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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.*

Keywords: sexual violence, law and policy, medico-legal, HIV/AIDS, Kenya, sub-Saharan Africa

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

be limited peer-reviewed literature on sexual violence against men and boys. While there is increasing evidence of widespread sexual violence in conflict settings in Africa, this paper does not cover the medico-legal issues emerging in these settings.

Comparing figures on sexual violence across most studies is difficult due to variations in definitions and concepts such as rape, sexual assault, and sexual violence, which compound the difficulties of comparing incidence and prevalence, challenges in measuring chronicity (frequency and duration), and standardised timeframes against which to measure violence (e.g. in the last one year/in your lifetime).[18,19] Data from Demographic & Health Surveys are limited by a tendency to underreport.[20,21] Even so, existing data provide an imperative for developing legislation and related services. Attaining the benefits of legislation and ensuring the privacy, informational and medical needs of survivors and their access to full legal process and protection is an enormous challenge, however.

Sexual violence legislation in sub-Saharan Africa

In sub-Saharan Africa, there has been an increase in sexual violence legislation in recent years. Laws covering sexual violence can draw on a range of international laws, regional conventions, covenants and agreements, as well as national commitments. The 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) provides a broad definition of gender-based violence which includes sexual violence.[22] The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa provides for protections against sexual violence.[23] Several statutes and jurisprudence arising from international tribunals such as the International Criminal Tribunal for Rwanda; Prosecutor vs. Akayesu, Prosecutor vs. Furundzija, and the Rome Statute of the International Criminal Court provide additional sources for formulating legislation.[1,24] However, the extent to which countries draw on these is unclear.

On the basis of existing literature, supplemented by information from the Nairobi conference, we have identified Liberia, Kenya, Namibia, South Africa and Tanzania as having laws specifically focusing on sexual violence; these define various forms of sexual violence and provide penalties for perpetrators and compensation for survivors. Botswana, Democratic Republic of Congo, Ethiopia, Ghana, Lesotho, Malawi, Nigeria and Uganda have provisions on various forms of sexual violence in a myriad of other legislation, including their Penal Codes and domestic violence legislation.

Various terms have been used to describe the different offences recognised by law. They include: rape, sexual assault, sexual violence, and defilement. There appears to be no consensus on the exact elements constituting these specific sexual offences across countries. "Rape" is the most commonly recognised offence, which has been outlawed in most sub-Saharan African countries. Common definitions of rape consider it to include penetration of bodily orifices, without consent, utilising a penis or other object.[1] However, the specific definitions of rape remain diverse and different countries place emphasis on different aspects of what constitutes rape. For example, legislation that describes the nature and extent of "penetration" may include partial or complete insertion of the genital organs of one person into another's, as in the laws of Kenya and Liberia.[1,8] More comprehensive legislation includes the use of foreign objects into any bodily orifice, as in the South African and Nigerian laws.[25] The definition of "consent" may be ambiguous or not present, such as in Nigeria,[1] and thus open to subjective interpretation. Lack of consent may also be assumed in legislation that recognises the use of violence or coercion. Marital rape is increasingly considered an offence. However, countries such as Democratic Republic of Congo, Kenya and Nigeria still accept the defence of rape within marriage.[1] Additional terms that have been used to describe sexual offences also differ in their application, such as "defilement" and "sodomy".

All sexual violence laws in sub-Saharan Africa draw age distinctions in their definitions either of sexual offences, consent requirements or penalties. Ethiopia, Democratic Republic of Congo, Mauritius, Tanzania and Ghana also provide stiffer penalties for sexual intercourse with minors, although age distinctions differ between countries.[1,7] There are often contradictions between legislation related to children, traditional laws, and laws on sexual violence. For instance, in Kenya, Tanzania, and Uganda, customary law and marriage law permit marriage of girls below

18 years while the Sexual Offences Acts, the Penal Codes and Children's Acts in these countries criminalise sex with persons below 18 years with or without consent.[26]

The sexual and reproductive health of survivors is considered in varying ways in current laws. Abortion following sexual violence is legal in Benin, Botswana, Burkina Faso, Cameroon, Ethiopia, Ghana, Namibia, Swaziland and Zimbabwe, although evidentiary requirements are high.[1,7,27] Ethiopian law requires treatment of sexually transmitted infections, excluding HIV, for survivors. Some countries, including Benin, Botswana, Kenya and Uganda, have criminalised the transmission of HIV, with more severe penalties mandated for persons who commit sexual violence while knowingly HIV infected.[1] Mandatory HIV testing for perpetrators and requirements for testing prior to giving anti-HIV medication to survivors have been introduced in law or policy in Uganda, South Africa and Kenya.[28]

