FACTORS ASSOCIATED WITH SEXUAL VIOLENCE AMONG FEMALE PATIENTS AGED 14 - 24 YEARS AT KENYATTA NATIONAL HOSPITAL, KENYA

BY

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DECLARATION

I, **Dr Carmen N. D. SOHOUENOU-TOGBETO** declare that this dissertation is my original work and has not been presented in any other University for a degree to the best of my knowledge.

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APPROVAL

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DEDICATION

This dissertation is dedicated:

- To my lovely husband for all the love and care and for his continued support in my education
- To my entire family for their encouragements and prayers.
- To all people who undergo any type of violence and most particularly to all children and women victims of sexual violence.

The solution of the sexual violence problem actually needs to include everything and everyone. No girl, no woman deserves to be sexually violated. Imagine if it was your daughter, sister or wife ...

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- To the health workers who gave me support and encouragement.
- The research assistants for working tirelessly to ensure the right data were collected.
- The statisticians who continuously advised me and helped me analyze data.

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ARVs	Anti-Retroviral drugs
CSOs	Civil Society Organizations
d.f	Degree of freedom
DRH	Division of Reproductive Health
GBVRC	Gender-Based Violence Recovery Center
EC	Emergency Contraception
ERC	Ethics and Research Committee
GOK	Government Of Kenya
HIV	Human Immunodeficiency virus
IRIN	Integrated Regional Information Networks
KDHS	Kenya Demographic Health Survey
KEPH	Kenya Essential Package for Health
KHPF	Kenya Health Policy Framework
Km	Kilometre
Ksh	Kenyan Shillings
KNASP	Kenya National AIDS Strategic Plan
KNH	Kenyatta National Hospital
KNHSSP	Kenya National Health Sector Strategic Plan
LSD	Lysergic Acid Diethylamide
MDGs	Millennium Development Goals
NACC	National AIDS Control Council
NASCOP	National AIDS and Sexually Transmitted Infections Control Programme

NGO	Non-Governmental Organization
OB	Occurrence Book
PTSD	Post-Traumatic Syndrome Disorders
SD	Standard Deviation
SE	Standard Error
SGBV	Sexual and Gender Based Violence
SOA	Sexual Offences Act
SPSS	Statistical Package for Social Sciences
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TSC	Teachers Service Commission
PASW	Predictive Analytics Software
PEP	Post-Exposure Prophylaxis
UN	United Nations
UNFPA	United Nations Fund for Population Activities (Currently, United Nations Population Fund)
UoN	University of Nairobi
VCT	Voluntary Counselling and Testing
VPA	Violence Prevention Alliance
WHO	World Health Organization
WRVH	World Report on Violence and Health

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DEFINITIONS OF OPERATIONAL TERMS

For the purpose of this study, the following key terms are used as defined below:

- **Sexual violence:**

  Sexual violence is defined as *"any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including, but not limited to home and work"*.

- **Sexual Harassment:**

  Sexual harassment refers to sexual advances through intimidation at work, educational institutions and elsewhere.

- **Sexual Abuse:**

  Sexual abuse is any contact or interaction (physical, visual, verbal or psychological) between some individuals when the victim is being used for the sexual stimulation of the perpetrator or any other person.

- **Sexual Assault:**

  Sexual assault is defined as any sexual act or manipulation of genital parts, whether attempted or completed by force, threat of force or coercion against another person's will, when a person is incapable of giving consent, or when the consent is obtained by force, threats or intimidation.

- **Rape:**

  Rape is any sexual intercourse that is obtained by use of force, coercion, intimidation by any kind of threats and includes penetration of the vagina and the anus of either women or men.

- **Defilement:**

  Defilement is the technical term used in Law for any act committed by any person who has sexual intercourse with an under-18 year old, whether this one agrees or not. The offence is termed "defilement" for girls and "sodomy" for boys.

- **Incest:**

  Incest is any sexual interaction between persons who are blood relatives whether assault or consensual.

- **Sodomy:**

  The word sodomy acquired different meanings over time, but it mostly consists of anal intercourse.

- **Attempted Rape:**

  Attempted rape is an act carried out by any person, who tries to unlawfully and intentionally penetrate with his genital organs into the private parts of another person.

- **Gang rape:**

  Gang rape is an offence, through any sexual intercourse, committed by 2 or more persons on one person.

- **Adolescent:**

  The World Health Organization (WHO) defines "Adolescents" as "*those between the age 10 and 19 years*". This is the definition followed by most UN Organizations.

- **Youth:**

  The World Health Organization (WHO) defines "Youth" as "*an individual aged between 19 and 24 years*".

- **Sexual Activity:**

  According to the WHO risk-screening criteria, one is regarded as being sexually active "*if he/she reports having had a sexual partner within the previous three months*".

- **Date/Acquaintance Rape:**

  Date/Acquaintance rape is any non-consensual sexual activity between two or more people who know each other.

- **Stranger Rape**

  Stranger rape is any non-consensual sexual activity perpetrated by an attacker unknown to the victim.

- **Spousal Rape**

  Spousal rape is non-consensual sexual assault whereby the perpetrator is the victim's spouse or partner.

- **Dating Violence**

  Dating violence is defined as a range of physical assaults committed by the boy, the girl or both, against the other in a dating relationship.

- **Vulnerability:**

  Vulnerability refers to the probability that an individual (or group) being in a situation or behavior that exposes them to a certain condition.

- **P3 form:**

  A P3 form is a document to help the criminal Justice system investigate, arrest and prosecute sexual violence perpetrators. It is provided at no charge by the Police, filled by the victim with the assistance of an authorized health worker and should then be returned to the Police station so that legal advice is sought.

ABSTRACT

Violent practices against women are commonplace, widespread and deeply entrenched in many cultures worldwide, as research on sexual violence, which is serious public health problem, is continuously being conducted all around the world (Youri P, 1994; Wood K *et al.*, 1998; Obunge O.K. *et al.*, 2001).

In Kenya, sexual violence remains highly prevalent and continues to escalate, thereby contributing to hindrance in the achievement of national goals as well as the Millenium Development goals.

Most studies on gender based violence usually develop interest in only one form of sexual violence: sexual assault. Moreover, factors associated with sexual violence among adolescents and youth have not been systematically explored by previous research in Kenya.

The purpose of this study is to determine factors associated with sexual violence among females aged 14 – 24 years reporting at KNH, with all forms of sexual violence being addressed, in order to understand the dimensions and the complexity of this public health problem.

A descriptive cross-sectional study was conducted at Kenyatta National Hospital (KNH) in order to determine factors that influence sexual violence among females aged 14 – 24 years. The study consecutively recruited 295 eligible participants who presented for health care services at KNH during the study period and who consented to participate in the study. They included both outpatients and in-patients. Of the eligible respondents, 285 (96.6%) consented to participate in the study.

Two pre-tested questionnaires were used to collect the relevant data. Four research assistants were recruited to assist with data collection and they received some training on interviewing techniques prior to data collection. Analysis of quantitative data was performed using Statistical Package for Social Sciences (presently, PASW) programme. Univariate analysis

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was performed in order to obtain descriptive statistics. Thus, proportions, means and standard deviations were determined during the analysis. The results are presented in form of tables and diagrams. Bivariate and multivariate analyses were also performed in order to examine associations between the independent variables and the occurrence of sexual violence among eligible female adolescents and youth. The chi-square test, student t-test (for comparing means) and logistic regression analysis were performed. The level of significance used was 5%. The researcher analyzed qualitative data manually in relation to study objectives and the results are presented in form of narratives. The variables measured included the following: socio-demographic characteristics, family settings, high-risk social behaviors and cultural factors. Of these, marital status, early sexual initiation and forced early marriage were found to be significantly associated with sexual violence prior to controlling for confounding factors while only marital status was found to be significantly associated with sexual violence after controlling for confounding factors.

