THE EXPERIENCES OF FEMALE SURVIVORS OF GENDER BASED VIOLENCE IN RECOVERY CENTRES IN NAIROBI CITY COUNTY.

Annes Mkamburi Kassim

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A RESEARCH PROJECT PAPER SUBMITTED TO THE DEPARTMENT OF ANTHROPOLOGY, GENDER AND AFRICAN STUDIES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF ARTS IN GENDER AND DEVELOPMENT STUDIES OF THE UNIVERSITY OF NAIROBI.

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DECLARATION

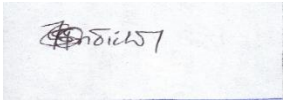
This research project is my original work and has not been presented for examination in any other university.

Signature:  **Date:** 30th August 2022

Annes Mkamburi Kassim

N69/86959/2016

This research project has been submitted for examination with my approval as the university supervisor.

Signature:  **Date:** 30th August 2022

Prof. Tom Ondicho

DEDICATION

I dedicate this work to my beloved late mother, Mary Wakesho, for always believing in me, for always encouraging me to never give up on my goals despite the struggles. And to my daughters; Valerie and Zara who I hope to be a source of inspiration to. To the Janzen and Barasa families, you are the miracle sent from heaven. Finally, I dedicate my work to God almighty, without whom, I wouldn't have made it this far.

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ABSTRACT

The main aim of this descriptive study was to examine the experiences of female survivors of GBV in two recovery centres in Nairobi City County. The study intended to document these women's journeys as they sought support services in GVRCs after episodes of GBV. Research from various secondary sources show that the number of women seeking support services at GBV Centres in Kenya has increased dramatically over the past few years. Examining the experiences of GBV survivors in the recovery Centres at Kenyatta National Hospital and Nairobi Women's Hospitals therefore begs the question, what really happens when GBV survivors seek support services in a recovery Centre? What kind of services do they receive and how do they perceive them? The city is chosen specifically due to convenience in accessibility and the assumption that the population ought to be more knowledgeable on matters GBV and where to seek services than people in rural areas.

Gender-based-violence against women is a serious social problem in the world today. In Kenya cases of GBV are increasing each passing day prompting many responses. One of the responses is the establishment of GBV recovery centres to offer health and other support services to the survivors. While this study examined the experiences of female survivors of GBV in two recovery centres in Nairobi City County, specifically, it investigated the survivor's perception of the services offered at the GBV recovery centres in Kenyatta National Teaching and Referral Hospital and Nairobi Women's Hospital. The study also tries to understand the challenges GBV survivors face in these two centres. The experiences of the female survivors were explained within the social learning theoretical perspective and various methods were employed in the collection of the data used in this study; these included case narratives taken from 20 purposely selected respondents and 4 Key Informant Interviews (KIIs) who provided professional insight on GBV.

The findings indicated that GVRCs are indeed impactful in the fight against GBV. It was observed that some survivors preferred the Nairobi Women's GVRC due to the perception that services offered in Kenyatta Hospital GVRC are not satisfactory because it is a public facility. Further, the Nairobi Women's GVRC was preferred due to availability of information online, privacy accorded, location seemed favorable to participants who sought help there. Other participants who visited the GVRC were confident that their preference of medical professional would be adhered

to; this was mostly as a result of religious affiliation. The findings also revealed a lack of information on costing of services offered in GVRCs. Survivors who visited the Kenyatta Hospital GVRC for instance pointed to the fact that public facilities offer such GBV post care services at no cost. Also observed from the findings was the dissatisfaction on services provided in public facilities and lack of professionalism from some caregivers. The study further shed light on the survivor's perceptions of GBV and the normalization and helplessness associated with various acts of GBV.

The findings showed that women who seek help at these centres still experience a number challenges. Some of the commonly cited challenges include; difficulty in accessibility due to lack of finances to access the centres, discrimination due to poverty, abuse and mishandling by caregivers, failure to follow up for after care and therapy by the centres, lack of finances to seek counselling services, poor collection of evidence making it difficult to prosecute the perpetrators among others as discussed in the study. Despite the various challenges that women face as they seek to obtain help from these centres, the value of GVRCs is still immense. The study recommends the need for further sensitization on GBV management and the need to establish more centres now that Nairobi is a growing city with a rapidly expanding population.

LIST OF ACRONYMS AND ABBREVIATIONS

CEDAW: Convention on the Elimination of all Forms of Discrimination against Women.

FGD: Focus Group Discussion

GA: General Assembly

GBV: Gender-Based Violence

GVAW: Gender-Based Violence against Women

GVRC: Gender Violence Recovery Center

IPPFAR: African Population and Health Research Center

IPV: Intimate Partner Violence

KDHS: Kenya National Demographic Health Survey

NCRC: National Crime and Research Center

NGEC: National Gender and Equality Commission

SIDA: Swedish International Development Cooperation Agency

UN: United Nations

UNECA: United Nations Economic Commission for Africa

UNFPA: United Nations Population Fund

UNICEF: United Nations Children's Fund

VAW: Violence against Women

WHO: World Health Organization

CHAPTER ONE

BACKGROUND TO THE STUDY

1.1 Introduction

Gender based violence (GBV) is a serious problem that kills, injures, and tortures individuals physically, economically, psychologically, and sexually across the globe (UNICEF, 2000). GBV is one of the most prevalent forms of human rights violation which cuts across all statuses of women: educated, uneducated, employed, unemployed, rich, poor, religious, non-religious, in rural and urban settings, and in all ethnic and racial groups (UN, 2000; UNECA, 2012). While the problem affects both genders, women are the majority as victims and men as perpetrators (UNECA, 2012). GBV directly and indirectly affects the lives of thousands of women around the world. Even women who are indirect victims know other women, friends and family members who are survivors of gender-based violence perpetrated by men. There is no country in the world where GBV is non-existent; however, the vice varies in differences in the types, patterns, trends, and rates.

While it may not be possible to have a true picture of the magnitude of VAW in domestic settings and in different countries, the consequences of this violence are clear and well documented in the literature (UNICEF, 2000; Ellsberg & Heise, 2005; WHO, 2013). In addition to the physical injuries ranging from bruises to death, female victims of gender-based violence endure a multiplicity of psychological and health related consequences. Most victims of GBV exhibit high levels of somatic complaints, depression, anxiety, and stress in comparison to women who have not experienced such abuse.

Generally, GBV denies women and girls access to enjoy fundamental human rights, equality, and equity which in turn pose a major challenge to the social, economic, public health and political advancement in many countries (Ondicho, 2018; UNICEF, 2000). Despite its negative consequences on the victims, their children, families, and societies, for many years, GBV was never recognized as a serious problem in most parts of the world, especially in those societies where patriarchal structures are deeply entrenched and continue to define the relationships between men and women (Ellsberg & Heise, 2005).

Emerging research from various countries of the world show that GBV is a long standing and complex problem that permeates women's lives daily (WHO, 2013). Multiple and interconnected factors have been identified as the forces that continue to render women vulnerable to men's violence. These include but are not limited to cultural beliefs that normalize violence as well as socialization to view violence as a normal occurrence. In many patriarchal societies especially in Africa and Asia, violence against women (VAW) is often viewed as a very personal issue, which is promoted, justified, and accepted as a normal cultural practice (WHO, 2013). Thus, it is viewed as normal for a male partner to be beat his female partner regardless of the injuries caused but it's often considered abnormal for a woman to beat her husband or girlfriend to beat a boyfriend. GBV is a product of the unequal power relations that exist between women and men (UNICEF, 2000; Ondicho, 2018). This unequal power relations render violence against women invisible, unreported, under-reported, unrecorded, and often tactfully condoned (Evoy, 2012).

In Kenya, GBV, especially wife beating, was traditionally viewed as a normal cultural practice that is supported by customary practices (Mbote, 2000). GBV in Kenya encompasses acts such as domestic violence, intimate partner violence, violence in same-sex relationships, female genital mutilation, forced and child marriages, rape, sexual assault, sexual abuse, and exploitation of girls,

trafficking of women and exploitation of female sex workers, psychological, emotional, and physical attacks on the woman's body which occur both within and outside the family (UNICEF, 2000; Anderson and Anderson, 2008, Ondicho, 1993). While the true levels of GBV in Kenya remain largely unknown, Kimuna et al (2008) reported that over 40% of married women in Kenya have been victims of either sexual abuse or various forms of domestic violence at least once in their lifetime. This could be due to male dominance in the Kenyan society. For many years, the patriarchal structures of the Kenyan society have tended to favor men through inheritance of land and property, acquisition of education and good jobs and money, which give them power over women. This has made it possible for women whether wives or daughters to be dependent on men. For a long time, daughters did not inherit anything from their fathers as well as did not own or control property. Instead, they were encouraged to get married so that their husbands would take care of them by providing them with shelter and land to cultivate. Payment of dowry to the woman's father upon marriage therefore gave the man absolute power over his wife including the right to use force to discipline his wife (Ondicho, 1993).

In modern times, most Kenyan women live under very difficult circumstances characterized by absolute poverty, which makes it hard for them to become independent of men. The only choice they have is between living in poverty or a violent relationship. The circumstance is further made worse by the fact that most women have children whom they could find it difficult to support without a husband. With the high levels of illiteracy and unemployment among women, it is very difficult for most women to live on their own with their children and men seem to understand that women have limited choices and hence they take advantage of the situation to abuse them knowing that nothing will happen to them. These unequal gender power relationships, which are still prevalent in Kenya, have been exacerbated by modern conditions, thus rendering women

vulnerable to GBV (NGEC, 2016). Some groups of women have become targets of gender based violence because they have limited resources, less support and have either been socialized to accept violence as a normal aspect of their life or come from families in which intergenerational abuse is the norm. Women from such backgrounds are often likely to face multiple forms of violence but rarely seek assistance from external sources including the criminal justice system.

Most cultural beliefs in Kenya regard GBV as a private affair that does not require the intervention of outsiders hence resulting in limited information (NCRC, 2014). Research on GBV in Kenya is also relatively new and anecdotal. Generally, there has been no comprehensive nationwide survey to determine the prevalence and magnitude of the problem. The existing research literature indicates that VAW is a problem about which society prefers to remain ignorant. Statistics gathered from different sources including the Kenya Demographic Health Survey (KDHS) the National Crime Research Center Survey (2014), and the National Gender and Equality Commission (2016) show that GBV does exist, but victims are often reluctant to speak out about their suffering, they may fail to report abuse due to fear of being ashamed by their husbands; they may be afraid and/or to preserve the family loyalty. This undermines their ability to not only to speak out but also to seek redress and thus most GBV cases remain unreported, and therefore undocumented (Evoy, 2012). It is from this extensive background that this study was designed to explore the experiences of the female survivors with the services offered at two Gender Violence Recovery Centres (GVRCs) in Nairobi County.

