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Using Photovoice to Assess Perceptions of Mental Health Services for Survivors of Sexual Violence in Kenya



Acknowledgements

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About Physicians for Human Rights and the Survivors of Sexual Violence in Kenya Network

Physicians for Human Rights (PHR) uses medicine and science to document and call attention to human rights violations. PHR was founded on the idea that physicians and other health professionals possess unique skills that lend significant credibility to the investigation and documentation of human rights abuses. In response to the scourge of sexual violence, PHR launched its Program on Sexual Violence in Conflict Zones in 2011 that has worked to confront impunity for sexual violence in the Central African Republic, the Democratic Republic of Congo, Ethiopia, Iraq, Kenya, Myanmar, and Ukraine.

The Survivors of Sexual Violence in Kenya Network (SSVKenya) is convened by the Wangu Kanja Foundation and brings together survivors of sexual violence, both women and men, to amplify their voices towards restoring their dignity while accessing justice in a timely manner. The Network is anchored within the already existing community structures for purposes of ensuring innovation and sustainability overall.

PHR and SSVKenya have collaborated since 2011 to advocate for justice, accountability, and access to health services, including mental health, for survivors of sexual violence in Kenya.

Cover: A member of the Survivors of Sexual Violence in Kenya Network sorts images that show survivors' perceptions of mental health services as part of a Photovoice data analysis workshop. Photo: Photo: SSVKenya/PHR

Executive Summary

Background

Sexual and gender-based violence (SGBV) is a global health crisis. More than 730 million women worldwide have experienced physical or sexual violence at least once in their lifetime.¹ In Kenya, the Demographic and Health Survey of 2022 showed that 34 percent of women and girls² surveyed reported having experienced physical violence at least once in their lifetime and 13 percent reported having experienced sexual violence, with many of these cases going unreported to authorities.³ SGBV has profound impacts on a survivor's physical and mental health.⁴ Access to mental health care is a major challenge for survivors of sexual violence.⁵

Physicians for Human Rights' Program on Sexual Violence in Conflict Zones began working in Kenya in 2011 to confront impunity for sexual violence committed during the unrest that followed the 2007 national elections.

From 2020 to 2022, PHR worked with partners, including the Survivors of Sexual Violence Network in Kenya (SSVKenya) convened by the Wangu Kanja Foundation, to address challenges faced by survivors. These included medical-legal documentation of the mental health impacts of sexual violence and access to quality mental health services in Kenya. The project, supported by the Comic Relief & UK Aid Mental Health Programme, aimed to enhance the capacities of health professionals and institutions in Kenya to provide post-rape mental health care and to forensically document the mental health impacts of sexual violence, as well as to strengthen the legal and policy framework on mental health care in Kenya.

This assessment arose out of PHR's interest in understanding the impact of these interventions and related advocacy from the perspective of survivors of sexual violence, themselves. To ensure the voices of survivors remained at the heart of the assessment, PHR partnered with SSVKenya, an advocacy coalition comprised of survivors of sexual violence in Kenya.



"The bridge you see here represents the community health volunteer where the survivor must pass through in order to get to the Tumaini clinic."⁶



"This is by the roadside where the survivors pass when they want to go and access medical care. Sometimes it becomes hard for them to pass through this road feeling shy that people may say bad things about them."⁷

Executive Summary

continued

Methodology

To conduct the assessment, PHR and SSVKenya jointly identified 10 survivors of sexual violence from across Nairobi who lived in areas that benefitted from the intervention, were active in SSVKenya, and were engaged in their communities as activists, human rights defenders, and volunteers helping other survivors access health services.

The assessment team selected Photovoice – a participatory action research (PAR) methodology through which community members document their experiences using photography – as well as voice recordings for this assessment.

The use of this methodology reflected a deliberate choice to empower survivors and mitigate the risk of re-traumatization that is inherent in traditional, interview-driven methodologies. The assessment team included self-selected survivors who were motivated to document issues important to them and their community and three PHR staff members. Using this methodology, survivors were equal partners in the assessment.^{9,10}



Photo: SSVKenya/PHR

“ This is the living standard of most of the survivors where I represent. This is how they live.”⁸

“This is a photo representing survivors of sexual violence ... waiting for the PRC form to be filled by the doctor. You can see there are five survivors who have stayed in the line for more than 2 hours.”¹¹
Photo: SSVKenya/PHR



Executive Summary

continued

Findings

The assessment team took a total of 223 photos during a one-week period in October and November 2022 representing their experiences accessing mental health services in Nairobi. These photos were accompanied by a total of 99 WhatsApp voice notes.

Analysis of these materials, conducted by the assessment team and the survivor-collaborators, showed that survivors perceived gaps in the availability, accessibility, acceptability, and quality (AAAQ) of mental health services. As the AAAQ are the essential elements to realizing the right to health, they provide a powerful framework to understand sexual violence-related mental health services from a rights-based perspective.¹²

Availability

Survivors said mental health services for survivors of sexual violence are often unavailable in their communities, due to closed facilities, missing staff, or infrastructure challenges. They said there is minimal prioritization of mental health care services in general, and specifically of services targeting survivors of SGBV and other vulnerable groups.

Accessibility

Survivors identified difficulties accessing mental health services across Nairobi, with transportation a major challenge. They also experienced challenges accessing private facilities, primarily due to the high cost of mental health services and medication.

Acceptability

Survivors felt that many services being offered were not acceptable for their particular needs, including lack of private spaces for counselling sessions. They feared breaches of confidentiality and others learning about their history of sexual violence. They also noted challenges in accessing survivor-centered care, including the fact that providers multitasked during care.

Quality

Survivors frequently reported challenges related to the quality of services being offered. They shared their doubts regarding the skill level of health professionals on providing mental health services and how to engage with survivors of sexual violence. Survivors saw challenges in the implementation of existing policies and standards ensuring quality care in their areas.

Kenya has a clear obligation under national laws and policies to address these gaps and provide high quality, accessible, acceptable, and available mental health care. The Constitution of Kenya affirms that “every person has the right to the highest attainable standard of health.”¹³ The Mental Health Amendment Act’s 2022 revisions state that survivors of sexual violence are entitled to access affordable mental health services in Kenyan health facilities.¹⁴ The Sexual Offences Act Medical Regulations operationalize the provisions of the Sexual Offences Act and provide a legal foundation for access to no-cost post-rape care, which includes mental health services (i.e., counselling) for survivors of sexual violence.¹⁵ The National Guidelines on Management of Sexual Violence in Kenya¹⁶ provide guidance on the survivor-centered implementation of health services for survivors, including mental health services. This solid legal framework provides a robust platform from which Kenya’s national and local governments can implement existing laws to realize the right to mental health of survivors of sexual violence. Despite the strong domestic legal and policy landscape for the provision of mental health care for survivors of sexual violence, there is a gap in the implementation of these policies.

Finally, the government of Kenya, as a party to international human rights treaties and obligations – including the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women, the African Charter on Human and Peoples’ Rights, and the Protocol to the African Charter on the Rights of Women in Africa (the Maputo Protocol) – is obligated to ensure that all sexual violence-related care (including mental health care) is provided in line with the AAAQ framework and should address obstacles to the realization of these standards.

Survivors perceived gaps in the availability, accessibility, acceptability, and quality of mental health services. They said there is minimal prioritization of mental health care services in general, and specifically of services targeting survivors of SGBV and other vulnerable groups.

Conclusion and Recommendations

This assessment not only deepened understanding of the perceptions of survivors of sexual violence about the challenges they face in accessing mental health services, but it also prioritized the engagement of survivors in advocating for change in their communities. This enables the results of this assessment to contribute to action and advocacy efforts. Finally, this assessment shows that Photovoice, as an example of a participatory research and evaluation method, can be a powerful tool to ensure that survivors of sexual violence can remain in the center of assessments, research, and evaluations conducted to understand their experiences.

