“Who do I turn to?”
The experiences of Sudanese women and Eritrean Refugee women when trying to access healthcare services in Sudan after being subject to gender-based violence

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Abstract

Aim: To explore the experiences of Sudanese women and Eritrean refugee women in Sudan when seeking healthcare after being subject to gender-based violence.

Background: In Sudan there is a general assumption that anyone who is subject to violence, including gender-based violence, must first go to the police department to file a report and be given “Form Eight”, a legal document, which they must present to the healthcare provider before they receive any care. Without this form healthcare providers are, supposedly, by law not allowed to treat the person. This complicates an already vague system of services for women subject to gender-based violence.

Methods: A qualitative study using semi-structured interviews of eight Sudanese women and seven Eritrean refugee women. Data was analyzed through a framework analysis (a form of thematic analysis).

Results: Women had to bring Form Eight before they received any help, this led to a delay in the time to receive care. There was a general lack of cooperation by police officers. Some women feared the consequences of help seeking, apparent amongst those subject to domestic violence and the Eritrean refugee women. Generally, the healthcare provided to these women was inadequate.

Conclusion: This study concludes the experiences of all the women in this study when seeking healthcare after being subject to gender-based violence were far from international standards. A lot needs to be done in order for women to know the clear answer to the question posed in the title of this study; “Who do I turn to?”.
Acknowledgment

I would like to dedicate this thesis to all the women who took the time to share their stories and speak out for the millions of women who cannot speak for themselves. I thank them for taking part in the study and more importantly having the courage to speak about such a difficult topic.

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Introduction

In Sudan there is a general assumption that anyone who is subject to any form of violence and requiring healthcare of any sort must first go to the police department to file a report and be given “Form Eight”, a legal document, which they must present to the healthcare provider before they receive any care. Without this form healthcare providers are, supposedly, not allowed to treat the person and if they do they are subject to legal consequences. This is also the case for women who have been subject to gender-based violence (1), which complicates an already vague system of services for these women, increasing the number of people that women must disclose the incident to and the length of time until care is initiated.

Gender-Based Violence

Gender-based violence, often interchanged with the term “violence against women”, is defined as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life” (2). According to World Health Organization, 35 percent of women around the world experience some form of gender-based violence in their lifetime, a third of these 35 percent experience it from an intimate partner (3). Gender-based violence is most commonly prevalent in the South-East Asian, Eastern Mediterranean and African regions with prevalence rates of 37.7, 37 and 36.6 percent respectively; though it is also prevalent, in lower percentages, in the regions of America with 29.8 percent, European region with 25.4 percent and Western Pacific region with 24.6 percent (4). It can therefore be considered as a significant problem worldwide violating basic human rights and causing noteworthy morbidity and mortality among those affected (5,6). Gender-based violence is particularly significant among refugees during conflict and displacement (7). According to the United Nations High Commissioner for Refugees there are currently 22.5 million refugees around the world (8), with women making up 50 percent of this population (9). A meta-analysis of 19 studies across 14 countries affected by conflict was conducted to determine the prevalence of gender-based violence, particularly sexual violence, among female refugees (7). The study concluded that 21.4 percent of refugee women experienced some form of sexual violence such as rape, coerced sex and sex trafficking (although the authors believe that this is under-reported) (7).
It is important for the sake of this study to clarify what types of violence are considered to be gender-based. According to the European Unions’ Council Conclusions, gender-based violence can be broadly classified into two forms; direct and indirect. Direct gender-based violence includes violence from an intimate partner; sexual violence, ranging from harassment and sexual assault to rape in a private or public setting; trafficking, whether in the form of human beings, slavery or sexual exploitation; harmful practices, such as female genital mutilation and child marriage and emerging forms of violence, such as stalking or bullying. Indirect forms of gender-based violence are less easy to define, generally relating to structural violence in relation to social norms related to gender, though no consensus has been reached regarding any specific subdivision (10).

**Healthcare for Women Subject to Gender-Based Violence**

In response to the emergence of gender-based violence a number of different organizations took the initiative in addressing this issue, individually, or collectively as a group of organizations, developing guidelines to, in their opinions, effectively manage gender-based violence. Examples include the Assembly of the African Union’s which developed the “Maputo Protocol”(11) in 2003; the guidance notes and protection principles within the Minimum Initial Service Package, part of the “Humanitarian Charter and Minimum Standards in Humanitarian Response”(12) which originally started in 1997; and the International Association of Forensic Nurses’ “Sexual Assault Nurse Examiner Guidelines”(13) originally released in 2004.

The most widely used guidelines by healthcare providers in clinical settings are the World Health Organization’s clinical and policy guidelines for responding to intimate partner violence and sexual violence, developed in 2013 (14). The aims of these guidelines are to provide health-care providers with evidence based guidance on the ideal steps to respond to intimate partner violence and sexual violence, as well as to inform them and policy makers of the need for appropriate responses to violence against women (14).

**Healthcare for women subject to gender-based violence in refugee and displaced settings**

In refugee and displaced population settings the most widely used guidelines are the “Guidelines for integrating gender-based violence interventions in humanitarian action” endorsed by the Inter-Agency Standing Committee (15). The aims of these guidelines are to help humanitarian actors and communities to reduce the risk of gender-based violence in humanitarian setting, strengthen national
and community based preventive systems and to create sustainable interventions to reduce the overall prevalence of gender-based violence specifically among refugee and internally-displaced populations (15).

A systematic review was conducted by Asgary et al. in 2013, aimed at evaluating strategies and approaches to manage and/or prevent gender-based violence in refugee and displaced settings (16). The study found that there were no published articles on the evaluation of these strategies and approaches and their health consequences (16). Many of the above-mentioned guidelines and recommendations were mentioned in the review and it concluded that although many articles were found which outlined specific strategies based on expert opinion, none of which were supported by research on displaced populations (16).

**Healthcare for women subject to gender-based violence in Sudan**

In Sudan, there are currently no national statistics to determine the prevalence of certain forms of gender-based violence, such as physical and sexual gender-based violence (17). The only form of gender-based violence for which prevalence rates can be found is female genital mutilation which is estimated at 87 percent (17). A specific national protocol, which unifies the management of gender-based violence in all healthcare facilities is currently not available in Sudan. Certain efforts were made in order to establish national protocols, for example, in August 2006 the Unit for Combating Violence against Women and Children in cooperation with the United Nations Population Fund and the Federal Ministry of Health produced a guide to clinical treatment for rape victims that was based on a World Health Organization protocol (18). Unfortunately, only 500 copies were printed and distributed, although the report does not mention where, and leaving the majority of healthcare providers still unaware of how to manage women who have been subject to gender-based violence (18).

Healthcare providers in Sudan, are bound by the doctors’ oath which states that they have to provide equal medical care for anyone, whether virtuous or a sinner, a friend or an enemy, rich or poor regardless of race or religion and that they strive to pursue knowledge for the benefit of mankind (19). This oath is the basis through which they provide care to all individuals, regardless of how much knowledge or training they have on matter they are medically presented with. In the case of management of all the different forms of gender-based violence, the majority of healthcare providers have not received any formal training (19). From my personal experience and talking to fellow
doctors in Sudan it seems that doctors simply rely on their personal experiences when dealing with women who have been subject to some form of gender-based violence and whatever information they gathered during their undergraduate studies or by their own personal efforts to manage women who have been exposed to any form of gender-based violence.

All this means that there is no available information about the number of women subject to gender-based violence who do seek healthcare, in Sudan, or on what type of care these women receive and thus no means of improving the services.