This paper presents the findings of a qualitative study conducted among female adolescents and youth at KNH (Nairobi, KENYA), which revealed that the prevalence of sexual violence among females aged 14 – 24 years is alarmingly high -overall (72.6%)- considering all forms of sexual violence, as well as various categories of variables. In actual fact, all the socio-demographic categories of respondents were found to be affected by the problem whereas neither family settings, nor high risk social behaviors significantly influence the high prevalence of sexual violence among the study population. Regarding cultural factors, forced marriage was the only variable that was found to predispose to sexual violence. Therefore, the findings of this research, like others, show that sexual violence is a universally prevalent problem.

Although the reduction of sexual violence remains a big challenge, mostly due to the stigma associated with it, this serious public health problem can be better understood and controlled

through the development and the implementation of preventive strategies at the social, policy and political levels.

CHAPTER 1: INTRODUCTION

Background Information

In the World Report on Violence and Health (WRVH), the Violence Prevention Alliance (VPA) defines **violence** as "*the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation*" (www.WHO.int, September 2009).

In a report developed by Mwangi and Jaldesa in 2009, violence is said by the World Bank's Gender and Development Group to include, but is not limited to:

- Physical violence with slapping, kicking, hitting, or use of weapons.
- Emotional violence (systematic humiliation, controlling behavior, degrading treatment, threats).
- Economic violence expressed through restricting access to financial or other resources with the purpose of controlling the person.
- Sexual violence, i.e. being forced into sexual activities considered degrading or humiliating.

Various forms of sexual violence have been described in literature namely sexual harassment, sexual abuse and sexual assault (Ashlee and Foshee, 2005, Mwangi and Jaldesa, 2009).

Sexual harassment is mostly verbal (www.unfpa.org, October 2009) while sexual abuse can be physical, visual, verbal or psychological. Sexual assault is described as a violent act expressed through sexual activity not sexual desire (St Mars and Valdez, 2007).

Sexual violence is a worldwide problem, with up to one-third of adolescent girls reporting first sexual experience as being forced. Violent practices against women are widespread, common and deeply entrenched in many societies worldwide (Wood *et al.*, 1998). In countries of East and Southern Africa, social, economic and gender issues are becoming increasingly recognized as significant factors that increase the likelihood that sex will not be safe, voluntary, or pleasurable for many women. Like other countries in Sub-Saharan Africa, sexual violence continues to be widespread, highly prevalent and on the increase in Kenya (Sunday Nation, November 29, 2009:30-31).

Data obtained from the Gender-Based Violence Recovery Centre (GBVRC)'s records, for a period of three months (October 2009 to December 2009), presented in the table below, illustrate the magnitude of the problem.

Table: GBVRC' Statistics: October – December 2009

Months	**S.A. Adults**		**S.A. Children**		**Total**
	Males	**Females**	**Males**	**Females**	
October 2009	1	16	1	8	26
November 2009	3	25	0	17	45
December 2009	7	33	4	7	51
Total	11	74	5	32	122

Key: S.A. = Sexually Assaulted

The increasing prevalence of sexual violence in Kenya led to the enactment of the Sexual Offences Act (SOA) in 2006. This law contains 14 offences and also criminalizes sexual harassment (Mwangi and Jaldesa, 2009). In Kenya, over one half of all women and girls surveyed reported some form of sexual violence as a lifetime experience (Johnston T, 2003). Rape has become commonplace in the local dailies and survivors of sexual violence continue to undergo traumatic experiences that negatively affect their lives. This is indeed alarming.

In Kenya, most of rape victims fall into the age group of 16-25 years; thus, victims are mostly adolescents and youth. Perpetrators are often well known to their victims who fear reprisals from their attackers (www.wangukanjafoundation.org, September 2009). But unfortunately, most men do not view sexual violence as a crime. Some of them argue that "*somehow, consent is given by the women in the process, because they do not scream*". They do not understand that during the process of being raped, victims end up complying with the assailants because they do not want to get hurt, especially in circumstances where weapons are used to threaten them (Mwangi and Jaldesa, 2009).

While the government through the Kenya Police has initiated processes that aimed at reducing sexual violence, very little has been achieved so far. Due to inadequacies in the legal processes, the judiciary system seems to be slow in convicting persons accused of perpetrating sexual violence. Most of the time, perpetrators of sexual violence are acquitted and let loose to continue perpetrating this vice (www.wangukanjafoundation.org, September 2009).

Another great concern is that sexual violence is rarely reported because of shame and lack of knowledge among the victims. Most of the time, victims have no where to turn. Women who have been sexually or domestically abused are often too scared to tell their families for fear of stigma and ostracism and thus, do not report their attacks to the relevant authorities (www.IRINAfricaEastKenya, September 2009). Frequently, girls who are sexually abused will not talk about it because they may think that the incident is their fault or think that nobody would believe them. They are often threatened and occasionally forced to keep quiet (Johnston T, March 2003; www.IRINAfricaEastKenya, September 2009).

In Kenya, various Non-Governmental Organizations (NGOs), private faith-based organizations and Government institutions are committed to fight sexual violence and have been working for justice and equity for all Kenyans.

Non-Governmental Organizations (NGOs) include Liverpool VCT-Care and Treatment (LVCT), the Coalition On Violence Against Women-Kenya (COVAW-K), The CRADLE-The Children's Foundation and Girl Child Network.

A private faith-based organization named Caritas Kenya is an institution which is strongly involved in the war against gender based violence in Kenya. In actual fact, Caritas Kenya is an organization of the Kenya Episcopal Conference whose purpose is to enhance holistic development of the human person.

Government institutions encompass the Ministry of Public Health and Sanitation/ Division of Reproductive Health -DRH- (in collaboration with all health facilities countrywide, the Police and all relevant Ministries), the Nairobi City Council, Kenyatta National Hospital (KNH) through its Patient Support Centre- Casualty and its Gender-Based Violence Recovery Centre (GBVRC), and various hospitals in the country, such as the Nairobi Women's Hospital, where Gender Based Violence Recovery Centers are found.

CHAPTER 2: LITERATURE REVIEW

2.1 Definition and Types of Sexual Violence

There is no single or universal definition of sexual violence. Understandings differ according to country, community and legal context. That is why sexual violence is said to be "multi-faceted" (Vanwesenbeeck, 2008). The lack of clear and commonly accepted language inhibits the development of an effective reporting system and / or databases, and thus restrains prevention, monitoring and advocacy efforts (Mwangi and Jaldesa, 2009).

This study adopts the inclusive terminology employed by the World Health Organization, which defines **sexual violence** as "*any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including, but not limited to home and work*" (www.WHO.int, September 2009).

Sexual violence includes the use of sexual contact by one person towards another against his or her will and may include acts such as forced penetration of the vagina or anus with a penis or other objects, touching the perineum including the penis, vagina or anus, oral sex (placing the mouth or tongue on a person's vagina, penis or anus, rubbing of a penis, hand or other objects against another person's perineum and performing such acts with an animal. However, the law defines each of these activities differently (www.google.co.ke/ National Guidelines Management of Rape/ Sexual Violence 1st Edition - January 2010).

Sexual violence encompasses sexual harassment, sexual abuse and sexual assault (Ashlee and Foshee, 2005, Mwangi and Jaldesa, 2009). **Sexual harassment** refers to sexual advances

through intimidation at work, in educational institutions and elsewhere (www.unfpa.org, October 2009).