Based on the assessment's results, PHR and the Survivors of Sexual Violence Network in Kenya offer the following topline recommendations (full recommendations can be found starting on page 20):

To the Nairobi City County Government:

- Allocate county health funds to guarantee no-cost post-rape care and affordable mental health care for priority populations.
- Establish the Mental Health Council, as mandated by the Mental Health Amendment Act.
- Fully implement the National Guidelines on Management of Sexual Violence in Kenya at health facilities that provide post-rape care.
- Allocate more financial resources to mental health service provision and increase the number of staff offering mental health services.
- Conduct annual capacity development for all health care providers on the provision of mental health services.
- Train and engage community mental health workers to offer appropriate first-line mental health services to and referral for survivors of sexual violence.
- Develop new programs to ensure mental health services are more accessible to survivors of sexual violence.

To the Ministry of Health:

- Fund and implement comprehensive training and awareness building on mental health care for survivors of sexual and gender-based violence for all health care workers, including mental health counseling and documentation of psychological evidence of sexual violence.

To all Stakeholders, including National and County Governments, Donors, and Civil Society Organizations:

- Ensure support to survivors' groups and adoption of measures to engage survivors' perspectives and voices in all processes to improve mental health services for survivors.
- Promote and fund participatory methods for engaging survivors to understand survivor priorities.

Background

Sexual and gender-based violence (SGBV) shatters the lives of survivors and remains underreported and under-prosecuted globally.¹⁷ The stigma of SGBV is pervasive enough to keep survivors from seeking medical and psychological care, let alone pursuing justice.¹⁸ In Kenya, the 2022 Demographic and Health Survey found that 34 percent of women and girls aged 15-49 years surveyed have experienced physical violence at least once in their lifetime and 13 percent have experienced sexual violence, with many of these cases going unreported.¹⁹ SGBV has profound impacts on survivors' physical and mental health, and access to mental health care is a major challenge for survivors of sexual violence.^{20, 21}

In 2011, Physicians for Human Rights (PHR) launched its Program on Sexual Violence in Conflict Zones to confront near impunity for sexual violence committed during the unrest that followed the 2007 national elections in Kenya and during the conflict in the Democratic Republic of the Congo (DRC). In both countries, legal protections for sexual violence survivors were too few and too narrow. Judicial capacity and police investigations were absent or weak. There were very few trusted safe places to report sexual violence crimes. As a result, the crimes went undocumented by medical professionals and unreported to investigative authorities, and cases that made it to courts often failed because of insufficient probative evidence to support allegations.

Despite stated commitments by government officials to address sexual violence, they did little to close the gap between victims and justice. Laws meant to protect people from sexual violence went unenforced. Other obstacles to accountability included the government's inability or unwillingness to effectively prosecute sexual violence cases locally; lack of resources to support investigations and prosecutions; difficulties gathering court-admissible evidence (evidence that demonstrates chain of custody from the initial collection of evidence to its final submission into the court record); personal risk involved in reporting rape; weakness of local judicial systems, especially in remote areas; and inadequate security in post-conflict environments. In addition, there was an overreliance on physical injuries, which may disappear over time, as evidence of sexual violence and not enough attention paid to psychological impacts, which are important in substantiating claims of sexual violence after longer time periods have elapsed.

Background

continued

To address these challenges, PHR launched “Strengthening Mental Health Care and Forensic Psychological Evidence Collection in Kenya” in 2020 to strengthen mental health care and forensic psychological evidence collection related to crimes of sexual violence in Kisumu, Nairobi, and Nakuru Counties in Kenya.

The project addressed two distinct gaps identified in previous engagement with stakeholders (from health, law enforcement, judicial, academic, development, and civil society sectors): 1) A lack of understanding of existing health sector practices and an insufficient capacity to conduct mental health assessments to support sexual violence cases; and 2) A lack of clarity on the role that psychological evidence collected using the psychological assessment (Part B) of Kenya’s Post-Rape Care Form plays in sexual violence prosecutions.

The project aimed to improve sexual violence survivors’ access to mental health care by strengthening the capacities of health professionals at three health care institutions in Kenya to provide post-rape mental health care and forensically document mental health impacts of sexual violence. It also sought to raise public awareness on the importance of mental health care and advocate for national policy changes to sustain improvements. Through these interventions, PHR aimed to reduce common barriers that survivors face to mental health care and justice. The project was supported by the Comic Relief & UK Aid Mental Health Programme.

Following the implementation of this project in 2020, it was important to understand the perceptions of survivors who accessed these services. Engagements with survivors should not only empower survivors of sexual violence, but also provide as much direct benefit as possible to the survivors themselves. To ensure these values were reflected in this evaluation, PHR partnered with the Survivors of Sexual Violence in Kenya Network (SSVKenya) to conduct this evaluation, building on many years of collaboration. SSVKenya is a unified movement of survivors that exists to amplify their voices and empower them to address forms of sexual violence across Kenya through advocacy. The assessment team selected Photovoice, a participatory method that uses photography to document issues important to participants and their communities. Photovoice engages participants to take photographs in their community and participate in a process of reflection and exploration of the reasons for their selection of the photos and the experiences guiding their chosen images.

A review of Photovoice found that the Photovoice method evaluates sexual assault climates in ways that other methods, such as surveys and interviews, cannot.^{23, 24} Photovoice offers an important shift from international organizations viewing survivors as subjects to survivors being equal collaborators by centering their knowledge, values, and expertise. Finally, Photovoice seeks to collaboratively collect and analyze information, and to subsequently use the results of the assessment to advocate for policy changes as a central tenet of this methodology. The Photovoice methodology has been used successfully around the world, including in Kenya.^{25, 26, 27}

Photovoice and participatory action research methodologies combined to produce a rich blend of images, captions, illustrations, and transcribed voice notes and focus group discussions, which serve as the data underlying the analysis presented in this assessment.

In Kenya, 34 percent of women and girls aged 15-49 years surveyed have experienced physical violence at least once in their lifetime and 13 percent have experienced sexual violence, with many of these cases going unreported. SGBV has profound impacts on survivors’ physical and mental health, and access to mental health care is a major challenge for survivors of sexual violence.

Methodology

For this project, Physicians for Human Rights (PHR) and the Survivors of Sexual Violence Network in Kenya (SSVKenya) identified 10 survivor-collaborators who acted as community-based collaborators and who were asked to take images representing their experiences accessing mental health care services following sexual violence. The photographs were then analyzed by the survivors themselves to inform recommendations and subsequent advocacy actions to affect change in their communities.²⁸ Using the Photovoice approach to collect data gave survivors the opportunity to tell their stories on their own terms and to uplift the voices of community members who are not traditionally represented in assessment, research, and evaluation.

PHR and SSVKenya jointly developed assessment questions that were refined, adapted, and validated, following the assessment's participatory action research (PAR) methods:

1. What are survivors' experiences of accessing and receiving mental health care and their interactions with health care professionals around mental health care?
2. What is the impact of national and facility-level policies on mental health care access and provision?
3. What are survivors' perceptions of progress toward making mental health care available for more survivors?

To answer the assessment questions, PHR and SSVKenya conducted a Photovoice assessment that was rooted in the principles of PAR and community-based participatory research (CBPR). PAR and CBPR are approaches to research that foster collaboration between researchers and members of affected communities and engage stakeholders to act to improve their communities based on the study findings.²⁹ The assessment team selected PAR methodology to empower survivors and avoid re-traumatization, which can occur in survey- and interview-based research. Finally, a review of relevant academic, scientific, and human rights literature informed the methodology.³⁰



*A photo board created by a survivor-collaborator.
Photo: SSVKenya/PHR*

Sampling and Recruitment

The survivors who participated in this project were engaged as collaborators and as full members of the assessment team.