**Medico-Legal Ties in Services for Women Subject to Gender-Based Violence**

Many scholars mention the importance of legislation for all forms of gender-based violence. Research has shown that women are seven percent less likely to experience domestic violence in countries were legislations are in place (20). Most countries have laws that criminalize rape and sexual assault but not on domestic violence or rape in the marital context (6). There has been an increase in sexual violence legislations in Sub-Saharan Africa in recent years in countries such as Liberia, Namibia, Kenya, Tanzania and South Africa (21). According to one study legislations, specifically those for sexual violence, “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” (21). The study, which focused on sexual violence legislations in Sub-Saharan Africa, argues that there is a need for integration between health services and legal and judicial system (21).

**Medico-legal ties in services for women subject to gender-based violence in refugee settings**

Unfortunately, there are limited, if any studies regarding the medico-legal ties in services for refugee or internally displaced women subject to gender-based violence. The above mentioned “Guidelines for integrating gender-based violence interventions in humanitarian action” (15) highlighted the need for host authorities to have a better understanding of international laws that are related to the provision of support and services to refugees. The guidelines talk about the weakness of legal and social protection, which increases the possibility of women not seeking care and support and also promoting a culture of impunity for offenders (15).
Medico-legal ties in services for women subject to gender-based violence in Sudan

From 1991 the Sudanese Criminal Procedure Act required that anyone who is subject to any form of injury or trauma, file a report at the police station, where they receive a medical evidence form known as “Form Eight” (see Annex 2 and 3), which they must take to a governmental hospital to receive any form of healthcare (22). Unfortunately, without this form the healthcare provider was legally bound to not treat the patient regardless of how critical their condition was, being prosecuted and sentenced to jail if they fail to follow this law. Once the health care provider was given Form Eight they proceed to examine the person, documenting all the findings on the form, which once filled, the person was then asked to return it to the police station (23). The rationale behind this form was to provide legal proof of violence, a form of forensic evidence, in the instance that the injured party decides to pursue the case, so that they do not lose their legal rights and damage their case (24).

In 2004, after the visit of, then, Secretary General of the United Nations, Kofi Annan, the government of Sudan and the United Nations issued a joint communiqué (25). In it the Government of Sudan committed itself to investigate all of the cases of violations that occurred in Darfur and ensure that all accused of violation of human rights were brought to justice (25). The Government of Sudan also committed to establishing a fair system that allowed abused women to be able to press charges against alleged perpetrators (25). The visit by Kofi Annan and subsequent embargo put international focus on Sudan, placing substantial international pressure on the Ministry of Justice to ease the steps required for women to receive medical treatment (25,26). This pressure led to the law requiring victims to present Form Eight before receiving healthcare to be overturned and the Ministry of Justice issuing a circular in Darfur which was allegedly conveyed to all medical personnel recognized by the Ministry of Health (25). Although this change has occurred over 13 years ago very few officials in law enforcement and even fewer healthcare providers are currently aware of it (26).

Many doctors still refuse to provide healthcare without first receiving Form Eight (26). Form Eight is said to be a poor means of collecting basic information in cases of gender-based violence, especially rape, because it only asks for very little information instead of a comprehensive medical report (1). Healthcare providers are also not aware of whether they should declare that, in cases of sexual violence, that rape has occurred or to simply describe the medical presentation of the woman (1). Unfortunately, until this day, Form Eight is the only form of medical documentation admissible in
court according to Sudanese law. In many cases it is only admissible when filled in by doctors who have received full registration in the Sudanese medical council meaning that they have a medical license to legally practice in Sudan (24). Medical intern, in theory are not included as they have not received full registration, although, in a lot of settings the intern is the only healthcare provider that is in the healthcare facility (24).

Women are also reluctant to file a report and take Form Eight due to a number of socio-economic factors. Many women cannot afford to pay for the form which costs 50 Sudanese pounds (equivalent to $2.77), which is a substantial amount of money for those of poor socioeconomic status. More often than not, the police station is far from the hospital, thus requiring the use of transport between the hospital and the police station, which to many women is an extra cost that they cannot afford. The time and efforts needed to file the report also increases the risk of further injury due to long distances of travel is another reason why women are reluctant to file a police report (1).

It has been reported that police refuse to provide the form to women for a number of reasons such as ethnicity or tribe (22), causing a substantial hurdle or even a complete barrier for women to access health services. In one article it stated that “these women are victimized twice: first by the men who assaulted them, and then by the legal authorities who treated each of them as the guilty party” (27). Officers and judges have in some cases rejected medical proof that was gathered before the filing of a police report (24). Police are often unhelpful and poorly trained in handling gender-based violence and at times even verbally abusive. Many believe that all of the above are deliberate tactic to stop the reporting of gender-based violence, especially rape (1,26).

Another important point worth mentioning is that people with government affiliations are granted legal immunity in Sudan (1), which means that police officers are protected by law from any criminal proceedings and shall not be tried unless the general commander allows prosecution to take place. This provides police officers with what can be considered as a ‘free pass’ to do whatever they like without fear of repercussions (26). It is not uncommon that police officers are the perpetrators in crimes of sexual violence and with the above-mentioned law it means that they are almost never prosecuted, creating yet another obstacle for women seeking healthcare and justice (26).
Rationale of Study

Currently no information regarding the prevalence of gender-based violence in Sudan is available, nor is there a specific national protocol for the provision of healthcare for women who have been subject to gender-based violence (17). Healthcare providers lack the basic knowledge of the management of these women and rely on their own experiences. What complicates matters even further is the process to access care. As mentioned above although the law which prevented healthcare providers from managing women after being subject to gender-based violence without Form Eight was lifted in 2004, many healthcare providers are still under the impression that this law exists and thus refuse to treat women without the form (25,26). Police officers sometimes refuse to provide women with the form for numerous unjustifiable reasons (1,26).

This study aims to look at the experiences of women when seeking healthcare after being subject to gender-based violence, considering all the factors mentioned above that might affect these experiences.

Overall Aim

The overall aim of this study is to explore the experiences of Sudanese women and Eritrean refugee women in Sudan when seeking healthcare after being subject to gender-based violence.

Specific Objectives

I. To explore the healthcare provided for Sudanese women and Eritrean refugee women when seeking care after being subject to gender-based violence.

II. To describe the implications Form Eight has on the experiences of these women when seeking healthcare in Sudan after being subject to gender-based violence.

Theoretical Framework

The Three-Dimensional View of Power

The three-dimensional view of power was used in this study to analyze and discuss the data in order to find out the possible ways in which power was hindering or facilitating access to healthcare for both Sudanese and Eritrean women after being subject to gender-based violence.
Steven Lukes’s was the first to describe the three-dimensional view of power in his book; Power: A Radical View (28). He described the three dimensions by first looking at their historical roots and describing the one-dimensional and two-dimensional views of power (28).

The one-dimensional view, was described by Robert Dahl as “A has power over B to the extent that he can get B to do something that B would not do otherwise”, which he considered as potential power, or “to involve a successful attempt by A to get a to do something he would not otherwise do”, which is, in his point of view, actual power (29). Identifying this form of power is said to be done by analyzing decision-making in order to determine who in a society is most influential (30), with whoever prevailing in decision-making being the one who has the most power in society (31).

The two-dimensional view of power was described by Bachrach and Baratz, who criticized the one-dimensional view, calling it restrictive and stated that power has two faces not one (32). The first face, is totally embodied and fully echoed in concrete decisions or activities based on the making of the decision, in other words the decision-making face (33). The mobilization of bias was brought into the discussion of power by Bachrach and Baratz, in which a set of predominant beliefs, rituals, values and institutional procedures operate consistently and systematically to benefit certain people or groups at the expense of others (33). The second face of the two-dimensional view, according to Bachrach and Baratz, is the non-decision-making face, “a decision that results in suppression or thwarting of a latent or manifest challenge to values or interests of the decision-maker”, which is a means of silencing demands for change before they are even voiced(33). This non-decision-making prevents ‘potential issues’ from actually happening, issues that may involve a threat or challenge to the authority or power of those who are the decision makers (33). Bachrach and Baratz believe that if “there is no conflict, overt or covert, the presumption must be that there is consensus on the prevailing allocation of values, in which case non-decision-making is impossible” (33).