Sexual abuse is defined as any contact or interaction (physical, visual, verbal or psychological) between some individuals when the victim is being used for the sexual stimulation of the perpetrator or any other person (St Mars and Valdez, 2007). Sexual abuse includes sexual insults, unwanted sexual touch, forced early marriage, female circumcision and girl-child prostitution.

Forced early marriage is regarded as a form of sexual abuse since it denies women the right of choice or freedom to choose a marital partner. Moreover, early marriage to very young brides poses a significant threat to the health of young women with immature immune and reproductive systems. Early forced marriage also leads to early childbirth, which also carries high risks of maternal and infant death (Johnston T, 2003).

Female circumcision is considered sexually abusive because it denies women their right to sexual enjoyment and fulfillment. It is also regarded as a means of economic slavery as some societies strongly believe that it guarantees virginity, and is thus supportive of bride price (Johnston T, 2003; Mwangi and Jaldesa, 2009). Moreover, female genital mutilation has very serious consequences for the physical and sexual health of women, namely: fistula, lower abdominal pain, and irregular bleeding which can become lifelong experiences for circumcised women.

According to Johnston T (2003), girl-child prostitution is regarded as a form of sexual abuse because in larger towns, girl-child commercial sex workers (especially the youngest ones

aged 10-15 years) club together to rent boarding rooms where they are "looked after" by a "madam or matron" who takes unfair advantage of them by requesting them to provide sexual services for 50 Ksh in slum bars or for 2000 to 3000 Ksh in upper class bars, hotels and massage parlours.

Sexual assault is defined as any sexual act or manipulation of genital parts, whether attempted or completed by an acquaintance or a stranger, by force, threat of force or coercion against another person's will, when a person is incapable of giving consent, or when the consent is obtained by force, threats or intimidation (Johnston T, March 2003). A person is legally incapable of giving consent if less than 18 years of age, if intoxicated by drugs and/or alcohol, if developmentally disabled or if temporarily or permanently mentally or physically unable to do so. Different types of sexual assault include rape, defilement of a minor, incest and sodomy (Mwangi and Jaldesa, 2009).

Rape is defined as any sexual intercourse that is obtained by use of force, coercion, intimidation by any kind of threats and that includes penetration of the vagina or the anus of either women or men. Rape is defined by the Kenyan Law as having sex with a woman or a girl without her consent or with her consent if it is obtained under threat, force, intimidation of any kind, fear of bodily harm or misinterpretation as to the nature of the act or by a person impersonating her husband (www.google.co.ke/ National Guidelines Management of Rape/ Sexual Violence 1st Edition, January 2010). In Kenya, rape is a crime carrying a penalty of not less than 10 years imprisonment, which may be increased to life imprisonment (Sunday Nation, November 29, 2009:30-31).

Rape encompasses date/acquaintance rape, stranger rape and intimate partner sexual assault also referred to as spousal rape.

Date/ acquaintance rape refers to any non-consensual sexual activity between two or more people who know each other (Rickert and Wiemann, 1998) .

Considering stranger rape, it is any non-consensual sexual activity perpetrated by an attacker unknown to the victim (www.google.com/definitionofrape, March 2010).

Spousal rape is non-consensual sexual activity whereby the perpetrator is the victim's spouse or partner (www.google.co.k/en.wikipedia.org/wiki/Intimate_partner_sexual_assault, April 2010).

All forms of rape have on victims the same effects which include physical pain, loss of self-esteem, feelings of degradation and devastation, depression (Miller *et al.*, 1995) and sometimes the risk of contracting STDs and HIV/AIDS.

Technically, in law, having sexual intercourse with a minor (an under-18 years), who has not had sexual intercourse before, whether this one agrees or not is termed "**defilement**". An individual less than 18 years is deemed incapable of consenting to sex in law and therefore sex with him/her is considered a crime even with his/her consent (www.googlee.co.ke, kenyalaw.org, March 2010).

Incest is any sexual interaction between persons who are blood relatives whether assault or consensual (www.google.com/legaldefinitionofincest, March 2010).

As for sodomy, it refers to anal or oral intercourse between human beings, the act being punishable as a criminal offence. Traditionally courts and statutes referred to it as a "crime against nature" or as copulation "against the order of nature" (www.google.com/legaldefinition of sodomy, March 2010).

2.2 Factors Influencing Sexual Violence

Factors associated with sexual violence can be related to: the family settings (e.g. family structure, the quality of parent-child relationships, observing parental aggression), the extra-familial settings (e.g. influence of peers, acquaintances) and the victim-specific settings (such as dating practices, risky social behavior and substance abuse). Of these systems, the extra-familial system is the broadest in scope, as it encompasses the larger social context in which adolescents operate (Kotchick *et al.*, 2001).

Other factors increasing women's vulnerability include: having a history of sexual victimization as either a child or an adolescent (Rickert and Wiemann, 1998), being young, having many sexual partners, becoming more educated and economically empowered (as this might bring the concerned females more into contact with a wide range of people/ - potential perpetrators -, thus may render them more vulnerable), poverty, emotional distress (Resnick *et al.*, 2004), certain social norms (Petersen *et al.*, 2005), as well as conflicts and wars.

2.2.1 Family Settings

Family settings have been discussed in previous research on sexual violence among young people (Symons *et al.*, 1994; Berenson *et al.*, 2001; King *et al.*, 2004).

The quality of an adolescent's relationship with his or her parents, including how the adolescent perceives this relationship is a crucial aspect of the family system. In addition to providing structure (in form of parental monitoring), support (trough a positive parent-child relationship), and information (by communicating about sexual matters), parents serve as role models for their adolescent children in terms of sexual behavior and attitudes (Kotchick *et al.*, 2001).

Family structure was also found to be significantly related to rape as persons who lived with a single parent and those who resided with one biological parent and one step parent were found to be more likely to have been victims of sexual abuse than those living with both biological parents (Petersen *et al.*, 2005).

Poor and neglectful parent-child relationships have been found to render children more vulnerable to engaging in high-risk behavior, thereby increasing the chances of either perpetrating or falling victim of rape. Poor parental monitoring and parental neglect is most often a product of poverty with poor families sometimes having to leave their children for long periods to secure employment and generate income. With regard to boys, there generally appears to be poor parental monitoring, particularly after they reach puberty, which increases vulnerability to negative peer influences and promotes rape (Petersen *et al.*, 2005).

2.2.2. Extra-Familial Settings

It is worth recognizing that adolescence is a period of development characterized by the increased influence of factors outside the family.

Peers become an important source of reinforcement, modeling and support concerning value and belief systems during adolescence. Research has repeatedly indicated that association with a deviant peer group, such as one that is involved with alcohol and drug use or delinquency, has been related to participation in high-risk sexual practices. Thus, adolescents whose peers are sexually active are more likely to be sexually active themselves (Kotchick et al., 2001). According to the WHO risk-screening criteria, sexually experienced girls are regarded as being sexually active if they report having had a sexual partner within the previous three months (Obunge *et al.* 2001).

Peer influence emerges as a factor perceived to render male siblings (brothers) less protective of their female siblings. Sometimes male siblings get bribed by their friends to

give them some space so as to rape their sisters. Male siblings can do anything as long as they get liked by their friends. Negative peer influences and the need to comply with perceived norms emerges as weakening the traditional protective role that brothers play in protecting their sisters from rape and abuse by other boys (Petersen *et al.*, 2005).

2.2.3 Victim-Specific Settings

2.2.3.1 Dating Violence

According to Petersen *et al.* (2005), adolescence is a critical developmental period for establishing normative sexual behavior and it is necessary to explore the different factors that render adolescent girls vulnerable to becoming victims of sexual violence.

Research regards adolescence as a time of multiple developmental challenges surrounding normative body changes, psychological and emotional expression, and social milestones such as dating.