Based on the assessment's inclusion criteria, survivor-collaborators had to be:

- a self-identified survivor of sexual violence who is member of or engages with SSVKenya or another survivors' organization/network;
- someone who has used or engaged with mental health services at a facility in Nairobi where PHR has conducted activities related to the Comic-Relief project;
- someone motivated to document their community and collaborate with PHR to advocate for policy change; and
- an adult or an adolescent (over the age of 16) who could provide parental/guardian consent to participate in the project.

Assessment Team

The Photovoice team included three PHR staff members (one male and two females; of these, one was from Kenya and two were from the United States) with expertise in PAR, Photovoice, and mental health. They were joined by 10 adult, female sexual violence survivors who were active members of SSVKenya and who live in the Dandora, Eastleigh South, Githurai, Korogocho, Majengo, Mathare, Mukuru kwa Njenga, Mukuru kwa Ruben, and Nairobi South areas of Nairobi that had benefitted from PHR's mental health-related interventions. Despite the selection criteria allowing for their inclusion, no male or other non-female-identified people or minors over the age of 16 chose to participate in the assessment. The 10 survivor-collaborators jointly selected a lead facilitator and an assistant facilitator from within the group to act as coordinators.

The survivor-collaborators were selected based on the criteria above and due to their roles as activists, human rights defenders, and community health volunteers, as well as their active engagement in their communities as volunteers helping other survivors access health services, including mental health care. The survivor-collaborators thus represented not only their own experiences, but also the experiences of survivors whom they have assisted in accessing services following sexual violence.

Methodology

continued

Data Collection

Data, in the form of photographs and voice memos, was collected by the 10 survivor-collaborators in Nairobi between October 28 and November 4, 2022. Survivor-collaborators participated in four workshops to formulate the assessment questions, learn how to use Photovoice, analyze the photographs, and develop advocacy around the findings.³¹ As is typical practice of participatory research methodology, data collection and analysis at times occurred simultaneously. The stages of the assessment process included:

- **An introductory workshop** to introduce the assessment project, to collaborate on assessment questions and tools, and to understand the training needs of survivor-collaborators to use Photovoice methodology for the assessment. This session included a participatory ethics review session to adapt the assessment protocol based on survivor-collaborators' feedback.
- **A Photovoice training workshop**³² to train survivors on how to use the Photovoice methodology.³³
- **A one-week data collection period.** During this period, survivors shared photographs and voice notes describing and analyzing the photographs over the mobile messaging application WhatsApp with the PHR assessment team.
- **A data analysis workshop** to analyze data and to organize photos into personal photo board collages of themes captured in the photographs. Photo boards were reviewed and analyzed by the group to identify key themes related to the central assessment questions.
- **An advocacy workshop** to review results, elaborate a policy brief, and determine the final course of post-assessment advocacy.



Survivor-collaborators analyze a photo board during a data analysis workshop.
Photo: SSVKenya/PHR

Data Analysis

Survivors' perspectives were also centered in the data analysis process. This ensured that the assessment team interpreted all data through the lens of the survivor-collaborators without jeopardizing the objectivity of the data or community members' confidentiality and safety. To do this, PHR organized a data analysis workshop with the partners to review and discuss the photos and the themes that emerged from the photos. The analysis sessions were conducted following best practices in collaborative data analysis in Photovoice studies, by using the SHOWeD questioning technique.³⁴ SHOWeD is a five-step questioning analytical framework to analyze data in workshops and identify action points for post-assessment advocacy. The five questions used in SHOWeD are:

- What do you **S**ee in this photograph?
- What is **H**appening in this photograph?
- How does this relate to **O**ur lives?
- **W**hy do these issues exist?
- What can we **D**o to address these issues?

These sessions were audio recorded and transcribed. The assessment team analyzed the data (photographs, transcripts of voice memos, and transcripts of analysis sessions) by coding and assessing themes using Dedoose software.³⁵ The assessment team reviewed the coded data, representing excerpted portions of the interview transcripts, to identify cogent themes and patterns and write a cohesive analysis that is reflective of the data. The assessment team used an iterative analytical process and held regular team debrief sessions to further reflect upon and analyze data.

Limitations

As this participatory, qualitative assessment project engaged only female, adult survivors of sexual violence in specific areas of Nairobi, this assessment is not generalizable to the experiences of all survivors of sexual violence or the challenges of survivor interactions with the mental health system in other parts of Kenya or elsewhere.

The intensive engagement of survivors in the assessment process may have affected who was able to participate and may have excluded the points of view of those who were not able to participate, perhaps due to family or other obligations. Additionally, there is a selection bias that results from working with an established survivors' group, thus not representing the points of view of less engaged, connected, and empowered survivors. While the assessment team collaborated with survivors who help other survivors access services to address this bias, it is unlikely all points of view were included in the assessment.

The methodology itself that focuses on the personal perspective of the photographer is a limitation, potentially excluding other perspectives from the assessment.

Ethical Considerations

The Physicians for Human Rights' Ethics Review Board reviewed and approved the assessment protocol.³⁶ In addition to the external ethics review board session, PHR also conducted a participatory ethics review session during which the assessment protocol was reviewed, adapted, and approved by the survivor-collaborators who participated in the assessment, as they are the experts on their own rights and safety.

The assessment team received and documented full informed consent for all survivor-collaborators in this assessment. In addition, photographers were required to obtain written permission or guardian approval to take photos of other people and use these photos in the Photovoice project. The process included seeking consent to take, publish, or publicly display the photographs (such as at a professional meeting or community gathering). The consent process also allowed survivors to not be anonymous – if they so choose – in the public presentation of the photographs and data in order to provide them with agency to determine how they engage with their own work. The assessment team anonymized and de-identified all recordings and transcriptions of interviews. Audio was stored on an encrypted, password-protected platform and destroyed once transcripts were completed and verified. The subjects of photos were depicted in a manner that maintains the confidentiality of their identity unless they indicated in writing and verbally that they want to be identified. Any personal identifiers that informants disclosed during the interview were redacted from the final transcript and the audio files were destroyed after transcription and translation. Final transcripts were coded, organized by a unique identifying code, and compiled into an assessment that will not identify individuals (through names, personal identifiers, or demographic characteristics). All data was stored on secure computers and private, secure, cloud-based storage systems.

The choice of engaging with survivors' networks reflects the assessment's ethical considerations. In addition to the ethics-based CBPR and PAR methodological choices for engagement (described above), Photovoice has its roots in art therapy, and can help contribute to the healing process for survivors by giving survivors control over their narrative.³⁷

Finally, being a member of a survivors' network can serve as a built-in safety and reporting mechanism for any adverse effects of the assessment. This is because survivors may find validation, support, and a sense of community through the membership in the network. This can contribute to survivors feeling supported and empowered to speak up if they experience adverse effects of participating in the assessment and seek referral. Finally, the network can refer survivor-collaborators participating in the assessment to mental health services in the event a survivor-collaborator experienced adverse effects of the assessment, as this is a core area of their work.

Description of Data

There was a total of 10 survivor-collaborators in this assessment, representing seven sub-counties in Nairobi (Embakasi North and South, Kamukunji, Mathare, Roysambu, Ruaraka, and Starehe). Over the course of seven days, survivor-collaborators took a total of 223 photos representing their experiences accessing mental health services in Nairobi. At least 99 WhatsApp voice memos, the durations of which averaged less than one minute, accompanied the photos.

Using these photos and voice notes, the survivor-collaborators came together during a workshop to analyze the photos and voice notes through the development of photo boards. Each survivor-collaborator developed a photo board and engaged in group discussions that were recorded and later analyzed by the assessment team. The groups' 10 photo boards resulted in more than three hours of discussion and dialogue, later used for analysis.

Findings

Health Services

Survivor-collaborators in this assessment universally reported gaps in the availability, accessibility, acceptability, and quality of mental health services for survivors of sexual violence in target communities in Nairobi. Survivor-collaborators also identified some areas of progress and good practices.