The three-dimensional view of power, as described by Steven Lukes, “involves a thoroughgoing critique of the behavioural focus of the first two views as too individualistic and allows for consideration of the many ways in which potential issues are kept out of politics, whether through the operation of social forces and institutional practices or through individuals’ decisions” (28). According to Lukes people’s thoughts can be controlled in mundane forms, through the mass media, the control of information and through the process of socialization (28). Lukes believes that the greatest exercise of power is to prevent people from having conflict or grievances by shaping their
cognitions, preferences and perceptions in a way that they accept their role in the existing social order (28). In this view of power ‘latent conflict’ may be seen, which is the paradox between the interest of those in power and the actual interests of the people they exclude, even if those excluded are not conscious of their interests (28).

The three-dimensional view of power exist when people are subject to domination and comply silently or without protest to this domination (34). Domination was defined by Max Weber as “the probability that a command with a given specific content will be obeyed by a given group of persons” saying that “the existence of domination turns only on the actual presence of one person successfully issuing orders to others” (35). Power is thought of as domination when significant constraint is imposed on, rather than influencing, a person or their desire, interest or purpose which it disturbs or even prevents from occurring, rendering the person ‘less free’ (28). In other words, domination can negate people’s interests by altering their power of judgement and reducing their self-perceptions and understanding (28). To Lukes, there was no way for anyone to escape domination because power is everywhere. He believed that democracy and power are paradoxically related (28).

This study will focus on the third-dimension of power that was introduced by Steven Lukes, that in which potential issues are kept out of politics and the ways in which power is imposed on people in mundane forms such as mass media and the control of information. Viewing the results of this study through the lens of the third-dimension of power I try to identify what role this third-dimension has on the experiences of women seeking healthcare after being subject to gender-based violence in Sudan.

**Methods**

**Research Design**

A qualitative study in the form of semi-structured individual interviews was conducted with women who have been subject to some form of gender-based violence and sought healthcare in Sudan. The reason for this choice of research design is that qualitative research generally aims to explore peoples’ experiences or to understand a phenomenon (36). It was also chosen because research on the experiences of women in Sudan when seeking healthcare following gender-based violence is limited and hence unexplored (37). An interview guide was developed following a literature review
of other studies that focused on the experiences of women when seeking healthcare after being subject to gender-based violence (see Annex 5). Once a draft of the guide was complete it was cross-checked and approved by a female senior lecturer at the department of women’s and children’s health with extensive background in qualitative research. The study was piloted during the first interview, which was also included in the results due to the limited number of respondents. The questions in the interview guide were meant to guide me and some changes were made throughout the study process depending on the responses of each participant.

**Study Setting**

Sudan is a country in North-East of Africa, neighboring Central African Republic, Chad, Egypt, Eritrea, Ethiopia, Libya and South Sudan with a total area of 1,861,484 km² (38). Sudan gained its independence 1956 and since then has been run by military regimes and unstable parliamentary governments (38) and has been affected by conflict ever since (39). Today the government of Sudan is run by a “presidential representative democratic republic” (40), and a governing party called the National Congress Party (41).

The study was carried out in the capital of Sudan, Khartoum (see Figure 1), the largest metropolitan area in Sudan with an estimated population of between six to seven million people (42,43), with approximately two million people internally-displaced from war zones and drought affected areas (44). The literacy rate in Sudan is estimated to be higher amongst men in 2008, with 60 percent of males ages 15 and above being literate, while only 47 percent of women in the same age group are literate (45). The total dependency ratio (the age-population ratio of those not in the labor force and those who are) in Sudan is estimated at 81 (42,46). Unfortunately official national statistics on the lifetime physical and/or sexual intimate partner violence or non-partner violence (17), with the only statistics on any form of gender-based violence available being the percentage of females aged 15 to 59 who have undergone female genital mutilation/cutting which is 87 percent (17).

Eritrean refugees began arriving in Sudan during the 1960s fleeing from the war of independence this number peaked in the 1980s with almost 500,000 Eritrean seeking refuge in Sudan (47). These numbers started to steadily decline until the beginning of 2014 where there was a marked increase with 10,700 seeking refuge in Sudan (48).
Study Sites

The participants were recruited and interviewed in two different sites namely;

**SEEMA center**

SEEMA Center for Training and Protection of Women and Child’s rights is a non-profit organization that was established in Sudan in 2008 (49). It is operational in a number of different states across Sudan. It has a number of activities but mainly provides integrated services for survivors of gender-based violence, in the form of legal aid, health service referrals, psychotherapy and social support (49). It provides similar services to survivors of child abuse. SEEMA center keeps a record of all the individuals that it has provided any service for since the time of its establishment. Other activities include training of activists, survivors of gender-based violence and potential service providers (49). SEEMA also works in advocating for women and children’s rights working with other groups and organizations on issues such as against laws that negatively affect women (49). SEEMA’s mandate is “promotion and protection of women and children’s rights, combating gender-based violence and building a protective environment for women and children” (49). The women recruited for this study
from SEEMA center approached it at some point in order to utilize the services it provided, some requiring legal aid, others psychotherapy and social support and the rest for health service referrals.

**Eritrean safe house**

The Eritrean safe house is mainly funded by the United Nations Population Fund and United Nations High Commissioner for Refugees and functions as a women’s shelter for Eritrean refugees who are extremely vulnerable in Sudan (50). It provides accommodation for Eritrean refugee women with no relatives in Sudan (50). Within the safe house there is a health clinic which provides basic health services for these women (50). The safe house has ties with other organizations which help provide services that are unavailable in the safe house such as psychological support and complicated medical or surgical procedures (50). The women recruited from the Eritrean safe house for this study had sought shelter and/or healthcare at the safe house including psychosocial support.

**Participants and Sampling**

The sampling method that was chosen for this study was purposive sampling. Overall 16 women met the eligibility criteria, which included age (over 18 years of age); being subject to some form of gender-based violence; making the decision to seek any form of healthcare anywhere in Sudan and were interviewed. The first point of recruitment was SEEMA center from which initially over 20 women were contacted using the records kept by the center, with the hope that all participants would be recruited from there. Unfortunately, many women did not show up for the interview (although they initially agreed to partake in the research). Towards the end of the data collection period only six interviews were conducted with participants recruited from SEEMA center, so I contacted the doctor of the clinic at the Eritrean safe house in order to increase the number of interviews. Interviews were conducted until similar themes and patterns began to appear. In the end 16 women were interviewed, nine from SEEMA center and seven from the Eritrean safe house. One interview was excluded during the data analysis phase because the scope of her injuries and the reasons for seeking healthcare were not directly related to gender-based violence but rather due to being tortured while imprisonment for alleged political opposition.

**Data Collection**

Seven of the nine Sudanese women were literate, read and signed the consent form themselves. I read the consent form to the women who were not literate and explained the information in layman’s
terms after which the women signed the form themselves as they were able to write their names. The interpreter of the interviews with the Eritrean women was an Ethiopian doctor who provided care for these women at the safe house and he translated the consent form for all seven Eritrean women and each signed the form as they were literate though not in Arabic. The women were informed that participation in the research was voluntary and that they could withdraw from the study at any time. The interviews took place in the same place where they were recruited, in other words, the Sudanese women were interviewed at SEEMA center and the Eritrean women were interviewed at the Eritrean safe house. I, a Sudanese female doctor, conducted the interviews with the help of the interpreter for the interviews with the Eritrean women. Semi-structured individual interviews lasting between 10 minutes to an hour were conducted. The duration of these interviews differed depending on how much information the participant was willing to disclose. Some of the interviewed women had very little contact with the healthcare facility for numerous reasons that will be discussed later, which led to relatively short interviews. Nine interviews were translated from Arabic and transcribed in English and crosschecked by a fellow researcher who is a native speaker of Arabic. During the seven interviews with the Eritrean women an interpreter was present and translated for the interviewer and interviewee, this was crosschecked by a follow female researcher who is fluent in Tigrinya and Tigre. Field notes were added to the end of each transcript.

