



# External Barriers to Help-Seeking Behaviour among Intimate Partner Violence Women Survivors in Nairobi: A Study at Mama Lucy Kibaki Hospital

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## Abstract

This study investigates the external barriers that hamper help-seeking behaviour among survivors of Intimate Partner Violence (IPV) at Mama Lucy Kibaki Hospital, a key referral facility in Nairobi's Eastlands region. By examining institutional, socio-cultural, and systemic obstacles, this research aims to provide insights into the structural constraints that prevent survivors from accessing timely and appropriate support. The study population comprised 390 women survivors of IPV and 12 key informants who were purposively selected. The study was guided by the Barrier Model, which provided a framework for understanding the social and structural factors that shape survivors' help-seeking behaviour. Adopting a mixed-methods research design, the study integrated both quantitative and qualitative data collection techniques informed by the positivist philosophy and interpretivist philosophy, respectively. Key findings showed that the most significant obstacles were logistical inconveniences ( $M = 2.86$ ), financial constraints ( $M = 2.25$ ), societal pressures, language barriers, and stigma. Cultural norms and religious teachings also discouraged survivors from seeking help. The study concludes that addressing external barriers is essential for improving help-seeking among IPV survivors. Understanding these barriers is critical for informing policy, improving service delivery, and ultimately enhancing the safety and well-being of IPV survivors in Kenya. The study recommends offering transport and childcare support, providing multilingual materials, and involving religious and community leaders to change perceptions and encourage help-seeking.

## Introduction

Barriers to help-seeking are multifaceted, encompassing structural, cultural, and personal dimensions (Ringwald et al., 2022). Yet, in Kenya, there is a paucity of comprehensive studies that explicitly explore these barriers within the socio-cultural and economic context. Understanding these obstacles is crucial for developing tailored interventions that empower women to seek help and access the support they need to break the cycle of Gender Based violence (GBV). To this end, this study aims to investigate external barriers to help-seeking behaviour in Nairobi County, focusing on women survivors of Intimate partner violence at Mama Lucy Kibaki Hospital. The specific objectives were:

1. To identify institutional and structural barriers affecting survivors' access to formal support services.

2. To examine socio-cultural and religious influences on survivors' decisions to seek help.
3. To explore the logistical and financial constraints that limit survivors' ability to access care.
4. To generate recommendations for policy and practice aimed at improving help-seeking among IPV survivors in urban healthcare settings.

### **Theoretical Underpinning**

The Barrier Model, developed by Gondolf and Fisher (1988), served as the foundation for this investigation. It describes multiple interconnected barriers that keep victims of intimate partner violence (IPV) from getting assistance. The victim is positioned in the middle of four concentric circles, each representing a barrier layer, as illustrated in Figure 1. Environmental factors like poverty, inaccessible mental health or legal services, and a lack of police support are included in the outermost layer. The second layer consists of social and cultural norms, including deeply ingrained views on gender roles and relationships, which frequently lead women, particularly in Sub-Saharan Africa, to normalise violence and accept blame (Ringwald et al., 2022). The third layer captures psychological barriers, including fear, trauma, and isolation, while the deepest layer deals with neglect and early exposure to violence. The majority of survivors encounter a combination of these barriers. This model provided a comprehensive framework for analysing how external factors influence the behaviour of IPV survivors when seeking assistance in Kenya.

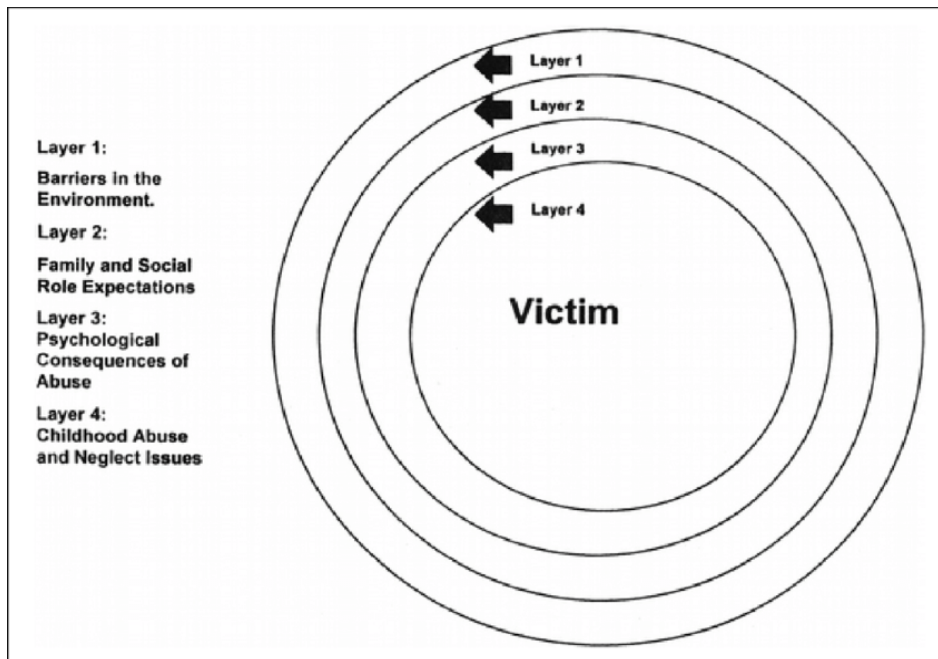


Figure 1: Barriers Model

Source: Adopted from Grigsby and Hartman (1997).

