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Actionable gaps: Help-seeking behavior among young women experiencing intimate partner violence and non-partner sexual violence in Nairobi, Kenya

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Abstract

Background

Intimate partner violence (IPV) and non-partner sexual violence (NPSV) remain prevalent and underreported forms of gender-based violence (GBV) globally, with adolescent girls and young women (AGYW) in sub-Saharan Africa facing unique help-seeking barriers. While GBV-related service provision has expanded in Kenya, few studies have simultaneously examined IPV and NPSV and corresponding help-seeking among AGYW.

Methods

We employed a mixed-methods design using quantitative survey data from 831 young women aged 15–29 years in Nairobi, Kenya, and in-depth interviews (IDIs) with a purposive subsample of 15 young women. Quantitative measures captured the prevalence of past-year IPV and NPSV, help-seeking behaviors, service utilization, and barriers

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to care. IDIs explored lived experiences, community norms, perceptions of formal and informal services, and structural barriers to support.

Results

Among partnered women, 28.0% reported past-year IPV, while 5.2% of all women reported NPSV. Nearly all women who experienced NPSV also experienced IPV. Help-seeking was low: 31% of IPV and NPSV survivors sought any form of support. Survivors reported seeking help primarily from informal networks, such as friends or relatives; formal service utilization remained limited, with counseling and medical services more commonly accessed than police or legal services. Qualitative data revealed three major themes shaping help-seeking: (1) normalization of violence, (2) perceived quality and accessibility of GBV services, and (3) structural and socio-cultural barriers, including economic dependence, fear of retaliation, shame, and corruption.

Conclusion

Help-seeking among AGYW experiencing IPV and NPSV in Nairobi is hindered by deeply entrenched social norms, limited youth-friendly services, and pervasive institutional mistrust. Interventions need to address the normalization of violence, enhance trauma-informed and context-responsive services, and leverage trusted community intermediaries to improve access and support. Integrated, survivor-centered approaches are essential to address the complex interplay of IPV and NPSV and reduce barriers to care for young women.

Keywords
intimate partner violence, non-partner sexual violence, help-seeking, youth, Kenya

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Introduction

Gender-based violence (GBV) is a multi-faceted phenomenon that is deeply rooted in gender inequality and violates human rights.[1] GBV can take many forms including intimate partner violence (IPV), or violence from a current or former intimate partner,[1] and non-partner sexual violence (NPSV), or sexual violence perpetrated by someone other than an intimate partner.[1] Global statistics on GBV are alarming: one in three women worldwide will experience either IPV or NPSV in her lifetime.[2] Women are disproportionately affected by both IPV and NPSV,[3,4] both of which contribute to devastating physical, psychological, and, in some cases, life-threatening outcomes.[2,4–6]

Violence-related help-seeking is linked to greater safety and improved health outcomes,[7–10] however, globally, less than 40% of women who experience GBV seek help.[7,8] Barriers to help-seeking can be intrapersonal,[7] interpersonal,[11,12] or systemic,[13] and include things such as limited agency,[14] fear of escalating violence,[15] lack of information about sources of help,[7,9,16] self-blame,[10] shame,[7,17] and fear of social exclusion.[9,18] Help-seeking behaviors vary by GBV type and co-occurrence of violence[12,13]—a key predictor of help-seeking for IPV is severity of violence,[8,18,19] while for NPSV, the perpetrator relationship is more influential.[9,20] Globally, services for GBV survivors have expanded, though many settings lack services altogether and those that exist can be underdeveloped and inaccessible,[15,21] with many lacking trauma-informed care.[22] As a result, many women turn to informal sources of support, like family and friends, instead of formal sources.[7,23]

For most women violence begins early—one in every four ever-partnered girls aged 15-19 globally report past-year IPV,[3,24,25] and young survivors face additional help-seeking challenges given intersecting vulnerabilities. Specifically, they may encounter judgment due to their age, stigma surrounding youth relationships, or restrictive sexuality norms.[10,12,20,26] Family dynamics—such as control over mobility, financial dependence, or pressure to protect the family reputation—can also discourage them from disclosing abuse.[26] In many contexts, cultural and religious taboos additionally contribute to survivor shame and silence.[27]

While research exists on help-seeking among women experiencing GBV globally, a notable gap persists within sub-Saharan Africa, specifically among adolescent girls and young women. Sub-Saharan Africa is a hotspot for GBV, with the highest global prevalence of IPV, at 36%, though there is substantial variation by country.[28] Kenya, specifically, records a 20.5% lifetime GBV prevalence, with 40% of the women experiencing sexual and/or physical violence from an intimate partner.[29] Underreporting remains a significant challenge; nearly half of all sexual violence incidents are never reported.[29,30] Structural barriers such as mandatory parental consent for service utilization can play an additional role in delaying or preventing young people from getting the medical, psychosocial, or legal support they need.[11,31] Distrust in formal systems—like the police, courts, and healthcare—remains a significant barrier.[11,32] In Kenya, as elsewhere, young survivors' lack of financial independence[33,34] and the absence of youth-friendly reporting channels[31,35] make it even harder to access support.[31,36]

Evidence suggests that women experience diverse forms of GBV; however, there are currently no studies that explore the differences in IPV and NPSV among adolescent girls and young women and corresponding help-seeking in Kenya. Additionally, there is currently limited qualitative evidence on youth help-seeking for IPV and NPSV in this setting. Given these gaps, this study aims to: 1) qualitatively explore the experiences of and barriers to formal and informal help-seeking; 2) quantitatively examine the prevalence of past-year IPV, past-year NPSV, and related help-seeking behaviors, among adolescent girls and young women in Nairobi, Kenya.