Analysis

In this study a framework analysis technique was used as the main method of analysis. Framework analysis is a form of thematic analysis, similar to the regular thematic analysis, which was originated from social policy research but has become more popular in medical and health research (36). It differs from the regular form of thematic analysis in its intention to compare between different participants views first then the different parts of the data for each participant. The analytical framework has been defined as “a set of codes organized into categories that have been developed by researcher(s) that can be used to manage and organize the data. The framework creates a new structure for the data (rather than the full original accounts given by participants) that is helpful to summarize/reduce the data in a way that can support answering the research questions” (36).

The interviews were recorded and then translated and transcribed. This was then revised by listening to the recordings and reading the transcripts to ensure proper transcription. Four interviews were back translated by fellow researchers in order to check the accuracy of my translation and transcription, one who is a native of Arabic for the Sudanese women and one who is fluent in
Tigrinya and Tigre for the Eritrean women to verify the translation. Field notes were incorporated within the process. Open coding was first done, and I ended up with 142 codes, which were checked by a fellow researcher with experience in qualitative research and the framework analysis. Then together we came up with coding labels to group the open codes. We were constantly going back and forth to check if these codes fit and whether or not they were of relevance to the study, those found irrelevant were taken out. After that a comparison of the different coding labels was done, where we reflected on them and the field notes to group these coding labels into categories.

A framework matrix was generated by putting the data into a table in Microsoft word. The cells showed illustrative quotes under each category (column) for each participant (row). Then looking into the patterns inside each category and comparing between the different participants interpretation of the framework matrix was done. Themes were established based on the interpretation of these patterns. The final framework contained 11 main categories and four themes. Figure 2 shows an example of an open code, coding label, category and theme.

**Open Code**
- I went to the (police) department, the people in the (police) department told me I have to go to the hospital, “you have to bring the form from the hospital”.

**Coding Label**
- Have to go to hospital to bring Form Eight

**Category**
- Reasons for seeking Form Eight

**Theme**
- “You must bring Form Eight or how else will we believe you?”

![Figure 2 – Example of an open code, coding label, category and theme](image)

**Reflexivity**

As a researcher it is important that one is aware of their role in the process and outcome of this research. Being a doctor who has received full registration in Sudan, I experienced numerous
encounters women who have been subject to gender-based violence and witnessed the ways in which gender-based violence was managed in Sudan. Some of these encounters were during my internship, which meant that I was not the one providing management for these women or filling in Form Eight, but I was always curious about the process and assisted my superiors in the case management. After completing my internship, I worked as a healthcare provider on a project which provided reproductive health services for migrants and refugees. During this time, I managed a number of Eritrean and Ethiopian women who had been subject to sexual violence, many of whom had become pregnant following their assault and were looking for antenatal care. All these experiences led to my curiosity to conduct this research, looking into at the health services provided to women subject to all the different forms of gender-based violence.

The interview process was truly overwhelming, and I found myself consciously controlling myself from expressing my outrage at the responses that these women received from healthcare professionals and police officers. I avoided influencing the interview by steering the conversation into the direction of what I knew to be right or wrong and rather focused on just listening to their experiences and thoughts. Hearing their stories was a heavy emotional burden and, especially at the beginning, I questioned whether I would be able to complete this research. However, the more stories I heard the more determined I was to do so. Having some women express their appreciation for my interest in their stories and how they wished that I would be able to improve the situation for others was more fuel for me to complete this research.

Starting this research, I greatly underestimated the effect of Form Eight on the experiences of these women when seeking healthcare. It was not until after I finished transcribing that I became aware of how much weight this form had on their experiences. What was even more surprising was how as a doctor, even I was not aware that there was no longer a law requiring that women present form eight before receiving healthcare.

**Ethical Consideration**

Ethical approval for this research was obtained from the health research council of the national Ministry of Health in Sudan. The submission checklist included an ethical application form (23 pages long including the consent form) (51), my CV, study protocol, interview guide and a letter from the institute to which I was affiliated with, namely Uppsala University, approving the research and stating that no conflict of interest or financial benefit was received by me. The Helsinki ethical
guidelines were followed as part of the ethical considerations of this study (52). The fact that the participants of this research were women who sought medical care after being subject to gender-based violence, which is a very sensitive topic, meant that special considerations were made during the study. It was important to explain the aim of the study to the participants and allow them to share only what information they were comfortable with sharing. The participants were given an information sheet with the consent form in Arabic (see Annex 4), which was read out to those illiterate, with details about the study and were free to ask questions regarding the study. They were also informed that their participation in the study was voluntary and that they were free to withdraw from the study at any time without the need to give an explanation for their withdrawal. My contact information as well as an information regarding the study was provided to the participants for further inquiry if required.

This research was strictly confidential, with the identity of the interviewees hidden throughout the process. Their names have not been used in the process of the study. The recordings were saved under pseudonyms on my laptop, which only I have access to. Informed consent was obtained from all participants who took part in the study once all information regarding it was answered to their satisfaction. No information obtained within this research will be used outside the scope of scientific research.

**Results**

**Descriptions of Study Participants**

In order to get a better understanding of why these women needed healthcare, it is important to briefly describe what form of gender-violence each woman was subject to (all the names are pseudonyms to protect the identity of the interviewees).

Four of these women were subject to gang rape. Samia was a 38 year old Sudanese married woman with three children, who was raped by three men, who initially intended to rob her, in her home in front of her children while her husband was away for work. Yousra, a 27 year old Eritrean woman, was arrested by the police for having an expired ID card and was raped by three police officers. Selma was another Eritrean woman, 30 years old, who was taken from the street while on her way home and raped by six men. Leila, a 22 year old Eritrean woman, was taking a rickshaw, when the rickshaw driver took her elsewhere where she was raped by him and another man.
Domestic violence was a reason why four of the women in the study tried seeking help. Najat was a 53 year old Sudanese woman, who was attacked by her husband who beat her on the head with a brick. Itidal was another woman who had been suffering from domestic violence for 29 years, by her husband who was a police officer. She only sought care for her injuries once and regretted it because her husband found out and beat her even more. Nusaiba was a 37 year old Sudanese woman who was subject to numerous counts of domestic violence, each time she going to the police station to take Form Eight and would get treated but would never return the form to the police station. Amina, a 28 years old Sudanese who was constantly being beaten by her husband.

Kawthar was a 26 year old Sudanese social worker who was beaten and raped by a man in the street in broad daylight on her way out and left for dead. She was one of three women in this study who were raped. Alaa was another Sudanese woman who was raped. She was 25 year old and was raped by a rickshaw driver. Astar was a 25 year old Eritrean woman who was also raped by a rickshaw driver after being kidnapped in the street by a number of men.

Three of the Eritrean women were victims of human trafficking. Lisa was a 34 year old Eritrean woman who was trafficked into Sudan and during the process she was raped by a number of smugglers. Sally was another Eritrean woman who was trafficked into Sudan. She was 20 year old and raped by the trafficker who threatened to kill her with a knife if she refused. Assil was a 22 year old Eritrean woman who was raped numerous times by two men while being trafficked into Sudan. Mehad was the only woman in the study who was subject to attempted rape. She was a 22 year old Sudanese midwife who was kidnapped by two men on a motorcycle. They took her to a secluded area and tried to rape her but she was very resistant and so they left her abandoned in the middle of nowhere.