Anterior research showed that women who begin dating early come into contact with a higher number of potential perpetrators. Age at first date and age at first sexual activity have also been shown to increase vulnerability to sexual assault in adolescent and young adult women. MILLER B. C. et al found in their study that girls who were young at first intercourse hold more sexually permissive attitudes and are subjected to sexual abuse (Miller *et al.*, 1995).

It is also suggested that sexual assault is a result of a power disparity between dating partners, making age difference of a couple a possible risk factor contributing to date/acquaintance rape (Rickert and Wiemann, 1998). Dating carries with it the risk of dating violence (Ackard and Neumark-Sztainer, 2002, Smith *et al.*, 2003; St Mars and Valdez, 2007). Dating violence is defined as a range of physical assaults committed by the boy, the girl or both, against the other in a dating relationship. The assault may range from milder acts, such as throwing something or pushing the other, to such violent acts as using a weapon against the other

person. Dating violence may, and often does include sexual and/or emotional assault". Previous research has widely demonstrated that dating violence is the primary predictor of sexual violence among adolescent and youth (Symons *et al.*, 1994; Wingood *et al.*, 2001, Ackard and Neumark-Sztainer, 2002, Smith *et al.*, 2003; St Mars and Valdez, 2007).

The influence of parents on dating violence was also examined and it was indicated that observing parental aggression increases the likelihood of date violence (Symons *et al.*, 1994; Smith *et al.*, 2003), and thus that of sexual violence. Unfortunately, recognition of abusive relationships might be difficult because many adolescents deny such a relationship (Symons *et al.*, 1994, St Mars and Valdez, 2007).

2.2.3.2 Risky Social behavior

Adolescent sexual behavior is an important determinant to develop under social behavior. Adolescents with multiple sexual partners may be at greater risk for experiencing conflict with peers, and even sexual violence, because of unresolved previous relationships' issues, jealousy and other related tensions (Brady *et al.*, 2004).

The incorporation of body, psychological, and social changes is important towards the development of a stable self-concept. Many studies suggest total loss or low self-esteem to be one of the consequences of sexual violence (Miller *et al.*, 1995, Ackard and Neumark-Sztainer, 2002, Resnick *et al.*, 2004, Petersen *et al.*, 2005).

Risky social behaviors also have even been related to substance abuse (Mezzich *et al.*, 1999; Sarigiani *et al.*, 1999).

2.2.3.3 Substance Abuse

Other potential risk factors for sexual violence include the use of illegal drugs and alcohol (Symons *et al.*, 1994; Rickert *et al.*, 1998; Rickert *et al.*, 2004). Rickert *et al.* demonstrated in

their study that under the influence of alcohol, men may be more likely to misinterpret friendly cues as sexual invitations, and women are more at risk of having diminished coping responses and being unable to ward off a potential attack. The same study has also indicated that men perceive women who drink alcohol as more sexually available than women who do not. It is also important to note that the use of drugs such as marijuana, cocaine, Lysergic Acid Diethylamide (LSD), and Flunitrazepan (also known as Rohypnol) increases women's vulnerability to date/acquaintance rape (Rickert *et al.*, 1998). In 2008, Brady *et al.* reported that substance use may increase aggressive impulses and compromise youth's ability to recognize and safely negotiate situations in which violence may occur. Substance abuse related to sexual violence can also be looked at under a different angle. In fact, adolescents may engage in substance use as response to violent encounters (Brady *et al.*, 2008). There is evidence that victims of both physical and sexual assault may turn to substance abuse in attempts to cope with the emotional suffering and physical pain caused by assault (Wu *et al.*, 2003, Champion *et al.*, 2004). However, the direction of the relationship between sexual victimization and substance use is not clear, as substance use has been considered both a precursor and a consequence of sexual victimization. An estimated 50% of all sexual victimizations involve the use of alcohol or other drugs by the perpetrator or by the victim or both (Champion *et al.*, 2004).

2.2.4 Cultural Factors

The social norms that prescribe that boys/men should have sexual relations as a mark of their masculinity motivate those without partners to rape in order to comply with these norms. There is also the wrong and dangerous cultural belief that having sexual intercourse with a virgin would cure a person of HIV/AIDS. That wrong belief is thought to have originated in Central Africa (Petersen *et al.*, 2005).

2.2.5 Conflicts and Wars

Sadly, in conflict and post conflict times, women face sexual and gender based violence (SGBV) on a vast scale as rape and other types of gender based violence seem to be a "*rule of war*". Gender-based violence against women and girls is a feature of all violent conflicts, such as the one that had happened in Kenya, between late December 2007 and early 2008. Kenyan women heavily "paid the price". For example, between late December 2007 and end of February 2008, the GBVRC alone treated a total of 443 survivors of sexual and gender-based violence, of whom 80% were rape / defilement cases, 9% were physical assault cases, 7 % were domestic violence cases and 4% were indecent assault. The *Commission of Inquiry into the Post-Election Violence* (the "Waki Commission") has even highlighted the problem and brought the discussion and the dimensions of sexual and gender based violence against women in the post-conflict period into the mainstream of public attention in Kenya.

(www.google.com/ Gender based violence in Kenya's post-election crisis, March 2010).

2.3 Management of Sexual Violence in Kenya

Sexual violence is an important risk factor contributing towards vulnerability to HIV infection especially in areas with high HIV prevalence, such as Kenya. Kenya's national HIV prevalence is 7.4% (www.plusnews.org, November 2009). HIV infection can result from direct sexual contact which, in the context of rape, is violent, resulting in tears, injuries and Sexually Transmitted Infections (STIs) that increase the risk of contracting HIV. The context of rape actually interferes with women's ability to negotiate condom use (Howard *et al.*, 2003; Kangara, 2005). In Kenya, women aged 15 - 24 years are particularly at risk; they are over five times more likely to become infected with HIV than men of the same age. In response to the growing awareness of the link between sexual violence and the spread of HIV/AIDS, the Ministry of Public Health and Sanitation, through the Division of

Reproductive Health (DRH) and in collaboration with various professional and civil stakeholders, has facilitated the development and approval of policy guidelines. These include the Kenya National AIDS Strategic Plan (KNASP), the National Training Curricula and the National Guidelines for the Management of Rape and Sexual Violence.

2.3.1 The Kenya National AIDS Strategic Plan (KNASP)

The Kenya National AIDS Strategic Plan (KNASP) of the National AIDS Control Council (NACC) is a national policy document in which management of sexual violence has been included as a means of preventing HIV amongst survivors of sexual violence identified as "a vulnerable group needing protection" (Mwangi and Jaldesa, 2009). Kenya's third National AIDS Strategic Plan, running from 2010-2013, was launched on 12th January 2010 in Nairobi (www.aidskenya.org, April 2010).

2.3.2 The National Training Curricula

The National Training Curricula enables training manuals on management of survivors of sexual violence to be developed by the Division of Reproductive Health (DRH) for clinicians and trauma counselors (Mwangi and Jaldesa, 2009).

2.3.3 The National Guidelines for the Management of Rape and Sexual Violence

Through the National Guidelines for the Management of Rape and Sexual Violence, the Ministry of Public Health and Sanitation recommends the provision of post-rape care services through 3 phases: medical management, legal support and psychosocial support (Mwangi and Jaldesa, 2009).