Methods

Study population

The present study is a mixed-methods analysis, incorporating cross-sectional quantitative survey data and qualitative in-depth interviews (IDIs). This study uses data from the Nairobi Youth Cohort, established via Performance Monitoring for Action (PMA) Agile. In 2019, a cohort of young people was enrolled using respondent-driven sampling (RDS), a recruitment method where participants invite their peers to join the study by distributing uniquely numbered coupons. This method is valuable for populations and behaviors that risk being hidden, including sexually active, unmarried youth. The recruitment process began with nine strategically chosen "seeds" who initiated the chain, eventually resulting in the enrollment of 1,357 eligible participants for the baseline survey (Round 1), conducted from June to August 2019. To participate, individuals needed to be unmarried, aged 15-24 years, and residing in Nairobi County for at least a year before joining the study. Participants who agreed to follow-up were included in Round 2 (August to October 2020) and Round 3 (April to June 2021). By Round 4, conducted from April to June 2023, the cohort retained 1,101 participants, now aged 19-29 years. To expand the study, a replenishment sample was added, focused on recruiting those aged 15-19 years. This additional recruitment brought in 601 new participants (320 young men and 281 young women), increasing the total sample size to 1,702 participants for Round 4 (2023).

Qualitative methods

A purposive sample of youth participating in Round 4 were selected to participate in IDIs (young men n = 15, young women n = 15). Purposive sampling was used to ensure representation across gender, age, and violence experience. IDIs were conducted between July and August of 2023 by trained interviewers. The goal of the IDIs was to generate detailed narratives on key topics including GBV risk and response mechanisms. Semi-structured interview guides, tailored for young women and young men, respectively, were developed. The interview guide for young women included questions and probes related to relationships, perceptions of risk and safety within partnerships and their community, help-seeking experiences and norms, access to technology, and household roles and decisions. For young men, the guide explored relationships, fertility pressures, family planning decision-making, and perceptions of their own risk and safety, in addition to their perceptions of women's safety. Interviews were conducted in English or Kiswahili, lasted approximately 45 to 60 minutes, and were audio recorded with consent. Kenya national guidance on conducting adolescent sexual/reproductive health research defines youth ages 15 and over as "mature minors", and notes that mature minors may be able to consent for themselves; as such, a waiver of parental permission was sought. In line with best practices for research on violence against women, verbal consent was documented by the interviewer.

IDI recordings were transcribed verbatim by the interviewer (with simultaneous translation into English from Kiswahili, if needed), and loaded into Atlas.ti, a qualitative data management software. A codebook was developed to correspond to topics outlined in the interview guides. Using the developed codebook, deductive coding was completed by a team of four researchers, including two from the Johns Hopkins Bloomberg School of Public Health and two from Kenya, one at Kenyatta University and the other at University of Nairobi. The team conducted three rounds of paired coding to evaluate agreement between coders. Differences in coding were reviewed and resolved through discussion to ensure the codebook was applied consistently across all team members and IDI transcripts. Changes to the codebook were made to reflect emergent inductive codes, as needed.

Only IDIs with young women (n = 15) were included in the present analysis to reflect women's direct behaviors and experiences. A code query report was generated to identify and export all relevant quotations for codes of interest. Codes related to perceptions of risk and safety within partnerships/community and help-seeking experiences and norms were included (inclusive of 25 different codes). Quotes were systematically analyzed using a matrix display to identify overall experiences and perceptions of GBV and related help-seeking, and well as those specific for IPV and NPSV.

Quantitative methods

Study sample and data collection

Round 4 included a total sample size of 1,702 participants (including both Round 3 follow-up participants and sample replenishment participants). Round 3 participants who had previously agreed to follow-up were contacted via text message to confirm their willingness to participate in Round 4. Once participants confirmed, a resident enumerator, preferably the one who conducted previous survey(s) with the participant, followed up with a phone call to reaffirm their participation and schedule a convenient time for survey data collection. Following informed consent, participants completed data collection. Quantitative informed consent followed similar procedures to qualitative, with verbal consent documented by resident enumerator and parental waiver of consent sought. The analytic sample for this study is young women surveyed in Round 4 between June and August 2023 (n = 831). IPV was assessed among those who had a sexual or dating partner in the past 12 months (n = 596), while NPSV was assessed among all young women (n = 831).

Measures

All data were self-reported. IPV, NPSV, and violence-related help-seeking were explored descriptively to accompany qualitative data. IPV was assessed via two items: 1) In the past 12 months, has a partner ever pushed you, thrown something at you that could hurt you, punched or slapped you? and 2) In the past 12 months, have you had sex with a partner when you did not want to due to threats, pressure, or force? Response options included never, once, a few times, and often, and was operationalized as binary measure (never/ever past-year experience). IPV subtypes—physical IPV (item 1) and sexual IPV (item 2)—were also explored. NPSV was assessed using a single item: In the past 12 months, have you had sex when you did not want to with anyone else (not a partner) due to threats, pressure or force? Response options included never, once, a few times, and often, and it operationalized as binary (never/ever past-year experience).

