Baseline Survey Report on Gender Based Violence in Kasarani, Nairobi

Presented to

Kenya Women and Children's

Wellness Centre

By John K. Otsola

Kenya Women & Children's wellness centre
Your health. Our commitment!

USAID
FROM THE AMERICAN PEOPLE

Published by Kenya Women and Children's Wellness Centre,
P. O. Box 16681 - 00620,
Nairobi, Kenya.
info@kwcwc.org

Disclaimer

This study is made possible by the support of the American people through the United States Agency for International Development (USAID). The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of USAID or KWCWC.

Table of Contents

List of Tables

List of Figures

Acknowledgement

This report presents the findings of the Gender Based Violence Baseline survey in Kasarani District. We are grateful to USAID 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 the KWCWC community outreach staff for participating in data collection.

Ms Sunita Naithoo,

Managing Director,

Kenya Women and Children's Wellness Centre

Forward

It is with great pleasure that we publish this report, which maps out the state of GBV in Kasarani. The study was made possible with the assistance from the American people with an aim to reduce GBV in Kasarani and surrounding areas with an ultimate goal of reducing HIV/AIDS infections and political violence. The program is able to reach the teachers and schools; community and faith based organizations; youth and health workers; provincial administrative leaders and paralegals. The implementation activities are geared towards behavior change in order to entrench a culture that respects the sanctity and dignity of human beings irrespective of gender.

This report is very useful to Kenya Women & Children's Wellness Centre and other gender based organizations/institutions that need to understand the state of GBV in Kasarani and the existing the social capital as well as multi-sectoral resources that can inform a GBV intervention.

In this regard, the baseline study should be seen as a precursor for the development of a comprehensive GBV intervention strategy in Kasarani for the multi-sectoral stakeholders. The findings and recommendations for the baseline study are recorded and discussed in this report.

Ms Sunita Naithoo,

Managing Director,

Kenya Women and Children's Wellness Centre

Abstract

The objective of this baseline study was to provide reliable quantitative and qualitative information that would enable KWCWC and her partners to develop strategies and interventions aimed at fighting against Gender-Based Violence in Kasarani.

At the global level, research by WHO has strongly indicated that Gender-Based Violence is perpetrated by husbands or male partners (WHO 2002). This finding resonates with what the results in this study found that in Kasarani 47,551 women aged 15–49 are likely to have experienced physical violence since age 15 while 39,352 women aged 15–49 are likely to have experienced physical or sexual violence committed by a husband/partner. This baseline survey seeks not only to measure the frequency of incidents of Sexual Gender-Based Violence experienced by women in Kasarani but also to analyze the perceptions that the community has about the nature, causes and consequences of these incidents of violence.

It is against this background that a baseline survey that was undertaken to measure the magnitude of the phenomenon of Sexual Gender-Based Violence and to determine its underlying causes and consequences. The study was carried out in the Githurai, Kahawa, Kariobangi, Kasarani, Korogocho, Roysambu, and Ruaraka areas of the larger Kasarani administrative unit. Factual data was collected using GIS technology, interviews as well as analysis and extrapolation of Census Data and Kenya Health and Demographic survey data.

This baseline study documented the resources available in Kasarani that can be utilized in GBV interventions. This study enumerates the causes of GBV in Kasarani as well as the GBV risk factors. The findings in this study indicate that GBV is more prevalent among low income earners. In this regard, this study recommends a GBV intervention strategy that takes into consideration the underlying causes of GBV. The strength of such an intervention should be constructed on linkages and synergies with governmental, non-governmental and community stakeholders. As it is evident from

the findings of this study, a sustainable GBV intervention should espouse sectorial synergies.

KWCWC should make efforts to coordinate its activities with the various sectors and stakeholders at different levels. This is necessary in avoiding a situation where different institutions are pulling the ship in different directions, resulting in a minimum progress. Different partners should strengthen each other and enhance progress. Coordination enhances synergies between interventions and increases the efficiency of the operations.

Acronyms

AP	Administration Police
CBO	Community Based Organization
CSW	Commercial Sex Workers
DC	District Commissioner
DHS	Demographic and Health Survey
DO	District Officers
DTC	Diagnostic Testing and Counseling
EC	Emergency Contraception
ECSA	East, Central and Southern Africa
GBV	Gender Based Violence
HIV/AIDS	Human Immunodeficiency Virus Infection / Acquired Immunodeficiency Syndrome
KDHS	Kenya Demographic and Health Survey
KNBS	Kenya National Bureau of Statistics
KWCWC	Kenya Women and Children's Wellness Centre
MDG	Millennium Development Goal
MSF	Médecins Sans Frontières
NGO	Non-Governmental Organization
PEP	Post Exposure Prophylaxis
PWD	Person with Disability

SGBV	Sexual and other forms of Gender-Based Violence
SPSS	Statistical Package for the Social Sciences
STIs	Sexually Transmitted Infections
UN	United Nations
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
WHO	World Health Organization

1.0 Introduction

1.1 Background

At the global level, studies have shown that Gender-Based Violence is mostly perpetrated by men. Literature reviewed by Population Council (2008), indicate that between 12% and 25% of women are coerced to have sexual intercourse with men. Despite the fact that in 1979 at the UN Convention on the Elimination of all Forms of Discrimination against Women there was an overwhelming vote against Gender Based Violence, the incidences are still being reported. The convention made references to the inalienable rights of women. The state of affairs can be explained in various ways. It can be assumed that women do not know their rights and sometimes placed in situations where they are unable to institute legal proceedings. Compared to men, women have a more limited access to the economic resources that would enable them to demand justice in cases of sexual violence. Moreover, institutions such as legal services, health, and the police do not provide the appropriate atmosphere for women to report any form of sexual abuse by their male partners. It is against this backdrop that a baseline survey that is both quantitative and qualitative has been undertaken to measure the extent in which the program objectives have been achieved. The study was carried out in Kasarani. Nearly 100 percent of the individual respondents within the institutions where the project runs responded to the household questionnaire. Focus Group Discussions and interviews were also conducted out.

Addressing the scourge of gender based violence requires capacity building in terms of prevention and eradication in all the sections of the justice system, medical and health system, and the society. Critical institutions such as the police and legal systems have to be stressed because they are involved in one way or another with victims of gender based violence. There is also the need to carry out more research projects at the national level in order to verify the validity of the causes/factors of gender-based

violence in Kenya, to establish relationships that link these factors in order to arrive at a more definitive diagnosis and provide explanations.

1.2 Project overview

KWCWC is a healthcare facility whose programming shares a common intent to serve the health and wellness of the community. Currently, the organization is implementing a community outreach program that focuses on GBV prevention within the geographical settings of Kasarani District. The outreach project focuses on sensitization, awareness creation and training the community on Gender Based Violence prevention, response and referrals. The focus is on schools, religious groups, community based organizations, and faith based organizations, through the healthcare providers in health facilities and the administrative leaders.

The primary goal of the project is to improve the wellness of Kasarani community through the reduction of Gender Based Violence. Its main objectives include:

- Educating the community, healthcare providers and the police about appropriate responses to incidences of gender based violence and prevention methods.
- Reduce prevalence and incidences of GBV in the program area
- Increase in the number of health care workers that are trained to identify, care and refer victims of GBV.

1.3 Problem Statement

In Kenya, negatively GBV impacts on different sectors and stakeholders – political, international organizations, the civil society as well as the community as a whole. The consequences of this phenomenon include HIV/AIDS and STIs, unwanted pregnancies, physical and psychological trauma). This notwithstanding, its causes remain ill defined.

Many studies carried out on the SGBV emphasize the description and condemnation of the violence and the aspect of the violation of the human rights of women. There is need to identify and analyze the socio-cultural causes and motivations leading to GBV. This calls for the need for KWCWC to map out the existing structures through a baseline data that extrapolates on available retrospectively as well as demonstrate the gaps that KWCWC seeks to fill.

This baseline study on GBV would make it possible to: provide an overall understanding of the problem; facilitate the preparation of appropriate strategies for combating GBV; and provide a database for SGBV Intervention.

1.4 Objectives of the Survey

The study is intended to obtain reliable and relevant data on the prevalence and forms of gender based violence in Kasarani. Information obtained from the study will be used to inform programmatic interventions on GBV in Kasarani.

The specific objectives of the baseline study were:

a) To gather baseline information on attitudes and beliefs about gender based violence;

b) To identify the extent of different types of violence which are occurring or have occurred within Kasarani;

c) To identify the health needs which arise as a result of these forms of violence;

d) To identify groups which are especially vulnerable;

e) To identify the individual and community strengths and resources that exist to prevent and to respond to violence; and

f) To identify intervention strategies for prevention and treatment based on these community strengths and resources.

1.5 Rationale of the Baseline Survey

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. These are pertinent observations at the macro level. At the micro grassroots level, there is hardly concrete information about GBV despite its acrimonious implications. Grassroots evidence is critical in defining macro level interventions as well for evidence based planning. This is why KWCWC needs to map out the GBV situation in Kasarani and the existing critical resources that can be harnessed in effective GBV intervention.

In Kenya, sexual violence poses a myriad of problems that many wonder about its magnitude. GBV is a critical concern to political leaders, international organizations, the civil society as well as the community as a whole. The consequences of GBV include HIV/AIDS and STDs, unwanted pregnancies, physical and psychological trauma. This baseline study on SGBV would make it possible to: provide an overall understanding of the problem and facilitate the preparation of appropriate policies and strategies of dealing with it.

1.6 Definition of Key Terms

1.6.1 Gender-Based Violence (GBV)

GBV includes a variety of acts of violence committed against females because they are females and against males because they are males. It includes sexual violence, intimate partner or spouse abuse (domestic violence), emotional and psychological abuse, sex trafficking, forced prostitution, sexual exploitation, sexual harassment, harmful traditional practices and discriminatory practices based on gender. Research indicates that most GBV cases involve a female survivor and a male perpetrator. Research further indicates that the majority of acts of GBV against boys and men are also committed by male perpetrators (Beth, 2002).

1.6.2 Gender

The term gender refers to the different characteristics of men and women that are socially determined. Gender is not sex. The term sex refers to the different biological characteristics between males and females. Conversely, gender refers to the different social roles men and women have in a particular society. It defines culturally acceptable attitudes, behavior, responsibilities opportunities and constraints of men and women. Research indicates that women's needs tend to be overlooked (Population Council, 2008; Beth, 2002).

1.6.3 Power

According to UNIFEM (2008); Population Council (2008); WHO (2002); and Beth (2002), GBV involves the abuse of power. Within the GBV context, unequal power relations are abused. Power inequality is exploited by using physical force. There are instances where pressure is used to obtain sexual favors.

1.6.4 Violence

Violence refers to all acts or threats that cause direct physical, mental or sexual harm or suffering. Research defines violence to also include indirect acts such as coercion and intimidation. It is pertinent to point out that whereas women, men, boys and girls can be victims of GBV, women and girls are disproportionately affected. In GBV literature, a victim of GBV is most often referred to as survivor (UNIFEM, 2008; Population Council (2008); and Beth (2002).