1.2 Statement of the Problem

Media reports suggest that GBV is a common problem in Kenya. It is one of the most atrocious, systematic, and pervasive forms of human rights abuses. Incidents of such violence are not only

increasing every passing day but also affect most young girls and women. In the recent past an increasing number of horrific and ghastly incidents of violence against women perpetrated by men have featured prominently both in the electronic and print media. The most notable cases include that of Ivy Wangechi, a medical student from Moi University who was killed by Naftali Kinuthia, a boyfriend who later claimed that his love for her is what led to the heinous act. That of Pauline Wangari, who was stabbed to death by her boyfriend Joseph Ochieng, a man she had met on a social media platform (www.akilidada.org) among many others. 'Counting Dead Women-Kenya' A Facebook page that reports the number of women who die as a result of GBV in Kenya, indicates that 60 women in Kenya were killed by men between 1st January and 30th June 2019 (https://twitter.com/deadwomen_ke). GBV in Kenya, as is the case elsewhere, is treated as a private affair that takes place behind closed doors in seclusion and outside public glare. Many women also live-in fear of male violence in their homes and in the community. Others live in and or persevere violent relationships with their stories of suffering tightly kept secret. Evidence shows that many victimized women, for reasons of loyalty, fear, guilt, self-blame, and embarrassment, often tell no-one (Ondicho, 1993). The study is therefore provides an opportunity to explain and understand the factors that make GBV persistent despite existing laws and regulations.

Furthermore, moderately little research has been conducted in Kenya targeting women who seek help in Gender Violence Recovery Centres (GVRCs) and the kind of services they receive while in those centres. This means that there is a gap of literature and information about the experiences of women with gender-based violence who seek services at GVRCs. This study therefore seeks to interrogate and document women's lived experiences of GBV when they seek services in Gender Violence Recovery Centres (GVRCs). However, for the sake of narrowing down the scope and being more specific and concrete in problem diagnosing and analysis, the study would be confined

to Nairobi Women Hospital and Kenyatta National Hospital's Gender Recovery Centres. The study will seek to answer the following research questions:

1. How do female survivors of GBV perceive services offered at the Gender Violence Recovery Centres (GVRCs)?
2. What challenges do female survivors face as they seek services at the Gender Violence Recovery Centres (GVRCs)?

1.2 Objectives

1.3.1 Overall Objective

The general objective of this study is to document the experiences of female survivors of GBV with the services at two Gender Violence Recovery Centres (GVRCs) in Nairobi County.

1.3.2 Specific Objectives

1**.** To examine how female survivors perceive the services offered at Gender Violence Recovery Centres (GVRCs).

2. To analyse the challenges female survivors of GBV face as they seek services at Gender Violence Recovery Centres (GVRCs).

1.4 Significance of the Study

There have been relatively few studies regarding the experiences of female survivors of GBV with the services offered at the newly established gender violence recovery centers in the country (NCRC, 2014). Consequently, very little is known about how women perceive the services and the challenges they face when accessing these services. This study, therefore, will provide crucial

information that will help in understanding the experiences of victimized women when they seek services in GVRCs. The study seeks to establish the quality of services offered at these centres from the survivors' perspective. Further to this, the study will fill the gaps in the literature and in our understanding of the experiences of survivors when they seek services after victimization. It further sheds light and provides an understanding of why women may choose not to report acts of violence or seek medical and psychosocial assistance altogether.

The study will equally contribute to a growing body of knowledge on gender-based violence worldwide and most importantly, the study will provide important information to both state and non-state actors such as policymakers, civil society groups, human rights activists, researchers to re-evaluate service provision in GVRCs , thereby leading to the development of better interventions that will be beneficial to survivors of GBV, especially women who are often disadvantaged by power imbalances among other contributors of GBV.

1.5 Scope of the Study

This study targeted all women receiving treatment for gender-based violence related injuries at Nairobi Women's Hospital GVRC and Kenyatta National Hospital GVRC. The other survivors of GBV in Nairobi County not receiving treatment at these GBV recovery centres are not within the scope of this study. The study utilization of qualitative methods of data collection and data will be collected from 10 survivors in each of the two recovery centers using case narratives. While the findings of this study will be a great insight to the issue of GBV and women who have lived through the vice, the limitation is that the findings will not be generalized to all survivors of GBV because of the small sample size and use of non-probability sampling procedure.

1.6 Operational Definition of Terms

Gender Based Violence

Involves various acts of violence that have been committed by one person against another by virtue of their gender and as due to social constructs related to gender roles.

Violence against women

These are any acts of violence directed towards women and girls and lead to physical, sexual, or psychological consequences.

Intimate Partner Violence

This is when one individual in a relationship purposely hurts another person physically or emotionally.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This section outlines a review of studies related to the topic and includes theories, discourses concerning gender-based violence. The section also provides a summary of the theoretical framework to the study, a review of the literature and various gaps that informed the topic under study.

2.2 Defining Gender-Based Violence

There has been no universally agreed way of defining the term "gender-based violence". The most used terms have different meanings in different areas in the world and are often derived from diverse existing theoretical perspectives and disciplines. Defining GBV has been problematic in most societies. Most African patriarchal societies, for example, do not have labels for various types of violence, GBV is accepted as a justifiable culturally consistent behavior in ensuring women are well behaved (Ondicho, 2013). Such cultural norms and beliefs have made it difficult to change the perception of men and women into accepting that such practices are inhuman, criminal behavior and no individual should be subjected to such. However, the United Nations (UN) in adopting the Declaration on the Elimination of Violence Against Women (VAW) was embraced by the General assembly (GA) in 1993 and defined Gender-Based Violence as "any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (UNFPA, 2012). The abuse involves different forms of threats of violence such as

emotional violence, economic violence, forced sex, physical assault and may manifest in several ways including beating, biting, boxing, stabbing, spitting, and strangling. The terms GBV and VAW are used interchangeably because GBV mostly affects women and girls, (SIDA, 2015). The United Nations (UN) definition of GBV has been captured and interpreted to capture various emerging forms of violence:

2.3. Types of Violence

2.3.1 Physical violence

Physical violence manifests in various forms; physical assault, battering, human trafficking, domestic violence, slavery, kicking, slapping, hitting, and or use of weapons) etc. Physical violence against women is prevalent in Kenya (Ministry of Devolution and planning-National Policy for Prevention and Response to Gender Based Violence, 2014). The 2008 /2009, KDHS report shows that 64.8 percent of women have been in marriages before having experienced physical violence by a partner. Further, 35.9 percent of unmarried women have equally recounted being physically abused by their mothers and 40.6 percent by teachers. According to the KDHS report, the high rates of physical abuse from a younger age are highly likely to contribute to a cycle of violence since most of the perpetrators are intimate partners and parents.

2.3.2 Cultural Violence

Physical violence may also manifest through detrimental cultural practices such as child marriages, forced marriages, infanticide, widow inheritance, disinheritance killings, FGM etc. In Kenya, 27 percent of women who are between the ages 15-49 have gone through FGM (NPPR 2014:17)**.** The recorded percentage is a decline from 32 percent that was recorded in the year 2003. Government campaigns have contributed to the reduction in cases. In Kenya, the most severe cases of cultural

violence are 95 percent in the North Eastern region, with Somalis contributing to 98 percent, Kisiis 96 percent and Maasais 73 percent. FGM has been attributed to cultural beliefs and tradition among the communities.

2.3.3 Human trafficking

This is a human rights violation and may involve acts such as recruiting, transporting, transferring, harboring people using force for sexual exploitation. Most victims of such acts are often women and children. In Kenya, victims of human trafficking are often trafficked from Kenya to and from other countries such China, India, and Pakistan. Further, some Kenyans also voluntarily move to countries in Europe and the Middle East where they may become victims of trafficking.

2.3.4. Sexual violence

This is the leading form of GBV in Kenya. Reports from different sources indicate an increase of cases from 3,525 in the year 2007 to 4,703 in the year 2012 (Ministry of Devolution and planning, National Policy for Prevention and Response to Gender Based Violence 2014:15). Sexual violence is referred to as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work". Sexual violence manifests in various forms that include; rape, defilement, incest, sexual abuse, sexual harassment, sexual exploitation, forced prostitution, trafficking for sexual exploitation etc.

2.3.5 Rape and Sexual Coercion

Rape is the involuntary penetration of the mouth, vagina, or anus of a victim by a perpetrator or by an object used by the perpetrator (WHO, 2003). A 2014 report by NCRC reveals that rape was the commonest form of sexual violence in Kenya.

2.3.6 Intimate Partner Violence

Refers to the execution of acts of physical and or sexual violence by a current or former partner or spouse. Is interchangeably used to refer to domestic violence and can manifest in the form of physical, sexual, emotional abuse. The definition of intimate partner varies from one setting to another and may include formal partnerships as well as informal ones (WHO, 2013: 13). According to a KDHS 2008/2009 report intimate partner violence is the most perpetrated form of sexual violence (53.4%). While fathers were found to form the biggest number of perpetrators of sexual violence against children (Ministry of Devolution and planning, National Policy for Prevention and Response to Gender Based Violence 2014:15). Sexual violence in children especially girls has become a national crisis as indicated by the KDHS 2008/2009 figures which show a 32 percent incidence for women and girls and 18 percent for male children especially in learning institutions.

2.3.7 Emotional/psychological violence,

Emotional and psychological violence are some of the forms of violence that have been greatly overlooked due to their sensitive and hidden nature (pg.18). Emotional violence refers to humiliation, controlling partner behavior and threats. This type of violence is however widespread and may include acts such as confinement, silent treatment, controlled socialization, emotional

abuse, and infidelity in intimate relationships. The 2008/2009 KDHS report indicated that 60% of men who were interviewed were jealous if their partners talked to other men; 20 percent controlled their spouses' interactions with other people, and 35% monitored their spouses' whereabouts..

2.3.8. Economic violence

Any act or behavior directed towards another person that could lead to economic harm to an individual. This form of violence may occur in many forms such as property damage, failure to comply with economic responsibilities, taking away partner earnings, restricting partner access to income and controlling partner access to health services and or education (EIGE, 2017). The distinct roles between men and women often give rise to gender inequalities leading to inequalities in the social, economic, and political spheres. The gender that is considered weak is therefore exploited by the powerful one hence leading to a limitation in access to social and economic goods and services as well as exposure to various forms of sexual and non-sexual, violent, and non-violent offences (NCRC, 2014). Despite the comprehensive coverage of different forms of violence in the definition of Gender-based violence, various issues arise in its interpretation and application. The problematic nature of GBV is seen in the various contexts in which it occurs and how the various forms of GBV are defined.

2.4 Prevalence and Magnitude of Gender-Based Violence in Kenya

According to The Kenya Demographic and Health Survey (KDHS) 2008-09, about 45per cent of women between the ages 15-49 have experienced various forms of GBV. The Report further reveals that 25 percent of women have experienced physical violence while 7 percent have experienced sexual violence. According to the report, 14 percent of women have experienced both physical and sexual violence. The report also indicated that 3 percent of women were responsible

for various acts of GBV perpetrated against their husbands or partners. Kenya's Annual Police Crime Report for the year 2010 showed an increase of rape cases to eight percent and increase of defilement cases to 19 percent and an increase in incest cases to 22 percent.