Violence-related help-seeking was examined among young women who reported having any past-year IPV or NPSV. Overall help-seeking was assessed with a single item: Did you seek help for any experiences of harm or unwanted sex? If no, respondents were then asked to provide any reasons for deciding not to seek help (responses: did not know of any services, too far to services, did not think it was a problem, could not afford transport, could not afford service fees, did not

need/want services, afraid of getting in trouble, obstruction by family or community member, embarrassed for self or family, did not want abuser to get in trouble, afraid of being abandoned, not one to help me, other; not mutually exclusive). Respondents were also asked if they received any services after their experience of violence, and if so, what kind (responses: counseling services, medical services, legal counsel, traditional healer/spiritual healer services, police services, shelter or somewhere safe to stay, other, none; not mutually exclusive). Finally, they were asked if they spoke to anyone about their experience (responses: friend, relative, teacher, peer/student, peer educator/CHV, hotline, other, no one; not mutually exclusive).

Sample characteristics included age,[15–29] education (none/primary, secondary/higher), working for pay (no, yes), ability to meet basic needs (able, not able), past year sexual/dating partner (no, yes), past year number of sexual partners (0, 1, >1), cohabitation (self, partner, parents/siblings/non-relatives), and married (no, yes).

Statistical analysis

All analyses are descriptive. The distribution of sample characteristics was first examined overall and by past-year experience of IPV or NPSV. The prevalence of past-year IPV among partnered women (overall and sub-type), NPSV among all women, concurrence of past-year IPV and NPSV among partnered women, and proportion of participants who sought help for any violence in the past year was examined. Among those who did not seek help, the distribution of reported reasons, overall and by IPV or NPSV, was examined. The proportion of women who received specific violence-related services, overall and by IPV or NPSV, was estimated, including if and who women spoke to about their experience (among those who reported IPV only given survey question wording). Sampling weights were applied to accommodate the RDS study design (Volz-Heckathorn RDS-II weights), loss-to-follow-up among the original sample, and Kenya's population composition based on 2014 Kenya Demographic and Health Survey population data (age, sex, education levels). Analyses were conducted in Stata 18.

Research ethics approval

This study was approved by the Ethics Review Committee at Kenyatta National Hospital/University of Nairobi (P310/06/2020) and the Institutional Review Board at Johns Hopkins Bloomberg School of Public Health (IRB 00012952). All procedures aligned with ethical best practices for sensitive topics including specialized training, privacy protections (auditory privacy screener and protocol), and provision of resource referrals. Participants received transport compensation (500 KES or US$5 per survey) after participation. All participants provided informed verbal consent and could skip any questions they did not wish to answer.

Results

The qualitative findings are presented first, followed by quantitative results. The qualitative sample included 15 women aged 17 to 29 who were purposively selected from the quantitative survey sample. Of the 15 women, the majority had completed lower levels of education (primary/none; n = 12), were married (n = 8), and had experienced IPV or NSPV (n = 10). Approximately half (n = 7) sought help for GBV they experienced.

Qualitative results

Three themes emerged from the qualitative data, reflecting aspects that shape help-seeking among young women experiencing IPV and NPSV: 1) normalization of violence, 2) quality of formal GBV services, and 3) specific barriers to help-seeking. Where applicable, each theme is divided into IPV and NPSV, with quotes from either survivors directly or young women speaking more generally about experiences of violence.

1. Normalization of violence

Culture was cited as a prominent influence in shaping community perceptions that normalize violence and affect help-seeking for young women who have experienced IPV and NPSV. Emergent sub-themes included community norms that justify and promote tolerance of violence, including victim-blaming, as well as community norms impacting help-seeking and service delivery.

1.1 Community norms justifying and tolerating violence

Both IPV and NPSV were discussed as normal occurrences that did not warrant reporting in the Kenyan cultural context. This theme was particularly prominent regarding experiences of IPV—the family is considered a private entity, warranting minimal external intervention in cases of violence. Informants shared that their community would watch a woman be subjected to violence at the hands of her husband, but no one will come to her aide.

> *You can be walking on the road, find a man beating a woman and people have surrounded them but nobody tries to separate them. They'll just say that's a family matter and no one should interfere.*
>
> -17-year-old young woman

> *You know when I used to experience violence from my husband, my landlord never came to help me. If he came and took me out of the house, it would have been better. Even my friend would come and take me out of that house, it would have been better. No one came when I was being beaten.*
>
> -17-year-old IPV survivor

Women were also encouraged to keep their family's secrets, and any attempts to report IPV were faced with backlash and stigmatization. In instances where the survivor opted to seek help, it was considered good practice to consult family and community elders before seeking help from formal sources.

> *My cousin was badly beaten by her husband. He hit her with a stone and she bled heavily; we had to take her to the hospital. She was stitched up and we took pictures of her…We convinced her to report him to the police. He was arrested and taken to court, but before they went to court, there are some people who convinced her that it's not okay to report your husband and that they should sit down and talk about it. This was not the first time, it's something she is accustomed to. On the court day, she agreed for him to be released and the husband did not learn anything. Most women have normalized being beaten.*
>
> -17-year-old young woman

Informants shared that NPSV has been widely accepted by the community as a minor misunderstanding for which the victim is expected to either stand up for themselves in self-defense or walk away to avoid further altercations. This perception hinders help-seeking.

> *I was afraid, but I thought that going to report would be petty. I could have reported, but I felt like they would wonder why I was reporting such a minor thing.*
>
> -19-year-old NPSV survivor

When the perpetrator of NPSV is a family member, it is expected that the matter will be resolved at the family level. This is not only to avoid exposing family issues to the public, but also to mitigate conflict between family members. Oftentimes, however, the victim is not involved, nor is their opinion consulted, while the family works to resolve the issue.

