Gender Based Violence Response:

The Kasarani District Perspective

Presented to

Kenya Women and Children's

Wellness Centre

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This report presents the findings of the Gender Based Violence response in Kasarani District. We are grateful to USAID and James R. Jordan Foundation International (JRJFI) for commissioning and financing this study for the Kenya Women and Children's Wellness Centre (KWCWC). KWCWC wishes to express its gratitude to John K. Otsola (USIU) who undertook the study and Edwin Mokaya (USIU), Caroline Gichunge (USIU)and Pauline Mumbi (KWCWC) for editing this work. We sincerely thank KWCWC staff for their endless efforts which ensured the successful production of this report. We are grateful to Anne Njeri who supervised the data collection activities.

Ms. Sunita Nathoo,

Managing Director,

Kenya Women and Children's Wellness Centre

FORWARD

It is with great pleasure that we publish this report, which presents the findings of the Gender Based Violence response in Kasarani District. The study was commissioned and financed by USAID and James R. Jordan Foundation International (JRJFI) for Kenya Women & Children's Wellness Centre (KWCWC). JRJFI is dedicated to strengthening families, motivating youth and ensuring high quality academic opportunities for children in underserved communities.

This report is very useful to Kenya Women & Children's Wellness Centre and other gender based organizations/institutions, as it will contribute immensely to the GBV mitigation discourse and the formulation of the appropriate policies.

The study was done in Kasarani District and the purpose was to profile the state of GBV and GBV survivors in Kasarani as well as profile the state of Medical, Psychosocial, and Legal aspects of GBV in Kasarani with the aim of determining the best model of managing GBV in Kasarani using desk, qualitative and quantitative research by John K. Otsola under the overall guidance of KWCWC. John K. Otsola undertook a comprehensive review, assessment and analysis of all relevant information including the general review and analysis of published books, Media Reports and other published papers in order to measure Gender Based Violence in Kasarani District. Consultations were also carried out with key informants on Gender Based Violence to collect information on the GBV survivors in Kasarani District in

Nairobi. This involved collection of data from various regions which include Korogocho, Roysambu and Githurai.

The study intended to inform the Kenya Women and Children's Wellness Centre that aims to develop a hybrid of multi-sectoral and multi-level models in responding to GBV in Nairobi. The findings and recommendations for the study are recorded and discussed in this report.

Ms. Sunita Nathoo,

Managing Director,

Kenya Women and Children's Wellness Centre

Abbreviations

ACORD	Agency for Cooperation and Research in Development
AOR	Area of Responsibility
DHS	Demographic Health Survey
DTC	HIV Diagnostic Testing and Counseling
EC	Emergency Contraception
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
KWCWC	Kenya Women and Children's Wellness Centre
PEP	Post Exposure Prophylaxis
SGBV	Sexual and Gender Based Violence
SOP's	Standard Operating Procedures
STIs	Sexually Transmitted Infections
TOT	Training of Trainers
USAID	United States Agency for International Development
WHO	World Health Organization

ABSTRACT

The purpose of this study was to profile the state of GBV and GBV survivors in Kasarani as well as profile the state of Medical, Psychosocial, and Legal aspects of GBV in Kasarani with the aim of determining the best model of managing GBV in Kasarani. The study intended to inform the Kenya Women and Children's Wellness Centre (KWCWC) that aims to develop a hybrid of multi-sectoral and multi-level models in responding to GBV in Nairobi.

Specifically, this study set out to: profile the state of GBV and GBV survivors in Kasarani; profile the state of Medical, Psychosocial, and Legal aspects of GBV in Kasarani; and determine the best model of managing GBV in Kasarani.

This study adopted a descriptive design that utilized the use of a questionnaire. The study population entailed GBV survivors in Kasarani constituency in Nairobi. A working sampling frame was developed from the study sites for lack of an existing frame. The study was conducted in Kasarani constituency of Nairobi, where the KWCWC plans to put up its GBV intervention. Data was collected from male and female GBV survivors. There were three study clusters contiguous to the proposed Wellness Centre namely Korogocho, Roysambu and Githurai based on their unique demographic attributes within Kasarani. The Kenyan National Census results indicate that there are 333,401 people aged 15 to 49 in Kasarani. The vulnerable population at 29% is about 96,686 individuals. The sample was drawn from this population.

This study established that the causes of GBV in Kasarani include the following ranked in order of importance: alcohol and drug abuse; presence of crime and conflict; poverty; weak community sanctions against perpetrators of GBV; social norms that tolerate or justify violence against gender orientation; and traditional gender norms that support gender superiority and entitlement.

The risk factors identified include: traditional gender norms that support male superiority; social norms that tolerate or justify violence against women; weak community sanctions against perpetrators; poverty; and prevalence of crime and conflict in the society. These factors create an environment that predisposes men to commit rape. The findings in this study indicate that GBV is more prevalent in the informal settlements. It is almost twice as much in the informal settlement as compared with other low income settings in non slum areas.

This study therefore recommends that a successful GBV intervention should be cognizant of the underlying causes of GBV namely: Alcohol and drug abuse; Presence of crime and conflict; Poverty; Weak community sanctions against perpetrators of GBV; Social norms that tolerate or justify violence against gender orientation; and Traditional gender norms that support gender superiority and entitlement. In this regard, such an intervention should create linkages with governmental, non-governmental and civic entities that can address the underlying causes of GBV. Additionally, the GBV intervention should be responsive to the type of setting where the GBV survivors reside. There should be more vigorous interventions in the informal settlements that will have a higher GBV prevalence rate.

The findings of this study vouch for a need to integrate the multi-sectoral GBV model and the multi-level GBV model. The assumptions of multi-sectoral GBV model are that no single sector or agency can adequately address GBV prevention and response. The multi-sectoral model calls for holistic inter-organizational and inter-agency efforts across key including but not limited to health, psychosocial, legal/justice and security sectors. A supplemental model to the multi-sectoral model is the multi-level model. Effective GBV prevention necessitates that interventions must take place across all the key sectors and at three levels to institutionalize structural, systemic and individual protections.

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CHAPTER ONE

1.0 INTRODUCTION

1.1 Background of the Problem

Eliminating Gender Based Violence (GBV) is a great concern at the global level. Exclusion of women in the political, economic and social spheres of societies across the world is a great impediment to democratic development. Women participation in democratic development is adversely undermined by violation of their rights and freedom. Research indicates that promoting women's rights and reducing Gender Based Violence are necessary for increasing the effectiveness of development globally (USAID, 2009).

Sexual and Gender Based Violence (SGBV), is a critical phenomenon on the global scene. The fact that Gender Based Violence go hand in hand with sexual coercion considerably augments forced and transactional sex. Gender Based Violence (GBV) has immense implications on a myriad of life outcomes. Research indicates that GBV increases morbidity and mortality rates, exacerbates HIV transmission, among other health conditions. It is pertinent to note that while girls are the most visible survivors of sexual violence, children of both sexes constitute the majority of abused survivors, and adult men and the handicapped are minority groups who are often neglected in research and interventions (Population Council, 2008).

Literature indicates that in addition to this, few guidelines or frameworks exist to guide policymakers and program managers in

developing and implementing the comprehensive response necessary to address the health and criminal justice consequences of violence, and to reduce the determinants of violent behavior within communities. Moreover, in most situations, organizations and ministries are undertaking activities without reference to or liaison with other key actors and networks within their country or more widely in the region (Nathoo, 2012).

As far as children are concerned, research evidence postulates that in Kenya, there are very few health facilities and counseling centers equipped to counsel survivors of GBV. Among hospitals where counseling services are present, the GBV interventions have not been holistic. They have tended to focus on specific segments of the population. Sometimes physical abuse has been treated as a norm or as a correctional measure including denying GBV survivors food and clothing. In many cases when GBV survivors are raped or sexually abused by close relatives, they are told to keep quiet and the issue is rarely addressed. Sometimes the offender may pay in form of a cow or a goat leaving the GBV survivor's emotional state unaddressed. The Kenyan government adopted the 1989 United Nations Convention on the rights of a child and the Children Act that came to effect in 2006. Both the convention and the Act are meant to protect children from physical, mental and sexual abuse. Despite Kenya being a signatory to the convention, the last three years, have witnessed an increase in cases of rape in Kenya. Due to the increased cases, several measures have been put in place to protect children as outlined in the convention of the rights of the child. The few Hospitals and counseling centers that are out to help

GBV victims face a lot of challenges in the provision of these services. GBV survivors only go for counseling when receiving the Anti-retro-viral drugs from the hospital after a rape incident. Many do not complete their counseling sessions and lack family support either emotionally or financially (Nathoo, 2012).

The perpetrators of GBV across sub-Saharan Africa are frequently either known to the family, or are a family member. Children are relatively more likely to present to police or health facilities than adults which may reflect the widespread perception that sexual abuse of children is a crime, as opposed to the more complex attitudes towards sexual abuse of adults. Although more children present their cases, this trend is not necessarily representative of abuse in the general population. However, the disproportionate numbers of children seeking services, relative to adults, does suggest that the current focus on adult medical and psychological management should be balanced with protocols relating specifically to child survivors. The medical, psychological and legal needs of children are not adequately addressed and require revision (Keesbury, Skibiak and Zama. 2006; RADAR, 2006; Kilonzo & Taegtmeyer, 2005; Nathoo, 2012).