GBV in Kenya is attributed to cultural and gender norms that create power imbalances between men and women. According to a 2014 NCRC report, the respondents who participated in the study reported beliefs within their communities that supported men's dominance over women. The most common belief was that tradition allows men to discipline women.

> *"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" (NCRC, 2014:30)*

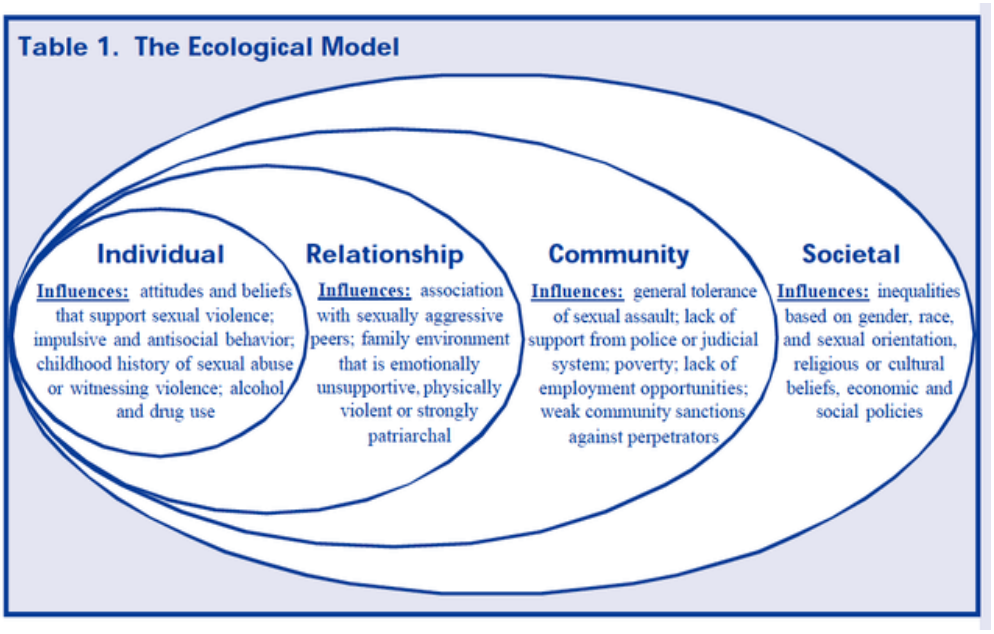
Further, the report indicates that GBV in Kenya is commonly viewed as an adult-to-adult affair. Abuses against children in Kenya are not viewed as a form GBV.

2.4.1 Risk Factors

The ecological framework provides evidence that GBV cannot be explained by a single factor but is an interlinkage of several factors explained at individual, relationship, community, and societal level; these factors provide insight as to why some people may be at a higher risk of violence than others (WHO, 2010). Feminist analysis of VAW indicates that it is a demonstration of existing unequal power relations between men and women as evidenced by unpaid work, lower wages for women, lack of decision-making power in families, unpaid reproductive roles among others (True 2012, Dobash & Dobash 1979). While the explanation is significant in understanding the causes of VAW, it does not sufficiently provide an understanding of why not all men are perpetrators of violence, or why some women and girls are more affected by violence than others (Heise, 1998).

The ecological framework is widely used in explaining VAW because it shows that violence is a manifested phenomenon based on the interplay of various factors operating at individual level, interpersonal relations, institutional environment, and the society at large (Heise, 1998, WHO 2005). Based on the framework, gender inequalities are viewed as elements that provide explanations at different levels while intersecting with other inequalities in a larger context to differentiate the experiences of violence for women as shown in the figure 2.1 below

Figure 2.1 Ecological Framework Diagram



Source**: (**CDC, 2018)

The innermost circle which represents the Individual level covers an individual's biological and personal history (Kerman et al, 2018), while the relationship level shows the environment where violence takes place, and this often happens within family. The community level involves formal and informal structures within the community which form the foundation of relationships. The fourth level is the society and it represents the cultural, social, economic and political environments

where cultures, policies, and norms emanate from (Heise, Ellsberg, & Gottemoeller, 1999).A study done by NGEC in 2014 shows that the most prevalent forms of GBV in Kenya include, sexual violence such as rape, intimate partner violence, female genital mutilation (FGM), various forms of economic violence such as denial of access to family resources, violence against the elderly, and child neglect.

2.4.2. Individual and Interpersonal Factors.

Childhood experiences have overtime proven to be one of the most agreeable factors in predicting the likelihood of IPV occurring or being perpetrated in future; children who witness violence against their mothers by either their fathers or partners in intimate relationships with their mothers are likely to be violent in their future intimate relationships (Kabeer, 2000). Equally, abused children are likely to end up in violent relationships and this can be attributed to the normalization of acts of violence as a result of acts constantly witnessed. Intergenerational transmission of IPV is not inevitable. According to Kabeer (2000), not all children who grow up in environments where violence was a norm end up as perpetrators or victims of violence.

2.4.3. Structural Factors

Some of the structural factors that contribute to GBV include:

2.4.3.1 Cultural Explanations

While some individual and interpersonal factors e.g., childhood experiences remain important when environmental factors are considered, other factors can be attributed to institutional and structural inequalities such as property ownership laws and marital laws. The World Health Organization has identified various evidence regarding risk factors at community and societal

levels where proof on contribution to GBV at higher levels is proven (Krug et al., 2002); these include social norms that normalize violence against women, failure to enforce laws on national sanctions against perpetrators, poverty, gender beliefs that support male superiority, high levels of criminal behaviour, conflict and war in society among others.

According to Kabeer (2000) violence against women tends to be higher communities where there are evident unequal power imbalances in the relations between men and women. In societies where being a man means being aggressive and dominant, where men have full control of family resources and where decision making, and authority is considered a man's responsibility (Kabeer, 2000). Cultural practices and beliefs can also lead to specific forms of violence where gender centered (Okin, 1999). Gang rape is for instance attributed to cultural practices through which men impose their masculinity along gender and cultural beliefs. Political explanations on the other hand are an indication of how uneven development and consequently poverty has led to failure to enact laws thereby leading to a systemic immunity for perpetrators of violence. Due to corruption, governments, police, and judicial institutions have failed to take prompt and effective action against perpetrators of violence.

2.4.3.2 Politico-Economic Explanations

Male superiority in economic and decision-making authority in the family is one of the biggest indicators of societies that demonstrate cases of VAW in large numbers (Heise, 1992). Women in South Sudan for instance encounter economic, political, institutional, and legal barriers that hinder them from participating in the development of policies and projects that are key for addressing gender inequalities in the society (Sudd Institute, 2014). According to the South Sudan National Bureau of Statistics, approximately 80 percent of its citizens are illiterate. The high illiteracy levels

because of socio-cultural practices and economic factors have long-term consequences which are negative. These affect women's participation in socio-political spheres and other leadership roles that would be impactful in reducing VAW.

2.5 Consequences of Gender-Based Violence

The effects of GBV go beyond the victim and or survivor and has both tangible and intangible consequences:

2.5.1 Health and Social Impact

GBV has various health consequences and these may include immediate and long term injuries that can result in broken body parts, loss of hearing and sight; while long term effects may include heightened risks of health complications and substance abuse as well stress related traumas (UNICEF, 2000), the Population Council, 2008 shows that there is a direct correlation between the maternal experience of violence and increased risk in child and mother mortality, low birth weight, malnutrition and undernutrition among children and mothers who have been abused. Further, DHS from Zambia indicates that there is a link between premature birth and a mother's experiences of GBV, evidence that there is the dissolution of reproductive autonomy amongst women who experience violence.

2.5.2 Psychological Effects

VAW is a traumatic event and results in psychological traumas such as sleep and eating disorders, depression, shame, anger, self-hate and blame, hatred of sex and low concentration levels (Kabeer, 2000). Violence belittles, degrades, and humiliates women (Mbote, 2000), it prevents women from living independent lives thereby increasing their vulnerability. Experiences of violence and threats related to violence limit women's abilities to have control over their lives often due to fear

of violent retaliation from their partners thereby limiting ability to negotiate for safe sex, family planning, therefore leading to unwanted pregnancies and sexually transmitted infections (Banwell, 1990). (Mbote, 2000) further notes that violence curtails women's everyday freedoms with fear of violence from both the public domain and from familiar men in familial contexts increasing women's overall sense of vulnerability.

2.5.3 Economic Impact

Economically, violence imposes wider costs in the society due to lowered productivity levels, devaluation of human abilities and capabilities and the endless continuity of violence through generations (Kabeer, 2000). Fear of acts of violence also strains women's abilities to participate in income generating activities due to threats of violence from partners who disapprove of their engagements (Jewkes, 2002). Similarly, violence in the public domain, which may include incidences of mugging, groping and verbal abuse, also inhibits women's desire to seek for jobs and any available opportunities to generate income that may sometimes require women to return home at night due to fear. Violence not only results in the denial of human rights and freedoms but also undermines a country's ability to achieve its developmental targets. A 2005 report by World Bank shows that gender-based violence is accountable for the loss of one in each five days of life lost to women are in the child bearing age; in Kenya, the estimated cost of provision of services that are required as a result of GBV services in the 47 counties over a period of five years is ten billion, seven hundred and ninety eight million, five hundred and twenty thousand, six hundred and forty four Kenya shillings (NGEC, 2016).

There are several reasons as to why violence against women should be given explicit attention, first, deaths that are occurring because of GBV fail to capture the true extent of harm of VAW as

which includes physical, sexual and psychological violence and other threats that occur daily (Kabeer, 2010). While such acts of GBV can result in medical injuries, data on other forms of violence that do not result in fatality is not available in many countries. When such data is available, the findings show that the number of women and girls do not reflect them as the bearers of greater extents of harm. In addition, VAW is also differentiated from the violence experienced by men and boys by the obvious difference in the causes, the effects of the violence and how the public perceives and responds to those acts of violence (Kellerman & Mercy 1992, Eckhardt & Pridemore 2009). Finally, while men are often victims of violence that occurs in public spaces violent crimes often committed by strangers or friends, women tend to be at risk from violence perpetrated by family members within the family setting though they also face sexualized risks in the public domain which may range from verbal abuse to rape.

2.6 Responses to Gender-Based Violence in Kenya

2.6.1 Health Responses

Most survivors of IPV seek help from health facilities due to the severity of injuries because of violence, health facilities are therefore crucial points through which information on victims of GBV as well as number of reported cases can be captured. Gender Violence Recovery Centers had not been established in Kenya until the year 2001 when the Nairobi Women's Gender Violence Recovery Center was established. The center is a non-partisan, no-profitable charitable trust that offers free extensive medical and psychosocial support to victims of GBV in Kenya (Ondicho, 2018). Overtime, there has been progress as gender violence recovery centres have been established in government medical facilities such as The Center for Assault Recovery of Eldoret (CARE) which was established at the Moi teaching and referral hospital in the year 2007, the Gender Violence Recover Center at the Coast Province General Hospital, also established in 2007

through a private-public partnership and collaborative between the government and private actors; this was then followed by the formation of the Kenyatta National Hospital Gender Violence Recovery Centre in the year 2009 .