> Actually, I was an early teen, so I didn't know these things. I went to her (mum), and actually, that person was my cousin. So, instead of it causing more drama in the family, mum just let it go. I suspect he didn't touch me much. I didn't know what raping was exactly, but the moment I told my mom, she checked on me and she saw that not much violence was done. So, it was solved among the family members.
>
> -17-year-old NPSV survivor

1.2 Community norms impacting help-seeking and service delivery

Community norms shape help-seeking trajectories given the anticipated and observed responses from survivors' sources of help, often exacerbated by the fact that there were minimal available resources for survivors of IPV or NPSV at the community level outside of family and decision-making clans.

Informants shared that cases of violence presented to the clan elders are presided over by men, who make up a majority of the community leadership. Meetings are done in the absence of the survivor, who is only informed of the outcome of the case. In many instances of IPV, survivors are referred back to their abusive partners for dialogue instead of taking more formal action against the perpetrator. One informant described how she was trapped in her abusive relationship because the elders said she couldn't just leave him, even though the abuse was recurrent.

> *For them to give me support and help me, they should not just speak to my boyfriend and say that the case is over. They don't help you; they only talk to the boy and tell him not to do it again. When he does it again, the clan elders will still send you back to him and say, 'If he does it again, leave the case to me.' That's it, that means they are tired of the case. The last time I just wanted to go home, like I should break up with him completely. I told them that but they said that is impossible. You can't just wake up and say you want to go home, you can't say you don't want him anymore.*
>
> -17-year-old IPV survivor

Even if survivors go straight to formal sources of help, such as the police station, they are often referred back to community leaders for resolution given the pervasive norm that IPV is a family matter.

> *If you go and report to the police, they forward the case to the clan elders. Yes, they don't interfere much with our community, they cannot interfere. Now they just send you back to the elders, they don't look into the matter. They just talk about the case, the guy is told not to repeat it, that's all. There is no place you can report the person even if he offends you.*
>
> - 17-year-old IPV survivor

There is also often resistance to help-seeking from the perpetrator's social network, such as family and friends, in cases of IPV. It is normative to protect one's own rather than ensure fairness and justice for the survivor. Informants expressed anticipatory fears about family or community reactions to help-seeking after experiences of violence, particularly if children were involved or if someone from their perpetrator's social network was affiliated with violence response services.

> *If you go to report, how will his people perceive you? They will hate you for reporting the father of your child.*
>
> -19-year-old IPV survivor

> *There is Nyumba Kumi [community policing initiative] where I was staying, but the Nyumba Kumi elder was a member of my husband's family, so I couldn't go there, I had to keep quiet about it.*
>
> -17-year-old IPV survivor

Informants also stated that in-laws may blame wives for their experiences of IPV, citing provocation of their husbands. In-laws' belief that wives deserved violence in certain scenarios resulted in their refusal to offer help when requested.

> *When I used to go and talk to my mother-in-law, tell her how her son beat me, she used to tell me that I was the one who made him beat me. 'You made him beat you, you disrespected the boy, a man is supposed to be respected.' I had gone to seek help but the blame fell on me.*
>
> -17-year-old IPV survivor

For both IPV and NPSV, fear of being judged by the community hindered survivors' help-seeking. A 17-year-old survivor of NPSV shared that she could not speak about her experience because she feared people in the community could start pointing fingers at her and talking about the ordeal. Others echoed the sentiment that judgment by the community can occur even they are seen coming from the house of a community elder in charge of community policing.

> *My friend who I told you about, went and reported to nyumba Kumi (community police). All of a sudden, people started asking her why she was at the nyumba kumi's house, they heard that she was there because she had gone to report her husband.*
>
> -19-year-old young woman

Informants shared that those who have experienced NPSV shy away from community help-seeking avenues such as family or clan elders, as is common in instances of IPV, given anticipatory fears of victim blaming and publicity. They prefer to disclose their experiences to close friends.

> *It's hard to predict how my mother will react. If I tell my friend, she will advise me and help me move forward. Yes, I can tell my mom, but after I have told other people, she is not the first person I would tell.*
>
> -17-year-old NPSV survivor

2. Quality of formal GBV services

Survivors of IPV and NPSV had diverse experiences with formal violence support services. Assured confidentiality increased survivors' confidence in the healthcare system, while service providers' attitudes, lack of evidence, and perpetrator retaliation contributed to negative experiences with police and justice systems. Subthemes of positive and negative experiences are presented separately below.

2.1 Positive experiences with formal services

Confidence in the availability and quality of violence support services was a major factor in survivors' help seeking and choice of help. Both survivors of IPV and NPSV exuded more confidence in health services than other forms of formal services, specifically the police and justice system. When referring to health services, informants were most often

describing their experiences with hospital-based services. Commonly cited reasons for confidence in hospital-based services included promptness, professionalism, respect (no discrimination or intrusive questions), appropriate referrals to other needed GBV services, and confidentiality. Confidentiality was particularly important to NPSV survivors who felt the large hospital-based systems provided anonymity.

> *I prefer if you go to the hospital, because at the hospital you'll be helped faster than at the police post, because they will take action and call the police, so it's like you've gone to the police indirectly, rather than going to them directly, because they'll ask you so many questions, you'd rather go to the hospital and get immediate help.*
>
> -19-year-old IPV survivor

> *If you go to the hospital, you will get the help you need. If you go to the village elders, word can get out, people will know and start gossiping about you or they might isolate you. A hospital is big and there are many people there and it's not easy for word to get out.*
>
> -17-year-old NPSV survivor

2.2 Negative experiences with formal services

Both IPV and NPSV survivors cited numerous challenges with formal services, particularly so at police stations given their refusal to take complaints seriously and their failure to offer or refer to trauma-informed, survivor-centered services. Some informants described the reception of survivors at the police station as discouraging, citing their use of demeaning tone and language. As a result, most survivors did not end up accessing legal services.