1.7 Scope of the Study

This study adopted a triangulation of qualitative and quantitative methods. The study population entailed GBV survivors, key stakeholders and programmers in Kasarani area of Nairobi. The main data collection was done in November 2012 and completed in early December 2012. The data analysis and report writing was done in December 2012 and finalized in January 2013.

2.0 Contextual Frameworks

2.1 International Context

The World Report on violence and health published by the WHO in 2002 indicates that the types of abuses women undergo are often perpetrated by husbands or male sexual partners. The private nature of this type of violence often makes it difficult to discern since everything happens behind closed doors. This issue is compounded by the fact that legal systems and cultural norms often deal with this violence not as an offence but as a family affair or as a normal part of life (WHO, 2002).

Research further indicates that the abuses suffered by women are almost exclusively perpetrated by men. Women are most often the victims of acts of violence committed by men they know. Women and girls are the primary victims of violence perpetrated by intimate partners. In Africa, the phenomenon of Sexual Gender-Based Violence takes on many forms including under age housemaids who are sent to the city, by their family to work for people known by their families and end up being exploited sexually. Additionally, in Africa, sexual violence is increased by wars and civil conflicts. In Africa, there is also the practice of early marriage (UNIFEM, 2008).

2.2 The Kenyan Context

There has been increasing concern about violence against GBV in both developed and developing countries. GBV has been acknowledged worldwide as a violation of the basic human rights. An increasing amount of research highlights the health burdens, generational effects, and demographic consequences of GBV. Gender-based violence occurs across all socioeconomic and cultural backgrounds. In Kenya, women are socialized to accept, tolerate, and even rationalize domestic violence and to remain silent about such experiences. GBV has a serious impact on the country's economy;

because women bear the brunt of domestic violence, they also bear the health and psychological burdens. Victims of GBV are abused inside what should be a secure environment–their own homes. To stop some of this violence, which may cause great physical harm, death, psychological abuse, separation, divorce, and a host of other social ills, the Kenya government has enacted the Sexual Offences Act No. 3 of 2006 (Rev. 2007) (KHDS, 2009).

2.3.0 The Kasarani Context

2.3.1 Socio-demographic Characteristics of Kasarani

2.3.1.1 Basic Indicators for Kasarani

Table 1: Basic Indicators for Kasarani

Indicator	Frequency
Male	266,684
Female	258,940
Total	525,624
Households	164,354
Average Household Size	3
Area in Sq. Km.	86
Density people per Sq. Km	6,082
Gender Index women: men	0.970961887
Density: households per sq km.	1901.585098
Geo-Location	(-1.21394666521, 36.9019637844)

Kasarani is densely populated with over 6,000 people and 1,900 households living within one square kilometer. Research (USAID, 2009; Population Council, 2008; Erik, 2006; Wermuth, 2003) indicates that there is a high correlation between the density in population and the likelihood for occurrence of GBV. This explains the high levels of GBV in Kasarani. This is further compounded by low levels of income and literacy in Kasarani. There is a fairly equitable gender balance in Kasarani. The gender index for women to men is 0.97.

2.3.1.2 Population Pyramid

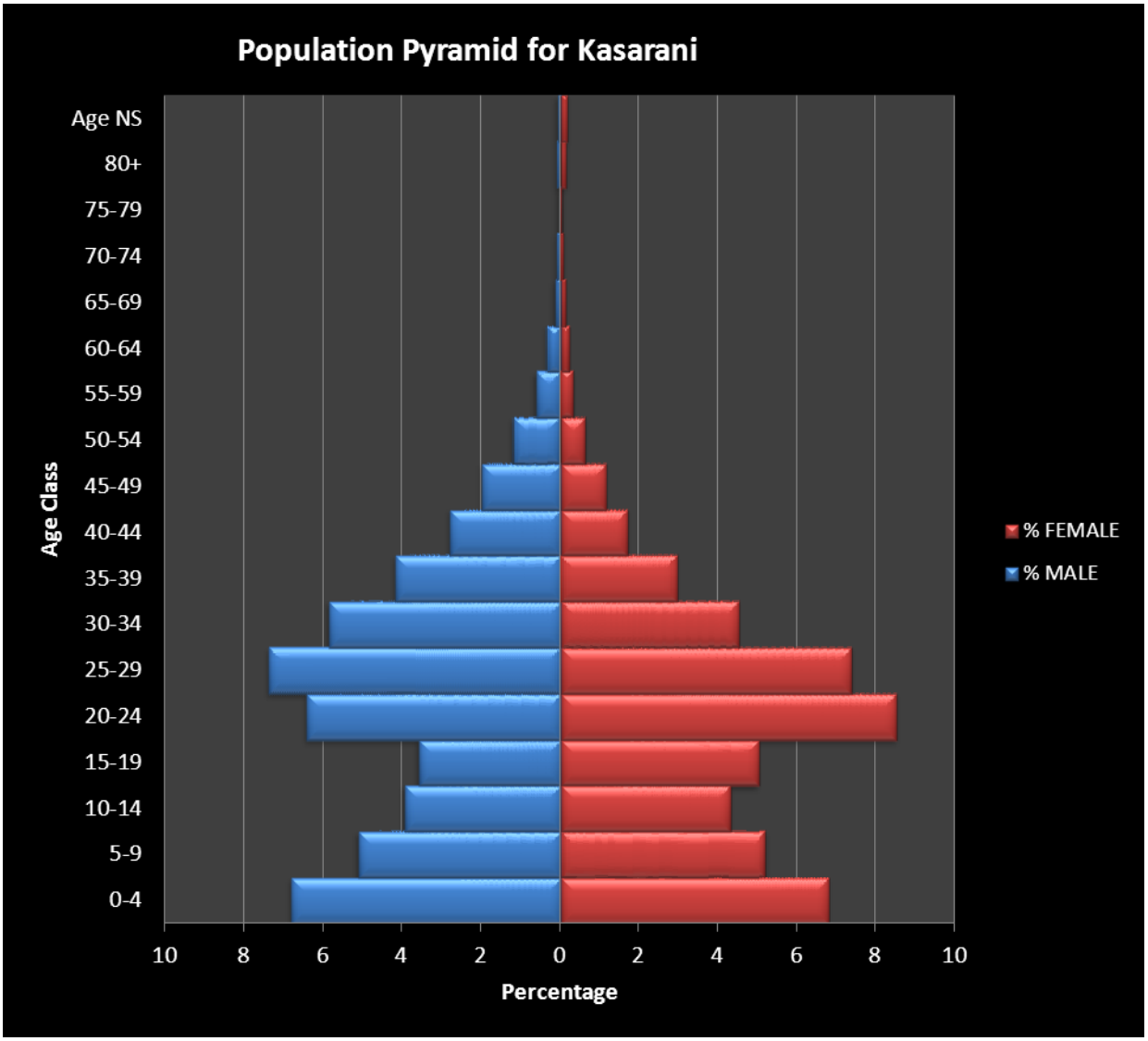


Figure 1: Population Pyramid of Kasarani

Using the Kenya Population raw census data, an analysis was done to visualize the age profiles of the people in Kasarani. This is represented in the pyramid with the male population on the left and female population on the right. Their relative ages are also presented ranging from the youngest at the bottom and the oldest at the top. Therefore from the population pyramid, it is possible to establish that the population

distribution across Kasarani is relatively equitable across the different gender orientations with 50.7% being male and 49.3% being female. This underscores the essence of designing GBV intervention programs that accommodate both male and female residents in Kasarani. As per the population pyramid, the majority of the population is aged 20 to 34 years.

Literature Review

3.0 Introduction

Gender based violence, in its various forms, cuts across national boundaries, religions, age, race, class all around the world. Girls and women who are exposed to gender based violence remain vulnerable in the society. The chances of their early sexual debut are increased significantly due to the exposure. In addition, these women and girls have increased chances of experiencing forced sex, engaging in transactional sex, and non-use of condoms.

The impact associated with sexual and gender-based violence revolves around all areas of social and health, legal and security programming. The areas include: increased rates of mortality and morbidity and exacerbated transmission of HIV among other health conditions. Studies have found that even though girls are the most visible survivors of gender based violence, they are not the only ones who experience and suffer from the consequences of GBV. Both male and female children form a significantly large part of survivor majority groups who are often researched. Nonetheless, the handicapped and adult men form the minority group which is often neglected by researchers. There is growing awareness of the links between sexual and gender-based violence, health, human rights and national development in East, Central and Southern Africa (ECSA). However, there are few programs that simultaneously address the determinants and consequences of GBV in an integrated and comprehensive manner, with responses being implemented separately by the NGO and public sectors, and by separate line ministries within national governments. 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 kasarani.

Kasarani has an array of health, legal and administrative resources that are utilized in the implementation of GBV intervention. These resources are not explicitly mapped out which undermines proper coordination and utilization of these resources. This situation is not unique to Kasarani but is a common problem facing GBV interventions in Kenya and the rest of the East and central African region (Population Council, 2008).

3.1 What is sexual and gender based violence?

The understanding of gender based violence differs with legal context, community, and country therefore there is no single definition that is acceptable universally. Prevalent definition of gender based violence does not include children. Similarly, since there is a general lack of a clear and commonly accepted language, development of databases and reporting systems is inhibited. As a result, efforts of advocacy, monitoring, and prevention are restrained region (Betron and Doggett, 2006).

However, a wide definition of the term gender based violence may refer to the physical, emotional or sexual abuse of a survivor. The sexual element of this definition is usually the primary focus of many GBV studies, but the management of the situation touches on the emotional and physical aspect. The World Health Organization, defines gender based violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work". This report adopts this definition by the World Health Organization. However, it expands the scope to include child sexual abuse, rape experienced by both sexes, and forced sex region (Population Council, 2008).

Sexual violence may also be used to represent behaviors that fall under scope of abuse, assault, and violation in relation to sex. Such activities or behaviors may include harassment and voyeurism. Gender based violence is used synonymously to sexual violence. Essentially, it is used to demonstrate the gender inequality that exist in the society and is the root cause of the violence witnessed. However, in as much as majority of the victims of gender based violence are women, in this report, the term sexual and gender based violence will be inclusive of men, children, and women region (Population Council, 2008).

3.2 Prevalence, consequences and risk factors associated with GBV

3.2.1 Prevalence

Gender-based violence and forced sex are highly prevalent in the east African region. In Kenya, 43% of 15-49 year old women reported having experienced some form of gender-based violence in their lifetime, with 29% reporting an experience in the previous year; 16% of women reported having ever been sexually abused, and for 13%, this had happened in the last year (KNBS and ICF Macro, 2010).

3.2.2 Consequences

Sexual and gender based violence is a major concern because of the consequences associated with it such as poor reproductive health. GBV studies conducted in various setting indicate that women and girls, who at one point in their lives experienced rape or sexual coercion, are more likely to develop genital tract infection problems, go through unsafe abortion, and experience unplanned pregnancy. This is primarily due to their unlikely hood of using condoms. These women have been found to lack sexual autonomy and as a result, they are under threat for violence and this increases their exposure to sexually transmitted infections. Studies have also found that sexual

violence is high in the homes among partners. If women do not have sexual autonomy and the power to negotiate for safe sex within the homes, they can easily contract genital tract infections (Betron and Doggett, 2006; Population Council, 2008).