The main aim of the centres is to offer free and full healthcare coverage for victims of GBV ranging from diagnosis, treatment, psycho-social support, legal referrals, and prevention of gender-based violence. GBV recovery centers also play a significant role in the creation of awareness regarding GBV and offer training programs to capacity build important players such as medical personnel and the police among others (Ondicho, 2018). The awareness campaigns provided by GVRCs seek to enable victims to break the silence surrounding GBV and seek treatment and legal interventions. While medical personnel offer a range of services to victims of GBV, it's important to note that medical services are often only rendered to victims who report or who, with the help of family and friends, are taken to hospitals for the services upon occurrence of GBV; one of the main hurdles encountered by the Ministry of health is the reluctance of survivors to report and seek medical help because most perpetrators are family members (NCRC, 2014). One medical practitioner reported:

> "*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 investigation 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." (NCRC, 2014: p.81).*

According to research by (NCRC, 2014) which targeted individuals that had not experienced sexual violence from an intimate partner showed that the main services received by women were psychosocial support (33.3 percent and HIV counseling and testing (26.7 percent). Similarly, (19.4 percent) of women received emergency contraception services while men had only received HIV

counseling and testing with a percentage of 16.7 percent; based on the services received for both genders, it is manifest that women are exposed to a greater number of risks upon exposure to GBV as opposed to men. Lack of reporting, therefore, translates to a higher exposure to further health complications and even death for these women.

Some of the major challenges faced by GVRCs include inadequate funds which limit geographical coverage, as well as the variety and quality of services given to victims (Ondicho, 2018). This study seeks to investigate the fact that violence has been disregarded and accepted as a norm in the society. In this regard, most of the health service providers tend to give particular attention to the injuries sustained while not paying attention to the causes, often viewing women's tribulations as a private issue that requires legal or family interventions. The study seeks to capture the lived experiences of victims who seek health services from GVR centres but rarely give an account of their tribulations.

2.6.2 Legal Responses

Women Organization's around the world have been at the forefront in developing and finding solutions on how to end VAW, Women movements have not only brought the issue of VAW onto the International limelight and focus through drives such as "the one billion rising for justice" but have also triggered state responsiveness to violence against women through legislation and provision of legal assistance to women seeking to leave lives free of abuse (World Bank, 2005).

The comprehensive insight into the issue of violence against women offered by the ecological framework shows how important responses are at each level and context they are provided. The World Bank has put emphasis on the need to develop initiatives that aim at preventing VAW rather than just coming in at the recovery stage. Notable milestones are noted, countries around have

signed international rights treaties that specifically make reference to violence against women and these include International instruments such as CEDAW (adopted in 1979), the elective Protocol to CEDAW (adopted in 1999) which oversees the implementation of CEDAW.

This has consequently led to the ratification of CEDAW by 177 countries and signing of the Optional Protocol by 75 of them. On the international front, efforts by international donors, UN monitoring bodies and Women's Rights Organizations are significant, the various bodies have called for the amendment of the civil and penal legislation by governments around the world. Other activities undertaken by these organizations include research and dissemination of research findings, public civil education, mass media campaigns and lobbying for legal reforms, educational programs on change of sexual attitudes, norms, and behaviors. Despite the progress, there have been challenges, some acts of violence such as honor killings and marital rape are not criminalized in penal codes for most countries thereby allowing criminals to evade prosecution, secondly, even where good legislation exists, law enforcement institutions often fail to prosecute the wrong doers.

It is in this regard that Kenya has shown commitment to shield women and girls from all types of violence perpetrated against them (Mbote, 2001). Retrospectively, it has ratified the Conventions on the Elimination of Discrimination against Women (CEDAW); the most comprehensive instrument that deals entirely with the rights of women as well as other documents such the Declaration on the Elimination of the Violence against Women (DEVAW); which sets out international rules that are fundamental in elimination of VAW despite not being legally committing (World Bank, 2005). Kenya has also ratified the International Covenant on the Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights. It is also a party to the African Charter on Human and Peoples Rights on the African Charter (Maputo Protocol) and on the Rights of the Child. Kenya has spearheaded the efforts to eradicate

all forms of VAW and SGBV since the promulgation of the Constitution 2010. Through the new Constitution of 2010, all international and regional legislative frameworks were approved and ratified by Kenya to become part of the domesticated laws to fight SGBV (NGEC, 2017).

Kenya has also put in place a national policy and legislative framework that supports the campaign against all forms of SGBV in practice. GBV is a manifestation of and entrenchment of retrogressive cultural beliefs and values therefore, by involving all stakeholders e.g. community elders, positive cultural values that promote non-violence can be reinforced (NGEC, 2014). Other NGOs that have focused on awareness creation and provision of legal aid for GBV related cases include FIDA Kenya, Kituo Cha Sheria, COVAW (the Coalition on Violence Against Women), Kenya Human Rights Commission, and Women Rights Awareness Programme (WRAP) (UNECA, 2010). Other efforts include; the provision of the National Guidelines for the Medical Management of Rape and Sexual Violence which was done in the year 2004 and the establishment of a family court in 2001 to ensure family matters are handled in privacy when reported (Mbote, 2002); such interventions have led to the creation of friendlier court environments through which victims can seek justice and most importantly since cases of violence are sensitive and the extents and magnitude vary among individuals, creating such platforms has therefore encouraged victims to report incidences of violence.

2.6.3 Police Responses

In Kenya, various agencies such as the National Police Service and NGO's collaborate in providing assistance in areas where they serve (NCRC, 2014), they do so by patrolling areas where GBV is prevalent, sentencing officers (Judges & Magistrates) adjudicate over GBV cases, administering justice, advocating for substitute dispute resolution mechanisms, hearing of cases, referring clients

and advising them how to seek medical services and psycho-social support and follow up on the process of ensuring perpetrators are punished. They also assist in arresting perpetrators, giving referrals, counseling and linking to relevant institutions. Officers in the Probation and aftercare Department offer preventive services through civic education through *barazas,* guiding students in secondary schools and offering guidance and counseling services on family and marital issues (NCRC, 2014).

The 2010 constitution propelled a series of ongoing reforms in the context of the Kenyan justice system under the leadership of Willy Mutunga with a focus on rapid results, a cultural shift and people-centered courts (Evoy, 2012).Unfortunately, most cases of GBV are not reported to the police stations; this is often attributed to the negative publicity of the general public towards the police and the lack the capacity to handle GBV cases, therefore, compromising their ability to ensure prosecution of victims (NCRC, 2014). The fact that only a small number of officers have undergone GBV training and orientation and lack of mechanisms to ensure the safety of witnesses due to failure of implementation of the Witness Protection Act is a setback in fighting the vice.

2.6.4 Responses by Welfare and Community Sectors

The establishment of GVRCs in Kenya in both government facilities and private ones have been a great milestone in the fight against GBV, in addition to provision of free medical assistance to victims of GBV, the centers play a significant role in lobbying the government to establish programs necessary for survivors of violence (Ondicho, 2018).While Kenya has undertaken substantial legislative efforts and has developed a countrywide system of "Victim Support Units" to address VAW, progress has been hindered by barriers which include, cultural and social barriers to legal redress to women and children, women's reluctance to seek legal remedies due to

ignorance, fear of retaliation from the perpetrator where they are often threatened to prevent ‘shame' upon their families where the perpetrator is a relative; sometimes, the perpetrator is the sole breadwinner and the family's only source of economic support (Enikő et. el, 2007). Backing of new laws is however often low due to law standing traditions of discriminations against women and lack of cooperation by law-making institutions.

The other challenges faced include poor coordination between national and county governments due to confusion on mandates, responsibilities, and roles (IRC, 2014). Further noted, most county governments are still not well informed in the overall issue of gender-sensitive development nor are they conversant about GBV matters often leading to little or nil budgetary allocation. While GBV organizations, especially CBO activities have increased after the 2008 post-election violence, most survivors of GBV initial report GBV cases to relatives, in-laws, and village elders, often going to the police as a last resort. The impact of chiefs and elders while appreciated as frontline responders and influential in helping communities shun and eradicate GBV, in some cases, the elders are the ones who create an enabling environment for the perpetrator’s impunity. Similarly, research indicates that there is no gender balance in the composition of the elders as most of them are usually male dominated often leading to prejudice against women who seek justice through them, a good example being the *Kaburwo* elders among the Nandi (Kalenjins).

Further evident is the under-funding of GBV services as a majority of GBV services are funded by international well-wishers and donors; while organizations like the German Corporation for International Cooperation (GIZ) and The German Development Bank (KFW) contributed a total KES 336,000,000, the Government of Kenya only contributed KES 13,776,000 for the financial year 2013/2014. This greatly questions the sustainability of the government in managing the vice should the donors pull out their support (NGEC, 2016). Budgetary constraints greatly affect service

delivery in GVRCs since services provided are cost-free in most centers. Women who seek help from these centers therefore do not get comprehensive services since referrals to specialists and follow-ups are costly hence resulting in more difficult experiences. Despite successes in the GVRCs, one of the greatest challenges is the limitation in number, Nairobi city, despite its huge population only has two GBV recovery centers (Ondicho, 2018). A high number of clientele and constrained budgetary allocations to these centers greatly limit their functionalities.

Theoretical Framework: Social Learning Theory

This study will be guided by the Social Learning Theory which was developed by Albert Bandura (1973). The theory assumes that people learn through observing and children can obtain new knowledge and consequently learn new behavior by paying attention to family members, friends, and even famous figures on television. Secondly, according to the theory, a person's belief in their ability is important in influencing learning and motivation towards learning. That people's behaviors are influenced by the environment which in turn influences them and finally, that learning may or may not result in behavior change. The Social learning theory gives insight into the intergenerational transmission of violence and stipulates that the family provides a platform through which children may directly or indirectly learn violence from other members of the family such as parents, siblings, or relatives (Bandura, 1973).

The reinforcement of violence in childhood often serves as a mechanism for coping to stress and or as a method of resolving conflicts later in life (Bandura, 1973). The Social Learning Theory (Bandura, 1973) and the Social Cognitive Theory (Bandura, 1977) can be applied to provide a conceptual basis in explaining how childhood experiences in the family can contribute to the risk of committing various acts of violence during adulthood. Children often tend to use adult behavior

as markers for desirable behavior and therefore imitate the same through learning (Bandura, 1989). Children who grow up in family settings where violence is experienced may acquire the violent behaviors and later copy and apply them in their relationships later in life. According to Bandura (1973), "behavior partly creates the environment, and the resultant environment, in turn, influences behavior" (p.43). When children grow up in environments where violence is perpetuated by modelers of a higher status such as parents and caregivers; learned behavior and experiences are seen to be salient.

According to Robinson and Taylor (1995) high levels of childhood exposure to violence have been found among federal offenders and this is supported by the fact that in the stages of childhood and adolescence, observation of how parents act toward each other provides some of the earliest learning behavior options which are then processed as acceptable for relationships in such settings. Some studies have observed that post-traumatic stress disorder (PTSD) has been partially linked to some forms of traumatic events that happen during the formative years which consequently lead future acceptance and further condoning of violence against women (e.g., Markowitz, 2001). This may increase the likelihood of being perpetrators of violence as well as risk of entering abusive relationships.

