

# SEXUAL VIOLENCE RESEARCH INITIATIVE

## A BRIEFING PAPER

### Research Priorities for Strengthening the Medico-Legal Response to Sexual Violence in Eastern, Central and Southern Africa<sup>1</sup>

**S**exual violence is a profound human rights violation and public health problem. There are no rape free societies. It is estimated that 1 in 4 women experience sexual violence by an intimate partner in their lifetime, and 1 in 3 adolescents report their first sexual experience as being forced (Jewkes et al 2002). Prevalence rates vary markedly worldwide as do the types of sexual violence that occur. This variation indicates the importance of societal factors in fuelling rates and types of sexual violence within and between countries. More importantly, it also signifies that high rates of sexual violence are not inevitable (Astbury 2008). In many settings sexual violence remains one of the least researched, resourced and punished forms of gender based violence and continues to remain low on the agenda of policy makers, service providers, and funders ([www.svri.org](http://www.svri.org)).

The associated mental, physical and social harms of rape and sexual assault are complex and multifaceted. These consequences can be both short and long term. Responses to rape include psychological distress, including anxiety, depression, post-traumatic stress disorder (PTSD), suicide, sexual risk taking, pregnancy, sexually transmitted infections, HIV, genital and other injuries, genital fistulae, pregnancy loss and death (Jewkes and Dartnall 2008). Appropriate, positive and effective responses by services can minimise some of these post rape health

related harms (Bletzer & Koss 2006).

Services for victim/survivors of sexual violence in most countries, particularly low and middle income countries, have been neglected (Christofides et al 2005). The types of services essential to recovery include basic clinical care including psychological support; treatment for possible sexually transmitted diseases, including prophylaxis against HIV; treatment for physical injury and examinations and documentation of injuries for legal purposes (Jewkes and Dartnall 2008). Moreover, criminal justice system interventions are often adversarial and as a result can re-traumatise and re-victimise survivors (Kohsin-Wang and Rowley 2007).

A desk review commissioned by the SVRI on women's responses to sexual violence highlights a lack of research on the needs of sexual violence survivors from the perspective of survivors, and limited focus on developing models of intervention and practice, 'that are effective, acceptable and affordable in diverse cultural settings' (Kohsin-Wang and Rowley 2007). The SVRI review on medico-legal responses to sexual violence found insufficient evidence to establish whether collection and processing of medico-legal evidence improves criminal outcomes for sexual assault victims (Du Mont & White 2008). These reviews tell us that there is still a great deal we do not know both in terms of women's responses and medico-legal responses to rape. For

<sup>1</sup> This review was prepared by Liz Dartnall, SVRI Programme Officer, and reviewed by Rachel Jewkes, Jill Astbury & Carol Ajema.

example, the minimum amount of medico-legal evidence needed to impact in court has not been established; nor have the circumstances in which medico-legal evidence is most valuable. Similarly, we do not know the answers to the following: How do socio-cultural factors influence the use of medico-legal evidence? Does training to better collect and utilise evidence enhance the value of medico-legal evidence? What is the value and meaning of the medical forensic examination for survivors?

In response to these gaps, and to promote evidence based programming, a regional workshop was organised by Liverpool VCT Care & Treatment (LVCT) and Sexual Violence Research Initiative. Workshop participants were asked to discuss in groups how and where we should focus limited research resources in order to ensure efforts to strengthen sectoral responses to sexual violence are evidence based. This brief provides you with an overview of these discussions.

### Magnitude and Nature of Sexual Violence in the Region

Research on sexual violence is essential for understanding the extent of the problem and how best to respond and prevent it. Research on the nature and magnitude of the sexual violence in east and southern Africa is limited. Regional insight on the magnitude of sexual violence can however be gained from the findings of the WHO multi-country study on violence against women.<sup>2</sup> Three African countries, Ethiopia, Tanzania and Namibia were included as research sites in this global study (Garcia-Moreno 2005). Sexual violence by an intimate partner ever reported by women interviewed in this study ranged from 16.5% in Namibia up to as high as 58.6% in Ethiopia. Whilst 16.6% of respondents from both Ethiopia and provincial respondents in Tanzania, report their first sexual intercourse as being forced. Table below refers.

