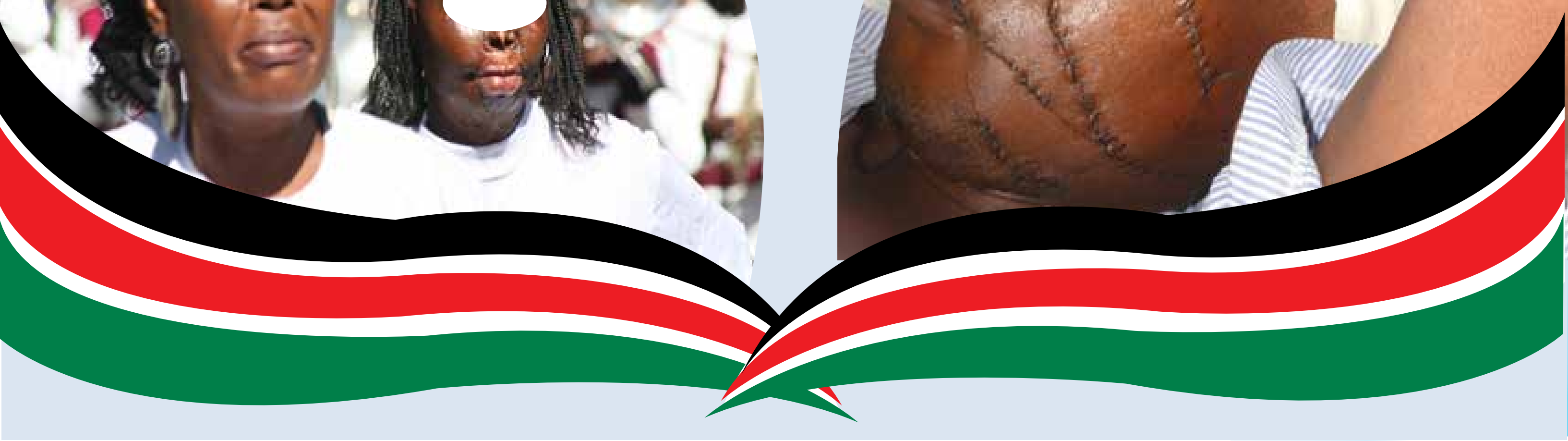
NATIONAL CRIME RESEARCH CENTRE

GENDER BASED VIOLENCE IN KENYA



NATIONAL CRIME RESEARCH CENTRE

GENDER BASED VIOLENCE IN KENYA

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TABLE OF CONTENTS

COPY RIGHT i
TABLE OF CONTENTS ii
LIST OF TABLES iv
LIST OF FIGURES v
ACKNOWLEDGEMENTS vi
FOREWARD vii
GLOSSARY viii
EXECUTIVE SUMMARY x
ABBREVIATIONS AND ACRONYMS xiv
CHAPTER ONE 1
INTRODUCTION 1
1.1 Background of the Study 1
1.2 Justification of the Study 10
1.3 Assumptions of the Study 10
1.4 Scope of the Study 10
1.5 Theoretical and Conceptual Framework of the Study 11
1.6 Review of Existing Legal and Policy Framework for Addressing GBV 13
CHAPTER TWO 15
METHODOLOGY OF THE STUDY 15
2.1 Introduction 15
2.2 Research Design 15
2.3 Methods and Tools of Data Collection 18
2.3.1 Data Collection Methods 18
2.3.2 Data Collection Tools 18
2.4 Data Collection and Management 19
2.5 Methods of Data Analysis 20
2.6 Ethical Considerations 20
CHAPTER THREE 21
FINDINGS AND DISCUSSION 21
3.1 Introduction 21
3.2 Prevalence of GBV by Type 23
3.2.1 Knowledge and Awareness of GBV 23
3.2.2 Common Forms of GBV in the Community 25
3.2.3 Lifetime and Current Experience of GBV from an Intimate Partner 31
3.2.3.1 Experience of Acts of GBV in the Last 12 Months from an Intimate Partner 34
3.2.3.2 Lifetime Experience of Sexual Violence from an Intimate Partner 35
3.2.3.3 Experience of Sexual Violence from an intimate partner in the Last 12 Months 36
3.2.4 Lifetime and Current Experience of GBV from Non-Intimate Partner 37
3.2.4.1 Respondents' Experience of GBV in their lifetime from a Non-Intimate Partner 38
3.2.4.2 Non-Intimate Perpetrators of Acts of GBV 39
3.2.4.3 Experience of Acts of GBV from a Non-Intimate Partner in the Last 12 Months 40

3.2.4.4 Lifetime Experience of Sexual Violence from a Non-intimate Partner 41
3.2.4.5 Experience of Sexual Violence from a Non-Intimate Partner in the Last 12 Months 43
3.2.4.6 Lifetime and Current Experience of Psychological/Emotional Violence from a Non-Intimate Partner 44
3.2.5 Comparison of Acts of GBV from Intimate and Non-Intimate Partners 44
3.2.5.1 Comparison of Experiences of GBV from Intimate and Non-Intimate Partners............. 44
3.2.5.2 Comparison of Acts of GBV from Intimate and Non-Intimate Partners 46
3.3 Socio-economic and Cultural Causes of GBV.. 46
3.3.1 Association between Demographic Variables and GBV..46
3.3.2 Common Beliefs about GBV…………………………………………………………49
3.3.3 Common Beliefs about GBV in Relation to Religious and Constitutional Provisions.........50
3.3.4 Perception of Common Causes of GBV in the Community...51
3.4 Socio-economic Consequences of GBV 54
3.4.1 Lifetime and Current Experience of Psychological/Emotional Violence from an Intimate Partner………………………………………………………………………54
3.4.2 Experience of Injuries from Acts of GBV in the Last 12 Months from an Intimate Partner...55
3.5 Individual and Institutional Responses to GBV.. 59
3.5.1 Reporting of GBV by the Victim..59
3.5.2 Services the Victims of GBV receive after Reporting...61
3.5.3 Role of Health Staff...62
3.5.4 Individuals and Agencies to Whom GBV is Reported..63
3.5.5 Action Taken after Report of GBV is Made...64
3.6 Appropriate Policies and Programmes for Effective Intervention... 68
3.7 Findings from Case Studies 69
3.7.1 Case Study 1- Court Case of an Alleged Rape……………………………………69
3.7.2 Case Study 2 – Victim……………………………………………………………..71
CHAPTER FOUR……………………………………………………………………74
SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS……………74
4.1 Summary of Major Findings 74
4.2 Conclusion……………………………………………………………………………...75
4.3 Recommendations……………………………………………………………………75
REFERENCES.. 77
APPENDICES 81

LIST OF TABLES

Table **Page**

Table 2.1: Sample Determination....15
Table 2.2: Targeted Sample Distribution....16
Table 2.3 Actual Sample Distribution per Region....17
Table 2.4: Actual Specific Study Locations and Samples....18
Table 3.1: Demographic Characteristics of Sample Respondents....21
Table 3.2: Knowledge and Awareness of GBV....24
Table 3.3: Perceptions about Common Forms of GBV in the Community....26
Table 3.4 Perceptions about Common Forms of GBV as per County....28
Table 3.5: Experience of GBV from an Intimate Partner by County....33
Table 3.6: Acts of GBV in the Last 12 Months from an Intimate Partner....34
Table 3.7: Experience of GBV from a Non-Intimate Partner by County....38
Table 3.8: Non-Intimate Perpetrators of Acts of GBV....40
Table 3.9: Acts of GBV in the Last 12 Months from a Non-Intimate Partner....41
Table 3.10: Lifetime and Current Experience of Psychological/Emotional Violence from a Non-Intimate Partner....44
Table 3.11: Comparison of Experiences of GBV from an Intimate and a Non-Intimate Partner by County....45
Table 3.12: Comparison of Acts of GBV from Intimate and Non-Intimate Partners....46
Table 3.13: Lifetime and Current GBV Experience among Intimate Partners by Household Status....47
Table 3.14: Common Beliefs about GBV in the Community....49
Table 3.15: Common Beliefs about GBV in Relation to Religious and Constitutional Provisions....51
Table 3.16: Perception of Common Causes of GBV in the Community....52
Table 3.17: Experience of Psychological/Emotional Violence in Lifetime from an Intimate Partner....54
Table 3.18: Experience of Psychological/Emotional Violence in the Last 12 Months from an Intimate Partner....55
Table 3.19: Injuries from Acts of GBV in the Last 12 Months from an Intimate Partner....55
Table 3.20: Injuries from Acts of GBV in the Last 12 Months from a Non-Intimate Partner....56
Table 3.21: Comparison of Injuries from an Intimate and a Non-Intimate Perpetrator in the Last 12 months....57
Table 3.22 Number of Respondents who had Ever Experienced different Types of Sexual Violence and had the violence incident reported....60
Table 3.23: Services received by Victims of Sexual Violence after Reporting....61
Table 3.24: Individuals and Agencies to Whom GBV is Reported....64

LIST OF FIGURES

Figure 1: Conceptual Framework 12
Figure 2: Picture of a 17 year-old victim……………………………………………..................27
Figure 3: Lifetime Prevalence.. 32
Figure 4: Current Prevalence 32
Figure 5: Lifetime Prevalence of Sexual Violence 35
Figure 6: Forms of Lifetime Sexual Violence from an Intimate Partner 36
Figure 7: Forms of Sexual Violence from Intimate Partner in the Last 12 Months 37
Figure 8: Lifetime Experience of GBV from a Non-Intimate Partner 39
Figure 9: Experience of acts of GBV from a Non-Intimate Partner in the Last 12 Months 40
Figure 10: Forms of Lifetime Sexual Violence from a Non-Intimate Partner............................. 42
Figure 11: Form of Sexual Violence from a Non-Intimate Partner in the Last 12 Months 43
Figure 12: Lifetime and Current GBV Experience by Marital Status 47
Figure 13: Lifetime Experience of GBV by Gender and Age 48
Figure 14: Comparison of Injuries from an Intimate and a Non-Intimate Perpetrator in the Last 12 Months...57
Figure 15: Picture of a 2 years old victim of GBV...58
Figure 16: Response to Reporting GBV 65
Figure 17: Picture of a female GBV victim for Case Study 2 …………………………………..73

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J. ORIRI ONYANGO
DIRECTOR/CEO
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FOREWORD

Gender based violence is one of the most prevalent human rights violations. It knows no social, economic, class or cultural confinement. It occurs in families, schools, workplaces, social structures and communities across the world. Women and girls, and to a lesser degree men and boys, either directly experience or face the impact of some form of gender based violence. Gender based violence involves a wide variety of agents from intimate partners and family members, to strangers and institutional actors such as teachers, pastors, office managers and police.

Despite its pervasiveness, gender based violence (GBV) is still the least talked about violation of mainly women's human rights. It remains largely unreported or in reported instances, retracted and settled. Since the Beijing World Conference on women in 1995, the issue of gender based violence has gained greater visibility. Governments have played their part in developing policy and legislation to mitigate against its occurrence. Non-state actors have filled a critical gap in providing victim psycho-social support and public sensitization. The health system has designed custom programmes and interventions targeted at the vulnerabilities and peculiarities of the phenomena. These efforts have played a significant role in ameliorating this morally repugnant vice. The efforts, though laudable, have yet to yield significant gains and foster the envisioned culture of respect for the rights of men and women, boys and girls.

A large amount of research exists today on the types of gender based violence, the variations of the violence, and the strategies for reducing the prevalence of gender based violence and its non-occurrence. By identifying and targeting the underlying causes of violence and supporting shifts in the social environment that normalizes discrimination, these interventions have provided concrete guidance on how to stop gender based violence before it occurs.

The report on 'Gender Based Violence in Kenya' is one among these initiatives that aims to support policymakers and relevant institutions in their efforts to combat and prevent gender based violence. It provides comparable data and information for effective, evidence-based decisions and policy improvement. It further seeks to identify the challenges in operationalization and their impact on effectiveness so as to inform the strategies and interventions of criminal justice system actors in particular and thereby guide the coordination of efforts going forward.

I am confident that continued and sustained effort by state actors in particular towards addressing the criminal justice aspects of gender based violence will be the tipping point in the fight against this vice, and the hallmark moment towards a new social revolution.

GITHU MUIGAI, EGH, SC.
ATTORNEY GENERAL/CHAIRMAN
GOVERNING COUNCIL
NATIONAL CRIME RESEARCH CENTRE

GLOSSARY

Prevalence or **prevalence proportion** is the proportion of a population found to have a condition or experience (such as Gender Based Violence). It is arrived at by comparing the number of people found to have the condition with the total number of people studied, and is usually expressed as a fraction, as a percentage or as the number of cases per 10,000 or 100,000 people. "Point prevalence" is the proportion of a population that has the condition at a specific point in time. "Period prevalence" is the proportion of a population that has the condition at some time during a given period ("12-month prevalence", etc.), and includes people who already have the condition at the start of the study period as well as those who acquire it during that period. "Lifetime prevalence" (LTP) is the proportion of a population that at some point in their life (up to the time of assessment) have experienced the condition. In this study prevalence was indicated by lifetime and period prevalence (12- month)**.**

EpiData: Entry used for simple or programmed data entry and data documentation. Entry handles simple forms or related systems Optimised documentation and error detection features. E.g. double entry verification, list of ID numbers in several files, codebook overview of data, date added to backup and encryption procedures.

Intimate partner violence: Intimate partner violence (IPV) is defined as threatened, attempted, or completed physical or sexual violence or emotional abuse by a current or former intimate partner. IPV can be committed by a spouse, an ex-spouse, a current or former boyfriend or girlfriend, or a dating partner.

Non-intimate violence: Violence perpetrated by people whom the victim does not have any sexual relationship with, may be of same or different gender.

P value: Statistic relating whether or not the sample supports the tested hypothesis. *P* values are the probability that a calculated test statistic as large or larger occurred by chance alone. *P* values range from 0 to 1. A zero *P* value would indicate that the probability of sampling a population and obtaining a test statistic with as large or larger a value was nonexistent. Typically, *P* values less than 0.05 are deemed statistically significant, resulting in rejection of the null hypothesis.

Sexual violence: Conduct of a sexual or indecent nature toward another person that is accompanied by actual or threatened physical force or that induces fear, shame, or mental suffering.

Psychological violence: Set of actions that directly impair the victim's psychological integrity. This may be through intimidation, isolation, harassment and threats.

Emotional violence: Mental violence that has no physical form. It occurs when someone says or does something to make the victim feel stupid or worthless. It may express itself as indifferent treatment and name-calling or as threats of violence and intimidation.

Gender Based Violence (GBV): An umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between men and women. The nature and extent of specific types of GBV vary across cultures, countries and regions. Examples include rape, sexual exploitation and forced prostitution; domestic violence; trafficking; forced or early marriage; and harmful traditional practices, such as female genital mutilation and honor killings (Baker, 2007).

Survivor/victim: Person who has experienced gender-based violence. The terms "victim" and "survivor" can be used interchangeably. "Victim" is a term often used in the legal and medical sectors.

EXECUTIVE SUMMARY

Gender Based Violence is a criminal offence and a moral indignation as provided in the Kenyan Penal Code, the Sexual Offences Act 2006 and the Constitution 2010. GBV also contributes to health problems which ultimately translate into social and economic burdens for society members and the Government. It therefore impedes the achievement of developmental goals, for instance, in the context of the Millennium Development Goals and Kenya's Vision 2030.

This report is based on a baseline survey carried out in 13 counties namely, Nairobi, Mombasa, Kilifi, Machakos, Meru, Kiambu, Nyeri, Nakuru, Samburu, Kisii, Migori, Busia and Vihiga. The purpose was to establish the prevalence, cause and effects of GBV at the community level. The overall design was a cross-sectional survey while a questionnaire and interview guide were used for data collection. The unit of analysis was the individual while the units of observation were individual community members and key informants. Individual respondents were selected randomly with a priori decision targeting a sample of 80.0% women and 20.0% men. Key informants were drawn from Government Departments in the frontline of addressing GBV including National Police Service, Judiciary, Probation and Aftercare Service and Ministry of Gender, Children and Social Development.

The existence and nature of GBV in the community was measured by respondents' awareness of forms and underlying causes of GBV. Individual level experience was measured: by self-reported experience of acts of GBV in one's lifetime and in the last 12 months from intimate and non-intimate partner; types of experience disaggregating for physical, sexual and emotional assaults; reporting of the acts; and institutional and community responses to GBV.

Quantitative data were analyzed through descriptive and inferential statistics and presented in tables and figures. The analyses were aided by EpiData and SPSS computer programs. Qualitative data were analyzed through identification of relevant themes and presented through descriptions and quotations.

Some of the key findings in the report are:

i. The most common description of what constitutes GBV was "bodily harm inflicted by man on woman" reported by 73.8% of female and 68.9% of male respondents. There was low level of viewing abuses on children as GBV, which seems to indicate that respondents generally considered GBV only in relation to "adult to adult" behaviour and not "parent to child" behaviour.

ii. More men than women report GBV to be "bodily harm inflicted by woman on man" and "psychological harm inflicted by woman on man". This reflects a gender bias in which women "trivialize" the experience of men and a cultural change in which men admit being victimized by women.

iii. Among the key informants, the Judiciary and Probation Officers demonstrated clear understanding of what constitutes GBV while the understanding of the Police and Provincial Administration was ambiguous.

iv. Respondents generally reported existence of beliefs in their areas/communities indicating men's dominance over women in their areas; for instance, 52.5% of female and 56.6% of male respondents reported that in their community it is believed that "disciplining a woman is a man's traditional right". Thus, the most fundamental cause of GBV is the traditional belief about men's dominance over women.

v. The commonest forms of GBV mentioned by both men and women were "inflicting bodily harm/physical assault", "verbal abuse" and "rape". Clear gender differences were indicated by more women than men identifying "bodily harm" as a common form of GBV, and more men than women identifying "discrimination".

vi. Lifetime prevalence of GBV was 38% for women and 20.9% for men while current prevalence was 37.7% for women and 48.6% for men. This shows that while women's vulnerability remained fairly constant, that of men increased appreciably in the last one year. This is consistent with the common belief about increased vulnerability of men as reported in the media.

vii. Significant proportions of women (15.2%) and men (7.4%) had ever experienced sexual violence. While women's vulnerability to sex violence is well know, that of men is a new finding. Focusing on sexual violence in the last 12 months among women, rape was the commonest form (compared with sexual threats and sexual humiliation). More women (37.5%) reported having experienced rape (that is, physically forced to have sexual intercourse against one's will) from an intimate partner than a non intimate partner (9.6%).

viii. GBV reporting was found to be low. Only 15.2% of female and 16.7% of male respondents who had ever been sexually violated had reported or had someone else report the act of sexual violence. Only 10.3% of women and 6.8% of men reported to have ever been asked at a health facility of any GBV physical or sexual experience they might have encountered. Among respondents who had ever reported GBV experience, most of them had reported to the Police and Provincial Administration indicating the importance of these institutions (even though the study found their understanding of GBV being inadequate). Interestingly, more men (56.5%) than women (32.4%) reported to the police confirming the general assumption that women are intimidated when reporting GBV.

ix. Only a few of the respondents reported GBV to "mother", "father" or "religious leader", which raises a serious concern since these are the closest in providing immediate intervention.

Arising from these findings, some of the conclusions drawn include:

i. There is generally a clear understanding of what constitutes GBV among community members.

ii. The critical factor underlying GBV is cultural beliefs supporting men's dominance over women.

iii. GBV prevalence rate is relatively high with an apparent indication of increasing men's vulnerability. Whether this is a fundamental change in society does require further study.

iv. Sexual violence, as a form of GBV, is indeed a common occurrence. The results confirmed that women carry the greater burden of sexual violence with the difference being statistically significant.

v. Respondents who experience GBV reported to the Police and Provincial Administration and relied less on family members and religious leaders.

Key Recommendations

Arising from the above findings and conclusions, the following recommendations were made:

i. There is need to increase awareness among community members about GBV including its forms, causes and appropriate responses. The Department of Gender and Social Development can play a leading role by increasing awareness through media advertisements. The Department may also consider identifying and partnering with NGOs working in the area of GBV in the community as a strategy for enhancing GBV awareness in the community.

ii. Inasmuch as GBV is a criminal offence, there is need to affirm a zero-tolerance policy on GBV by state agencies including the National Police Service, Public Prosecutions and the Judiciary.

iii. GBV is generally rooted in socio-economic, cultural and political exclusion of both women and men. While victimization can be addressed through legal instruments, there is need for greater empowerment of both women and men so as to minimize long-term vulnerability to violence. Responsible state institutions such as the Gender Commission should utilize the findings of this study and partner with other non-state and state agencies involved in developmental programs (such as the Department of Culture and that of Children Services) to ensure that the zero tolerance policy to GBV is integrated in programming. Moreover, the Department of Culture has a significant role in addressing retrogressive cultural practices (such as FGM and early and forced marriages) and beliefs (such as men are more superior that women) in the country.

iv. Most of the people who reported GBV did so to the Police and Provincial Administration. Hence particular advocacy, education and facilitation for these institutions and others involved in addressing GBV is needed to make them more effective in detection and management of GBV cases.

v. The greatest barrier to prevention and control of GBV was found to be failure to report GBV cases and lack of cooperation by witnesses. Different stakeholders need to roll out programmes aimed at encouraging increased reporting of GBV to relevant

authorities and supporting prosecution of perpetrators by providing witness evidence. Witness protection mechanisms are therefore paramount.

vi. GBV, like any other social behaviour, is likely to assume new patterns with time as attested by the confirmed increasing men’s vulnerability. For this reason, there is need to continuously monitor GBV trend in the country. The government may actually set up various GBV monitoring centres.

vii. NCRC may also play a leading role in promoting and supporting GBV studies conducted by other stakeholders including students and researchers in universities.

ABBREVIATIONS AND ACRONYMS

CBOs	Community-Based Organisations
CEDAW	Convention on the Elimination of Discrimination against Women
FBO	Faith Based Organisation
FGM	Female Genital Mutilation
FIDA	Federation for Women Lawyers
GBV	Gender Based Violence
GNP	Gross National Product
HIV/AIDS	Human Immuno-Deficiency Virus/Acquired Immuno-Deficiency Syndrome
KDHS	Kenya Demographic Health Survey
EUROMED	Euro-Mediterranean Partnership
MDGs,	Millennium Development Goals
MOPHS	Ministry of Public Health and Medical Services
NCRC	National Crime Research Centre
NGOs	Non-Governmental Organisations
PPS	Probability Proportional to Size
REEEP	Rural Education and Economic Enhancement Programme
SAGA	Semi-Autonomous Governmental Agency
SPSS	Statistical Package for Social Sciences
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Gender-based Violence (GBV) describes the specific type of violence that is linked to the "gendered" identity of being a woman, man or a person with transgender identity. Gender refers to the socially constructed roles, behaviour, activities and attributes that a particular society considers appropriate for men and women. The distinct roles and behaviour may give rise to gender inequalities, that is, differences between men and women that systematically favour one group. In turn, such inequalities can lead to inequities between men and women in both social, economic and political status and relationships. Thus the "weaker" gender is rendered vulnerable to domination and exploitation by the more "powerful" one. Such domination and exploitation may be symptomised in limited access to social goods like health, education, security, nutrition as well as victimisation from violent and non-violent sexual and non-sexual offences against the person. Acknowledging that the common victim of GBV is the female gender, the World Health Organisation (WHO, 2005) observes that for women in many parts of the world, violence is a leading cause of injury and disability, as well as a risk factor for other physical, mental, sexual and reproductive health problems.

GBV takes form in a variety of behaviour including physical, mental, or social abuse (UNHCR, 2000) and sexual abuse and harm (UNFPA, 2003). According to (UN-GA, 1993), in 1993, the United Nations General Assembly presented a partial list of GBV which included:

- Physical, sexual and psychological violence within the family
- Child sexual abuse
- Dowry-related violence
- Marital rape
- Female genital mutilation
- Rape and sexual abuse
- Sexual harassment in the workplace and educational institutions
- Trafficking in women
- Forced prostitution.

A significant characteristic of GBV is that the victim has no choice to refuse or pursue other options without severe social, physical, or psychological consequences owing to the fact that it is rooted in a society's social structure, that is, the society's nerve centre or its system of norms, values and beliefs (UNHCR, 2000). It is also an important characteristic that GBV can be perpetrated by an intimate partner as well as a stranger, and within and outside the family and home environment.

In Kenya, the existence and nature of GBV is documented in various studies as well as media reports. Generally the victims are women although incidents of men's victimisation are also reported. An important source of GBV data is the Nairobi Women's Hospital Gender Violence Recovery Centre that is a unit dedicated to providing medical and psychosocial support to GBV survivors. According to Omondi (2008), the Centre's data indicated that since inception and up until 2008, the hospital had received over 10,145 GBV survivors summarised as follows:

- 90% of the cases are of sexual violence (rape, defilement and sexual assault)
- 9% are domestic violence cases
- 1% are physical violence
- 49% were children
- 45% were women
- 6% were men
- The youngest GBV survivor was 1 month old baby girl, the oldest 90 yrs old woman, both of whom experienced sexual violation.

Presently, the data availed at the Centre's Website (http://www.gvrc.or.ke/) indicate that since 2001 to date, the Centre has supported over 21,341 survivors of GBV, of whom 56% were women, 36% girls, 3% men and 5% boys. Other data available at the Website indicate that:

- In Kenya, 45% of women aged between 15 and 49 years have experienced either physical or sexual violence;
- One in five Kenyan women (21%) has experienced sexual violence;
- Most violence is perpetrated in familial relationships where the perpetrator is known to the victim;
- Strangers account for only 6% of GBV in Kenya;
- Most violence towards women is committed by an intimate partner,

The high prevalence of sexual violence against the female gender is supported by other studies, for example, by Federation for Women Lawyers (FIDA, 2011).[1]

GBV occurs in every corner of the world. Its manifestations and prevalence rates vary, and robust statistics are scarce. According to the UN (2006), 10 to 70 percent of all women have experienced violence and GBV targeting lesbian, gay, bisexual, and transgendered people is endemic. At the same time, approximately 80 countries criminalize consensual homosexual acts and multiple countries fail to prosecute crimes against those who identify as gay, lesbian, or transgendered. Globally, nearly 50 percent of all sexual assaults are against girls 15 years or younger (UNFPA, 2003).

Gender-based violence affects many people in society. However, ascertaining its prevalence has been a matter of conjecture. A multi-country WHO study (WHO, 2003) established that between 15 percent and 71 percent of women report physical or sexual violence by a husband or partner;

[1] Note that the study by FIDA studied a sample of 164 respondents (and 8 focus group discussions) in four locations namely Kibera, Kawangware, Eldoret and Kisumu. The report does not state the age and gender distribution of the respondents.

between 4 percent and 12 percent of women reported being physically abused during pregnancy, and up to one in five women and one in 10 men report experiencing sexual abuse as children. According to WHO, an estimated 100 to 140 million girls and women worldwide are currently living with the consequences of Female Genital Mutilation (FGM).

Economic and cultural forms of GBV are globally acknowledged and contribute to vulnerabilities experienced especially by women and girls. The implication is that gender-based violence has profound implications for health but is often ignored. WHO's World Report (WHO, 2003) on Violence and Health notes that "one of the most common forms of violence against women is that performed by a husband or male partner”. This type of violence is frequently invisible since it happens behind closed doors, and effectively, when legal systems and cultural norms do not treat it as a crime, but rather as a "private" family matter, or a normal part of life (Saltzman, Fanslow, McMahon and Shelley, 1999).