Research demonstrates GBV has implications for almost every aspect of health policy and programming. Women experience considerable morbidity and mortality as a result of GBV which also aggravates other health conditions. Violence against women cannot be understood in isolation from the social structures that influence women's vulnerability to violence. Women's subservient social, economic, and legal status often makes it difficult for them to get

help once violence occurs. Forms of GBV include physical, sexual, and psychological/emotional violence. Research postulates that although men can also be victims of intimate partner and sexual violence, this type of violence affects women disproportionately. In essence, although both males and females report sexual coercion, the majority of GBV survivors are female and the vast majority of perpetrators are male. Comparative data on the prevalence of GBV are difficult to collect. The revelations in the literature notwithstanding, a multi-country study on the prevalence of GBV conducted by the World Health Organization (WHO) confirms that GBV is a serious and widespread problem (USAID, 2006).

1.2 Statement of the Problem

Violence against women and children of both sexes has internationally been recognized as a serious social and human rights concern affecting all societies. Research evidence shows that violence is a major cause of ill health among women and girls, as seen through death and disabilities due to injuries, and through increased vulnerability to a range of physical and mental health problems. The ramifications of GBV include physical injuries, unintended pregnancies and reproductive tract infections. Research further indicates that violence and the fear of violence limits women's contribution to social and economic development, thereby hindering achievement of the Millennium Development Goals, Vision 2030 and other national and international development goals (Population Council, 2008). The World Health Organization reveals that 5-10% of healthy years lost by women are due to GBV (WHO, 2001).The Demographic Health Survey (DHS), 2008/2009 reports

that 39% of women have experienced Violence since they were 15 and one in four reported experiencing violence in the 12 months preceding the 2008 DHS survey. The main perpetrators are husbands, and to a lesser extent, teachers, mothers, fathers, and brothers.

The consequences of GBV are adverse. Research from different parts of the world indicate that girls and/or young women who had previously experienced sexual coercion are significantly less likely to use condoms, and more likely to experience genital tract infection symptoms, unintended pregnancy and a higher incidence of unsafe abortion. GBV has been found to be independently associated with HIV infection (Population Council, 2008). The population council (2008) further indicates that research by Jejeebhoy (1998), Ganatra, Coyaji, and Rao (1998), Asling-Monemi, Pena, Ellsberg & Persson. (2003), and Kishor & Johnson, (2004) provide a direct link between maternal experience of violence and evidence of increased mortality and under nutrition among children of abused mothers. This postulation corroborates DHS findings over the years.

Notwithstanding the reality and adverse consequences of GBV elucidated above, there lacks an elaborate and coordinated intervention for GBV in Kenya. Consequent upon this, this study sought to profile the state of GBV in Kasarani with the aim of formulating a robust and well-coordinated GBV intervention framework that will mitigate the prevalence and adverse effects of GBV in Kasarani that can be replicated in other parts of the world.

1.3 General Objective of the Study

The general objective of this study was to profile the state of GBV and GBV survivors in Kasarani as well as profile the state of Medical, Psychosocial, and Legal aspects of GBV in Kasarani with the aim of determining the best model of managing GBV in Kasarani. The study intended to inform the KWCWC that aims to develop a hybrid of multi-sectoral and multi-level models in responding to GBV in Nairobi.

1.4 Study Objectives

This study was guided by the following objectives:

1.4.1 Profile the characteristics of GBV and GBV survivors in Kasarani.

1.4.2 Profile the state of Medical, Psychosocial, and Legal aspects of GBV in Kasarani.

1.4.3 Determine the best model of managing GBV in Kasarani.

1.5 Significance of Study

Research has shown that the impact of violence against women on development progress goes beyond short-term injury and disability. It has been established that GBV leads to the isolation and even ostracism of the victims, and ultimately, to longer-term mental, medical and economic consequences. Additionally, children of both sexes raised in a violent family will be shaped by the experience (USAID, 2009). According to Population Council (2008), there is a correlation between sexual and Gender Based Violence, health, human rights and national development in East, Central and

Southern Africa. The findings of this study will contribute immensely to the GBV mitigation discourse and the formulation of the appropriate policies.

Current GBV interventions are directed by either multi-sectoral GBV model or the multi-level GBV model. This has led to glaring ineffectiveness in adequately addressing the GBV phenomenon. This study therefore sought to explore the viability of a hybrid GBV intervention that integrates the multi-sectoral GBV model and the multi-level GBV model.

1.6 Scope of the Study

This study adopted a descriptive design that utilized the use of a questionnaire. The study population entailed GBV survivors in Kasarani constituency in Nairobi. A working sampling frame was developed from the study sites for lack of an existing frame. The study was conducted in Kasarani constituency of Nairobi, where KWCWC plans to put up its GBV intervention. Data was collected from male and female GBV survivors. There were three study clusters contiguous to the proposed Wellness Centre namely Korogocho, Roysambu and Githurai based on their unique demographic attributes within Kasarani. The Kenyan National Census results indicate that there are 333,401 people aged 15 to 49 in Kasarani. The vulnerable population at 29% is about 96,686 individuals. The sample was drawn from this population.

1.7 Definition of Terms

1.7.1 Gender Based Violence

Gender Based Violence refers to any harmful act that is perpetrated against a person's will as a result of gender differences between males and females. WHO postulates that GBV has a greater impact on women and girls since they are more predisposed to suffer greater physical damage than their male counterparts (IASC, 2005; WHO, 2005; Betron and Doggett, 2006; Population Council, 2008; USAID, 2009). Gender Based Violence refers to *sexual violence* perpetuated against women, men, girls and boys.

1.7.2 Sexual Violence

Sexual violence refers to an unwanted and coercive sexual act or advance. It also includes forced sex, of adult and adolescent men and women, and child sexual abuse. The dimensions of sexual violence include: use of physical violence or psychological pressure to compel a person to participate in a sexual act against their will, whether or not the sexual act is consummated (Population Council, 2008).

1.7.3 The multi-sectoral GBV model

The assumptions of this model are that no single sector or agency can adequately address GBV prevention and response. The multi-sectoral model calls for holistic inter-organizational and inter-agency efforts across key including but not limited to health, psychosocial, legal/justice and security sectors (GBV-AoR, 2010).

1.7.4 The multi-level GBV model

GBV-AoR (2010) underscores that one of the limitations of the multi-sectoral model is that it specifies many of the sectoral responsibilities in terms of response but gives limited attention to prevention. A supplemental model to the multi-sectoral model is the multi-level model. Effective GBV prevention necessitates that interventions must take place across all the key sectors and at three levels to institutionalize structural, systemic and individual protections. The three levels include:

- Primary prevention/structural reform (preventative measures that ensure rights are recognized and protected through international, statutory and traditional laws and policies.
- Secondary prevention/systems reform (systems and strategies to monitor and respond when rights are breached).
- Tertiary prevention/operational response (response at the individual level through direct services to meet the needs of women and girls who have been subjected to GBV).

1.8 Chapter Summary

This chapter focused on the purpose of the study, which was to profile the state of GBV and GBV survivors in Kasarani as well as profile the state of Medical, Psychosocial, and Legal aspects of GBV in Kasarani with the aim of determining the best model of managing GBV in Kasarani. The study intended to inform KWCWC that aims to develop a hybrid of multi-sectoral and multi-level models in responding to GBV in Nairobi. This study adopted a

descriptive design that utilized the use of a questionnaire. The study population entailed GBV survivors in Kasarani constituency in Nairobi. There were three study clusters contiguous to the proposed KWCWC namely Korogocho, Roysambu and Githurai based on their unique demographic attributes within Kasarani. This chapter has covered background and statement of the problem in addition to the purpose and scope of the study. The key terms used have also been defined.

In Chapter two, the literature review will be discussed based on the study objectives while chapter three will look at the research methodology used to conduct the study. The methodology will include the research design, population, and sampling design, data collection methods, research procedures and data analysis methods in chapter three. Chapter four will include results and findings while chapter five will comprise of the conclusions and recommendations of this study.

CHAPTER TWO

2.1 LITERATURE REVIEW

A review of literature on GBV by the Population Council (2008) indicates that the focus in both research and programmatic interventions is on violence on women. Conversely, research indicates that most of GBV survivors are children of both sexes. It is evident that program managers and policy makers model interventions that are primarily cognizant of adult women as the GBV survivors. Population Council further observes that children are very vulnerable to sexual violence mainly because they occupy weak social position and are economically depended. An increasing number of children are being initiated into sex in many parts of the world like South Africa, Tanzania and Namibia (WHO,2001).