2.3.3.1 Medical Management

Counseling services are necessary for survivor and family. It is advised that before sexually violated persons are medically examined, they should not shower so as to preserve all the relevant evidence. All sexual violence survivors should be offered Emergency Contraception (EC), a follow-up pregnancy test after six weeks from the time of the incident and antibiotics as a presumptive treatment of Sexually Transmitted Diseases (STDs). Post-Exposure Prophylaxis (PEP) is also administered immediately and continues for 28 days after the exposure to HIV. PEP is the administration of a combination of two ARVs, namely Zidovine-300mg and Lamuvidine-150mg, recommended for all survivors of sexual violence. Because the efficacy of PEP decreases with the length of time from exposure to first doses, the first dose should be administered before the lapse of 72 hours. On the other hand, minor physical injuries should be cleaned with antiseptic and dressed. Severe injuries must be sutured under sedation and Tetanus vaccine administered to the victim. Hepatitis B vaccine should also be administered to survivors of sexual violence.

2.3.3.2 Legal support

Survivors should be encouraged to report to the Police immediately after medical attention. Police should enter the report into the Occurrence Book (OB) and record the statement of the survivor and any witnesses. Once the survivor is satisfied with what the Police have written down, he or she signs. The Police will collect two types of evidence: evidence to confirm that sexual assault occurred and evidence to link the alleged assailant to the assault. Lack of proper documentation may mean lack of evidence that may cause a case of thrown out in Court. That is why it is important for medical practitioners to collect specimen, preserve evidence in laboratory, keep torn or soiled clothing and pass these to the Police. Based on the

clinical notes and with the help of an authorized health worker, the survivor should fill in the P3 form provided free of charge by the Police.

2.3.3.3 Psychosocial support

All survivors of sexual violence and their families need to be offered counseling. The counseling needs to cover: trauma counseling (for victims and families), HIV pre and post test counseling and PEP adherence counseling.

CHAPTER 3: STATEMENT OF RESEARCH PROBLEM

3.1 Research Problem

In Kenya, reported cases of sexual violence continue to escalate. The KNH/ Gender Based Violence Recovery Centre (GBVRC) records increasing numbers of sexual violence victims since its creation in 2006 (i.e. 1500 cases of rape from April 2006 to December 2009 – KNH/ GBVRC, January 2010).

In addition, the Kenya Demographic Health Survey (KDHS, 2009) highlights that 49% of Kenyan women reported to have experienced sexual violence between November 2008 and November 2009. Considering rape on its own, recent statistics indicate that reported cases of rape have risen by 50 per cent over the last five years, with slums in urban centres registering the highest prevalence. This situation is indeed alarming.

On the other hand, while factors associated with sexual violence among Kenyan female adolescents and youth have not been systematically explored, fear, shame and stigma prevent victims of sexual violence from raising the alarm. Therefore, they prefer to suffer in silence, bearing a high psychological burden and suffering from different health problems. It is then crucial to establish the determinants of sexual violence among female adolescents and youth in order to understand the complexity of this serious public health issue.

3.2 Justification

Violence and the fear of violence severely limit women's contribution to social and economic development, thereby contributing to hindrance in the achievement of the Millennium Development Goals (MDGs) and other national and international development goals (Vanwesenbeeck, 2008). In addition, sexual violence carries with it social and economic implications for the families and governments and has negative impacts on victims' health, including mental health disorders, risky behaviors such as substance abuse, sexual and

reproductive health problems such as Sexually Transmitted Diseases (STDs), infection with HIV/AIDS, unintended pregnancies and induced abortions.

In Kenya, the public sector and in particular, the health sector bears much of the economic burden of sexual violence through public financing or direct public expenditures (Kenya National AIDS Strategic Plan 2009/10 – 2012/13, November 2009). Preventing sexual violence and its heavy consequences remains a big challenge for most countries worldwide. Meanwhile, it can be controlled through the implementation of relevant interventions.

It is also worth noting that factors associated with sexual violence among female adolescents and youth have not been systematically explored by previous research in Kenya.

For these reasons, it is necessary to design a study that looks into the factors that predispose female adolescents and youth to sexual violence in order to understand the dimensions and intricacies of this public health problem.

Besides, contrary to most studies on gender-based violence which focus on adult samples or to those that address only dating violence among adolescents and youth -only-, this study also aims to contribute to the literature by investigating the different forms of sexual violence within a young population.

The findings of this study are highly expected to contribute towards supporting the use of a dual strategy of reducing risk factors and enhancing protective factors in the lives of Kenyan female adolescents and youth.

3.3 Research Questions

1. What is the prevalence of sexual violence among female adolescents and youth?
2. Under what circumstances do female adolescents and youth experience sexual violence?

3. Do socio-demographic characteristics and poor family settings provide risks for sexual violence among female adolescents and youth?
4. Do high risk social behaviors influence sexual violence among female adolescents and youth?
5. Do cultural factors impact sexual violence among female adolescents and youth?

3.4 Study Objectives

3.4.1 Broad Objective

To identify the factors associated with sexual violence among female adolescents and youth at Kenyatta National Hospital, Kenya.

3.4.2 Specific Objectives

1. To determine the socio-demographic characteristics (i.e. age, level of education, employment status, marital status and residence) of the respondents.
2. To determine the prevalence of sexual violence among female adolescents and youth.
3. To identify the circumstances under which sexual violence occurs.
4. To relate family settings of the respondents to sexual violence.
5. To assess the influence of cultural factors on high risk social behaviors of the respondents.

3.5 Research Hypotheses

1. Socio-demographic factors (i.e. age, level of education, employment status, marital status and residence) have no influence on prevalence of sexual violence among female adolescents and youth.
2. Family settings do not influence the occurrence of sexual violence.

3. High risk social behaviors have no influence on sexual violence among female adolescents and youth.
4. Cultural factors (such as forced early marriage and female circumcision) do not influence sexual violence.

CHAPTER 4: METHODOLOGY

4.1 Study Design

This was a cross-sectional study conducted in order to determine factors that influence sexual violence among females aged 14 – 24 years. The study included eligible participants who presented for health care services at KNH.

4.2 Variables

4.2.1 Dependent Variable

The dependent variable for this study was the occurrence of sexual violence among female adolescents and youth aged 14 – 24 years.

4.2.2 Independent Variables

The independent variables included:

1. Socio-demographic data (i.e. age, level of education, employment status, marital status and residence).
2. Family settings, namely :
    - Family structure
    - Parents' level of education
    - Extent of exposure to substance use at home (i.e. alcohol, tobacco smoking, drug use)
    - witnessing of domestic violence
3. High risky social behaviors (i.e. sexual initiation, dating practices, sexual activity, risky sexual behavior and substance abuse).
4. Cultural factors (namely forced early marriage and female circumcision

4.3 Study Site

The study was carried out at Kenyatta National Hospital (KNH). KNH, which is located about 3 Km from the city centre, is the oldest hospital in the country, having been founded in 1901 as the Native Civil hospital and then King George VI in 1952. It is currently the largest national referral, teaching and research hospital in Kenya. It has staff capacity of 6,000 and bed capacity of 1,800.

KNH has 50 wards, 20 out-patient clinics, 24 theatres (of which 16 are specialized) and Accident & Emergency Department. Out of the total bed capacity of 1800, 225 beds are for the Private Wing. There is a Doctors Plaza consisting of 60 suites for various consultant specialties. The hospital offers a wide range of diagnostic services such as Laboratories, Radiology/ Imaging and Endoscopy among other specialized services. On any given day the Hospital hosts in its wards between 2500 and 3000 patients. On average the hospital caters for over 80,000 in-patients and over 500,000 out-patients annually (www.marsgroupkenya.org, October 2009).

4.4 Study Population

The study population comprised female adolescents and youth aged 14 – 24 years, who presented for health care services at Kenyatta National Hospital (KNH). It comprised of participants who were admitted as well as those who were seeking the services as out-patients.

In addition, five key informants who were directly involved in handling victims of sexual violence were interviewed. These included trauma counselors from the KNH-Gender based Violence Recovery Centre (GBVRC), the Patient Support Centre-KNH/ Casualty and the KNH/ Youth Centre.