Accessibility

Multiple survivor-collaborators³⁸ noted difficulties accessing mental health services across Nairobi. Multiple survivors described challenges in being able to physically access the facilities where mental health services are provided due to distance, physical infrastructure that is difficult to navigate, and volume of patients that makes it difficult to be seen by a mental health professional. One survivor-collaborator illustrated accessibility challenges for survivors with physical disabilities by taking a photograph of a staircase:



"...[These] photos show the entrance to the facility. This is a facility that doubles up as the infirmary/the counseling room area. And as you can see, there is inaccessibility when it comes to persons with disabilities to access the counseling room. Because of the staircase, there is no ramp, for example. So, one has to be carried up, as is visible by the staircase."³⁹

In a focus group discussion during a data analysis session, a survivor noted that, in addition to physical barriers preventing access to the facility, there are additional infrastructural barriers that prevent survivors from accessing mental health services once they enter the facility:

"...the reception area, which unfortunately doubles up as a storage point for the whole facility. ... I was not surprised not to find anyone on the waiting bay ... I think because of the issue again of stigma. There is no privacy, because it is a room that is very busy because it is a storage and it is also used for many other things."⁴⁰

Even if survivors were able to access facilities, non-clinical staff sometimes prevented survivors from accessing services. Survivor-collaborators shared examples of survivors not being able to access resources because staff provided unclear information about when services would be available and non-clinical staff gave confusing directions within facilities; they also described feeling stigmatized because their history of sexual violence was disclosed to other patients at the hospital.

Even if survivors were able to access facilities, non-clinical staff sometimes prevented survivors from accessing services. "I wanted to inquire about something, then he told me no there is a meeting going on there. So, I felt I was denied a chance to even have some information about the mental health service or even about counselling."

Findings

continued

One survivor-collaborator shared a recent experience during a data analysis session:



Photo: SSVKenya/PHR

“ There is ...[a]... Youth Friendly Center and these are the services that they offer: there's health information, health referrals, health newspapers, and games, and working hours are 8:00 a.m. to 4:00 p.m. but we do not know the days, then there are no activities happening inside that place. It is managed by a youth organization. There was a lady at the desk inside but there were also other meetings going on. So, these services are not the ones going on inside. The place is like a hall for hire because it is just other meetings happening inside there. I remember even as I entered the place I was asked where I was going by someone who was cleaning there. I told him I wanted to go to Youth Friendly. He asked me whether I was invited, and I told him no, this is Youth Friendly. I wanted to inquire about something, then he told me no there is a meeting going on there. So, I felt I was denied a chance to even have some information about the mental health service or even about counselling because something different was going on here. So, I felt maybe if I had wanted information to do with mental health or to find out about what days the counsellor is available, but I was denied. Most of the youth here know that this is a youth friendly service center where one is supposed to be given all the information that one may require but in real sense nothing is going on which makes youths not to access this place.”⁴¹

This experience was not unique to this health facility. Another survivor-collaborator described police officers preventing survivors from accessing a facility because they did not have their identification (ID) card, a barrier encountered particularly when survivors seek services in facilities co-located at other government sites, including prisons.

“ In this facility, at the main gate there's usually... police officers because it's inside a prison and they usually ask for an ID card. You might find the survivor does not have an ID and this will make the survivor maybe not able to access the services.”⁴²

Survivor-collaborators reported that because survivors experience challenges accessing care at public facilities, they are forced to seek care from private facilities, which they perceive as having a greater availability of services. While private facilities are not legally obligated to ensure affordability of products and services, survivor-collaborators described the financial challenges associated with having to turn to the private sector for care. One survivor-collaborator highlighted:



Photo: SSVKenya/PHR

“ This is a private facility as you can see, they have medicine and all they need to take care of a survivor but accessing them is not easy at all.”⁴³

Findings

continued

Many survivor-collaborators observed that transportation to and from facilities is a major challenge for accessing services. Survivor-collaborators described long distances they had to travel to reach mental health services or the high cost of transportation.



Photo: SSVKenya/PHR

" After sharing with a survivor about their experiences, they told me that some of the challenges they are facing as a survivor ... is transport. So, some of them use *boda boda* (motorcycle taxi) others may use a *matatu* (shared minibus) but transportation is the greatest challenge."⁴⁴

One survivor-collaborator described the transportation challenges associated with displacement following the forced evacuation of some communities:



Photo: SSVKenya/PHR



Photo: SSVKenya/PHR

" The massive demolition that happened in Mukuru kwa Njenga slums last year, the people around this hospital were very much affected. And until they are still IDPs [internally displaced persons], they cannot even afford the transport, even the cheapest, which is the motorcycle ... [for]... Ksh 100...[which]... they cannot afford."⁴⁵

Findings

continued

Others described the cumulative effect of these multiple challenges survivors face when accessing mental health services. One survivor-collaborator said that these challenges contributed to survivors missing follow-up mental health services.



Photo: SSVKenya/PHR

" So, this green fence represents the survivor's consistency in assessing mental health. But as you see from the first end it is a bit good, but as it goes further and further, you can say the first session, the second session. As the fence goes further and further, the consistency gets narrower and narrower and narrower. It is very difficult. And that is how some survivors miss and do not get all the required sessions."⁴⁶

Survivor-collaborators also identified the cost of mental health care as a major barrier to accessing these services. One survivor-collaborator represented this in a photograph of currency:



Photo: SSVKenya/PHR

" You must have money to access private facilities in the communities where we live."⁴⁷

Not limited to the cost of services at private facilities, survivors also perceived the cost of health record cards as a barrier to care and perceived corruption in the higher cost of these cards being sold by some health professionals. Health record cards are required to record patient medical data and cost 100 Kenyan shillings,⁴⁸ or one fifth of the average daily income in Kenya,⁴⁹

" The clinic book ... is supposed to be given freely at all ... public health facilities and even private but for this specific facility at the gate there's somebody is selling it at 100 Kenyan shillings but inside the clinic, there's a nurse selling it at 200 Kenyan shillings compelling the patient that the one being sold outside is lacking some pages and information."⁵⁰

Others described survivors being emotionally distraught because they were not able to purchase notebooks for their medical records:

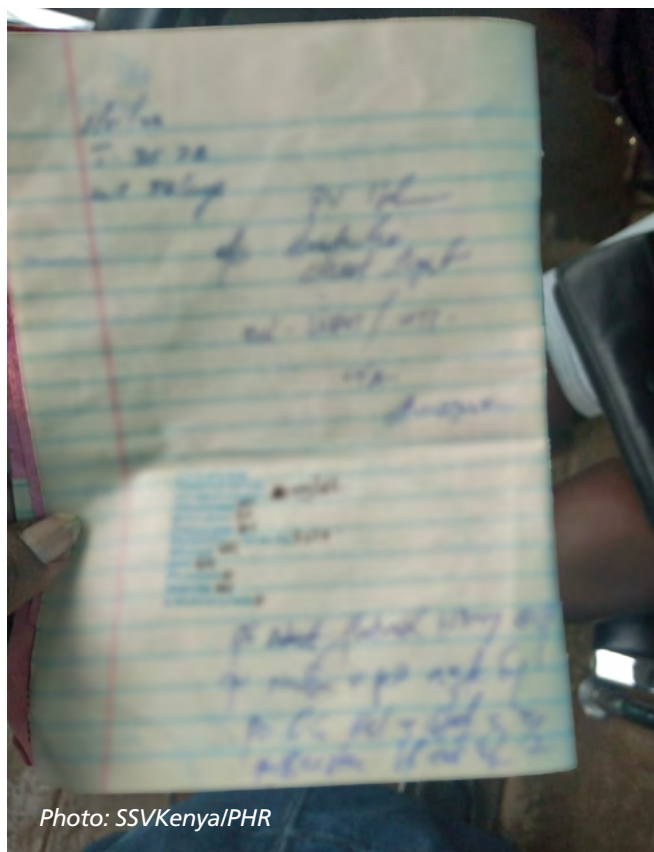


Photo: SSVKenya/PHR

" Most patients who use these public health facilities are people who cannot afford the services that are provided at private hospitals. So, when they come here, most of them do not even have money to buy these exercise books that serve as a [health record] card. So, this is mental torture to the patient. So, most of the patients will sometimes walk away."⁵¹

Findings

continued

Availability

Even if survivors were able to access facilities that offer mental health services, most survivor-collaborators perceived that mental health services for survivors of sexual violence are often unavailable in their communities.