Further, survivors felt that the intention to ensure they got justice through formal avenues was lacking, as mediation, family intervention, and personal conversations with perpetrators were encouraged.

> *Sometimes when you go and report, the police ask you if you had a family conversation, but if he has hurt you, they will tell you to push the case forward. And sometimes when you go there, they refuse to help you, they say 'this is a family issue, go and talk about it at home.'*
>
> -17-year-old IPV survivor

Survivors also described a lack of standardized procedures at police stations; the kind of service a survivor gets is highly dependent on the police on duty. While some survivors reported that the officers they encountered were kind and willing to help, many described interactions lacking empathy, sensitivity, or urgency.

> *When they go to report, it also depends on the person you find there. There are people who are sympathetic but there are others… There are some who will treat you well, look for evidence and help you faster, and some will throw words at you.*
>
> -19-year-old IPV survivor

> *You know if you get beaten up, you can't go to the hospital before you go to the police. You must go to the police get a P3 form and then go to the hospital. When my friend was beaten, they were very slow to help her and yet she was bleeding. So, she had to go to the hospital first to reduce the bleeding and then go back to the police.*
>
> -17-year-old NPSV survivor

In certain instances, survivors were asked for sexual favors before they could receive any help from the police, further delaying their access to care or justice. Additionally, both survivors of IPV and NPSV stated that a lack of evidence was a barrier to legal help.

> *My friend said there was another girl who was raped and took a shower before she went to the police station, when she got to the police station, she was told "Go back home so that person can rape you first and come back with the evidence."*
>
> -19-year-old IPV survivor

> *I won't have any evidence that he has abused me verbally. I can go and report him that he said this and that but if he denies there is no way I can prove that he said so.*
>
> -17-year-old NPSV survivor

In some cases, reporting an incident to the police could warrant an arrest for the perpetrator; however, informants expressed that that was risky for the reporting survivor or her family, given the perpetrator could act violent upon their

release. The fear of retaliation was enough to keep women from reporting: "*Well, there was a time I told my husband's friend to go and talk to him. He went and talked to him and in the evening, he came home and beat me more," said a 17-year-old IPV survivor*. Most IPV survivors shared that they would prefer to leave their violent partnerships rather than face the potential retaliation associated with an arrest.

> *He beat the girl and beat her badly, until he hurt her, the girl went and reported to the police station, and then the man was arrested. The girl was asked, what do you want, and she said, 'I don't want him to be arrested, if he is arrested, he will come out and disturb me', so, I just want us to break up completely.*
>
> -19-year-old IPV survivor

NPSV survivors similarly feared further violence as retaliation. A survivor of NPSV mentioned that she feared reporting because the perpetrator could follow them at night as they went shopping and beat them up for reporting.

> *I was thinking, fine I have gone and reported him and he is arrested for six months, then he is released. I knew that when he comes out, he will come out hurt and I will have to hide because he will hurt me again.*
>
> -17-year-old NPSV survivor

3. Specific barriers to help-seeking

IPV and NPSV survivors' ability to seek and access help was hindered by myriad barriers that are deeply rooted in cultural, institutional, and socio-economic factors. Sub-themes include economic dependence, feelings of embarrassment and shame, helplessness, inaccessibility of needed services, and corruption.

3.1 Economic dependence

Economic dependence on a spouse or partner was indicated as a major barrier to help-seeking. Many women depend on their partners for financial support, including for raising their children. As a result, those experiencing IPV shy away from seeking help because it could put them and their children in a financially compromised situation. Additionally, seeking legal help for IPV could potentially result in the arrest of the perpetrator, who is most likely the sole provider for the home.

> *Sometimes I am afraid to speak out because I have a child and if we break up with my husband, who will help me? I don't have a job.*
>
> -19-year-old IPV survivor

> *You can't just wake up and say you want to go home, you can't say you don't want him anymore, it doesn't happen like that. I wanted them to take bus fare from my boyfriend so that I can go home, and he can stay there. He didn't even give me money for the hospital bill.*
>
> -17-year-old IPV survivor

3.2 Embarrassment, self-blame and shame

Informants shared that seeking help for IPV or NPSV is at times coupled with embarrassment and shame. Survivors reported that it was shameful to share experiences of NPSV especially if the abuser was someone they knew, like a family member. Women's feelings of shame and embarrassment were often coupled with self-blame, or assuming that their actions warranted violence or that they deserved it.

> *If he hits me because of another reason other than my phone, I don't even think it's wrong. I feel like I'm the only one who makes mistakes dating so many people. I agree that I deserved to be beaten up.*
>
> -17-year-old IPV survivor

> *It's somehow difficult to talk about the violence you have experienced, you will find it embarrassing to tell someone. If you go to a male friend's house and he does something bad to you, you will be scared of telling anybody. If I tell my mother, what will she think of me or if I tell my friends, what will they think of me. First, the question will be, what did you go to do there? Then people will now see that she has been raped by an older man and now it is a shame.*
>
> -19-year-old NPSV survivor

3.3 Helplessness

Survivors of IPV and NPSV often described feeling helpless due to perceived and actual barriers. Corruption and lack of confidentiality within formal services, along with victim-blaming, shaming and embarrassment in informal services led survivors to question whether any avenue for support was truly available for them. Survivors of NPSV saw no value in sharing their experiences because it amounted to blame and no help.