4.5 Inclusion and Exclusion Criteria

4.5.1 Inclusion Criteria

1. Female patients aged 14 - 17 years whose accompanying parents/ guardians provided informed consent for them to participate in the study after they had themselves assent to participate in the study.
2. Female patients aged 18 - 24 years who consented to participate in the study.
3. Key informants who consented to participate in the study.

4.5.2 Exclusion Criteria

1. Female patients aged below 14 years or above 24 years.
2. Female patients aged 14 – 17 years who did not consent to participate in the study.
3. Female patients aged 14 – 17 years whose accompanying parents/ guardians did not consent for them to participate in the study.
4. Female patients ages 18 – 24 years who did not consent to participate in the study.
5. Key informants who did not consent to participate in the study.

4.6 Selection of Study Participants

4.6.1 Selection of female Adolescents and Youth

i. Sample Size Determination

The sample size was determined by applying the following formula for prevalence studies (Lwanga and Lemeshow, 1991; Daniel W. W, 1999):

$$n = \frac{Z^2 x\ P(1-P)}{d^2}$$

Where Z represents the standard normal deviate corresponding to the 95% confidence level (= 1.96);

P - the estimated prevalence of the characteristic being studied (in this case, an estimated prevalence of sexual violence among females adolescents and youth 18 – 24% was used (Youri P., 1994; Erulkar A., 2004).

d - the degree of precision or margin error (set at ± 5%).

Substituting the values in the above formula, the sample size was:

$$n = \frac{1.96^2 x\ (0.24)\ (1-0.24)}{0.05^2}$$

$$n = 280$$

Therefore, a minimum sample size of 280 female adolescents and youth aged 14 - 24 years was to be recruited in the study. A total of 295 respondents constituted the eligible respondents, with 285 (96.6%) of them having consented to participate in the study while the remaining 10 did not. Thus, the non-response rate was 3.4%.

ii. Sampling Procedure

The study participants were selected among the female outpatients and in-patients who presented for health services at KNH.

a) Selection of Out-Patients

The different departments considered for selection included the Gender Based Violence Recovery Centre, the Patient Support Centre- KNH/ Casualty, the KNH/ Youth Centre, the Paediatric Ward, the ante-natal clinic, the post-natal clinic and the Doctors' Plaza. These departments were specifically considered because they handle patients who fall into the age

bracket targeted by this study. The key-informants actually referred the researcher to those departments. The eligible study participants who presented at those out-patient clinics and who consented to participate in the study were consecutively selected for the study. It was expected to recruit a larger proportion of study participants among the out-patients on the assumption that there would be more out-patients than in-patients seeking various health services during the study period.

For the respondents aged less than 18 years, accompanying parents/ guardians were required to provide informed consent first before they could be recruited into t he study.

b) Selection of In-Patients

The different wards considered for selection included the ward ID and the Mothers' Hostel (part of the Obstetrics and Gynaecology Department). These wards were specifically considered since they handle patients who fall into the age bracket picked on by this study. The key-informants actually referred the researcher to those wards. The eligible female adolescents and youth drawn from those wards and who gave informed consent were consecutively recruited for the study. The parents/ guardians accompanying respondents aged less than 18 years were required to provide informed consent for them to participate in the study.

4.6.2 Selection of Key Informants

In order to supplement and bear out results arising from the survey, key informant interviews were conducted. Purposive sampling procedure was applied in the selection of five key-informants. The eligible key informants were health care providers directly involved in handling survivors of sexual violence, also referred to as trauma counselors. They comprised

two from the KNH/GBVRC, two from the KNH/Patient Support Centre-Casualty and one from the KNH/ Youth Centre.

4.7 Data Collection

The main purpose of data collection was to explore characteristics associated with sexual violence among female adolescents and youth aged 14 – 24 years.

4.7.1 Data Collection Instruments

Two structured questionnaires were administered in order to collect the relevant data. These included a questionnaire for the female adolescents and youth aged 14-24 years and a guide for key informant interviews which was used to collect qualitative data (Appendices 1 and 2). The questionnaire for the female adolescents and youth aged 14-24 years was translated into Kiswahili so that participants who were not comfortable with English could be interviewed in Kiswahili.

The data collection tools were pre-tested in one of the Nairobi City Council health centres, prior to actual data collection.

4.7.2 Recruitment of Research Assistants

Four research assistants were recruited to assist with data collection. They were trained on interviewing techniques (including ethical considerations) prior to data collection. They were consistently monitored by the principle investigator during data collection period.

4.7.3 Study Procedures

The researchers introduced themselves to the study participants and acknowledged their participation in a research study that aims to contribute to a reduction in sexual violence among female adolescents and youth. The participants were instructed that completing the questionnaire was voluntary and that they would not be identified by participating in the study. They were also told that they could decline to participate in the study. The parents or guardians to the participants aged less than 18 years were informed about the survey and its purposes, and were free to choose not to have their child participate. The participants, as well as parents/guardians to those less than 18 years were reassured about confidentiality of responses. Once informed consent was obtained, the interview was conducted in secluded places. The principle investigator was personally involved in conducting key informant interviews.

4.8 Data Processing and Analysis

4.8.1 Quantitative Methods

The filled questionnaires were first edited and coded. Then, data entry was done using Microsoft Office Excel 2003 program. Data analysis was performed using Statistical Package for Social Sciences (SPSS- presently, Predictive Analytics SoftWare -PASW-) Version 13 program.

Univariate analysis was performed in order to obtain descriptive statistics. Thus, proportions, means and standard deviations were determined during the analysis. The results are presented in form of tables and diagrams. Bivariate and multivariate analyses were also performed in order to examine associations between the independent variables and the occurrence of sexual violence among eligible female adolescents and youth. The chi-square test, student t-test (for

comparing means) and logistic regression analysis were performed. The level of significance used was 5%.

4.8.2 Qualitative Methods

The researcher analyzed manually the data obtained from the key informant interviews in relation to study objectives and the results are presented in form of narratives.

4.9 Minimization of Biases and Errors

The assessment of the respondents' experience of sexual violence relied on self-reported information. Biases could have been introduced with self-reported data due to the strong social stigma against victims of sexual violence, and might also be significantly associated with the sensitive questions asked. However, in order to minimize biases and errors:

1. The data collection instruments were pre-tested prior to data collection.
2. The filled questionnaires were edited every day so that any mistakes/errors could be detected and corrected.
3. The research assistants were trained on data collection techniques and were consistently monitored.
4. Confidentiality of the responses was emphasized in order to reassure the study participants.

4.10 Ethical Considerations

The study has potential for significant ethical issues as the subject under study is highly sensitive and often not discussed openly. Discussion on the subject matter is likely to evoke

emotions and bad feelings that may be traumatic and cascade to poor relations. For these reasons, the subject of this study was approached with caution as follows:

1. Permission to conduct the study was sought from Kenyatta National Hospital and University of Nairobi Ethics and Research Committee (KNH/UoN-ERC) (See Appendix 6).
2. Permission to carry out a pre-testing survey was sought from the City Council of Nairobi.
3. The value of the study was well explained to all respondents, as well as to parents/ guardians of respondents aged less than 18 years.
4. All participants and parents/ guardians to those less than 18 years were instructed that completing the questionnaire was voluntary and that they could decline to participate in the study.
5. Informed consent of the eligible study participants was sought prior to running the interview.
6. Parents / guardians who allowed their daughters/ relatives to participate in the study were requested to provide informed consent on their behalf.
7. Confidentiality was assured by conducting interviews in private rooms and assurance that records were not traceable to respondents as no names were recorded.