One survivor described how some facilities only operate during a fraction of their official hours.

Speaker A: What about the time at which the facility is supposed to be operating? It is from 8 a.m. to 4 p.m.

Speaker B: Yet they come late.

Speaker A: They come at 10 a.m. then they do for one hour.

Speaker B: They are supposed to close at 5 p.m.

Speaker A: In most facilities they do not operate after lunch."⁵²

When reviewing the image during an analysis session, survivor-collaborators described how the perceived lack of qualified clinical mental health staff at their local health facilities impacted patients.

" These are victims seated in a hospital, with just one counsellor attending to them one at a time. So, this is one of the health centers that I visited and found just one counsellor with many patients. So even in that situation their mental health is not secured because they sit there for long hours waiting to be attended to, where they start thinking they could have been attended to quickly they would have been home doing something else. If you look here, you can see survivors in a waiting room. They have already been treated and given medication now waiting for PRC [Post Rape Care] forms. I also found out that people can wait for the PRC forms for two to three hours. Sometimes they are even told to go away and come back later which is not good for their mental health."⁵³

Another survivor-collaborator attributed the perceived lack of availability of mental health professionals at clinics to the problem of public-sector professionals having other jobs in private facilities.

" I think we pretend not to know yet we know that there is a counselor in that facility. She is there but is held up somewhere else. Like the former president said, 'We know you are very busy working in other private facilities.' Yes, these services are available in the private facilities but not available in the public ones. Doctors know that they are paid but open up private facilities as side hustle. They just get interns or sisters to do some of the work."⁵⁵

While challenges were identified, some survivor-collaborators also highlighted facilities where professionals come on time and are available to treat patients, one survivor observed the positive effects on survivors:

" The doctors are in the facility on time. There's a counselor in the facility. So the survivor will not waste time in the facility and their mental health will be will not be affected because they get the services they need, and they also do follow up to their patients."⁵⁶

Acceptability

Survivor-collaborators identified the lack of confidentiality and survivor-centeredness of services as a major barrier to care in their communities. One survivor-collaborator described patients not being comfortable in facilities that are not conducive to therapy:



" This is a ... [simulation] ... of a survivor who is being examined by the doctor and as you can see, the survivor is not comfortable because [of the lack of privacy at] the hospital where the survivor is being examined... So, the survivor is even trying to hide herself off because she is not comfortable at all..."⁵⁷

Findings

continued

Survivor-collaborators also described the clinicians' behavior and the lack of privacy and confidentiality in facilities providing mental health services to survivors.

" In the facility, you find the service provider ... comes late... So, here you find the survivor is sitting outside because they do not want to sit with the others because of stigma. At the waiting bay, also the line is very long, and you will find when the service provider arrives, they will not be able to attend to the survivor first. They follow the line. Also, the people of the community will not allow anyone to cut the line. Here you find the service provider is attending to a patient at the waiting bay and sometimes they shout, "Did you say you have gonorrhea?" "Where's the lady who was raped?"⁵⁸

Another survivor-collaborator described how the lack of privacy in facilities also contributes to the stigmatization of survivors.

" There is no privacy, and the rest of the patients know what your problem is— most people in these clinics know each other. They know who lives where. So, it causes stigma, and it affects... mental health...."⁵⁹

While survivors appreciated improvements to facilities, a third survivor-collaborator observed counseling happening next to a construction site.



Photo: SSVKenya/PHR

" Here there's a structure being built and beside it is where the counseling session happens."⁶⁰

While survivor-collaborators identified many challenges, survivors also identified and valued clean physical environments at health facilities that provide mental health services.



Photo: SSVKenya/PHR

" I also want to share this success about the pavement, the pathway parts leading to mental hospital. You can see they are very clean. And also, you can see it's a secure place for patients to walk in, to walk in the facility to get medical treatment."⁶¹

Findings

continued

Quality

Survivor-collaborators frequently reported concerns about the quality of mental health services available at facilities in their communities. One survivor-collaborator questioned how well clinicians in her community were trained to provide counselling:

“ About the doctor, sometimes we cannot tell if they are really qualified to offer counselling. I do not know if there is that experience. They might not even get the time to offer counselling, given the many tasks they have been assigned to. They have to also attend to the sick. That is a problem.”⁶²

Another survivor-collaborator described challenges with health care professionals multitasking during sessions with patients, which is at odds with survivor-centered care.

“ So, these patients cannot fully access those services. Those who have come for counseling ... will not access because the doctor may be held up on the treatment and someone waiting for counseling is just there.... You will find that those that came in the morning might have to wait for a long time and they know that is where they are to get the help they need. So, they multitask.”⁶³

Another survivor-collaborator described observing health care professionals having to balance physical and mental health care:

“ This is ...[a] ... facility in our area whereby you find a doctor multitasking. They are a doctor and still a counselor. The room also serves two purposes. The doctor uses that room to provide the two services.”⁶⁴

Survivor-collaborators expressed concern for the well-being of health workers and suggested that the challenges in quality of care could also be related to how health workers are treated. While participating in a data analysis session, one survivor shared:

“ The advocacy[goal] is [that] the rights of health personnel should be considered. Their salaries should be paid on time...”⁶⁵

Another survivor-collaborator identified that the working conditions of health workers are not conducive to self-care.

“ ... You can see the nurses. They are sitting on a maternity bed because after they finish their work, they don't have somewhere to ... they don't have a bedroom or somewhere to rest. So, they are resting on the patient beds and that's where they are taking tea. They don't have a good space where they can take tea.”⁶⁶

Another survivor-collaborator identified that these workplace challenges for health workers may contribute to vicarious trauma for those who are tasked with supporting survivors and providing mental health services:

“ ... don't forget the issue of self-care, you find that...[health care workers]... go through such trauma...”⁶⁷

Prioritization of Services for Survivors

Survivor-collaborators voiced their belief that services for survivors of sexual violence were not being prioritized by hospital officials. One survivor-collaborator noted:

“ I have also noticed something that cuts across all these. In most public hospitals they do not prioritize their patients according to their situations and conditions. There should be a way of creating some kind of order, for example by having a specific place for patient consultation, mental health room, etc. This will make it easier to even know where to go next.”⁶⁸

In data analysis sessions, many survivor-collaborators said there is minimal prioritization for services specifically tailored to survivors of sexual violence. In addition, they shared their belief that other vulnerable groups – such as people living with disabilities, the elderly, children, LGBTQIA+ groups, and sex workers who experience sexual violence – do not have their specific needs prioritized.

Survivor-collaborators described police officers and prisoners being prioritized over patients in counselling sessions at facilities, with some survivor-collaborators having seen prisoners come in the room during a counseling session.

Speaker A: ... you find when the police come to the facility, they are given first priority.

Speaker B: Even the prisoners and also if you have gone for counseling and a prisoner comes in, they don't stop. They just continue counseling you.”⁶⁹

Findings

continued

Community Factors

Survivor-collaborators identified several community factors they believe negatively impact the quality of care and the ability of survivors to access mental health services: 1) safety, 2) informal justice, 3) stigma, and 4) responsibilities of duty bearers.

Safety and security were frequently identified as major challenges:

“ Here, I tried to have a discussion with the community and this person you see here was writing issues affecting the sick in the community. So, they were trying to explain about what happens especially when there is no security especially during blackouts and maybe the security lights are off, a lot happens during that time in informal settlements in Mathare. The youths are the ones who mess up with the security lights so that they can steal or violate people in the community. Here, you can see a human rights defender with a placard. When there are a lot of violence cases, there could be corruption at the courts or by the police, the human rights defenders show up to amplify the victim’s voices demanding justice for the victims.”⁷⁰

One survivor-collaborator noted that there is positive progress in addressing security challenges in their community.