Male GBV survivors are very disadvantaged. This is because according to research evidence, sexual abuse of male adults and children is under-reported. Additionally, research is scantly done in this area. The result of this is a misrepresentation of the prevalence rates among the male population (Krug, Etienne, Dalhberg, Mercy, Zwi, and Lozano, 2002; WHO, 2003; Population Council, 2008). It is for this reason that interventions targeting male GBV survivors are very limited.

Population Council (2008) indicates that sexual abuse of male adults and children is endemic but vastly under-reported and poorly understood. Niang, Diagne, Niang, Moreau, Gomis, Diouf, Seck,

Wade, Tapsoba, & Castle (2002) and Barker and Ricardo (2005) in Population Council (2008) postulate that in Kenya, nearly 40 percent of men who had sex with men reported having been raped outside their home and 13 percent report having been assaulted by the police. Literature posits that programmatic interventions targeting male abuse survivors are extremely limited.

A review of literature vouches for a comprehensive approach in mitigating GBV (Krug *et al*., 2002; Kishor & Johnson, 2004; Population Council, 2008). The findings in the literature correlate community and societal-level risk factors with GBV. The risk factors identified include: traditional gender norms that support male superiority; social norms that tolerate or justify violence against women; weak community sanctions against perpetrators; poverty; and prevalence of crime and conflict in the society (IGWG of USAID, 2006).

Researchers indicate that in Kenya like many other developing countries GBV is characterized by inequalities in human development. Disparities are seen in terms of ownership of resources, distribution of wealth, income and access to economic and social goods and services. Such inequality greatly impacts on economic and social outcomes with implications on human development (Kenya Human Development Report, 2001).

Research postulates that the violation of women is normalized in pre-conflict situations. This means that GBV occurs during conflict situations as well as situations where legal systems and institutions

have failed. The argument set forth in the literature is that communities justify various forms of GBV (ACORD, 2010).

Literature attributes the collapse of the rule of law in conflict situations to increased sexual crimes on a massive scale. It is also evident in the literature that in conflict situations, the protector turns to be a perpetrator. Perpetrators and perpetuators of sexual crimes in conflict and post-conflict settings include: rebel groups; family and community members; and the interveners. This is due to the fact that government mechanisms experience a stall and social services, law and order frameworks, institutions and systems have become inefficient (ACORD, 2010). This state of affairs resonate the typical description of life in the informal settlements by Okombo and Sana (2010).

A review of the literature reveals that there are factors at Individual and Community level that predispose communities to rape. These factors are outlined in the table below.

Table 1: Factors Influencing Men's Risk of Committing Rape

Individual factors	Relationship factors	Community factors	Societal factors
• Alcohol and drug use	• Associate with sexually aggressive and delinquent peers	• Poverty, mediated through forms of crisis of male identity	• Societal norms supportive of sexual violence
• Coercive sexual fantasies and other attitudes and beliefs supportive of sexual violence	• Family environment characterized by physical violence and few resources	• Lack of employment opportunities	• Societal norms supportive of male superiority and sexual entitlement
• Impulsive and antisocial tendencies	• Strongly patriarchal relationship or family environment	• Lack of institutional support from police	• Weak laws and policies related to sexual violence

• Preference for impersonal sex • Hostility towards women • History of sexual abuse as a child • Witnessed family violence as a child	• Emotionally unsupportive family environment • Family honour considered more important than the health and safety of the victim	and judicial system • General tolerance of sexual assault within the community • Weak community sanctions against perpetrators of sexual violence	• Weak laws and policies related to gender equality • High levels of crime and other forms of violence

Source: Krug, Etienne, Linda Dalhberg, James Mercy, Anthony Zwi, and Rafael Lozano, Eds. 2002. *World Report on Violence and Health*. Geneva: WHO in Population Council (2008), *Sexual and Gender Based Violence in Africa Literature Review*, Population Council

Literature indicates that people with low income and low literacy levels have low bargaining power in terms of accessing or purchasing quality health care. Additionally, low literacy levels inhibit understanding on health education and timely access to health and medical services in cases of ill health or abuse. Information on psychosocial and legal services is critical for judicious access to the services. Literature further postulates that basic information on human rights and the justice system is important in responding to health issues at a personal and community level (Erik, 2006).

Households with low levels of income are characterized by scarce resources. In this regard, there are hardly any resources set aside to protect members from life's stresses. It is for this reason that researchers argue that if the health problems of the poor are ignored, economic growth is likely to result in an even greater

divide between the health of the rich and the poor. The resultant effect of the social inequality is deteriorating social relationships and greater alienation among social groups creating a fertile ground for violence. The situation is converse in situations with higher levels of income; education and occupation (Wermuth, 2003).

Population Council (2008) indicates that comprehensive and integrative post-rape care aims to reduce the physical and psychological consequences of sexual violence. An integrated care package should include: treatment of injuries and clinical evaluation; pregnancy testing and emergency contraception (EC); prophylaxis of sexually transmitted infections (STIs); HIV diagnostic testing and counseling (DTC) and Post Exposure Prophylaxis (PEP); forensic examination; and trauma counseling.

Emotional consequences of GBV are often longer lasting and more difficult to diagnose and deal with than physical symptoms. They include behavior changes and personality changes that are manifested physically. Counseling has been identified as key in speeding the recovery process. The need for counseling is not necessarily limited to the survivor it also reflects on the family and/or partners also undergo trauma and may require support (Population Council, 2008).

Framework for a comprehensive model of care, support and prevention of SGBV

1. Medical management of sexual violence at point of first contact with the survivors.
2. Psychological counselling of rape survivors.
3. Sensitive approaches to managing child survivors of sexual violence (of both sexes), and to encouraging and enabling presentation by male survivors.
4. Collection of forensic evidence (at health facility during medical management and/or at police station) and creation of a chain of evidence that can be used during a prosecution.
5. Strong links between police and health facility to enable incidents to be referred in either direction so that, if desired, a prosecution can be initiated. Ensure prosecutions initiated by the police are sustained through the judiciary.
6. New or strengthened community-based prevention strategies that are relevant and appropriate for the local context and that are directly linked to the nearest medical/police structures.
7. Physical (and psychological/emotional) violence between domestic or intimate partners addressed through:
   a. Messages communicated during the prevention strategies;
   b. Screening for signs and symptoms of such violence during routine health consultations.

Source: Population Council, 2008.

Figure 1: Framework for Implementing the GBV Interventions

An extensive review of literature on GBV by the Population Council indicates that in order to develop a comprehensive model of care, support and prevention of GBV, there are seven components that need to be adapted as a whole or as particular components. The seven components are presented in figure 1 above.

According to USAID (2008), Tanzania has a robust National Plan of Action for the Prevention and Eradication of Violence against Women and Children. This plan makes a number of recommendations for ameliorating GBV. First, it recommends for the amendment of laws that directly affect women's and children's rights as well adoption of legislative measures to ensure the protection and removal of all forms of discrimination against women and children. Second, with regards to Social, Economic, Cultural, and Political Measures, it recommends for the building of the capacity of grassroots women's and men's groups on the eradication of traditional norms, religious beliefs, practices, and stereotypes, which exacerbate violence against women and children. Additionally, it recommends for the increase in gender awareness on violence against women and children. Third is the enhancement of provision of information on services available to GBV survivors. Fourth is the provision of efficient and effective police response, gender-sensitive prosecution services, and health and social welfare services as well as legal services. Fifth is to conduct research education, training, and awareness building among the GBV survivors.

USAID (2009) identifies five fundamental guiding principles for GBV intervention. First, there needs to be respect for survivors' safety, rights and confidentiality. Second, there is need for multi-sectoral interventions for enhanced effectiveness. Third, a good intervention should encourage coordination and partnership at all levels. Fourth, the intervention should include development and human rights perspectives. Fifth, a good intervention needs to

include monitoring and evaluation as an essential component of GBV programs. Sixth, an effective intervention ought to work with men, especially youth, and communities at large, to change attitudes and behaviors.

USAID (2009) further outlines the strategies for designing Gender Based Violence prevention and response activities organized around the five objectives namely: Peace and Security; Governance; Investing in People; Economic Growth and Humanitarian Assistance. Peace and conflict strategies entail the involvement of women in conflict prevention, resolution and management at all levels. Governance entails the legislation that makes all forms of GBV a crime and to prosecute perpetrators. This strategy calls for: the development of national plans or strategies to combat GBV; lobbying for legislative change to criminalize GBV and to create civil protection orders and most importantly train law enforcement agents to increase their awareness of GBV. Additionally, there is need to develop public education campaigns as well as establish and train community paralegals to assist and advise GBV victims on legal recourse.

There are various areas of investment in people required to establish a robust GBV intervention. At the National and local there is need to sensitize and train health care professionals, develop protocols for management of GBV, establish operational policies, partnerships and referral services, and support development of national GBV policies. Regarding economic growth, research indicates that women with more economic opportunities are generally less vulnerable to violence and are less likely to resort to harmful behaviors for survival. This call for the establishment of

targeted job training programs for GBV survivors to rejoin the workforce as well as enhance women's ability to succeed in business and grow enterprises. In the light of humanitarian assistance past research indicates that acts of violence, abuse and exploitation occur during conflict-related disasters as well as natural disasters (USAID, 2009).