**Themes**

The study results are presented in four themes;

- “You must bring Form Eight, or how else will we believe you”
- Indirect effects of Form Eight
- Fear of consequences of help seeking
- Inadequate care
“You must bring Form Eight, or how else will we believe you?”

One of the most dominant themes that appeared was that revolving around Form Eight and the need to acquire it before receiving any help. Some of the women sought help from the police to report the incident hoping to catch the perpetrator and protect themselves from further violence. Others went to healthcare facilities to seek treatment for injuries they acquired during the incident. In either circumstance the women reported that the response of the service provider was the same, “you must bring Form Eight”.

“I went to the hospital and they refused to treat me until I brought Form Eight and I refused to bring the form at that time and I went back home.” Amina, a 28 year old Sudanese woman.

All of the women who sought healthcare immediately after the incidence stated they were required to bring Form Eight before receiving treatment. Form Eight was also necessary in other instances such as in Samia’s case, who wanted to get a pregnancy test after being raped. She said that Form Eight was necessary in this situation to give her the legal right to have an abortion if she was found to be pregnant.

“They (the healthcare providers) said ‘okay, bring the form, we will do the (pregnancy) test now and then if there is a pregnancy we will abort it for you, but this way we can’t.’” Samia, a 38 years old Sudanese woman.

According to most of the women the healthcare providers were generally compassionate but followed the ‘alleged’ law refusing to treat the women without Form Eight. One participant spoke about how the doctors wanted to help but were bound by the form, without which they could not do anything to treat her:

“I told him (the doctor) ‘I fell from the wall, I was talking to my neighbor and the wall fell, I didn’t tell him it happened. But he said, ‘there are signs of beating on your body, this isn’t someone who fell, the person who falls, (the signs of) the fall would be apparent that it was a fall, but the signs of the whips and so on. You were subject to beating and you have to bring form eight’. He (the doctor) treated me well, he said ‘we are not refusing to treat you, just bring Form Eight and come to us to get treated’.” Amina, 28 year old Sudanese woman.
Indirect effects of Form Eight

Another theme that appeared was the indirect effect of Form Eight. According to these women all the service providers believed that the law regarding Form Eight still existed and hence continued to follow it. This had a number of effects on the experiences of these women. Healthcare providers were unaware of the fact that they could treat these women without Form Eight, so women ended up going to the hospital then having to wait, for one of the people that was accompanying them to go file a report and bring Form Eight from the police station to the hospital before they could receive care. This lead to delay in the care that was needed, some waiting for hours to receive care, especially in situations where the police station was not located near the healthcare facility.

“(The incident) happened at 11 or 12 we were in the hospital until 3 in the morning. These things should be if someone is injured, everything should be quick, and everything should be inside (hospital).” Najat, 53 year old woman.

For these women to receive Form Eight they had to go to the police station and file an official report. Some of the women said they were intimidated by the police who refused to give them Form Eight or file a report. According to some of these women the police were very uncooperative, often prolonging the process of reporting or in some cases actually refusing to file a report, without any legitimate justification.

“I am going to the police, but I am not a virgin because I have two children, so they did not accept me by the cases, when I visit them, I am afraid that’s why I stopped.” Yousra, 27 year old Eritrean woman.

First, we went and filed a report, we came to file it and the (police) officer said “hey, each one of you (women) fights with her husband, is this an age to fight in, you work and come, ma’am go home and make amends, go find someone, do you not have an elder, you yourself should solve this”. Najat, 53 year old Sudanese woman.

Police officers are in a position to greatly affect the experiences of these women. Since they are, in a number of circumstances, the first person these women approach for help, they play a crucial role in what happens to these women and how much trust they put in the system that is designed to help them. Any bad experience will leave a permanent mark on these women and could be bad enough to
cause them to no longer trust authority. An example is when according to one woman a police officer tried to gain financial benefits from her in order to help her.

“(The police officer) said, ‘if you have money we will go arrest him for you’, he (her husband) was in the gold mines, ‘we will go arrest him for you there and if you don’t have money then wait until he comes back here so we can catch him’. He had given me his phone number, I called him when my husband was back, and he said ‘no, no this is our strengths and if we try to use it, we will use it for money’. I asked him why he said, ‘because the government doesn’t have anything’. Itidal, 49 year old Sudanese woman, who lost hope in the system saying;

“So, I surrendered my matter to God and I told him that ‘I surrender my matter to God, since I came to you and showed you that this person is threatening me and how much I fear him, like terrorizing and beating and insults and there is no one so, who do I turn to? I will not turn to anyone but God.”

**Fear of consequences of help seeking**

Another theme that was apparent was the fear of the consequences of seeking help from formal services. This was seen particularly in Sudanese women who were subject to domestic violence. To them it was easier to stay quiet and tolerate the abuse than to seek help because the repercussions were much worse in their eyes.

“Why should I need Form Eight for the hospital? When I return Form Eight (to the police station), what happened is that my husband caught up with me there and he did not show mercy. He met me and said, ‘you are coming to report me’, he found me next to the (police) department, he is also a police officer, ‘I am the government, I was the government and you want to report me to the government’, and then he took me home. After that I was scared of the authorities.” Itidal, 49 year old Sudanese woman.

In order to avoid the consequences and still receive care one woman stated that she would go pick up Form Eight from the police department and once she received care would not return the form to them. This way, in her point of view, she would be treated and at the same time avoid her husband finding out that she sought help because she never went back to the police station, thus reducing the chance of him seeing her there and at the same time not completing the formal complaint which would lead to her husband getting arrested.
“A number of times he would hit me I would go to the hospital but the form, I lose the form that’s the problem. I went like seven or eight times.” Nusaiba, 37 year old Sudanese woman.

All the Eritrean women greatly feared the consequences of seeking help, many of whom claimed to have not sought help for that particular reason. Many were not legally registered as refugees at the time of the incident so, according to them, complaining might lead to them being deported. Others feared the consequences of filling a report against a Sudanese man and how this would be dealt with by the authorities considering the fact that they were refugees. So instead of filling a report, or seeking help, they remained quiet and stayed at home until they heard about the safe house and went to seek care there.

“I didn’t go to the hospital, or healthcare because I am very afraid, one of the actors of the violence is living here. . So, I am afraid if I tell the police or something, it will happen something.” Lisa, 34 year old Eritrean refugee woman.

“I did not go to a hospital because I was afraid. . I am afraid because the boys are Sudanese they do like this, so I am not going to file a report in Sudan I am afraid.” Selma, 30 year old Eritrean refugee woman.

All of the women who were raped feared pregnancy and yet all (with the exception of one) said that they did not receive emergency contraception. Although some of these women went on their own to get a pregnancy test not all of them had the chance to do so. For those Eritreans who feared the consequences of filing a report and thus seeking healthcare they did not receive emergency contraception, nor did they do a pregnancy test. This lead to some of these women becoming pregnant.

“I was very sick. After this happened I get pregnant but at the first term I am not going to treatment because I am very afraid. I have so many challenges because the child is from them or from my husband. . That’s why I am not following up for my case, but I have a lot of medical problems. At the first months I am not going to medical treatment and then I went to hospital I follow up for the pregnancy.” Yousra, 27 year old Eritrean refugee woman.
“It’s a very bad situation, I get pregnant but in the first month when I am very stressed by its own it abort. Not by medicine or by medical support by its own, it’s a very (big) psychological problem.” Assil, 22 year old Eritrean refugee woman.