According to Bandura (1977) observational learning not only includes the primary family members but goes beyond and includes extended family members within which a child is brought up as well as activities such as exposure to television violence. While researchers such as (Freedman, 1984 & 2986) have not found any substantive evidence that links aggressive behavior to television; other researchers such as Eron, Gentry and Schlegel (1994) have concluded that there may be an association and that children's experiences with television violence and the overall prevalence of violence acts as a mediating influence where repeated exposure could result in

desensitization. Bandura's Bobo doll experiment showed that children who observed adults acting aggressively towards a doll imitated the aggressive behavior that had been earlier shown while children who observed adults playing nicely with the doll, reciprocated the behavior. Bandura goes further to show that "observation" goes beyond to include oral instructions where if certain explanations and descriptions are heard, learning is enhanced. He also observed "symbolic" models where both fiction and no-fiction characters in television programs, online media and books could result in learning of behaviour. Children can therefore learn through various models and imitate the learned behaviour.

Bandura's (1986) Social Cognitive Theory states that individual experiences, other people's behaviour, and environmental factors can influence change in individual behavior. A study conducted by Jati et al (2019) where the social cognitive theory was applied showed that power dynamics in decision-making in the household was the main cause of domestic violence. All interviewees who had experienced domestic violence were aware of the existence of male-dominated authority and control in the household as well as other external factors such as patriarchy. The study by Lati et.al (2018) shows that there are differences in how women perceive gender inequality as well as the overall concept of masculinity in relation to violence and the existing perception that men have ownership over women. This therefore explains why factors such as educational background does not affect violence and that discrimination and violence against women occurs despite the woman's; level of education (Maisah, 2016). Women's experiences of GBV/IPV therefore vary and can be as a result of several factors including their experiences of aggressive behavior from a young age.

2.7.1 Relevance of the theory to this study

The Social learning theory can be used to explain men's perpetration of GBV as well as women's tolerance of it. Boys who witness violence being perpetrated against their mothers end up perceiving violence as normal and therefore a normal way to control their partners (Cyr, et al, 2013). Boys may also believe that violence is the only way to express male superiority and dominance over others, more so women (Nicholls, 2006). Various models of social learning through the gender perspective are an indication that a man's exposure to violence through witnessing and not necessarily through experience, will influence his view of power and control in intimate relationships.

Various studies show that the exposure of childhood violence puts such adults at a higher risk of being a source of abuse to their children, similarly, men who witnessed their male parents and parental figures abusing their female parents or female parental figures when they were children are at a greater risk of abusing their own female partners Kaufman & Ziegler (1987) Carpenter (2000) Dutton (1995). In addition, research shows that exposure to violence at childhood either leads to individuals who are perpetrators or who condone violence in intimate relationships Cappell & Heiner, (1990), Marshall (1990). Abused children are likely to end up in violent relationships and this can be attributed to the normalization of acts of violence because of acts constantly witnessed. Intergenerational transmission of IPV is not inevitable. However, according to Kabeer (2000), there are exceptions as not all children who grow up witnessing violence end up as perpetrators or victims of violence. Bandura's theory also explains why women stay in violent relationships. Women who bore witness to or underwent abuse of any kind while growing up are

more likely to view violence as a normal occurrence and therefore fail to report acts of violence until they suffer from severe injuries. The experiences of women who have been part of the intergenerational cycle of violence will therefore provide useful insight to this study.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This segment describes the research design, the research site and study population, the sample population, sampling procedure, data collection and methods of analysis. In addition, the chapter details the ethical considerations the researcher took into consideration during collection of data.

3.2 Research Site

The research study took place in Nairobi City County where respondents were drawn from two Gender Violence Recovery Centers (GVRCs); Nairobi Women's Hospital and Kenyatta National Hospital. The two GBV recovery centres were selected as the site for this study because they provide medical and social support to many victims of GBV in Nairobi city-county and beyond. They are funded by various donors, so most survivors do not have to pay for the support services. Thus, they provide a fertile ground for generating data to answer the questions posed in this study.

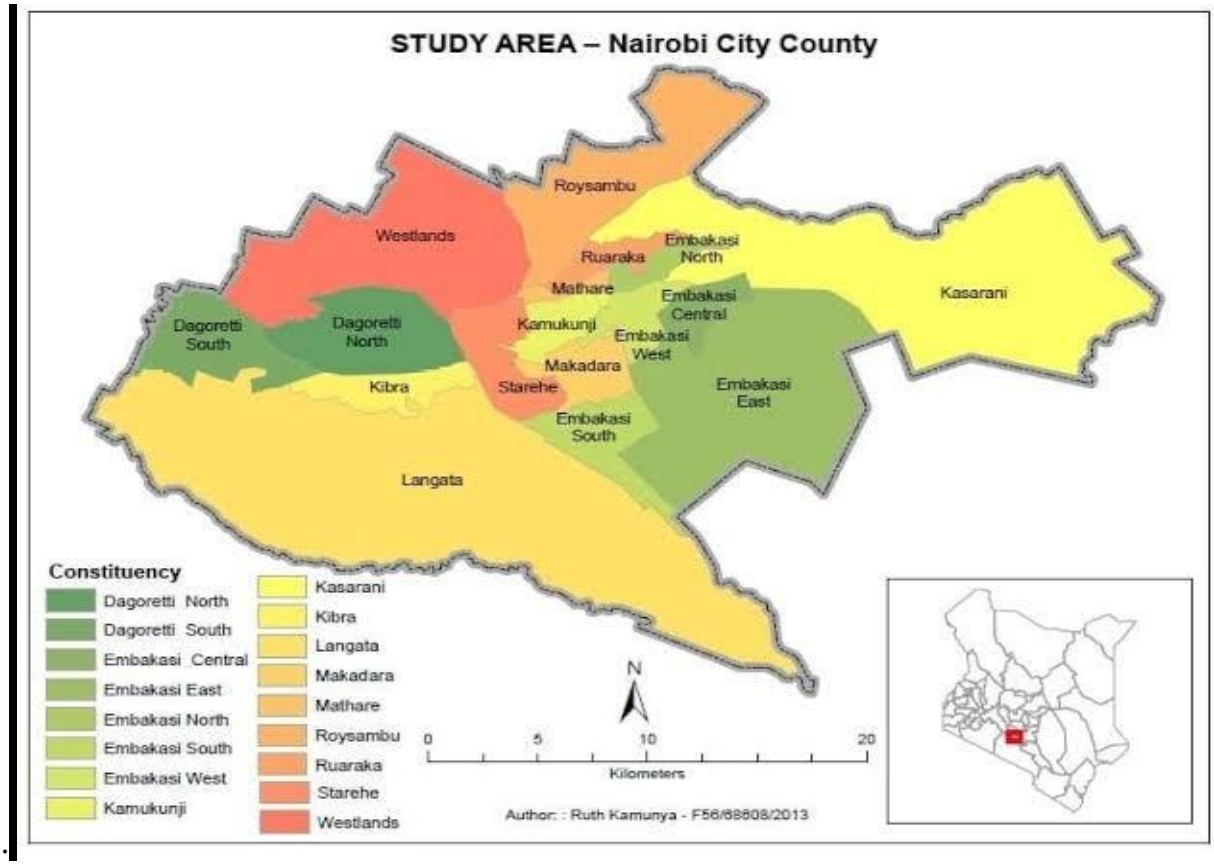
3.2.1 Nairobi Women's Hospital Gender Violence Recovery Centre

The Kenyatta National Hospital and Nairobi Women's GVRCS are the most accessible, the best equipped and well known GVRCs in Nairobi County. The Nairobi Women's GVRC for instance, offers free services to victims of GBV hence the most preferred. It is the first GVRC in Kenya. It was founded in March 2001 as non-profit trust of the Nairobi Women's hospital whose intention was to offer free all-inclusive medical treatment and psychosocial support to survivors of GBV in the country (Ondicho, 2018).

3.2.2 Kenyatta National Hospital Gender Recovery Centre

The Kenyatta National Hospital is the largest referral hospital in Kenya. It was set up to help survivors of Gender Based Violence in Kenya to access better, quality healthcare services. The center was set up as part of the collaborative efforts with the German Development Cooperation (GDC). This Centre also offers medical services and psychosocial support to survivors of violence (Ondicho, 2018).

Figure 3.1 Map of Nairobi County



Source: (Tuko, 2019)

3.3 Research Design

The study employed a descriptive research design. A descriptive research design is a scientific technique that involves observing and providing a description of the behavior of a subject without manipulating it in any way. This design was appropriate since the study was to be carried out in a setting where survivors of GBV were getting medical and other support services which the researcher could easily observe and document within a short period of time. In this respect the researcher was able to ask respondents questions on things that she had already observed and thus was while still able to capture the perceptions and challenges victims face while seeking services from GVRCs. The study involved various qualitative methods of data collection, namely, Case narratives, Key Informant Interviews and Secondary sources.

3.4 Study Population and Unit of analysis

The study population consisted of all women survivors of GBV obtaining services/ treatment at the two GBV recovery centers. The unit of analysis was the individual woman who had experienced violence during the period of study and was seeking help at any of the two GVRCs.

3.5 Sampling Procedure and Sample Size

A sample of 20 respondents from the two GVRCs who were willing to be a part of the study was purposefully selected and their lived experiences of GBV documented. The client register where all the names of all GBV victims who have received support services at each recovery centre were used as the sampling frame. However, only those survivors who were at the GBV centres during the time of the study were included in our sample and interviewed. Due to time and resource

constraints the sample size was considered large enough for this qualitative study whose aim was to provide a descriptive analysis of the perceptions and challenges a particular group women face when they seek services at the two GBV recovery centres. Four (4) Key Informant Interviews were selected to be a part of the study interviewees' first-hand knowledge and insight in the matter. Further information was gathered from secondary sources.

3.6 Data Collection Procedures

The data collection procedures that were utilized in the study were case narratives, key informant interviews and secondary sources.

3.6.1 Case Narratives

A guide (Appendix II) was used to document the experiences of female survivors of violence who were held at the GVRCs. The researcher interviewed 20 respondents. The interviews were audio recorded with permission granted by the respondents. Only the willing participants were engaged. The informants for the case narratives were conveniently chosen by seeking consent from participants willing to be a part of the study. Only women survivors of GBV who were seeking services from the two GVRCs were interviewed, and their personal experiences seeking to capture and understand the abuse in terms of how they perceive the services offered at the GVRCS and the challenges they encountered as they sought the services were documented.

3.6.2 Key Informant Interviews

Four (4) key informant interviews were undertaken, and these involved a Gender officer/social worker, Police officer at the gender violence desk, a Nurse and a Doctor. The interviews provided an in-depth understanding of GBV and issues surrounding the reporting when acts of violence

against women take place. It equally provided insight on the roles the players play and the mechanisms that have been put in place to end GBV against women. A guide (Appendix III) was used to capture the expert insight into the issues under examination.