The Population Council (2008) observes that many sub-Saharan African countries lack systematic and reliable data on GBV. The council therefore argues that there is need for systematic data collection on the prevalence and forms of SGBV. The reason for this postulation is that program design is hampered by the absence of evaluation of the impact of former preventative or responsive interventions. The results of this study will be pertinent in defining the GBV intervention programs that are evidence based.

Population Council (2008) indicates that children are especially vulnerable to sexual violence by nature of their relatively weak social position, economic dependence and lack of political protection. Additionally, there are practices that predispose children to rape. These include: myths that sex with young virgins can cleanse the perpetrator of the HIV; forced sexual initiation, particularly among girls. Ironically, the perpetrators of child sexual abuse across sub-Saharan Africa are frequently either known to the family, or a family member. This calls for the need to adequately meet the medical, psychological and legal needs of children. The evaluation of children requires special skills and techniques in history taking, forensic interviewing and examination.

Standard Operating Procedures (SOPs) are specific procedures that reflect a plan of action and identify individual organizations' roles and responsibilities with regard to GBV prevention and response. SOPs include agreed-upon reporting and referral systems, mechanisms for obtaining survivor consent and permission for information-sharing, incident documentation and data analysis, coordination, and monitoring. They should also tackle ethical and safety considerations and guiding principles for issues related to GBV intervention. The development of SOPs should involve consultations with key stakeholders and actors in the setting. Inclusiveness, participation and transparency are very pertinent considerations (GBV-AoR,2010).

Research indicates that every GBV intervention strategy involves partners with different levels of capacity related to GBV programming and GBV coordination. There is need to build the capacity of partners to improve their skills. Capacity building should be a collaborative process in which the expertise of all members is shared amongst coordination partners to develop a strong and effective coordination mechanism (Population Council, 2008; GBV-AoR, 2010).

2.2 Chapter Summary

This chapter is a succinct review of literature by previous researchers on the: characteristics of GBV and GBV survivors; state of Medical, Psychosocial, and Legal aspects of GBV; and best model of managing GBV. The next chapter will look at the methodology used to collect data, research design, population and sampling,

sampling design, data collection methods, research procedures and data analysis methods.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Research Design

Research design is the procedure of conditions for collection and analysis of data in a manner that aims to combine relevance with the research purpose. According to Saunders, Adrian and Lewis, (2009), research is conducted within the conceptual structure. It constitutes the blueprint for collection, measurement, and analysis of data.

This study adopted a descriptive design. According to Saunders *et al* (2009), descriptive studies are concerned with descriptions of phenomenon or characteristics associated with a subject population. A survey was employed for collection of the primary data. A questionnaire was administered; confidentiality and anonymity of the respondents were assured. This design was effective to describe this study, as its purpose was to investigate issues that affect GBV survivors.

3.3 Population and Sampling Design

3.3.1 Population

Population is defined as the total collection of elements about which researchers sought to make inferences (Cooper and Schindler, 2003; Neuman, 2000). The study population entailed GBV survivors in Kasarani constituency in Nairobi.

3.3.2 Sampling Design

3.3.2.1 Sampling Frame

A sampling frame is designed as the list of elements from which the sample will be actually drawn. Ideally, it is a complete and correct list of population members only (Cooper and Schindler, 2001). A working sampling frame was developed from the study sites for lack of an existing frame. The study was conducted in Kasarani constituency of Nairobi, where KWCWC plans to put up its GBV intervention. Data was collected from male and female GBV survivors.

3.3.2.2 Sampling Technique

Saunders *et al* (2009) suggest that once a suitable sampling frame and the actual sample size required has been established then the most appropriate sampling technique is to be selected. They suggest that five main techniques can be used: simple random, systematic, stratified random, cluster and multistage. Cluster random sampling technique was used. As pointed out by deVaus (2002), the sample frame in some cases is already divided into strata (Easterby-Smith, Thorpe and Lowe 2002).

The sampling frame was developed at the site level from each cluster based on the cluster's contribution to the total population. This approach was chosen since it had a higher statistical efficiency than simple random sampling and it provides adequate data for analyzing the various sub-populations and finally it enables

different research methods and procedures to be used in different clusters

(Cooper and Schindler, 2003). The clusters were divided into three regions contiguous to the proposed KWCWC namely Korogocho, Roysambu and Githurai based on their unique demographic attributes within Kasarani.

3.3.2.3 Sample Size

According to Saunders et al, (2009), the margin of error is contingent upon the heterogeneity of the study population. For national level studies entailing millions of people, the recommended margin of error is between 1 and 5. For smaller and relatively homogeneous a margin of 6 to 9 is recommended.

According to DHS (2008), the prevalence rate for GBV in Nairobi is about 29% computed on a population of 15 to 49 years. The Kenyan National Census results indicate that there are 333,401 people aged 15 to 49 in Kasarani. The vulnerable population at 29% is about 96,686 individuals. This gives us a margin of error of 6. The sample size for this study was determined by: the vulnerable population in Kasarani (29%); the desired level of confidence of 95%; and the scientifically acceptable margin of error of 6% for a small heterogeneous population.

Since the research design for this study is based on a random sample at the cluster level, the sample size required was calculated as follows:

$$\mathbf{n= \frac{z^2 \times p(1-p)}{}}$$

$$\mathbf{m^2}$$

n = required sample size
z = confidence level at 95% (standard value of 1.96)
p = the vulnerable population in Kasarani (29%)
m = margin of error at 6% (standard value of 0.06)

$$\mathbf{n} = \frac{1.96^2 \times .29(1-.29)}{.06^2}$$

n = 219.7181778 ~ **220**

An additional data set was used for the Roysambu area.

3.4 Data Collection Methods

A structured questionnaire was used to collect the data which allowed respondents to answer structured questions. Structured questions were used because they offer an increased respondent rate and are easily coded and analyzed (Saunders, et al, 2009). They were assured of confidentiality and anonymity. The research instruments were based on the literature review. The instrument used a Likert Scale (from strongly disagree to strongly agree). This is expected to be valid since several studies had used similar factors and items and found them to be valid and reliable measures.

3.5 Research Procedures

Cooper and Schindler, (2001) point out that a pilot test is conducted to improve in design and instrumentation and to provide proxy data for selection of a probability sample. Saunders *et al*, (2009) explains that the pilot test is critical in helping to refine the questionnaire so that respondents will have no problems in

answering the questions and in recording data. Additionally, a pilot test allows suggestions to be made on the structure of the questionnaire thus establish content validity and enable one to make necessary amendments prior to the actual field work. A pilot test was carried out on 5% of the sampled as postulated by Saunders *et al* (2009) to ascertain the validity and accuracy of the questionnaire in capturing the intended objectives of the study. The study instrument was designed, pilot tested and amended and the sample size selected. A total of 12 interviewers were trained and used to collect data in the three study locations.

3.6 Data Analysis Methods

This study utilized both descriptive and inferential statistics to analyze the survey data. The statistical package for social scientists (SPSS) version 20 and STATA version 12 were used to analyze the data.

3.7 Chapter Summary

This chapter identified and described the methods and procedures that were used to carry out the study. It looked at research design, population, and sampling design, data collection methods, research procedures, data, and analysis methods. The next chapters will look at the results and findings.

CHAPTER FOUR

4.0 RESULTS AND FINDINGS

Interview Site

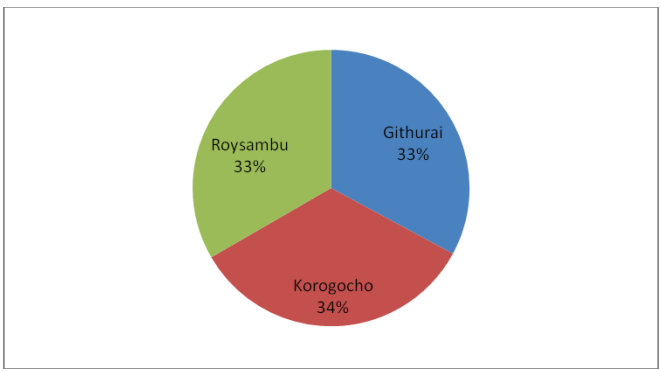


Figure 2: Interview Site

The respondents for this study were drawn from the key areas in Kasarani constituency namely: Roysambu, Githurai and Korogocho.

Table 2: Level of Education

Area of Interview		Frequency	Percent	Less than Secondary Education
Githurai	None	1	1.4%	
	Primary	18	26.1%	**27.5%**
	Secondary	35	50.7%	
	College	14	20.3%	
	University	1	1.4%	
	Total	69	100%	
Korogocho	None	1	1.4%	
	Primary	39	54.9%	**56.3%**
	Secondary	24	33.8%	
	College	7	9.9%	
	Total	71	100.0%	
Roysambu	Primary	19	27.1%	**27.1%**
	Secondary	37	52.9%	
	College	14	20.0%	
	Total	70	100%	

The level of education is low in the study site. Over 27% of the respondents had attained primary level of education in Githurai and Roysambu area while in Korogocho, more than half of the respondents (56.3%) had not been to secondary school. The relationship between gender and education was statistically insignificant ($r = -.091, p>0.05$) and therefore there was no need to truncate the education level on the basis of gender.