Despite these provisions, survivors face procedural, cultural and bureaucratic hurdles to access care; for example, in South Africa survivors are required to report to the police as a pre-condition for receiving health care, which can discourage them from doing so.[1,25] Further, laws in most countries do not explicitly require the health sector and health care providers to provide survivors with the range of treatment options necessary after sexual violence. However, some countries have developed health care policy for the delivery of post-rape care services within the health sector without reference to legislation. For instance, Kenya, South Africa and Zambia have policies located in health sector documents on reproductive health policy for delivering emergency contraception and HIV post-exposure prophylaxis to survivors.[29,30]

Traditional law and informal systems of justice in many countries have greater cultural authority and thus more practical impact than national legislation. This is particularly so for laws targeting gender-based violence.[1] Common traditional punishments, such as compensation to the victim's family or marriage between the victim and perpetrator, often undermine legislative enactments and criminal sanctions and do not take into consideration the consequences of sexual violence – or the wishes of the (woman) survivor.

ROBIN HAMMOND / PANOS PICTURES

13-year-old girl and her 3-month-old baby, born after her rape, Goma hospital, Democratic Republic of Congo, 2008

Kenya Sexual Offences Act, 2006: a case study

No nationally representative data on sexual violence in Kenya existed until the 2003 Demographic & Health Survey.[31] The limited published literature reporting gender-based and, particularly, sexual violence in Kenya is as follows. In a study of 324 HIV positive women in Kenya, 19% had experienced violence from their partner.[32] In a nationwide study of young women aged 12–24 years, 25% said they lost their virginity through forced sex.[33] A study of 10,000 female secondary school pupils in 1993 found that 24% of sexually active girls reported forced sex as their first encounter.[34] In a study on contraceptive use among high school students, 9% reported not using a method at last intercourse because they had been forced to have sex.[35] A countrywide study showed that pressure starts at an early age, with 29% of girls and 20% of boys aged 13 years and below reporting one or more episodes of sexual harassment.[36] While studies document these high rates of sexual violence, reporting rates to the justice system are low. Police reports in 2006 and 2007 showed 3,518 and 3,667 as the total number filing charges with the criminal justice

system in Kenya out of a population of 35 million (i.e. about 0.001% of the population),[37] a very poor rate of presentation. Justice outcomes have also been reported as poor. The factors that impact on justice are poorly understood and largely unknown.[38]

Prior to the Sexual Offences Act 2006, Kenya had a weak legal framework for addressing sexual violence, with various clauses in the Penal Code, Criminal Code and Evidence Act. In September 2004, a motion on sexual offences was tabled through a Private Members Bill.[8] A task force formed by the Attorney General agreed on content, taking into consideration Kenya's obligations under international conventions and treaties and other legislation. It also borrowed from local and regional debates, including the then ongoing court cases against Jacob Zuma of South Africa and Kizza Bisigye of Uganda. Parliament, predominantly male (93%), rejected the inclusion of three elements that were originally included in the bill: marital rape, arguing for implied consent for sex in marital relationships; female genital mutilation, arguing for its acceptability as a cultural traditional practice; and male medical castration, arguing that it was not humane.

In 2006, the Sexual Offences Act was finalised and passed. It consolidated all laws relating to sexual offence in Kenya and provided for the offences of rape to include both males and females as survivors and perpetrators. "Defilement", the offence of sex with a girl of below 16 years of age with no option of consent, is a non-baillable offence and has stiffer penalties attached to it than if the victim is older.[8] New offences were also introduced, such as gang rape, sodomy, trafficking for sexual exploitation and child pornography. The definition of rape was expanded to include penetration by other objects in addition to the penis; the offence of sodomy was defined as the anal penetration of boys below the age of 14. Deliberate infection with HIV was criminalised. Minimum sentences were introduced. The Act required rules and regulations from the Ministry of Health, with a specific mandate to hasten court processes through collection, storage and delivery of evidence. The Act also provided for the setting up of a DNA data bank and a paedophile registry in Kenya. Evidence admissible in court was not clearly articulated, however, and there were no guidelines for use by medical doctors in presenting medical evidence in court.