Sexual and gender-based violence both contributes to, and is exacerbated by, the economic and socio-political discrimination experienced by women in many countries. Women's lack of economic empowerment is reflected in lack of access to and control over economic resources in the form of land, personal property, wages and credit. Power, and the lack of power, is a recurring factor in all types of violence: the powerlessness of survivors, whether women, men or children, is also manifest in their relative lack of resources and access to support institutions (Population Council, 2008).

3.2.3 Causes and Risk Factors

According to the World Health Organization, the following have been supported by evidence to be critical causes and risk factors:

- Traditional gender norms that support male superiority and entitlement
- Social norms that tolerate or justify violence against women
- Weak community sanctions against perpetrators
- Poverty
- High levels of crime and conflict in society more generally

Studies also show that the risk is higher among young women of age between 15 and 19. Gender based violence has been identified as one of the main reason why women would opt for divorce. According to a report by the World Health Organization, most divorced women normally site cases of gender based violence that lead to the divorce or separation (WHO, 2005). Previous experience of sexual abuse, drug consumption, and alcohol use also correlate with sexual violence among adulthood. The literature by

Krug et al. (2002), however holds a different opinion in regards to the relationship of education to sexual violence. The World Report on Violence and Health (Krug et al., 2002) cites two studies conducted in Zimbabwe and South African that shows a correlation between increased vulnerability to sexual violence and higher levels of female education. The authors reason that highly educated women or women who have been empowered normally resist patriarchal norms. This in turn causes men to be violent as a means to regain their dominance and control in the home (Jewkes et al., 2002). However, the study also suggests that higher level of education among women confers protection to women in certain levels. This implies that empowering women up to secondary school increases the risk of violence however it is only when women are empowered to higher levels of education that their vulnerability to gender based violence decreases. The same assertions have been confirmed by a multi country study conducted by the World health Organization.

3.3 Programmatic Flaws

Countries within the sub-Saharan region do not have reliable and systematic data on gender based violence. The systematic data on the prevalence rate and forms of gender based violence are important because the data will assist in developing meaningful strategies for addressing the scourge. Designing an effective program is usually hindered by the fact that there is evaluation of the impact of former preventative or responsive interventions. According to a report by the UN Secretary-General on violence against women, valuable suggestions are given to for effective data collection. The report further provides guidelines on the areas that need more research because of their current under-researched status (UN-GA, 2006). The focus of many research studies on programmatic intervention and further research on the issue of gender based violence is aimed at alleviating the impacts on women. This is another major area where there is existence of flaws since majority of the survivors of gender based violence are children of both sexes while the minority includes adult women and adult

men. Most of the intervention programs in Sub-Saharan Africa are focus on servicing this minority group. Policy makers and program designers tend to only see adult women to be most vulnerable, which is inaccurate. There are few examples of intervention programs aimed at addressing the needs of children who experience gender based violence. In addition, there is also limited examples of intervention programs focusing addressing the needs of other minority groups such as the physically handicapped, the mentally handicapped, and adult men. The existing intervention program are not entirely biased on these minority group, however they only tend to serve them as special category or additional group.

3.4 Ethical considerations for researching SGBV

Cognizant with the principles of GBV research this study upheld pertinent ethical principles especially the ones on confidentiality and respect. The subject material was highly regarded as sensitive and traumatic which created the need to uphold strong ethical standards. Authorities in GBV research agree that conceived or implemented research may have dangerous consequences for the respondents and/or interviewers therefore research designs have to consider issues of confidentiality, problems of disclosure, and the need to ensure adequate and informed consent (Ellsberg & Heise, 2005). The basic ethical principles that guided this research that involved human subjects included:

- Respect for persons (including respect for confidentiality, the need to protect vulnerable populations, and respect for autonomy);
- Nonmaleficence (minimizing harm);
- Beneficence (maximizing benefits); and
- Justice.

The key ethical principles utilized in this study are universally applicable, and the details were adapted to local settings, in order to minimize misunderstandings or potential harm. The researcher was under obligation to consider how the information will be used and reported, and to whom, and who will benefit from it, and when. These

considerations are highly emphasized by international standards (WHO, 2007). The principle of respect for persons utilized in this study incorporated two fundamental ethical principles: respect for autonomy and protection of vulnerable persons. These were addressed by individual informed consent procedures that ensured that respondents understood the purpose of the research and that their participation was voluntary. This approach is highly recommended by Ellsberg & Heise (2005).

3.5 Management of Child Sexual Abuse

Child sexual abuse has different dynamics than that of adult sexual abuse. For instance, compared to adults, children will disclose as part of a process rather than a single event over a longer period of time (WHO, 2003). This tendency can have unlikely implications in collection of forensic data and in medical management. In order to evaluate children, there is need for special skills in examination, forensic interviewing, and history taking. Care providers have to engage the children's parents in counseling and taking note of the issues of reporting child abuse and the issue of consent. Reporting cases of child abuse is a mandatory requirement in many countries. The cases are supposed to be reported to the local authorities including the police and child welfare. Programs intending to focus on child sexual abuse have to take note of all the legal requirements involved.

3.6 Clinical Evaluation and Treatment of Injuries

Survivors of sexual abuse may have physical injuries that require immediate attention. Life-threatening injuries take precedence over other components of medical management. Health care providers are advised to ensure that they do not take actions that will jeopardize forensic evidence. Where qualified, health providers need to collect and conserve evidence for forensic analysis. The components of the clinical evaluation (forensic examination, specimen collection, analysis and documentation) act as a vital

link between health care and the judicial system. The examination includes establishing the background of the survivor, taking the history of the occurrence, a medical history and a full body physical examination that is efficiently documented (Kilonzo & Taegtmeyer, 2005). Care should be taken to minimize additional trauma by providing initial comfort counseling and a full explanation of the logic and process of the procedures. A coordinated approach to delivering medical services is advised to eliminate the need for referrals and delay.

3.7 GBV Programming

Children are particularly susceptible to sexual violence due to their relatively weak social position, economic dependence and lack of political protection (WHO, 2001). Child sexual abuse has extensive emotional and physical repercussions. It is evident that people experience sexual abuse during their childhood, are more likely to commit abuse against others. The undercurrents of child sexual abuse differ from those of adults. The assessment of children requires distinctive abilities and techniques in history taking, forensic interviewing and examination. In Kenya, Zambia and South Africa most child survivors report to the police, prior to referrals to health facilities (Population Council, 2008). The early involvement of the police underscores the need for police sensitization and reinforcement of effective referral networks.

According to Population Council (2008), sexual abuse of male adults and children is vastly under-reported and poorly understood. Nearly 40 percent of men reported having been raped outside their home and 13 percent report having been assaulted by the police. Although Male survivors of sexual violence require the same physical examination and medical interventions as women, the genital examination requires a specific approach. Population Council further observes that men require treatment for STIs, hepatitis B and tetanus, and need an HIV-test followed by HIV prophylaxis, if eligible. Additionally, male survivors tend to be reluctant to access counseling due to

the perceived and actual stigma related to the abuse. This notwithstanding, men have the same psychological needs as women, and should be encouraged to receive trauma and follow-up. This calls for counselors who understand the realities to of male sexuality or masculinity. According to Ganju et al (2004), men rarely seek legal redress, due to the stigma attached. The mitigation of this issue rests in enhance sensitization programs to address the stigma associated with GBV.

Population Council postulates that comprehensive post-rape care aims to reduce the physical and psychological consequences of sexual violence. An integrated care package should include:

a) Treatment of injuries and clinical evaluation

b) Pregnancy testing and emergency contraception (EC)

c) Prophylaxis of sexually transmitted infections (STIs)

d) HIV diagnostic testing and counseling (DTC) and Post Exposure Prophylaxis (PEP)

e) Forensic examination

f) Trauma counseling.

Methodology

4.0 Introduction

4.1 Research Design

This study utilized both quantitative and qualitative data. Quantitative data was useful for tracking trends accurately and highlighting differences. Qualitative data was useful for understanding the context in which the trends/differences occur and to interpret quantitative data accurately. This included in-depth interviews.

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 baseline study triangulated descriptive and explanatory designs. According to Saunders *et al* (2009), descriptive and explanatory studies are concerned with descriptions as well as linkages 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. Additionally, raw data was analyzed from census data and KDHS data.

4.2 Population and Sampling Design

4.2.1 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, leaders, health providers and the general population in Kasarani constituency in Nairobi.

4.2.2 Sampling Design

4.2.2.1 Sampling Frame

A sampling frame is a complete and correct list of population members (Saunders et al, 2009). The study population constituted different subsets of the population that called for a triangulation of sampling strategies for each population segment

4.2.2.2 Sampling Technique

Saunders *et al* (2009) suggest five main sampling techniques namely: simple random, systematic, stratified random, cluster and multistage. Where the population is relatively small (about 30 cases or less) census sampling is suggested. This study utilized a triangulation of the sampling strategies above to collect the following types of data:

Table 2: Sampling Technique

Types of Data	Sampling Strategy
GBV Survivors Health Facility Data	Census
Mapping of Resources	Census
Quantitative Data from Kasarani Residents	Simple Random, Cluster and Multistage sampling
Qualitative Data from Kasarani Residents and Community leaders	Purposive sampling

4.2.2.3 Sample Size

a) The GBV Survivors

This study utilized health facilities data of all 35 GBV survivors that sought care specifically in Kasarani and are monitored by KWCWC.

b) Kasarani Community

This study utilized a data set that was developed in 2012 from the community. A sample was randomly selected using the following assumptions:

i. 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.

ii. The sampling procedure for the utilized data was as below:

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

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**

c) 2009 Census Data

The Census data consisted of a sample size of 525,624 people in Kasarani

d) 2008 KHDS Data

The Kenya Demographic and Health Survey (KDHS) sample was of 8,444 women age 15 to 49 and 3,465 men age 15 to 54.

e) 2012 Health Facilities Data

The health facilities survey constituted a sample of 35 GBV survivors.

4.3 Data Collection Methods

The following sources of data were utilized:

1) Primary data for: residents of Kasarani; Kasarani health facilities; Primary and Secondary Schools in Kasarani; GBV cases in Kasarani
2) Facility surveys - Client exit interviews; provider surveys
3) Secondary data set from a KWCWC survey in 2012
4) The Kenya Census and Population data set
5) The Kenya Demographic and Health Data for domestic violence information
6) The Kenya Police Data - Client exit interviews; provider surveys
7) Health service statistics
8) KWCWC Program statistics
9) Behavioral surveillance

Data from a variety of sources was used in this survey. These included population-based survey, facility surveys, health service statistics, qualitative data, and KWCWC program statistics. Population-based survey utilized was on violence against women by

the KHDS. Facility surveys included provider surveys and health facility surveys. The provider survey provided information on provider knowledge, attitude and practices related to GBV. Health services statistics provided information about clients. Qualitative information included in-depth interviews. KWCWC program information included training information and KWCWC activities. The police provided information on crime statistics on substantiated cases of GBV, prosecutions and convictions as well as incident-based reporting.