The 2010 Kenya Demographic Health Survey report showed that almost half (45 percent) of women aged 15-49 have experienced either physical or sexual violence. The report specifically reveals that 25 percent of women have experienced only physical violence, 7 percent have experienced only sexual violence, and 14 percent have experienced both physical and sexual violence. Kenya Police crime records for 2007 showed 1,151 cases of rape and 1,782 cases of defilement as having taken place in Kenya. The Waki Report (GoK, 2008) notes that approximately 524 or 80 percent of survivors of GBV treated at the Nairobi Women’s Hospital alone suffered from rape and defilement, 65 or 10 percent from domestic violence with the remaining 10 percent from other types of physical and sexual assault. The KDHS report also indicated that 3 percent of women had perpetrated physical violence against their husbands or partners (KNBS and ICF Macro, 2010).

Research has identified factors associated with GBV at the individual, situational and societal levels. Academic disciplines and practitioners weight each level differently in their theories and the design of interventions. Clinical psychologists and legal scholars have often focused on the individual level, specifically on the pathological personality traits of GBV perpetrators as a means to identify, counsel, or prosecute potential or previous perpetrators. Sociological and feminist scholarly perspectives traditionally focus on situational and societal levels, such as gendered power asymmetries in a society or an Organisation (Black and Weisz, 2008). While the relevant literature is large, this study covers the most prominent factors featured in social psychological accounts of GBV.

From a social psychological perspective, societal factors will be most predictive of a GBV event when they are salient in the immediate situation. Such societal factors include power asymmetries, gender norms, roles, scripts, societal representations of women, and armed conflict or other crises, among others. These factors can become salient when physical or social

arrangements create the expectation of such a factor (for example, the asymmetrical representation of men at a meeting promotes the idea of male dominance at the Organisation), when implicit rules that stem from these factors are violated (for example, a man's behaviour that appears to violate a gendered norm causes him stress), or when they are raised in social interactions or media communications, for example, representations of violence against women are primed by pornography playing on a nearby computer screen (Paluck, 2009).

There are power asymmetries in GBV. Across many different literatures, GBV is understood as partially arising from power inequity. Violence is used as a mechanism for the social control of the less powerful and serves to maintain male dominance and female subordination. Men in such cases enjoy greater economic, political, and social power in the vast majority of human societies, but there also exists variability in these power inequities. Scholars have used this variation to study the circumstances under which power or motivation to gain power leads to GBV. Feminist and evolutionary accounts describe violence as a by-product of motivation to maintain status and control of economic resources. Evolutionary accounts ground this motivation in the desire to attract mates. Males attempt to maintain their advantageous, unequal status and resources by coercing other males and females (Pratto, 1996).

Power and power differences, translate directly into explicit and implicit expectations of gendered behaviour—called roles, scripts, and norms—which in turn are associated with GBV. Gender roles are socially shared expectations about behaviour that apply to individuals on the basis of socially identified sex. For any given person, gender roles exist as abstract knowledge structures about groups of people. For instance, as men are more likely to occupy roles that wield power, individuals often expect and socialize males to behave in dominant, assertive manners. As women are more likely to occupy roles as caretakers, individuals often expect and socialize women to be passive, communal, and responsive (Anderson, John, Keltner, and Kring, 2001).

Societal gender roles have been linked directly to GBV, serving to justify behaviour or define relationships. Interview studies have revealed that men who beat their wives justify the violence by citing "unwifely" behaviour (Anderson and Anderson, 2008). Other scholars conclude that masculine gender roles have become defined in part by sexual access to and dominance over women. Indeed, research has shown that "sex role stress," that is, when men feel they are inadequately meeting prescribed masculine gender roles, predicts sexual aggression (Koss, Goodman, Browne, Fitzgerald, Keita and Russo, 1993). Closely related to gender roles, gendered scripts are essentially roadmaps for behaviour considered appropriate for men and women. In gender-polarized societies, scripts for men and women rarely overlap (Bem, 1993). Koss et al (1993) cite studies of sexual scripts among middle school through college aged students showing that, for example, 25 percent of boys believed that if a man spends money on a woman, then it is acceptable for him to force her to have sex. Gendered scripts are often reflective of social norms: socially shared perceptions of where a social group *is* or *ought to be* on some dimension of

attitude or behaviour. Descriptive norms (where the group is) imply a perceived consensus about a descriptive pattern of behaviour (for example, "in our group, men typically hit their wives"), whereas injunctive norms (where the group ought to be) imply a perceived consensus about a prescribed or proscribed behaviour (for example, "in our group, hitting your wife is not acceptable") (Fitzgerald and Ormerod, 1993). Research has identified norms supporting the acceptability of GBV across a variety of group settings, including workplaces, and the military (Russell and Frohberg, 1995). Social norms influence behaviour when they are made salient by situational features, often through media. For example, a television or radio program depicting relationships between spouses can reinforce descriptive norms of spousal abuse by featuring a husband abusing his wife. Exposure to sexual violence in popular movies leads many men to become less bothered.

War and general instability in the East and Central African region continues to catalyse the occurrence of GBV. For instance, in the Democratic Republic of Congo, UNFPA (2008) reported 15,996 new cases of sexual violence in 2008. The report also indicated that 19 percent of 1,575 Burundian women surveyed in 2004 had been raped; 40 percent had heard about or had witnessed the rape of a minor. According to UNFPA (2003) study, one in three women in rural Uganda are subject to verbal or physical threats from their partners, while 50 percent of those women who have been threatened subsequently receive injuries. Beating a female partner was viewed as justifiable in certain circumstances by 70 percent of the male respondents and ninety percent of the female respondents.

UNFPA (2008) estimates that gender-based violence kills and disables more women between the ages of 15-44 than does cancer; and its toll on women's health surpasses that of traffic accidents and malaria combined. At individual level, GBV has adverse effects on the person's functioning which ultimately affects the community, country and the world at large. The immediate effects include poor health, lowered social participation and economic productivity among others. Physical abuse may lead to pregnancy complications like miscarriage, placental abruption, premature delivery, low birth weight and fetal or infant death. Non-pregnancy complications seen include fractures and head injuries which can ultimately result in death. Consequences of sexual abuse on reproductive health includes STIs, HIV/AIDS, unwanted pregnancies, unsafe abortion, urinary tract infections, pelvic inflammatory disease, infertility and genital injuries including obstetric fistulae. When a woman is not able to seek proper health care in the period surrounding pregnancy or after physical abuse, the consequences can be fatal (UNFPA, 2008).

GBV also causes psychological problems such as post-traumatic stress syndrome, depression, anxiety and low self-esteem, which can lead to alcohol and drug abuse, risky sexual behaviour and victimisation (UNFPA, 2008). These outcomes are evident in Kenya where women who suffered during the post-election conflict are still enduring similar symptoms (CREAW, 2008). Thus, the current context of extreme violence serves to exacerbate already existing problems

related to post-conflict trauma. In relation to physical and sexual reproductive health, GBV is directly linked to increased vulnerability to sexually transmitted infections and HIV. In Kenya where HIV/AIDS prevalence rates are still high, GBV ought to be recognised, as a key driver of the epidemic (Morrison and Orlando, 1999).

Violence against women within the family unit greatly hinders family cohesion; children growing up with no mother or in a violent environment will more than likely reproduce violent patterns and have behavioural problems. In terms of coping capacity at family level, GBV undermines livelihood strategies and economic alternatives and thus impoverishes the family. This has been evidenced in studies elsewhere, such as Nicaragua, where violence limits women's ability to maintain a job (Morrison and Orlando, 1999).

GBV at community level can be regarded as a new form of subjugating the population and limiting freedom of movement through the use of terror, in particular in relation to women, and as such, impedes progress in participation and peace-building. A lasting consequence of the internal armed conflict has been the dissolution of social capital and community networks, as these have been replaced by mistrust and pervasiveness at local and national levels. In this regard, affected women and their families become isolated as violence hinders their participation in their community's social, political and economic life (Carrillo, 1992).

Violence against women, like general insecurity, is also an important factor in emigration. Overall, violence directed at both males and females exerts considerable economic impacts and therefore it can be assumed that GBV also takes its toll on the state. In 2005, according to conservative estimates, violence cost the state the equivalent of 7.32% of GNP based on costs incurred in the health sector and the justice system as well as lost investment and material loss. Taking into account the death toll of victims in 2005, UNDP estimated a substantial loss of potential production which represents significant economic costs (WHO, 2005).

It is indisputable that violence against women is felt in all sectors. Firstly, it burdens the health and security systems, diverting funds from the national budget allocated to primary health and education. Secondly, in terms of macro-level economic production, violence against women erodes human capital and accounts for a loss of productivity from both paid and unpaid work as well as the foregone value of a lifetime's earning on the part of women who have died. Thirdly, GBV undermines and destabilizes democracy building, good governance and the promotion and defence of human rights. At institutional level, it destabilizes the state, reducing citizens' confidence in government authorities and institutions. Fundamentally, it renders it more difficult for the government to build a truly democratic and legitimate state and accomplish one of its main duties, that of protecting the life and development of its citizens (Carrillo, 1992).

In essence, GBV is a public health, security and human rights problem directly impeding long-term development efforts. Development is clearly under threat when women are excluded from participating in, contributing to and benefiting from development initiatives and from political decision making at micro and macro levels, since their participation is crucial to promote lasting change. Lastly, when violence is accompanied by discriminatory legislation, women are obstructed even further from exercising and enjoying their human rights and from participating in development initiatives (Morrison and Orlando, 1999; Scheepers, 2001; Sugg, Thompson , Thompson, Maiuro, and Rivara. 1999).

Though many interventions have been designed to combat and reduce GBV, it is not possible to discuss all of them within the scope of this study. We have focused on several which are applicable to the Kenyan context. They can be divided onto primary and secondary interventions. Primary interventions seek to prevent violence before it has begun by targeting social norms or through educational outreach. These programs focus on societal and situational factors. Secondary interventions address or "treat" violence once it has occurred, often at the situational or individual level. Secondary interventions include barterer intervention programs, couples therapy, programs to increase help-seeking behaviour by targets, civil protective orders, and criminal sanctions, among others. Many interventions include both primary and secondary elements, an overlap we note when present. We may also classify interventions based on whether they target individual, situational, and societal factors, or an interaction of these factors. One of the primary interventions is educational interventions. In looking at such interventions, the exaggeration of gender roles by youth and adolescents is hypothesised to increase the risk of dating violence and therefore should inform the design of primary interventions in schools (Black and Weisz, 2008). This could be a school-based intervention program targeting early adolescents. Other curricula could target adolescents' attitudes, specifically those that may "justify the use of dating aggression" (Avery-Leaf, Cascadi, O'Leary and Cano, 1997). Other primary intervention programs may target adolescents and young adults through community centres or other gathering places. One such intervention, a program targets participants' perceptions of social norms of masculinity. By changing perceptions of norms of masculinity, the program hopes to encourage more gender equitable behaviour and attitudes among participants. This intervention uses social modelling techniques to communicate gender equitable social norms and to transfer relationship skills in peer-to-peer educational sessions.

In some settings, programmes also target men outside of these small group sessions using media campaigns such as radio transmissions and billboards. Male participants in peer-to-peer workshops develop the media campaigns in order to insure that the norms communicated originate within the audience's own social group. This strategy is an excellent example of the person and situation interactive approach, which posits that social norms must be activated in situations where the targeted behaviours might take place (Ajzen, 1991; Avery-Leaf et al., 1997).

Some programs focus on potential targets of violence, seeking to help them avoid future violence. The design and implementation of target-oriented programs can be controversial in the context of GBV, because frequently targets of violence are blamed for their suffering based on their failure to conform to societal norms. This is generally true of rape. The primary preventive strategy is to reduce rape and sexual assault among adults in the country (Brecklin, 2008). Thus one approach would be media and social norms marketing campaigns. This is because the perception of community disapproval may affect behaviour, despite personal attitudes and beliefs to the contrary. Because of the theorized relationships between many types of GBV and perceived norms regarding violence and gender, social norms marketing is a promising primary intervention to reduce GBV. Social norms marketing includes marketing techniques, such as mass media and face-to-face campaigns, that are designed to alter individuals' perceptions of social norms, specifically perceptions of attitudes and behaviours that are typical or desirable in their community. Rather than directly targeting personal attitudes or beliefs, social norms marketing targets perceptions of the prevalence of certain attitudes or beliefs in the community. Social norms interventions are supported by research showing that social norms affect behaviour change more dramatically than personal attitudes (Paluck, 2009).

Social norms can sustain GBV rooted in community customs, including Female Genital Mutilation (FGM). Even when families oppose FGM, they may have their daughters cut because they perceive that other community members view it as normal or desirable, or they believe their daughter's chances of marrying will be reduced by foregoing FGM. The idea here is that personal disagreement with a norm alone does not change behaviour; even when a large percentage of a group no longer personally supports the behaviour, it may persist due to the belief that other members of their group subscribe to the norm. This is the basis of "conservative lag" (Paluck, 2009).

The media's power to influence gender norms has been demonstrated in studies examining instances in which media depicted widespread adoption of different gender roles and responses to GBV. For example, viewing television programs that depict neighbours and family members rejecting domestic violence was correlated with a decreased likelihood that survey respondents defend or approve of domestic abuse (Scheepers, 2001). Likewise, access to cable television in India, including international programming where women are more outspoken, was associated with a significant decrease in the reported acceptability of domestic abuse. Edutainment (the integration of educational messaging with popular entertainment) is a common form of social norms marketing. Initially popular as a public health intervention, edutainment now includes programming seeking to reduce GBV (Jensen and Oster, 2009).

GBV is a significant problem for the Kenyan society. It is a crime and a moral indignation as provided and envisioned in the Kenyan legal system. For example it violates the penal code and

the recent Sexual Offences Act in reference to protection of lives and property. It is a violation of the constitutional rights of a person (KLRC, 2010).

GBV also contributes to health problems not only among the direct victims but also among their significant others. Such health problems translate into social and economic burdens for society members and policy problems for the Government. For instance the monies used in treatment of victims and capturing, prosecution and punishment of offenders could find better use in developmental initiatives (Otsola, 2012; Zwi, 1994)).

Consequently GBV impedes the achievement of developmental goals, for instance, in the context of the Millennium Development Goals and Kenya's Vision 2030. With regard to the eight MDGs, GBV undermines the eradication of extreme poverty and hunger, achievement of universal primary education, promotion of gender equality and empowerment of women, reduction of child mortality rates, improvement of maternal health, combating HIV/AIDS, malaria, and other diseases, ensuring environmental sustainability and developing global partnerships for development; all of which require the active participation of all members of society (UN, 2006).

Vision 2030 is a long-term development blueprint that seeks to transform Kenya into "a newly-industrializing, middle income country providing a high quality of life to all its citizens in a clean and secure environment". The plan is anchored on three pillars namely economic, social and political governance. The economic pillar aims to achieve an economic growth rate of 10 per cent per annum and sustaining the same till 2030 in order to generate more resources to address the MDGs. The vision has flagged out projects addressing the MDGs directly in key sectors such as agriculture, education, health, water and environment. The social pillar seeks to create just, cohesive and equitable social development in a clean and secure environment. The political pillar aims to realise an issue-based, people-centred, result-oriented and accountable democratic system. These aims cannot be efficiently achieved in an insecure socioeconomic environment as epitomised by GBV (GoK, 2011; IASC, 2005). Thus, GBV needs to be prevented and controlled. Where it has already occurred, victims need to be rehabilitated and restored; and perpetrators punished and corrected. Such interventions ought to be based on scientific evidence. Hitherto, there were only few studies on GBV in Kenya and were limited in geographical scope. There was, therefore, need to conduct the study on GBV to update its prevalence rate and patterns and on a larger scale so as to inform national intervention policies and programmes.

The research questions of the study were:

1 What is the prevalence rate of GBV by type?
2 What are the socio-economic and cultural causes of specific types of GBV?
3 What are the socio-economic consequences of GBV?
4 What are the individual and institutional responses to GBV?

5 What is the existing legal and policy framework for addressing GBV?
6 What are the appropriate policies and programmes for effective intervention?

1.2 Justification of the Study

The study sought to establish prevalence and patterns of GBV in Kenya. GBV undermines developmental goals such as the MDGs and Vision 2030 hence it needs to be prevented and controlled. The mandate of NCRC includes advising the Criminal Justice Agencies on crime and its control. Consequently the importance of this study is in providing information to the Police, Judiciary and other stakeholders that would assist them in their work. Furthermore, this report has adopted a scientific approach meaning that the knowledge generated is valid and reliable thus filling knowledge gaps.

1.3 Assumptions of the Study

GBV experience especially sexual violation or the victimization of men is generally a taboo area. Victims are more likely to experience stigma and therefore fail to report having encountered such experiences. Against this background the study made the following assumptions:

1. Individuals can report their own GBV experience despite the stigma;
2. State agencies including the police, Judiciary and probation officer are knowledgeable about GBV and would be permitted to share such information without fear.
3. GBV correlates with demographic as well as with socio-cultural factors; hence, a stable pattern can be obtained.

1.4 Scope of the Study

Prevalence was indicated by two variables: Life time prevalence and current prevalence. This was obtained by asking respondents whether they have personally encountered GBV in their lifetime or in the last one month. Types of GBV were indicated by the various forms it takes such as sexual, physical and emotional abuses.

The social economic and cultural causes were indicated by respondent's characteristics including education levels, occupation/primary economic activity, demographics (age, gender, marital status). The study did not seek data on religious affiliation. This would have been an important cultural factor to consider. However, religious perspectives were captured by seeking respondent's views about cultural and religious beliefs regarding GBV.

The individual consequences of GBV were indicated by bodily and emotional injuries as reported by respondents. Responses were indicated by the actions taken by individuals who had experienced GBV as well as actions by the frontline institutions (including the Police and the Courts). Data on saliency of legal and policy frameworks were obtained by examining where the provisions available in Kenya are implemented and with what success and challenges. Data were obtained from key informants.

1.5 Theoretical and Conceptual Framework of the Study

In social sciences such as criminology, psychology, sociology and anthropology, social control theory has been used to illustrate variables related to inappropriate behaviour in society. This theory is associated with the works of theorists such as Gottfredson and Hirschi (1990). The theory proposes that exploiting the process of socialization and social learning builds self-control and reduces the inclination to indulge in behaviour recognised as antisocial. It was derived from Functionalist theories of crime and proposes that there are four types of control. One of them is direct control in which punishment is threatened or applied for wrongful behaviour, and compliance is rewarded by parents, family, and authority figures. The second one is indirect by which a youth refrains from delinquency through the conscience or superego. The third is internal control whereby identification with those who influence behaviour, say because his or her delinquent act might cause pain and disappointment to parents and others with whom he or she has close relationships. Finally, there is control through needs satisfaction, i.e. if all an individual's needs are met; there is no point in criminal activity.

The relevance of this theory to the study is found in sense that people's relationships, commitments, values, norms, and beliefs encourage them not to break the law, in this case gender-based violence. Thus, if moral codes are internalised and individuals are tied into, and have a stake in their wider community, they will voluntarily limit their propensity to commit deviant acts. The theory seeks to understand the ways in which it is possible to reduce the likelihood of criminal act such as gender-based violence developing in individuals. It does not consider motivational issues, simply stating that human beings may choose to engage in a wide range of activities, unless the range is limited by the processes of socialisation and social learning. Thus, morality is created in the construction of social order, assigning costs and consequences to certain choices and defining some as evil, immoral and/or illegal.

Thus, the propensity to engage in gender-based violence is behaviour consequent to the failure of personal and social controls. In this case, personal control is seen as the ability of the individual to refrain from meeting needs in ways which conflict with the norms and rules of the community while social control is the ability of social groups or institutions to make norms or rules effective. To understand why individuals engage in behavioural deviance such as rape, defilement and spousal battery requires an understanding and specification of such "abilities" and the specific control mechanisms leading to conformity. This means that the failure of primary groups such as the family to provide reinforcement for non-delinquent roles and values was crucial to the explanation of gender-based violence. Values such a respect, trust and commitment are taught by the primary groups and reinforced by secondary actors like states and governments. This may explain why, for instance, the uncommitted adolescent is a candidate for gang socialization. This argument acknowledges "gang socialization" towards gender-based violence as part of the causal, motivational, dynamic leading to delinquency.

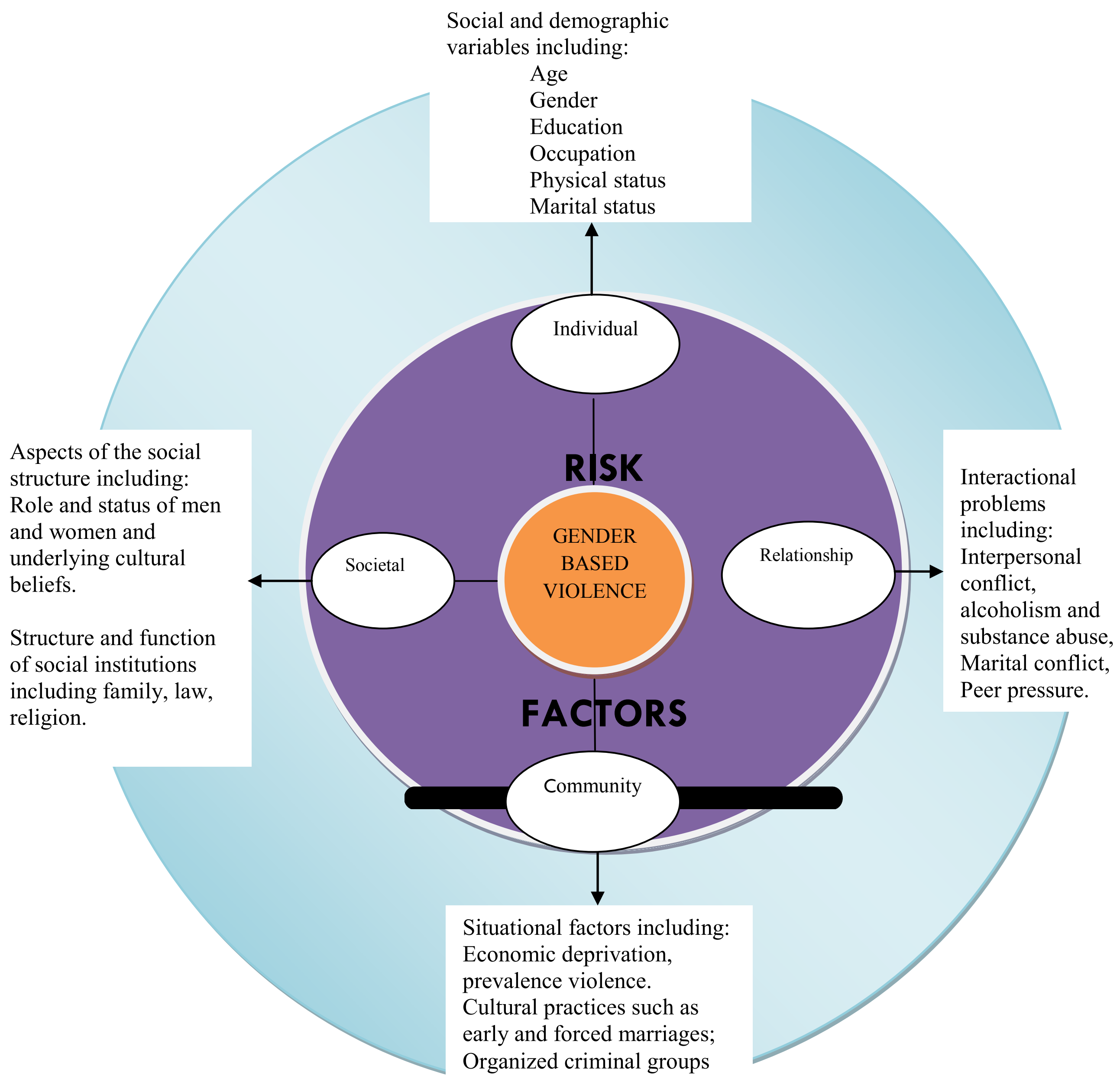

Figure 1: Conceptual Framework

The model shows various risk factors associated with GBV that occur at the micro (individual) and macro (societal) levels usually with varying impact on the victims. Studies conducted on GBV have concluded that there is no single path to GBV and that there are the risk factors are varied and intertwined. In particular, there are four categories of risk factors responsible for GBV in society and include:

i. Individual risk factors, which are social and demographic factors including age, gender, marital status etc.
ii. Relationship risk factors, which are interactional factors such as interpersonal conflict, marital conflict, peer pressure etc.
iii. Community risk factors, which are situational factors including economic deprivation, prevalence of violence or of organized criminal groups etc.
iv. Societal risk factors, which are macro level predisposing factors such as prevalence of norms and values determining asymmetrical power relations between men and women, general social change in statuses and roles etc.

1.6 Review of Existing Legal and Policy Framework for Addressing GBV

The legal and policy instruments addressing GBV in Kenya are essentially the Constitution of Kenya 2010, the Sexual Offences Act 2006, the Penal Code and the United Nations Committee on the Elimination of Discrimination against Women (CEDAW) 1979. Other relevant instruments include the Prohibition of female genital mutilation Act 2011 and the Gender policy 2011 (KLRC, 2010; 2011). This section reviews the contributions of these instruments to addressing GBV in contemporary Kenya.

Chapter four of the Constitution consists of the Bill of Rights and has the following important provisions: Section 27 (1): "Every person is equal before the law and has the right to equal protection and equal benefit of the law". Section 27 (2): "Equality includes the full and equal enjoyment of all rights and fundamental freedoms". Section 28: "Every person has inherent dignity and the right to have that dignity respected and protected." Section 30 (1): "A person shall not be held in slavery or servitude". Section 30 (2): "A person shall not be required to perform forced labour".

The Sexual Offenses Act 2006 is a comprehensive law that criminalizes a wide range of behaviours including rape, sexual assault, defilement, compelled or induced indecent acts with child imbeciles or adults, gang rape, child pornography, child trafficking, child sex tourism, child prostitution, exploitation of prostitution, incest by male and female persons, sexual harassment, deliberate transmission of HIV or other life threatening sexually transmitted disease, stupefying with sexual intent, forced sexual acts for cultural or religious reasons among others. The Act also has orders for medical treatment for victims including free HIV prophylaxis, emergency pregnancy pill and counseling. The Act provides stiff penalties in which most of the crimes

attract minimum of ten years imprisonment which can be enhanced to life imprisonment. Considering the wide range of behaviours covered and the stiff penalties, the Act is definitely an important tool in combating sexual offences.

International and regional legal policy frameworks have also sought to address gender based violence. Over the years, different bodies have been formed to monitor implementation of the international human rights treaties. The bodies have continually taken up States parties' obligations to address violence against women. For example, in its general recommendation No. 19 (1992) on violence against women, the Convention on the Elimination of Discrimination against Women (CEDAW) recommended that States parties should ensure that laws against family violence and abuse, rape, sexual assault and other gender-based violence give adequate protection to all women, and respect their integrity and dignity. The Convention also urged states to take all legal and other measures that are necessary to provide effective protection of women against gender-based violence, including effective legal measures, including penal sanctions, civil remedies and compensatory provisions and to protect women against all kinds of violence. In addition, the prohibition of FGM Act 2011 seeks to prevent any girl circumcision as a harmful cultural practice while the gender policy 2011 seeks to promote interventions for the reduction of sexual and gender based violence and to promote the generation of sex disaggregated data to guide interventions (KLRC, 2011).

In terms of the efficacy of the above legal and policy frameworks, it is reasonable to assert that ordinarily behaviour change is a process whose impacts may be realized in the short, medium and long term. However, the Kenya Demographic and Health Survey (KNBS and ICF Macro, 2010) indicated that about 45% of women aged 15-49 have experienced either physical or sexual violence. Specifically, the report reveals that 25 percent of women have experienced physical violence, 7 percent have experienced sexual violence, and 14 percent have experienced both physical and sexual violence. The KDHS report (Ibid. 2010) also indicated that 3% women had perpetrated physical violence against their husbands or partners.