The Act provides only a limited number of penalties and compensations for short- and long-term adverse sexual and reproductive health consequences following sexual violence. For instance, it provides penalties for willful transmission of HIV and obliges the Ministry of Health to provide HIV post-exposure for survivors. Whilst difficulties with the burden of proof of impregnation during sexual violence must be acknowledged, the law does not recognise this even as a potential outcome or make provisions in either penalties, compensations or obligations for health or child care. There are also no penalties attached to physical or psychological trauma, nor any obligation on the Ministry of Health to provide treatment for other sexually transmitted infections, emergency contraception or safe abortion, or address the potential long-term impact of physical and psychological trauma. The acceptability of rape within marriage as a defence also presents challenges for the uptake of post-rape care services by married women and men who experience sexual violence from their partners.

Limited medico-legal linkages

Medico-legal linkages are required in a functional chain of evidence that includes accountable tracking mechanisms for obtaining, preserving and conveying evidence from the community and health facility to the police and the courts. Forensic evidence with DNA testing, as provided for in the law, requires a functional evidence chain, a criminal data bank, decentralised DNA capacity and follow-up mechanisms, all currently unavailable in Kenya. Offenders' registers do not exist, and thus any DNA matching would be problematic.[39,40] In response to these limitations, during the development of national standards on medical management of rape/sexual violence, the Division of Reproductive Health developed a form with detailed examination and legal documentation criteria for clinical notes, which could be used in court to supplement the inadequate police form (MoH 363/PRC1 form). This form captures the medical, obstetric and gynaecological history, injury details, reproductive health and HIV outcomes and medical care and treatment provided. However, it remains a health sector document with no recognition in law. Thus, examining clinicians are not obliged to use it, and

it is not required by law as part of evidence in court. This represents a barrier to the gazettement of this form as supplementary evidence; if it were a requirement in court, its utilisation would be increased. Further, requirements for delivery of evidence by an "expert witness", defined as a medical doctor, is problematic, as it is nurses and clinical officers who provide first-line treatment and care in a context where medical doctors are few, especially at decentralised levels.

No linkages between implementing the Act and developing post-rape care services

A situational analysis in 2003 had revealed a lack of policy, coordination and service delivery mechanisms for post-rape care services in Kenya. Post-exposure prophylaxis (PEP) against HIV infection was not being offered. A standard of care was developed and services established at government facilities in three districts in 2003. The first port of call was the casualty department, with subsequent referral to counselling services in HIV testing and counselling sites. A post-rape kit facilitated collection of evidence. A counselling protocol was developed and training was provided to clinicians, laboratory personnel and trauma counsellors. From 2004-2007, 784 survivors were seen in the three centres at an average cost of US$27, with numbers increasing each year. 43% were children under 15 and 84% arrived in time for PEP. Key lessons learned were the importance of a participatory development process, political commitment and flexibility to develop solutions at local level where paediatric uptake was high. Challenges included issues around confidentiality and increased workloads of service providers.[4]

While legislation was being developed, the Division of Reproductive Health in the Ministry of Public Health and Sanitation initiated a parallel and unconnected process of developing post-rape care, following the results of the situation analysis. In 2006, a post-rape care committee was established and mandated to develop national guidelines on the medical management of rape/sexual violence to standardise care, and a training curriculum and materials for health providers. A scale-up plan was developed. Post-rape care indicators and outputs were captured in the Division of Reproductive Health business plan 2006-07, thus allowing for public accountability on the extent of services actually delivered. Further, within the national AIDS response, survivors of sexual violence were categorised as a vulnerable group in the national AIDS strategic plan for 2005/6–2009/10 and HIV PEP indicators developed in the monitoring and evaluation framework. Expanded training utilising the national training curricula for nurses, clinical officers and doctors, and counsellors aimed to support decentralisation of services in the context of scale-up.

In an effort to strengthen multi-sectoral linkages, especially with the health sector, as proposed in the Act, the Attorney General constituted a multi-sectoral Task Force to draw up rules and regulations to govern implementation. It comprised the police, the judiciary, the Attorney General's Office, civil society representatives, Ministry of Health and Ministry of Education officials.