Photo: SSVKenya/PHR

“ ... the community is really working towards upgrading its own people through different environments like water project, electricity projects. And they also have a section of good governance like health care, maternal health care for women, mental health care for women, which is provided by our health center.”⁷¹

The same survivor-collaborator also noted progress by the government to enhance their community, such as efforts to electrify informal settlements, which is seen as improving the safety of women and children.



Photo: SSVKenya/PHR

“ ... most of it is actually ... funded by the government of Kenya. And the community is also appreciating the fact that every resident is able to access electricity despite them being in an informal settlement, especially where this informal settlement is flooded with women and children. And we do understand that women are the most people who happen to face gender-based violence...”⁷²

In addition to security, survivor-collaborators identified the impact of informal justice processes, in which cases of sexual and gender-based violence are negotiated in out-of-court settlements by others that do not always involve the survivor. These kinds of agreements are illegal in Kenya, as sexual violence is a crime; as such, sexual violence cases should not be settled out of court. One survivor described the impact of the informal justice process on the mental health of survivors in her community:

“ First, I will begin from here, you can see that this is the chief’s office whereby all cases of incest, defilement [sexual violence against a minor], rape, GBV, and the rest are negotiated by the community elders and when they negotiate these cases, they never see the light of the day. So, in many cases the decisions are made on behalf of the victim by the community elders or sometimes by the family of the perpetrators. So, the victim ends up really suffering mentally.”⁷⁴

Findings

continued



Photo: SSVKenya/PHR

Stigma associated with sexual violence often affects survivors. One survivor-collaborator illustrated the experience of community-level stigma in her photo essay:

“ The dirty water, which is under the bridge, represents the gossip, the bad language they have, the bad-mouthing. They talk about the survivor, the blame games they put on survivors, especially when the survivor is an adolescent girl, maybe 15 years and above, or 17 years and young women, or even older mothers, they put blame.”⁷⁵

Survivor-collaborators identified the impact of informal justice processes, in which cases of sexual and gender-based violence are negotiated in out-of-court settlements by others that do not always involve the survivor. “...[I]n many cases the decisions are made on behalf of the victim by the community elders or sometimes by the family of the perpetrators. So, the victim ends up really suffering mentally.”

Survivor-collaborators described it as the duty of the government to address the lack of services by prioritizing mental health services for survivors and understanding the community’s needs. One survivor described how facilities and governments must be held accountable by the community for the services they are meant to provide.

“ We can start the intervention with the Board of Health for the County government because these people I remember two years back when we were doing something to do with Reproductive Health and Rights, we called our area ... Member of County Assembly ... who was a member of the Board of Health. So, we asked him to call for us the people in charge of the Board of Health. They do not even know what is happening in the community and yet they are the ones in charge on behalf of the boards. So, when they come, we will tell them our problems so as to address the needs of the citizens when they are on those boards....”⁷⁶

Survivor-collaborators described challenges in engaging with the government, including when trying to participate in public processes. One survivor-collaborator shared:

“ When we go for these processes, we should go there prepared and ready to fight, you put on as if you are going for a fight. They always deny us to talk at our sub-county and when we get to the county government meeting at the City Hall Annex they also deny us the opportunity to talk saying that we never participated in the sub-county instead we fought so we are not given the mic. So, we have to fight and we will continue fighting.”⁷⁷

This sense of commitment to advocate for changes in how mental health services are provided to survivors was universally shared by survivor-collaborators. Another described the power of survivors’ networks to influence policy makers and stakeholders in their communities.

“ It is by having the stakeholders’ meetings whereby we invite them. We engage them in a stakeholder analysis. When you invite them in the forums and they get to know who you are, they can change. When we held meetings at Lion’s I noticed that they were afraid whenever they saw me passing by. The moment they know you work for the community, and you are a defender, they just change the way they work.”⁷⁸

Discussion

Public Health, Policy, and Legal Context

The perspectives shared by survivors in this assessment show that, despite notable bright spots, there are significant gaps in the provision of mental health services to survivors of sexual violence in Nairobi, Kenya. Survivors described challenges to the availability, accessibility, acceptability, and quality of mental health services. These factors have been identified as essential elements of the right to health by the World Health Organization (WHO) and the United Nations Office of the High Commissioner for Human Rights.⁷⁹ The findings presented in this assessment represent the perspectives, priorities, and analysis of a group of sexual violence survivors in Kenya and can be situated within a public health, policy, and legal context that can guide key stakeholders to take steps to realize survivors' right to mental health.

Public Health Context

The findings are consistent with findings from other public health studies suggesting the need for significant improvements in service delivery to survivors of sexual violence in Kenya. While Kenya has strong models of holistic care for survivors of sexual violence, such as the Gender Based Violence and Recovery Centers that include mental health services for survivors of sexual violence, there remain deep challenges in delivering these services.

Evidence from outside Nairobi shows that challenges in mental health service delivery are common across Kenya. One study found that only 19 percent of survivors at Coast Provincial General Hospital in Mombasa returned for a second counselling session, and that sites in other parts of Kenya that were not part of this assessment experience similar challenges.⁸⁰ A 2017 assessment using the WHO's Assessment Instrument for Mental Health Systems in Kilifi County found that there was no specific budget for mental health care, no efforts to integrate mental health care into primary care, and only two psychiatric nurses and no psychiatrists or psychologists for a population of 1.2 million people.⁸¹

Another study conducted in Naivasha found that psychological assessments were only available for 14 percent of medical records reviewed in the study.⁸² The same study found that hospitals lacked "a formal way of following up survivors to ensure that they returned to complete their treatment," which includes follow-up counselling visits which typically happen after the initial visit at the facility.⁸³ Survivor-collaborators identified public sector clinicians who provide mental health services being pulled away from their duties by having a separate private practice; this finding is supported by a 2022 study that found that most doctors in Kenya had both public and private practices.⁸⁴

Survivor-collaborators also identified gaps in health worker training on mental health. An assessment of mental health literacy in Kenya that found that "primary health care workers had very low mental health literacy indicated by low diagnostic accuracy for serious and common mental disorder."⁸⁵ This finding is supported by another study, which found that 87 percent of clinicians surveyed in Kenya lacked formal qualifications in mental health.⁸⁶ Other studies have similarly found that additional capacity development in mental health care is needed.⁸⁷ This assessment also highlighted the practice of multitasking by clinicians, finding that these habits have "detrimental effects on task performance and increase errors."⁸⁸ The PHR/SSVKenya assessment identified capacity gaps in service providers that should be addressed to ensure that survivors have access to high-quality services.

This lack of adequate training could impact the ability of clinicians to fill out the Post-Rape Form necessary for survivors of sexual violence to initiate a legal process. Currently, the psychological assessment section on the Post-Rape Care form in Kenya can be completed by trained medical officers, nurses, clinical officers, psychiatrists, psychological counselors, and medical social workers recognized by the Ministry of Health.

Despite these challenges, mental health services are being provided at some facilities in Kenya. In Nairobi County, the site of this assessment, the Directorate of Health, under the [Nairobi Metropolitan Services \(NMS\)](#), set up mental health departments in 32 Level I, II, and IV health facilities across Nairobi.⁸⁹ The services provided in these departments include psychiatry clinics, counselling, mental wellness clinics, and community mental health, as well as child and adolescent mental health assessments. These are currently being supplemented by community units to help ensure survivors have access to services at a wider range of facilities. The Level IV facilities are Mama Lucy Hospital in Embakasi West, Mbagathi Hospital in Langata, Mutuini Hospital in Dagoretti South sub-County, and Pumwani Maternity Hospital in Kamukun. The Level II and III facilities include Dandora II and Kasarani health centers in Kasarani sub-County, Mathare North in Ruaraka, and Mukuru kwa Njenga in Embakasi East sub-County.