Table 3: Risk Factors for GBV

Causes of GBV	Mean	Std. Deviation	Coefficient of Variation
Alcohol and drug abuse in our community lead to increased cases of GBV	4.6	0.74	0.16
Presence of crime and conflict in our community lead to increased cases of GBV	4.3	0.96	0.22
Poverty in our community leads to increased cases of GBV	4.4	1.01	0.23
Weak community sanctions against perpetrators of GBV lead to its increase in our community	4.2	1.06	0.25
Social norms that tolerate or justify violence against some gender orientation lead to GBV in our community	4.1	1.06	0.26
Traditional gender norms that support gender superiority and entitlement lead to GBV in our community	4.0	1.22	0.31

In order of importance, the following factors were identified as the critical causes of GBV in Kasarani area: Alcohol and drug abuse (CfVar = 0.16); Presence of crime and conflict (CfVar = 0.22); Poverty (CfVar = 0.23); Weak community sanctions against perpetrators of GBV (CfVar = 0.25); Social norms that tolerate or justify violence against gender orientation (CfVar = 0.26); and Traditional gender norms that support gender superiority and entitlement (CfVar = 0.31).

Age Profile of GBV Survivors

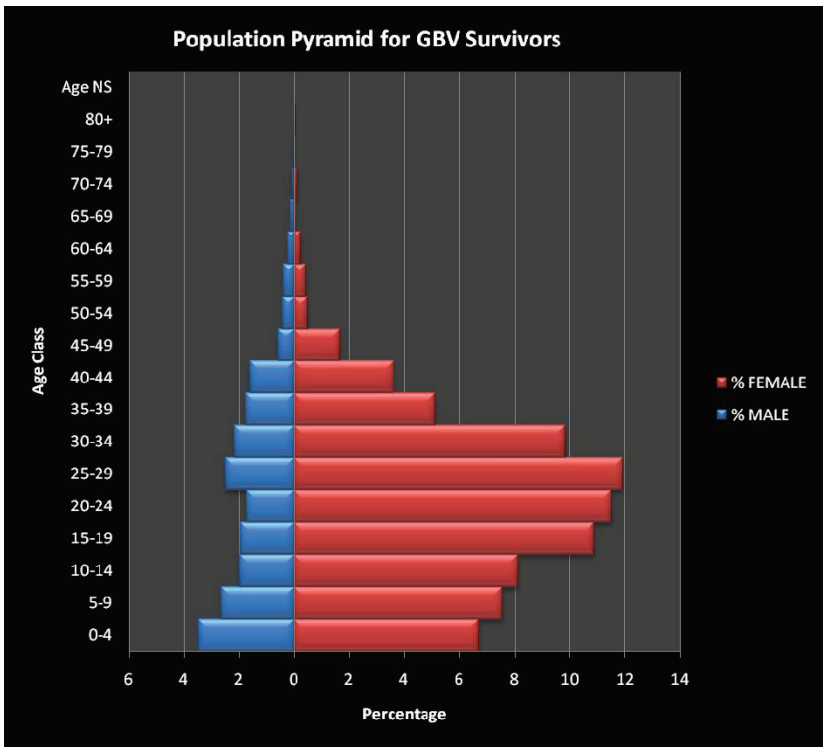


Figure 3: Age Profile of GBV Survivors by Gender

An analysis of about 100 health facilities in Nairobi indicates that there exist a large number of children of both sexes aged below 15 years who have suffered GBV.

Table 4: Physical Violence Against Self

Area of Interview * Physical violence against self-Cross-tabulation				
Area of Interview		Physical violence against self		Total
		Yes	No	
Githurai	Count	24	45	69
	% within Area of Interview	34.8%	65.2%	100.0%
Korogocho	Count	36	35	71
	% within Area of Interview	50.7%	49.3%	100.0%
Roysambu	Count	16	54	70
	% within Area of Interview	22.9%	77.1%	100.0%
Total	Count	76	134	210
	% within Area of Interview	36.2%	63.8%	100.0%

Slightly more than one third (36.2%) of the respondents had experienced physical violence personally. More than half of the respondents that experienced physical violence personally were from Korogocho informal settlements.

Table 5: Physical Violence in the Neighborhood

Area of Interview	Response	Frequency	Percent
Githurai	Yes	37	53.6%
	No	24	34.8%
	Not Sure	8	11.6%
	Total	69	100.0%
Korogocho	Yes	47	66.2%
	No	22	31.0%
	Not Sure	2	2.8%
	Total	71	100.0%
Roysambu	Yes	38	54.3%
	No	28	40.0%
	Not Sure	4	5.7%
	Total	70	100%

In all the areas where the interviews were done, more than half the respondents had witnessed physical violence within the neighborhood. In Korogocho, more than 2/3 of the respondents had witnessed violence within the neighborhood.

Table 6: Independent Samples Kruskal-Wallis Test

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of Physical violence at the community level is the same across categories of Kasarani area.	Independent-Samples Kruskal-Wallis Test	.159	Retain the null hypothesis.
2	The distribution of Emotional violence at the community level is the same across categories of Kasarani area.	Independent-Samples Kruskal-Wallis Test	.928	Retain the null hypothesis.
3	The distribution of Sexual violence at the community level is the same across categories of Kasarani area.	Independent-Samples Kruskal-Wallis Test	.002	Reject the null hypothesis.
4	The distribution of Economic violence at the community level is the same across categories of Kasarani area.	Independent-Samples Kruskal-Wallis Test	.005	Reject the null hypothesis.

Asymptotic significances are displayed. The significance level is .05.

The Independent Samples Kruskal-Wallis Test indicates that physical violence and emotional violence at the community level are equally high among all the areas of Kasarani. However, sexual and economic violence although high in most areas of Kasarani, they tend to be more pronounced in Korogocho and Roysambu areas as demonstrated in tables 3-6.

Table 7: Chi square Tests for distribution of Sexual Violence in Kasarani

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	20.210[a]	4	.000
Likelihood Ratio	19.180	4	.001
Linear-by-Linear Association	4.003	1	.045
N of Valid Cases	210		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 8.21.

Table 8: Kasarani area * Sexual violence at the community level Cross-tabulation

Prevalence of Sexual Violence			Sexual violence at the community level			Total
			Yes	No	Not Sure	
Kasarani area	Githurai	Count	16	36	17	69
		% within Kasarani area	23.2%	52.2%	24.6%	100.0%
	Korogocho	Count	30	38	3	71
		% within Kasarani area	42.3%	53.5%	4.2%	100.0%
	Roysambu	Count	19	46	5	70
		% within Kasarani area	27.1%	65.7%	7.1%	100.0%
Total		Count	65	120	25	210
		% within Kasarani area	31.0%	57.1%	11.9%	100.0%

Sexual violence is more pronounced in Korogocho and followed by Roysambu area of Kasarani.

Table 9: Chi square Tests for distribution of GBV – Economic Violence

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.967[a]	4	.011
Likelihood Ratio	12.931	4	.012
Linear-by-Linear Association	7.082	1	.008
N of Valid Cases	210		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 8.87.

Table 10: Kasarani area * Gender Based Economic Violence

Prevalence of Gender Based Economic Violence			Economic violence at the community level			Total
			Yes	No	Not Sure	
Kasarani area	Githurai	Count	17	36	16	69
		% within Kasarani area	24.6%	52.2%	23.2%	100.0%
	Korogocho	Count	30	37	4	71
		% within Kasarani area	42.3%	52.1%	5.6%	100.0%
	Roysambu	Count	29	34	7	70
		% within Kasarani area	41.4%	48.6%	10.0%	100.0%
Total		Count	76	107	27	210
		% within Kasarani area	36.2%	51.0%	12.9%	100.0%

Gender Based Violence is highly linked to economic outcomes especially in Roysambu and Korogocho areas of the larger Kasarani area.

Table 11: Death as a Result of GBV at Family and Community Levels

Death against family member	Frequency	Percent
Yes	18	9%
No	187	89%
Not Sure	5	2%
Total	210	100%

Death at the community level	Frequency	Percent
Yes	42	20%
No	156	74%
Not Sure	12	6%
Total	210	100%

Eighteen respondents indicated that they had witnessed the death of a family member as result of GBV. At the community level, 20% of the respondents indicated that they had witnessed the death of a community member as result of GBV.

Table 12: One Sample T-test on Causes of GBV in Kasarani

One-Sample Test	Test Value = 4					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Causes of GBV in Kasarani	5.375	209	.000	.27222	.1724	.3721

On a scale of 1 (Strongly Disagree) to 5 (Strongly Agree), the respondents were asked to score each of the GBV causes in table 12. The overall rating was statistically above 4 (p=0.000, MD= +0.27).