Monitoring and evaluation

Despite all the efforts described, implementation of the Act has been slow, with continued separation of developments in the health and legal sectors. There are still low levels of awareness of the Act and its provisions by implementers in government agencies and departments, the police, the prosecution, the judiciary and the general public. Public knowledge of what is needed to secure a conviction or to access health care and prevent negative sexual and reproductive health outcomes is low. Evidentiary requirements from survivors are often unknown and evidence is often destroyed by survivors and their families, or survivors present too late for care to enable effective collection of evidence.[41]

Finally, Kenya has no national or common reporting mechanisms for collecting data on sexual violence across the medical and justice sectors. Although indicators developed by the Sexual Offences Implementation Task Force and those by the Division of Reproductive Health[42] each focus on scale-up of post-rape care services, there are no defined mechanisms for data capture or systematic reporting that could be used to harmonise data on numbers of survivors accessing the range of post-rape care health and legal services and referrals across sectors.

Discussion

A primary challenge for sexual violence legislation across sub-Saharan Africa relates to

definitions, which are often problematic in themselves and vary across contexts. These limit the comparability of routine health and legal data across countries in the region and create barriers to developing policy transfer and co-ordinated advocacy between countries. Development of standardised definitions of concepts such as rape and sexual violence could potentially strengthen learning of lessons on legislation and service delivery across the region, and facilitate cross-country advocacy and adaptability of common research and monitoring tools.

The lack of linkages between the health and legal/judicial sectors to implement the Sexual Offenses Act in Kenya is not unusual. In other sub-Saharan countries with legislation, neither the published literature nor evidence presented at the Nairobi conference show any indications of such linkages. This means that survivors have to contend with recounting their experiences to varied providers as they access the health and justice systems. Common procedures, information on service delivery standards and protocols, and referral mechanisms across these sectors could potentially improve linkages between the sectors and access to services by survivors. Further, there are no legal obligations on Health Ministries to deliver post-rape care services nor legal provisions and penalties for the consequences of HIV and other STIs, unwanted pregnancy and other adverse consequences of sexual violence in many laws. This potentially means lack of accountability and responsibility by any sector for providing services. Legal placement of responsibility would facilitate the development of standards and harmonised referral pathways across the health and justice systems.

Other problems common to the region include poor documentation of long-term sexual and reproductive and mental health outcomes of sexual violence. Post-recovery family planning needs, long-term HIV risk reduction, sexuality and sexual well-being of survivors are largely unknown, making legal penalties and compensations difficult to articulate and implement. Psychosocial and mental health care is also undefined, inconsistent and not recognised as a core part of primary care. Thus, the extent to which psychosocial effects and counselling outcomes can be measured and used to create sentences or other compensation benchmarks for justice or as evidence is untested.

Forensic evidence collection and DNA testing are increasingly viewed as a primary part of sexual violence legislation,[34] and important in securing necessary evidence for the prosecution of offenders. However, most sub-Saharan African countries lack the requisite facilities for testing, criminal data banks and offenders registries. Minimum standards for examination, specimen collection and legal documentation are inadequate and health providers are untrained. This means that collection of specimen and forensic evidence, including DNA, is challenging for health providers. However, even where collected, specimens often cannot be utilised effectively, as results cannot be matched unless perpetrators are already known. In addition, DNA can only provide evidence of sexual contact but cannot demonstrate force. Jewkes et al demonstrate that proper examination and documentation is more likely to result in justice being done, as it has the capacity to demonstrate force, and providers can be trained to undertake examination and appropriate documentation.[43,44] Evidence of STIs, pregnancy and HIV, whose results can form supplementary evidence where admissible, also rely on proper documentation and a functional chain of evidence collection, preservation, analysis and delivery in court. Kenya's development of a detailed form for health providers is an example of a possible way forward, although such documents require force in law. Strengthened coordination between health and justice sectors will require training in common medico-legal procedures that are understood by providers in both systems.

Sexual offences and other acts that criminalise or support the criminalisation of the deliberate transmission of HIV are problematic. The burden of proof of prior knowledge of HIV status by the perpetrator, and intent to transmit HIV where sexual violence is proven, increases the complexity of applying the law. Placing a duty of disclosure on the HIV positive person places HIV positive survivors of sexual violence at risk of accusation of HIV transmission to perpetrators. This is of particular concern where HIV testing programmes have been implemented, as it is primarily women who know their HIV status, often through antenatal testing. Further, the limited focus on HIV, including HIV testing and PEP delivery, potentially undermines access to and delivery of comprehensive post-rape care

services. While HIV is increasingly utilised as a platform for responding to sexual violence in sub-Saharan Africa, due consideration for the broader range of consequences of sexual violence is necessary in both legislation and health service provision.