> *I didn't tell anyone. I thought to myself, even if I told anyone, how will they help me? I already left the tout [bus conductor] at the bus stop.*
>
> -17-year-old NPSV survivor

Seeking help also resulted in mixed emotions, sometimes including regret, which exacerbated feelings of helplessness. Survivors shared that people's responses to their disclosure of violence, which often made them feel blamed, judged, and re-traumatized, led them to question why they told anyone at all. One informant said that survivors may disclose their experiences to someone they think will offer substantial help, but instead of offering help, they label them as the "problem."

> *Sometimes they regret sharing the situation because of the trauma. There is someone you might go to and they won't understand you. Some you'll go to and they will blame you, or expose you.*
>
> -17-year-old young woman

3.4 Inaccessibility of services

Some services were inaccessible to women experiencing violence. Women experiencing IPV, specifically, reported that temporary shelters, or places providing safety from abusive partners while they figured out next steps, were not available in the community, and when available, information about their existence, services offered, and procedure of accessing them was limited.

> *I think a shelter would have been beneficial, because at that time I had to wait until morning but if there was a nearby place at least I would have found shelter until the time I would have been okay to go to home, it would have been better if I didn't wait for all that beating to end.*
>
> -17-year-old IPV survivor

Proximity to services also influenced the help-seeking behavior of survivors of IPV. Survivors opted to speak to people who are close to them, including family members. Distance was directly related to the turnaround time of response, and this could expose the survivor to further danger.

> *I sought help once from his mother. There was a day when I called her at night but she didn't come, she came the following day in the evening. I can't even seek help from my people because they are far away. I was in a lot of pain, I was beaten the whole night and when I called his mother, she didn't come.*
>
> -17-year-old IPV survivor

3.5 Corruption

Corruption was consistently reported as a significant help-seeking barrier faced by survivors of IPV and NPSV. Multiple informants provided specific examples showing that police services are not equally accessible to all survivors. Those with financial resources can pay bribes to police officers for assistance, while those without money—often survivors themselves—are neglected or dismissed, hindering access to justice for many.

> *That's what happens when the person who beat you has a lot of money. He gives the police bribes, so you are the one who will get hurt because you don't have money.*
>
> -17-year-old IPV survivor

This scenario is similar among chiefs, or local administrators who are tasked with listening to and mediating conflict within a locality.

> *You know this world. There is bribery. You can find the chief has been given something little (bribe). He takes the side of the wrong doer.*
>
> -24-year-old NPSV survivor

Corruption further determined help-seeking behavior and ultimately, the choice of service.

> *You can go to the health care people because they are the ones I trust. We are told that the police are human beings just like us, he can change at any time, now if you don't have money that will make him happy, and you will stay there with your case.*
>
> -19-year-old IPV survivor

Quantitative results

Sample characteristics of women in the quantitative sample, overall and by exposure to past-year IPV and NPSV, are presented in Table 1. The majority of women were aged 18-29 (67.3%), had a primary level of education or less (62.5%), were working for pay (68.7%), were able to meet their basic needs (66.3%), had a sexual or dating partner in the past year (82.7%), and were not currently married (66.8%). Compared to the full sample, higher proportions of women who experienced past-year IPV or NPSV were married (61.5% and 55.7%, respectively). The majority of those who experienced past-year IPV reported being able to meet their basic needs (60.4%) and having one sexual partner in the past year (58.6%), while most of those reporting past-year NPSV reported being unable to meet their basic needs (54.1%) and having more than one sexual partner in the past year (70.9%).

Prevalence of past-year IPV and NPSV are presented in Table 2. Approximately five percent (5.2%) experienced past-year NPSV. Nearly one-third of partnered women experienced past-year IPV (28.0%); physical IPV was more prevalent than sexual IPV among partnered women, at 23.6% and 17.7%, respectively. The intersection of IPV and NPSV among

Table 1. Sample characteristics of women, overall and by exposure to violence, weighted.

	Total sample (n = 831)		Past-year IPV (n = 168)		Past-year NPSV (n = 36)	
	N	%	N	%	N	%
Age						
15-22	272	32.7	37	22.0	11	30.7
23-29	559	67.3	131	78.0	25	69.3
Education						
None/primary	518	62.5	123	73.0	28	78.0
Secondary/higher	312	37.5	45	27.0	8	22.0
Cohabitation						
Self	155	18.6	20	12.0	7	18.3
Partner	225	27.2	70	41.4	10	29.0
Parents, siblings, or non-relatives	450	54.3	78	46.5	19	52.7
Married						
No	555	66.8	65	38.5	16	44.3
Yes	276	33.2	103	61.5	20	55.7
Number of past year sexual/dating partners						
0	144	17.4	8	4.6	1	1.3
1	550	66.2	98	58.6	10	27.9
>1	137	16.5	62	36.8	26	70.9
Working for pay						
No	260	31.3	40	23.8	7	80.4
Yes	571	68.7	128	76.2	29	80.4
Able to meet basic needs						
No	280	33.7	66	39.6	19	54.1
Yes	550	66.3	102	60.4	17	45.9

Table 2. Prevalence and help-seeking for past-year IPV and NPSV, weighted.

	All women (n = 831)		Partnered women (n = 596)	
	N	%	N	%
Any past-year NPSV	36	4.4	31	5.2
Any past-year IPV	–	–	168	28.0
Physical IPV	–	–	140	23.6
Sexual IPV	–	–	105	17.7
Any help-seeking[±]	11	31.5	51	30.7

[±]Any help-seeking among those who reported IPV (N = 168) or NPSV (N = 36).