The Police Annual Crime Report showed an increase of 8% in rape cases, 19% in defilement cases and 22% in cases of incest (GoK, 2010). Sexual violence and general vulnerability like weak capacity to negotiate sex are key factors limiting the ability of women and girls to prevent HIV/STI transmission. This is undermining Kenya's progress towards achieving its national HIV targets. At the same time, CSA (the Centre for the Study of Adolescence) (2008) reported that between 10,000 and 13,000 girls dropped out of school annually due to pregnancy. The foregoing shows the need for vigilance by all stakeholders in enforcement of laws and policies for effective management of GBV. As to the specific impacts of the laws and policies concerned, that is an empirical question suitable for further study.

CHAPTER TWO

METHODOLOGY OF THE STUDY

2.1 Introduction

This chapter presents the research design, methods and tools of data collection, data collection, and management procedures, methods of data analysis and ethical considerations.

2.2 Research Design

The overall design of the study was a descriptive cross-sectional survey. This means the study aimed at capturing the prevalence and patterns of GBV at a particular point in time. This study adopted triangulated methodology research survey design. The basic idea behind survey methodology is to measure the influence of selected independent variables on given dependent variables by asking people questions and then to examine relationships among the variables. In this instance, the survey attempted to capture attitude or patterns of behaviour. The cross-sectional survey sought to answer the question '*why*' in order to identify causal mechanisms with a view to formulating plausible research answers to the problem at hand.

In the survey research, households were randomly sampled where all households were given an equal chance to be selected as part of the study. This is the basis of quantitative methods, the hallmark of the survey. Respondents who provided qualitative data included Key Informants (KIs) such as Government Departmental Heads, local community leaders and team leaders drawn from partner agencies. Additional background information was gleaned from desk review of secondary data in the form of project design documents, project reports and official government records. The study combined both quantitative and qualitative methodologies in obtaining and analyzing data.

The target population consisted of female and male community members ages 12 – 64 years. The choice of 64 years as the upper age limit was to ensure that respondents were generally with clarity of mind to recall incidents of GBV, if any, in their past years. Table 2.1 captures the eligible and ineligible population for the study.

Table 2.1: Sample Determination

Total population of Kenya	**38,610,097**
Total ineligible population (0-11 and 65 and older)	4,294,263
Total eligible population (12 - 64)	34,315,834
Proportion of eligible population (eligible divided by total population)	0.889 (or 88.9%)

The study used stratified multistage random sampling technique. The region was used as the sample domain in order to make the findings representative at the region level. The process involved randomly selecting a few counties from each region, and from each selected county, taking a random sample of clusters, which were villages. The sample was generated using probability proportional to size (PPS) techniques whereby the selected sample is distributed proportionately across the regions. To determine sample size, the study used the UN recommendations (United Nations, 2005) for designing household survey samples. The formula for sample determination is as follows:

Sample size (household selected) $nh = \frac{(84.5)(1-r)}{(r)(p)}$

As indicated earlier, the estimated prevalence rate of GBV (45%) has been captured for women age 15 – 49 years leaving other age groups and the male gender. Based on this rate, it is assumed that the average rate of GBV indicators (e.g., knowledge of what the terms means, personal experience) is about 40%. Further, according to the 2009 Census reports, people aged 12-64 years account for 88.9% of the population. Women are more likely to experience GBV and therefore the sampling was designed to capture 80% of female respondents and 20% male respondents.[2]

Arising from these considerations, a total sample was 1,152 (921 women and 231 men) was targeted as shown in Table 2.2 below.

Table 2.2: Targeted Sample Distribution

	Total population	Sample	Females (80%)	Males (20%)
1. Central	4,383,743	131	105	26
2. Coast	3,325,307	99	79	20
3. Eastern	5,668,123	169	135	34
4. Nairobi	3,138,369	94	75	19
5. North Eastern	2,310,757	69	55	14
6. Nyanza	5,442,711	162	130	32
7. Rift Valley	10,006,805	299	239	60
8. Western	4,334,282	129	103	26
Total	**38,610,097**	**1,152**	**921**	**231**

Source: 2009 Housing and population census

Out of the expected 1,152 respondents the study managed to capture 819 respondents – 656 women (80%) and 163 (20%) men representing 71.1% of the expected sample size. The lower

[2] The sample quotas for women and men were determined arbitrarily simply because there are no studies indicating the GBV prevalence across genders. Since GBV ordinarily has a woman's face, 80% quota is a fair representation while 20% quota for men is also fair to capture any incidents that might be happening.

rate of coverage was attributed to non-contact in Garissa and Wajir due to the heightened insecurity situation at the time of the study which made it impractical to collect data from community members, failure of respondents to know or state their exact age, interviewer errors of including persons above 64 years of age and respondents' failure to respond to key questions on GBV experience. Missing cases on the questions whether the respondent has "ever experienced a form of GBV" were discarded.

The study was therefore located in the following regions (formerly provinces): Central, Coast, Eastern, Nairobi, Nyanza, Rift Valley, and Western. To enable fair representation of a region, two counties were selected from each region with the exception of Nairobi which is officially a single county. Table 2.3 below presents the actual sample distribution per region where data was collected for the study.

Table 2.3 Actual Sample Distribution per Region

	Total population	Sample	Females (80%)	Males (20%)
1. Central	4,383,743	127	97	30
2. Coast	3,325,307	95	78	17
3. Eastern	5,668,123	167	131	36
4. Nairobi	3,138,369	94	77	17
5. Nyanza	5,442,711	102	81	21
6. Rift Valley	10,006,805	129	104	25
7. Western	4,334,282	105	88	17
Total	**36,299,340**	**819**	**656**	**163**

Source: 2009 Housing and population census

Sampling for individual respondents targeted 80% of women and 20% of men. Sampling of respondents was conducted at the household level. A household was operationally defined as people who share the same pot (cook and eat together). The selection of individual respondents followed the pattern that upon entry, the household head or in his/her absence, the spouse or any adult member of the household was approached to provide household information including the number of members and important characteristics including names, age, gender, marital status among others. From the household list, one member aged between 12 – 64 years was randomly selected. In keeping with the 4:1 female –male ratio, the procedure required that after every four females the fifth was to be male. In the absence of the required respondent, replacement was allowed only once. The specific locations and samples selected for the study are shown in Table 2.4 below.

Table 2.4: Actual Specific Study Locations and Samples

Region	County	Location	Male	Female	Total Respondents
Central	Kiambu	Kiambaa, Githunguri	16	48	64
	Nyeri	Mweiga, Migumo	14	49	63
Coast	Kilifi	Mtwapa, Kikambala	9	39	48
	Mombasa	Kisauni, Miritini	8	39	47
Eastern	Meru	Township, Tigania North	20	63	83
	Machakos	Katoloni, Mwambuli	16	68	84
Nairobi	Nairobi	Kawangware, Kayole	17	77	94
Nyanza	Kisii	Marani, Sameta	4	10	14
	Migori	Sare, Bwirege	17	71	88
Rift Valley	Nakuru	Molo, Gilgil	12	54	66
	Samburu	Kisima, Wamba	13	50	63
Western	Busia	Matayos, Alupe	10	42	52
	Vihiga	Busali, Bokoli	7	46	53
Total			**163**	**656**	**819**

2.3 Methods and Tools of Data Collection

The study combined both quantitative and qualitative methodologies in obtaining and analyzing data. The quantitative approach employed the survey method, while the qualitative approach employed the Key Informant interviews.

2.3.1 Data Collection Methods

Data enumerators were trained on the protocol before administering it in face-to-face interviews. Interviews were conducted in vernacular (local language), Kiswahili or English depending on what language a particular respondent was most comfortable with. Each enumerator was supervised to ensure that recording was done correctly.

The study also involved interviews with Key Informants to establish the institutional responses of the institutions they represented.

2.3.2 Data Collection Tools

Data from individual respondents were collected through a questionnaire (Appendix 1). The questionnaire was adapted from the European Union's EUROMED Gender Equality Programme recommendations contained in the document "Gender Based Violence Methodological Protocol: Harmonized Methodology and Concepts to conduct GBV surveys". The questionnaire obtained data on the following:

- Profile of household head and all members
- Household information

- Knowledge and awareness of gender based violence
- Forms and causes of gender based violence in the community
- Forms and causes of gender based violence in the community
- Individual experience from an intimate partner
- Individual experience from an non-intimate partner
- Individual and institutional responses to gender based violence

Data from Key Informants were obtained through an interview schedule (Appendix 2). The Key Informants were drawn from institutions in the criminal justice system agencies (including the Police, Judiciary, Prisons and Probation), departments from line government ministries (such as Gender and Social Development Department, Children Services Department) and Non-Governmental Organisations (such as Safe houses/rescue homes, Religious Organisations).

2.4 Data Collection and Management

The National Crime Research Centre (NCRC) worked closely with relevant institutions for support in realizing the objective of the study especially in securing authority for the study and for the institutions to participate in the interviews.

Draft questionnaire and a Key Informant Guide based on the research questions were prepared. The Researchers conducted a pre test of the draft tools in parts of Nairobi County which did not form part of the study sites for the actual data collection. The purpose was to identify any bias and ambiguities in the tools. Respondents in the pre test were requested to highlight any ambiguous or biased questions and to point out if the questions would be able to measure the key issues of the study. This enabled the preparation of the final instruments prior to administration to the actual respondents.

Qualified Research Assistants were identified and trained. They were then allocated study sites and facilitated with required resources for the exercise (that is, funds, data collection tools and authority letters). Supervision of the Research Assistants and quality control of the exercise was done by the Lead Researchers. After collecting data within the time allocated for fieldwork, interviews were stopped to enable the commencement of data organization and analysis.

All data collected from the field was then organized and analyzed. A draft report of the study was compiled for review by NCRC's Research and Development Committee of the Governing Council, the full Governing Council and later for stakeholder validation before the final dissemination to the relevant agencies and the public.

2.5 Methods of Data Analysis

Data entry template was prepared using EpiData Software. EpiData refers to a group of applications used in combination for creating documented data structures and analysis of quantitative data. The importance of using EpiData lies in its ability to control entries and therefore reduces the risk of making wrong/erroneous entries.

After entry, data were exported to the Statistical Package for Social Sciences (also called Statistical Product and Service Solution) for verification of accuracy and analysis. The verification involved crosschecking entries with questionnaires for consistency and checking completeness of questionnaires. In doing this, 10% of the returned questionnaires were randomly selected and their entries compared with the corresponding computer entries.

Questionnaires that did not specify the age of respondents were discarded as well as those with respondents above 64 years of age. Questionnaires in which the gender of respondents could not be clearly ascertained (out of enumerators mistakes, for example, entering the code male and further in the questionnaire recording data only for females) were also discarded. Data analysis was done using descriptive statistics (including frequencies, averages) and inferential statistics (mainly Chi-square). Chi square is basically a measure of association, which compares observed data and expected data based on a specific hypothesis. For example, the test can demonstrate difference between men and women on any GBV indicator. The report of the survey was written thematically guided by the research questions.

2.6 Ethical Considerations

Ethical considerations observed in the study included the following:

i. Adequate training was carried out for research assistant before going out to the field. This enabled them understand the questionnaire in detail before data collection.

ii. Consent to carry out interviews was sort from respondent before interviews were carried out.

iii. Respondents were allowed not to answers questions they were not comfortable with.

iv. Only views given by the respondents were recorded.

v. Due to the sensitivity of the study, the language used when administrating the questionnaire was decent.

vi. For the subjects under the age of 18, parental consent was sought and the individuals interviewed in the presence of the parents.

CHAPTER THREE

FINDINGS AND DISCUSSION

3.1 Introduction

The chapter presents the findings of the study guided by the research questions outlined in Chapter One. However, demographic data of the respondents are also presented. Quantitative data are presented as percentage and Chi-square (symbolised χ^2). The data are presented through tables and figures. The percentages are generally presented in descending order (from highest to lowest) and a common pattern is identified when reported by at least 25% of the respondents. Chi-square statistics and associated probability are only shown where a significant association is established. Qualitative data are presented through discussion of views of Key Informants and where necessary, emphasis is made through quotations.

A total of 819 respondents were interviewed of whom women constituted 80% (n = 656) and men 20% (n = 163). Of the women, majority occupied the usual household statuses of "first wife" (50.5%), "household heads" (28.8%) and sons or daughters (12.5%). The same pattern emerged for men where the commonest statuses were "household heads" (75.5%) and "sons or daughters" (20.2%).

The average (mean) age for women was 33 years and for men 37 years (both with a range of 12 – 64 as predetermined). For both genders, all the age groups from 12 to 64 years were represented in the random sample. The distribution across the age groups was consistent with the Kenyan population structure that has a bulk of young people and few elderly. Majority of the respondents belonged to the "youth" age groups of 20 – 29 years and 30 – 39 years. The sample was also well distributed across marital status, education level, physical status and primary economic activity. The spread of the sample across various categories of the demographic variables allows for the examination of the association between these variables and GBV experience. Table 3.1 captures the demographic characteristics of the sample respondents

Table 3.1: Demographic Characteristics of Sample Respondents

Variable	Category	Women %	Men %
Respondent status (in relation to Household head)	First wife/spouse	50.5	0.0
	Head of household	28.8	75.5
	Son or daughter (Offspring)	12.5	20.2

Variable	Category	Women %	Men %
	Other relative	2.4	1.8
	Son or daughter in law	2.0	0.0
	Grandson/daughter	1.2	0.6
	Additional wife/spouse	1.1	0.0
	Brother or sister	0.6	1.2
	No relationship	0.6	0.0
	Mother or father	0.2	0.6
	Mother or father in law	0.2	0.0
Age	Average (Mean)	33 yrs	37 yrs
Age Groups	12 – 19	9.3	6.7
	20 – 29	35.9	24.4
	30 – 39	28.5	31.7
	40 – 49	15.6	17.1
	50 – 59	7.6	14.6
	60 – 64	3.1	5.5
Marital status	Married	60.6	72.2
	Single	22.1	22.2
	Widowed	8.6	1.3
	Divorced or separated	8.6	4.4
Level of education	None	12.2	5.6
	Pre-primary	0.8	0.6
	Primary school	42.5	31.2
	Secondary school	32.9	40.0
	College/University	11.7	22.5
Physical Status	Able bodied	97.1	93.9
	Moderate disability	0.9	4.9
	Extreme disability	0.6	0.6
	Elderly and unable to work	1.4	0.6
	Ill for three months/chronic illness	0.0	0.0
	Disabled and ill for more than three months	0.0	0.0

Variable	Category	Women %	Men %
Primary Economic Activity	None	15.4	17.3
	Farming	28.0	21.6
	Housewife	11.9	0.0
	Formal wages	10.1	20.4
	Petty trade (e.g., sale of firewood)	9.5	4.3
	Medium/large business	8.2	10.5
	Livestock raising	2.9	1.9
	Skilled trade/artisan	2.7	7.4
	Agricultural casual labor	1.8	3.7
	Vegetable sales	1.0	0.6
	Beer brewing	0.6	0.0
	Commercial sex worker	0.5	0.0
	Non agricultural casual labor	0.3	3.1
	House helps	0.3	0.0
	Bar attendants	0.2	0.6
	Other	3.5	4.3

3.2 Prevalence of GBV by Type

3.2.1 Knowledge and Awareness of GBV

Knowledge and awareness of GBV as an indicator of existence of GBV was measured by the respondents' description based on their own understanding of what constituted gender based violence. The most common description was "bodily harm inflicted by a man on a woman" which was reported by 73.8% of female and 68.9% of male respondents. The least common descriptions of GBV were: "harmful traditional practice inflicted on man"; "any type of abuse inflicted by parent on boy child"; "any type of abuse inflicted by parent on girl child"; "psychological harm inflicted by woman on man (fear, shame)"; and "other forms of abuse (e.g. accusing the old of witchcraft, overworking women, insubordination of men by women, discrimination of women)". These findings are shown in Table 3.2 below.

Table 3.2: Knowledge and Awareness of GBV

Narrative/item	Female %	Male %	Chi-Square	P-Value
Bodily harm inflicted by man on woman	73.8	68.9		
Sexual assaults on women and children (e.g. rape, digital finger, etc.)	41.2	41.0		
Verbal Abuse	36.5	34.8		
Bodily harm inflicted by woman on man	26.8	36.0	6.988	0.008
Deprivation (economic, sexual, etc)	27.6	19.9	6.156	0.013
Harmful traditional practice on woman (FGM, early marriage, etc)	24.3	29.2		
Psychological harm inflicted by man on woman (fear, shame)	21.8	22.4		
Other forms of abuse (e.g. accusing the old of witchcraft, overworking women, insubordination of men by women, discrimination of women)	9.5	8.8		
Psychological harm inflicted by woman on man (Fear, shame)	9.0	17.4	5.214	0.022
Any type of abuse inflicted by parent on girl child	5.4	4.3		
Any type of abuse inflicted by parent on boy child	3.1	4.3		
Harmful traditional practice inflicted on man	2.8	1.9		

From the above findings, the low level perception of abuses on children as GBV seems to indicate that respondents generally considered GBV only in relation to adult – to – adult behaviour rather than parent – child behaviour.

According to female respondents , common descriptions (in this case, those reported by at least 25% of respondents) included “sexual assault on women and children”, “verbal abuse”, “bodily harm inflicted by woman” and “deprivation such as in economic and sexual terms”. From this perspective, it is notable that about a quarter of the female respondents (24.3%) viewed “harmful traditional practices on women such as female circumcision and early marriage” as GBV. There was a low number of women reporting “psychological harm inflicted by man on woman”. This is probably due to lack of awareness about psychological forms of violence.

The common descriptions of GBV by men included “bodily harm inflicted by man on woman”, “sexual assaults on women and children”, “bodily harm inflicted by woman on man” and “verbal abuse” and “harmful traditional practice on woman”.

Comparing the views of women and men, statistically significant differences ($p < 0.05$) were indicated by more men than women reporting GBV to be "bodily harm inflicted by woman on man" and "psychological harm inflicted by woman on man". This reflects a gender bias in which women trivialize the experience of men as well as a cultural change in which men admit being victimized by women. Another significant gender difference is the more women than men reporting "deprivation" as GBV which reflects women's challenge to a cultural value that allows or justifies men's dominance over women in social, cultural, economic and political relations.

3.2.2 Common Forms of GBV in the Community

To measure through perceptions the existence of GBV in the community, respondents were asked in an open-ended question to indicate the main forms of GBV in their community or areas. As shown in Table 3.3 below, the commonest forms, as reported by at least 25.0%[3] of respondents, were: inflicting bodily harm (expressed as hitting/battering/beating) which was reported by 74.1% of female and 68.1% of male respondents; domestic conflict (which is a general term that can include both bodily harm and verbal abuse) which was indicated by 51.5% of female and 58.3% of male respondents; verbal abuse/abusive language (reported by 44.6% of female and 49.1% of male respondents); and rape reported by 43.7% of female and 38.7% of male respondents.

Broadly, most of the forms of GBV identified fall into: bodily harm (battering, murder), verbal abuse, sexual violence (marital and non-marital rape, defilement), psychological harm (humiliation, frustration), economic deprivation, human trafficking, harmful traditional practices (forceful and early marriages, forceful circumcision/initiation) and restricted association and movement of women.

Significant gender differences ($p < .05$) were indicated by more female (74.1%) than male (68.1%) respondents identifying "bodily harm", which indicates a cultural gender difference whereby men are more likely to underestimate violence against women and/or women are more likely to overestimate violence against them. Another significant difference was more male (9.2%) than female (5.8%) respondents identifying "discrimination" as forms of GBV. This indicates that men are more likely to overestimate discrimination and/or women to underestimate the same as a form of GBV, which is challenging to interpret on the basis of gender-based cultural beliefs.

[3] 25% is here used as an arbitrary mark or cut-point whereby a view or occurrence reported by 25% of respondents is termed as "common" or "frequent".

Table 3.3: Perceptions about Common Forms of GBV in the Community

Forms of GBV	Female %	Male %	Chi-Square	P value
Hitting/Battering/ Beatings	74.1	68.1	3.668	0.055
Domestic conflict	51.5	58.3		
Verbal abuse/Abusive language	44.6	49.1		
Rape	43.7	38.7		
Economic abuse/deprivation (financial restrictions)	21.9	23.3		
Psychological humiliation	20.8	24.1		
Deprivation of resources (e.g., land, swindling widows' property)	21.3	15.3		
Early marriages for girls below 18 years of age	21.0	19.0		
Defilement	18.7	19.6		
Forced marriages	16.4	14.7		
Frustration	14.1	10.4		
Sexual Assault	12.0	13.5		
Other forms of GBV (accusation of witchcraft, infidelity, mistreatment of widows, denial of freedom of expression, overworking women, child labour)	10.6	8.6		
Forceful initiation of girls	9.5	9.8		
Killings/murders of GBV victims	7.2	6.7		
Restrictions or denial of freedom of movement	6.0	6.1		
Discrimination (e.g., at workplace, by in-laws)	5.8	9.2	5.577	0.018
Sexual deprivation	5.1	6.7		
Marital Rape	4.8	2.5		
Trafficking of women and children	4.1	4.3		
Isolation from friends by husband	2.5	1.2		
Forceful initiation of boys	2.0	2.5		

Figure 2 (photo courtesy of REEEP) below illustrates the case of early marriages of girls below 18 years. The victim was aged 17 years, was a mother of three children and had been divorced at the time of the study.

Figure 2: Picture of a 17 year-old victim

This study further examined the common forms of GBV to establish their prevalence in each of the 13 counties. Their prevalence was as captured in Table 3.4 below.

Table 3.4 Perceptions about Common Forms of GBV as per County

Forms of GBV	Responses in Percentages												
	Kilifi	Mombasa	Machakos	Meru	Kiambu	Nyeri	Nakuru	Samburu	Vihiga	Busia	Kisii	Migori	Nairobi
Hitting/Battering/ Beatings	66.7	97.8	95.2	88.0	45.3	71.4	38.5	95.2	49.1	82.7	92.9	64.6	75.5
Domestic conflict	12.5	53.3	90.5	66.3	35.9	52.4	30.8	15.9	56.6	61.5	64.3	86.6	44.7
Verbal abuse/Abusive language	4.2	95.6	66.7	66.3	15.6	17.5	29.2	39.7	30.2	67.3	57.1	52.4	50.0
Rape	97.9	66.7	71.4	24.1	23.4	33.3	50.8	7.9	13.2	13.5	85.7	31.7	64.9
Economic abuse/deprivation (financial restrictions)	8.3	15.6	11.9	8.4	6.3	22.2	27.7	22.2	18.9	65.4	28.6	7.3	50.0
Psychological humiliation	0.0	86.7	21.4	45.8	1.6	4.8	13.8	4.8	7.5	9.8	21.4	3.8	51.1
Deprivation of resources (e.g., land, swindling widows' property)	18.8	0.0	75.0	7.2	7.8	4.8	6.2	6.3	30.2	7.7	7.1	2.4	48.9
Early marriages for girls below 18 years of age	60.4	8.9	0.0	2.4	3.1	1.6	7.7	76.2	1.9	21.2	14.3	69.5	5.3
Defilement	6.3	60.0	58.3	4.8	1.6	17.5	9.2	7.9	0.0	1.9	57.1	17.1	24.5
Forced marriages	29.2	40.0	0.0	12.0	1.6	4.8	4.6	90.5	0.0	21.2	7.1	9.9	3.2
Frustration	4.2	75.6	0.0	4.8	1.6	0.0	10.6	1.6	7.5	0.0	21.4	3.7	51.1
Sexual Assault	6.3	22.2	4.8	2.4	0.0	4.8	20.0	42.9	7.5	5.8	42.9	2.4	21.3
Forceful initiation of girls	0.0	0.0	0.0	1.2	1.6	1.6	7.6	57.1	0.0	1.9	0.0	26.8	9.6
Killings/murders of GBV victims	0.0	0.0	6.0	34.9	3.1	9.5	15.2	1.6	0.0	3.8	0.0	0.0	1.1
Restrictions or denial of freedom of movement	0.0	4.4	15.5	15.7	1.6	4.8	3.1	0.0	0.0	3.8	7.1	7.3	6.4
Discrimination (e.g., at workplace, by in-laws)	0.0	0.0	0.0	10.8	6.3	1.6	7.6	6.3	0.0	1.9	85.7	2.4	13.8
Sexual deprivation	2.1	2.2	13.1	0.0	1.6	1.6	12.3	1.6	1.9	0.0	7.1	7.3	11.7
Marital Rape	0.0	22.2	4.8	1.2	1.6	0.0	7.7	0.0	1.9	1.9	42.9	1.2	5.3
Trafficking of women and children	4.2	28.9	0.0	4.8	0.0	1.6	3.1	0.0	0.0	5.9	0.0	2.5	6.4

Isolation from friends by husband	0.0	2.2	3.6	6.0	0.0	0.0	1.5	0.0	0.0	0.0	7.1	3.7	4.3
Forceful initiation of boys	0.0	0.0	1.2	1.2	1.6	4.8	7.6	0.0	0.0	1.9	0.0	3.7	2.1
Other forms of GBV (accusation of witchcraft, infidelity, mistreatment of widows, denial of freedom of expression, overworking women, child labour)	2.1	0.0	1.2	19.8	6.3	4.8	21.2	20.6	28.3	15.4	14.3	2.4	2.1

From the findings of this study, "hitting/battering/beating" emerged as one of the most prevalent forms of GBV and was experienced in all counties. This form of GBV ranged from a low of 38.5% in Nakuru to a high of 97.8% in Mombasa. The top five rates were in Mombasa (97.8%), Machakos (95.2%), Samburu (95.2%), Kisii (92.9%), Meru (88.0%) and Busia (82.7%).

Domestic conflict ranged from a low of 12.5% in Kilifi to a high of 90.5% in Machakos. This form of GBV was most prevalent in counties of Machakos (90.5%), Migori (86.6%), Meru (66.3%), Kisii (64.3%) and Busia (61.5%).

Verbal abuse/Abusive language ranged from a low of 4.2% in Kilifi to a high of 95.6% in Mombasa. The top five rates were in Mombasa (95.6%), Busia (67.3%), Machakos (66.7%), Meru (66.3%) and Kisii (57.1%).

Rape is a serious criminal offence. This form of GBV ranged from a low of 7.9% in Samburu to a high of 97.9% in Kilifi. The top five rates came from the counties of Kilifi (97.9%), Kisii (85.7%), Machakos (71.4%), Mombasa (66.7%) and Nairobi (64.9%).

GBV in form of "Economic abuse/deprivation (financial restrictions)" ranged from 6.3% in Kiambu to 65.4% in Busia. The top five rates were witnessed from Busia (65.4%), Nairobi (50.0%), Kisii (28.6%), Nakuru (27.7%), and Nyeri and Samburu each scroring 22.2%.

Psychological humiliation was more reported in Mombasa (86.7%), Nairobi (51.1%), Meru (45.8%), Machakos and Kisii (each registering 21.4%) and Nakuru (13.8%).

GBV in the form of "Early marriages for girls below 18 years of age" was common in Samburu (76.2%), Migori (69.5%), Kilifi (60.4%), Busia (21.2%) and Kisii (14.3%).

Defilement was more reported in Mombasa (60.0%), Machakos (58.3%), Kisii (57.1%), Nairobi (24.5%) and Nyeri (17.5%).

Forced marriages is a retrogressive cultural practice perpetrated by a number of ethnic groups in the country. This form of GBV was common in Samburu (90.5%), Mombasa (40.0%), Kilifi (29.2%), Busia (21.2%) and Meru (12.0%).