Site	Sexual Abuse in Childhood Sex before Age 15 (best estimate)*		Sexual Coercion by an Intimate Partner			Non-partner Sexual Coercion Since Age 15			
	N	%	N	%	N	Ever %	Current %	N	%
Ethiopia province	3014	7.0	2238	16.6	2261	58.6	44.4	3016	0.3
Namibia City	1492	21.3	1357	6.0	1367	16.5	9.1	1498	6.4
United Republic of Tanzania City	1816	12.2	1557	14.3	1442	23.0	12.8	1816	11.5
United Republic of Tanzania prov.	1443	9.5	1287	16.6	1256	30.7	20.2	1443	9.4

Source: Garcia-Moreno C, et al (2005)

In those sites where anonymous reporting was not linked to the individual questionnaire, the best estimate is the highest prevalence given by either of the two methods of data collection used in the multi-country study ie face-to-face and anonymous report.

The types of sexual violence experienced by women in this study included: Rape within marriage or dating relationship; rape by strangers; rape during armed conflict (small lake region); unwanted sexual advances or sexual harassment in return for favors; sexual abuse of the mentally or physically challenged; child sexual abuse (both male and female); and forced cohabitation including marriage (child marriages, widow inheritance, tribal marriages including kidnapping of young brides) (Mwambo, 2008).

<sup>2</sup> In the study, randomly-selected samples of women aged 16-49 years from 10 different countries, often from rural and urban areas, were interviewed to create a dataset of more than 24,000 women.

## Regional responses to sexual violence: promising practices

Regionally, (sub-Saharan and East Africa), there have been a myriad of legislative and health sector responses to sexual violence. Few of these responses are informed by the needs and perspectives of victims or focus on the medico-legal linkages that are critical for a comprehensive delivery of service to the survivor and for justice to prevail. Very few have been properly evaluated (LVCT/SVRI Workshop Report 2008).

A series of papers on work being undertaken in the region were presented during the workshop.

A Kenya based study on standards for “Custody of Evidence” chain for post rape care services found a lack of knowledge among service providers on types of sexual violence, and what legally constitutes rape, as well as ambiguity over the most appropriate first points of contact among both survivors and service providers, and problems related to record collection. Lack of training of all service providers and poor inter-sectoral linkages between the various service sectors were identified as barriers to providing comprehensive post rape care in Kenya. The use of alternative forms of justice by survivors and their families was seen by the police and justice sectors as an additional challenge (Ajema et al 2008).

A further presentation from Kenya provided an overview of a partnership project between LVCT and the Ministry of Health through the Division of Reproductive Health that is working to scale up comprehensive post rape care services. The initiative was accelerated due to an existing lack of services. Key programme objectives include: the strengthening of government capacity to institutionalize standard quality assured post rape care services; and to use evidence to facilitate policy reform in prevention of sexual violence & strengthening care and rehabilitation services. The programme works at multiple levels including policy,

services, research and training, and directly supports 16 public health facilities in the provision of comprehensive Post Rape Care services (Muchela & Meme 2008).

From South Africa, an overview on models of care currently provided in one province in the country was given. A number of different models were presented, ranging from crisis services, one-stop centres, medico-legal services centres to centres of excellence. Using the lessons learned from these various models, Gauteng province is developing a uniform service package, that will address sexual assault, domestic violence, general assault, perpetrator examinations, drunken driver assessments, age assessments, para-suicides and suicides. It was considered essential that the needs of survivors lie at the heart of this service. Challenges include the need to retain trained staff utilising various incentive models, the development and resourcing of a research programme to guide and monitor development of the service and the ongoing development and strengthening of inter-sectoral collaboration (Makhosane 2008).

A baseline survey undertaken in Zambia to inform the development of a multi-sectoral response to sexual violence found that most sexual assaults reported to the police were young adolescent girls and that the police were the first point of institutional contact for virtually all women seeking assistance. Provider attitudes were found to present significant barriers to providing effective post rape care. For example, only one-third (33%) of health care providers believed that a rape survivor has “serious medical problems”, and the majority of police (80%) agreed that “some women lie about rape to punish men.” The intervention developed as a result of this project demonstrates that police can be a vehicle for service provision and that they

are successfully able to provide emergency contraception to rape survivors (Zama 2008).

Work presented on strengthening post rape care services in Malawi aims to create a functional and effective network of key sexual and gender based violence stakeholders. The findings of a baseline survey on services for survivors found the criminal justice was slow in processing rape cases, and that survivors do not trust the system. As a result, cases are dropped and some opt for dispute resolution alternatives. Lack of capacity and negative attitudes among health care providers was seen as a key challenge for improving services in Malawi. In order to create a functional and effective network of key stakeholders, including the community, on sexual and gender based violence the need to build capacity among service providers and to address negative attitudes and practices were seen as priority key areas of action (Njawili 2008).