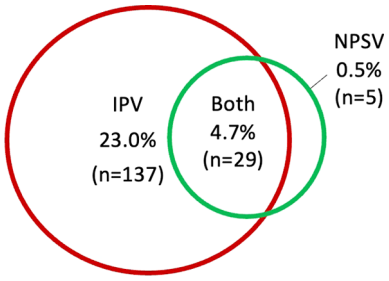

Figure 1. Intersection of past-year IPV and past-year NPSV among partnered young women (n=592). Among partnered women with no missing values for either NPSV or IPV.

partnered women is presented in Figure 1. Concurrent experiences of violence were common—of the 5.2% of partnered women who experienced NPSV, 4.7% also experienced IPV; only 0.5% of women experienced NPSV alone.

Overall, the prevalence of help-seeking for experiences of violence was low. Approximately one-third of women who experienced IPV and NSPV sought help, at 30.7% and 31.5%, respectively (Table 2); help-seeking was slightly higher among partnered women who experienced both IPV and NPSV (35.4%) (not shown). Reasons for not seeking help varied by violence type (Table 3). The most commonly reported reasons for not seeking help among those reporting any GBV were not thinking it was a problem (30.2%) and being afraid of getting in trouble. When disaggregating by violence type, the most commonly reported reason was not perceiving the violence to be a problem among those who experienced IPV

Table 3. Reasons for not seeking help, among those who experienced any past-year abuse and did not seek help, overall and by IPV or NPSV, weighted.

	GBV[±] survivors who did not seek help (n = 123)	IPV survivors who did not seek help (N = 117)	NPSV survivors who did not seek help (N = 26)
	Column %		
Afraid of getting in trouble	32.0	30.2	49.1
Did not think it was a problem	30.2	30.6	26.9
Embarrassed for self or family	23.5	23.5	53.0
Didn't know any services	22.3	22.5	34.4
Afraid of being abandoned	17.0	17.1	23.7
Did not want abuser to get into trouble	10.9	10.6	9.9

Table 3. *Continued*

	GBV[±] survivors who did not seek help (n = 123)	IPV survivors who did not seek help (N = 117)	NPSV survivors who did not seek help (N = 26)
	Column %		
No one to help	7.9	8.0	0.6
Did not want/need services	7.6	7.8	1.9
Could not afford service fees	6.4	6.6	11.3
Could not afford transport	4.8	4.9	0.0
Obstruction by family/ community member	4.4	4.5	8.3
Too far to services	1.7	1.7	0.0

Reasons not mutually exclusive.
[±]GBV survivors are those who experienced any IPV or any NPSV.

Table 4. Services received, among those who experienced any abuse, overall and by IPV or NPSV, weighted.

	GBV[±] survivors (n = 175)	IPV survivors (N = 168)	NPSV survivors (N = 36)
	Column %		
Counseling services	29.5	29.9	38.2
Medical services	20.9	21.2	22.5
Shelter or somewhere safe to stay	9.6	9.8	10.5
Police services	6.6	6.8	6.8
Traditional/spiritual healer services	2.6	2.6	7.5
Legal counsel	1.1	1.1	5.1
Any services received	47.4	48.1	54.1

Services not mutually exclusive.
[±]GBV survivors are those who experienced any IPV or any NPSV.

Table 5. Who survivors spoke to, among those who experienced any IPV and reported speaking to anyone (n = 84), weighted.

	Column %
Friend	71.5
Relative	31.6
Peer educator/CHV	9.9
Other[±]	6.1
Peer/student	2.7
Hotline	1.4
Teacher	0.0
Spoke to anyone[+]	54.5

Person spoke to not mutually exclusive.
[±]Others included siblings, parents, elders.
[+]Spoke to anyone among those who experienced IPV (n = 168).

(30.6%) and feeling embarrassed for themselves or their family among those who experienced NPSV (53.0%). Additionally, those who experienced NPSV more often reported being afraid of getting in trouble compared to those who experienced IPV (49.1% vs. 30.2%). In contrast, those who experienced IPV cited having no one to help them more than those who experienced NPSV (8.0% vs. 0.6%) and not wanting or needing services (7.8% vs. 1.9%).

Violence-related services that survivors of abuse received, overall and IPV or NPSV, are presented in Table 4. Among those who reported any GBV, 47.4% received any service. A higher proportion of NPSV survivors received services than did IPV survivors (54.1% versus 48.1%). Counselling was the most sought-after service by both IPV and NPSV survivors, at 29.9% and 38.2%, respectively. Approximately one in five IPV (21.2%) and NPSV (22.5%) survivors received medical services. Less common were shelters, at 9.7% and 10.5% for IPV and NPSV survivors, respectively, followed by police services (6.8% for both IPV and NPSV survivors), traditional or spiritual healer services (2.6% for IPV and 7.5% for NPSV) and legal counsel (1.1% for IPV and 5.1% for NPSV).

Despite low help-seeking and use of formal violence-related services, women did tell others about their experiences (Table 5). Over half of those who experienced IPV spoke with someone about it (54.5%). The majority reached out to friends (71.5%), followed by relatives (31.6%), peer educators/community health volunteers (9.9%), peers/students (2.7%), and hotlines (1.4%). No one spoke to teachers. Some reached out to siblings, parents or elders (6.1%).