Counties which registered top rates of GBV in form of "Frustration" were Mombasa (75.6%), Nairobi (51.1%), Kisii (21.4%), Nakuru (10.6%) and Vihiga (7.5%).

With regard to GBV in form of "Sexual Assault", the top five rates were from Samburu (42.9%), Kisii (42.9%), Mombasa (22.2%), Nairobi (21.3%) and Nakuru (20.0%).

Forceful initiation of girls was common in Samburu (57.1%) and Migori (26.8%) while killings/murders of GBV victims were common in Meru (34.9%), Nakuru (15.2%) and Nyeri (9.5%). Meru (15.7%) and Machakos (15.5%) led in GBV in form of "Restrictions or denial of freedom of movement" while Kisii (85.7%), Nairobi (13.8%) and Meru (10.8%) led in "Discrimination" as a form of GBV.

Among the 13 counties that were covered in the study, Machakos (13.1%), Nakuru (12.3%) and Nairobi (11.7%) were leading in GBV in the form of "Sexual deprivation" while Kisii (42.9%) and Mombasa (22.2%) were leading the counties in "Marital Rape".

Mombasa (28.9%) led the counties in "Trafficking of women and children" while counties which led in other "Other forms of GBV (suchaccusation of witchcraft, infidelity, mistreatment of widows, denial of freedom of expression, overworking women, child labour)" were Vihiga (28.3%), Nakuru (21.2%), Samburu (20.6%), Meru (19.8%) and Busia (15.4%).

Generally, the above findings are an indication that most counties experience different types of GBV in varying proportions. Focus needs to be in addressing all forms of GBV in all counties but with emphasis on counties (such as Kilifi, Kisii, Machakos, Meru, Mombasa and Nairobi) which featured prominently especially in the serious forms of GBV.

The findings on forms of GBV are clearly highlighted by Key Informants in most of the counties that were covered. A Children Officer based in Meru County commented that:

> *"Cases of GBV in this County are many. Some men in parts of this county, Tigania included, are very temperamental. I have handled cases of husbands who have battered and maimed their wives and children after disagreeing in the family. Property in this area is fully controlled by men and it is not strange to hear that a woman is taking casual jobs to feed the family when the husband is enjoying proceeds from sale of Miraa (Khat) with commercial sex workers"*

An official of the Interior and Coordination of National Government (formerly, Provincial Administration) in Kilifi County reported and said:

> *"Old people (especially men)in some areas in this county can be regarded as 'endangered' because of increased cases of their killings after being accused of witchcraft. It is unfair to kill a person on unfounded allegations. We are sensitizing the community through barazas to respect and treat their elderly members humanely and not to take law into their own hands"*

A District Probation Officer in Kisii County had this to say:

> *"Cases of defilement of women and girls are rampant. There is also brutal killing and burning of old women suspected of being wizards. Female Genital Mutilation in Kisii and Kuria is a common practice despite the laws criminalizing and prohibiting the same. Our old women here circumcize the girls secretly these days"*

The above statements of Key Informants confirm that different forms of GBV occur in the counties and efforts must therefore be put in place to profile and address them.

3.2.3 Lifetime and Current Experience of GBV from an Intimate Partner

Individual experience of GBV from an intimate partner was tested with questions asking about life time and current experience. Life time experience was indicated by whether one has ever experienced any acts of GBV while current experience was indicated by whether one had any such experience in the last 12 months. The results in Figure 3 below showed that 38.0% (n=249) of female and 20.9% (n=34) of male respondents have ever experienced acts of GBV. Of those who have ever experienced GBV, 37.7% (n=93) of female and 48.6% (n=17) of male respondents had experienced acts of GBV in the last 12 months as shown in Figure 4 below.

The lifetime prevalence of 38.0% is lower, though only to a small extent, than 45.0% rate reported for women ages 15 – 49 years by the KDHS 2008/09 report (KNBS and ICF Macro, 2010). In the report, only 3% of women reported to have perpetrated violence against their spouses or partners. While the above data reiterate the vulnerability of women to GBV, they also in a significant way demonstrate the vulnerability of men as well. It is especially curious that the percentage of men reporting current prevalence is higher than that of women which (disregarding the fact that the men's sample was small) suggests increasing men's vulnerability overtime. Whether this is a fundamental change in society does require further study.

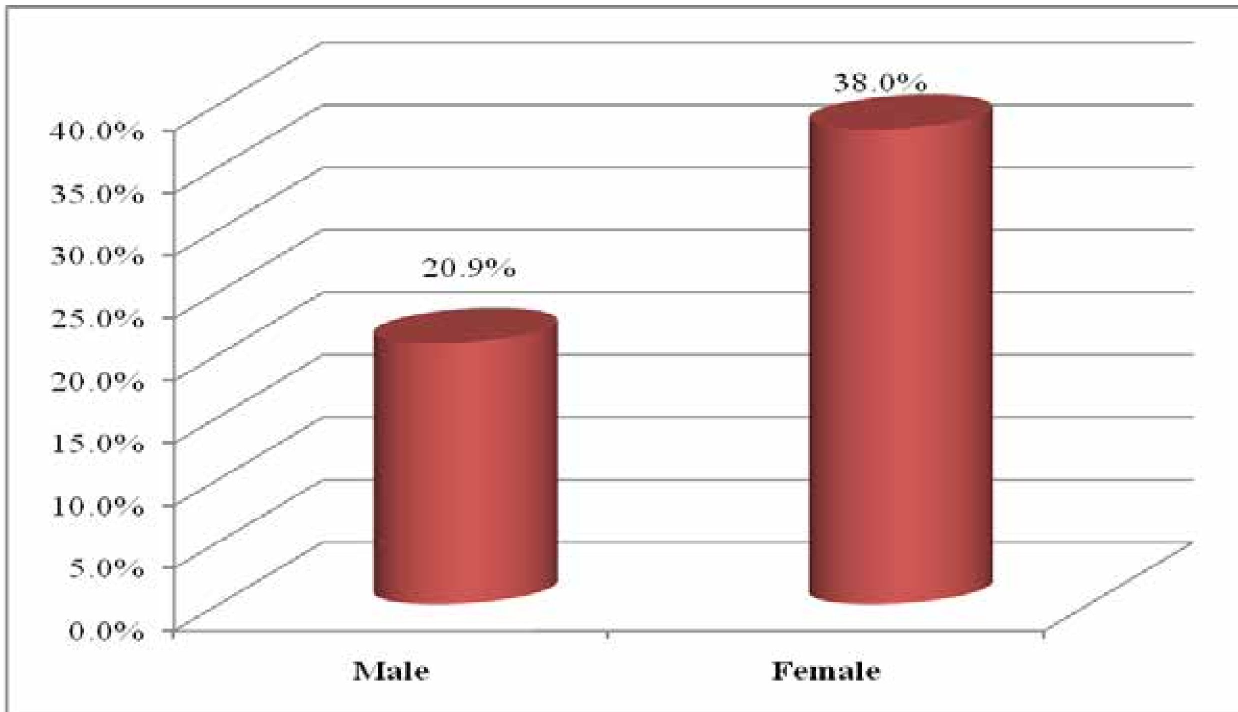

Figure 3: Lifetime Prevalence

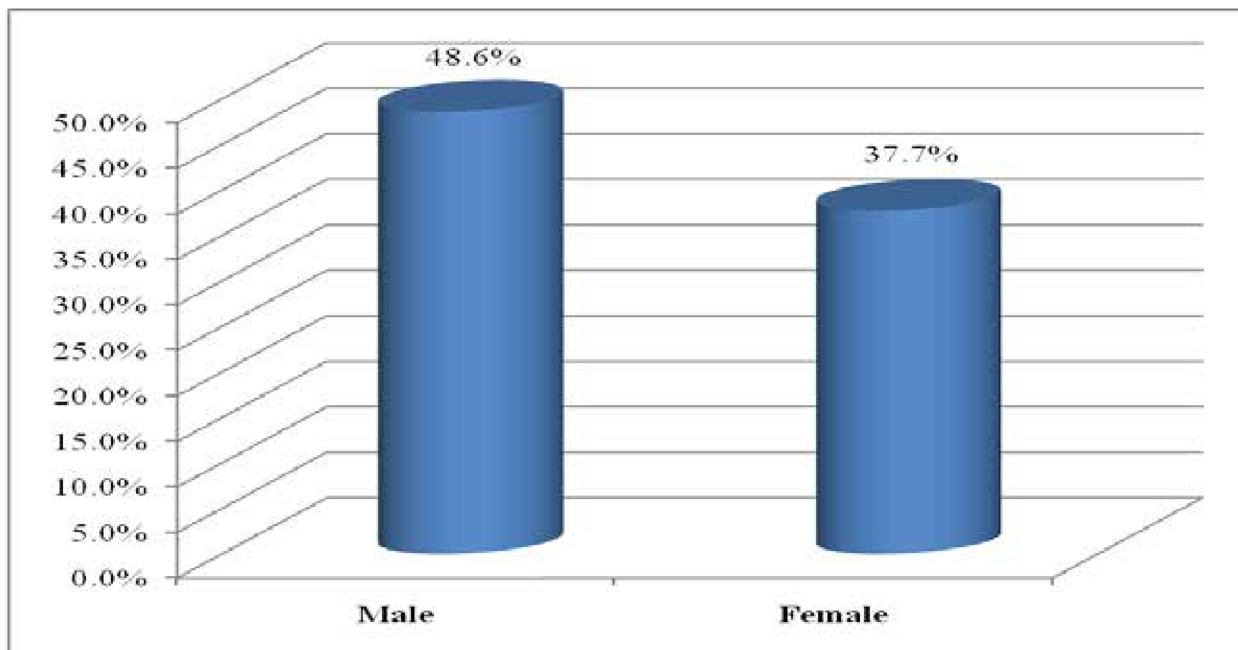

Figure 4: Current Prevalence

An examination of GBV by county is important because some acts of GBV may be area specific with the implication that interventions need to be localised.

Lifetime experience of GBV from an intimate partner ranged from a low of 12.2% in Meru to a high of 54.9% in Busia. Disaggregating for gender, the top five rates for females were in Busia (56.1%), Nairobi (46.1%), Samburu (46.0%) and Mombasa (44.7%) and Vihiga (43.5%), and for males in Busia (50.0%), Vihiga (42.9%), Mombasa (37.5%), Nyeri (35.7%), and Nakuru (33.3%). Comparing across genders, only in Nyeri and Nakuru where more male than female respondents reported GBV experience.

Experience of GBV in the last 12 months ranged from a low of 12.5% in Kiambu to a high of 66.7% in Meru. Based on gender, the top five rates for females were in Meru (60.0%), Machakos (57.1%), Nakuru (53.8%), Nairobi (45.7%) and Busia (43.5%). With regard to males, the top five rates were in Meru and Samburu (each at 100.0%), Busia (80.0%), Nakuru (75.0%), Machakos and Migori (each at 66.7%) and Nyeri (60.0%).

The findings on lifetime and current experience of GBV from an intimate partner per county are presented in Table 3.5 below.

Table 3.5: Experience of GBV from an Intimate Partner by County

County	In Lifetime			In the Last 12 Months		
	Total	Female	Male	Total	Female	Male
Busia	54.9%	56.1%	50.0%	50.0%	43.5%	80.0%
Mombasa	43.5%	44.7%	37.5%	35.0%	41.2%	0.0%
Vihiga	43.4%	43.5%	42.9%	30.4%	35.0%	0.0%
Nairobi	41.3%	46.1%	18.8%	42.1%	45.7%	0.0%
Samburu	39.7%	46.0%	15.4%	32.0%	26.1%	100.0%
Machakos	36.9%	41.2%	18.8%	58.1%	57.1%	66.7%
Migori	36.4%	42.3%	11.8%	24.2%	20.0%	66.7%
Kilifi	35.4%	41.0%	11.1%	23.5%	25.0%	0.0%
Nyeri	34.9%	34.7%	35.7%	45.8%	42.1%	60.0%
Kisii	28.6%	40.0%	0.0%	25.0%	25.0%	0.0%
Nakuru	25.8%	24.1%	33.3%	58.8%	53.8%	75.0%
Kiambu	25.0%	29.2%	12.5%	12.5%	14.3%	0.0%
Meru	12.2%	14.5%	5.0%	66.7%	60.0%	100.0%
Total	**34.8%**	**38.2%**	**21.0%**	**39.0%**	**37.7%**	**48.6%**

According to the above findings, the wide variation of the location of counties with high or low rates of GBV demonstrates that regionality is not a significant variable in patterning GBV in Kenya today.

3.2.3.1 Experience of Acts of GBV in the Last 12 Months from an Intimate Partner

Respondents who had experienced acts of GBV in the last 12 months were asked to state what had "happened" to them. The results showed marked differences which simply relate to physiological attributes between men and women. For women, the commonest experiences as indicated by at least 25.0% of respondents were: "slapped or thrown something that could hurt" (reported by 62.2% of female and 47.1% of male respondents); "kicked, dragged and beaten" (reported by 52.2% of females and 5.9% of males; "pushed or shoved" which was reported by 42.2% of females and 29.4% of males; "hit with a fist or something that could hurt" (reported by 30.0% of females and 5.9% of males. These findings are presented in Table 3.6 below.

Table 3.6: Acts of GBV in the Last 12 Months from an Intimate Partner

Acts of GBV	Female %	Male %	Chi-Square	P value
Slapped or threw something that could hurt	62.2	47.1		
Kicked, dragged or beaten	52.2	5.9	12.4	0.0
Pushed or shoved	42.2	29.4		
Hit with a fist or something that could hurt	30.0	5.9	4.3	0.04
Twisted arm or pulled hair	17.8	0.0		
Threatened, or actually used a gun, knife or other weapon against victim	14.6	23.5		
Chocked or burnt	3.3	0.0		

According to the above findings, for men, the corresponding commonest experiences were: "slapping or throwing something at someone" and "pushed or shoved". Statistical differences between men and women were indicted by more women than men being kicked and shoved and hit with fist or something else that could hurt.

Although not statistically significant, the only act experienced by more men (23.5%) than women (14.6%) was being "threatened or actually hurt with a gun, knife or other weapon". This indicates that while men use their muscular strength, women are likely to use weapons to compensate for their muscular limitations. Indeed, although it did not come out clearly in this study (that is, none of the men reported being burnt even though in a subsequent question a few men reported having burn injuries),[4] it is generally reported that women do scald their victims with hot water. Still, media reports do also indicate that men use weapons against women

[4] Note that in a survey it is not often possible for interviewers to keep tab of responses and when an inconsistent occurs they go back in the questionnaire and ask for clarification. In any case, in administering a questionnaire the respondent has right not to answer any question. Informed analysis, for instance, referring to other data sources like key informants and secondary data can assist in clarifying data and making conclusions.

including firearms and machetes. These often result in deaths; hence, cannot be captured in an interview. Thus the fewer women reporting being threatened or hurt with weapons should not be interpreted to mean that men do not use weapons as much as women could.

3.2.3.2 Lifetime Experience of Sexual Violence from an Intimate Partner

Sexual violence is a grievous harm to persons inasmuch as it violates their fundamental sense of self-worth. While this is held to be the case for women, it may also be the same for men. The study showed that 15.2% (n=99) of female and 7.4% (n=12) of male respondents had ever experienced sexual violence demonstrating that sexual violence is indeed a common occurrence. Figure 5 captures these results. The results confirmed that women carry the greater burden of sexual violence with the difference being statistically significant ($\chi 2= 6.632$, $p = 0.10$).

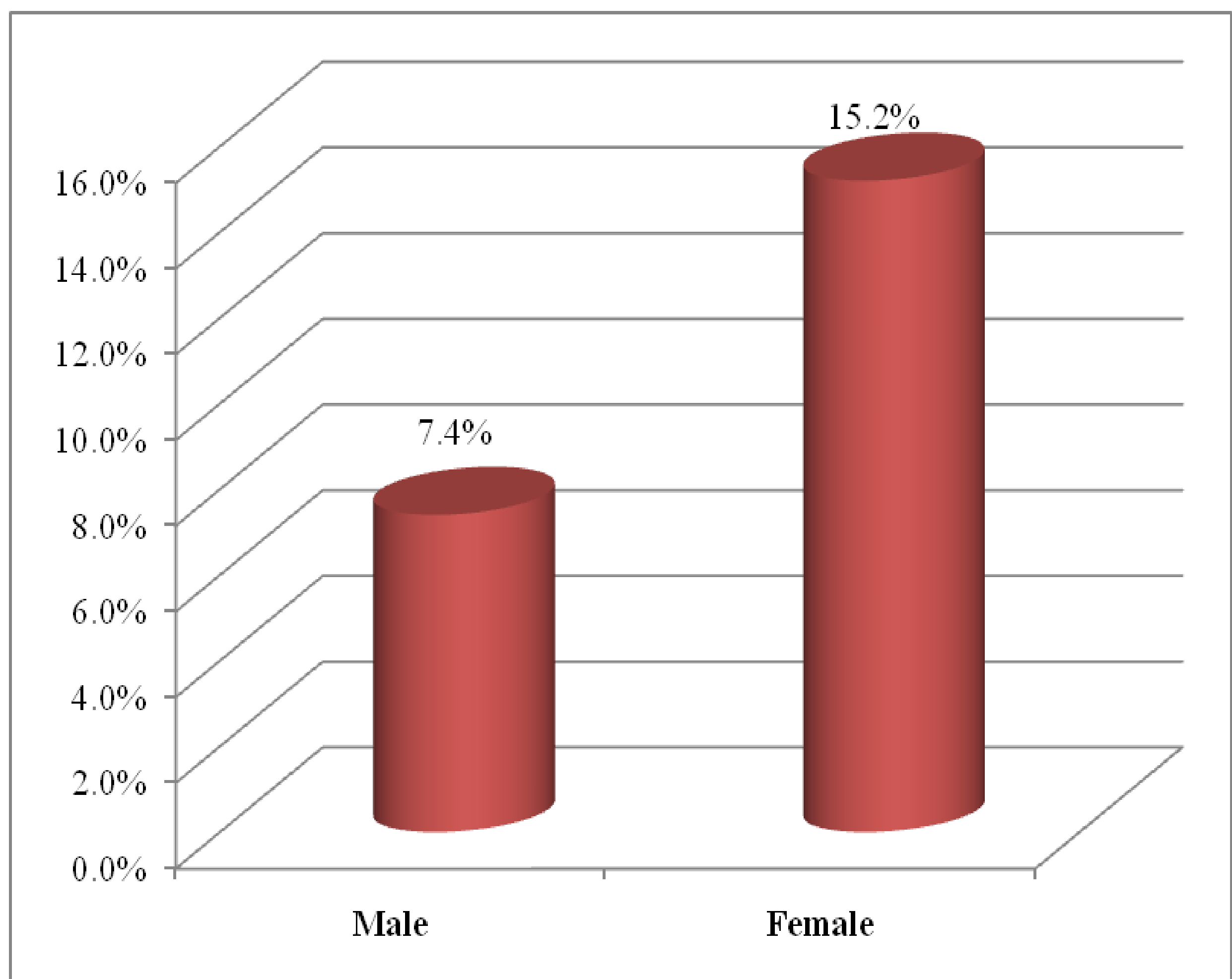

Figure 5: Lifetime Prevalence of Sexual Violence

The most common form of sexual violence highlighted was physical force to have sex against one's will, reported by 90.9% (n=90) of the female and 63.6% (n=7) of the male respondents

(χ2= 7.066, p = 0.008). According to Figure 6 below, more men (18.2%) than women (7.1%) were forced to perform a sexual act they found degrading and humiliating.

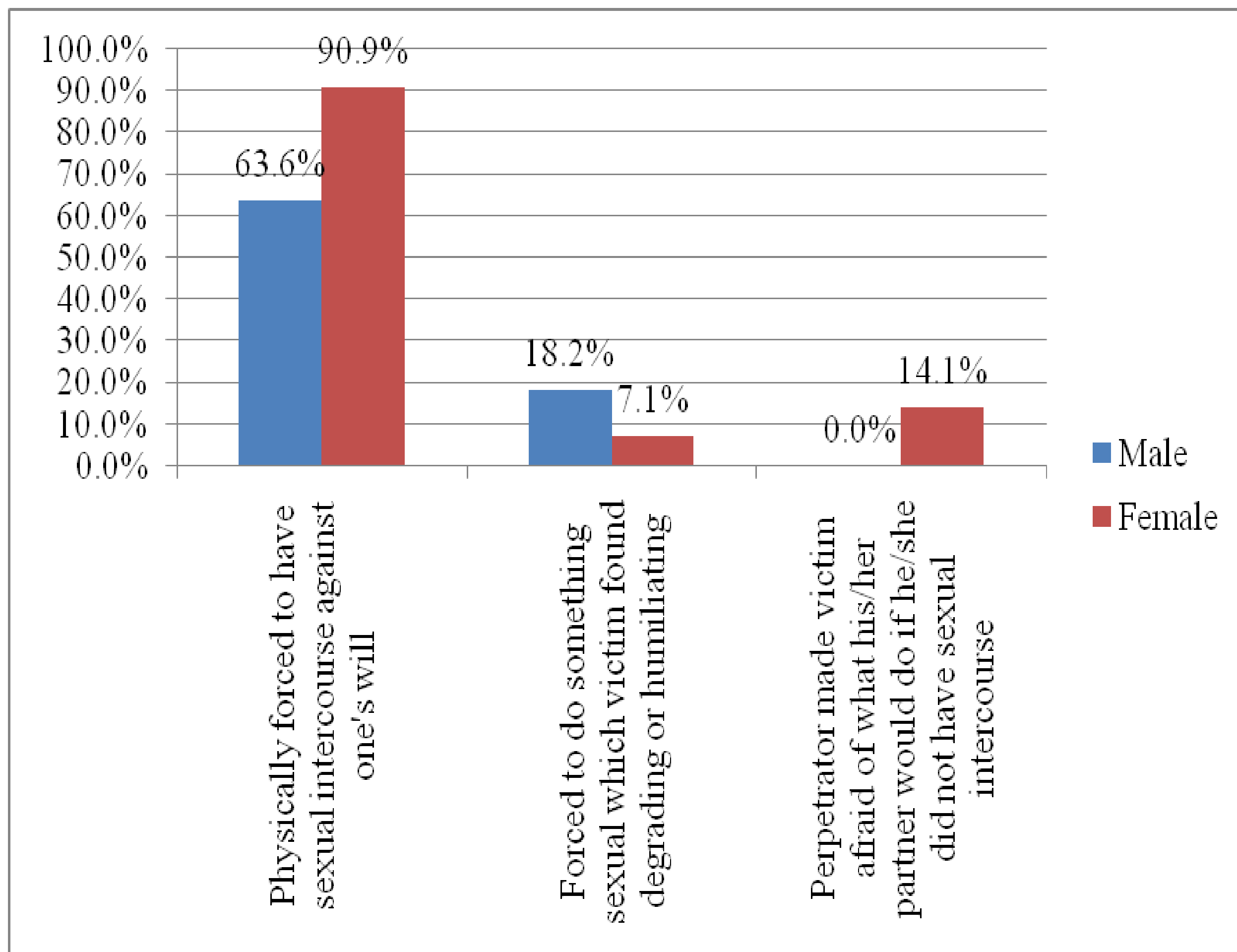

Figure 6: Forms of Lifetime Sexual Violence from an Intimate Partner

3.2.3.3 Experience of Sexual Violence from an intimate partner in the Last 12 Months

Findings in Figure 7 below indicate that among the women, physical force to have sexual intercourse against one's will in the last 12 months was the most common form of sexual violence. "Threats" and being "forced to do something sexual that one found degrading and humiliating" were reported by very few respondents. In addition, the data showed none of the male respondents had experienced sexual violence in the last 12 months**.**

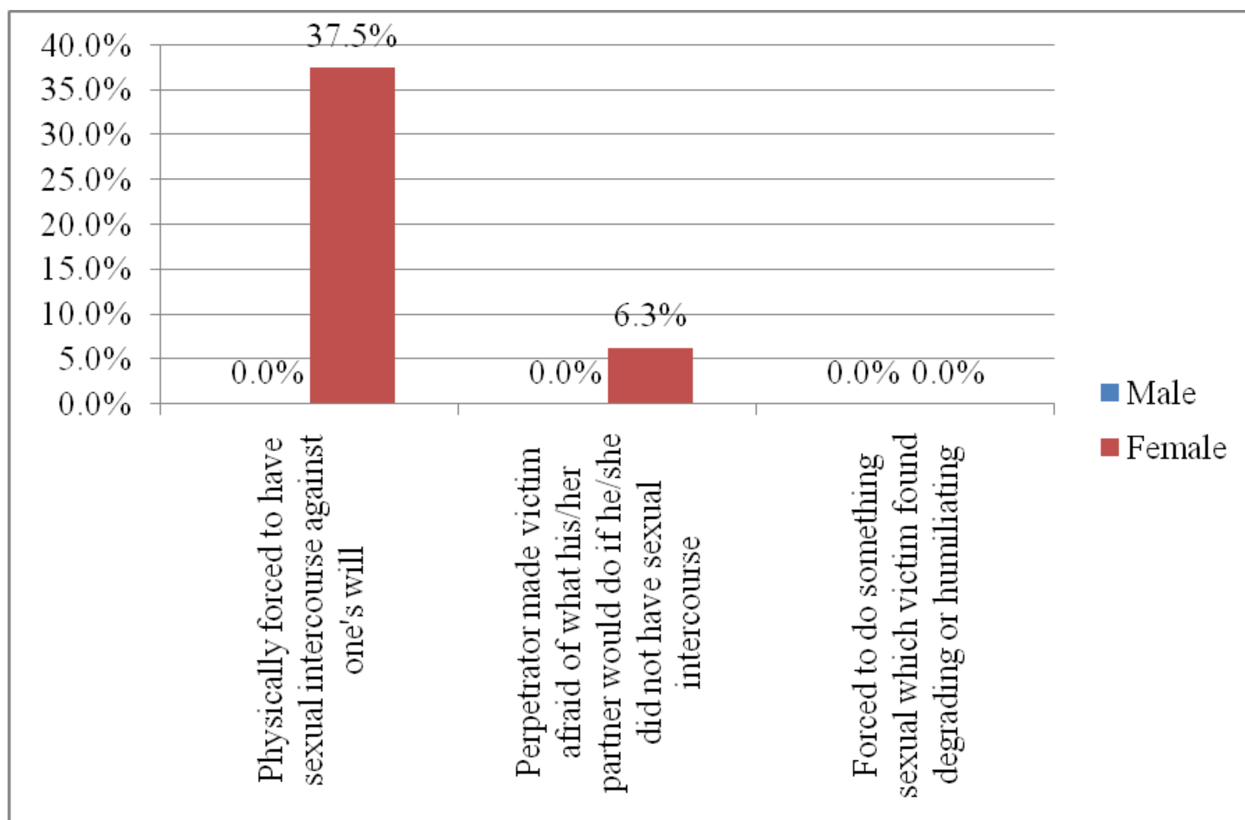

Figure 7: Forms of Sexual Violence from Intimate Partner in the Last 12 Months

3.2.4 Lifetime and Current Experience of GBV from Non-Intimate Partner

An examination of GBV from a non-intimate partner by county is important because some acts of GBV may require county-specific interventions.

Lifetime experience of GBV from an intimate partner ranged from a low of 10.4% in Kilifi to a high of 72.1% in Samburu. Disaggregating for gender, the top five rates for females were in Samburu (85.4%), Vihiga (55.8%), Busia (45.0%), Nairobi (42.1%) and Nyeri (41.7%), and for males in Kisii (75.0%), Vihiga (71.4%), Meru (65.0%), Nakuru (58.3%) and Nairobi (56.3%). Comparing across genders, in Vihiga, Nairobi, Migori, Kilifi, Nyeri, Kisii, Nakuru, Kiambu and Meru (that is, 9 out of 13 counties), more male than female respondents reported GBV experience in their lifetime perpetrated by a non-intimate partner.