Inadequate care

In all the women who went to seek help, there seemed to be a pattern of inadequate care. Based on what the women said this inadequacy was either in terms of the health services or in the legal services they received or in many instances both. The women said they found police officers generally insensitive and made the process of filing the report harder in many instances. When asking the women about specific steps taken in treating them by the healthcare provider, it seems that from their accounts most healthcare providers were providing inadequate care to these women. Only one participant had healthcare that was in line with international standards, but even in her case there was a gap in the legal care:

“So, they brought him (the police officer) to court and (the judge) told him ‘you should have this and this and this in the report, these are things you didn’t do’. So, he (the police) replied ‘it slipped my mind’. (The judge) said to him, ‘there is no such thing as it slipped my mind, this is one of her rights, like if it wasn’t apparent in front of my face and I heard it from her own mouth, I wouldn’t think anything happened in the first place. The report should be complete and these samples (referring to forensic evidence) if it wasn’t for the gynecologist that wrote it here, that this was done and what not and it was taken to the forensic lab and so on I would also disregard this’

Kawthar, 28 year old Sudanese woman.

Most of these women were unaware of the international standards and therefore were not concerned with or affected by the steps in management. They were more concerned with the way the healthcare provider dealt with them. The time taken by the healthcare provider to talk to the women and the tone used, whether compassionate or stern, greatly affected the experience of the women when seeking help. In one instance a woman spoke about her disapproval of the care provided by the doctors:

“There wasn’t a doctor who asked me ‘what happened to you’, or ‘how did you get injured’ or ‘what happened’. We waited for hours for the consultant. He just came looked at the x-ray, what was in them, wrote a report and gave me the form (Form
Eight) and that was the end of it. He gave me medication in a prescription and said ‘this is the form (Form Eight), this is the (follow up) card, if there is anything come back, and these are your medications’, that’s it. He didn’t do anything else for me and I left right after. I didn’t even go back to him, I started following up with a private consultant outside the hospital because even if I went back to him what will he do? Nothing.” Mehad, 22 year old Sudanese woman.

The challenges to accessing and receiving care were even more apparent within the Eritrean community, based on their accounts, which were summarized by one of the women;

“There is so much sexual violence in the Eritrean community, but we have more challenges about how to management, the clinical management of rape cases, because our community does not know about the cases, which hospital they do management for these, even in that hospital there are no translators or interpreter for these cases because most of the cases they management by Sudanese, so they misunderstand, the feeling is not good for victims. So even when you ask me I feel good because I tell you my history for other girls like me they will be learned to them. So, I need like this, aware(ness) to our community, to me, to others about the situation of the right of the woman.” Astar, 25 year old Eritrean refugee woman.

Discussion

This study explored the experiences of Sudanese women and Eritrean refugee women when seeking healthcare after-being subject to gender-based violence in Sudan through the lens of the Steven Lukes third-dimension of power (28). The original intention of the study was to merely look at the experiences of women when going to a healthcare facility to seek healthcare.

There are a number of key findings in this study. First of all, according to the participants Form Eight was mandatory for them to receive any formal service whether legal or healthcare and was also mandatory for women who have been sexually abused and became pregnant to get an abortion. The need to acquire Form Eight led to a delay in the time until care was provided to these women. When trying to acquire Form Eight from the police station the women stated that the police were often uncooperative and sometimes even refusing to provide the form. Another key finding was that a number of women feared the consequences of seeking help and at time remained quiet and tolerated
the abuse. The last major finding was that all the women seemed to receive inadequate care, when compared to international standards (14), although they were unaware of these standards and were therefore not concerned with the standard but rather how the healthcare provider dealt with them.

These results generally show that there are numerous short-coming in the health services that need to be addressed. First and foremost a general lack of awareness of these women as to the steps needed in order to seek help was quite common. It seems that whether they were seeking justice or healthcare many of these women were unaware of how they should go about doing so. This in a number of cases led to a delay in the required services, with some women having to wait for hours to receive care for quite serious injuries. Based on the accounts of these women, healthcare providers seemed to generally lack the knowledge or training on how to manage and treat women who have been subject to gender-based violence.

Another short-coming and possibly the most major finding of the study was the experiences related to the acquisition of Form Eight. The original intention of Form Eight may have been to protect the legal rights of these women in case they chose to pursue criminal charges (24), but the fact remains, that according to these women From Eight was doing more harm than good. Since, as mentioned in the introduction, the legislation prohibiting doctors from treating anyone subject to violence without being presented with Form Eight was revoked in 2004 (53), one cannot help but question why over a decade later doctors are still refusing to treat these victims without Form Eight.

**Three-dimensional view of power in relation to women seeking healthcare and Form Eight**

Based on the results of the study it seems that power has a significant impact on the experiences of women when seeking healthcare after being subject to gender-based violence. The excursion of this power is predominately seen in the experience of these women in relation to Form Eight.

When Form Eight was first introduced in 1991, service providers and the general public were made aware of the law requiring that no healthcare be given without it. Healthcare providers stopped treating those injured or abused without Form Eight and police officers refused to file police reports without receiving Form Eight filled by a healthcare provider. This is a clear example of the first dimension of power, the decision-making face. The decision was made by those in power that a law was to be instated and people simply conformed to this law. The reason behind this conformity may
be due to the fact that the decision to introduce the law was made publicly and people were told of the intention of the law, which was, supposedly meant to protect the rights of those injured although many speculate that it was to keep track of all those who claim to be injured, particularly those injured by police officers or during imprisonment.

In 2004, after the international pressure to ease the steps required for abused women to receive healthcare, the law was revoked. The decision was made by the same people who set the law in the first place but unlike during its introduction the public was not made aware of this decision. This is in line with the second-phase of power in which a clear mobilization of bias was made. The choice to not inform everyone about the revocation of the law seems to be a form of suppressing latent or manifest challenges for the values or interests of the “decision makers”.

The third dimension of power, as described by Steven Lukes, considers the many ways in which potential issues are kept out of politics, whether through the operation of social forces and institutional practices or through individuals decision making (28). This view of power can be considered in this study as a reason why no one seems to be aware of the fact that the law related to Form Eight was revoked in 2004. The third dimension of power exists when people are subject to domination and comply silently without protest to this domination. Healthcare providers continue to refuse to treat those with injuries until they are presented with Form Eight. Their lack of awareness is an example of this domination. They continue to apply a law without question because that is what they know, simply abiding by what they consider to be true. It seems that there is a deliberate attempt to prevent people from knowing about the revocation of the law. It seems that much more research is needed to identify why Form Eight is still considered a necessity for those injured when seeking healthcare and the reasons behind its initial introduction. Regardless of the rational Form Eight has several implications on women who are seeking help after being subject to gender-based violence.

**Implications of Form Eight**

Form Eight had a number of implications on the experiences of women when seeking health care after being subject to gender-based violence. These included increasing the time required for women to receive healthcare. A number of studies illustrated the importance of time on the experiences of women when seeking healthcare. Lundell mentioned how women felt as though they were a burden to healthcare providers for taking time to try and catch their attention of healthcare providers to receive care (54) and although the study was not referring to a specific barrier, such as Form Eight, it
illustrated the importance of how the time taken to initiate treatment for women to seek care greatly influenced their experience. Another study in Kenya, had a similar procedure to that of Sudan, where sexual assault victims who presented to the police station to file a report were told to go to the hospital to receive treatment and bring evidence of the sexual assault back to the police station (55). In the study in Kenya, emphasis was also placed on the importance of timely management of sexual assault and the implications it has on women who have been sexually assaulted (55).

Another implication of Form Eight was that it prevented women from going to the police station out of fear that the perpetrator might find out. These findings were similar to a study conducted in conflict and displaced settings in Columbia (56), which concluded that barriers to care were related to fear of violent repercussions if the perpetrator were to learn that the survivor disclosed her experience. This fear was even more apparent among the Eritrean refugee women included in this study, many of whom did not have legal documents to stay in Sudan making their pursuit to care impossible.