Table 13: Best Practices for ameliorating GBV

Best Practices for ameliorating GBV	Mean	Std. Deviation	CfVar
There is need to have a centre in this community or near this community where treatment, counseling, legal and forensic services are available at the same place	4.6	0.65	0.141
If Alcohol and drug abuse are tackled in this community then GBV incidence will decrease	4.5	0.76	0.171
If crime and conflict are tackled in this community then GBV incidence will decrease	4.4	0.77	0.173
If people are well sensitized, then GBV incidence will decrease in this community	4.4	0.84	0.191
If poverty is tackled in this community then GBV incidence will decrease	4.3	0.94	0.217

On a scale of 1 (Strongly Disagree) to 5 (Strongly Agree), the respondents were asked to score each of the GBV best practices in table 13. The community in Kasarani strongly feels that if a centre is put up in Kasarani or its environs where treatment, counseling, legal and forensic services are available at the for GBV survivors at the same place (CfVar = 0.141, Mean=4.6), then the survivors will access quality care in a timely manner. The other critical factor that needs to be addressed by a GBV intervention is to tackle other underlying causes of GBV like rampant alcohol and drug abuse, crime, poverty as well as community sensitization.

Table 14: One Sample T-test for GBV Best Practices

One-Sample Test						
	Test Value = 4					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
GBV_Best Practices	11.290	209	.000	.44667	.3687	.5247

On a scale of 1 (Strongly Disagree) to 5 (Strongly Agree), the respondents were asked to score each of the GBV best practices in table 14. The overall rating was statistically above 4 (p=0.000, MD = +0.45).

Table 15: Availability of Service for GBV Survivors

Availability of Service	Mean	Std. Deviation	CfVar
Pregnancy testing and emergency contraception (EC) IS NOT readily available in this community for GBV survivors	3.69	1.03	0.28
HIV diagnostic testing and counseling (DTC) and Post Exposure Prophylaxis (PEP) IS NOT readily available in this community for GBV survivors	3.85	1.10	0.29
Prophylaxis of sexually transmitted infections (STIs) IS NOT readily available in this community for GBV survivors	3.64	1.10	0.30
Treatment of injuries and clinical evaluation IS NOT readily available in this community for GBV survivors	3.46	1.17	0.34
Trauma counseling IS NOT readily available in this community for GBV survivors	3.48	1.23	0.35
Forensic examination by the police IS NOT readily available in this community for GBV survivors	3.36	1.31	0.39

Table 15 ranks the scarcity of care for GBV survivors in Kasarani beginning with the most scarce service being pregnancy testing and emergency contraception (CFVar = 0.28).

Table 16: Availability of Service for GBV Survivors

Affordability of Care	Mean	Std. Deviation	CfVar
Treatment of injuries and clinical evaluation - There are GBV survivors in this community who need this service but cannot afford it	3.72	1.11	0.30
Prophylaxis of sexually transmitted infections (STIs) - There are GBV survivors in this community who need this service but cannot afford it	3.47	1.15	0.33
Pregnancy testing and emergency contraception (EC) - There are GBV survivors in this community who need this service but cannot afford it	3.49	1.18	0.34
Forensic examination by the police - There are GBV survivors in this community who need this service but cannot afford it	3.40	1.23	0.36
Trauma counseling - There are GBV survivors in this community who need this service but cannot afford it	3.36	1.28	0.38
HIV diagnostic testing and counseling (DTC) and Post Exposure Prophylaxis (PEP) - There are GBV survivors in this community who need this service but cannot afford it	3.24	1.37	0.42

Table 16 ranks the cost of the different types of care for the GBV survivors. The respondents indicated that treatment of injuries and clinical evaluation is the most expensive service (CfVar = 0.30)

followed by Prophylaxis of sexually transmitted infections (STIs) (CfVar = 0.33).

Table 17: One-Sample Test about the available quality of service for GBV survivors

	Test Value = 4					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Forensic examination by the police - This service offered in our community is of HIGH QUALITY	-15.655	209	.000	-1.243	-1.40	-1.09
Trauma counseling - This service offered in our community is of HIGH QUALITY	-11.674	209	.000	-.995	-1.16	-.83
HIV diagnostic testing and counseling (DTC) and Post Exposure Prophylaxis (PEP) - This service offered in our community is of HIGH QUALITY	-10.529	209	.000	-.905	-1.07	-.74
Prophylaxis of sexually transmitted infections (STIs) - This service offered in our community is of HIGH QUALITY	-10.804	209	.000	-.871	-1.03	-.71

Treatment of injuries and clinical evaluation - This service offered in our community is of HIGH QUALITY	-8.959	209	.000	-.748	-.91	-.58
Pregnancy testing and emergency contraception (EC) - This service offered in our community is of HIGH QUALITY	-8.837	209	.000	-.743	-.91	-.58

Table 17 ranks the rating of the current services for GBV survivors beginning with the poorest service being Forensic examination by the police (p=0.000, MD = -1.243). The second poorest quality of service is Trauma Counseling (p=0.000, MD = -0.995). Overall the quality of service available is very poor (p=0.000, MD <0 for all the variables).

Cases Reported to the Police

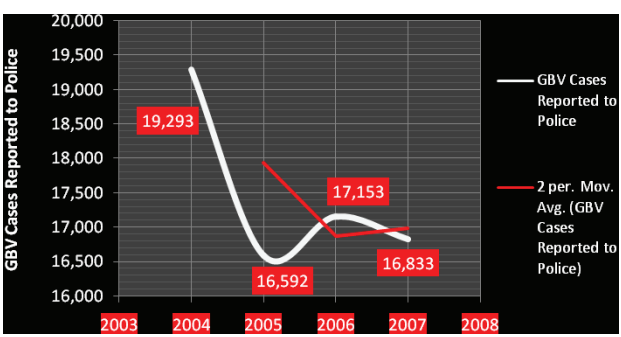


Figure 4: Cases Reported to the Police

There are less people reporting GBV instances to the Police. Figure 4 indicates that there has been a steady decrease in the number of GBV cases reported to the police according to the Kenya Police Department (Economic Survey 2008). A two period moving average indicates that there will be minimal change in reporting unless an appropriate intervention occurs. This is a pertinent consideration for KWCWC. GBV survivors are dissatisfied with the waiting time at Gender desks at police stations in a study by the institute of economic affairs in 2008.

GBV Prevalence Rates

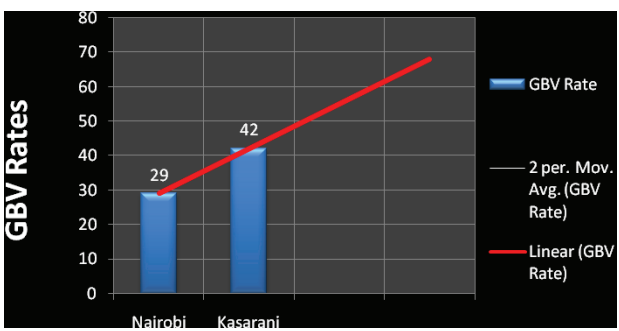


Figure 5: GBV Prevalence Rates

A macro level analysis by DHS of GBV prevalence among women in Nairobi indicated that there are about 29% of women GBV survivors. A micro level analysis by the Nairobi Wellness Centre indicates that there are 42% of such women in Kasarani. This implies a higher presence of GBV survivors in Kasarani Area of Nairobi at the micro

level. The prevalence of GBV in Kasarani likely to grow exponentially if there is no intervention as the Linear Forecast Trend-line indicates.

CHAPTER FIVE

5.0 DISCUSSIONS AND RECOMMENDATIONS

5.1 Risk Factors for GBV

This study established that the causes of GBV in Kasarani include the following ranked in order of importance; Alcohol and drug abuse (CfVar = 0.16); Presence of crime and conflict (CfVar = 0.22); Poverty (CfVar = 0.23); Weak community sanctions against perpetrators of GBV (CfVar = 0.25); Social norms that tolerate or justify violence against gender orientation(CfVar = 0.26); and Traditional gender norms that support gender superiority and entitlement (CfVar = 0.31). These findings corroborate the postulation in the literature that vouches for a comprehensive approach in mitigating GBV (Krug et al., 2002; Kishor & Johnson, 2004; Population Council, 2008). The findings in the literature correlate community and societal-level risk factors with GBV. The risk factors identified include: traditional gender norms that support male superiority; social norms that tolerate or justify violence against women; weak community sanctions against perpetrators; poverty; and prevalence of crime and conflict in the society. This correlation corroborates the results of this study above. These factors create an environment that predisposes men to commit rape.

The findings of this study above also corroborate what is in the literature. A review of the literature indicated that the violation of women is normalized in pre-conflict situations. This means that GBV occurs during conflict situations as well as situations where legal systems and institutions have failed. The argument set forth in the

literature is that communities justify various forms of GBV (ACORD, 2010).