4.4 Research Procedures

Data was collected from the various stakeholders using highly trained field staff. KWCWC has a highly trained outreach team that was utilized to supervise the data collection exercise.

4.5 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 quantitative. Qualitative data was analyzed using content analysis.

5.0 Key Results and Indicators from the Baseline Survey

5.1 Kasarani Administration Baseline Data necessary for GBV Programing

5.1.1 Constituencies

Kasarani is divided into three constituencies that are newly constituted namely:

a) Kasarani constituency

b) Ruaraka constituency

c) Roysambu constituency.

5.1.2 District Officers

Kasarani has 5 District Officers (DOs) and 1 District Commissioner (DC). The DOs operate are based in the following divisions:

a) Kasarani District Headquarters-D.O1

b) Roysambu Division

c) Kasarani Division

d) Kariobangi North Division

e) Githurai Division

5.1.3 Kasarani Constituencies and Locations

Table 3: Constituencies and Locations

Division	Location (11 Chiefs)	Sub-location
Kasarani	Kasarani	1) Kasarani 2) Clay City 3) Mutirithia
	Mwiki	1) Mwiki
Githurai	Githurai	1) Githurai 2) Kamuthi
	Kahawa West	1) Kahawa West 2) Kongo Soweto 3) Kiwanja
	Zimmerman	1) Zimmerman
Roysambu	Roysambu	1) Roysambu 2) Njathaini 3) Garden Estate
	Ruaraka	1) Ruaraka 2) Mathare North
	Utalii	1) Mathare 4 "A" 2) Utalii
Kariobangi North	Kariobangi North	1) Kariobangi North 2) Marura
	Korogocho	1) Korogocho 2) Gitathuru 3) Nyayo
	Baba Dogo	1) Baba Dogo 2) Lucky Summer

5.1.4 Kasarani Police Force

5.1.4.1 Administration Police (AP)

Kasarani has 140 Administration Police officers who are based in the following AP posts:

1. Githurai
2. Zimmerman
3. Kahawa west
4. Kiwanja
5. Kamae
6. Ruaraka
7. Korogocho
8. Kariobangi
9. Lucy summer
10. Kasarani district head quarters
11. Starehe girls post

Additionally, Kasarani has 574 Regular Police Officers who are based in the following six police posts:

1. Ngomongo
2. Njathaini
3. Maziwa
4. Santon
5. Marurui
6. Kahawa sukari

5.1.4.2 Police Stations frequently utilized by the GBV Survivors of Kasarani

The following were identified as the critical police stations where GBV survivors around Kasarani seek help

Table 4: Major Police Stations

Police Station	Area where it is located
Kasarani Police Station	A 2 road, Nairobi
Mwiki Police Station	Sunton Area
Kayole Police Station	Kayole
Ruaraka Police Station	Baba Dogo
Dandora Police Station	Dandora phase 1
Mowlem Police Station	Njiru

5.1.4.3 Observational Data and Qualitative Interviews

The majority of police stations in Kasarani are dilapidated due to inadequate allocation of resources. This was revealed by poor equipment, infrastructure and inadequate information on gender violence. Qualitative data gathered from some of the GBV survivors and community leaders indicate that GBV survivors had their complaints improperly recorded, were unsatisfied with recording gender violence complaints in the police occurrence book, waited for hours to be served by a police officer and found the police to be unfriendly.

5.2 Paralegals Data

5.2.1 Kasarani Paralegals

Kasarani has a total of 72 paralegals trained by five different institutions over a period of 4 years as outlined in the table below.

Table 5: Kasarani Paralegals

Organization	Number of Paralegals	Date Trained
Legal Resource Foundation trust/Caritas	27	2012
Kituo Cha Sheria	20	2010
KWCWC/CREAW	9	2011
BHSEP	12	2011
Aphia 2	4	2009

***Legal resource are currently training 30 widows who will graduate in 2013.*

5.2.2 Magnitude of the Paralegal Intervention

There has been a steady training of paralegals in Kasarani before and during KWCWC intervention period. Notably, there is an upsurge at the intervention entry point (2011). This is a steady upsurge. However, KWCWC needs to collaborate with other partners like Kituo Cha Sheria whose intervention had a significant upsurge above the linear line in 2010 to sustain a high output of Paralegals. Another critical partner is Legal Resource Foundation trust/Caritas. This will not only enhance the number of paralegals trained but also avoid a duplication of resources in training the paralegals.

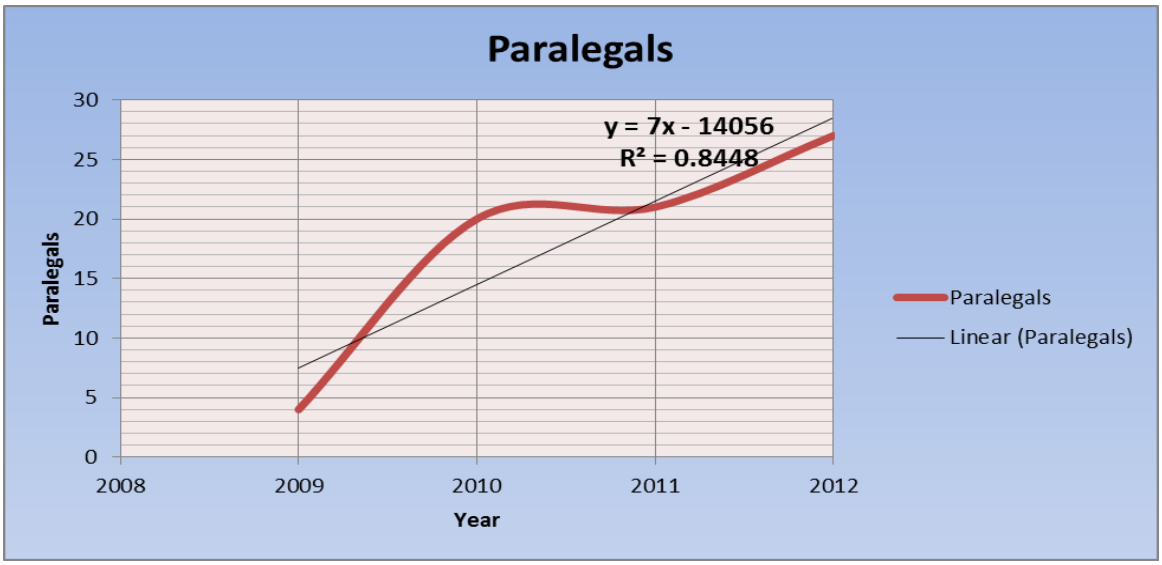


Figure 2: Magnitude of the Paralegal Intervention

5.3 Education Data

5.3.1. Education Levels in Kasarani

The researcher analyzed the 2009 Kenya National Census Data. From the analysis of raw census data in Kasarani, it is evident that there is a high level of the population with only primary level education which calls for enhanced awareness campaigns on health issues including GBV campaigns that are packaged to reach out to this cadre of population.

Table 6: Education Levels in Kasarani

Level of Education	Male		Female	
	F	%	f	%
Never Attended	33,841	6.93%	41,306	8.79%
Pre-Primary	27,056	5.54%	26,776	5.70%
Primary	178,511	36.57%	188,951	40.21%
Secondary	165,868	33.98%	140,474	29.89%
Tertiary	46,440	9.51%	46,662	9.93%
University	27,681	5.67%	18,144	3.86%
Youth Polytechnic	3,729	0.76%	2,504	0.53%
Basic Literacy	1,252	0.26%	1,279	0.27%
Madrassa	3,721	0.76%	3,858	0.82%
TOTAL	**488,099**	**100%**	**469,954**	**100%**

5.3.2. An Overview of Schools in Kasarani from a sampled Population

The highest proportion of schools in Kasarani (53.9%) is non-formal schools. The GBV intervention efforts targeting school going children should have a high concentration on the informal schools.

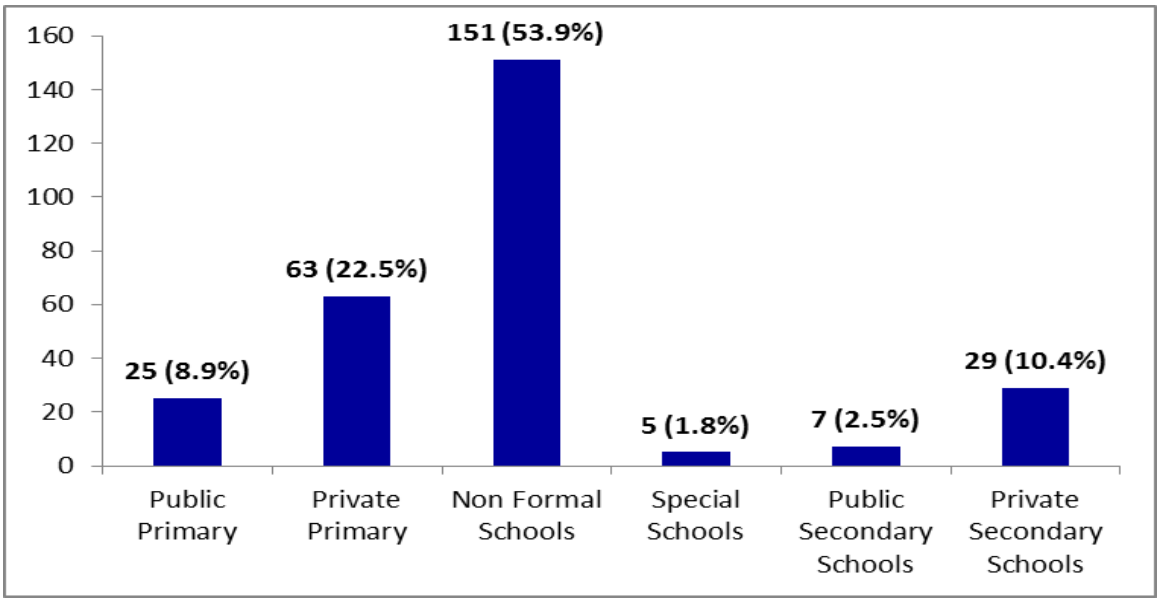


Figure 3: An Overview of Schools in Kasarani

5.3.3. Characteristics of Primary Schools in Kasarani

Table 7: Primary Schools in Kasarani

Characteristics of Primary Schools in Kasarani	Frequency	Percent
Status of Schools		
Private Schools	337	92.1%
Public Schools	29	7.9%
Sponsor of Schools		
Central Government/DEB	7	1.9%
Community	35	9.6%
Local Government Authority	18	4.9%
NGO/CBO	38	10.4%
Private Individual	223	60.9%
Religious Organization	45	12.3%
Gender Distribution		
Boys Only	2	0.7%
Girls Only	3	1.0%
Mixed	296	98.3%
Pupil Residence		
Boarding Only	4	1.3%
Day & Boarding	6	2.0%
Day 7 & Boarding	1	0.3%
Day Only	290	96.3%
Number of Pupils		
Total Boys	20,819	49.5%
Total Girls	21,210	50.5%
Number of Teachers	2,660	

In the outreach work that involves working with primary schools, KWCWC needs to take note of the following characteristics for primary schools in Kasarani:

i. There are over 360 primary schools in Kasarani that KWCWC needs to work with in the GBV intervention strategy. There is need to reach out to all these schools in the GBV intervention.

ii. Most (92.1%) of the primary schools in Kasarani are private. This calls for a need to form strong working relationships with both the government and private entities in the education sector for a successful implementation of a GBV

intervention. Other than the central government, KWCWC needs to work with the Community; Local Government Authority; NGOs/CBOs; Private Individuals; and Religious Organizations that govern the primary schools.

iii. Almost all (98.3%) primary schools in Kasarani are mixed. The GBV interventions should be designed to target both boys and girls. Thus the interventions for boys and girls can run concurrently as the school system provides such a platform. The total population is evenly distributed across boys and girls.

iv. The majority of pupils (96.3%) in Kasarani are day scholars. GBV intervention strategies should therefore take cognizance of the limited opportunity for GBV interventions that calls for a closer working relationship with the school administration.