Despite the presence of these services, survivor-collaborators perceived challenges in government prioritization of mental health. These findings are consistent with findings from a study from Makeni County that, while policy makers were cooperative in identifying gaps in mental health services, there "were no operational governance, policy or administrative structures specific to mental health, despite recognition by the County Government of the importance of mental health."⁹⁰ These results suggest that further government intervention is necessary to ensure implementation of mental health policies in Kenya.

Discussion

continued

The findings contribute to a growing body of public health evidence on mental health services in Kenya by centering the voices and priorities of survivors in the assessment and analytical process. As such, this assessment offers the point of view of those most directly engaging with the system, including their perceptions about the role that transportation, privacy of spaces, and clinician training, among others, play in their ability to access care. This unique perspective can inform policy makers in efforts to enhance mental-health services for survivors.

Policy, Human Rights, and Legal Context

While there are well-documented challenges related to the delivery of mental health services, Kenya has a robust policy and legal framework supporting the implementation of mental health services. The right to health is enshrined in the Constitution of Kenya and provides for the “highest attainable standard of health.”⁹¹ The constitution is further supported by the Health Act (2017) that recognizes the importance of integrated services, including mental health, for the well-being of people in Kenya.⁹² The Mental Health Amendment Act, enacted in 2022, recognizes the right to mental health in Kenya and provides a framework for mental health services delivery.⁹³ The Kenya Mental Health Policy 2015-2030 expands and enhances the obligations in the Kenya Health Policy⁹⁴ and provides a framework that details interventions crucial to the right to mental health and necessary reforms in Kenya.⁹⁵ Finally, Section 16 of the Nairobi City County Sexual and Gender Based Violence (SGBV) Management and Control Act (2021) provides for the establishment of safe houses/shelters, and makes budgetary allocations for new and existing safe spaces/shelters for survivors of SGBV.

This strong policy landscape also includes several specific provisions related to the obligations for mental health care for survivors of sexual violence. The Mental Health Amendment Act’s 2022 revisions ensure that survivors of sexual violence are entitled to access affordable mental health services in Kenyan health facilities.⁹⁶ The Sexual Offences Act Medical Regulations operationalize the provisions of the Sexual Offences Act and provide a legal foundation for access to no-cost post-rape care, which includes mental health services (i.e., counselling) for survivors of sexual violence.⁹⁷ This solid legal framework provides a robust platform from which the national and local governments can implement existing laws to enhance mental health services to realize the mental health of survivors of sexual violence.

The feedback from survivor-collaborators is aligned with some of the major themes outlined in existing national guidelines. For example, the National Guidelines on Management of Sexual Violence in Kenya⁹⁸ stipulate that every survivor must receive a psychological assessment, and that psychosocial support sessions employ a survivor-centered approach to counselling. The National Guidelines even include specific guidance that trauma counselling should occur in comfortable, private, child-friendly areas that are not disturbed by others. The guidelines specifically state that counselling should occur behind closed doors (and not only a curtain). In addition to supportive national-level practical guidelines, standards for mental health services for survivors of sexual violence benefit from guidelines drawn up by international organizations to set standards of practice. The World Health Organization’s Guidelines for Medico-legal Care for Victims of Sexual Violence and the United Nations Population Fund’s Essential Services Package for Women and Girls Subject to Violence provide additional detailed guidance for service providers and health system duty bearers. These guidelines provide broad frameworks for county- and national-level officials to provide enhanced, survivor-centered service delivery for survivors of sexual violence, including mental health services. These preexisting guidelines should be used as a practical roadmap for enhancing mental health services for survivors of sexual violence; their full implementation could help to ensure that mental health services are more accessible, available, acceptable, and of high quality for survivors of sexual violence.

From an international human rights law perspective, Kenya has obligations to ensure access to mental health services for survivors of sexual violence. The International Covenant on Economic, Social and Cultural Rights, acceded to by Kenya in 1972, obliges States to “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”⁹⁹ As a signatory to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Kenya must ensure the government take “all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services.”¹⁰⁰ CEDAW was further clarified in 1992 through general recommendation 19, which affirmed that gender-based violence is a form a discrimination against women and that “appropriate protective and support services should be provided” for survivors, and general recommendation 25, which calls on states parties to ensure “access to financial assistance, gratis or low-cost, high-quality ... psychosocial and counselling services...for women who are victims/survivors and their family members. Health-care services should be responsive to trauma and include timely and comprehensive mental... health services.”¹⁰¹ These standards provide powerful clarification on the state’s obligations to provide services to support survivors of sexual violence, including mental health support.

Discussion

continued

Similarly, at the regional level, Kenya is party to several treaties that acknowledge the right to health, reproductive rights, and the rights of survivors of sexual violence, that become law in Kenya under Article 2 (5) (6) of the Constitution of Kenya 2010.¹⁰² The African Charter on Human and Peoples' Rights acknowledges the right to health and highlights access to medical care, including mental health care.¹⁰³ The charter also provides for "the elimination of every discrimination against women."¹⁰⁴ The Maputo Protocol deepens the rights of women in the African Union by recognizing the right to "adequate, affordable and accessible health services" as well as reproductive health rights for survivors of sexual violence.¹⁰⁵ Additionally, the Kampala Declaration of the Heads of State and Government of the Member States of the International Conference of the Great Lakes Region furthers Kenya's commitment to providing comprehensive services, including psychosocial services.

Public health evidence and human rights bodies have been clear that mental health services are an essential element of health care, reparations, and remedy for survivors of sexual violence.¹⁰⁶ Yet, health-related remedies are at times overlooked in sexual violence cases. For example, in the High Court judgment in Constitutional Petition No. 122 of 2013, the court issued a groundbreaking decision that recognized state responsibility for election-related sexual violence and ordered financial compensation but failed to award any of the health-related remedies sought by petitioners.¹⁰⁸

The findings of this assessment suggest that the government of Kenya's domestic and international legal commitments as well as important guidelines related to mental health services for survivors of sexual violence may not yet be fully implemented in the communities of Nairobi where this assessment was conducted, and their progressive implementation demands greater resources and attention from national and county-level governments. Additional measures must be taken to ensure that policies are implemented in ways that ensure that survivors of sexual violence have access to mental health services that meet the essential elements of a rights-based approach to health. The assessment identified challenges related to the key operational elements of the right to health – availability, accessibility, acceptability, and quality – of mental health services in Kenya. The data collected by PHR and survivor-collaborators indicates that Kenya is not meeting its obligations set out in the laws and regulations related to mental health care and treatment for survivors of sexual violence. Against this backdrop, the findings of this assessment affirm the need for rights-based policy reform and enhanced mental health services for survivors.

Conclusions and Recommendations

The experience of survivor-collaborators suggests that there is a gap in the availability, accessibility, acceptability, and quality (AAAQ) of mental health services being offered to survivors of sexual violence in their communities in Nairobi, Kenya. This framework, which emerged organically from the survivor-led analysis session, contains the "interrelated and essential elements" of a State's obligation to ensure the right to health.¹⁰⁹ These findings show that using a rights-based approach, such as the AAAQ framework, to enhance mental health services would meaningfully affect the ability of survivors of sexual violence to realize their right to health.

Survivor-collaborators in Nairobi suggest that there is a general lack of prioritization of mental health services in the health care sector, which has profound effects on survivors of sexual and gender-based violence (SGBV) seeking treatment. Despite the existence of policies and protocols on SGBV response, survivors' experiences show that there is little emphasis and follow-up on the provision of mental health services to SGBV survivors. While this assessment focuses on data from Nairobi alone and from a small group of survivors, the findings of this assessment should prompt a broader regional and national effort to assess access to mental health care for survivors of sexual violence in Kenya.¹¹⁰

Additional governmental prioritization, at national and county levels, of mental health care is needed, including by allocating funding for mental health services, ensuring that mental health care is available and accessible at the primary care level, training health care workers to provide high-quality and survivor-centered mental health services, and reducing financial and logistical barriers to accessing services. In addition to this, there is a lack of accountability for less-than-adequate mental health services when these are provided. These additional steps can contribute to an environment that enables survivors to fully realize their rights to mental health services.