The findings in this study indicate that GBV is more prevalent in the informal settlements. It is almost twice as much in the informal settlement as compared with other low-income settings in non slum areas (42.3% in the slum setting as compared with 23.2% and 27.1% in the low income non slum setting). The chi- test results (p=0.000) indicate a statistically significant relation between the type of setting and the occurrence of GBV. These findings compare with the postulations in the literature that correlate the collapse of the rule of law in conflict situations to increased sexual crimes on a massive scale. It is also evident in the literature that in conflict situations, the protector turns into the perpetrator. Perpetrators and perpetuators of sexual crimes in conflict and post-conflict settings include: rebel groups; family and community members; and the interveners. This is due to the fact that government mechanisms experience a stall and social services, law and order frameworks, institutions and systems have become inefficient (ACORD, 2010). Literature compares this state of anarchy to the typical life in the informal settlements by Okombo and Sana (2010).

Policy Recommendation

This study therefore recommends that a successful GBV intervention should be cognizant of the underlying causes of GBV namely: Alcohol and drug abuse; Presence of crime and conflict; Poverty; Weak community sanctions against perpetrators of GBV; Social norms that tolerate or justify violence against gender orientation; and Traditional

gender norms that support gender superiority and entitlement. In this regard, such an intervention should create linkages with governmental, non-governmental and civic entities that can address the underlying causes of GBV. Additionally, the GBV intervention should be responsive to the type of setting where the GBV survivors reside. There should be more vigorous interventions in the informal settlements that will have a higher GBV prevalence rate.

5.2Age and Gender of GBV Survivors

A review of literature on GBV by the Population Council (2008) indicates that the focus in both research and programmatic interventions is on violence on women. Conversely, research indicates that most of GBV survivors are children of both sexes. It is evident that program managers and policy makers model interventions that are primarily cognizant of adult women as the GBV survivors. This postulation in the literature is corroborated by this study's analysis of about 100 health facilities in Nairobi which shows that that there are a large number of children of both sexes aged below 15 years who have suffered GBV.

Research reveals that male GBV survivors are very disadvantaged. This is due to the fact that sexual abuse of male adults and children is under-reported leading to limited programmatic intervention (Krug *et al* 2002; WHO, 2003; Population Council, 2008).This should be an area of concern for KWCWC that need to be cognizant of this dimension while designing GBV interventions. Additionally, Population Council (2008) shows that programmatic interventions targeting male abuse survivors are extremely limited. This is a critical concern since the population pyramid in this study show that GBV is not unique to

women. In this regard, there is need for GBV interventions to target both male and women of different age categories.

A review of the literature indicated that sexual abuse of male adults and children is endemic but vastly under-reported and poorly understood (Population Council, 2008). Niang et al. (2002) and Barker and Ricardo (2005) in Population Council (2008) argue that in Kenya, nearly 40 percent of men who had sex with men reported having been raped outside their home and 13 percent report having been assaulted by the police. This is a big concern since the police have been identified as key stakeholders in the GBV intervention discourse by the findings in this study. This reinforces the need to build the capacity of all stakeholders including the police to meaningfully participate in the GBV intervention.

Policy Recommendation

KWCWC should design interventions that are applicable to all age categories as well as both male and female GBV survivors. Additionally, there is need to build the capacity of all the stakeholders so that they can coherently be integrated in the GBV intervention framework.

5.3 Levels of Awareness

Literature indicates that people with low income and low literacy levels have low bargaining power in terms of accessing or purchasing quality health care. A review of the literature also indicates that low literacy levels inhibit understanding on health education and timely access to health and medical services in cases of ill health or abuse. Researchers therefore suggest that information on psychosocial and

legal services is critical for judicious access to the services (Erik, 2006). The finding of this study indicate that there is a higher level of GBV prevalence and a corresponding low awareness of GBV services as the income and level of education of GBV survivors diminish. The study findings revealed that sexual violence is more pronounced in Korogocho followed by Roysambu area of Kasarani. This finding corroborates the literature since Korogocho has the lowest level of literacy as well as the lowest level of income as compared to Roysambu and Kasarani.

Policy Recommendation

A robust GBV intervention model should focus on enhancing people's awareness on GBV and educating them on entrepreneurship to increase their participation in economic production, which will consequently enhance the participation on decision-making. This will mitigate their vulnerability to Gender Based Violence.

5.4 The Guiding Principles and Strategies for GBV Intervention

A review of literature by USAID (2009) identified five fundamental guiding principles for GBV intervention. First, there needs to be respect for survivors' safety, rights and confidentiality. Second, there is need for multi-sectoral interventions for enhanced effectiveness. Third, a good intervention should encourage coordination and partnership at all levels. Fourth, the intervention should include development and human rights perspectives. Fifth, a good intervention needs to include monitoring and evaluation as an essential component of GBV programs. Sixth, an effective intervention ought to work with men, especially youth, and communities at large,

to change attitudes and behaviors. Additionally, USAID outlined five strategies for designing GBV interventions namely: Peace and Security; Governance; Investing in People; Economic Growth and Humanitarian Assistance.

The findings of this study resonate well with what is stipulated in the literature. This study established that a good GBV intervention should be holistic and include: a centre in the community or near the community where treatment, counseling, legal and forensic services are available; a program to tackle alcohol and drug abuse; tackle crime and conflict in the community; sensitize people on the GBV incidence; and tackle poverty in the community.

5.5 Profile the state of Medical, Psychosocial, and Legal aspects of GBV in Kasarani

A review of the literature indicates that comprehensive and integrative post-rape care aims to reduce the physical and psychological consequences of sexual violence. An integrated care package should include: treatment of injuries and clinical evaluation; pregnancy testing and emergency contraception (EC); prophylaxis of sexually transmitted infections (STIs); HIV diagnostic testing and counseling (DTC) and Post Exposure Prophylaxis (PEP); forensic examination; and trauma counseling (Population Council, 2008).

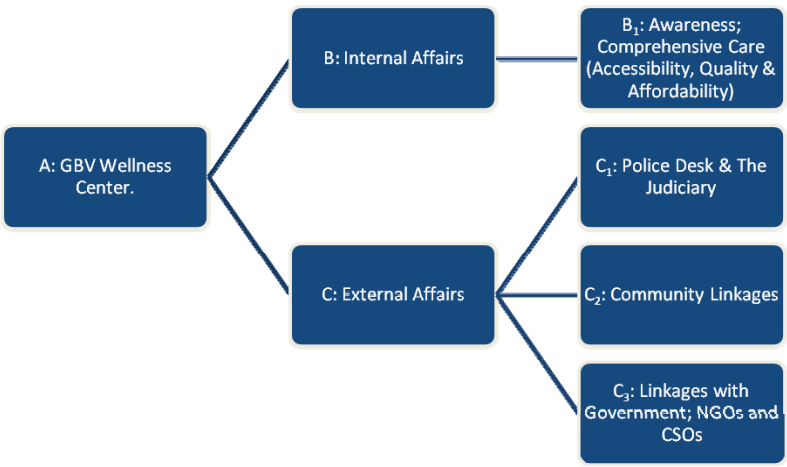
Literature also indicates that emotional consequences of GBV are often longer lasting and more difficult to diagnose and deal with than physical symptoms. They include behavior changes and personality changes that are manifested physically. Counseling has been identified as key in speeding the recovery process. The need for

counseling is not necessarily limited to the survivor it also reflects on the family and/or partners also undergo trauma and may require support (Population Council, 2008). These observations in literature corroborate the findings in this study where the respondents vouched for a comprehensive and integrative GBV intervention.

5.6 Determine the best model of managing GBV in Kasarani

The Population Council (2008) observes that many sub-Saharan African countries lack systematic and reliable data on GBV. The council therefore argues that there is need for systematic data collection on the prevalence and forms of SGBV. The reason for this postulation is that program design is hampered by the absence of evaluation of the impact of former preventative or responsive interventions. The results of this study will be pertinent in defining the GBV intervention programs that are evidence based. Based on the findings of this study, the following intervention framework was identified.

5.7 Framework for Implementing the GBV Interventions



A	The results of this study strongly indicate that there is need to set up a comprehensive Centre that addresses all the components of GBV.
B	The internal division of KWCWC should focus on three key pertinent issues namely enhancing accessibility, quality and affordability of comprehensive care for GBV survivors
C	The external division of KWCWC should liaise with external entities so that it sets up a one stop comprehensive model. There should a police desk where the GBV survivors can access all the required police services like P3 forms. Additionally, there should a justice desk where the GBV survivors can access legal services.

These findings corroborate the finding by the Population Council (2008) to adhere to comprehensive framework for addressing the GBV phenomenon.

Policy Recommendation

Based on the results of this study, it is recommended that the efficacy of a GBV intervention in Kasarani will be a function of its comprehensive dimension. KWCWC should address all the medical, socio-psychological and legal implications of GBV

5.8 Approaches to Managing Child Survivors of Sexual Violence

A review of literature by Population Council (2008) indicates that children are especially vulnerable to sexual violence by nature of their relatively weak social position, economic dependence and lack of political protection. Additionally, there are practices that predispose children to rape. These include: myths that sex with young virgins can cleanse the perpetrator of the HIV; forced sexual initiation, particularly among girls. Ironically, the perpetrators of child sexual abuse across sub-Saharan Africa are frequently either known to the family, or a family member. This calls for the need to adequately meet the medical, psychological and legal needs of children. The evaluation of children requires special skills and techniques in history taking, forensic interviewing and examination.