5.3.4. Characteristics of Secondary Schools in Kasarani

Table 8: Secondary Schools in Kasarani

Characteristics of Secondary Schools in Kasarani	Frequency	Percent
Status of Schools		
Private Schools	61	92.4%
Public Schools	5	7.6%
Sponsor of Schools		
Central Government/DEB	4	6.1%
Community	2	3.0%
Local Government Authority	0	0.0%
NGO/CBO	4	6.1%
Private Individual	44	66.7%
Religious Organization	12	18.2%
Gender Distribution		
Boys Only	4	7.1%
Girls Only	7	12.5%
Mixed	45	80.4%
Student Residence		
Boarding Only	7	12.5%
Day & Boarding	8	14.3%
Day Only	41	73.2%
Number of Students	7,469	
Number of Teachers	522	

In the outreach work that involves working with secondary schools, KWCWC needs to take note of the following characteristics for secondary schools in Kasarani:

i. There are over 60 secondary schools in Kasarani that KWCWC needs to work with in the GBV intervention strategy. There is need to reach out to all these schools in the GBV intervention.

ii. Most (92.4%) of the secondary schools in Kasarani are private. This calls for a need to form strong working relationships with both the government and private entities in the education sector for a successful implementation of a GBV intervention. The key stakeholders in the secondary education sector in Kasarani that KWCWC needs to work with on GBV intervention include the central

government/DEB, the local Community; NGOs/CBOs; Private Individuals; and Religious Organizations that govern the primary schools.

iii. Whereas most (73.2%) of the secondary schools in Kasarani operate as day only, there are an equally high number of schools (26.8%) that are either boarding schools or are both boarding and day. This calls for a diversified GBV outreach strategy.

iv. The majority (80.4%) the primary schools in Kasarani are mixed. The GBV interventions should be designed to target both boys and girls. Thus the interventions for boys and girls can run concurrently as the school system provides such a platform.

5.4. Household Assets in Kasarani

In Kasarani, Radio, Television and Mobile phones are critical modes of communication that can be utilized to reach out to the residents.

Table 9: Household Assets in Kasarani

Household Item	**% of Households**
Radio	77.9
TV Set	63.2
Mobile Phone	87.8
Landline	2.9
Computer	10.1
Bicycle	9.1
Motorcycle	1.2
Car / Truck / Tuk tuk	8.5
Total households	**327,428**
Geo-Location	**(-1.225618057, 36.8911257)**

5.5. Health Facilities

5.5.1 Health Facilities in Kasarani

Kasarani has 62 key health facilities that the residents rely on for health care and can therefore be critical partners in the GBV intervention. Notably, there are only three hospitals serving over 525,624 residents. There is need for KWCWC to set up a hospital that will supplement the facilities in Kasarani.

Table 10: Health Facilities in Kasarani

#	HEALTH FACILITY	GOK	FBO	NGO	PRIVATE	TOTAL
1	HOSPITALS	0	2	0	1	3
2	HEALTH CENTRES	2	3	0	10	15
3	NURSING HOME	0	0	0	1	1
4	DISPENSARY	10	2	0	29	41
5	CLINICS	2	0	0	0	2
	TOTAL	**14**	**7**	**0**	**41**	**62**

5.5.2 Kasarani District Health Facilities Workforce

There is a total workforce of 347 in the health facilities in Kasarani. This presents a deficit of 54.1% of the health workforce that calls for the need of different stakeholders to supplement the existing workforce.

Table 11: Kasarani District Health Facilities Workforce

	CADRE	CURRENT STAFF	DEFICIT
1	Medical Doctors/Dentists	13	14
2	Registered Clinical officers	55	45
3	Nurses	200	497
4	Lab Tech	36	14
5	Pharm. Tech	22	28
6	PHO's/PHT	14	0
7	Nutrionists	7	43
TOTAL		**347**	**641**

5.5.3 Kasarani District Major Health Facilities

The following are the most frequently utilized health facilities in Kasarani. KWCWC needs to form linkages with the 19 major health facilities in Kasarani. The Geolocation coordinates are critical in utilizing the Google map interface to locate the facilities.

Table 12: Kasarani District Major Health Facilities

#	Facility Name	Area Located	Geolocation
1	BABA DOGO HEALTH CENTRE	BABA DOGO	(-1.2441, 36.88416)
2	KAHAWA HEALTH CENTRE	KONGO SOWETO	(-1.18716, 36.91278)
3	KAMITI HEALTH CENTRE	KAHAWA WEST/JUJA K	(-1.1761, 36.89342)
4	KARIOBANGI CHESIRE HOME DISP	KARIOBANGI NORTH	(-1.25123, 36.88111)
5	KARIOBANGI HEALTH CENTRE	KARIOBANGI NORTH	(-1.25174, 36.87978)
6	KARIOBANGI MCH / FP DISP	KARIOBANGI NORTH	(-1.25174, 36.87978)
7	KASARANI SHC	KASARANI	(-1.21821, 36.90139)
8	LITTLE SISTERS OF ST FRANCIS	MWIKI	(-1.23415, 36.92214)
9	MATHARE NORTH HEALTH CENTRE	UTALII	(-1.25323, 36.86485)
10	NYS HEALTH CENTRE	UTALII	(-1.24995, 36.86425)
11	NYS PUBLIC HEALTH	UTALII	(-1.24995, 36.86425)
12	P & T MCH DISP	MATHARE NORTH	(-1.247265, 36.872106)
13	UTALII COLLEGE DISP	UTALII	(-1.25503, 36.85362)
14	GSU HEADQUARTERS HEALTH CENTRE	GARDEN	(-1.24233, 36.86556)
15	GSU HQ MCH / FO CLINIC	GARDEN	(-1.24233, 36.86556)
16	KAMITI G.K. PRISON HOSPITAL	KAHAWA WEST/JUJA K	(-1.17611, 36.89343)
17	KENYATTA UNIVERSITY CLINIC	KIWANJA	(-1.17123, 36.93214)
18	MATHARE POLICE DEPARTMENT CLINIC	GARDEN	(-1.256133, 36.849069)
19	KAHAWA MAT. UNIT	KONGO SOWETO	(-1.18716, 36.91278)

5.6. State of GBV in Kasarani

5.6.1 Physical or Sexual Violence by Age

In Kasarani the risk of GBV is equally high among all the age categories. Notably, the incidence of GBV increases with age. This demonstrates a high vulnerability to GBV notwithstanding the age category.

Table 13: Physical or Sexual Violence by Age

Age	2008 KDHS	Kasarani Statistics
15 – 19	16%	6,287
20 – 29	26%	10,356
30 – 39	29%	11,243
40 – 49	29%	11,465

5.6.2 Prevalence Rates of GBV by Type of Assault

The four critical types of GBV in order of severity include Defilement; Rape; Incest; Sodomy; and Indecent Assault. A GBV intervention in Kasarani should reach out to survivors from the four categories.

Table 14: Prevalence Rates of GBV by Type of Assault

Type of Violence	Magnitude
Defilement	69.1%
Rape	19.7%
Incest	5.0%
Sodomy	3.4%
Indecent Assault	2.8%

Data Source: Kenya Police Crime Data, 2010

5.6.3 Views about the Police Service from the qualitative data

a) Overall, most of the survivors were not satisfied with the services with the police.

b) There were indications that more than half the GBV survivors waited for more than an hour to be served at the gender desks.

c) It was also indicated that the majority of the GBV survivors reported their cases to the police.

d) There were complaints about lack of privacy in the police stations.

e) The perception of the GBV survivors is that the police are more concerned with arresting GBV perpetrators.

f) There was an indication that the cases were only pursued if the police were bribed.

g) Although the statistics published by the Kenya Police, show the extent of GBV cases reported, it is not clear how many cases were investigated and prosecuted.

h) The survivors do not have an easy access to the P3 form should ideally be free. There were indications that the forms are sold.

i) An observation of the police gender desks portrays a dilapidated and inadequate space and facilities.

5.6.4 Women's Experience of Violence in Kasarani

In Kasarani, 47,551 women aged 15–49 are likely to have experienced physical violence since age 15 while 39,352 women aged 15–49 are likely to have experienced physical or sexual violence committed by a husband/partner.

Table 15: Women's Experience of Violence in Kasarani

Description	KDHS	Kasarani Statistics
Ever experienced physical violence since age 15 (women 15–49)	29%	47,551
Ever experienced physical or sexual violence committed by a husband/partner (women 15–49)	24%	39,352

5.6.5 Types of Violence in Kasarani

Four types of violence were reported as existing in Kasarani, namely: Physical violence (slapping, kicking, hitting, or use of weapons); Emotional violence (systematic humiliation, controlling behavior, degrading treatment, threats); Sexual violence (coerced sex, forced into sexual activities considered degrading or humiliating); and Economic violence (restricting access to financial or other resources with the purpose of controlling a person). These forms of violence were reported at the individual level, the household level and the community level. The prevalence of sexual violence was reported as 31% from the quantitative survey.

Table 16: Types of Violence in Kasarani

Action	Has it ever happened to Respondent?	Has it ever happened in respondent's household or family?	Has it ever happened in the neighborhood?
1. Physical violence (slapping, kicking, hitting, or use of weapons)	36.2%	40%	58.1%
2.Emotional violence (systematic humiliation, controlling behavior, degrading treatment, threats)	55.2%	36.2%	45.2%
3.Sexual violence (coerced sex, forced into sexual activities considered degrading or humiliating)	16.2%	13.8%	31%
4.Economic violence (restricting access to financial or other resources with the purpose of controlling a person).	35.7%	28.6%	36.2%

5.6.6 The Consequences of GBV in Kasarani

The people of Kasarani have experienced high levels of GBV related physical injuries, Sexual and reproductive complications, Psychological and behavioral complications and death. All these consequences need to be addressed by GBV interventions. From the sampled respondents, 8.6% of the households had experienced a death episode as a result of GBV. Extrapolated on the Kasarani population, more than 14,000 households have ever lost a member due to GBV.