Jina (2008) presented a project through which a training programme for sexual assault health care providers was developed in South Africa. The national curriculum developed as a result of this project, builds on over a decade of initiatives undertaken across South Africa at policy, training, research and service levels to improve sexual assault care. Multiple methods were used in the development of the curriculum to ensure it was evidence based, locally relevant and in line with international training standards. The development process included an international review of best practice; commissioning of local experts to draft modules which were then reviewed by local and international experts, nation-wide piloting and evaluation. The training emphasizes a holistic approach to care and the central importance of meeting the basic health care needs of survivors in mitigating potential harms of sexual assault by providing treatment to prevent pregnancy and sexually transmitted infections being acquired from the assault, and to support and assist in navigating its emotional impact. It also highlights the

valuable role of collecting evidence to assist the process of securing justice for sexual assault survivors (Jina 2008).

Based on these presentations and group discussions, a number of key challenges to the development and delivery of comprehensive multi-sectoral post-rape care models in the region were identified. These included:

- o Limited human resource at all the levels of the medical and legal sectors;
- o A lack of trained service providers and inter-sectoral training programmes;
- o Lack of guidelines/policies to govern and support delivery of medico-legal services to survivors;
- o Lack of all levels of services to refer survivors of sexual violence including places of safety (particularly in the case of children);
- o Lack of facilities for forensic examination and weak laboratory services to analyse results timeously if at all;
- o Lack of transport to carry survivors from one part of the service to another;
- o Limited referrals/interactions between traditional and formal systems.

A multi-partner project being undertaken in 9 African countries: Kenya, South Africa, Zambia, Rwanda, Uganda, Malawi, Zimbabwe, Senegal and Ethiopia identified a number key cross cutting lessons for strengthening services for survivors of sexual and gender based violence (Keesbury 2008), including:

- o Standardized, multi-sectoral frameworks, guidelines and protocols are essential for ensuring coordinated medico-legal responses to sexual and gender based violence.
- o The special needs of child survivors are under-addressed in police, medical, legal and long-term care settings.
- o Enabling access and utilization of the full range of medical (and medico-legal) services remains a core challenge of sexual and gender based violence programs.

- o Training and capacity building of service providers is necessary for increasing quality of care and improving provider attitudes.
- o Specialized police units, or Victim Support Units, present a promising approach to strengthening medico-legal responses.

### Regional research priorities for strengthening care and support for survivors of sexual violence

The research priorities identified through the process of this workshop fell into the following categories: nature, prevalence and social context; appropriateness and effectiveness of sexual violence services; justice and community based responses; child sexual abuse; and sexual violence prevention. According to these categories, the regional research priorities are outlined below.

#### Nature, prevalence and social context priority areas for research include:

- o Assessment of the prevalence and patterns of sexual violence in a range of settings, using the WHO Multi-country study tool to allow for regional comparisons;
- o Identification of mental and physical health and social consequences of sexual violence;
- o Identification of the social contexts which fuel different forms of sexual violence in different countries and settings and the risk arising from ideals of gendered behaviour.

#### Regional research priorities to address the appropriateness and effectiveness of sexual violence services include to:

- o Undertake a situational analysis of formal sector services, and the level of services provided and the degree to which staff are specifically trained to respond to sexual violence;
- o Establish the contributory factors of the various forms of sexual violence, the effectiveness of the current

interventions, and the perceptions of the survivors and the community towards the different interventions;

- o Evaluate different community based models of post rape support for survivors, both in terms of mental health outcomes and cost effectiveness e.g. to what extent do support groups (other forms of support) assist in reducing mental health outcomes of survivors?;
- o Evaluate the impact of the integrated clinical care practices and different mental health therapies on the well-being of the survivors;
- o Identify the various pathways to care after sexual violence, the responses encountered and the challenges to meeting survivors' needs post rape;
- o Determine the psychological consequences of sexual violence in relation to the coping strategies of the survivors;
- o Determine the impact of traditional healing practices on recovery;
- o Establish the efficacy of screening interventions and to determine their impact on the emotional and health outcomes of survivors.

#### Priority areas for research in the area justice and community based models include:

- o In the African context, what type of forensic evidence is most useful in securing prosecutions?;
- o What is the relationship between formal and traditional courts?;
- o What is 'justice' for survivors, and how can programs best ensure that?

#### Sexual violence prevention priority areas for research include:

- o Identification of risk factors for perpetration of sexual violence and the contexts in which it occurs;
- o Development and evaluation of African based primary prevention programmes and strategies.

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