4.11 Limitations of the Study

The study limitations include reliance on self-reported data as well as the social stigma about sexual violence. Therefore, the researcher might not have got information that really illustrate the magnitude of the problem, as reporting sexual violence remains strongly related to fear and stigma. In addition, the fact that this study was cross-sectional did not allow for a critical

examination of the direction of effects. On the other hand, respondents and key-informants who did not consent to participate in the study might have made the researcher miss precious information about this research topic.

CHAPTER 5: RESULTS

This chapter presents the results of the survey, focusing on socio-demographic characteristics, family settings, high risk social behaviors, the prevalence of sexual violence and cultural factors. The results of the relationships between the independent variables and sexual violence are also presented in this chapter. Of the 295 eligible respondents, 285 (96.6%) consented to participate in the study. Thus, the non-response rate was 3.4%.

Of the 285 respondents who consented to participate in this study, 235 (82.5%) were out-patients while the remaining 50 (17.5%) were in-patients.

5.1 Socio-Demographic Characteristics

The socio-demographic characteristics assessed included age, level of education, employment status, marital status and residence.

The age of the participants ranged from 14 to 24 years (Mean age: 21.02 years). Three age categories were taken in consideration: less than 15 years, 15 – 19 years and 20-24 years. More than three quarters of the respondents (79%) comprised those aged 20 – 24 years, followed by those aged 15 – 19 years (19.6%). The remaining 1.4% comprised those aged less than 15 years. On level of education, 43.9% of the respondents reported having a post-secondary level of education while 38.6% had secondary level of education. Those who reported having primary level of education represented 17% and only 0.7% of the 285 respondents reported having no school education. On the other hand, employment status was subdivided into two categories namely paid work and no paid work. A majority of participants (78.6%) declared not to be involved in paid work while the remaining 21.4% reported to be engaged in paid work. On marital status, three quarters (75.4%) of the total

sampled population declared that they were unmarried while the remaining 24.6% stated that they were married, either officially or cohabiting. With regard to residence, a majority of respondents (82.8%) were residing in Nairobi.

Table 5.1 shows the socio-demographic characteristics of the study population.

Table 5.1: Socio-Demographic Characteristics of the Respondents ($N = 285$)

Characteristics	Number	Percent (%)
Age (in years)		
Less than 15	4	1.4
15 – 19	56	19.6
20 – 24	225	79
Level of Education		
None	2	0.7
Primary	48	16.8
Secondary	110	38.6
Post-Secondary	125	43.9
Employment Status		
Paid Work	61	21.4
No paid work	224	78.6
Marital Status		
Unmarried	215	75.4
Married (Officially/ Cohabiting)	70	24.6
Residence		
Nairobi	236	82.8
Other places	49	17.2

5.2 Prevalence of Sexual Violence

5.2.1 Prevalence of All Forms of Sexual Violence

Questions were asked in order to determine how prevalent sexual violence is among female adolescents and youth. Thus, proportions, mean ages and standard deviation were determined.

On the specific aspects of sexual violence, 64.2% reported having experienced sexual abuse (Mean Age: 21.01 years; SD: 2.41), 27.0% experienced sexual harassment (Mean Age: 20.82 years; SD: 2.57) and 23.5% reported having undergone sexual assault (Mean Age: 20.93 years; SD: 2.38).

Since sexual violence encompasses sexual harassment, abuse and assault, if a respondent reported to have experienced any of these three main forms of sexual violence, she would be categorized as a victim of sexual violence. Therefore, of the 285respondents, 207 (72.6%) were considered victims of sexual violence.

Table 5.2 shows the prevalence of sexual violence, both overall and for all forms of sexual violence.

Table 5.2: Prevalence of Sexual Violence (N= 285)

Forms of Sexual Violence	Number	Percent (%)
Sexual Harassment	77	27.0
Sexual Abuse	183	64.2
Sexual Assault	67	23.5
Overall Sexual Violence	207	**72.6**

Globally, nearly 73% of the 285 respondents underwent somehow one of the three major forms of sexual violence in their lifetime. Twenty-seven percent underwent sexual harassment while about two-thirds of the respondents experienced sexual assault.

All the five key informants acknowledged that "*sexual violence is a serious concern in Kenya as it is dangerously on the increase in our country, mostly since the December 2007 elections in Kenya*".

Key informants from the KNH/Patient Support Centre actually pointed out that "*rape and defilement are the most perpetrated sexual crimes*" while their colleagues from the KNH/GBVRC stated that "*the KNH/GBVRC Department alone handles an average of five victims of rape (including males and females) weekly. Women and children represent the most vulnerable population, helplessly prone to sexual violence and its consequences*".

To support their assertion, figures were quoted by the two key informants from the KNH/GBVRC. The quoted figures from the Department Registrar are that "*120 cases of rape have been gradually recorded between October and December 2009*"; which is double the average of rape cases they routinely handle (an average of 5 weekly, thereby, by pure arithmetic, they should have handled an average of 60 per quarter).

5.2.2 Circumstances under Which Sexual Violence Occurred

Considering circumstances under which sexual violence occurred, the following were assessed: places of occurrence, perpetrators, substance abuse either by the victim or by the perpetrator and incident reporting.

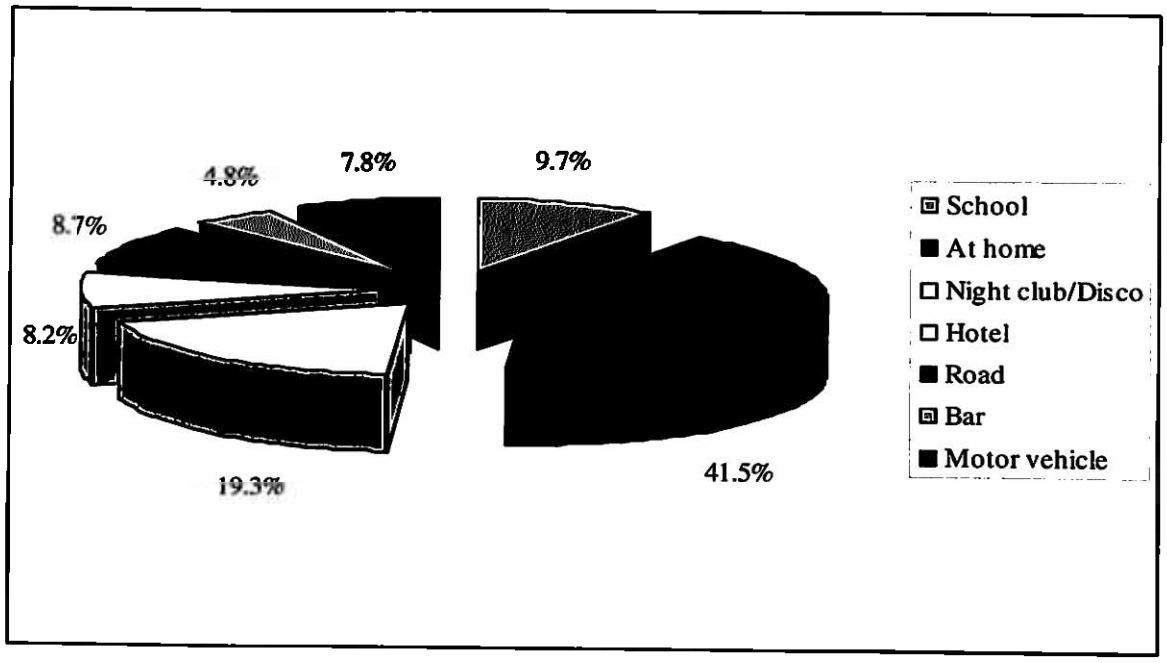
5.2.2.1 Places Where Sexual Violence Occurred

According to the respondents' answers, sexual violence happened in a wide range of places namely at home (41.5%) which could be caused by close relatives or friends, in a discotheque (19.3%), in school (9.7%), along the road (8.7%), in a hotel (8.2%), in a motor vehicle (7.8%)

and in a bar (4.8%). The different places of sexual violence perpetration mentioned by the respondents are summarized in figure 1.