Table 17: Consequences of GBV in Kasarani

Action	Has it ever happened to Respondent?	Has it ever happened in respondent's household or family?	Has it ever happened in the neighborhood?
1. Physical injuries and chronic conditions	17.1%	22.4%	43.8%
2. Sexual and reproductive complications (Sexually Transmitted Illnesses; pregnancy complications etc.)	6.2%	9.5%	23.8%
3. Psychological and behavioral complications (Depression, Drug Abuse, Low self-esteem etc.)	20%	20%	30%
4.Death		8.6%	20%

5.6.7 The Causes of GBV in Kasarani

In order of importance, the following are the key causes of GBV in Kasarani: Traditional gender norms that support gender superiority and entitlement; Presence of crime and conflict; Poverty; Weak community sanctions against perpetrators of GBV; Social norms that tolerate or justify violence; and Alcohol and drug abuse.

Table 18: Causes of GBV in Kasarani

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

5.6.8 What are the desirable GBV Interventions in Kasarani?

The residents of Kasarani feel that if the 5 factors below are addressed, then GBV levels will significantly decline.

Table 19: Desirable GBV Interventions in Kasarani

Variable	Rank
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	1
If Alcohol and drug abuse are tackled in this community then GBV incidence will decrease	2
If crime and conflict are tackled in this community then GBV incidence will decrease	3
If people are well sensitized, then GBV incidence will decrease in this community	4
If poverty is tackled in this community then GBV incidence will decrease	5

5.6.9 GBV Needs in Kasarani

The six needs for GBV intervention above were identified by the residents of Kasarani in order of importance.

Table 19: GBV Needs in Kasarani

Variable	Rank
Pregnancy testing and emergency contraception (EC) IS NOT readily available in this community for GBV survivors	1
HIV diagnostic testing and counseling (DTC) and Post Exposure Prophylaxis (PEP) IS NOT readily available in this community for GBV survivors	2
Prophylaxis of sexually transmitted infections (STIs) IS NOT readily available in this community for GBV survivors	3
Treatment of injuries and clinical evaluation IS NOT readily available in this community for GBV survivors	4
Trauma counseling IS NOT readily available in this community for GBV survivors	5
Forensic examination by the police IS NOT readily available in this community for GBV survivors	6

5.7 Current KWCWC Penetration Impact

KWCWC has had a very strong impact on the administration. KWCWC needs to work with its partners in mobilizing more resources that would be used to focus more on school and teacher training. Additionally, KWCWC should collaborate with other partners who have similar goals to meet specific programmatic areas as it happens with the Paralegal training where there are other actors training paralegals in Kasarani. For the other forms of interventions, there is need to set explicit benchmarks to measure performance at the broader Kasarani level.

Table 20: Current KWCWC Penetration Impact

Group	Number Trained	Denominator	KWCWC Impact	Legend for Denominator
Youths	932	-		*No benchmarks*
**Administration	71	720	9.9%	*DOs, Chiefs, Sub Chiefs & Community Leaders*
GBV Networking Group members	27	-		*No benchmarks*
Paralegals	39	-		*No benchmarks*
Religious Leaders	460	-		*No benchmarks*
Community Members	1612	-		*No benchmarks*
Schools - primary schools pupils	5052	42029	12.0%	*Primary Pupils*
College students	867	-		*No benchmarks*
Teachers trained	292	3182	9.2%	*Primary and Secondary School Teachers*
Health workers	774	1247	62.1%	*Includes health facility based health workers and community health workers*

** The impact is expected to be low due to lack of funds to support police training in Kasarani.

5.8 Profile of GBV Survivors who sought health care from Health Facilities

5.8.1 Where the GBV survivors got help

Most of the GBV survivors sought their first help from Mathare North Health Centre. Additionally, there is a high reliance on community members for arbitration and help. This calls for increased awareness campaigns by KWCWC on the steps that GBV survivors need to take including health care and police service which makes the cases legally relevant.

Where the GBV survivors made their first stop for help

1. Mathare North Health Centre
2. Community Members
3. Kariobangi Health Centre
4. Fellow partner /Family Members
5. Kariobangi Catholic Church
6. Mathare North Youth Group
7. Chief
8. Muthaiga Police Station
9. Community Health Workers

Source of Data: KWCWC field office (January 2012 – November 2012)

5.8.2 The referral point for the GBV survivors

The chief's offices are very instrumental referral points for GBV survivors. KWCWC should leverage on working with the chief's offices (or the equivalent in the county government). Other critical partners include the police, health facilities and NGOs working in Kasarani.

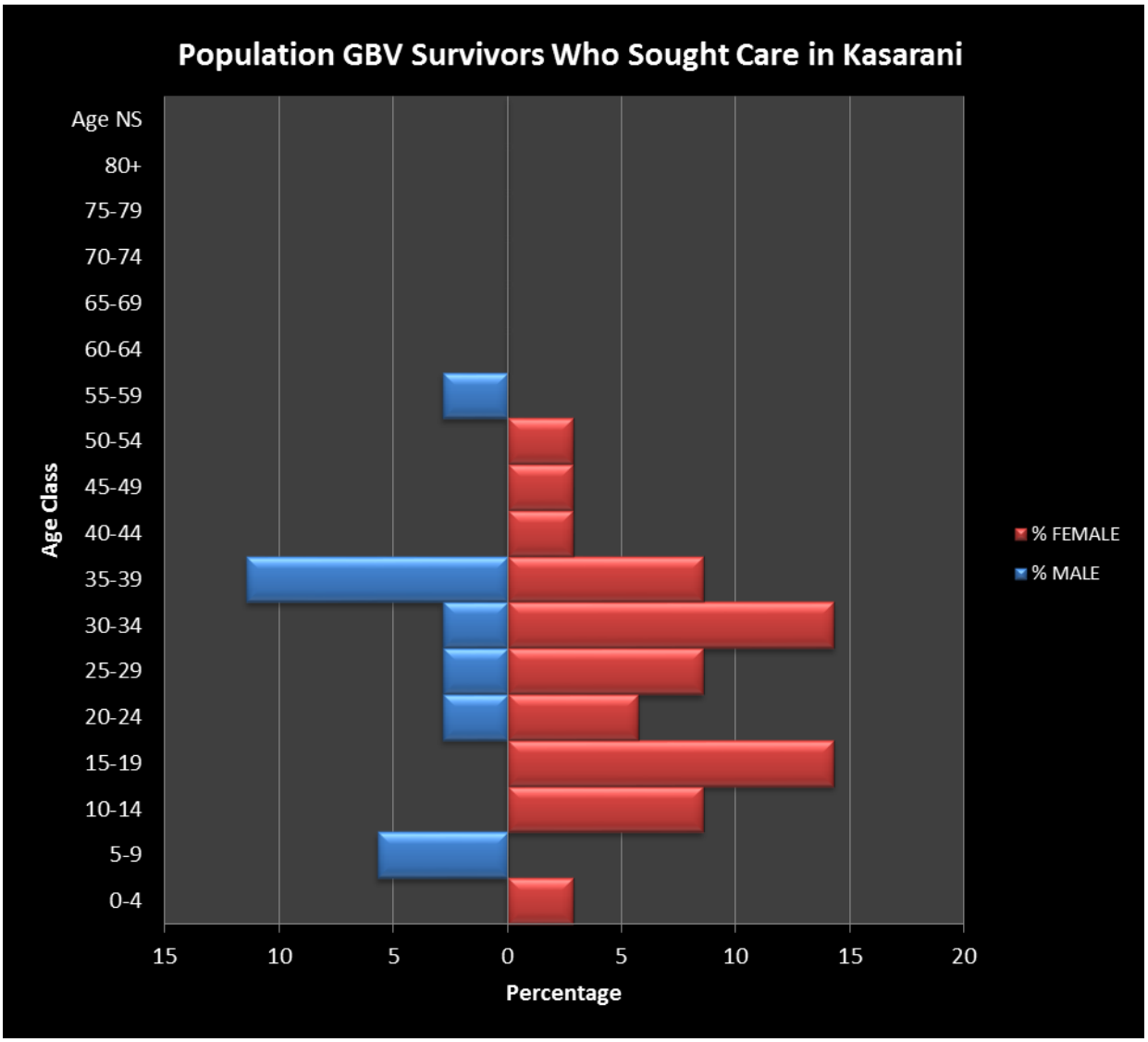
What was the referral point for the GBV survivors?

1. Chief
2. Police
3. Health Centre/Hospital/Health Facility
4. MSF
5. CREW
6. KWCWC
7. Relative
8. Children's Office
9. CRADLE
10. MNH
11. CLAN

Source of Data: KWCWC field office (January 2012 – November 2012)

5.8.2 The Population Profile of GBV Survivors who sought Care – Various Facilities

The most vulnerable group of female that experienced GBV and sought health care were between ages 10 and 39 while the men were between ages 35 and 39. Girls below 5 years experienced GBV and sought health care. The situation was similar for boys 5 to 9 that experienced GBV and sought health care.

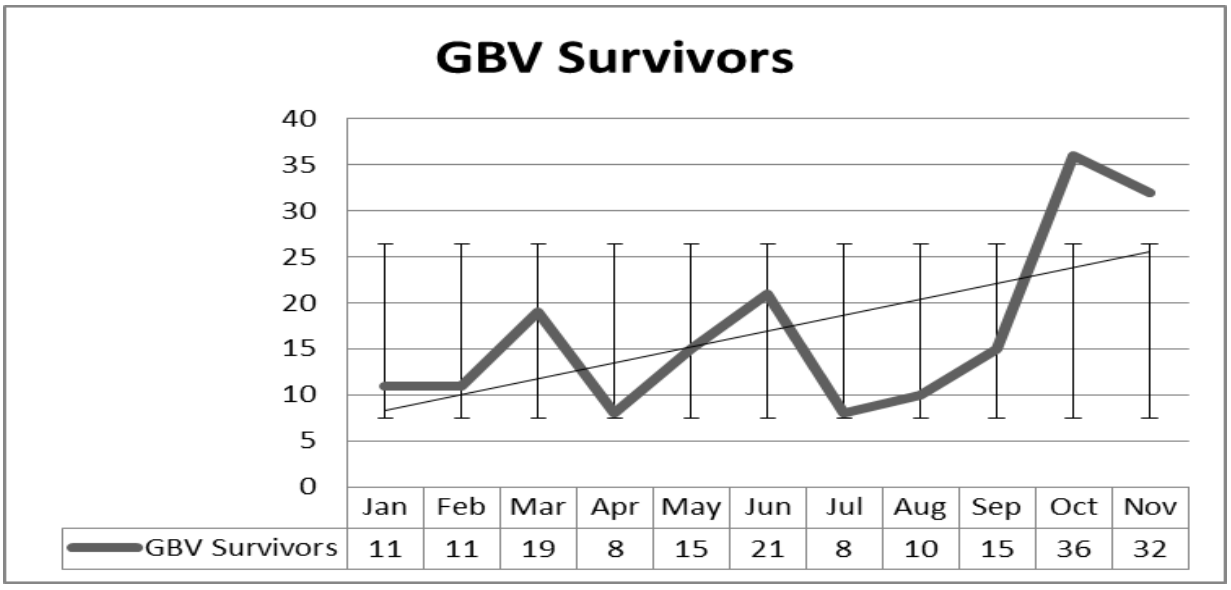


Source of Data: KWCWC field office (January 2012 – November 2012)

Figure 4: Population Profile of GBV Survivors – Various Facilities

5.8.3 The Population Profile of GBV Survivors Identified by Community Leaders

The community leaders representing the different sections of Kasarani provided numbers of GBV cases that had been explicitly reported and recorded at the community level. In total, 186 GBV survivors were identified between January 2012 and November 2012. The figures were retrieved for each month. There is a non-linear increase in the number of GBV survivors. This underscores the volatility in GBV management that calls for contingent planning in GBV intervention. The KWCWC response compares fairly well with the volatile occurrence.