### **Literature Review**

Intimate partner violence (IPV) against women is widespread internationally and regionally. According to WHO estimates from 2021, 30% of women globally have experienced sexual or physical IPV, with Africa having the highest proportion at 37% (WHO, 2021). Given the societal and systemic barriers that prevent people from seeking help, IPV is still significantly underreported despite these concerning statistics. Inaccessible services and discriminatory institutions are among the additional difficulties faced by marginalised populations, including older women, immigrants,



LGBTQ+ people, caregivers, and people with substance use disorders (Tenkorang, 2021). Particularly in remote places where access to assistance is restricted by lack of awareness and budgetary constraints, survivors frequently lack trust in law enforcement and health care providers. Reporting is also discouraged by social stigma, fear of being "outed," or an increase in violence, particularly in same-sex partnerships (Ollen et al., 2017). Deaf or minority women are further excluded from necessary treatment due to language challenges. Patriarchal cultural norms frequently justify violence and put family harmony ahead of women's safety, which encourages victim silence. Many women are also compelled to remain in violent relationships due to financial dependency, a lack of housing, and childcare options. Enhanced access to legal protection, education, and economic empowerment for women is necessary for long-lasting solutions (Robinson et al., 2020).

In the United States, IPV survivors face several obstacles to obtaining help, according to a comprehensive review by Robinson et al. (2020). These include a lack of knowledge, restricted access, fear of repercussions upon exposure, material restrictions, personal limitations, and systemic failures. Criminal justice practices such as "no-drop" prosecutions, which prioritised perpetrator accountability but did not guarantee survivors' long-term safety, were frequently seen as ineffectual or even detrimental. Women were further deterred from pursuing justice by the legal system, discrimination, and fear of reprisals, particularly as a result of inadequate protective policies. Reluctance among survivors was also influenced by police attitudes (Serrano-Montilla & Lozano, 2021).

Women in Mexico who felt they were separated or divorced, had significant mortality risks, or were unaware of available options were less likely to seek assistance, according to Willie et al. (2020). Family and community influences were also important; women frequently feared shame or condemnation from friends and family (Heron & Browne, 2021). When seeking help, 74.6% of Arab women were afraid of being rejected and stigmatised by their families (Elghossain et al., 2019). Similar trends were noted on a regional scale. According to Mannell et al. (2015), societal, economic, and legal barriers affect people's decision to seek aid in Rwanda.

Patriarchal norms were found to be a significant factor in Ugandan women's reluctance to seek assistance. Social norms requiring women to show their husbands respect prevented them from reporting abuse since any disagreement was seen as disrespectful (Gardsbane et al., 2021). By giving preference to men in court, the judicial system perpetuated this disparity. In Kenya, Maticka-Tyndale and Barnett (2019) discovered that formal and informal help-seeking attempts were impeded by cognitive, interpersonal, and structural stigma in informal settlements. Together, these findings show that access to support for IPV survivors is severely restricted in different locations by institutional, cultural, and interpersonal constraints.

## **Methods**

### ***Study Design***

The study employed a convergent parallel mixed-methods research design, collecting both qualitative and quantitative data simultaneously to adequately address the research objectives and establish causal inferences.

### ***Study Location***

The study was conducted at Mama Lucy Kibaki Hospital in Nairobi's Eastlands region, selected for its volume of GBV cases and its integrated GBV response centre serving socioeconomically vulnerable populations.

### ***Study Population***



The study population consisted of 65,000 women survivors of gender-based violence in heterosexual relationships for at least two years who sought services at the Mama Lucy Kibaki Hospital SGBV in Nairobi.

### **Sample size and Sampling**

The study employed stratified sampling based on types of violence experienced and purposive sampling for 12 key informants, resulting in a sample size of 397 IPV survivors drawn from a population of 65,000, using Yamane's (1967) formula with a 5% margin of error.

### **Data Collection**

Data were collected using the 78-item BHS-TR scale, administered to 390 participants for quantitative data, and semi-structured interviews with 12 key informants for qualitative data.

### **Data Analysis**

The study employed quantitative analysis using SPSS version 27.0 for descriptive statistics and thematic analysis, utilising NVivo Version 14.0 for qualitative data with inductive coding to identify common themes across participant narratives.