Lack of research on legislation and its implications for and impact on service delivery, in order to meet survivors' health and justice needs, means we still have a limited understanding of what is required in legislation and for evidentiary purposes, including the type of evidence that will have an optimal impact and how evidence can best be collected and delivered. Data to demonstrate the impact of sexual violence legislation on sexual and reproductive health outcomes and HIV transmission are also lacking. Limited capacity for research exacerbates the scarcity of data.

Conclusion

Many sub-Saharan African countries do not yet have comprehensive post-rape care services, nor do they have substantial co-ordination between HIV and sexual and reproductive health services, the legal and judicial systems, sexual violence legislation and supporting legal instruments. There is a need to ensure that these are integrated by cross-referrals between these sectors, using standardised referral guidelines and pathways, treatment protocols, medico-legal procedures and information provided in the health sector and justice system. This requires common training approaches and harmonised information across the different sectors. Common indicators that bridge the interface of legislation and health services would facilitate government accountability. Strengthened research capacities and additional research in this area are necessary. Joint and collaborative planning and working at in-country level, through sharing of information and data between the criminal justice system, legal system and health sector, remain key to achieving this.

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Résumé

Six pays d'Afrique subsaharienne ont actuellement des lois sur la violence sexuelle, notamment le Kenya, et huit autres des dispositions sur la violence sexuelle dans une autre législation. Une législation efficace exige des liens médico-légaux pour permettre à la justice de s'exercer en cas de violence sexuelle et aux victimes de recevoir des soins de santé. Le secteur de la santé doit aussi assurer des soins après un viol, recueillir et transmettre les indices au système de justice pénale. Cet article examine les données sur la violence sexuelle en Afrique subsaharienne, et résume le contenu de la législation s'y rapportant dans la région ainsi que les forces et les faiblesses des liaisons médico-légales existantes, en utilisant le Kenya comme étude de cas. Beaucoup de pays d'Afrique subsaharienne n'ont pas de services complets de soins après un viol, ni de coordination substantielle entre les services de santé génésique et de traitement du VIH, les systèmes juridique et judiciaire et la législation sur la violence sexuelle. Ils doivent être reliés par des références croisées, au moyen de directives standard d'aiguillage et de passerelles, de protocoles de traitement et de procédures médico-légales. Des approches communes de formation et une information harmonisée entre secteurs, ainsi que des indicateurs communs, aideraient les autorités à se responsabiliser. Une planification et des activités conjointes et concertées au niveau national, par le partage d'informations et de données entre différents systèmes, demeurent essentielles pour y parvenir.

Resumen

En seis países de África subsahariana, contando a Kenia, existen leyes sobre la violencia sexual, y en ocho más existen disposiciones al respecto en otra legislación. La legislación eficaz requiere enlaces médico-jurídicos que funcionen para permitir el cumplimiento de la justicia en casos de violencia sexual y la prestación de servicios de salud para las sobrevivientes. El sector salud debe proporcionar servicios de atención post-violación y recolectar y entregar evidencias al sistema de justicia penal. En este artículo se analizan los datos sobre la violencia sexual en África subsahariana y se resume el contenido de la legislación sobre la violencia sexual en la región y las fortalezas y debilidades de los enlaces médico-jurídicos, usando a Kenia como un estudio de caso. En muchos países de África subsahariana aún no existen servicios de atención integral post-violación, o coordinación entre los servicios de VIH y los de salud sexual y reproductiva, los sistemas jurídico y judicial y la legislación sobre la violencia sexual. Estos deben integrarse mediante referencias, usando directrices y vías de consulta, protocolos de tratamiento y procedimientos médico-jurídicos estandarizados. Enfoques comunes de capacitación e información armonizada en todos los sectores, e indicadores comunes, facilitarían la responsabilidad del gobierno. Una planificación conjunta y colaborativa, así como trabajar a nivel nacional, mediante el intercambio de información y datos entre los diferentes sistemas, continúan siendo esenciales para lograrlo.