Source of Data: Credible Implementing partner Records

Figure 5: Population Profile of GBV Survivors Identified by Community Leaders

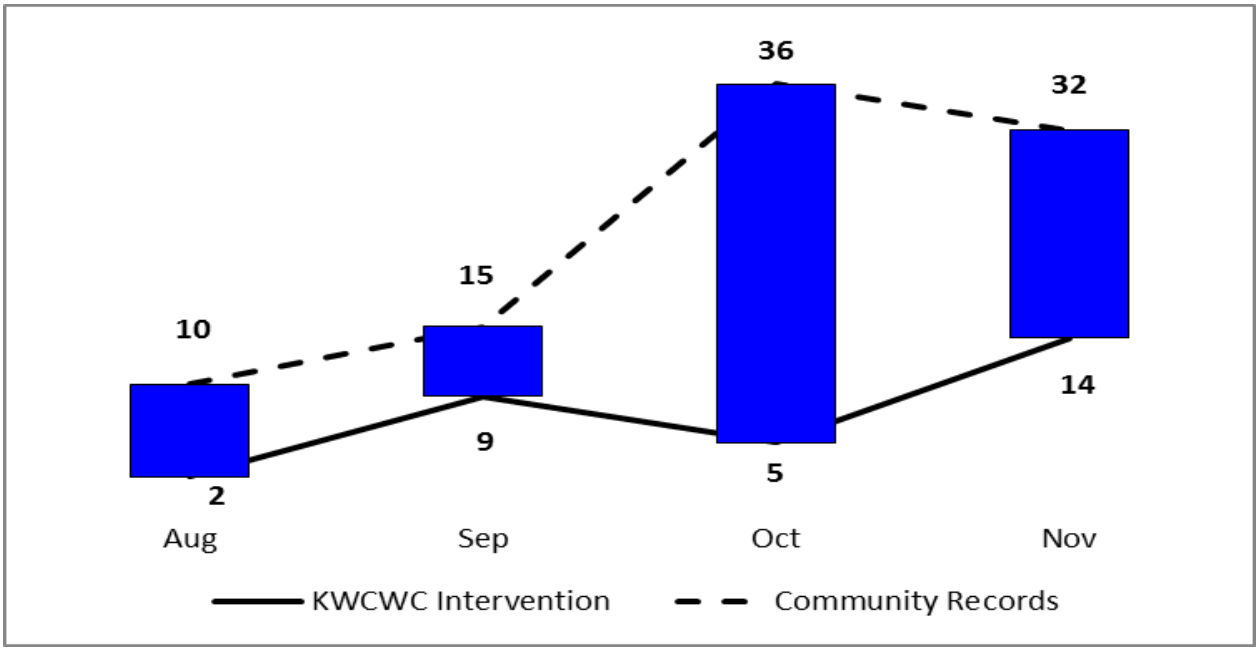


Figure 6: Implications of volatility of GBV on KWCWC Intervention

5.9 Harmful Traditional Practices

5.9.1 Female Genital Mutilation (FGM)

The harmful traditional practice of FGM is widely condemned as harmful, because it poses a potentially great risk to the health and well-being of the women and girls who are subjected to it in Kenya. Research indicates that as the awareness of the dangers of FGC increases, fewer people tend to practice it. The qualitative data collected from community leaders indicate that members of "Highridge Village" in Korogocho area of Kasarani mainly inhabited by Boranas and a few somalis practice FGM. The Kenya Demographic and health survey indicate that 27 percent of women ages 15–49 in Kenya had experienced FGC as of 2009 (KNBS and ICF Macro, 2010). The practice is performed more secretively usually under unsanitary conditions and at younger ages. Although 27% is a high percentage, KDHS data indicate that there has been a steady decline (38% percent reported in the 1998 KDHS and 32% reported in the 2003 KDHS). KWCWC is likely to bring the rates down by utilizing the outreach platform to increase the levels of awareness in the Kasarani.

5.9.2 Early Child Marriage

In Kenya, girls and boys can legally marry at the age of 18. Qualitative data from community leaders indicate that girls marry so young (as young as 13 years) in informal settlements in Kasarani like Korogocho, Mathare, Marurui, Njathaini and Soweto. There are also instances where girls are forced to marry men much older than themselves.

5.9.3 Persons with Disabilities and GBV

The qualitative data highlighted the following critical issues regarding GBV and disability. First, persons with disabilities (PWD) are more prone to violence or rape and yet less likely to obtain health and legal intervention. Secondly, PWDs are sexually active. Third, sexual abuse of PWDs happens in homes and learning institutions by people we least expect like the care givers primarily because of the dependence on care-givers by the PWDs. Additionally, the dependency syndrome is made worse by low literacy level among the PWD and unemployment. Thirdly, the health workers indicated that they do not have specialized training in handling PWD cases. Fourthly, there seemed to be no systematized data stored about PWD cases in Kasarani.

5.9.4 Commercial Sex Workers (CSW) and GBV

Two CSW lobby groups were identified in Korogocho area of Kasarani. They include "Ladies of Hope" (25 members) and "Hope and Faith Group" (30 members). The other lobby groups that were identified in the larger Kasarani area include BHSEP (Bar Hostess Empowerment Program) and CREAW (Centre for Rights Education and Awareness- based in Lavington). Most of the members reside at Kasarani area, Kariobangi, Korogocho, Huruma, Marurui, Mathare, Njathaini and Kongo Soweto in Kahawa West. These are critical groups that KWCWC needs to create synergies with.

Table 21: CSW - KASARANI DISTRICT

	CSW GROUP	LOCATION	APPROXIAMTE NUMBERS
1	Hope Sex workers		30
2	Mombasa Raha Sex Workers	Mathare Area 2	30
3	Jitegemee Sex Workers		30
4	Damp Site Sex Workers	Mathare Area 1	30
5	Baba Dogo Sex Workers	Baba Dogo	30
6	Kambi Moto Sex Workers		30
7	Jangwani Sex Workers	Mathare Area 4	30
8	Destiny Sex Workers		30
9	Night nurse Sex Workers		30
10	Victoria Sex Workers		30
11	Step Forward Sex Workers		30
12	Imani Sex Workers		30
13	Happy Ladies Sex Workers		30
14	Kasarani pamoja Sex Workers		30
15	Sasa Sex Workers	Roasters Area	30
16	SWOP	Around Blue Springs Hotel	30
	TOTALS		**480**

Source: Key Informants

5.9.5 HIV-AIDS and GBV

Table 22: Comprehensive care givers in Kasarani

Facility Name	Type of Facility	Location
Baba Dogo Health Centre	Government	Baba Dogo Next to Chandaria Industries
Baraka Medical Clinic	Mission	Mathare 4A
EDARP (Baba Dogo)	Mission	Baba Dogo Catholic Church; Dandora; Kariobangi North; Mathare North;
GSU Ruaraka Health Centre	Government	GSU Headquarters, Thika Road
Kamiti Prisons	Government	Kamiti Maximum Prison
Kariobangi Health Centre	City Council of Nairobi	Kariobangi North
Kasarani Health Centre	City Council of Nairobi	Near Kasarani DC's Office
Lea Toto Clinics	Mission	Landmark Plaza
Mathare North Health Centre	MOH	Mathare North
St. Francis Hospital	Mission	Mwiki
St. Joseph Mukasa	Mission	Kahawa West

5.10 Kasarani GBV Actors and Partners

Table 22: Kasarani GBV Actors and Partners

	INSTITUTION/ORGANIZATION	TYPE OF ORG.	AREA OF FOCUS	LOCATION
1	Kenya Women & Children's Wellness Centre	NGO	GBV prevention	USIU, Roysambu
2	No Means No Worldwide	NGO	Rape defense Skills	Korogocho
3	WRAP Kenya	NGO	Shelter /psychosocial	Muthaiga
4	Micro Justice for all Kenya	NGO	Legal Assistance	Kasarani
5	Women Empowerment Link	NGO	Women Empowerment	Kasarani
6	BHSEP	NGO	Human Rights for Women	Kasarani
7	MSF France	NGO	Post Rape care	Starehe/Kasarani
8	UNGASS	NGO	HIV testing/GBV	Kasarani
9	Kasarani CCI	NGO	Child Protection	Kasarani
10	Kenya National Scouts Association	-	Schools	Kasarani/Scout office
11	Children Protection Unit	Government	Child Protection	Kasarani Police
12	Kasarani Police Station	Government	Security	Kasarani Police
13	Ministry of Medical Services	Government	Health	Kasarani
14	Ministry of Public Health & Sanitation	Government	Health	Kasarani
15	Ministry of Education	Government	Health	Kasarani
16	Ministry Local Government	Government	Health/Social Work	Kasarani
17	Ministry of Gender, sports , culture & Social services	Government	CBO's, GBV network, youth	Kasarani
18	Barak Medical Centre (German Doctors)	NGO	GBV/Child protection	Mathare
19	Mathare North Health Centre	City Council	Health	Kasarani
20	Kenyatta University	Government	Gender	Kasarani
21	Kasarani GBV network	Network	GBV networking	Kasarani
22	Kasarani Area Advisory Committee	AAC	Social issues	Kasarani
23	Community Policing	Community	Security/ Peace	Kasarani

6.0 Discussions, Conclusions and Recommendations

6.1 GBV programming in the light of MDGs

In Kasarani, GBV intervention programs need to address four critical needs: community mobilization; behavior change communication; service delivery; and Security/police and legal programs. The community mobilization programs should focus on mobilizing community groups and other stakeholders like faith based organizations, opinion leaders, schools, the police, and NGOs to coordinate the GBV interventions and avoid the duplication of resources. The behavior change communication programs are critical in addressing beliefs and norms that exacerbate GBV in the community. The service delivery programs are pertinent in identifying GBV cases and providing care to the GBV survivors. Such programs are important in documenting information critical in providing court evidence. Other areas that the service delivery programs need to be concerned with include provision of emergency contraception to women. The Legal programs should address the human rights dimension of the GBV.

Using a multi-sectoral approach, KWCWC should lobby for the elimination gender disparity in in line with MDG 3 that calls for the promotion of gender equality and women's empowerment. Gender disparity came out as a contributing factor for the occurrence of GBV in Kasarani.