3.6.3 Secondary Sources

Secondary sources of information were utilized throughout this study. Secondary data was obtained from books, newspapers, journals, research reports, internet sources and unpublished theses. The development of this proposal involved the use of secondary sources, and the same sources were utilized to source contextual background information to the study, and other relevant information that was used to verify and confirm findings obtained in this study.

3.7 Data Analysis and Processing

The study is qualitative and therefore only qualitative data was generated. The researcher utilised various qualitative methods to process and analyze the data. Data obtained from the interviews was transcribed, translated, and then sorted thematically and summaries made from each set of data. The data was then presented in key thematic areas guided by specific objectives.

3.8 Ethical Considerations

Approval from the Ministry of Education was obtained through the National Commission of Science, Technology, and Innovation (NACOSTI). The Researcher also sought clearance from the two GVRCs before commencement of data collection. The Researcher outlined the purpose, target population, selection procedures, duration, the use of the findings, conditions of privacy and

confidentiality, the risks, and benefits of the to the participants prior to the beginning of the interviews. The respondents were provided an opportunity to seek clarification regarding their participation in the study and were requested to sign a consent form if willing to participate. The respondents were informed of their free will to stop ongoing interviews without fear of victimization or harm. They were also made aware of all that all the information collected would be kept private and anonymous, and that the names and contact details of participants were not to be recorded. Benefits of the study were also highlighted and surety to keep treat data collected with confidentiality.

3.9 Problems Encountered in the Field

In the process of the study, the researcher faced some problems which are worth mentioning. Some participants responded to the research questions with the kind of caution that almost bounded on outright mistrust. In fact, some were not able to complete the case narrative interviews and therefore had to be replaced. Others could not participate in the study because they were in pain and nursing injuries from episodes of GBV. In cases where potential respondents refused to participate for reasons based on suspicion and mistrust, all efforts were made to persuade them about the pure academic orientation of the present study and how its findings could possibly be used to improve services at the recovery centre. If such efforts were unsuccessful, new respondents were obtained from the reserve sample.

The other challenges included the long and tedious process of obtaining approvals from the Centres. Transport to and from the centres was also tedious and time consuming since the survivors could only be interviewed at set hospital hours.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1 Introduction

This section presents findings and the interpretation of the findings of this study which intended to answer the following questions how female survivors perceive the services offered at Gender Violence Recovery Centres (GVRCs) and to analyse the challenges female survivors of GBV face as they seek services and help from the Centres located in Nairobi City County.

4.2 Characteristics of Study Participants

4.2.1 Age of the participants

Age facilitated the researcher to know the age group of the participants. Twenty (20) respondents took part in the study. The study findings indicate that all the participants were of legal age as presented in the table below:

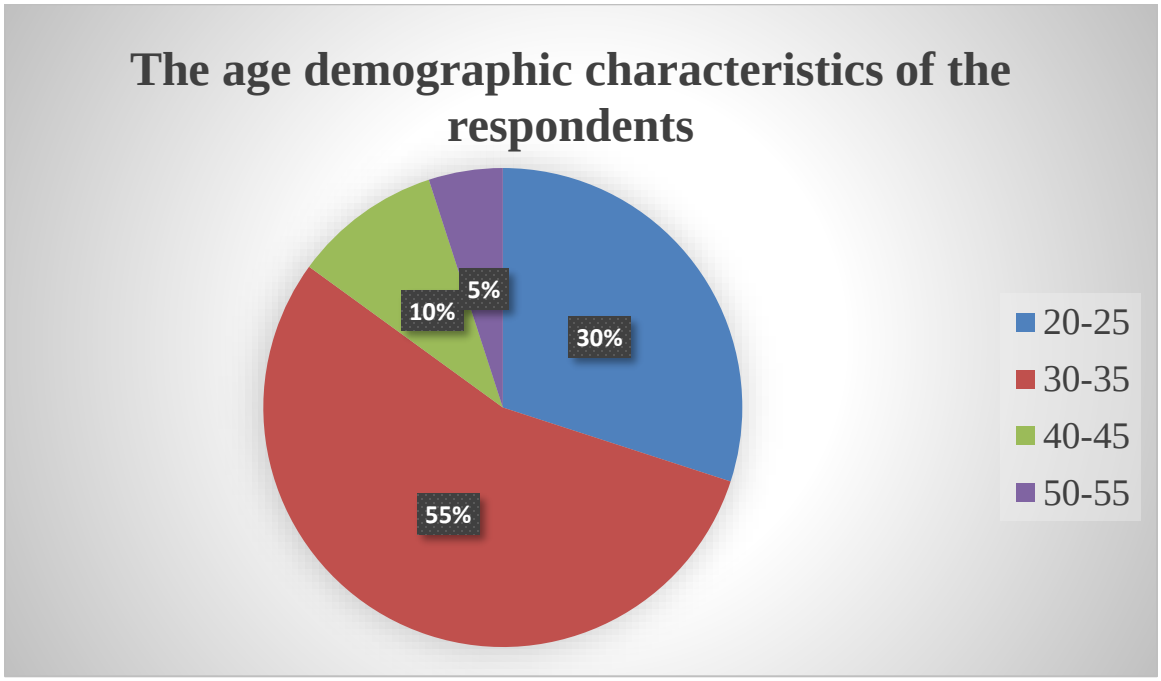


Figure 4.2: Age demographic characteristics of participants

Most of the respondents were between ages 30-35. There were no respondents from age 55 going up. The findings are presented below:

Table 4. 1: Demographic characteristics of the participants

Age	Frequency
20-25	6
30-35	11
40-45	2
50-55	1
Total	**20**

4.2.2 Highest level of education

The researcher sought to establish the highest level of education attained by the respondents. The education levels included were below primary education, secondary education, and college education. The level of education was significant in establishing knowledge about GVRCs and the kind of services to expect when seeking for medical care after experiences of violence.

Table 4.2: Highest level of education

Education level	Frequency
Below primary	1
Secondary	10
College	9
Total	**20**

4.2.3 Religion of the participants

Religion plays a major role in influencing decisions and behaviour of several respondents towards GBV, reporting of the same and perceptions in general. Further, certain religious indoctrinations have strict beliefs as to how female and male members should be treated. Muslim women for instance can only be treated by fellow female doctors, nurses and or care givers. The table below provides and analysis of the religious indoctrinations of the respondents.

Table 4.3: Religion of the participants

Religion	Frequency
Christian	15
Muslim	4
Atheist	1
Total	**20**

4.2.4 Marital status of participants

The researcher sought to know the marital status of the respondents to comprehend the significance attached to the institution of marriage and to try and establish the linkage of partners to violence and the kind of support the participants received especially where partners were not behind the acts of violence they experienced. From the findings, it is clear that the majority of the participants were married.

Table 4.4: Marital status

Marital status	**Frequency**
Single	7
Married	11
Divorced/separated	1
Widowed	1
Total	**20**

4.3 Perceptions of Survivors on Services Offered at GBV Recovery Centres

It was observed from the findings of the narrations by the participants that a decent number of the respondents did not have prior information on the existence of GVRCs while some did not see the need to visit the centres until they were convinced by close allies. Other respondents were cases of repeated violence and therefore were fully aware of the processes to follow in the event violence occurred having sought services at the Centres before. This begged the question on what kind of

services the participants received at the Centres, taking into consideration the psychosocial support, Counselling and follow up services offered with an end goal of ensuring survivor safety and existence in safe spaces away from the abuser. GVRCs also serve as part of the majority of first points of contacts for reporting of violence especially where injuries are experienced. That said, it is expected that if evidence is well collected and properly handled, survivors should be able to get justice and have their perpetrators prosecuted. The following are presentations of findings on perceptions of the survivors regarding the services they received at the Centres having experienced different forms of GBV.

4.3.1 Perceptions of GBV Survivors on Services Received at Nairobi Women's Hospital Gender Recovery Centre

Ten women survivors of GBV who participated in the study were from the Nairobi Women's Hospital Gender Violence Recovery Centre. Most of the survivors found the services at the Centre very supportive, helpful, and educational. From the narrations provided by the participants seeking to answer the research questions, the Nairobi Women's GVRC seemed to be the most preferred. Some of the respondents who had experienced violence before and sought help from other Centres preferred this centre due to, according to them, the quality of services available and the affordability. One aspect of the Centre that stood out was the ability to find information regarding it online through their website which made the ability to communicate and seek further assistance easier.

> *"One of the first impressions I got about this centre is the availability of a wealth of information on its website. When I was raped, my friends who came to offer me help just googled the best hospitals to obtain services from at no cost, seeing as am a student and a single mother and the Nairobi Women's hospital GVRC came up. They contacted them through the number provided on the Website and I was able to get to the centre for help. "**(Participant, NWGVRC)***

The other commonly cited aspect of services at the Centre was the privacy accorded to the participants by virtue of both location of the GVRC which is on the fourth floor of the building in a secluded floor and the assistance offered by the line officers who provide directions including the people in charge of security and the receptionists.

> *"…when I arrived, I was disoriented and confused. I sought information on how to access the GVRC and the receptionist was very helpful in providing me the direction. She even offered to escort me to the Centre. I also found the guys at the security area very friendly and charming since they did not dismiss me because of how I looked but instead, guided me accordingly."* ***(Participant, Nairobi Women's GVRC)***

> *"…I was so scared of going to the hospital. I was ashamed as I had never expected that a woman of my social status would experience domestic violence. I liked the fact that the Centre was in a secluded corner away from many where other hospital services were offered. "****(Participant, Nairobi Women's GVRC)***

From the findings, it was also observed that the common perception regarding the services at the Centre was the anticipation of high-cost implications for treatment. The Centre is in an uptown area of the city hence the perception that the charges for services offered would be exorbitant.

> *"I honestly went to the Centre to just try my luck. I am a jobless woman and the person who I depend on was the one who battered me. I only had money to get me to Hurlinghum, so I decided to try my luck there. I was surprised that I have not been charged for the services I have received."* ***(Participant, Nairobi Women's GVRC)***

The women respondents from this study found the members of staff from the Centre to be very supportive and empathetic. Some respondents described the service providers as cheerful, informative. They described the treatment provided as dignified and very assuring. According to the survivors, the treatment provided restored their faith in hospitals and public service in general.

> *"…I am a Muslim lady, and my greatest fear was coming to the hospital and further worsening my situation. I requested to be seen by a female specialist and my wish was granted. I have gone through FGM, and you can imagine how much pain I was in having been gang raped. The caregivers did not judge me or question my situation. I will be forever grateful to these people."* ***(Participant, Nairobi Women's GVRC)***

"*We offer different kinds of services here; when a survivor reports, we provide minimum GBV Package, legal assistance, referrals and linkage. Some of the commonly encountered form of violence include SGBV, physical, emotional violence, discrimination, and neglect. Usually, some clients report here as the first point of contact and others report after reporting to the police station and other facilities. From my observation, Power imbalances, economic, and social cultural norms. Seems to be the common causes of violence in the community around here. As a social worker, therefore, my role is to ensure I make follow-up calls for survivors and schedule them for subsequent visits for psychosocial support. We also work with a team of CHVs (GBV champions) that help us in implementation of both preventive and responsive GBV measure. I like what we do here and am sure that through implementation of preventive and responsive measures on GBV, we are headed in the right direction*." ***(KII, Social worker)***

4.3.2 Perceptions of GBV Survivors on Services Received at Kenyatta National Hospital Gender Recovery Centre

Ten respondents were also engaged and participated in the study from the Kenyatta National Hospital. The respondents reported that they had opted for the hospital because it is a public hospital and services received are cheaper compared to private hospitals. From the findings, the respondents were not aware that there were no charges for the comprehensive medical treatment and psychosocial support and counseling services provided at the GVRC until they sought services from the Centre.