Experience of GBV in the last 12 months ranged from a low of 0.0% in Kilifi and Mombasa to a high of 100.0% in Kiambu. Based on gender, the top five rates for females were in Kiambu (100.0%), Busia (80.0%), Nyeri (66.7%), Nairobi (50.0%), and Nakuru (33.3%). With regard to males, the top five rates were in Nakuru and Nairobi (each at 100.0%), Nyeri and Kisii (each with 66.7%), Vihiga (42.9%), Samburu (33.3%) and Meru (27.3%).

The findings on lifetime and current experience of GBV from a non-intimate partner per county are presented in Table 3.7 below.

Table 3.7: Experience of GBV from a Non-Intimate Partner by County

County	In Lifetime			In the Last 12 Months		
	Total	Female	Male	Total	Female	Male
Busia	42.0%	45.0%	30.0%	80.0%	80.0%	0.0%
Mombasa	28.3%	31.6%	12.5%	0.0%	0.0%	0.0%
Vihiga	58.0%	55.8%	71.4%	23.1%	14.6%	42.9%
Nairobi	44.6%	42.1%	56.3%	57.9%	50.0%	100.0%
Samburu	72.1%	85.4%	23.1%	6.5%	4.7%	33.3%
Machakos	15.7%	16.4%	12.5%	5.1%	4.6%	7.1%
Migori	26.4%	25.4%	31.3%	20.0%	22.7%	0.0%
Kilifi	10.4%	10.3%	11.1%	0.0%	0.0%	0.0%
Nyeri	43.5%	41.7%	50.0%	66.7%	66.7%	66.7%
Kisii	55.6%	40.0%	75.0%	40.0%	28.6%	66.7%
Nakuru	38.5%	34.0%	58.3%	42.9%	33.3%	100.0%
Kiambu	22.4%	20.0%	30.8%	100.0%	100.0%	0.0%
Meru	42.9%	35.1%	65.0%	29.4%	30.4%	27.3%
Total	**37.1%**	**36.3%**	**39.9%**	**21.2%**	**18.8%**	**33.3%**

The above findings show a wide variation of the location of counties with high or low rates of GBV from a non-intimate partner therefore further demonstrating that regionality is not a significant variable in patterning GBV in Kenya today.

3.2.4.1 Respondents' Experience of GBV in their lifetime from a Non-Intimate Partner

A significant number of both female (36.4%) and male (40.3%) respondents had experienced acts of GBV from a non-intimate partner as indicated in Figure 8 below. The difference between genders was not significant; however, the high proportion of men reporting this form of GBV goes against the common public perception that women are the usual targets of GBV.

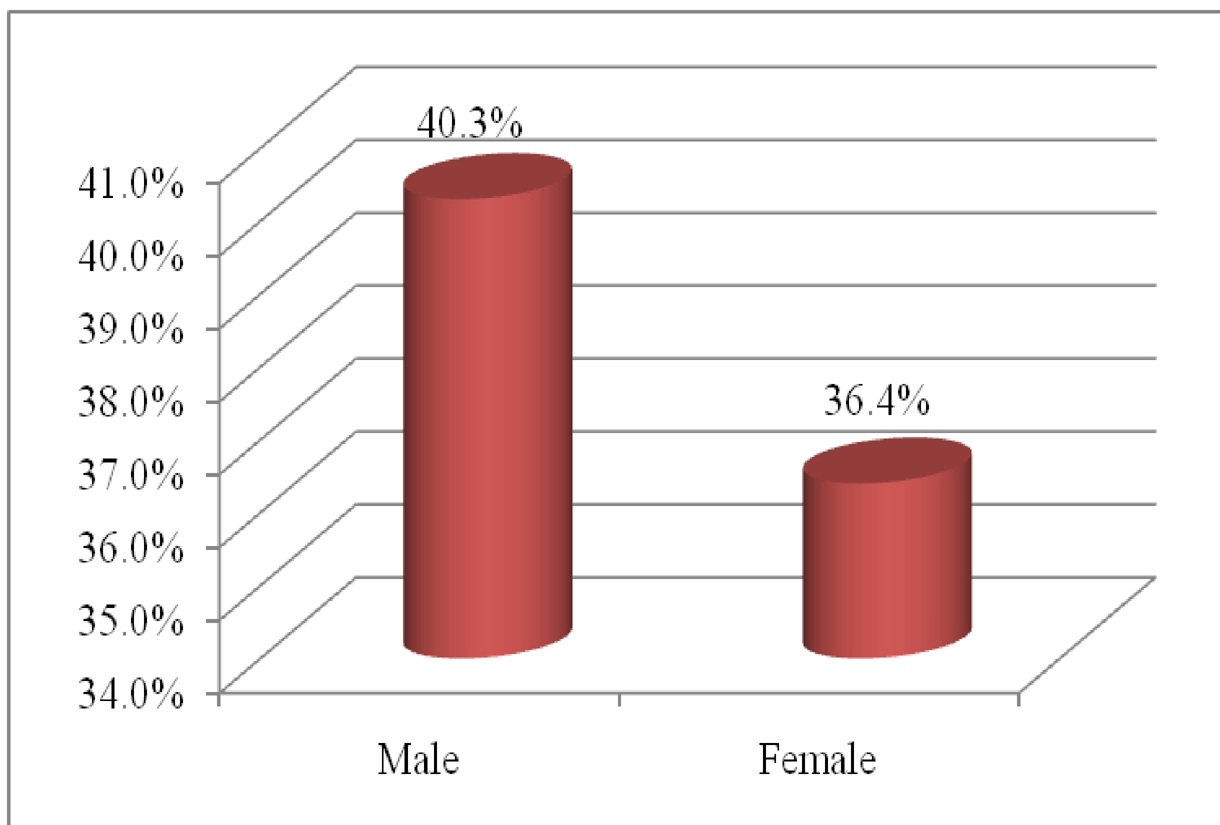

Figure 8: Lifetime Experience of GBV from a Non-Intimate Partner

3.2.4.2 Non-Intimate Perpetrators of Acts of GBV

With regard to non-intimate perpetrators of GBV, no specific population group from the predetermined categories emerged to be the most common (as indicated by at least 25.0% of the respondents). For women and men, the most reported category was "someone I knew", meaning the person was not a stranger and was not in the unspecified category of "others". This in part shows respondents' unwillingness to disclose the perpetrator.

A large proportion of female respondents (32.6%) indicated the perpetrators were "others" and in specifying, they included "co-wives", "FGM practitioners", female members of family including "step-mother", "step sister", "mother –in law" and "sister-in-law".[5] None of the respondents indicated "doctors" and "male nurses" despite their direct contact with patients, which in part infers their adherence to professional ethics. These findings are captured in Table 3.8 below.

[5] Note that the absence of female categories of perpetrators in the standard protocol (and our failure to reflect them in adapting the tool) reflects the common thinking that women are the usual victims of GBV and men the invariable perpetrators.

Table 3.8: Non-Intimate Perpetrators of Acts of GBV

Perpetrator of acts of GBV	Female	Male
Someone known by the victim	21.3%	27.4%
Male member of immediate family	20.9%	16.1%
Male member of extended family	18.3%	22.6%
Friend	10.9%	19.4%
Male teacher	3.9%	1.6%
Stranger	3.9%	9.7%
Police officer	2.2%	4.8%
Doctor	0.0%	0.0%
Male nurse	0.0%	0.0%
Others	32.6%	8.1%

The perpetration of violence against women (and of course against men) implies that prevention and control of GBV such as through education or legal interventions should focus also on women as it does on men.

3.2.4.3 Experience of Acts of GBV from a Non-Intimate Partner in the Last 12 Months

The results in Figure 9 below showed that one-third (33.3%) of male respondents had experienced acts of GBV from a non-intimate partner in the last 12 months compared with 19.1% of the female respondents (Chi square 4.821, p=.028).

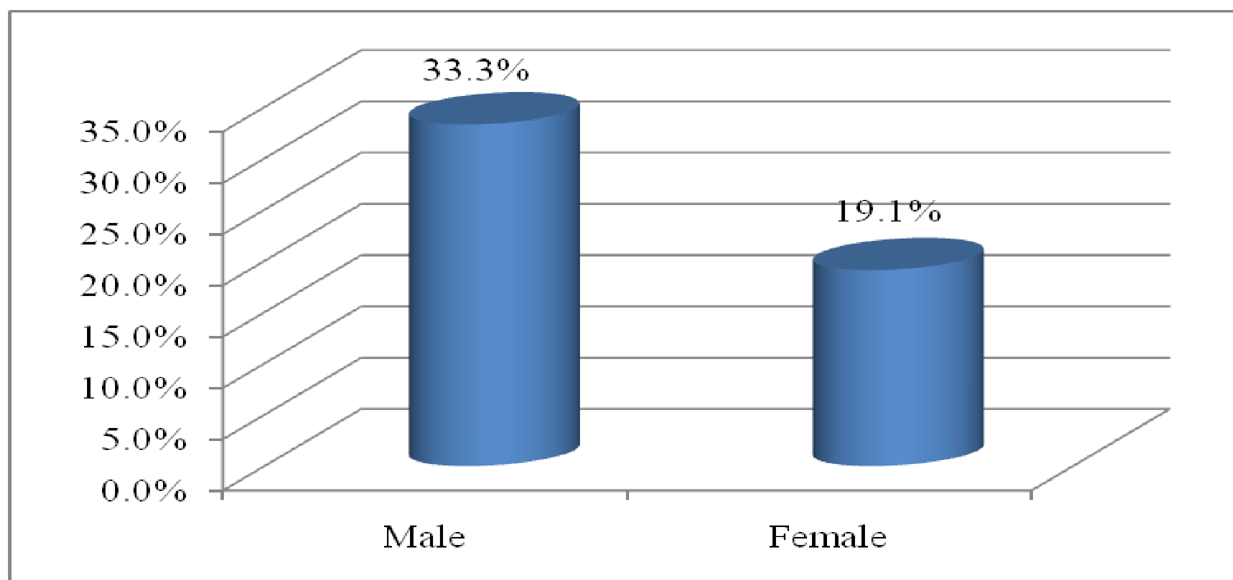

Figure 9: Experience of acts of GBV from a Non-Intimate Partner in the Last 12 Months

As indicated in Table 3.9 below, the most common form of GBV experienced by respondents from non-intimate partners in the last 12 months was "slapped you or threw something at you that could hurt you" indicated by 47.9% of female and 29.4% of male respondents. An appreciable 20.8% of female and 23.5% of male respondents indicated being "threatened, or actually hurt with a gun, knife or other weapon". There were no statistical differences between women and men in all the acts of GBV from an intimate partner.

Table 3.9: Acts of GBV in the Last 12 Months from a Non-Intimate Partner

Acts of GBV	Female	Male
Slapped or threw something that could hurt	47.9%	29.4%
Threatened, or actually used a gun, knife or other weapon against victim	20.8%	23.5%
Kicked, dragged or beaten	20.8%	11.8%
Hit with a fist or something that could hurt	18.8%	11.8%
Pushed or shoved	16.7%	23.5%
Twisted arm or pulled hair	10.4%	0.0%
Chocked or burnt	0.0%	5.9%

3.2.4.4 Lifetime Experience of Sexual Violence from a Non-intimate Partner

Sexual violence from anyone is abhorrent and this may be augmented when it comes from a non-intimate partner. The results of the study in Figure 10 below showed that 3.8% (n=3) of male and 15.4% (n=43) of female respondents who had ever experienced GBV from a non-intimate partner (for males, n=78 and for females n= 279) had been "physically forced to have sexual intercourse against their will" by a non-intimate partner. The results confirmed that women carry the greater burden of this form of sexual violence with the difference being statistically significant ($\chi2= 7.265$, $p = 0.007$).

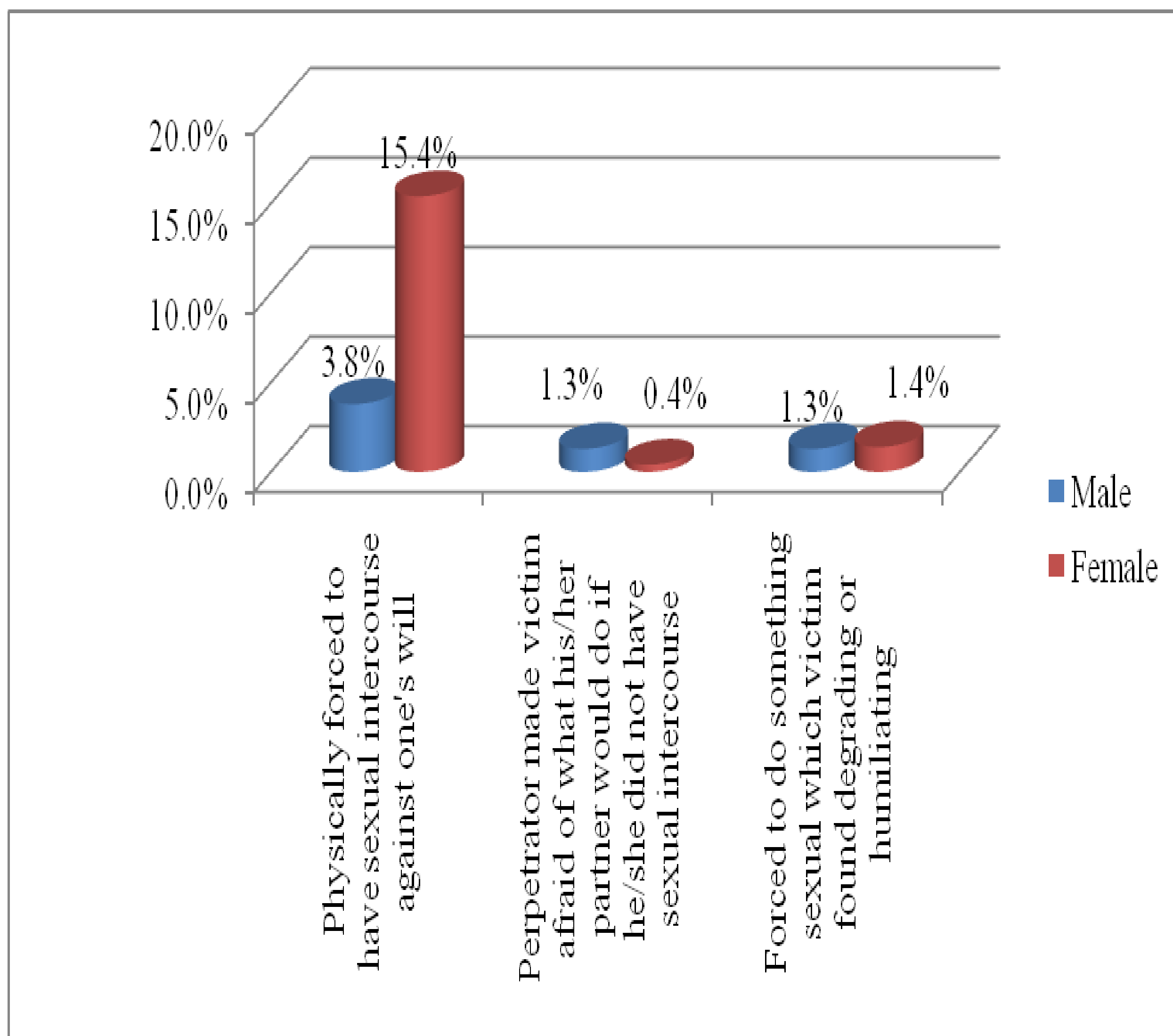

Figure 10: Forms of Lifetime Sexual Violence from a Non-Intimate Partner

A senior Police Officer based at the Busia border point observed that some perpetrators were non-intimate partners when the officer observed that:

> *"Some cases of GBV have reportedly been orchestrated by bodaboda operators/riders against unsuspecting new female customers crossing the border to Uganda side especially during the evening hours. On reaching some places, the riders threaten the customers to have sex with them or else they kill them. There have also been isolated cases reported of truck drivers sexually assaulting commercial sex workers operating along this route"*

A Police Officer based based in Nairobi County also observed that:

> *"The slum areas of Nairobi witness many incidents of GBV. Girls walking from schools to their homes in the evenings, female vegetable vendors going to wholesale markets for stocks in the early hours of the morning and female passengers carjacked by criminals have all been victims of GBV by non-intimate perpetrators"*

The above statement of the Key Informants help to indicate that GBV is also orchestrated by non-intimate partners some of who are business associates or service providers.

3.2.4.5 Experience of Sexual Violence from a Non-Intimate Partner in the Last 12 Months

The results in Figure 11 below showed low levels of forms of sexual violence from a non-intimate partner in the last 12 months. However, 9.6% (n=10) of 104 female respondents reported to have been physically forced to have sexual intercourse against their will.

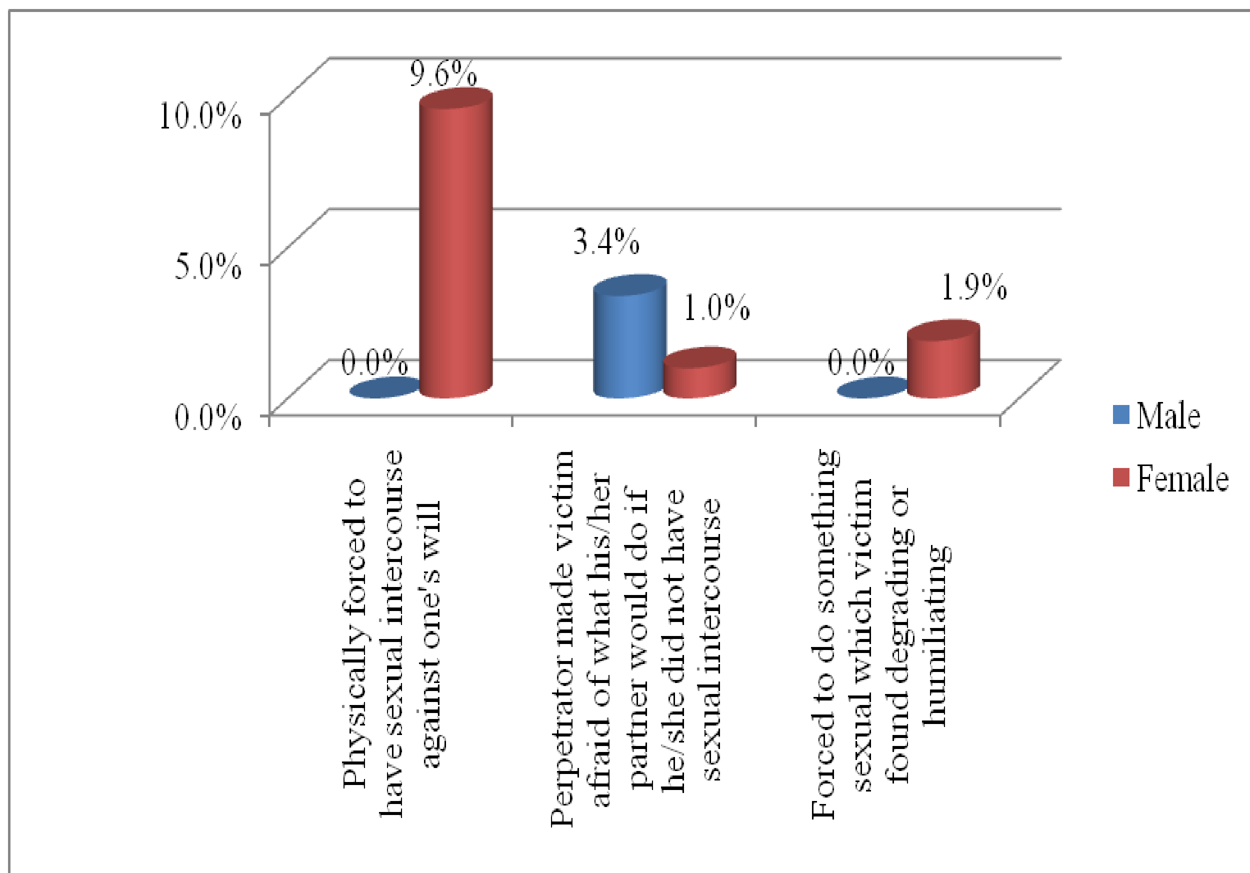

Figure 11: Form of Sexual Violence from a Non-Intimate Partner in the Last 12 Months

3.2.4.6 Lifetime and Current Experience of Psychological/Emotional Violence from a Non-Intimate Partner

Verbal abuse and humiliation were the commonest forms of psychological and emotional violence in both female and male respondents, and for both lifetime and current prevalence. Others include denial of opportunities or services, discrimination, neglect and confinement in as indicated in Table 3.10.

Table 3.10: Lifetime and Current Experience of Psychological/Emotional Violence from a Non-Intimate Partner

Forms of Psychological/Emotional Violence	Lifetime Prevalence		Current Prevalence	
	Female	Male	Female	Male
Verbal abuse	46.0%	53.0%	33.5%	44.0%
Humiliation	26.5%	25.5%	17.9%	18.4%
Denial of opportunities or services	12.0%	8.7%	7.5%	5.7%
Discrimination	8.2%	4.7%	3.9%	1.4%
Neglect	3.5%	4.0%	2.6%	2.1%
Other (e.g, disturbing telephone calls, being threatened with witchcraft, pressure from parents)	2.5%	3.4%	0.9%	3.5%
Confinement	0.7%	0.7%	0.2%	0.7%

3.2.5 Comparison of Acts of GBV from Intimate and Non-Intimate Partners

3.2.5.1 Comparison of Experiences of GBV from Intimate and Non-Intimate Partners

Overall, intimate partner GBV cases appeared to have recently increased and non-intimate partner cases appeared to have reduced (based on lifetime experience of GBV and experience of GBV in the last 12 months). The possible explanation for this is that victims who are intimate partners are in most cases not willing to report their perpetrator intimate partners to authorities for action for fear of further victimization or breaking up of their relationships. This makes the perpetrator undeterred in committing further acts of GBV. However, with the increased implementation of relevant laws such as the Sexual Offences Act, a sizeable proportion of victims of non-intimate partner GBV are reporting non-intimate partner perpetrators for action thus deterring other potential non-intimate partner perpetrators.

Comparisons based on county revealed the following as captured in Table 3.11 below: in Mombasa, Vihiga, Samburu, Migori, Kilifi and Kisii, all cases of intimate and non-intimate GBV reduced; in Busia and Kiambu, cases of GBV from intimate partners reduced but increased with regard to non-intimate partners; in Machakos, cases of intimate partner GBV increased but experienced a reduction in non-intimate partner cases; in Nairobi, Nyeri and Nakuru, all cases of intimate and non-intimate GBV increased; and in Meru, intimate partner cases increased but non-intimate partner cases reduced. This means that 53.8% of the counties (that is, 7 out of 13 counties) appeared to have experienced increased cases of GBV in the last 12 months. The variation could be as a result of increased GBV reporting and mitigation measures in some counties or failure of reporting and mitigation measures in others. The implication of these findings is that measures should be taken to address the apparent increasing cases of GBV in general but with priority focus on the increasing intimate partner GBV cases. It might also be of interest to understand the reasons behind the apparent reduction in GBV cases in counties which appeared to have experienced reduction in the GBV cases so that appropriate measures are put in place.

Table 3.11: Comparison of Experiences of GBV from an Intimate and a Non-Intimate Partner by County

County	In Lifetime		In the Last 12 Months	
	Total for Intimate	Total for Non-Intimate	Total for Intimate	Total for Non-Intimate
Busia	54.9%	42.0%	50.0%	80.0%
Mombasa	43.5%	28.3%	35.0%	0.0%
Vihiga	43.4%	58.0%	30.4%	23.1%
Nairobi	41.3%	44.6%	42.1%	57.9%
Samburu	39.7%	72.1%	32.0%	6.5%
Machakos	36.9%	15.7%	58.1%	5.1%
Migori	36.4%	26.4%	24.2%	20.0%
Kilifi	35.4%	10.4%	23.5%	0.0%
Nyeri	34.9%	43.5%	45.8%	66.7%
Kisii	28.6%	55.6%	25.0%	40.0%
Nakuru	25.8%	38.5%	58.8%	42.9%
Kiambu	25.0%	22.4%	12.5%	100.0%
Meru	12.2%	42.9%	66.7%	29.4%
Total	**34.8%**	**37.1%**	**39.0%**	**21.2%**

3.2.5.2 Comparison of Acts of GBV from Intimate and Non-Intimate Partners

Comparing between GBV acts from intimate and non-intimate partners in the last 12 months, more women reported being "threatened, or actually hurt with a gun, knife or other weapon" by a non-intimate than by an intimate partner as indicated in Table 3.12 (the differences are bolded and asterisked). More of the men from a non-intimate partner (than an intimate one) were "hit with a fist or something that could hurt", "kicked, dragged or beaten up" and "chocked or burnt".

Table 3.12: Comparison of Acts of GBV from Intimate and Non-Intimate Partners

Acts of GBV	Intimate Partner		Non-intimate Partner	
	Female	Male	Female	Male
Slapped or threw something that could hurt	62.2%	47.1%	47.9%	29.4%
Kicked, dragged or beaten	52.2%	5.9%	20.8%	11.8%*
Pushed or shoved	42.2%	29.4%	16.7%	23.5%
Hit with a fist or something that could hurt	30.0%	5.9%	18.8%	11.8%*
Twisted arm or pulled hair	17.8%	0.0%	10.4%	0.0%
Threatened, or actually used a gun, knife or other weapon against victim	14.6%	23.5%	20.8%*	23.5%
Chocked or burnt	3.3%	0.0%	0.0%	5.9%*

The results showed in the Table above suggest that acts of GBV tend to get more violent where non-intimate partners are involved especially for men. There is therefore need to sensitize potential victims (especially male) on the precautions to be taken when confronted by such non-intimate perpetrators of GBV.

3.3 Socio-economic and Cultural Causes of GBV

3.3.1 Association between Demographic Variables and GBV

One of the objectives of this study was to identify the socio-economic and cultural causes of GBV. The study examined the association between various demographic variables and lifetime and current experience of GBV among intimate partners. Focusing on the common household statuses of household head, spouse and offspring, the results in Table 3.13 below showed that: for women, lifetime experience of GBV was highest among "additional wife" (57.1%) compared to where the woman was the household head (50.0%) or the first wife (23.5%). In current (in the last 12 months) experience, the "additional wife" was still more vulnerable than the other categories.

Table 3.13: Lifetime and Current GBV Experience among Intimate Partners by Household Status

Household Status	Lifetime		Current	
	Male	Female	Male	Female
Additional wife	-	57.1%		50.0%
Household head	22.8%	50.0%	41.4%	27.5%
1st wife	-	35.8%	-	45.3%
Son or daughter	12.1%	23.5%	75.0%	25.0%

Across marital status, for women, the most vulnerable categories in lifetime experience were the divorced/separated (76.4%) and widowed (52.7%) compared with married (35.1%) and single (25.2%, χ^2= 50.519, p< .0001). For current experience, women's greatest vulnerability was among the married (49.3%) followed by the divorced and separated (39.0%). The results are presented in Table Figure 12 below.