### **Ethical Consideration**

The study adhered to key ethical considerations, including avoiding plagiarism through proper citation and originality checks, ensuring participants' confidentiality by omitting identifying data, securing voluntary participation through informed consent and obtaining necessary legal approvals from NACOSTI, the researcher's institution and Mama Lucy Kibaki Hospital.

### **Results**

This study employed descriptive statistics to assess the impact of four external barriers that hinder IPV survivors from accessing support services: Financial Constraints, Unavailability, External Constraints, and Inconveniences, as outlined in Table 1. Consistent comparisons across these constructs were made possible by a listwise sample of  $N = 387$ , providing valuable information to develop successful policies and interventions.

*Table 1. External barriers to help-seeking behaviour*

<b>Descriptive Statistics</b>						
	N	Minimum	Maximum	Mean	Std. Deviation	Coef. of Var.
Finance	389	1.00	4.00	2.2481	.78535	0.35
Unavailability	390	1.00	4.00	1.9214	.57817	0.30
External Constraints	390	1.00	4.00	2.2103	.51563	0.23
Inconveniences	388	1.00	5.00	2.8600	.80347	0.28
Valid N (listwise)	387					

According to descriptive statistics gathered from 387 female survivors, there was a moderate clustering of external barriers to seeking help. Procedural and logistical challenges were the most significant obstacles, since inconveniences had the highest intensity ( $M = 2.860$ ). The least reported barrier was the unavailability of services ( $M = 1.921$ ), while financial concerns ( $M = 2.248$ ) and external constraints ( $M = 2.210$ ) were moderately troublesome. Based on the coefficient of variation, survivors' experiences of financial strain varied the greatest, followed by inconveniences and unavailability, although their perceptions of external constraints were more uniform. According to these findings,



financial challenges differ widely, access to services was less of a challenge, and logistical challenges were the most frequent barrier.

Using NVivo and thematic analysis, qualitative data from semi-structured interviews at the GBV centre of Mama Lucy Kibaki Hospital were examined. The results showed that the main external barriers to accessing IPV support were social constraints, financial constraints, and procedural obstacles.

### ***Religious barriers***

Religious teachings and traditional norms framed abuse as a private or even sacred trial, discouraging survivors from seeking external help. Victims were told to endure for the sake of family honour or faith. Religious teachings further reinforced endurance and submission, making it difficult for victims to seek external support. The NVivo visualisation word cloud analysis highlights dominant terms such as "Church," "pray," and "respect", among others, emphasising the role of religious and cultural beliefs in shaping victims' reluctance to seek assistance.

Religious teachings also emerged as a significant factor discouraging victims from seeking support, with some pointing to how religious teachings frame suffering as a test of faith:

*My church leader advised me to pray and stay patient, saying that marriage is for better or worse. (Personal communication, Participant 2)*

*Some religious teachings make women believe they must endure suffering as a test of faith. (Personal communication, Participant 6)*

Cultural customs and norms normalised violence, inhibited reporting, and put family pride ahead of safety, according to respondents. The loss of agency, social pressure, and humiliation were common obstacles that led to victims' silence. Words like "control," "shame," and "disclose" demonstrated how deeply culture shapes conduct while seeking assistance.

From the interviews, respondents were quoted as saying:

*In her culture, women are expected to endure. Leaving a marriage because of abuse is seen as a failure. (Personal communication, Participant 4)*

*In her community, reporting her husband would mean her family would disown her. (Personal communication, Participant 3)*

*Some women believe that if they endure the abuse, they will earn more respect as good wives. (Personal communication, Participant 5)*

Another participant emphasised the role of cultural expectations in perpetuating silence, saying, "You can't just go and tell people what happens at home. It stays within the family." (Participant 5). Another respondent intimated, "Some communities believe the husband disciplining the wife is normal. The woman is expected to stay silent." (Participant 6)

### ***Dependency***

This theme emphasised how women remain in abusive marriages because of their financial dependence and lack of economic options. The link between economic vulnerability and limited help-seeking behaviour was further supported by survivors' citation of high living expenses, a lack of shelters, and economic control by abusers as significant obstacles to reporting abuse or fleeing.



Additionally, financial insecurity was identified as a significant factor limiting victims' ability to access help. Participants noted that the costs associated with living, such as rent, transport, and childcare, often outweighed the perceived benefits of reporting abuse.