The population pyramid in this study indicates that there are a number of children adversely affected by GBV. An effective intervention GBV framework needs to have a platform that adequately deals with the GBV survivors who tend to be children.

Policy Recommendation

The involvement of the police, teachers and other education professionals with children calls for the need to sensitize them on handling children GBV survivors within a GBV intervention strategy.

5.9 The Hybrid Model of Managing GBV

The findings of this study vouch for a need to integrate the multi-sectoral GBV model and the multi-level GBV model. The assumptions of multi-sectoral GBV model are that no single sector or agency can adequately address GBV prevention and response. The multi-sectoral model calls for holistic inter-organizational and inter-agency efforts across key including but not limited to health, psychosocial, legal/justice and security sectors (GBV-AoR,2010). The limitations of the multi-sectoral model are that it specifies many of the sectoral responsibilities in terms of response but gives limited attention to prevention. A supplemental model to the multi-sectoral model is the multi-level model. Effective GBV prevention necessitates that interventions must take place across all the key sectors and at three levels to institutionalize structural, systemic and individual protections. The three levels include:

a) Primary prevention/structural reform (preventative measures that ensure rights are recognized and protected through international, statutory and traditional laws and policies.
b) Secondary prevention/systems reform (systems and strategies to monitor and respond when rights are breached).

c) Tertiary prevention/operational response (response at the individual level through direct services to meet the needs of women and girls who have been subjected to GBV).

Policy Recommendation

A robust GBV intervention model should be a hybrid of the multisectoral model and multi-level model where all sectors are envisaged in the intervention within a systematized multi-level approach.

5.10 Standard Operating Procedures

Standard Operating Procedures (SOPs) are specific procedures that reflect a plan of action and identify individual organizations' roles and responsibilities with regard to GBV prevention and response. SOPs include agreed-upon reporting and referral systems, mechanisms for obtaining survivor consent and permission for information-sharing, incident documentation and data analysis, coordination, and monitoring. They should also tackle ethical and safety considerations and guiding principles for issues related to GBV intervention. The development of SOPs should involve consultations with key stakeholders and actors in the setting. Inclusiveness, participation and transparency are very pertinent considerations (GBV-AoR, 2010).

Policy Recommendation

KWCWC need to clearly articulate the implementation of the GBV intervention by formulating SOPs in consultation with the various stakeholders and actors that are involved in the GBV intervention.

KWCWC should be cognizant of the fact that the SOP is not a policy document but documented guidelines meant to provide operational guidance based on a multi-sectoral approach to GBV. The multi-sectoral involvement requires the endorsement of the SOPs by multiple GBV actors and agencies

5.11 Building the Capacity of GBV Partners

Research indicates that every GBV intervention strategy involves partners with different levels of capacity related to GBV programming and GBV coordination. There is need to build the capacity of partners to improve their skills. Capacity building should be a collaborative process in which the expertise of all members is shared amongst coordination partners to develop a strong and effective coordination mechanism (Population Council, 2008; GBV-AoR, 2010).

Policy Recommendation

It is evident from the literature that training is one of the key methods for building capacity of partners as it requires a relatively small investment of technical and financial resources. In this regard, it is pertinent for KWCWC to identify possible potential training areas based on the existing needs. For sustainability of such training, it is essential to conduct trainings-of-trainers (TOTs) for posterity.

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Appendices

Appendix 1 Questionnaire

Consent

I. Hello, my name is [……]. I am collecting this information on behalf of the KWCWC. We are conducting a survey in Kasarani Constituency to learn about Gender Based Violence (GBV) and how it can be addressed. You have been chosen to participate in the study. I want to assure you that all of your answers will strictly confidential. I will not keep a record of your name or address. You have the right to stop the interview at any time, or to skip any questions that you don't want to answer. There is no right or wrong answer. Your participation is completely voluntary. The information that we collect will be used to inform the government and other service providers on the best policy practices.

II. Do you have any questions*? (If yes, address the issues. In case the person needs care, ask them to visit the GVRC at the Nairobi Women's Hospital)*.

III. The interview will take about 10 minutes to complete.

IV. Do you agree to be interviewed? Yes = [1]; No = [2]; *(If no terminate interview)*

Research Instrument

Area of Interview:	Githurai	1	Korogocho	2	Roysambu	3

Section A – Background Information. (Please circle the applicable option in the cells provided)

Q_A.1 Gender:	Male	1	Female	2

Q_A.2 Age:	Below 18 years	1	18-25 years	2	26-35 years	3	36-45 years	4	46 years and above	5

Q_A.3 Highest level of education attained:	None	1	Primary	2	Secondary	3	College	4	University	5

Q_A.4 Marital Status:	Child	1	Single	2	Married	3	Separated	4	Divorced	5	Widowed	6

Q_A.5 What do you do for a living?:	Child	1	Student	2	Not employed	3	Employed	4	Self employed	5

Q_A.6 What is your Monthly Income?:	Below Kshs. 5,000	1	Between Kshs. 5,001-10,000	2	Between Kshs. 10,001-30,000	3	Between Kshs. 30,001-50,000	4	Over Kshs. 50,000	5	No income	6

Section B. (Circle the appropriate code: (Yes = {1}; No = {2}; Not Sure = {3})*State whether any of the following has happened to you, a member of your household or family or a member in your neighborhood on the basis of their gender*

Action	a. Has it ever happened to you?	b. Has it ever happened to a member of your household or family?	c. Has it ever happened to a member in your neighborhood?
1. Physical violence (slapping, kicking, hitting, or use of weapons)	1 3	1 2 3	1 2 3
2.Emotional violence (systematic humiliation, controlling behavior, degrading treatment, threats)	1 3	1 2 3	1 2 3
3.Sexual violence (coerced sex, forced into sexual activities considered degrading or humiliating)	1 3	1 2 3	1 2 3
4.Economic violence (restricting access to financial or other resources with the purpose of controlling a person).	1 3	1 2 3	1 2 3

Section C. (Circle the appropriate code: (Yes = {1}; No = {2}; Not Sure = {3})*State whether any of the following has happened to you, a member of your household or family or a member in your neighborhood as a result of Gender Based Violence:*

Action	a. Has it ever happened to you?	b. Has it ever happened to a member of your household or family?	c. Has it ever happened to a member in your neighborhood?
1. Physical injuries and chronic conditions	1 3	1 2 3	1 2 3
2.Sexual and reproductive complications (Sexually Transmitted Illnesses; pregnancy complications etc)	1 3	1 2 3	1 2 3
3.Psychological and behavioral complications (Depression, Drug Abuse, Low self esteem etc)	1 3	1 2 3	1 2 3
4.Death		1 2 3	1 2 3

Section D : *State whether you :strongly agree, agree, not sure, disagree or strongly disagree with the following statements by circling the appropriate*	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree

value:						
1.	Traditional gender norms that support gender superiority and entitlement lead to GBV in our community	5	4	3	2	1
2	Social norms that tolerate or justify violence against some gender orientation lead to GBV in our community	5	4	3	2	1
3	Weak community sanctions against perpetrators of GBV lead to its increase in our community	5	4	3	2	1
4	Poverty in our community leads to increased cases of GBV	5	4	3	2	1
5	Presence of crime and conflict in our community lead to increased cases of GBV	5	4	3	2	1
6	Alcohol and drug abuse in our community lead to increased cases of GBV	5	4	3	2	1

Section E : *State whether you :strongly agree, agree, not sure, disagree or strongly disagree with the following statements by circling the appropriate value:*		Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
1	There is need to have a centre in this community or near this community where treatment, counseling, legal and forensic services are available at the same place	5	4	3	2	1
2	If people are well sensitized, then GBV incidence will decrease in this community	5	4	3	2	1
3	If poverty is tackled in this community then GBV incidence will decrease	5	4	3	2	1
4	If crime and conflict are tackled in this community then GBV incidence will decrease	5	4	3	2	1

5	If Alcohol and drug abuse are tackled in this community then GBV incidence will decrease	5	4	3	2	1

Section F:*State whether you :strongly agree =5, agree =4, not sure=3, disagree=2 or strongly disagree=1 with the following statements by circling the appropriate value regarding services available for GBV survivors:*

Services		a). This service **IS NOT** readily available in this community for GBV survivors	b). There are GBV survivors in this community who need this service but cannot afford it.	c). This service offered in our community is of **HIGH QUALITY**
1.	Treatment of injuries and clinical evaluation	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
2	Pregnancy testing and emergency contraception (EC)	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
3	Prophylaxis of sexually transmitted infections (STIs)	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
4	HIV diagnostic testing and counseling (DTC) and Post Exposure Prophylaxis (PEP)	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
5	Forensic examination by the police	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
6	Trauma counseling.	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1