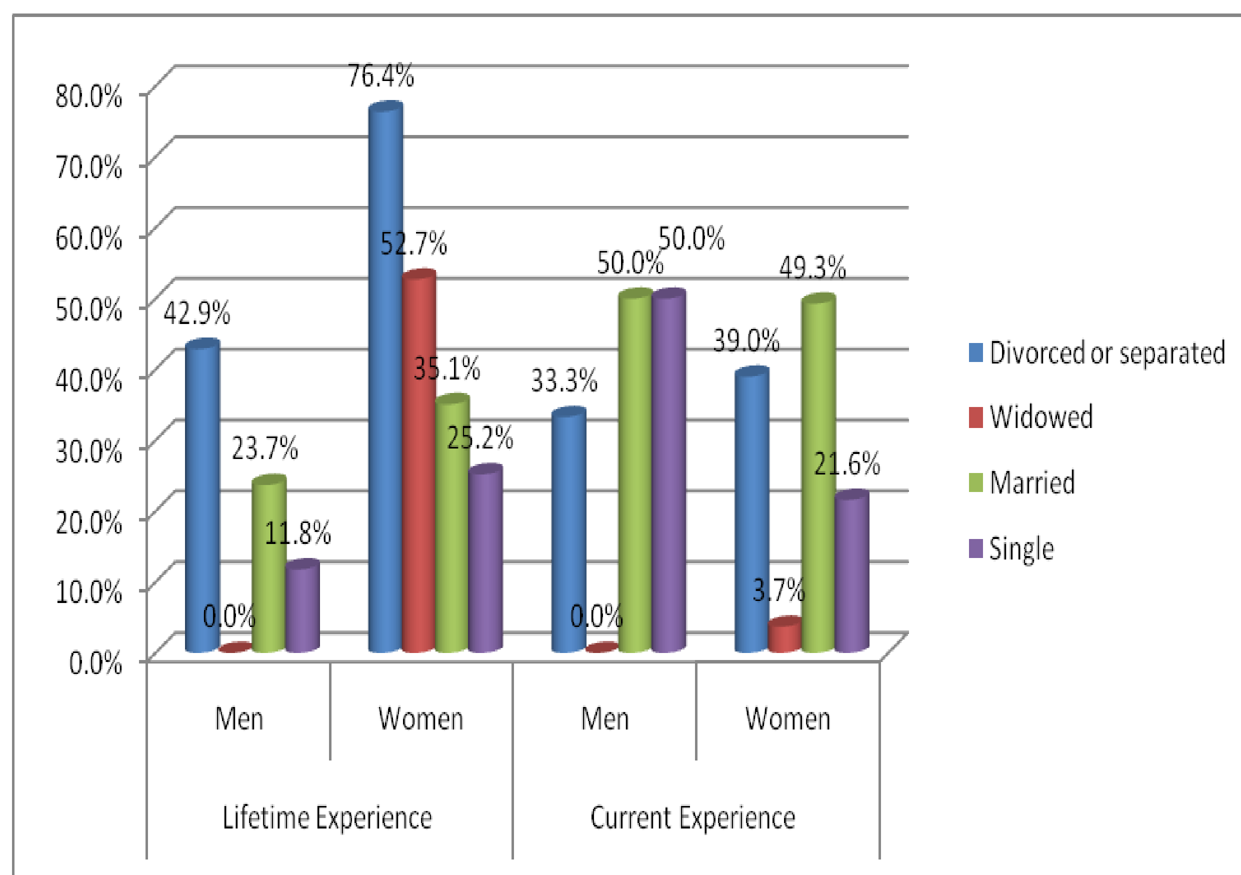

Figure 12: Lifetime and Current GBV Experience by Marital Status

With regard to age, the results presented in Figure 13 below showed that vulnerability to lifetime experience GBV increased with age especially for women. The difference between the younger and the older women age groups was statistically significant (19.695 p>0.0001) but not so for the men age groups. The implication of these findings is that deliberate counter-GBV measures need to be put in place to protect and assist divorced/separated and widowed women. Couples experiencing marital problems need to be encouraged to seek guidance and counseling services rather than resort to GBV.

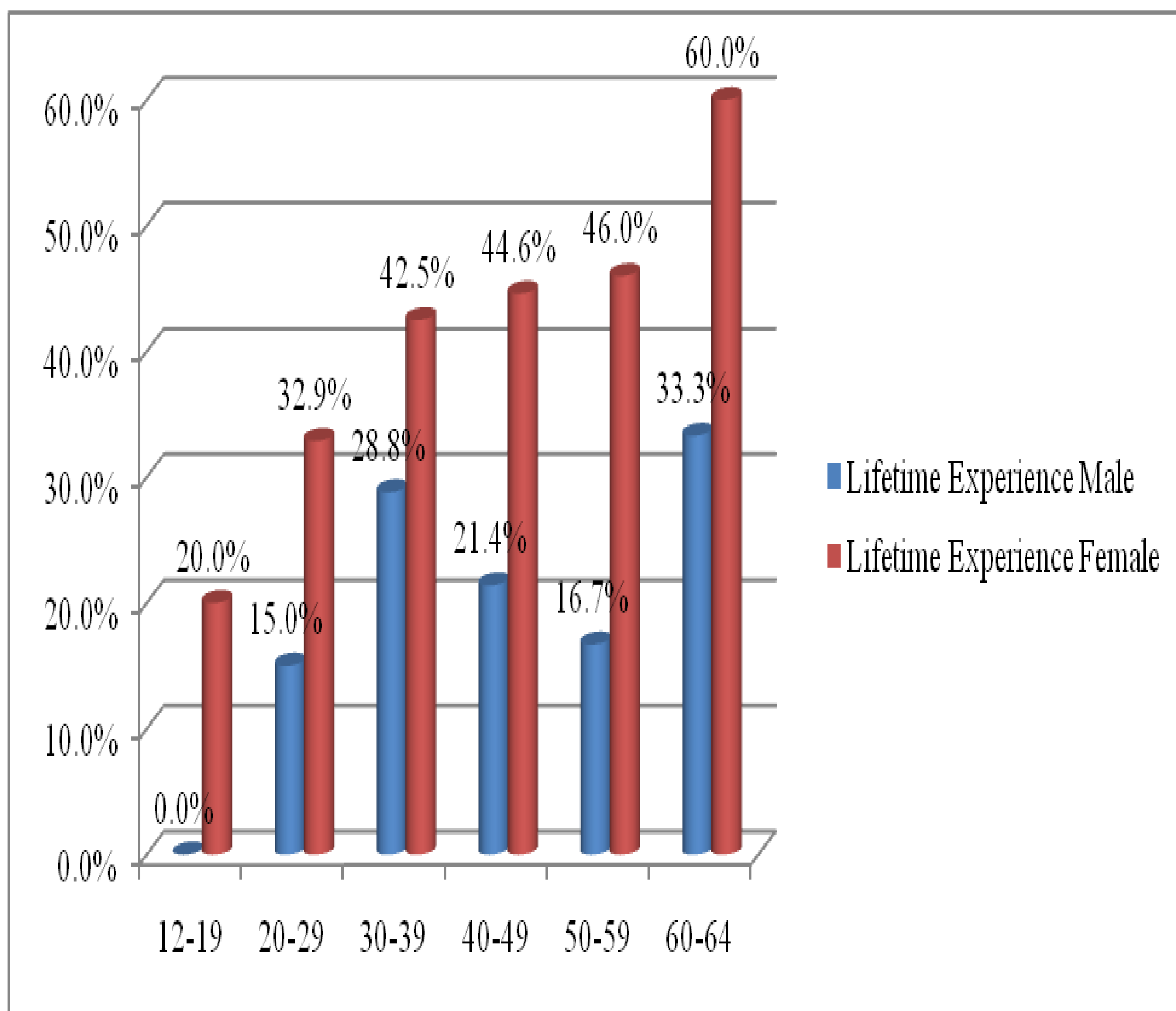

Figure 13: Lifetime Experience of GBV by Gender and Age

These results call for measures towards reducing GBV vulnerability of aged members of the community and especially the women.

3.3.2 Common Beliefs about GBV

Ajzen (1991) theory of planned behaviour states that beliefs – such as espoused in attitudes, are the greatest predictor of behaviour. Common beliefs about GBV were measured by asking respondents to state with "yes" or "no" on the existence in their community of five (5) predetermined assumptions that suggested men's dominance over women (and children by extension) (Table 16). Both male and female respondents reported existence of beliefs indicating men's dominance over women. A total of 58.3% of male and 52.4% of female respondents reported that in their community it is believed that "disciplining a woman is a man's traditional right". The significance of the commonness of this belief is that it is usually the justification for wife beating in some (if not many) cultures in the country.

Another belief is the assumption that the boy child is regarded as more important than the girl child, which was reported by 49.2% of female and 47.9% of male respondents. The results captured in Table 3.14 below also showed that respondents who reported that disciplining a woman was according to the teachings of the holy books were few (although not negligible), meaning that religious organisations played a pivotal role in combating GBV at the community level. Further, the results showed that there were no statistical differences ($p < .05$) between men and women in all the five belief items.

Table 3.14: Common Beliefs about GBV in the Community

Belief	Female %	Male %
Men are heads of families and must control their families	94.5	95.7
Women and children are subordinate to men and need to be directed	85.9	89.6
Disciplining a woman is a man's traditional right	52.4	58.3
The boy child is more important than the girl child	49.2	47.9
Disciplining a woman is according to the teachings of the holy books	16.5	15.1

The key informants representing the Criminal Justice System, Provincial Administration and Children's Department reported that in the communities they served, GBV was regarded with mixed reactions. That is, GBV was seen as a human rights violation and as a cultural practice. The Police, Judiciary, Provincial Administration and Probation Officers mentioned that the most important indicator of GBV as considered to be a human rights issue in the community was "increased reporting of GBV cases to authorities". These key informants noted that the root

cause of the prevalence of GBV was the cultural beliefs that regarded GBV as a private matter (for example early marriages, FGM, wife beating) and therefore did not require intervention by outsiders. For instance, a Chief in one of the locations in Vihiga County observed that:

> *"GBV is against the laws of this country because it violates the rights of the victim. For example, there is no law allowing a man to beat his wife. The girl child has the right to be schooled and marry the man of his choice when she grows up. Children who come with their mothers when she gets married to another man should not be mistreated. The unfortunate thing is that some people in the community in this area are still holding onto cultures which are outdated such as beating a wife to show that you love her or to prove that you are the man of the house"*

However, key informants from NGOs expressed the view that GBV was not considered as a human rights violation at the community level. For example, a Key Informant who was a Paralegal working with a Non-Governmental Organization in Kakamega known as Rural Education and Economic Enhancement Programme (REEEP) which covers the Western region observed:

> *"One of the most serious types of GBV in this region and which is a violation of human rights but not serious considered as such by some communities is the killing of boy children born out of wedlock. This is based on cultural beliefs that if some taboos are not performed, legitimate children in the family would die or the illegitimate children would take the "luck/blessings" of the legitimate children. I recently handled a case where a boy child was intentionally stepped on the chest by a stepfather. The ribs broke and when we took him to hospital, he died later. The stepfather was arrested and prosecuted"*

These findings point to the need for institutions responsible for preservation and promotion of culture and heritage in the country to mount sensitizations aimed at addressing retrogressive cultural beliefs contributing to GBV in the society.

3.3.3 Common Beliefs about GBV in Relation to Religious and Constitutional Provisions

Respondents were asked to indicate their views with "agree" and "disagree" responses to four questions relating to religious and constitutional provisions. As shown in Table 3.15 below, both male (90.7%) and female (95.7%) respondents generally "agreed" with the provisions: that religious books prohibit violence against any human being; that women have rights and should

not be exposed to GBV (reported by 94.5% of female and 90.1% of male respondents; and that it is against the law to inflict violence on any woman or man (reported by 92.0% of female and 90.8% of male respondents). About one-third of the respondents from both genders, however, "disagreed" that women have equal rights as men. This is a significant challenge because the belief by both men and women, that women have lesser rights than men is a foundation for men perpetrating GBV (even if in non-violent forms) on women and the same women subjugating to the belief. Statistical gender differences were indicated by more female respondents "agreeing" that the holy books prohibit violence and that women have rights and should not be exposed to GBV. This shows that the change of attitude is required more among men compared to women.

Table 3.15: Common Beliefs about GBV in Relation to Religious and Constitutional Provisions

Belief	Female %	Male %	Chi-Square	P value
The holy books prohibit violence against any human being	95.7	90.7	5.238	0.022
Women have rights and should not be exposed to GBV	94.5	90.1	4.892	0.027
It is against the Kenya law (Constitution) to inflict violence on any woman or man	92.0	90.8		
Women have equal rights as men	71.5	66.0		

The above findings were further expressed in the words of a male Children Officer in Nakuru County who observed that:

> *"The laws of this country provide for gender equality and equity. It is a criminal offence and against the Constitution for a man to violate the rights of a woman and the vice versa. The boy and girl child should be treated equally in all respects. I urge our religious leaders especially in communities which place women and children in one category of less important community members to use the pulpit and sensitize them to change such attitudes. In fact, were it not for women who have now taken over the responsibilities of taking care of families after men in many communities became irresponsible, society would be collapsing"*

3.3.4 Perception of Common Causes of GBV in the Community

Respondents were asked to state the common causes of GBV in their community. The results presented in Table 3.16 below showed that most common causes were: Alcohol and drug abuse (reported by 65.0% of female and 69.8% of male respondents); poverty/stress (reported by 53.8% of female and 55.6% of male respondents) and interpersonal conflict (reported by 48.5%

of female and 50.0% of male respondents). Patriarchy (male dominance), which would be expected to be reported as a cause of GBV in Kenya because of the prevalence of patriarchal norms, was reported by 19.3% of female and 18.5% of male respondents. The only statistically significant gender difference (Chi-square- 9.948; P value -0.002) was in more male (22.2%) than female (12.6%) respondents reporting cultural rites to be a cause of GBV. Although reported by few respondents, it is instructive that respondents reported other causes of GBV to include: "perpetrators lack of fear of consequences"; dowry payment; "societal encouragement of violence"; and "peer pressure", all of which reflect the critical role of cultural norms in the perpetration of GBV.

Table 3.16: Perception of Common Causes of GBV in the Community

Common Causes	Female %	Male %	Chi-Square	P value
Alcohol and Drug Abuse	65.0	69.8		
Poverty/stress	53.8	55.6		
Interpersonal conflict	48.5	50.0		
Patriarchy (male dominance)	19.3	18.5		
Cultural rites	12.6	22.2	9.948	0.002
No fear of consequence on the part of perpetrator	11.3	6.8		
Peer pressure	9.8	13.6		
Perpetrator more powerful than the victim	9.4	12.3		
Paid dowry for her	8.3	7.4		
Mental disturbance	7.2	3.1		
Society encourages the violence	5.4	6.8		
Raping instincts	3.1	2.5		

A Prisons Officer at King'ong'o GK Prison in Nyeri observed this of causes of GBV in the locality:

> *"I think alcohol and drug abuse is the major cause of GBV in this area. Some men abuse alcohol and use drugs such as bhang. They become irresponsible, with some failing to take care of their families, others sexually abusing their daughters and others beating their wives. The women can no longer persevere and decide to also beat the men when drunk, others pour hot water on them while others just stab them to revenge or vent out the frustrations caused by the irresponsible behaviour"*

An official of the Ministry of Health at the Potreitz Hospital in Mombasa County observed:

> *"One of the most serious forms of GBV in the area is battering of women leading to grievous bodily harm. Men around like drinking mnazi (traditional beer made from coconut) because it is a culturally accepted cultural brew used even in traditional worshipping such as appeasing ancestors . Some husbands who get drunk with the Mnazi beat their wives ruthlessly. Other men beat the wives arising from differences over infidelity of the husband or wife"*

Based on the above findings, efforts are needed to address the problem of alcohol and drug abuse as an integral measure to addressing GBV in Kenya. Further, the reduction of poverty levels in society through creation of economic opportunities would work to reduce incidences of GBV. Chang of attitude and behaviour contributing to GBV in the country could be realized through sensitizing community members to abandon retrogressive cultural practices.

An official of the Interior and Coordination of National Government (formerly, Provincial Administration) in Changamwe, Mombasa County observed that:

> *"Poverty in this area is a cause as well as a contributing factor in GBV. Due to frustrations arising from poverty, some men vent out the frustrations on their women and children. The poor economic background of the abused women does not allow them to leave the abusive men. Other women have been made to believe that the act of husbands beating their wives is a sign of love and should therefore not desert the marriage"*

A Gender and Social Development Officer in Kisii County raised concern and said:

> *"Female Genital Mutilation in this region is supported by the culture of the Kuria and Kisii community. It is a major contributing factor to GBV as young girls are married off predisposing them to violence from some irresponsible men"*

The interpretation of these findings is that women need to be socio-culturally and economically empowered to be able to address acts of GBV in their communities.

3.4 Socio-economic Consequences of GBV

This findings of this study showed that acts of GBV had mainly psychological/emotional and physical consequences on the individual victim (and the community by extension). Sample respondents confirmed experiencing these consequences as highlighted in the sections that follow.

3.4.1 Lifetime and Current Experience of Psychological/Emotional Violence from an Intimate Partner

The results showed that the most common forms of psychological/emotional violence for both female (58.5%) and male (52.4%) respondents was "verbal abuse", and an appreciable 35.3% of female respondents cited "humiliation". Significant differences between men and women were indicated by more women who experienced "humiliation", "neglect" and "confinement". These results are shown in Table 3.17 below.

Table 3.17: Experience of Psychological/Emotional Violence in Lifetime from an Intimate Partner

Forms of Psychological/ emotional violence	Female	Male	Chi-square	P value
Verbal abuse	58.5%	52.4%		
Humiliation	35.3%	22.8%	8.247	.004
Neglect	21.4%	10.3%	9.150	.002
Denial of opportunities or services	19.5%	17.9%		
Discrimination	5.8%	6.9%		
Confinement	7.8%	1.4%	7.872	.005

With regard to the last 12 months, Table 3.18 below shows that verbal abuse was the commonest form of psychological/emotional violence for both women and men reported by 39.8% and 42.1% of female and male respondents respectively, while some 25.3% of male respondents reported "humiliation". A significant difference was indicated by more female (6.1%) than male (0.8%) respondents experiencing "confinement".

Table 3.18: Experience of Psychological/Emotional Violence in the Last 12 Months from an Intimate Partner

Forms of Psychological/ emotional violence	Female	Male	Chi-square	P value
Verbal abuse	39.8%	42.1%		
Denial of opportunities or services	14.0%	15.0%		
Neglect	13.5%	8.3%		
Humiliation	18.8%	25.3%		
Confinement	6.1%	0.8%	6.372	.012
Discrimination	4.8%	6.0%		

3.4.2 Experience of Injuries from Acts of GBV in the Last 12 Months from an Intimate Partner

The injuries experienced from an intimate partner varied greatly between women and men. As shown in Table 3.19 below, for females, the commonest experienced injuries as indicated by at least 25.0% of respondents were “aches” (57.0%) and “bruises” (41.9%) while for males there were no such common injuries. Indeed, no male respondent reported experiencing dislocations, sprains, broken bones and teeth, and deep wound while few women did. Statistical differences between men and women were indicated by more female (57.0%) than male (7.1%) respondents reporting aches (Chi-square-11.960; Pvalue-0.001); and more male (14.3%) than female (1.2%) respondents reporting burn injuries (Chi-square-7.125; Pvalue-0.008). The latter result confirms the view that men are often victims of scalding with hot water or other substances.

Table 3.19: Injuries from Acts of GBV in the Last 12 Months from an Intimate Partner

Injury	Female %	Male %	Chi-Square	P value
Aches	57.0	7.1	11.960	.001
Bruises	41.9	21.4		
Cuts	12.8	21.4		
Dislocations	8.1	0.0		
Eye injuries	7.0	14.3		
Sprains	4.7	0.0		
Broken teeth	2.3	0.0		
Broken bones	1.2	0.0		
Deep wounds	1.2	0.0		
Burns	1.2	14.3	7.125	.008

An analysis of injuries sustained in the last 12 months from a non-intimate partner showed that none emerged to any appreciable level as each was reported by less than 10.0% of respondents of either gender. The results in Table 3.20 below indicate that more women than men suffer bruises, aches, cuts, dislocations and eye injuries from non-intimate GBV perpetrators. However, more men than women suffer sprains, broken bones, deep wounds and broken teeth from non-intimate GBV perpetrators. There were no statistical differences between men and women.

Table 3.20: Injuries from Acts of GBV in the Last 12 Months from a Non-Intimate Partner

Injury	Female %	Male %
Bruises	8.8	5.9
Aches	8.5	5.9
Cuts	2.6	1.2
Sprains	2.0	2.4
Dislocations	1.3	0.0
Eye injuries	1.0	0.0
Broken bones	0.7	1.2
Deep wounds	0.3	2.4
Broken teeth	0.0	1.2
Burns	0.0	0.0

The type of injuries suffered by women from non-intimate partner perpetrators is related to acts of GBV in the last 12 months such as “slapped or threw something that could hurt” which had been reported by 47.9% of the female respondents. The bruises, aches and cuts are also associated with struggles when women are “physically forced to have sexual intercourse against their will” reported by 9.6% of the female respondents who had experienced sexual violence from non-intimate partner perpetrators in the last 12 months. These results also reinforce earlier findings that acts of GBV tend to get more violent where non-intimate partner perpetrators are involved especially for men as indicated by broken bones, deep wounds and broken teeth arising from “threatened, or actually used a gun, knife or other weapon against victim” reported by 23.5% and “pushed or shoved” reported by 23.5% of the male respondents as acts of GBV in the Last 12 Months from a non-intimate partner.

Comparing between injuries sustained from GBV acts from intimate and non-intimate partners in the last 12 months, more women reported all types of injuries by an intimate perpetrator than by a non-intimate partner perpetrator. There were more males in a GBV encounter with an intimate partner perpetrator (than a non- intimate one) who aches, bruises, cuts, eye injuries and burns. However, there were more males in a GBV encounter with a non-intimate partner (than an

intimate partner) who suffered sprains, broken teeth, broken bones and deep wounds. These findings are presented in Table 3.21 and Figure 14 below.

Table 3.21: Comparison of Injuries from an Intimate and a Non-Intimate Perpetrator in the Last 12 months

Injury	Intimate Female %	Non-intimate Female %	Intimate Male %	Non-intimate Male %
Aches	57.0	8.5	7.1	5.9
Bruises	41.9	8.8	21.4	5.9
Cuts	12.8	2.6	21.4	1.2
Dislocations	8.1	1.3	0.0	0.0
Eye injuries	7.0	1.0	14.3	0.0
Sprains	4.7	2.0	0.0	2.4
Broken teeth	2.3	0.0	0.0	1.2
Broken bones	1.2	0.7	0.0	1.2
Deep wounds	1.2	0.3	0.0	2.4
Burns	1.2	0.0	14.3	0.0

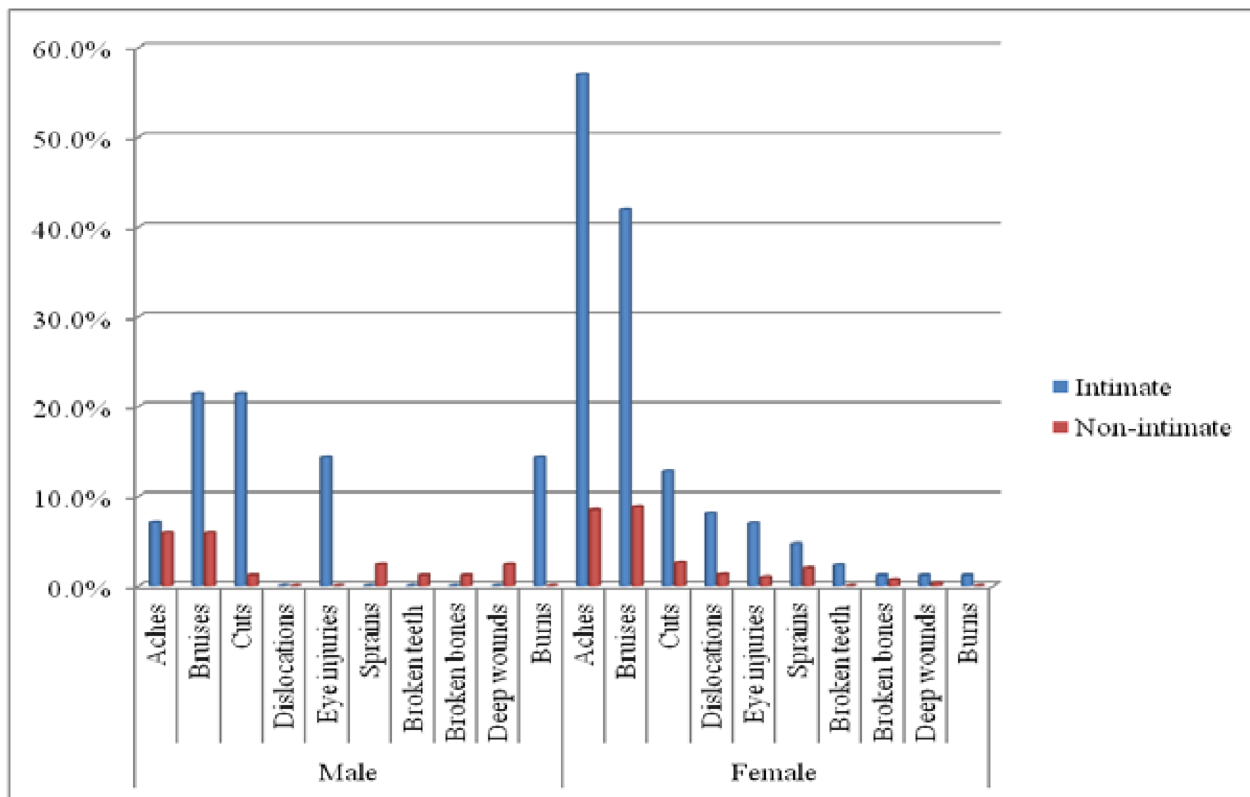

Figure 14: Comparison of Injuries from an Intimate and a Non-Intimate Perpetrator in the Last 12Months

Figure 15 below (photo courtesy of REEEP) illustrates the consequences of GBV on victims. The victim was a 2 year old boy undergoing treatment after his ribs broke after being intentionally stepped on the chest by his stepfather. The boy later died and the Stepfather was arrested and prosecuted.