Women’s experience with police officers when going to file a report was also an implication of Form Eight. Many of the women had a negative experience with police which in turn led to them refusing to pursue further care or lose hope in the system. These findings were similar that to another study where poor initial perceptions and experiences of women relating to the safety and quality of the services served as a barrier for them to follow-up their care or utilize other referrals (56). Although Form Eight and implications was the most important finding of this study it is important to highlight other findings in this study.

**Experience of Healthcare Received**

Among all the interviews only one participant described the healthcare received in a way that met international standards (14). This shows that there may be a serious fault in the management of cases of gender-based violence. These findings are similar to that of other studies. Two studies mentioned the importance of first line support for survivors of GBV, especially when it comes to providing care and support and offering information to help connect the survivor to psychosocial support and other service (55,57).

There is an apparent deficiency in the training of healthcare providers in Sudan according to the experience of the women in this study. A number of studies discussed the importance of training of
healthcare providers (54,55,58). They all highlighted the importance of the training of healthcare providers on the first line support of survivors, not only at a pre-qualification level but also during clinical practice to include different aspects of care such as identification, communication and clinical skills, proper documentation and awareness of the available and appropriate referral system. These studies state that because of the limitation in resources these trainings should be integrated in the same program.

Since Form Eight is still the only medical form that is permissible in court as evidence in these situations, healthcare providers need to be aware of the weight Form Eight has on the women’s pursuit to justice and the ideal way in which to fill it in. In other words it is crucial that healthcare providers are trained on the collection and documentation of forensic evidence. Similar findings were described in a study, which stated that there was limited awareness by healthcare providers about the various types of sexual offenses that were stipulated in Kenya’s Sexual Offense Act 2006, which could result in them not clearly documenting the incident (59).

Socioeconomic Factors

Another relevant finding was that the women’s socioeconomic status influenced their experiences. Women of low socioeconomic status relied on public transportation, such as buses and rickshaws, to get around. In some cases, the rickshaw drivers were the perpetrators of the gender-based violence. The fact that Form Eight cost 50 Sudanese pounds (equivalent to $2.77) meant that women of low socioeconomic status, especially those who weren’t the breadwinners of the family, were unlikely to have that kind of money. Since as stated in the introduction it was common that the police station was far from the hospital it required that women use public transport to move between the hospital and police station which to women of low socioeconomic status was an extra cost that they could not afford (1).

Strengths and Limitations

The study is one of the first to look at the experiences of women seeking healthcare in Sudan after being subject to gender-based violence. There is a general lack of research related to gender-based violence in Sudan and since this topic is relatively unexplored, a qualitative study looking at the experiences of these women is a strong contribution to the body of knowledge in this field. Being a female healthcare provider from Sudan gave me a deeper understanding of the context, which added to the strength of this study.
One of the most significant limitations of this study was that all the participants were recruited, and the interviews conducted in the places where they have received some form of service, which may have influenced their answers. Most of the Sudanese women who were recruited at SEEMA center had been coming to the center for a long period of time through where they not only received legal or health services but also trainings on women’s rights, women’s empowerment and combating gender-based violence. Since the interpreter of the interviews with the Eritrean women was also the doctor who provided care for them at the safe house, this may have influenced their responses. In an attempt to reduce this influence on the study results, their responses to the care provided at the safe house were excluded from this study.

Another limitation was that the time since they were subject to the violence and the interviews were taken greatly varied thus possibly skewing the responses and leading to recall bias. Since this study is a qualitative study, another limitation is that it is not generalizable, and the findings are only representative of the women in the study.

**Conclusion**

This study concludes the experiences of all the women in this study when seeking healthcare after being subject to gender-based violence were far from international standards. A lot needs to be done in order for women to know the clear answer to the question posed in the title of this study; “Who do I turn to?”. Healthcare providers were generally unaware of how to ideally manage these women and of the fact that they did not require Form Eight to initiate treatment. The majority of police officers were uncooperative, making it harder for women to access care. The steps to accessing care for these women remain unclear. More efforts need to be made to reduce the waiting time of for the acquisition of care and legal care, healthcare providers and law enforcement officials need to be more aware of how to manage cases of gender-based violence and more public awareness on the steps to seek care after being subject to gender-based violence should take place.

There is a need for more quantitative and qualitative research on gender-based violence in Sudan. It is essential that more information is made available on the prevalence on gender-based violence and on the effectiveness of implementation strategies aimed to reduce this prevalence as well as on effective means of management that are context specific.
References


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Annexes

Annex 1: Form Eight (Translated To English)
Form number (8) of forensic police

Forensic examination form

By the Police:
Department:………. Status number:………. Report number:………. Regulation:………. Date and time:………. Name:………. Gender:………. Nationality:………. Tribe:………. Occupation:………. Religious belief:……….
Address:…………………………………………………………………………………………………………………………………………………

Required investigation:
(A) Injury:…… (B) Sexual assault:…… (C) Alcohol Consumption:…… (D) Transfer to mortuary:…… (E) Other cases
(through the forensic laboratory): …………………………………………………………………………………………………………………

Head of police department: ………………………………………
Signature and Stamp: ………………………………………………….

By the Prosecution (in the case of transferring a corpse to the mortuary)
1. Autopsy of corpse to determine the cause of death and to write a medical report with the causes.
2. Handing over the body to the family through the police.
3. Burial of the body (after photographing and taking the finger prints in cases of those unidentified)

Prosecutor: ……………………………………………………………
Signature and Stamp: ………………………………………………….

By the Physician:
Place of examination:………………………………………… Date and time:…………………………………………………
Decision of physician:
(A) In case of injury, description of injury and possible cause for it:
 …………………………………………………………………………………………………………………………………………………………………
………………………………………………………………………………………………………………………………………………………………
………………………………………………………………………………………………………………………………………………………………
Severity of case:……………………………………………………………………………………………………………………………………
(B) In case of hospital admission: Date of discharge: ………….. Final report:…………………………………………………………
……………………………………………………………………………………………………………………………………………………………………
(C) In case of death:
Time of death:…………………… Possible causes of death by examination:…………………………………………………………
……………………………………………………………………………………………………………………………………………………………………
(D) In case of autopsy (attach report of the results of dissection)
(E) In case of alcohol consumption: Smells of alcohol ( ) Intoxicated ( ) Does not smell of alcohol ( )
(F) In case of sexual assault; describe the case:
……………………………………………………………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………………………………………………………
The medical examination confirms the incident ( ) Does not confirm the incident ( )
(G) In case of examination through forensic laboratory (attach the report)

Signature and Stamp: …………………………………………………
Name and specialty of physician or examiner: ……………………………
Annex 2: Form Eight (Arabic)

إِسْتِمَارَةُ شَرْطَةٍ جَنَائِيَّةٍ رَقْمِ (٨)

بِوَاسِطةِ الشَّرْطَةِ

القسم .......... رقم الأحوال ........ عدد التلاغ .. التاريخ والزمن ....

الاسم ........ النوع ........ الجنسية ........ القبيلة ........ الهيئة ........ المدينة ........

الأعمال ........

الفحص المطلوب:

(أ) آذي ........ (ب) إعتداء جنسي ........ (ج) سكر ........ (د) تحويل للمسحنة ....

(ه) حالات أخرى ........................................ (ب) بواسطة المختبر الجنائي ....

رئيس قسم شرطة

التوقيع والخطم

بِوَاسِطةِ النيابةِ (حالاتِ تحويلِ الوَفَاتِ للمَسْحَنَةِ)

٢. تسليم الجثة لدورها بِواسِطةِ الشرطةِ.

