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FEATURES

Sexual violence legislation in sub-Saharan Africa: the need for strengthened medico-legal linkages

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Abstract: *Six sub-Saharan African countries currently have laws on sexual violence, including Kenya, and eight others have provisions on sexual violence in other legislation. Effective legislation requires functioning medico-legal linkages to enable both justice to be done in cases of sexual violence and the provision of health services for survivors of sexual violence. The health sector also needs to provide post-rape care services and collect and deliver evidence to the criminal justice system. This paper reviews existing data on sexual violence in sub-Saharan Africa, and summarises the content of sexual violence legislation in the region and the strengths and weaknesses of existing medico-legal linkages, using Kenya as a case study. Many sub-Saharan African countries do not yet have comprehensive post-rape care services, nor substantial co-ordination between HIV and sexual and reproductive health services, the legal and judicial systems, and sexual violence legislation. These need to be integrated by cross-referrals, using standardised referral guidelines and pathways, treatment protocols, and medico-legal procedures. Common training approaches and harmonised information across sectors, and common indicators, would facilitate government accountability. Joint and collaborative planning and working at country level, through sharing of information and data between the different systems remain key to achieving this.*
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SUB-SAHARAN African countries are increasingly responding to sexual violence with a range of legislative and health care interventions. The aim of sexual violence legislation is to protect the fundamental rights of persons to bodily integrity through punishing and prosecuting perpetrators as an approach to preventing sexual violence and meting out justice, thus responding to the needs of survivors of such violence.[1]

Sexual violence can result in negative long and short-term health outcomes, including physical trauma such as vaginal fistula, HIV infection, unwanted pregnancy and where abortion is legally restricted, unsafe abortion. Vulnerability to sexually transmitted infections (STIs), including HIV, may be higher than in consensual sex due to genital trauma and in cases of multiple perpetrators. Resulting psychological trauma can have a negative effect on sexual behaviour and relationships, the ability to negotiate safer sex, and increased potential for drug abuse.[2]

The health sector is at the nexus of prevention, treatment and rehabilitation following sexual violence. It should provide clinical treatment, preventive therapy, psychological support, and information and advice,[3] commonly referred to as post-rape care services. These need to interface with HIV services for HIV testing and counselling, and HIV post-exposure prophylaxis (PEP) administration and adherence counselling. They also need to interface with reproductive health services for treatment of physical/genital trauma, emergency contraception, abortion, and STI prophylaxis and treatment.[4,5] The health sector should collect, store and analyse evidence of the effects of the violence and deliver that evidence to the criminal justice system for purposes of its investigations and use in any trial.[2] Thus, legislation cannot effectively offer justice to survivors without clearly articulated and functioning linkages between the medical and legal systems. This interface requires a policy framework, and implementation systems and structures.

The term "sexual violence" as used in this paper draws from the World Health Organization definition, while being cognisant of other terms, such as rape and sexual assault, which are often used interchangeably:

"...any sexual act, attempt to obtain a sexual act, unwanted sexual comments and advances or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim."[6]

This paper is about the medico-legal partnerships that are necessary to enable both justice to be done in cases of sexual violence and the health services that need to be provided for survivors of sexual violence. It reviews the limited existing data on sexual violence in sub-Saharan Africa, and summarises the content of sexual violence legislation in the region and the key challenges to its implementation, with a focus on Kenya as a case study of the strengths and weaknesses of existing linkages. It concludes by identifying opportunities to strengthen medico-legal partnerships in responding to sexual violence.

Methods

The paper draws on three sources of information: 1) the published literature from sub-Saharan Africa was searched on the WHO Bibliographic Database on Violence Against Women and the PubMed databases using the keywords sexual violence, legislation, laws, gender-based violence, rape and post-rape care in isolation or varied combinations. 2) We drew from experiences described in presentations and discussions at the first conference on "Strengthening linkages between reproductive health and HIV/AIDS in Africa: the sexual violence nexus", Nairobi, September 2008, referred to here as the Nairobi conference, which was attended by 317 delegates from 14 East, Central and Southern African countries. We reviewed the abstracts and presentations made under the categories "sexual violence legislation" and "sexual violence, reproductive health, STI/HIV services", identifying issues raised and recommendations made regarding medical and legal linkages.[7] In this paper, the Nairobi conference information is used to supplement the literature review and the case study. 3) We also drew on the limited literature on and personal experience and involvement in Kenya's Sexual Offences Act, 2006.[8] Co-author Hon. Njoki Ndung'u was the Kenyan parliamentarian who tabled a motion on sexual offences, undertaking background research and engaging the media, public and civil society in strategising to get Parliamentary support of the bill and negotiating with fellow parliamentarians during the law-making process. Co-author Nerida Nthamburi provided administrative support to the development of the bill and engagement of stakeholders.

Sexual violence in sub-Saharan Africa

Sexual violence in sub-Saharan Africa remains an under-researched and under-resourced area, despite evidence of how pervasiveness it is.[9–12] The WHO multi-country study on women's health and domestic violence against women[13] provides the first comparative data from around the world, including three African countries; Namibia (the capital), Tanzania (a rural and urban setting) and Ethiopia (a rural setting). In these three countries, 16–59% of women had ever experienced sexual violence from intimate partners, and women were at far greater risk of sexual violence from a partner than from others. These data are similar to in-country studies from South Africa, Mozambique, Kenya, Nigeria and Tanzania that also show a high prevalence and variation in types and definitions of sexual violence.[14–17] There appears to

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