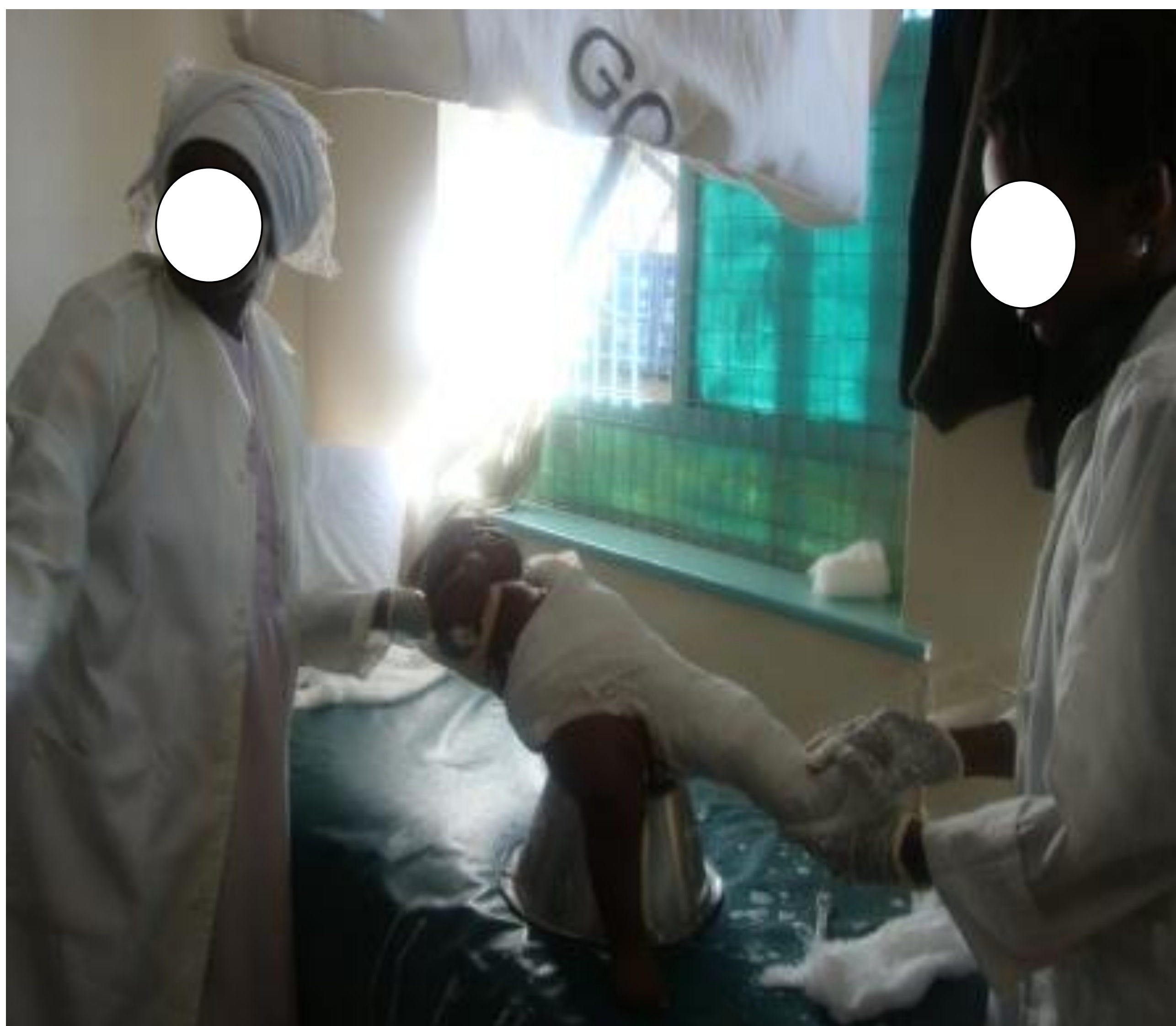

Figure 15: Picture of a 2 years old victim of GBV

Arising from the above individual effects of GBV, it can be argued that GBV has adverse social and economic effects at the community level. Some of these effects could be:

i. Increased criminality which is indicated by the existence of GBV itself.

ii. Physical and psycho-social ill-health which ultimately compromises social stability and economic production. This may be aggravated especially where the victim of rape is infected with HIV or any other devastating disease like hepatitis B.

iii. Economic costs implied in investigating, prosecuting and rehabilitating offenders as well as medical treatment of victims.

iv. Family tensions attributable to the fact that GBV often occurs within the family set up.

3.5 Individual and Institutional Responses to GBV

Individual and institutional responses to GBV are important in understanding, prevention and control of GBV. That is, if victims report and other actors take action, there is a greater likelihood for necessary counter-GBV action to be taken (such as offenders to be punished, deterred and/or rehabilitated). To gauge individual and institutional responses, the study focused on: the action of reporting of GBV by the victim; the services the victim of GBV had received; the role of health staff; those the victim reported to (whether individuals or institutions); and actions taken by those the victim reported to.

3.5.1 Reporting of GBV by the Victim

Of the 99 female and 12 male respondents who had ever been sexually violated by intimate partners, only 15 of these female and 2 of these male respondents had reported their experience or had their experience reported by someone else. This meant that only 15.2% of female and 16.7% of male respondents who had ever been sexually violated had reported or had someone else report the act of sexual violence. Analysis on the basis of the types of sexual violence showed that only 2 (22.2%) of the 9 male and 15 (13.5%) of the 111female respondents who had ever experienced the different types of sexual violence from an intimate partner reported or had the incident reported by someone else. None of the 5 male respondents who had ever experienced the different types of sexual violence from a non- intimate partner had reported or had the incident reported by someone else. However, 16 (33.3%) of the 48 female respondents who had ever experienced the different types of sexual violence from a non- intimate partner reported or had the incident reported by someone else. These results are captured in Table 3.22 below.

Table 3.22 Number of Respondents who had Ever Experienced different Types of Sexual Violence and had the violence incident reported

Lifetime Experience of forms of sexual violence	Experience from an intimate partner		Experience from a non-intimate partner		Reported sexual violence incident from an intimate partner		Reported sexual violence incident from a non-intimate partner	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Physically forced to have sexual intercourse against one's will	7	90	3	43	2	15	0	16
Perpetrator made victim afraid of what his/her partner would do if he/she did not have sexual intercourse	0	14	1	1				
Forced to do something sexual which victim found degrading or humiliating	2	7	1	4				
Total Responses	**9 (100.0%)**	**111 (100.0%)**	**5 (100.0%)**	**48 (100.0%)**	**2 (22.2%)**	**15 (13.5%)**	**0 (0.0%)**	**16 (33.3%)**

The above findings imply that women are more at ease reporting sexual violence perpetrated by non-intimate partners than that orchestrated by their intimate partners. The reluctance to report intimate partners contributes to increased acts of GBV by the same intimate partners. Men are known to be more reserved than women when dealing with personal issues and hence the probable reason their reporting rate of sexual violence by intimate and non-intimate partners was low.

With regard to reporting of physical and/or sexual violence committed against the respondent or anyone else in the last 12 months, the results indicated that only 15.7% of the female and 14.4% of the male respondents had reported. The results are almost the same as those which showed that 15.2% of female and 16.7% of male respondents who had ever been sexually violated had reported or had someone else report the act of sexual violence perpetrated against them.

Conclusively, the results of this study demonstrate low levels of GBV reporting, which is consistent with common anecdotal evidence. It is, for instance, believed that women victims of sexual violence are very unlikely to report their experience to authorities that are dominated by

men such as the police and family. This owes to the fact that men are likely to blame women (including their children or spouses) of having predisposed themselves for any sexual assault.

3.5.2 Services the Victims of GBV receive after Reporting

Respondents who had experienced the different types of sexual violence in their life time and during the past 12 months from both intimate and non-intimate partners and who had indicated that they had reported or someone else had reported the incident were asked to indicate the services they had received after the reporting.

With regard to victims who had ever experienced sexual violence from an intimate partner, the main services received by women were psycho-social counselling (33.3%) and HIV counselling and testing (26.7%). The corresponding figures for men were too few (n=2) to make any meaningful descriptions. With regard to victims who had ever experienced sexual violence from a non-intimate partner, women reported the services received to be "emergency contraception" (19.4%), "HIV counselling and testing" (19.4%) and "STI screening and treatment" (17.1%). For men, the only service they had received was "HIV counselling and testing" (16.7%) as shown in Table 3.23 below. These results clearly indicate lack of initiative or support for victims of sexual violence of both genders.

Table 3.23: Services received by Victims of Sexual Violence after Reporting

Services received	Ever experienced sexual violence from an intimate partner		Ever experienced sexual violence from a non-intimate partner	
	Female (n =15)	Male (n= 2)	Female(n =36)	Male (n= 6)
Psycho-social counselling	33.3%	50.0%	5.6%	0.0%
HIV counselling and testing	26.7%	50.0%	19.4%	16.7%
Referrals to legal and other community(safe shelter) services	20.0%	0.0%	8.3%	0.0%
STI screening and treatment	13.3%	0.0%	17.1%	0.0%
Emergency contraception	6.7%	0.0% (N/A)	19.4%	0.0% (N/A)
Access to safe abortion	0.0%	0.0%(N/A)	11.1%	0.0% (N/A)

The findings of sample respondents on services accorded to victims of GBV were supplemented by those of Key Informants. A Programme Officer working with RIPPLES International in Meru County observed the following:

> *"Our organization has rescued many children and especially girls who are victims of sexual abuse. Some have been infected with STIs and we ensure that they get the necessary treatment. We offer counselling for them to overcome the trauma associated with the ordeal and provide them with shelter in these blocks of during the post-violation period. The children have the opportunity to attend school with fees paid by this organization. We also work closely with Government agencies where legal action against perpetrators is necessary"*

A Gender and Social Development Officer in Suneka area of Kisii County observed that:

> *"One of the greatest challenges in providing services to some victims of GBV in this area is that of limited NGOs in the area for fighting for the rights of women. The Department of Gender and Social Development is equally not adequately facilitated to provide adequate counselling services to victims. Due to limited transport facilities such as vehicles and fuel, outreach programmes to sensitize the community on the need to observe and protect the human rights of both children, women and men are limited "*

3.5.3 Role of Health Staff

Respondents were asked whether during their visit to a health unit they had ever been asked by health staff about any experience of physical or sexual violence they might have had. The results showed that 10.3% of all female and 6.8% of male respondents had ever been asked by health staff of any physical or sexual violence they might have had. Considering that the lifetime GBV prevalence was 38.0% for women and 20.9% for men (see Figure 3), then these results reveal low levels of interventions. Similarly, when asked whether they had reported any physical and/or sexual violence done to them or anyone else in the last 12 months, only 15.7% of female and 14.4% of male respondents were affirmative. This contrasts the 37.7% female and 48.6% male respondents who reported having experienced any act of GBV in the last 12 months (see Figure 4).

Interventions by the medical personnel ranged from treating the victims, physical examination, counselling, psycho-social support, dispensing post exposure prophylaxis (PEP), emergency contraceptive pills (ECP), sexually transmitted Infections (STI) prevention, information dissemination, facilitate acquisition of P3 forms, referrals, and linkages with relevant authorities for further assistance. Most of the personnel reported offering comprehensive emergency

services. The Ministry of Health informs the public about their services through posters, media, district health forums, sensitization campaigns and health education at the outpatient bay. They reported their major collaborators to be the following: Aphia plus, Kenya Red Cross, Evans sunrise hospital, LVCT and Family Health Options Kenya. The main prevention services they offer are; Dispensing PEP, ECP and STI prevention. The major challenges faced by the Ministry varied from: survivors being reluctant to report because most perpetrators were family members, survivors unwilling to report to police for fear of humiliation and survivors reporting late to hospital. Although the medical personnel reported that the facilities were in good condition and that there were trained personnel, there were no adequate centres specifically established to deal with GBV cases. These findings were supported by the statements of an official of the Ministry of Health at the Potreitz Hospital in Mombasa County who reported that:

> *"As medical practitioners, we get the medical history of the victims of GBV, take necessary tests, undertake trauma management and general counseling and administer treatment. We also facilitate police investigations and prosecutions through testing of necessary blood and fluid samples especially for rape and defilement cases. The challenge in most public health centres (hospitals and dispensaries) is inadequate personnel and equipment. Some victims also decline to reveal the identities of their violators especially if they are close family members or when the non-intimate perpetrator threatened them against disclosing to others"*

3.5.4 Individuals and Agencies to Whom GBV is Reported

For the respondents who reported physical and/or sexual violence, they were asked to whom they reported the incident. As shown in Table 3.24 below, the commonest recipients for both women and men were the Police and local Provincial Administrators. This indicates the need to strengthen the Police and Provincial Administration in GBV interventions. Only a few of the respondents reported GBV to "mother", "father" or "religious leader", which raises a serious concern since these are the closest in providing immediate intervention. The role played by these actors also requires more dedicated analysis. The question that begs is: Is the low reportage to parents and religious leaders an effect of the "inability" to discuss sexuality that is so common in Kenyan cultures?

Significant gender differences were indicated by more male (56.5%) than female (32.4%) respondents reporting to the police. This confirms the belief that women find it difficult to reporting acts of GBV to the Police. Other appreciable differences were indicated by more male than female respondents reporting to a "religious leader" and more female respondents reporting to "workmate" and "father". The reporting to "local administrator" and "mother" were comparable (no respondents reported GBV to "teacher", which is an effect of the target population – ages 12 -64 in the community meaning most of them are not in school). The above

findings are consistent with the views of key informants who generally observed that the reporting of GBV was low although the trend was changing.

Table 3.24: Individuals and Agencies to Whom GBV is Reported

Individuals and Agencies	Female	Male	Chi-square	P value
Police	32.4%	56.5%	4.417	0.036
Local Provincial Administrator (Chief)	29.4%	26.1%		
Mother	16.7%	13.0%		
Father	12.9%	8.7%		
Religious leader	7.9%	17.4%		
Workmate	2.0%	4.3%		
Teacher	0.0%	0.0%		

3.5.5 Action Taken after Report of GBV is Made

An important element in GBV prevention and control is that action is taken against perpetrators and victims are made aware of such action so as to gain confidence in the recipients of reports. Respondents who had reported GBV experience were asked if they knew what action was taken against perpetrators. As indicated in Figure 16 below, only 13.9% of female and 29.4% of male respondents reported that the perpetrator was "arrested, prosecuted, and convicted". Another 29.1% of female and an almost similar proportion of male (29.4%) respondents reported "no action" and 11.8% of male and 8.9% of female respondents "did not know" what action was taken. These results demonstrate very low levels of institutional response and public knowledge of the action taken. Such a finding implies a serious difficult in the public gaining confidence to report acts of GBV either as victims or witnesses.

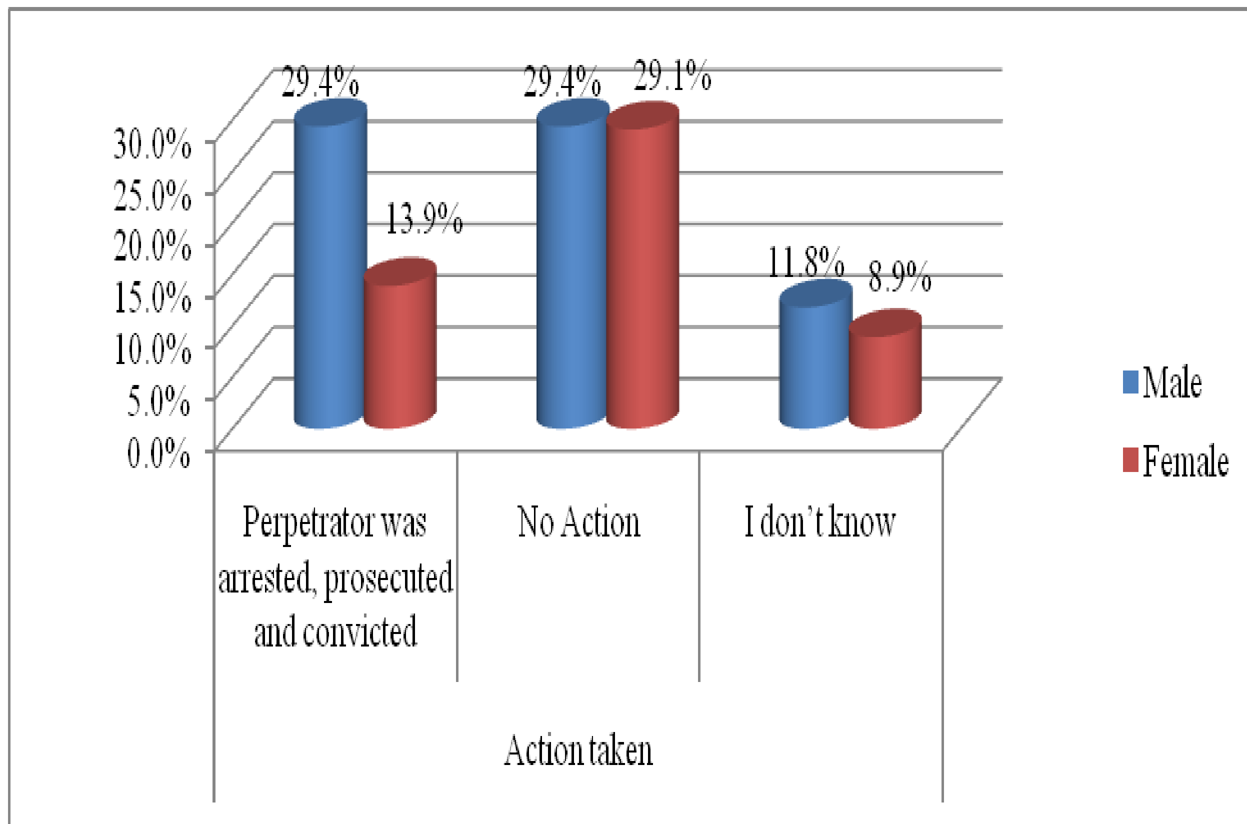

Figure 16: Response to Reporting GBV

Key informants from the National Police Service reported that their collaborators were principally Provincial Administration, Children Department and NGO's in providing GBV support in the areas they served. In the prevention of GBV, the Police's single most important intervention emerged as patrolling areas where GBV was known to be prevalent. According to the Police, the greatest barrier to prevention and control of GBV was "failure to report cases" and "lack of cooperation by witnesses". These challenges were quite evident where the perpetrator was a family member or relative. This shows the need for community education and witness protection mechanisms. These findings from Key Informants drawn from the National Police Service are articulated in the words of a senior Police Officer in Machakos County who said that:

> *"Families of victims of GBV acts perpetrated by intimate partners are many a time reluctant to report such cases to us. Even when GBV acts are reported by a third party, the witnesses will be unwilling to testify because of community ridicule and threats from the perpetrators. Our Judicial System would not allow a case to proceed without witnesses and water-tight evidence"*

Another senior Police Officer in Migori County commented and said that:

> *"In Kuria in areas such as Kegonga, early marriages of under-age girls after undergoing Female Genital Mutilation are rampant. We have been working with the Children Department and other relevant agencies in undertaking the investigations, arrest and prosecution of the perpetrators. We also facilitate the Children's Department in the rescue of the victims. However, one of the most serious challenges we go through as Police Department especially in dealing with the problem is the deeply entrenched cultural practice of FGM which is now conducted very secretly and under-reporting or no reporting at all of some cases.*

The Sentencing Officers (Judges and Magistrates) stated that their interventions to GBV were adjudicating over GBV cases, dispensing justice and advocating for alternative forms of dispute resolution like reconciliation. The officers hear the cases, advise victims to seek for medical help, they follow up on the process of punishing the perpetrators and refer victims of GBV to professionals for counselling. With regard to economic abuse, a formally employed accused is made to provide a letter from the employer and salary cuts are introduced to go directly to the upkeep or compensation of the aggrieved/victim. However, the challenge was that most of the perpetrators of GBV were not formally employed. The report of a Magistrate at the Migori Law Courts highlighted some of these issues when the Magistrate said:

> *"I had a case of consensual under-age sex and the boy was to be convicted under the Sexual Offences Act. We handled the matter by, among others things, referring the perpetrator and the victim to Probation Department for supervision, rehabilitation, guidance and counselling"*

The interventions of the officers in the Interior and Coordination of National Government on issues of GBV comprise counselling, assisting in arresting of perpetrators, giving referrals and linkages to relevant institutions, advice to victims on what action to take and they also oversee dispute resolution. Other interventions include referring GBV matters to the police, recommending victims to seek medical attention and referring them for guidance and counselling. The GBV matters are also discussed in the District Security and Intelligence Committee which discusses common threats to peace and security in the community. One District officer in Kakamega reported that:

> *"We create public awareness of GBV through community meetings (barazas) and any other social gatherings including funerals and weddings. In the process we collaborate with other government departments (including the Children department, Police and Gender and Social Development Officers) and NGOs"*

Key informants from the Interior and Coordination of National Government also highlighted the challenges they faced in addressing GBV. The single most important challenge that emerged was "non-reporting of GBV cases by victims and/or significant others". Another important challenge mentioned was insecurity which, especially in areas prone to cattle rustling like Samburu, discouraged people from travel for long distances to report such cases to authorities. For instance, an Assistant Deputy County Commissioner in Samburu County observed that:

> *"Pastoralists in this area practice early marriages of their girls. Some cattle rustlers raid for cattle in neighbouring communities. The raiders sometimes sexually assault the girls found in the villages. This has forced the girls to drop out of school. Although we have worked with the Police and Children Departments to address some of these issues such as rescuing the victims and arresting the perpetrators, the ragged terrain and insecurity from these bandits slows down the operations. Another challenge is that early marriages appear to be supported by both male and female parents who benefit from dowry paid in terms of cattle, sheep, goats and camels. They therefore do not report such cases to government departments for action"*

Many Key Informants in the Probation and Aftercare Department in different regions said that their organisation offers preventive services. This is done by educating the public through *barazas*, talks in schools and through offering marital counselling services. There were a number of services provided to victims of GBV by Probation Department. These included: in cases of physical abuse, Probation Officers advised the victim to report to the police and then took the victim for treatment in a recognised hospital. On cases of sexual violations, they referred the victim to the hospital for medical examination and treatment and then to the police. In case of emotional abuse, Probation Officers reported that they offered counselling services to victims. Probation Officers drawn from Central Province reported that if they came across a case of economic abuse, they rescued the individual and referred them to the Police and Labour officer. Some respondents especially from Nyanza did not answer this part of the questionnaire. It was not clear whether this was because they had no idea what to do in case a GBV case was reported or it was because they did not think of economic abuse as GBV.

On how the public found out about their services offered by Probation Department, it emerged from the findings that most Probation Department offices had not established adequate deliberate ways of making the public aware of their presence, services and mandate. For instance, in Central Province, Probation Officers said that they relied on word of mouth to make their services known. In Nyanza, informants did not answer this section and this was the same for most of the other provinces. The exception was Western Province where informants enumerated several methods that they used to make the public aware of their services: word of mouth, *barazas*, open day forums, field visits, brochures and posters.

Officers in the Probation Department reported that they collaborated with the Police Department, Children's Department, NGOs (for example, APHIA PLUS and International Justice Mission), churches, the Judiciary, hospitals and rescue counsellors. This means that the Probation Department offices in most areas had formed networks with other organizations to assist GBV victims. Challenges faced by the Probation Department while offering services to GBV victims included: lack of support from concerned families; lack of political good will from local leaders from communities which have practices supportive of GBV; inadequate training in guidance and counselling, reconciliation techniques and conflict management; and limited resources such as vehicles, fuel, and airtime for follow-ups. These responses offer an avenue for improvement towards addressing incidents of GBV. For example, a senior Probation Officer in Kiambu County commented that:

> *"Families around this place are not living harmoniously due to conflicts arising from land which is scarce and other resources. Cases creating disturbance and assault among family members including between a wife and a husband are rampant. When the accused is placed on a non-custodial sentence, we undertake guidance and counselling so that they can live peacefully. We undertake reconciliation of the offender and the victims. As a department we inform the public of our services through the Service Delivery Charter which we distribute to stakeholders. We work closely with all agencies in the criminal justice system. For some time, we had also accommodated the Red Cross in our offices in a partnership arrangement. Limited resources such as fuel for vehicles for undertaking follow-ups of the offenders in their homes is one of the challenges"*

3.6 Appropriate Policies and Programmes for Effective Intervention

Key Informants were asked to suggest what could be done as a way forward in improving mechanisms of interventions on GBV in Kenya. Based on their reports, the following policy and programme interventions were proposed for the management and control of GBV.

First; there is need for strong linkage between legal and medical policies and programmes to ensure the health and safety of victims and dispensation of justice. For example, there is no clear awareness among the public on how to manage evidence in a rape case. Notably, police and medical experts advise that victims should not to take a bath or wash clothes worn in a rape incident but this is not effectively communicated to the public. For example, it is common knowledge that rape would make the victim feel dirty and thus the first response would be to bathe or throw away the clothes. Also, experts advise that victims should pack clothes and present as evidence but doing so in a plastic bag would tamper with evidence. It is plausible that

a medical – liaison strategy or service be put in place because this would go a long way in assisting victims get justice while still not compromising their integrity.

Second; there is inadequate financing to address GBV prevention and response interventions. Most GBV interventions are funded by donors but the funds are far below the requirements. For instance, obtaining and testing DNA samples is expensive. Adequate public and private financing of counter-GBV programmes would work to address the vice. A public-private funding partnership would reduce the financial inadequacies.

Third; lack of a national framework and database for collating GBV is another limiting gap. Kenya does not have a national framework with clearly defined indicators on GBV. The absence of a database affects the accuracy, validity and integrity of national statistics available on GBV. There is therefore need to invest in a GBV database.

3.7 Findings from Case Studies

A case study refers to a particular instance of something used or analyzed in order to illustrate a thesis or principle. Case studies on GBV can be difficult to construct for two major reasons. First, when the research is to rely on primary data, participants may not tell the truth, may not remember all details, or may fail to respond. Second, when the research is to use secondary data, accessing such may be difficult because of its private nature.

3.7.1 Case Study 1- Court Case of an Alleged Rape

The following case study concerns an alleged rape documented in one of the police stations in the country.

The case is presently pending in court and being adjudicated vide Section 3(1)(a)(b(B) of the sexual offences Act No. 3 of 2006. The brief facts and circumstances surrounding this case are that on the 19th day of June 2013, the complainant was travelling in a Public Taxi (*Matatu*) to the Central Business District when she was joined by another passenger who is in this case the accused person. The accused person engaged the complainant to a talk and he asked the complainant where she works, the complainant told him that she works as a sales lady, and the accused person told her that he works with a commercial bank. The accused person told the complainant that he has a company and he can also offer her a job. The complainant was interested to an extent that she gave out her mobile number to the accused person who also gave his number to the complainant. They kept on communicating till on 29th day of June 2013, when the accused person called the complainant and asked her if they could meet at a bus terminus in town to talk about the business.

The complainant was at town and told him that she was in town and they could meet. The accused person and the complainant met and started talking about the business. The accused

person told the complainant that he had opened an office and he was already to offer the complainant a job.

As they were talking the complainant started feeling dizzy and asked the accused person if he could allow her to go, but the accused person told the complainant she could not leave “just like that”, and he asked the complainant to assist him with her mobile phone to call a taxi driver. The complainant then gave out her mobile phone to the accused person who communicated with the taxi driver. From that time the complainant could not recall anything else, only the following day at around 7.30 am she found herself in a lodging room, and she noted that she was raped and the accused person had fled away together with her mobile phone. The complainant then rushed to a nearby hospital but she was referred to another hospital where she was examined and treated. On 2nd July 2013, the complainant reported the matter to a Police Station. On 10th July 2013 the complainant traced the accused person in town where she alerted the police and he was arrested and charged for the offence.
According to the Post Rape Care Form filled by a medical officer the following observations were made:
The type of assault was vaginal
There was no use of condom
The incident had not been reported to the police
The survivor had had one pregnancy
The survivor was not pregnant
The survivor had had one pregnancy
The survivor’s last consensual sexual intercourse was more than four years ago.
The survivor blood pressure and pulse were normal and had a calm demeanour
The survivor had changed clothes
Clothes were not put in a non-plastic bag
The clothes were not given to the police
The survivor had had a bath
The survivor had gone to the toilet for both short and long calls
The survivor had no details on the assailant
The survivor did not know the assailant, was not related with him nor did she leave any mark on him.
The survivor mental state was normal
Genital examination of the survivor indicated that she was normal (hymen, vagina, outer genitalia and no physical injuries.
Prophylaxis first dose was administered
Emergency contraceptive pill was given
No stitching was done
Sexually Transmitted Infection treatment was given.
The survivor was referred to the Police

The survivor was referred to HIV test, trauma counselling, and outpatient department/comprehensive care /HIV clinic.

In defence, the accused claimed that he did rape because they were in a consensual relationship. He claimed that the relationship started in February 2013 and had had intercourse at various times before the June 29 incident. His position is that on that day they spent together in a Lodge but the following day he accessed the complainant's cellphone where he saw a message about a lover asking her where she was and that the baby was crying.[6] Thus a disagreement ensued because he did not know she had another lover and a baby. He took off with her cellphone and she threatened her with consequences. Then on 10th August 2013, she set a trap by boarding an upcountry bound Public Taxi in which he was a passenger and on a routine police check, she screamed that he had raped her and he was arrested.