These findings provide an innovative and powerful visual advocacy tool that can be leveraged to develop the capacities of hospital administrators, clinicians, policy makers, and other duty bearers on how to meaningfully enhance essential mental health services for survivors of sexual violence in Kenya through a rights-based approach grounded in the perspectives of survivors, themselves.

There is a need for additional capacity development and support for health care professionals, community leaders, human rights defenders, and members of the Survivors of Sexual Violence in Kenya Network as first responders on providing trauma-informed support to SGBV survivors.

Conclusion and Recommendations

continued

Survivor-collaborators also suggested that health administrators, clinicians, and other key stakeholders involved in mental health policy and service delivery receive additional training in survivor-centered mental health services, including on existing national guidelines. This can help ensure that all health care workers are equipped with the skills to provide trauma-informed, survivor-centered initial mental health support, forensic psychological documentation, and referrals as needed.

This project has implications for SGBV survivors, first responders, communities, and duty-bearers in addressing gaps in policy governing the provision and availability of quality mental health services. Survivors identified policy recommendations during data analysis and advocacy sessions, which were shared in a [policy brief](#). The following recommendations are offered based on the policy brief and with the input of Physicians for Human Rights staff:

To all stakeholders, including national and county governments and civil society organizations:

- Ensure that measures are taken to engage survivors' perspectives and ensure that their voices are included, listened to, and heard in processes to improve mental health services for survivors. This includes ensuring that survivors of sexual violence are able to engage at public meetings at the sub-county, city, national and other levels. Stakeholders must proactively engage survivor networks, such as the Survivors of Sexual Violence Network in Kenya, when developing laws, policies, and programs meant for survivors. Finally, stakeholders should leverage participatory methods to engage survivors to integrate survivor priorities in the design of policies and legislation.
- Engage in reparations and transitional justice processes to ensure the inclusion of mental health care and services for survivors of sexual violence, as part of survivor-centered and holistic reparations.

To the Nairobi City County Government:

- Prioritize the establishment of the Mental Health Council as per the provisions of the Mental Health Amendment Act. The council should include experts in mental health and representatives of survivors' groups to ensure that the specific mental health needs of survivors of sexual violence are represented on the council. They should be required to maintain a register of all private mental health facilities operating within their counties and submit these to the Mental Health Board annually. They should also be mandated to inspect these facilities and report their findings to the Mental Health Board for remedial action that may be necessary.

- Allocate more financial resources to mental health service provision and increase the number of staff offering mental health services. Dedicate additional funding and conduct annual capacity development for all health care providers on the provision of mental health services to ensure all are equipped with the skills to provide trauma-informed, survivor-centered initial mental health support, forensic psychological documentation, and referrals as needed.
- Strengthen the integration of mental health service provision into routine and primary health care, including ensuring that primary health care providers can identify and refer survivors of sexual and gender-based violence (SGBV) to mental health services.
- Fully implement the National Guidelines on Management of Sexual Violence in Kenya at health facilities that provide post-rape care, with particular emphasis on provisions of the guidelines that enhance the survivor-centered aspects of mental health-related service delivery, including ensuring privacy.
- In line with the Sexual Offenses Act Medical Regulations and The Nairobi City County SGBV Management and Control Bill, allocate county health funds to guarantee no-cost post-rape care and affordable mental health care for priority populations.
- Ensure that mental health providers are available to provide services during the hours of clinic operation.
- Train and engage community mental health workers to offer appropriate first-line mental health services to and referrals for survivors of sexual violence. This should include new and formal programs with survivors' networks to provide peer support and engagement with other survivors.
- Conduct public education campaigns to create awareness on the importance of mental health care, psychosocial support, and the mental health impacts of SGBV in order to address community-level stigma, discrimination, and negative attitudes related to mental health care and treatment that prevent many survivors from accessing services. This should include dissemination of information on the mental health services that are available to survivors, which clinics offer mental health services, hours of operation, and which services are free of charge.
- Develop new programs to ensure mental health services are more accessible to survivors of sexual violence. This should be done by providing transportation or transportation stipends to ensure survivors can return for mandated follow-up counselling sessions. Develop programs to offer home-based, online, virtual, or phone-based counselling services or at the community level to reduce the physical, logistical, and financial barriers to accessing mental health services.
- Ensure that health facilities and locations for mental health services are accessible and user-friendly. Additionally, provide wheelchairs, ramps, and signs that indicate where facilities are located, and update publicly available information about when service providers will be available to provide services.
- Ensure that the privacy of survivors of sexual violence seeking mental health is protected at all public facilities, in line with the National Guidelines on Management of Sexual Violence. This should include access to private and separated treatment rooms where survivors can access services without fear of disclosure or interruption.

Conclusions and Recommendations

continued

To the Ministry of Health:

- Prioritize the provision of trauma-informed, survivor-centered mental health services for survivors of SGBV, including, specifically, mental health counseling and access to psychological assessments, where needed, to capture critical evidence of sexual violence.
- Further develop and implement guidelines and protocols for the health sector on the provision of comprehensive mental health services to SGBV survivors. Specifically, expedite the adoption of the rules and regulations that will operationalize the Mental Health Amendment Act 2022, including ensuring access to mental health care without discrimination.
- Design, fund, and implement comprehensive training, campaigns, and awareness-building on the importance of mental health care for survivors of sexual violence for all health care workers, as well the scope and nature of legal obligations and national and international standards on the provision of such care. Develop standardized training materials and continuous medical education courses for health care workers to provide survivor-centered, trauma-informed mental health services and psychosocial to support survivors of sexual violence. This training should be conducted simultaneously with the development/implementation of facility and community health protocols to support the management of SGBV survivors.
- Through the National Treasury, allocate resources to county governments for the training, recruitment, and deployment of well-trained mental health service providers.
- Ensure the availability of funds at the county level and undertake monitoring to ensure survivors can meaningfully access no-cost services for post-rape care, including psychological assessments and mental health care, as mandated by the Sexual Offenses Act Medical Regulations. Increase the budgetary allocation to mental health services to, at a minimum, the recommended WHO standards at the national level.
- Undertake and fund additional assessments, research, and data collection on the impact of sexual violence on survivors' mental health to be used to increase the accessibility, availability, acceptability, and quality of mental health services for survivors of sexual violence.
- Implement accountability processes at the national and county levels to monitor and evaluate the provision of high-quality, acceptable, available, and accessible mental health care for survivors of SGBV, without discrimination, and provide redress and remedy where survivors face barriers in accessing such care, including investigations by the Kenya National Commission on Human Rights where there are suspected violations of rights related to the mental health care of survivors.
- Ensure targeted implementation of the existing laws, including the Constitution of Kenya (article 43) and the Mental Health Amendment Act, to ensure that the right to the highest attainable standard of health is realized.

To Donors:

- Continue to support survivor's groups and programs that provide mental health care for survivors, including capacity development for service providers on mental health care, survivor-centered approaches, and psychological documentation.
- Support programs that use participatory approaches to engage survivors in assessments, research, and monitoring and evaluation.

To organizations conducting assessments, research, and monitoring and evaluation with survivors of sexual violence:

- Use participatory research and evaluation methods, such as Photovoice, to leverage their utility as powerful tools that ensure survivors of sexual violence remain in the center of assessment, research, and monitoring and evaluation conducted with the aim of understanding survivor experiences and producing recommendations that will result in changes in spaces that matter most to survivors.

The data collected by PHR and survivor-collaborators indicates that Kenya is not meeting its obligations related to mental health care and treatment for survivors of sexual violence. The findings of this assessment affirm the need for rights-based policy reform and enhanced mental health services for survivors.

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