

BUDGET

1.	Incentives for Interviews for 20 patients	20 x500	10,000
2.	Credit		5000
3.	Communication, Printing, Photocopying and Binding proposals and reports	20,000	20, 000
4.	Charges for the Kenyatta National hospital/ The University of Nairobi Ethics Review Committee (KNH/UON –ERC) Services	3000	3000
	Transcription	20,000	20,000
5.	Statistician	30,000	30,000
6.	Contingency	5,000	5,000
	Total approved		93,000

REFERENCES

1. The Kenya police report EHS 2003
2. WHO report, (2001) Mental Health, A call For Action By World Health Ministers 54th World Health Assembly p. 6-7.
3. Krug et al., (2002) Krug, Etienne, Linda Dalhberg, James Mercy, Anthony Zwi, and Rafael Lozano, Eds. 2002. *World Report on Violence and Health*. Geneva: WHO.
4. Child Abuse Negl. 2004 Aug;28(8):833-44.Child sexual abuse in Tanzania and Kenya.Lalor K.Department of Social Sciences, Dublin Institute of Technology, Mountjoy Square, Dublin 1, Ireland.
5. South African Demographic and Health Survey (1998)
6. The Sexual Offences Act. No 3 of 2006, (2006)
7. Kenya Demographic and Health Survey (2008-2009) p.270.
8. KNH-GBVRC service report for the years (2007 –Sept 2011) p.5
9. Heise, L., M. Ellsberg, and M. Gottemoeller. (1999). *Ending violence against women*. Population. Reports, Series L, No. 11. Baltimore, Maryland.: Johns Hopkins University School of Public Health,Population Information Program.
10. Adudans MK, Montandon M, Kwena Z, Bukusi EA, Cohen CR. (2011) Afr J Reprod Health.
11. Jewkes, R., L. Penn-Kekana & J. Levin.(2002). Risk factors for domestic violence: findings from a South African cross-sectional study. *Social Science and Medicine,* 55:1603-1617
12. Nachega JB, Knowlton AR, Deluca A, et al.(2006). Treatment supporter to improve adherence to antiretroviral therapy in HIV-infected South African adults. A qualitative study. J Acquir Immune Defic Syndr.

13. United Nations General Assembly (UN-GA). (2006.) *In depth study on all forms of violence against women: Report of the Secretary-General.*
14. Alliance: Factsheets: Trauma of Victimization. Nycagainstrape.org. Retrieved on (2011-10-01)
15. Keesbury et al., (2006); Radar (2006); Kilonzo and Taegtmeyer , (2005)
16. . Uzma Mazhar, (2002). Rape & Incest: Islamic Perspective
17. How Sharia Law Punishes Raped Women. Aina.org. Retrieved on (2011-10-01).
18. Polk, Michael F. (1998). "Women Persecuted under Islamic Law: The Zina Ordinance in Pakistan as a Basis for Asylum Claims in the United States". *Georgetown Immigration Law Journal* 12: 379
19. J Interpers Violence. (2012). Epub 2012 Feb 10.Association between education and domestic violence among women being offered an HIV test in urban and rural areas in Kenya.Abuya BA, Onsomu EO, Moore D, Piper CN.African Population and Health Research Center, Nairobi, Kenya.
20. The Kenyatta National Hospital (Sexual) Gender based violence recovery centre strategic plan (2012-2017)
21. World Health Organization, (2005) 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.
22. Ms. Radika Coomaraswamy, (1995). Commission on Human Rights, *Preliminary Report by the UN Special Rapporteur on Violence against Women*,
23. Gender Based Violence Recovery Centre –Kenyatta National Hospital report, (2010)
24. WHO (2002), Jensen & Otoo-Oyortey (1999), and Gordon & Crehan (2000)

25. Abrahams, N., Jewkes, R., Hoffman, M. & R. Laubsher (2004). Sexual violence against intimate partners in Cape Town: prevalence and risk factors reported by men. *Bulletin of the World Health Organization.*
26. Kenya.Fonck K, Leye E, Kidula N, Ndinya-Achola J, Temmerman M.International (2005). AIDS Behav. 2005. Increased risk of HIV in women experiencing physical partner violence in Nairobi, Centre for Reproductive Health, Ghent University, De Pintelaan 185 P3, 9000 Ghent, Belgium.
27. Chersich MF, Luchters SM, Malonza IM, Mwarogo P, King'ola N, Temmerman M.International(2007) Nov;18(11):764-9.Heavy episodic drinking among Kenyan female sex workers is associated with unsafe sex, sexualviolence and sexually transmitted infections. Int J STD AIDSCentre for Reproductive Health (ICRH), Mombasa, Kenya. matthewf.chersich@icrh.org

APPENDIXES

APPENDIX I

THE UNIVERSITY OF NAIROBI

DEPARTMENT OF PSYCHIATRY

INFORMED CONSENT FOR PARTICIPANTS

Hello, my name is Janet Kamau.

I am pursuing a master's degree in clinical psychology at University of Nairobi. We are conducting a survey in Kenyatta National Hospital, to learn about the economic and socio-economic factors that influence visits to clinics for sexual gender based violence women survivors. You have been randomly chosen to participate in this study. I would like to assure you that the information you will provide will be kept confidential. You have a right to discontinue with the interview anytime you want to, or fail to answer any questions that you may not want to answer. There are no wrong or right answers. You may find that some topics may not be easy to discuss, but it may very helpful if you did. Your participation is completely voluntary but your experiences could be very helpful to other women in Kenya. You are allowed to raise any questions that you might have. If yes, is right now a good time to talk? It's very important that we talk in private. Is this a good place to hold the interview, or is there somewhere else that you would like to go?