"I opted for Kenyatta National Hospital because it is a government hospital. I didn't even know that the services I am receiving here are free of charge or can equally be obtained from other hospitals free of charge. I am so relieved because I did not have money, but I urgently needed the help; I was badly injured and lost a lot of blood due to deep cuts because of domestic violence. I am glad I have been treated" ***(Participant, Kenyatta National Hospital GVRC)***

Most of the survivors found the services offered to be very helpful but were not pleased with the attitudes of most of the caregivers and other service providers in the hospital in general. Some respondents cited cases of verbal abuse and discrimination where people who seemed well off were treated better than those who seemed poor.

"…I was not shocked when I asked for directions to the centre and I the response was; "pale kwa wamama wa rape?" Interpreted as "the place where women who are raped go?" It was really embarrassing because there were so many people around. I said no and sought help from another person who was able to help. I was not really shocked though; I frequent public hospitals and most of the staff are like that." ***(Participant, Kenyatta National Hospital GVRC)***

"I was surprised that the lady who received me did not seem bothered by my condition or my story, she lacked empathy and when she stepped out to pick a phone call, I could hear her telling the other person that my story seemed fake, that something else had happed to me but I had just chosen to seek help at the Centre to bother them. I also did not like the idea of narrating what had happened to me repeatedly, I wish they could record me or find better ways to deal with that" ***(Participant, Kenyatta National Hospital GVRC)***

From the findings, most of the survivors were pleased that they were able to get treatment for their injuries and most importantly were able to be protected from pregnancies and HIV infections because of the post rape care services provided. Some survivors were not aware that there are counseling services provided and were not sure they would be able to keep up with the follow- up arrangements provided.

> *"…I am glad I saw a counselor and found someone to confide in, but I am sure I cannot keep up because this hospital is so far from home, and I don't have the money to keep commuting. I will try my best, but I will talk to my pastor if I feel depressed. It's easier that way.* ***(Participant, Kenyatta National Hospital GVRC)***

4.4 Challenges survivors experienced in the GVRCs.

GBV is a life altering vice with several effects as earlier mentioned. Victims of GBV face several challenges as they seek to find possible solutions. The survivors cited various challenges as they sought to find help from the GVRCs.

1. **Transport Costs**

Many of the participants cited transport costs and distance of the centre from their residences as a big challenge. Further, the respondents pointed out that traveling to the Centre at night further

heightened their woes. Means of transport available for use especially when violence occurred at night was also cited as a big challenge. The economic situation, according to most participants, only allowed them to use motorbikes and motorcycles to ferry them to the nearest bus stage with the hopes of finding public means of transport to access the centres.

"…getting to this centre has been a challenge, I am used to the clinics in my neighborhood but they couldn't offer the assistance I needed so I had to come here. It was quite expensive because I live in the Nairobi metropolis." ***(Participant, Nairobi Women's GVRC)***

2. Mistreatment and Discrimination by Caregivers

The other commonly cited barrier was mistreatment and discrimination. This worried the survivors from seeking help from public facilities especially after experiencing acts of violence such as rape which are considered shameful and embarrassing. Most of the survivors cited preference to seeking help from private hospitals but were worried of the cost implications. The general perception regarding the quality of services offered at public hospitals according to the respondents, is the negative attitudes of the health care workers which most of the survivors had experienced in previous normal hospital visits. From the narrations of the respondents, there was a common worry that the situation would be worse when one seeks treatment after experiencing GBV which was indeed experienced at the centre. The survivors cited verbal abuse and preference by the caregivers to give attention to women who were of a higher social status.

> *"…I was asked very embarrassing questions when I got here. There was no privacy, and I didn't not like that at all. I also realized that other women who came to seek help at the Centre and seemed well off were treated better.* ***(Participant, Kenyatta National Hospital GVRC)***

3. Lack of knowledge of GVRC operations by staff

The other challenge cited by some respondents was the lack of knowledge of the existence of a GVRC within Kenyatta National Hospital. It was noted that the survivors consulted so many people within the hospital environs before they were able to access the Centre. The survivors found this to be exhausting. Some survivors considered going back home.

> *"…It had to consult six people before I was able to find the centre. I was tired and was almost going back home when I found a nurse who was able to show me where the Centre was. I also wish they had a different name for the Centre for ease of identification."* ***(Participant, Kenyatta National Hospital GVRC)***

Lack of sensitization of members of staff within the hospital is clearly key in ensuring that better services are offered and to encourage those who experience GBV to seek help.

4. Religious /Cultural Beliefs and Fear of condemnation

The study revealed that religious and cultural beliefs of the respondents were a hindrance to the quality and efficiency of services offered at two centres. Due to religious and cultural prohibitions, some participants could only be attended to by female doctors and where the preferred doctors were not readily available, the survivors had to wait longer before being attended to. This was cited as a common problem in the two centres. From the findings, it was also noted that some survivors experienced challenges in confiding in the social workers assigned to them for provision of counseling services. From the survivor's perspective, seeking medical treatment due to injuries was considered okay in some of the survivor's cultures but confiding in a stranger on domestic matters was considered a private affair. The respondents' revelations showed that it took assurance of confidentiality to agree to the counseling services offered while some only agreed to confide in social workers who came from similar cultures.

"As a Muslim woman, I had to wait longer to be attended to but I was okay with that as long as my preference was adhered to." ***(Participant, Nairobi Women's GVRC)***

"I was born and raised in Nairobi and since I was young, I wanted to be a Police officer. I was disappointed to grow up and find out that we don't have a very good reputation. I lost my father to the Post election violence and my mother to the blows of my step father. I am dedicated to my job because violence has robbed me of the people I love. I therefore ensure that any case of GBV I come across gets the proper attention it deserves. I do receive GBV reports often but they are somehow economical with the information, in fear of being condemned by the society. I guide the women who report violence at my station by referring them to hospitals and further direct them on how they can report the perpetrators so that they get the justice they deserve. In my opinion, harmful traditions contribute greatly to GBV, my mother stayed in an abusive relationship because she thought wife beating is normal. When we receive cases, we guide the survivor accordingly to ensure that the perpetrators are prosecuted and jailed to avoid physical contact with the victim. We also usually conduct GBV awareness programs through community policing and provide or seek Shelter, counseling, and protection, I hope I am making a difference in my community no matter how small." ***(KII, Police Officer)***

5. Follow up services and costs

The study further revealed that some of the survivors who had visited the centres for follow up services were overwhelmed by the costs of the visitation services that needed to be covered for them to get to the centres. Some of the associated costs that were cited included payment for child day care services as the mothers went for follow up, transport costs, costs for food, and sometimes long waits before being attended to.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter provides a summary of the key study findings of this research project and provides conclusions drawn from the study findings. The chapter also gives recommendations as per the research objectives then gives suggestions of areas of future research study.

5.2 Summary of Findings

The research sought to find out women's perceptual experiences as they sought services at GVRCs after experiencing violence. GBV is rampant in Nairobi; presently, the data availed at the Nairobi Women's GVRC Website indicates that over 44,000 survivors of GBV have since inception received medical treatment, management and psychosocial support (From inception to March 2018) and psychosocial support provided to over 180,000 survivors of the Post-Election Violence 2007/2008. Out of those supported 56% of them were women, 36% of them were girls, 3% of them were men and 5% of them were boys. Women clearly form the bigger percentage of the victims of GBV (https://gvrc.or.ke/about-us/).

The responses from the narrations of the participants revealed that lack of economic empowerment is one of the reasons why women stay in abusive relationships and further finding it difficult to access healthcare when violence occurs. The findings have also revealed that cultural beliefs and customs as a way of life have contributed to the perpetration of violence and late or failure to report and seek help at GVRCs. The normalization of violence has further led to perseverance of GBV.

While women in Nairobi have in recent years frequented GBVRCs to report and seek help because of the effects of acts of violence, there have been challenges. Survivors are further faced with security challenges when intending to access GVRCs considering most acts of abuse occur at night. GBV and its effects are costly, most of the survivors found transport costs and other non- medical expenses to be burdening this being because there are no GVRCs within their immediate environments. Most of these survivors come from low-income households where every coin count, spending money on medical related expenses seeing as not all services offered at GVRCs are free, becomes a tough choice.

In addition, survivors of GBV seem to experience discrimination and bias when they seek help from GVRCs while some are verbally abused and face negative attitudes which dissuade them from seeking help especially where follow up services are needed which is often the case with GVC related cases. Religious and cultural beliefs are still a hindrance today. Over and above their contribution to violence, the findings revealed that most women likely due to socialization are still not comfortable with the idea of going against their cultural and religious standings even where help is concerned and that a lot of time and need to provide timely assistance ends up being consumed as alternative ways to accommodate such survivors are sought.

The negative perception regarding services offered by various health and non-health workers at public hospitals affects the desire by survivors to seek help while preference for private hospitals is hindered by the perception that the Centres are too costly. This further shows the need for awareness creation on the GBV services, where they are offered and the cost implications. The findings further revealed the need for awareness creation within the hospitals to ensure that survivors can be guided accordingly with proper support from any member of staff within the

hospital setting from the security officers to line workers such as receptionists to other healthcare providers as in the case of Kenyatta National Hospital GVRC.

5.3 Conclusion

GVRCs provide crucial services as seen from the findings. The services provided have been helpful to the female survivors of GBV who are seeking help. However, there have been challenges. The most prominent challenge seems to be economic in nature where lack of money to facilitate transport to the GVRCs to enable access to treatment and aftercare services hinder survivors from getting proper help among other challenges of a varying nature.

Nairobi is growing City with a robust population and majority still wallowing in poverty. GBV is still rampant yet there are only few existing GVRCs. Awareness and consumption of information on GBV and reporting mechanisms is also still low in the city. It is shocking that even health providers in hospitals are not privy of the fact that GVRCs exist in the very hospitals they operate from.

There is therefore need for vibrancy in the operations of GVRCs. The Nairobi population with proper knowledge on GBV management and reporting, can serve as a starting point to spread information to other areas in the country and by doing so, save lives when acts of GBV occur.

5.4 Recommendations

Based on the study's findings, the following recommendations are made:

1. There' need to establish more centres to manage GBV. The Nairobi population is growing and the current centres can be overwhelmed.

2. There’s need for community-based sensitization on reporting procedures and evidence management to ensure that perpetrators are punished to the full extent of the law.
3. There’s a need to work closely with other sectors such as legal and security since they are often the first points of GBV reporting. While gender desks were established, they did not work and the intended officers never trained on GBV management.