Discussion

This mixed-methods analysis is the first to concurrently explore young women's experiences of IPV, NPSV, and related help-seeking in Nairobi, Kenya. Our findings reveal that GBV is a significant public health concern for young women in Nairobi, with more than a quarter of partnered young women (28.1%) experiencing past-year IPV and nearly 5% of all young women reporting past-year NPSV. Approximately 90% of partnered women who experienced past-year NPSV also experienced past-year IPV. Despite this prevalence, help-seeking among survivors remains complex and limited. Less than one-third of survivors reported trying to seek help (30.7% for IPV and 31.5% for NPSV). Additional indicators highlight the layered dimensions of help-seeking including whether the survivor sought help, talked to somebody about their experience, and received any support or service. Qualitatively, we found that help-seeking pathways for young women who have experienced GBV are profoundly influenced by interconnected sociocultural, institutional, and economic factors. Emergent themes centered on the normalization of violence, the quality of GBV services, and specific barriers to help-seeking (economic dependence, internalized feelings of shame and helplessness, and corruption), all of which inform if and how women seek care.

In qualitative interviews, young women consistently described that violence against women, both IPV and NPSV, was a normal occurrence in their communities. The normalization of violence fundamentally shaped whether women or others in their community recognized violence as something requiring intervention. Quantitative findings supported this, with approximately 30% of women who experienced GBV and did not seek help stating that they did not think the violence they experienced was a problem. Findings are consistent with existing literature documenting a complex interplay of factors that fuel normalization of violence. The community's perception of violence as common and intractable normalizes its occurrence,[35,37] and prevents survivors from seeking help.[38] Survivors' perceptions that their experiences were not problematic reflects a well-documented challenge in violence prevention—deeply ingrained social norms that minimize violence.[33,37,39]

Young women also shared that the quality of formal GBV services, particularly regarding healthcare and police, further determined where survivors sought help. Many survivors felt that violence-related medical care was respectful and timely, qualities they did not often experience when seeking help from the police. Qualitative results are supported by quantitative findings, where disparities the type of services women received (21% medial services versus 7% police services) were persistent. Although health facilities were identified as preferred intervention points, evidence shows that practitioners face challenges in providing quality care due to family interference and sociocultural barriers.[40] Provider trainings and tools, including the L.I.V.E.S (Listen, Inquire, Validate, Enhance safety, and Support) approach recommended by the World Health Organization,[41] can equip front-line responders with the necessary skills to provide trauma-informed care, and should also account for context- and youth-specific factors that may inhibit young women from seeking future care.

Additionally, specific barriers to help-seeking included economic dependence on perpetrators, feelings of shame and helplessness, limited accessibility of services, and endemic corruption within formal systems of care, such as police stations or with community chiefs. Our quantitative findings directly supported these barriers: of those who experienced GBV and did not seek help, 17% reported fear of being abandoned (reflecting economic dependence); 24% cited embarrassment for self of family (corresponding to feelings of shame); 8% indicated that they had no one to help them;

and inaccessibility of services was evident through multiple factors including inability to afford service fees (6%), lack of transportation funds (5%), geographic distance from services (2%). Existing research points to barriers at multiple socioecological levels, from individual factors, like self-blame, to societal norms emphasizing secrecy and maintaining the family unit.[42] Consistent with prior literature,[14,18,43] women experiencing both IPV and NPSV were more likely to seek help, which can potentially be attributed to increased distress and the need for support.[44]

Findings should be interpreted considering several methodological limitations, particularly for our quantitative data. First, help-seeking variables were not specific to type of GBV, limiting our ability to link violence experiences (IPV/NPSV) with specific help-seeking behaviors or services. We are therefore unable to fully disentangle if and how help-seeking differs by IPV and NPSV experiences. Sample sizes did not afford significance testing and all quantitative data should be interpreted as descriptive. This analysis did not incorporate other forms of violence such emotional or economic abuse, which could have offered a more comprehensive understanding of violence experiences and subsequent help-seeking. Lastly, this study was conducted in an urban setting in Nairobi, Kenya and may not be generalizable to young women in rural areas or other contexts.

Despite these limitations, this study makes numerous contributions to GBV research including a youth-focused lens, rich, contextual insights provided by the interviews that are not measurable in quantitative approaches alone, and a focus on both IPV and NPSV to afford a more holistic understanding of violence experiences that are often concurrent. Findings demonstrate how help-seeking behavior following GBV must be understood as a complex process embedded within broader structural constraints, rather than simply as an individual choice. The high prevalence of IPV and its concurrence with NPSV among partnered young women reinforces the urgent need for integrated prevention and response strategies. Existing interventions that address IPV and NPSV as discrete phenomena fail to recognize their interconnectedness, suggesting that holistic, survivor-centered approaches—including comprehensive multi-sectoral service provision and trauma-informed care—are essential. Familial- and community-level barriers to help-seeking suggest a need for strengthened community-based interventions that engage survivors in safe, accessible ways. While informal sources of support, such as families and clans, play a crucial role in women's help-seeking, our findings suggest that they may simultaneously reinforce silence when survivors anticipate judgment, blame, or discouragement from accessing more formal sources of care.[15] As such, community health volunteers or other accessible peer-led interventions could help bridge the gap between survivors and formal services. Ultimately, addressing GBV survivors' perception that abuse is "not a problem" requires sustained efforts in public awareness and social norm transformation, including challenging gender norms that perpetuate violence and silence survivors.

Data availability

Data are publicly available on Synapse upon reasonable request. Data are undergoing final preparation within the next month, when a DOI will be generated. For now the data can be found here: https://www.synapse.org/Synapse:syn66498482

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