*If she reports him, who will pay her rent? She will be homeless. (Personal communication, Participant 1)*

*She can't even afford transport to report him. Where does she even start? (Personal communication, Participant 3)*

*The husband controls everything, even her phone. She cannot even get money without asking him." (Personal communication, Participant 6)*

### **Social Stigma**

This theme was coded whenever participants discussed how societal attitudes discourage GBV victims from reporting abuse or seeking assistance. Findings indicate that stigma manifests in the form of victim-blaming, shame, and societal pressure to endure abuse. This discourages victims from speaking out, reinforcing silence and prolonging their suffering. Participants highlighted key aspects of stigma, including the perception that victims are weak or have failed in their relationships:

*Women fear speaking out because people will say they are weak, and they should have kept their home together. (Personal communication, Participant 3)*

*If she goes to report, everyone will know, and she will be seen as the woman who couldn't manage her husband. (Personal communication, Participant 1)*

*Some victims believe reporting abuse will ruin their reputation, especially if they are from conservative families. (Personal communication, Participant 6)*

Overall, results suggest that social stigma acts as a significant barrier to help-seeking among GBV victims. Fear of being perceived as weak, societal judgment, and concerns about reputation prevent many from accessing critical support services.

### **Language Constraints**

Language hurdles made it difficult for victims to report abuse or seek assistance, particularly for non-Swahili or non-English speakers. Language was identified as a significant barrier to support-seeking behaviour because a lack of interpreters and translated materials resulted in misunderstandings and frustration, which frequently led survivors to give up on attempts to access essential services.

From the interviews, respondents expressed the following concerns:

*Some victims don't report because they don't speak Swahili or English, and they fear being misunderstood. (Personal communication, Participant 5)*

*Victims from other countries struggle more because they don't know how to explain their abuse in a language that a language service provider understands. (Personal communication, Participant 1)*

*If you cannot explain your pain, you feel helpless. Some just give up and suffer in silence. (Personal communication, Participant 6)*

The findings indicate that language barriers lead to fear and frustration, preventing victims from effectively seeking help. Victims who do not speak widely used languages may avoid reporting abuse due to miscommunication concerns or past experiences of being misunderstood.



### **Financial barriers**

This theme encapsulated how the victims' inability to afford care, legal bills, or transportation prevented them from accessing assistance. With crucial terms like "afford," "money," and "transport" emphasising the clear connection between poverty and barriers to obtaining help, financial dependency and instability led many people to stay in abusive situations.

*One victim said that she wanted to go to the hospital, but she did not have fare, so she stayed home. (Personal communication, Participant 2)*

*Most women in Kenya are housewives. If they leave, they don't have any means of survival. (Personal communication, Participant 5)*

Financial dependence on abusive partners was a recurring concern. Many respondents indicated that victims lacked the financial autonomy to leave.

*Many women stay because their husbands provide for everything, and they have no way of supporting themselves alone. (Personal communication, Participant 12)*

*Many victims lack financial resources or transportation to seek help at hospitals or shelters. (Personal communication, Participant 10)*

One Respondent highlighted the economic vulnerability victims face, saying, "If a woman has no job, no money, and no family to support her, where can she go? She has no choice but to stay." (Participant 8)

### **Discussion of Results**

A moderately high mean score ( $M = 2.21$ ,  $SD = 0.52$ ) in external constraints indicated that religious and sociocultural standards were the primary external barriers to help-seeking among IPV survivors. Religious doctrine and cultural norms that defined enduring abuse as virtuous and seeking help as dishonourable frequently deterred survivors from obtaining formal assistance. Since they saw outside involvement as a breach of marital or familial obligations, many internalised these rules. These results align with those of Rohn and Tenkorang (2022), who noted comparable pressures in Ghana, and Lokot and Bhatia (2020), who emphasised how religious values promoted IPV tolerance in South Asian and African contexts.

According to survivors, finances were another significant barrier ( $M = 2.25$ ,  $SD = 0.79$ ), since they were unable to afford basic expenses like food and rent without their partners' help. The findings of Slyke et al. (2021) in Kenya, which connected poverty and financial reliance to IPV endurance, are consistent with this. According to research by Saint Arnault and Sinko (2022) and Maviya et al. (2021), the lack of interpreters or translated materials made it difficult for many survivors to express their experiences, especially for those who couldn't communicate in English or Kiswahili. Lastly, the most significant barriers were inconvenience in service delivery challenges, such as lengthy wait times, intricate processes, and insufficient staffing ( $M = 2.86$ ,  $SD = 0.80$ ), which is consistent with findings by Kimani et al. (2020) and Robinson et al. (2021).

### **Conclusion**

This study demonstrates that in Mama Lucy Kibaki Hospital and other urban public facilities in Kenya, IPV survivors' attempts to seek care are severely hampered by structural and practical barriers. Bureaucratic hold-ups, unclear referral processes, and financial reliance on abusers deter women from seeking help. Language difficulties further marginalise those who can't communicate in English or Swahili. Additionally, because disclosure is frequently discouraged by fear of shame and criticism, sociocultural norms and stigma silence survivors. Even though there are formal support structures in



place to help them, many women in societies where IPV is considered normal put their family's reputation before their safety, which keeps them stuck in abusive circumstances.

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