Millennium Development Goals 4 and 5 focus on reducing child mortality and maternal mortality rates. These goals are driven by the fact that GBV causes multiple reproductive health problems, teenage pregnancy, unsafe sexual behavior and sexually transmitted diseases. This calls for KWCWC to utilize a multi-sectoral approach in lobbying for the reduction of child mortality and maternal mortality rates. A related MDG is the 6th one that vouches for the mitigation of the spread of HIV/AIDS and other diseases such as malaria and tuberculosis by the year 2015 and begin to reverse the spread. A review of the literature on GBV has clearly indicated a correlation between GBV and HIV susceptibility.

6.2 Monitoring and Evaluating KWCWC GBV Intervention

A critical challenge of evaluating the KWCWC GBV intervention is how to attribute change in Kasarani in the light of the numerous activities being implemented by different institutions. In this regard, KWCWC needs to invest strongly in an M & E framework that utilizes strong quantitative evaluation designs. This calls for the need to collect data and subsequently measure indicators systematically and longitudinally.

The greatest challenge in monitoring GBV mainly originates from the limitation of under-reporting. KWCWC needs to acknowledge the widespread nature of GBV to mitigate the under-reporting problem.

6.3 The Nature of GBV

Research has established that the roots of GBV lie in inequities based on gender roles. The inequities are characterized by the domination of men and subsequently the subordination of women. There are numerous types of violence at the community level which include physical, sexual, psychological, economic or socio-cultural. The violence occurs in private or in public settings. There are laws and policies that are enshrined in the Kenyan constitution, international and regional human rights instruments that incriminate GBV acts. Subsequently, there is need for KWCWC to work with the law enforcement organs in effectively mitigating the GBV landscape in Kasarani.

It is imperative for KWCWC to acknowledge that GBV has psychological, social, medical and legal implications, calling for the need to develop holistic and multifaceted interventions that address all these issues.

6.4 The police

Qualitative data gathered from the GBV survivors in Kasarani suggest that KWCWC should lobby for setting up of more rooms for the gender desk in each police station that will serve as an office, and a separate interview room for GBV survivors. The gender desk should be computerized to allow compilation of GBV experiences.

6.5 Persons with Disabilities and GBV

KWCWC should integrate PWDs in their intervention strategy. The intervention strategies should be tailored to address different categories of PWD. For instance, PWDs may not easily access awareness rallies; the suggestion by the respondents was to have a door to door strategy targeting the PWDs. This therefore calls for a multi-sectoral approach in intervening GBV in the context of PWD as well as HIV and AIDS.

6.6 Coordination

This study recommends a need for KWCWC to take a Multi-sectoral approach to GBV intervention by working with the other actors as well other governmental and non-governmental bodies. As it is, everybody seems to have their own agenda in a poorly coordinated environment. This calls for the need to harness efforts and establish GBV coordination mechanisms in Kasarani that should bring together both governmental and non-governmental actors.

6.7 Sustainability

First, a critical component of GBV intervention sustainability is placing more emphasis on GBV prevention. Second, there is need to build local capacity to ensure sustainability. This can be achieved by encouraging community participation. These calls for KWCWC to know how to identify and support: communities; traditional mechanisms; and civil service organizations to advocate for implementation as well the enforcement of laws. Third, there is need for KWCWC to: apply the multi-sectoral

approach in strengthening the prevention and response mechanisms; support existing protection systems at the community level; and replicate and other tested mechanisms at the local level.

Fourth, KWCWC needs to lobby the government to: strengthen legal support for victims; ensure that the PEP Kits are available and free of charge for victims; develop a strategic framework for prevention and response to GBV and the subsequent implementation strategy; develop and enforce a cross-sector coordination; develop information systems concerning GBV; and harness the existing community level social capital in the GBV intervention framework. As indicated in this study, there are numerous existing programs at the community level that are *ad-hoc* and not well coordinated. Fifth, KWCWC needs to work with development partners to make long term commitment for ease of planning as well as contingent response in the volatile GBV environment.

6.8 GBV Intervention Framework

The results of the baseline survey indicate the following critical procedures in the KWCWC GBV intervention framework:

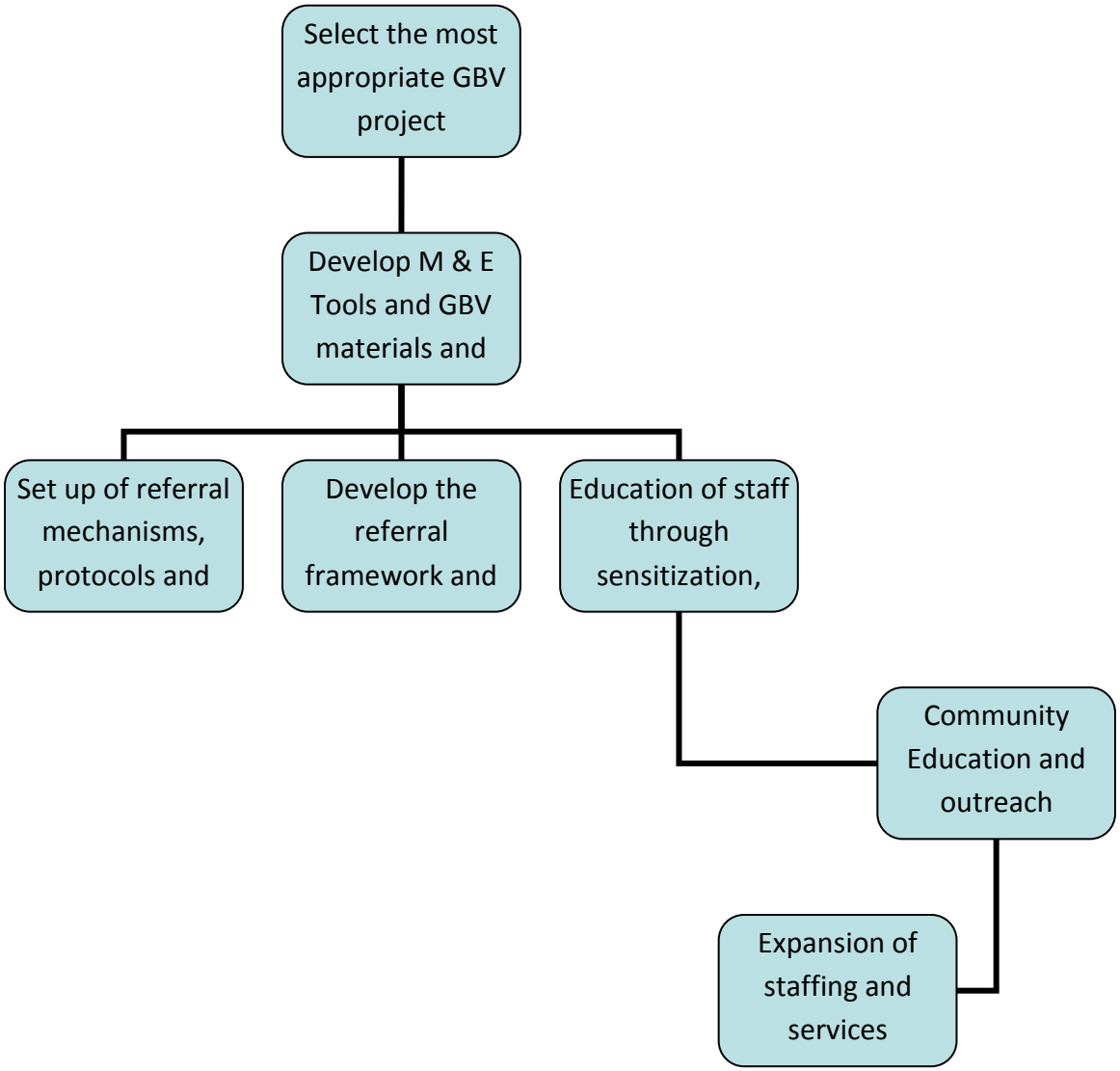


Figure 7: GBV Intervention Framework

References

Beth V, (2002) *Gender-Based Violence. Emerging Issues in Programs Serving Displaced Populations*. Reproductive Health for Refugees Consortium

Bloom, Shelah S. (2008) *Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators*. Ms.08-30. Chapel Hill, NC: Carolina Population Centre, the University of North Carolina and Chapel Hill.

Bott S, Guedes A, Claramunt MC, Guezmes A (2004) *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries*. 2004. IPPF.

Erik, N. (2006) *Child Rape Victim*: First edition; Peak Publishers.

Ganju, D. *et al*. (2004). *Sexual Coercion: Young men's experiences as victims and perpetrators.* Population Council.

IGWG (2004) *Addressing Gender-Based Violence from the Reproductive Health/HIV Sector: A Literature Review*. Washington, DC: POPTECH.

KNBS and ICF Macro, 2010, (Kenya National Bureau of Statistics KNBS and ICF Macro) *Kenya Demographic and Health Survey 2008-09*. Calverton, Maryland: KNBS and ICF Macro.

KNBS, (2010), *2009 Kenya Population and Housing Census Volume II*, Nairobi: KNBS

Population Council (2008). *Sexual and Gender Based Violence in Africa Literature Review*, Population Council

Saunders, M. Adrian, T & Lewis, P. (2009). Research Methods for Business Students. Financial Times, Prentice Hall, NY.

UNIFEM (2008), "An Empirical Analysis of Cases of Gender-Based Violence in Rutsiro, Kayonza, Ngororero Districts and the City Of Kigali", UNIFEM

USAID, (2009). *A Guide to Programming Gender-Based Violence Prevention and Response Activities*, Gender-Based Violence Working Group USAID, USAID.

Wermuth, L. (2003). *Global Inequality and Human Needs: Health And Illness In An Increasingly Unequal World*. Prentice Hall

WHO (World Health Organization) (2001). *Putting women first: Ethical and safety recommendations for research on domestic violence against women*. Geneva: WHO.

WHO (World Health Organization), (2000). *A Systematic Review of the Health Complications of Female Genital Mutilation Including Sequelae in Childbirth*, Geneva: WHO.

WHO (World Health Organization), (2005). *WHO Multi-country Study on Women's Health and Domestic Violence against Women: summary report of initial results on prevalence, health outcomes and women's responses*. Geneva, World Health Organization

World Health Organization (2003). *Guidelines for Medico-legal Care for Sexual Violence Victims.* Geneva: WHO.

Data Sources

Community Leaders

Community Members

KWCWC Field Office data

Mathare North Health Centre data

The Kenya Police data

The Field Research Team

This survey acknowledges the critical role of the following KWCWC field staff for enhancing the data collection exercise as well as the residents of Kasarani and all stakeholders and partners.

Name	Contributions made
Pauline Mumbi	Played a key role in the survey's administrative and logistics as well as reviewing and editing of the report
Michael Gaitho	He was instrumental in spearheading and coordinating the data collection process.
John King'ori	Instrumental in collating and managing data on administration work in Kasarani
Christine Mwakima	Coordinated data collection on primary, secondary and tertiary educational institutions
Lucy Gichia	Instrumental in conducting community focus group discussions (FGDs) and data collection on Youth and Faith Based Organizations
Jane Kareithi	Coordinated data collection on the prevalence and incidences of GBV cases in Mathare
Esther Muhia	Instrumental in conducting community focus group discussions with women and gatekeepers in Kasarani
Joseph Pumzile	Mobilized the community key respondents and also coordinated data collection on paralegals.