5.5 Avenues for Future Research

1) A call for an urgent need of an elaborate study to look at how the COVID-19 pandemic has led to the increase in GBV for both men and women and how GVRCs are handling the increase in number.
2) There is need for a comprehensive and comparative study that looks at how men can be champions and agents for change in reducing the numbers and rates of GBV. GVRCs such as the Nairobi Women’s hospital have developed programmes of this approach but others who are yet to implement, need to embrace the same (https://gvrc.or.ke/about-us/).
3) There's a need for an elaborate study to establish the impact of GBV and the silence of men.

REFERENCES

Albert Bandura (1973). Social Learning Theory. General Learning Press.

Banwell, S. S. (1990). "Law, status of women and family planning in Sub-Saharan Africa: A Suggestion for Action." Nairobi: The Pathfinder Fund.

Claire Mc Evoy (2012). Battering, Rape, and Lethal Violence. A baseline of Information on Physical Threats against Women in Nairobi. Small Arms Survey, Graduate Institute of International and Development Studies. Available at http://www.smallarmssurvey.org/fileadmin/docs/F-Working-papers/SAS-WP13-VAW-Nairobi.pdf

Dobash, R. E., & Dobash, R. P. (1979). Violence against Wives: A Case against the Patriarchy. New York, NY: Free Press

Ellsberg M, and Heise L. (2005). Researching Violence Against Women: A practical guide for Researchers and Activists. Available at https://apps.who.int/

Eniko Horváth Et Al., Gender-Based Violence Laws in Sub-Saharan Africa 45 (2007), http://www.nycbar.org/pdf/report/GBVReportFinal2.pdf [http://perma.cc/B5RC - DRNB].

Enikő Horváth, Monwabisi Zukani, Desmond Eppel, Monica Kays, Abdoul Konare, Yeora S. Park, Ekaterina Y. Pischalnikova, Nathaniel Stankard and Tally Zingher. (2007) Gender-Based Violence Laws in Sub-Saharan Africa. Center for International Justice. Available at https://www.nycbar.org/pdf/report/GBVReportFinal2.pdf

Gender Violence Recovery Center (GVRC) & GiZ Health Sector Programme (2012). Personal Stories on Gender-Based Violence in Kenya. Available at http://health.bmz.de/what_we_do/Gender_and_human_rights/Studies_and_articles/Gender-Based-Violence-Kenya/Personal_Stories_on_Gender_Based_Violence.pdf

Geraldine Terry & Joanna Hoare (2007). Gender-Based Violence. Oxfam.

Heise, L. L., M. Ellsberg, and M. Gottemoeller. (1999). "Ending violence against women." Population Reports Series L, no. 11. Baltimore, Maryland: Johns Hopkins University School of Public Health and S. L. Weldon. 2012. "The civic origins of progressive policy change: combating violence against women in global perspective, 1975-2005.

Hindin, Michelle J., Sunita Kishor, and Donna L. Ansara. (2008). Intimate Partner Violence among Couples in 10 DHS Countries: Predictors and Health Outcomes. DHS Analytical Studies No. 18. Calverton, Maryland, USA: Macro International Inc.

Hyde-Nolan, M.E. and Juliao, T (2012) Theoretical basis for family violence http://samples.jbpub.com/9780763780340/80340_CH02_FINAL.pdf Accessed September 2019.

International Rescue Committee (IRC), (2014). My Action Counts: An Assessment of Gender Based Violence Responses in Nine Counties of Kenya. (USAID).

IPPFAR.org, (2018). https://www.ippfar.org/sites/ippfar/files/2018-09/SOAW-Report-Chapter-5-Gender-Based-Violence-Against-Women.pdf Accessed July 2019.

Jewkes, R., Sen, P. and Garcia-Moreno, C. (2002) Sexual Violence. Word Report on Violence and Health. Word Health Organization, Geneva, 213-239.

Kabeer, Naila (2000) 'Social Exclusion, Poverty and Discrimination: Towards an Analytical Framework.' Institute of Development Studies Bulletin, 31 (4). pp. 83-97.

Kellerman, A. L., and J. A. Mercy. (1992). "Men, women and murder: gender-specific differences in rates of fatal violence and victimization." Journal of Trauma 33(1): 1–5.

Kenya Demographic Health Survey (KDHS), (2003). https://dhsprogram.com/pubs/pdf/fr151/fr151.pdf Accessed September 2019.

Krug EG et al., eds. World report on violence and health. Geneva, World Health Organization, 2002

Naila Kabeer (2014). (UNDP). Violence against Women as 'Relational' Vulnerability: Engendering the Sustainable Human Development Agenda. UNDP.

National Crime Research Center (NCRC), (2014). Gender-Based Violence in Kenya. NCRC.

National Gender and Equality Commission (NGEC) (2016). Gender-Based Violence in Kenya: The Economic Burden on Survivors. NGEC.

National Gender and Equality Commission (NGEC), (2017). https://www.ngeckenya.org/Downloads/NGEC%20Model%20Policy%20on%20GBV%20for%20County%20Govts.pdf Accessed September 2019.

Okin, Susan Moller (ed.), (1999). Is Multiculturalism Bad for Women? Princeton University Press.

Ondicho, T. (2018), “Violence against Women in Kenya: A Public Health Problem”, International Journal of Development and Sustainability, Vol. 7 No. 6, pp. 2030-2047.

Patricia Kameri Mbote (2001). (IELRC). Violence against Women in Kenya; An analysis of law policy and institutions. International Environmental Law Research Centre. Available at http://www.ielrc.org/content/w0001.pdf

Sarah Bott, Andrew Morrison, Mary Ellsberg (2005). Preventing and responding to gender-based violence in middle- and low-income countries: a global review and analysis. World Bank Policy Research Working Paper 3618.

Setia M. S. (2016). Methodology Series Module 3: Cross-sectional Studies. *Indian journal of dermatology, 61*(3), 261–264. https://doi.org/10.4103/0019-5154.182410

Standard Media Group (2019). https://www.standardmedia.co.ke/topic/ivy-wangeci-murder-case Accessed August 2019.

Swedish International development Cooperation Agency (SIDA), (2015). https://www.sida.se/contentassets/3a820dbd152f4fca98bacde8a8101e15/preventing-and-responding-to-gender-based-violence.pdf Accessed July 2019.

Sylvia M. Asay, John DeFrain, Marcee Metzger, Bob Moyer (2014). Family Violence from a Global Perspective: A Strengths-Based Approach: SAGE Publications Inc.

True, Jacqui. (2012). The Political Economy of Violence against Women. Oxford, UK: Oxford University Press.

United Nations Economic Commission for Africa (UNECA) (2010). Violence against women in Africa: A situational Analysis. UNECA.

United Nations Population Fund (UNFPA) (2012). Addressing Gender-Based Violence. https://www.unfpa.org/sites/default/files/resource-pdf/final%20sexual%20violence%20CSW%20piece.pdf Accessed July 2019.

World Health Organization (WHO), (2013). Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-partner Sexual Violence. Accessed July 2019.

Yanyi K. Djamba & Sitawa R. Kimuna (2015). Gender-Based Violence. Perspectives from Africa, the Middle East and India. Springer International Publishing. Switzerland.

APPENDICES

APPENDIX I: CONSENT FORM

Hello**,** I am Annes Kassim, a master's student in Gender and Development Studies at IAGAS, university of Nairobi. I am undertaking research on the experiences of women who have been victims of Gender-based Violence and have sought help from Gender-Based Violence Recovery Centres (GBVRCs) in Nairobi. The general objective of this study is to investigate and document the experiences of female survivors of GBV with the services at two Gender Violence Recovery Centres (GVRCs) in Nairobi County. Findings from the study will be used by the researcher for academic purposes only.

Participation in this study is voluntary and you can withdraw should you feel the need to. Information gained from this study will be dealt with in confidence and any recordings made destroyed after transcriptions have been done. In addition, personal details such as your name, contact will not be collected in this study to ensure your anonymity.

Your participation in this study will provide important information on GBV and will help shed more light on the issue. I will respond to any questions you may have, and I will also provide clarification where needed.

Respondent's consent: I have understood the information above, and I give my consent to participate in this study.

Proceed if you consent.

Date: …….

Thank you for your cooperation.

APPENDIX II: NARRATIVE GUIDE
SECTION A:

Section A: Demographic characteristics

1. What is your age? (Years)_____
2. Highest level of schooling you completed. Below primary [ ] Primary [ ] Secondary [ ] College/University [ ] none [ ]
3. Which religion do you belong to? Christian [ ] Islam [ ] other [ ] Specify……
4. What is your marital status? Specify…….

Section B: Perceptions and Challenges

Q1. Please describe how you found/find the services you received from the Gender-Based Violence Recovery Centres (GBVRC).

(Probe for how the survivor perceived the services received)

Q2. Please describe the challenges you have faced while seeking help at the Gender-Based Violence Recovery Centres (GBVRC).

APPENDIX III: KEY INFORMANT INTERVIEW GUIDE

1. What types of violence do you commonly encounter here?
2. Do you receive any reports of GBV here? If so, is this the first point of contact for victims who report?
3. What would you say are the common causes of the violence experienced by survivors here?
4. Are there any mechanisms put in place in following up how survivors cope with violence after treatment?
5. Does the community have mechanisms to address GBV?
6. What is your contribution towards creating awareness on GBV?
7. What kind of assistance do you provide victims of GBV?

APPENDIX IV: WORK PLAN

Main activities	Sub-activities	Timeline					
		Jun	Jul	Aug	Sep	Oct	August 2022
Proposal Preparation and literature review	❖ Conceptualizing research topic ❖ Reading on related research						
Proposal defense	❖ Presenting the proposal before the panel						
Data collection	❖ Conduct data collection activities.						
Data processing, analysis and reporting	❖ Management of the qualitative data. ❖ Qualitative data transcription, verification, listing, description and presentation. ❖ Coding, summary and compilation of qualitative data including transcripts, pictures and drawings.						
Final review, editing and presentation of the final report	❖ Writing the final report ❖ Final consultations with the supervisor ❖ Binding and presentation to the supervisor						

APPENDIX V: BUDGET

Items		Unit Type	Quantity	Unit Cost (KES)	Total (KES)
Stationery & services for data collection	i) Writing materials/pads	Units	10	40	400.00
	ii) Pens	Units	5	5	25.00
	iii) Document folders	Units	2	40	80.00
	iv) Data collection phones	Units	2	Own	00.00
	v) Research Assistants (Rate of 500 per day for 2 days)	Pax	2	500	1000.00
Sub-total A					**1505.00**
Facilitation	Public Transport for 5 days at 250 per day	Pax	5	250	1250.00
	Communication for 5 days at 50 per day	Pax	1	250	250.00
	Miscellaneous				500
Sub-total B					**2000.00**
Project submission	a)Printing of final submission report	Units	5	300	1500.00
	b)Binding final submission report	Units	2	50	100.00
Sub-total C					**1600.00**
TOTAL 2	**(Sub-totals A + B + C)**				**5105.00**