I CERTIFY THAT I HAVE READ THE ABOVE CONSENT PROCEDURE TO THE PARTICIPANT.

SIGN: ……..

Mobile number……

APPENDIX II

CONSENT FORM

Consent Declaration

I …….. I hereby consent to participate in this study. I have understood the all the risks and benefits. It has been explained to me that the study will be carried out in order to determine the influence of cultural and socio-economic factors on first visits to SGBV clinics for Sexual Gender Based Violence survivors. I also understand that am free to withdraw from participating in the study at any time I would like to discontinue without loss of benefits.

I understand that the all the information that I am going to provide will be kept confidential and my name will not appear on any documents and reports that will be shared with others. I had the opportunity to ask questions which were clearly answered.

Name of participant…….

Signature…….

APPENDIX III

FOMU YA IDHINI

Mimi kama .....Napeana ridhaa ya kushiriki katika utafiti huu. Nimeweza kuelewa hatari na faida zote za kushiriki. Nimeelezwa kuwa utafiti utafanyika ili kujua ushawishi wa kitamaduni na kijamii na kiuchumi juu ya ziara ya kwanza katika kliniki ya unyanyasaji wa ngono wa kijinsia kwa waathirika. Pia nimeelewa ya kwamba niko huru kuondoka kutoka kushiriki katika utafiti wakati wowote ningependa bila kusitishwa hasara ya faida. Naelewa kwamba taarifa yote nitakayotoa itakuwa siri na jina langu halitaonekana kwenye nyaraka zozote ambazo zitaonekana na watu wengine. Nilipata fursa ya kuuliza maswali ambayo nilijibiwa wazi.

Jina la mshiriki .....

Sahihi .....

APPENDIX IV

STUDY GUIDELINES

- Introductory question- Please tell me the circumstances surrounding the experience of sexual violence (rape) that led you to coming to the hospital in (date of first visit) last year

- **Circumstances around the rape**

1. When did the sexual violence take place?
2. Where did the rape take place?
3. What is your relationship to the perpetrator

- **Involvement of others**

1. Who did you tell about what happened to you
2. Who did you report to

- **Self initiated behavior**

1. What did you do after you had been sexually abused
2. What kind of help did you seek

- **Behavior initiated by others**

1. What kind of advice did others give you
2. What kind of help did you receive from those you told

- **Medical assistance**

1. Did you seek medical help
2. Which hospital/clinic did you first visit

- **Other help**

1. Did you seek any other kind of help?
2. How were you helped

- **Life circumstances and habits- biographical information**

1. Tell me about your family
2. Tell me about your education background
3. What is your source of income
4. Where do you reside
5. Are you married or single

APPENDIX V

STUDY GUIDELINES IN KISWAHILI

Swali la kutangulia -Tafadhali niambie hali ya mazingira na uzoefu wa unyanyasaji wa kijinsia (ubakaji) ambayo imesababisha kuja kwako katika hospitali (tarehe ya ziara ya kwanza) mwaka jana

- Mazingira kuzunguka ubakaji
    1. Ubakaji ulifanyika lini?
    2. Ubakaji ulifanyikia wapi?
    3. Je,una uhusiano upi na aliye kubaka
- Ushiriki wa wengine
    1. Ulimweleza nani kuhusu kile kilichokutendekea
    2. Ulipiga ripoti kwa nani
- Tabia za kibinafsi

    1.Ulifanya nini baada ya wewe kunajisiwa

    2. Ulitafuta msaada wa aina gani

- Tabia zilizoanzishwa na watu wengine

    1.Watu wengine walikupa ushauri wa aina gani

    2.Ulipokea msaada gani kutoka kwa wale ulioambia

- Msaada wa matibabu
    1. Je, ulitafuta msaada wa matibabu

2. Ulitembelea hospitali / kliniki gani kwanza

- Msaada mwingine

1. Je, ulitafuta aina nyingine yoyote ya msaada?
2. Ulisaidiwa kwa jinsi gani

- Maisha mazingira na tabia

1. Niambie kuhusu familia yako
2. Niambie kuhusu elimu yako
3. Je, chanzo chako
4. Unaishi wapi
5. Je, umeolewa

A DATA RECORDING FORM

AGE	18-24	25-30	31-40	45-50	50+
MARRIAGE STATUS	SINGLE	MARRIED	SEPARATED	DIVORCED	WIDOWED
EDUCATION	BELOW PRIMARY	PRIMARY LEVEL	SECONDARY LEVEL	COLLEGE LEVEL	UNIVERSITY LEVEL
DATE OF REPORTING	WITHIN FIRST 24 HRS	WITHIN 72 HRS	A DAYS AFTER 72 HRS	A WEEK(S) AFTER	MONTHS AFTER
DATE OF ASSULT	WITHIN THE LAST 72HRS	WITHIN THE LAST ONE WEEK	WITHIN LAST ONE MONTH	WITHIN THE LAST YEAR	MORE THAT AN YEAR AGO