The above case study illustrates at least the following:

1. The social context of GBV; that women are more vulnerable to GBV than men. The asymmetrical power-relations between men and women in society places women in a disadvantaged position and more vulnerable to GBV.
2. The challenge of institutional response to GBV; that the responsible institutions that are supposed to investigate and prosecute perpetrators of GBV demonstrate inept to delve into such as case. Thus even when it happens, most of the cases go unpunished for lack of evidence.
3. The advancement of medical-legal response to rape; that even though there was evidence of sexual intercourse, such was not presented in court as evidence for purposes of prosecution.

3.7.2 Case Study 2 – Victim

This victim of GBV was a married Kenyan female in her late 30s and a resident of Kakamega County. She had five children who were all schooling. Together with her husband, they are subsistence farmers.

The respondent walked in at the Rural Education and Economic Enhancement Programme (REEEP), an NGO based in Kakamega town which covers the Western region and involved in GBV activities. She found one of the NCRC Researchers who had visited the institution for a Key Informant interview. The Programme Officer on duty requested her if she could consent to a brief interview and a photograph with the NCRC Researcher (on condition that her true identity would not be revealed) which she did. She also consented the presence of the Programme Officer

[6] In Swahili "Sweety kwani ulienda wapi na mtoto ananililia".

in the interview to assist in interpretation because she was not very comfortable with English and Kiswahili language, probably because A room was then set for the interview.

The respondent was asked the purpose of her visiting REEEP. She said that she had endured for some time the act of battering by her husband of more than 10 years until she decided to visit for assistance the institution. She had known REEEP in a discussion with a woman from her area that had been through a similar ordeal. From her physical look, one could see marks of injury on her forehead and legs. She had a swollen face, leg and hand. She said that she could not hold a hoe to weed her crops as the hand was very painful

On being asked to narrate her ordeal, she indicated that her husband had been beating her for some time now following some family disagreements which she was not ready to divulge to the Researcher as it was a bit personal. She said that she had severally talked to her husband to stop the abuse but he repeated it every other time he returned home drunk. The victim had returned to her biological mother on several occasions to inform her how she had been suffering in the hands of the husband. However, her mother would always advise and encourage her to persevere and hang on to the marriage for the sake of the children. The mother had added that she too went through the same experiences when the victim and her siblings were young and that it was a normal thing in marriage to disagree and the husband beats her provided that he was not threatening to kill her.

The Researcher asked the victim if the husband was not deterred by the presence of the children when beating her. She said that he cared least but that he did it most of the times late in the night when the children had gone to sleep in their room. She would try to avoid crying loud lest the children and neighbours become alert.

The researcher asked her what action she had taken after the ordeal. She narrated that it was late in the night to run away and just persevered the beating. She woke up and sent for some pain killers after which she waited for the husband to leave home and decided to visit REEEP secretly. Asked if she had reported or would report the matter to the police for action, the victim said that she would not dare because she did not want the community to blame her when the husband is imprisoned. If the husband was imprisoned, her husband's brothers who are not far away would come and chase her away thus complicating the matter further. In fact, she would not love to see her husband imprisoned as he was the main breadwinner and she loved him. However, she did not approve of his battering behavior even though the local community appeared to approve of it saying that it was sign of husbands' love to their wives.

Asked why then she was reporting the matter at REEEP, she said that she wanted the institution to summon the husband and only give him warnings against the behavior. She was also

interested in receiving counselling offered by the institution and the institution to try and reconcile them.
The above case study illustrates the following issues in relation to GBV.

i. GBV is real in the Western region. The culture of the communities in the region appears to support the vice.

ii. Victims of GBV from an intimate partner treat the root causes of the problem as personal. This may frustrate efforts aimed at dealing with the root cause of GBV.

iii. Men remain to be the main perpetrators of GBV especially when under the influence of alcohol and drugs. Husbands are some of the main perpetrators.

iv. There is an element of inaction from some close relatives and victims themselves to address the problem of GBV.

v. Failure to report GBV to law enforcement authorities especially the police could have the effect of encouraging perpetrators to continue with the vice undeterred.

vi. NGOs play a critical role in addressing cases of GBV in society. Some of the critical services offered to victims are counselling and victim and perpetrator reconciliation.

Figure 17 below is a picture (Photo courtesy of REEEP) of the victim in Case Study 2 during research interviews at the REEEP Offices in Kakamega.

Figure 17: Picture of a female GBV victim for Case Study 2

CHAPTER FOUR

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

4.1 Summary of Major Findings

This study set to establish the prevalence and patterns of GBV in Kenya. The results revealed that the most common description of what constitutes GBV was “bodily harm inflicted by man on woman” reported by 73.8% of female respondents and 68.9% of male respondents. There was low level of viewing abuses on children as GBV, which seems to indicate that respondents generally considered GBV only in relation to “adult to adult” behaviour and not “parent to child” behaviour.

More male than female respondents report GBV to be “bodily harm inflicted by woman on man” and “psychological harm inflicted by woman on man”. This reflects a gender bias in which women “trivialize” the experience of men and a cultural change in which men admit being victimized by women.

Respondents generally reported existence of beliefs in their areas/communities indicating men’s dominance over women in their areas. For instance, 52.5% of female and 56.6% of male respondents reported that in their community, it is believed that “disciplining a woman is a man’s traditional right”. Thus, the most fundamental cause of GBV is the traditional belief about men’s dominance over women.

The commonest forms of GBV mentioned by both male and female respondents were “inflicting bodily harm/physical assault”, “verbal abuse” and “rape”. Clear gender differences were indicated by more female than male respondents identifying “bodily harm” as a common form of GBV, and more male than female respondents identifying “discrimination”.

The results showed that lifetime prevalence of GBV was 38.0% for women and 20.9% for men while current prevalence was 37.7% for women and 48.6% for men. This shows that while women’s vulnerability remained fairly constant, that of men increased appreciably in the last one year. This is consistent with the common belief about increased vulnerability of men as reported in the media. Significant proportions of female (15.2%) and male (7.4%) respondents had ever experienced sexual violence. While women’s vulnerability to sexual violence is well known, that of men is a new finding. Focusing on sexual violence in the last 12 months among women, rape was the commonest form (compared with sexual threats and sexual humiliation). More female respondents reported having experienced rape (that is, physically forced to have sexual intercourse against one’s will) from an intimate partner (37.5%) than a non intimate partner (9.6%).

Further, the results showed that GBV reporting was found to be low. Only 15.2% of female and 16.7% of male respondents who had ever been sexually violated had reported or had someone else report the act of sexual violence. Only 10.3% of female and 6.8% of male respondents reported to have ever been asked at a health facility of any GBV physical or sexual experience they might have encountered. Among respondents who had ever reported GBV experience, most of them had reported to the Police and Provincial Administration indicating the importance of these institutions. Interestingly, more male (56.5%) than female (32.4%) respondents reported to the Police confirming the general assumption that women are intimidated when reporting GBV. Only a few of the respondents reported GBV to "mother", "father" or "religious leader", which raises a serious concern since these are the closest in providing immediate intervention.

4.2 Conclusion

Arising from these findings, some of the conclusions drawn were that: there is generally a clear understanding of what constitutes GBV among community members; the critical factor underlying GBV is cultural beliefs supporting men's dominance over women; and the prevalence of GBV rate is relatively high with an apparent indication of increasing men's vulnerability. Whether this is a fundamental change in society does require further study. Sexual violence, as a form of GBV, is indeed a common occurrence. The results confirmed that women carry the greater burden of sexual violence with the difference being statistically significant. Respondents who experience GBV reported to the Police and Provincial Administration and relied less on family members and religious leaders.

4.3 Recommendations

Arising from the above findings and conclusions, the following recommendations were made:

i. There is need to increase awareness among community members about GBV including its forms, causes and appropriate responses. The Department of Gender and Social Development can play a leading role by increasing awareness through media advertisements. The Department may also consider identifying and partnering with NGOs working in the area of GBV in the community as a strategy for enhancing GBV awareness in the community.

ii. Inasmuch as GBV is a criminal offence, there is need to affirm a zero-tolerance policy on GBV by state agencies including the National Police Service, Public Prosecutions and the Judiciary.

iii. GBV is generally rooted in socio-economic, cultural and political exclusion of both women and men. While victimization can be addressed through legal instruments, there is need for greater empowerment of both women and men so as to minimize long-term vulnerability to violence. Responsible state institutions such as the Gender Commission should utilize the findings of this study and partner with other non-state and state agencies involved in developmental programs (such as the Department of Culture and that of Children Services) to ensure that the zero tolerance policy to GBV is integrated in

programming. Moreover, the Department of Culture has a significant role in addressing retrogressive cultural practices (such as FGM and early and forced marriages) and beliefs (such as men are more superior that women) in the country.

iv. Most of the people who reported GBV did so to the Police and Provincial Administration. Hence particular advocacy, education and facilitation for these institutions and others involved in addressing GBV is needed to make them more effective in detection and management of GBV cases.

v. The greatest barrier to prevention and control of GBV was found to be failure to report GBV cases and lack of cooperation by witnesses. Different stakeholders need to roll out programmes aimed at encouraging increased reporting of GBV to relevant authorities and supporting prosecution of perpetrators by providing witness evidence. Witness protection mechanisms are therefore paramount.

vi. GBV, like any other social behaviour, is likely to assume new patterns with time as attested by the confirmed increasing men's vulnerability. For this reason, there is need to continuously monitor GBV trend in the country. The government may actually set up various GBV monitoring centres.

vii. NCRC may also play a leading role in promoting and supporting GBV studies conducted by other stakeholders including students and researchers in universities.

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APPENDICES

NATIONAL SURVEY ON GENDER BASED VIOLENCE (GBV) IN KENYA

Appendix 1: Questionnaire for Respondents Aged 12 - 64 Years

INTRODUCTION AND CONSENT

Hello, my name is ______________________________ and I am working with the National Crime Research Centre (NCRC). We are conducting a national survey on Gender Based Violence (GBV) in our communities here in Kenya. GBV has now become a problem/issue of great concern, with much negative impact on development at individual, family, community and state levels, aggravated HIV/AIDS &STD, increase in unwanted pregnancies, trauma, increase on GBV in conflict areas, and Coordination constraints at national, district and grass-root levels. As a member of the community / one of the victims of GBV you have every reason to want to remove this scourge from the society with a view of eliminating all existing forms of GBV completely. Therefore, your assistance is kindly requested in making this research on GBV, successful. The study is expected to shed light on the GBV forms, incidence, their pervasiveness, prevalence, and magnitude in Kenya. The findings (data) from this survey will provide benchmarks and indicators for systematic and effective GBV interventions to be reflected in development frameworks, policies and programs in Kenya.

As part of the survey we would first like to ask some questions about direct/indirect experience with GBV. All of the answers you give will be confidential. Participation in the survey is completely voluntary. If we should come to any question you do not want to answer, just let me know and I will go on to the next question; or you can stop the interview at any time. However, we very much appreciate your participation in this survey since your views are important. The interview takes approximately between 20 and 30 minutes to complete.

At this time, do you have any questions about the survey?

May I begin the interview now?

Signature of interviewer: ___________________Date: _______________________

[ ] RESPONDENT AGREES TO BE INTERVIEWED

[ ] RESPONDENT DOES NOT AGREE TO BE INTERVIEWED ⟶ **END**

SECTION 1: HOUSEHOLD INFORMATION (TO BE ANSWERED BY HOUSEHOLD HEAD. OR, SPOUSE OR MOST AGED OFFSPRING/CHILD)

LINE #	PERSON'S NAME	SEX	RELATIONSHIP TO **HHH**	Date of birth (by date, month and year for each HH member)	Age of <NAME> in **years**	**Parental status** (for children 0-18 years) **(SEE CODES BELOW)**	Marital Status if name aged 12 and above	Level of education if Name aged 6 and above	Physical status of <NAME> **(SEE CODES BELOW)**	Primary Economic Act name **aged 15 and abo** **(SEE CODES BELOV CHOOSE ONE ONL INDIVIDUAL**
	Start with the HHH name followed by respondent name if different	Sex of <NAME> 1=Male 2=Female	Relationship of <NAME> to **HHH** **(Code Below)**				What is the marital status of <NAME>			
	B3	B4	B5	B6	B7	B8	B9	B10	B11	B12
1 HHH										
2										
3										
4										
5										
6										
7										
8										
9										
		Relationship to Head 01=Head of household 02=1st wife/Spouse 03= Additional wife 04.=Son or daughter 05= Son/daughter in law 06=Grandson/daughter 07=Mother or father of 01 08=Father/mother in law of 01 09=brother or sister of 01 10=other relatives 11= adopted child, custody 12=no relationship 88 = don't know		**Parental Status** 01= Both parents alive 02=Only Mother alive, 03= Only Father alive 04= None of the parents alive 05= Where-abouts unknown			**Marital Status** 01= Married 02= Single 03= Widowed 04= Divorced or Separated (Cross check with the age of <NAME>)	**Level of Education** 01= None 02= Preprimary 03= Primary School 04 = High School 05= College University	**Physical Status** 01=Able-bodied. 02.= Moderate disability 03=Extreme disability 04=Elderly unable to work 05=Ill for 3 months or more (that is . chronic illness); 06=Disabled and Ill for 3 months or more (that is . chronic illness)	**5.1.1.1.1.1.1.1.1** **Pri** 01 = None; 02 = Farming; 03 = Agric casual labor; 04 = Non agric casual labo 05 = Livestock raising; 06 = Skilled trade/artisan; 07 = Medium/large busine 08 = Petty trade, (firewo etc.); 09 = Beer Brewing; 10 = Formal wages (inc. pension); 11 = Fishing;

							12 = Vegetable sales; 13 = Housewife 14= Commercial sex work 15= Bar attendants 16 =House Helps 17=Casual Worl washers 18= Other (specify)

SECTION 2

INDIVIDUAL QUESTIONNAIRE

IMPORTANT NOTES

1. You are choosing only one male and four females in every 5 households
2. If the individual respondent is different from the household head above:
    a. Briefly introduce yourself again, state the objectives and benefits of the research and ask for the respondent's consent to participate in the survey.
    b. Establish the uniformity of information gathered from the household head regarding the individual respondents to ensure that the respondent **is aged 12 – 64** years of age.
    c. Establish respondent number in section 1 above and key it in at the start of section 2 below. Key in the number even if the individual respondent is the household head.

Respondent Number on the HH list [ ]

Respondent Sex [ ]

SECTION 2.1 KNOWLEDGE AND AWARENESS OF GBV

For the following question, **DO NOT READ THE OPTIONS** but tick as the respondent mentions them. Tick all that applies and probe by asking "anything else…"

1. In your own understanding, what constitutes GBV?
    a. Bodily harm inflicted by man on woman ( )
    b. Bodily harm inflicted by woman on man ( )
    c. Sexual assaults on women and Children (e.g. rape, digital finger, etc) ( )
    d. Psychological harm inflicted by man on woman (Fear, shame) ( )
    e. Psychological harm inflicted by woman on man (Fear, shame) ( )
    f. Harmful traditional practice on woman (FGM, early marriage, etc) ( )
    g. Harmful traditional practice inflicted on man ( )

h. All the above inflicted by parent on girl child ( )

i. All the above inflicted by parent on boy child ( )

j. Deprivation (economic, sexual, etc) ( )

k. Verbal Abuse ( )

l. Others(Please Specify)____

2. Are the following assumptions true in your community?
   a. Women and children are subordinate to men and need to be directed
      Yes ( ) No ( )
   b. Men are heads of families and must control their families
      Yes ( ) No ( )
   c. The boy child is more important than the girl child
      Yes ( ) No ( )
   d. Disciplining a woman is a man's traditional right
      Yes ( ) No ( )
   e. Disciplining a woman is according to the teachings of the holy books
      Yes ( ) No ( )
3. Do you agree or disagree with the following statements?
   a. It is against the Kenya law (Constitution) to inflict violence on any woman or man
      Agree ( ) Disagree ( )
   b. Women have equal rights as men
      Agree ( ) Disagree ( )
   c. Women have rights and should not be exposed to GBV
      Agree ( ) Disagree ( )
   d. The holy books prohibits violence against any human being
      Agree ( ) Disagree ( )

SECTION 2.2: FORMS AND CAUSES OF GBV IN THE COMMUNITY

4. What are the main forms of GBV in your community/this area? Please tick all that applies. **DO NOT READ THE OPTIONS**

   a. Rape ( )
   b. Defilement ( )
   c. Marital rape ( )
   d. Sexual assault ( )
   e. Economic abuse ( )
   f. Hitting/battering/beating ( )
   g. Forced marriages (women and girls) ( )

h. Trafficking of women and children ( )
i. Psychological Humiliation ( )
j. Abusive language ( )
k. Domestic conflict ( )
l. Restrictions or denial of freedom of movement ( )
m. Deprivation of resources ( )
n. Sexual deprivation ( )
o. Forceful initiation of girls ( )
p. Forceful initiation of boys ( )
q. Killings/murders of GBV victims ( )
r. Isolation from friends by husband ( )
s. Early marriages for girls below 18 years of age ( )
t. Frustration ( )
u. Discrimination (please specify in the space below) ( )

____

v. Other (please specify)____

5. Overall, what are the causes of the GBV experienced in your community/this area? **DO NOT READ THE OPTIONS**

a. Interpersonal conflict ( )
b. Alcoholism ( )
c. Drug and substance abuse ( )
d. Cultural rites ( )
e. Society encourages the violence ( )
f. Paid dowry for her ( )
g. Patriarchy (male dominance) ( )
h. Poverty/stress ( )
i. Mental disturbance ( )
j. Raping instincts ( )
k. More powerful perpetrator than victim ( )
l. Peer pressure ( )
m. No fear of consequence on the part of perpetrator ( )
n. Other (please specify)____

SECTION 2.3: INDIVIDUAL EXPERIENCE FROM AN INTIMATE PARTNER

6. Have you **EVER** experienced any acts violence from an intimate partner, past or present?
   a. Yes ( )
   b. No ( ) ⟶ **if NO skip to question 10**
7. During the **LAST 12 MONTHS**, have you experienced any acts of violence from an intimate partner, past or current?
   a. Yes ( )
   b. No ( ) ⟶ **if NO skip to question 10**
8. If yes to **SEVEN**, which of the following happened to you? Tick as applies
   a. Slapped you or threw something at you that could hurt you ( )
   b. Pushed you or shoved you ( )
   c. Twisted your arm or pulled your hair ( )
   d. Hit you with a fist or something else that could hurt ( )
   e. Kicked, dragged, or beat you up ( )
   f. Choked or burnt you ( )
   g. Threatened you with, or actually used a gun, knife or other weapon against ( )
9. During the **PAST 12 MONTHS**, have you experienced any of the following types of injury as a result of the act of violence by your Intimate partner? Tick as applies. **DO NOT READ THE OPTIONS**
   a. Cuts ( )
   b. Bruises ( )
   c. Aches ( )
   d. Eye injuries ( )
   e. Sprains ( )
   f. Dislocations ( )
   g. Burns ( )
   h. Deep wounds ( )
   i. Broken bones( )
   j. Broken teeth ( )
   k. Other serious injuries ( ) (specify ………………………………………………
10. Have you **EVER** experienced sexual violence from an intimate partner, past or present?
    a. Yes ( )
    b. No ( ) ⟶ **if NO skip to question 15**
11. If yes, which of the following types of sexual violence did you experience?Tick as applies
    a. Physically forced you to have sexual intercourse against your will ( )
    b. Made you afraid of what your partner would do if you did not have sexual intercourse ( )
    c. Forced you to do something sexual you found degrading or humiliating ( )
12. If yes to any of the above, did you or anyone else report the act of violence?

a. Yes ( )
b. No ( ) ⟶ **if NO skip to question 15**

13. If it was reported, which of the following services did you get?
    a. STI screening and treatment ( )
    b. HIV counseling and testing ( )
    c. Emergency contraception (rape survivors presenting within 72 hours) ( )
    d. Access to safe abortion ( )
    e. Psycho-social counseling ( )
    f. Referrals to legal and other community (safe shelter) services ( )
14. During the **PAST 12 MONTHS**, have you experienced any of the following types of sexual violence from an intimate partner, past or present? Tick as applies
    a. Physically forced you to have sexual intercourse against your will ( )
    b. Made you afraid of what your partner would do if you did not have sexual intercourse ( )
    c. Forced you to do something sexual you found degrading or humiliating ( )
15. Have you **EVER** experienced any of the following types of psychological/emotional violence from an intimate partner, past or present? Tick as applies
    a. Verbal abuse ( )
    b. Humiliation ( )
    c. Neglect ( )
    d. Discrimination ( )
    e. Denial of opportunities or services ( )
    f. Confinement
    g. Other ( ) (specify)____
    h. Never ( )
16. During the **PAST 12 MONTHS**, have you experienced any of the following types of psychological/emotional violence from an intimate partner, past or present?
    a. Verbal abuse ( )
    b. Humiliation ( )
    c. Neglect ( )
    d. Discrimination ( )
    e. Denial of opportunities or services ( )
    f. Confinement
    g. Other ( ) (specify)____
    h. Never ( )

SECTION 2.4: INDIVIDUAL EXPERIENCE FROM A NON-INTIMATE PERSON

17. Have you **EVER** experienced any type of the above acts of violence from someone other than an intimate partner, past or present?
    a. Yes ( )
    b. No ( )

18. If yes, who did this to you?
    a. male member of immediate family, ( )
    b. male member of extended family, ( )
    c. friend, ( )
    d. male teacher, ( )
    e. police officer, ( )
    f. Doctor, ( )
    g. male nurse, ( )
    h. someone I knew, ( )
    i. stranger( )
    j. other including females (specify) _____________________
19. During the **LAST 12 MONTHS**, have you experienced any type of the following acts of violence from someone other than an intimate partner, past or current?
    a. Yes ( )
    b. No ( )
20. If yes, which of the following happened to you? Tick as applies
    a. Slapped you or threw something at you that could hurt you ( )
    b. Pushed you or shoved you ( )
    c. Twisted your arm or pulled your hair ( )
    d. Hit you with a fist or something else that could hurt ( )
    e. Kicked, dragged, or beat you up ( )
    f. Choked or burnt you ( )
    g. Threatened you with, or actually used a gun, knife or other weapon against ( )
21. During the **PAST 12 MONTHS**, have you experienced any of the following types of injury as a result of the act of violence by someone other than your Intimate partner? Tick as applies. **DO NOT READ THE OPTIONS**
    a. Cuts ( )
    b. Bruises ( )
    c. Aches ( )
    d. Eye injuries ( )
    e. Sprains ( )
    f. Dislocations ( )

g. Burns ( )
h. Deep wounds ( )
i. Broken bones( )
j. Broken teeth ( )
k. Other serious injuries ( ) (specify ………………………………………………

22. Have you **EVER** experienced any of the following types of sexual violence from someone other than an intimate partner, past or present? Tick as applies
    a. Physically forced you to have sexual intercourse against your will ( )
    b. Made you afraid of what your partner would do if you did not have sexual intercourse ( )
    c. Forced you to do something sexual you found degrading or humiliating ( )
23. If yes, did you or anyone else report the act of violence?
    a. Yes ( )
    b. No ( )
24. If it was reported, which of the following services did you get?
    a. STI screening and treatment ( )
    b. HIV counseling and testing ( )
    c. Emergency contraception (rape survivors presenting within 72 hours) ( )
    d. Access to safe abortion ( )
    e. Psycho-social counseling ( )
    f. Referrals to legal and other community (safe shelter) services ( )
25. During the **PAST 12 MONTHS,** have you experienced any of the following types of sexual violence from someone other than an intimate partner, past or present? Tick as applies
    a. Physically forced you to have sexual intercourse against your will ( )
    b. Made you afraid of what your partner would do if you did not have sexual intercourse ( )
    c. Forced you to do something sexual you found degrading or humiliating ( )
26. Have you **<u>EVER</u>** experienced any of the following types of psychological/emotional violence from a non-intimate partner, past or present?
    a. Verbal abuse ( )
    b. Humiliation ( )
    c. Neglect ( )
    d. Discrimination ( )
    e. Denial of opportunities or services ( )
    f. Confinement
    g. Other ( ) (specify)____
    h. Never ( )
27. During the **<u>PAST 12 MONTHS</u>**, have you experienced any of the following types of psychological/emotional violence from a non-intimate partner, past or present?

a. Verbal abuse ( )
b. Humiliation ( )
c. Neglect ( )
d. Discrimination ( )
e. Denial of opportunities or services ( )
f. Confinement
g. Other ( ) (specify)____
h. Never ( )

SECTION 2.5: INDIVIDUAL AND INSTITUTIONAL RESPONSES TO GBV

28. During your visit to a health unit, have you **EVER** been asked by the health staff about any experience of physical or sexual violence you might have had?
    a. Yes ( )
    b. No ( )
29. During the past 12 months, have you reported physical and/or sexual violence done to you or anyone else?
    a. Yes ( )
    b. No ( ) ⟶ **if NO skip to <u>SECTION 3 FOR WOMEN</u> and <u>SECTION 4 FOR MEN</u>**
30. If yes, to whom did you report?
    a. Police ( )
    b. Chief ( )
    c. Mother ( )
    d. Father ( )
    e. Teacher ( )
    f. Religious leader ( )
    g. Workmate ( )
    h. Other____
31. If you reported to the police or chief, what action was taken against the perpetrator?
    a. I do not know ( )
    b. Was arrested, prosecuted and convicted ( )
    c. No action ( )
    d. Other ( ) Specify ______________________

Thank you very much for your cooperation

NATIONAL SURVEY ON GENDER BASED VIOLENCE (GBV) IN KENYA

Appendix 2: A Key Informant Guide for Public Officials

NAME OF PROVINCE _________________________

NAME OF COUNTY _______________________________

NAME OF DISTRICT _______________________________

Name of Interviewer ___________________________________

Date of Interview_______________________________________

1. Name of Organization you serve _______________________

2. Position/Title of officer responding to interview _______________________

3. In your own understanding, what constitutes Gender Based Violence (GBV)?
   a. __________________
   b. __________________
   c. ___________________
   d. __________________
   e. ___________________
   f. ____________________

4. Does the community you serve take GBV as a major human right concern?

   Why?
   ____
   ____
   ____
   Or why not?
   ____
   ____
   ____
   ____

5. Kindly list the most reported forms of GBV that occur in the area you serve.

   a. ____________________
   b. ____________________
   c. ______________________
   d. ____________________
   e. ______________________
   f. ______________________

6. Consider one of the most serious types of GBV and state its most likely cause(s) in the community you serve.

   ____
   ____
   ____
   ____

7. Given your position, state the actions you take when the following forms of GBV are reported to you:
   a. Physical abuse

   ____
   ____
   ____
   ____

   b. Sexual violations

   ____
   ____
   ____
   ____

8. Would you say that your organization has adequately established measures for immediate intervention in helping victims of GBV?

   Why

   ____
   ____
   ____
   ____

   Why not

9. What are the services your organization provides to GBV victims?

10. How do people get to know about your interventions on GBV?

11. Do you know of other organizations that are providing GBV support in the area you serve? If YES please provide us with four of your best collaborators.

12. Do you also provide preventive services on GBV? If YES what are the types of services does your organization provide?

13. What are the barriers / challenges / constraints does your organization face in providing services to GBV victims?

14. What is the condition and capacity of the organization's infrastructure in terms of services rendered?

____
____
____
____

15. What would you suggest be done as a way forward in improving mechanisms of interventions on GBV in Kenya

    (RANK UP TO 5 MOST IMPORTANT SUGGESTIONS IN ORDER OF IMPORTANCE)

    1. ____
    2. ____
    3. ____
    4. ____
    5. ____

Thank you very much for your cooperation.

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