٣. دفن الجثةِ (بعد التصويرِ واعتدادِ البصماتِ في حالةِ الجثثتينِ)

وكيل نِبَاية

التوقيع والخطم

بِوَاسِطةِ الطَّبِيبِ

مكان الفحص ........ التاريخ والساعة ........

قرار الطبيب ........

(أ) حالةِ الأذي وَفَاةِ الحالةِ والسببِ المحتملِ لِوقوعِها ........

مدى خطورةِ الحالةِ ........

(ب) حالةِ الحَجَزِ بالمستشفىِ: تاريخِ الخروج ........

(ج) حالةِ الانتظارِ ........

ال_awافِةِ ........

الأسبابِ المحتملةِ لِ الوُفَاةِ بالفحصِ الظاهريِّ ........

(د) حالةِ الشُرْحَ (إِرفاقُ تقريرِ بِنتيجةِ الشُرْحِ)

(ه) حالةِ السكر ........

(و) حالةِ الإعتداءِ الجنسي ........

(ز) حالةِ الفحصِ بالمختبرِ الجنائيِ (بِرفَعِ التقريرِ)

لا يوجدِ الواقعة ........

التوقيع والخطم

اسم ووظيفةِ الطبيبِ أو الخبير.
Annex 3: English Consent Form

I am Dr. Khalda Omer-Elfaroug Ahmed Abuelgasim from Uppsala university in Sweden. I am conducting a study on the experiences of those who are exposed to gender-based violence with health service providers.

You have been chosen to take part in this research with a number of other participants because of your experience of gender-based violence and with seeking health services for said violence. We expect that your participation and that of others will provide information that will help reach the research goals. By analyzing your experience when seeking health services, any shortcomings you experience the information can be used in developing research and improving health services.

During this study I will take information through private and individual interviews. All the information gathered in the interview will be kept confidential to minimize any risks that the participant may encounter or the spreading the information that has been shared.

We hope you will take part in this research. We assure you of the confidentiality of your information and documents and that only the relevant researcher will have access to this information and the National Health Research Ethics Committee if deemed necessary.

It is also noted that participation in the research is voluntary and that your refusal to participate in the research will not lose the right to any benefits from the research, with the assurance that you will not be given any monetary value for participation in this research (but you will be reimbursed for transportation expenses). Your participation will be one of the volunteers who are included in the research.

We also assure you of the possibility of withdrawal from the research at any time, without giving an explanation of the reasons for withdrawal. This is done by signing the request for withdrawal and this will also not affect your right to benefit from the research.

If you have any question or inquiry about the research, the participants with you in the research, or your rights as a participant during the search you can contact

Dr. Khalda Omer – Elfaroug on the mobile number 0122XXXXXXX
APPROVAL OF THE CONSENT OF THE PERSON SUBJECT TO THE SEARCH

I have read the current information which has been explained to me and I have been able to ask questions about it as often as I wished. I have received adequate answers to all the questions. I agree (or acknowledge my daughter) to participate voluntarily in this study and I know I have the right to stop participating in any time without affecting my rights.

Participant Code …………………………………………………………………………………………………
Name of Participant: ……………………………………………………………………………………………
Participants address: ……………………………………………………………………………………………
………………………………………………………………………………………………………………
Participants signature: ……………………………………………………………………………………………

If the participant is unable to read the statement and needs it to be explained or translated:

Name of person explaining (Translator) ………………………………………………………………………
Address of person explaining or (Translator): ………………………………………………………………………
………………………………………………………………………………………………………………
Signature of person explaining or (Translator): ………………………………………………………………………

Signature of researcher: ……………………………………………………………………………………………
Annex 4: Arabic Consent Form

أنا الباحث د. خالدة عمر الفاروق أحمد أبو القاسم من جامعة أويسالا بالسويد, أقوم بدراسة عن تجارب المتعرضين للعنف المبني على النوع مع مقدمي الخدمات الصحية.

لقد تم اختيارك لمشاركتك في هذا البحث. أنت ومعك عدد آخر من المشاركين لتحقيق أن تنص海淀区 للوصول لأهداف البحث من تحليل تجاربكم عند طلب الخدمات الصحية، وأوجه القصور وما يمكن المساعدة في تطويره من الناحيتين البحثية والعملية.

خلال هذه الدراسة سأقوم بأخذ معلومات عبر مقابلات خاصة وفردية. الإجراء الذي سأقوم به سيحتم علي التأكد من إبقاء المعلومات سرية بمعية الباحث فقط لتقليل أي مخاطر قد تنتج على المشارك أو من ينوب عنه من انتشار المعلومات التي تمت مشاركتها.

وإذا ألم في مشاركتك معنا في هذا البحث، نؤكد لك على سرية المعلومات والوثائق الخاصة بك، و أنه لن يطبع عليها إلا الباحث المعنى و لجنة أخلاقيات البحوث الصحية القومية متى اقتضى الأمر.

وأشير كذلك إلى أن المشاركة في البحث طوعية وأن رفضك للمشاركة في البحث لا تفقد الحق في أي فوائد من البحث، مع التأكيد على أنه لن يتم منحك أي قيمة تقديرية مقابل المشاركة في هذا البحث (إلا أنه قد يتم تعويضك عن نفقات الترحيل) وأنه بمشاركتك ستكون أحد المتطوعين الذين يتم استخدامهم في البحث.

كما نؤكد لك إمكانية الإسحاب من البحث في أي وقت تشاء، و بدون إبداء توضيح لأسباب الإسحاب، و يتم ذلك بالتوقيع على طلب الإسحاب.

إذا كان لديك أي سؤال أو استفسار تخص البحث، المشاركين معك في البحث، أو حقوقك كمشارك أثناء تنفيذ البحث يمكنك الاتصال على:

د. خالدة عمر الفاروق بالهاتف رقم 0122XXXXXXX.
إقرار موافقة الشخص الخاضع للبحث

 لقد أطلعت على المعلومات الحالية والتي تم شرحها لي وأتيح لي طرح الأسئلة عنها كيفما شئت، وقد تلقيت الإجابات الوافية عن كل الأسئلة، وأنا أقر بالموافقة (أو أقر عن إبني) على المشاركة طوعية في هذه الدراسة، وأعلم بحقني في التوقف عن المشاركة في أي وقت دون أن يؤثر ذلك على حقوقي.

رمز المشاركة: .................................................................

إسم المشاركة: .................................................................

عنوان المشاركة: .................................................................

توقيع المشارك: .................................................................

في حال عدم قدرة المشارك على قراءة الإقرار ويحتاج إلى من يشرح أو يترجم له:

إسم الشارح (الترجم): .................................................................

عنوان الشارح أو (الترجم): .................................................................

توقيع الشارح أو (الترجم): .................................................................

توقيع الباحث: .................................................................
Annex 5: In-Depth Interview Guide

Purpose and Introduction
Hello, my name is Khalda Abuelgasim, I am a masters’ student in international health. I am conducting a research on the clinical management of gender-based violence. You are being invited to take part in this research because we believe that your experience with health care professionals in helping you get quality care will play a role in identifying any gaps in the healthcare system necessary for survivors to receive gold standard care.

Questions
1. Can you tell me a little about yourself?
   a. How old are you?
   b. Where do you live?
   c. Are you married?
   d. Do you have children?
2. What made you decide to seek health care?
3. Can you please describe the services you received at the hospital/health center.
4. Can you tell me what happened to your health after this?
5. Looking back at your situation, what advice would you give another woman who has just started to have these sorts of problems?
6. Can you elaborate more/ is there anything else?

Recording comments
1. Audio-recorder
   An audio-recorder will be used to record the interviews.
2. Field notes
   Detailed notes of the respondents’ answers will be taken.