When the key informants were asked about the places where sexual violence might occur, they confirmed the above findings by saying that *"it can occur anywhere (and anytime): on children's way to or from school; on their way to or from duty for adults, during car-jacking, in discos, in buses, etc"*.

Figure 1: Places Where Sexual Violence Occurred



Home appears to be the highest venue for sexual violence while bars are found to be the lowest ones.

5.2.2.2 Perpetrators of Sexual Violence

Study participants who experienced sexual violence reported to have been sexually violated by intimate partners (22.1%), acquaintances (19.3%), strangers (18.8%), family members - including fathers- (14%) and family friends (7.7%). Other perpetrators include teachers (6.3%), co-workers (4.8%), care-givers (4.3%), and clergy members (2.9%).

The Key informants from the KNH/GBVRC confirmed that *"victims of sexual violence are mostly hurt by people close to them or by people in power or in higher position (e.g. fathers, uncles, employers)"*. At the same time, the key informant from the KNH/Youth Centre added that *"perpetrators can be parents, relatives, close family members to the victims, their employers, or sometimes strangers"*.

5.2.2.3 Substance Abuse Prior to Sexual Violence

When asked if the perpetrators had consumed alcohol prior to the incident, 26.6% (55) of the 207 study participants who had experienced sexual violence gave an affirmative answer.
Only 6.3% (13) of the respondents reported having consumed alcohol before they were sexually violated.

According to the key informants interviewed at the KNH/GBVRC and the KNH/Patient Support Centre, *"victims of sexual violence sometimes take alcohol or are drugged (especially in night-clubs) prior to being raped"*.

5.2.2.4 Incident Reporting

Of the 207 respondents who reported having experienced sexual violence, only 29.5% stated that they reported the incident. Those reported to included: mothers (16.4%), police (14.9%),

both parents (10.4%), close friend (9%), boyfriend (7.5%), aunty (6%), KNH-Casualty (6%), father (4.5%), teacher (4.5%), sister (4.5%), husband (4.5%), passengers in public transport (3%) and others (care giver, cousin, employer) (8.8%).

All the five key informants confirmed these findings by saying that "m*ost cases are not reported because of fear, shame, stigma and people do not seek medical attention because of lack of awareness.* At the KNH/GBVRC, the principle investigator was also told that *"in case the survivor opens up, the incident is most often reported to a family member, a close friend, or to the area chief, but mothers are the ones who mostly handle this problem their own way".*

Table 5.3, on next page, presents the results for circumstances of the respondents' experience of sexual violence.

Table 5.3: Circumstances under Which Sexual Violence Occurred.

Features	Number	Percent (%)
Places of Occurrence of Sexual Violence (N=207)		
Home	86	41.5
Discotheque	40	19.3
School	20	9.7
Road	18	8.7
Hotel	17	8.2
Motor vehicle	16	7.8
Bar	10	4.8
Perpetrators of Sexual Violence (N= 207)		
Intimate Partners	45	21.7
Acquaintance	40	19.3
Strangers	39	18.8
Family Members	29	14
Family Friends	16	7.7
Teachers	13	6.3
Co-workers	10	4.8
Care-givers	9	4.3
Clergy Members	6	2.9
Substance Abuse Prior to Sexual Violence (N= 207)		
By Perpetrators	55	26.6
By Victims	13	6.3
Incident Reporting (N= 207)		
Reported	61	29.5

5.2.3 Sexual Violence by Socio-Demographic Characteristics

Statistical analyses were carried out to determine the relationships between socio-demographic factors and sexual violence.

The respondents aged less than 15 years accounted for 75%. Those aged 15 – 19 years who experienced sexual violence accounted 76.8%. The respondents aged 20 - 24 years who underwent sexual violence represented 71.6%.

The mean age for the participants who had experienced sexual harassment was 20.82 years while that for those who had not experienced it was 21.09years. The difference was not statistically significant (p= 0.383).

The mean age of the respondents who had experienced sexual abuse was 21.01 years while that for those who had not undergone it was 21.05 years. The difference was not statistically significant (p= 0.894).

The mean age for the respondents who underwent sexual assault was 20.93 years while that of those who had not experienced it was 21.05 years. The difference was not statistically significant (p= 0.708).

Based on the above comparisons, there is no statistically significant association between age and the different forms of sexual violence.

The proportion of sexual violence among the participants with no education was the highest (100%) while that among the respondents with primary level of education was 64.6%. Whereas the prevalence of sexual violence among those with secondary level of education was 72.7%, those with post-secondary level of education who reported to have been sexually violated comprised 75.2%. There was no statistically significant association between level of education and the occurrence of sexual violence (χ^2=4.574, p=0.334).

Study participants engaged in paid work, and who are therefore economically empowered, were found to be more prone to sexual violence (73.8%) compared to those who were unemployed (72.3%). However, the difference was not statistically significant (χ^2= 0.051, p=0.873).

Among the participants who were unmarried, 76.7% had experienced sexual violence compared to 57.1% among those who were married (60%). Although the prevalence of sexual violence was high in both groups, there was a statistically significant association between marital status and sexual violence (χ^2= 7.448, p= 0.006).

The respondents who reported to reside in Nairobi were found to be more at risk (74.6%) compared to those who came from other places within Kenya (69.4%). However, there was no statistically significant association between the place of residence and the occurrence of sexual violence (χ^2=0.922, p=0.381).

The relationships between socio-demographic factors and sexual violence are illustrated in **Table 5.4.**

Table 5.4: Sexual Violence by Socio - Demographic Characteristics

Characteristics	Sexually Violated	Percent (%)	χ^2 - Statistic	p-value
Age (years)				
Less than 15 (n= 4)	3	75		
15 – 19 (n= 56)	43	76.8	0.953	0.369
20 – 24 (n= 225)	161	71.6		
Level of Education				
None (n= 2)	2	100		
Primary (n= 48)	31	64.6	4.574	0.334
Secondary (n= 110)	80	72.7		
P. Sec. (n= 125)	94	75.2		
Employment Status				
Paid Work (n= 61)	45	73.8		
No Paid W. (n= 224)	162	72.3	0.051	0.873
Marital Status				
Unmarried (n= 215)	165	76.7		
Married (n= 70)	42	60	7.448	0.006
Residence				
Nairobi (n= 236)	176	74.6		
Other Places (n= 49)	34	69.4	0.922	0.381

Key: P. Sec. = Post-Secondary; No Paid W. = No Paid Work

5.3 Sexual Violence in Relation To Family Settings

5.3.1 Family Settings

Family settings included family structure, parental education level, extent of exposure to substance abuse and domestic violence exposure at home.

Table 5.5 (p.45) shows the distribution of the respondents according to family settings.

5.3.1.1 Family Structure

The family structure of the respondents was assessed in order to find out whether the respondents live in a one-parent family, in a two-parent family or with any others.

Of the 285 respondents, 37.5% declared that they live with both parents, 4.9% live with the father alone, 13.3% live with the mother alone, 20.7% live with their husbands and 4.6% said that they live alone. The remaining 19% of the respondents live with other persons, namely, brother/sister, grandparents, aunt, cousin, uncle, friends or employers.

When asked if their parents were separated, 68 (23.9%) of the respondents answered in the affirmative. The respondents when asked to give the reasons for their parents' separation, 20.6% of them did not know why their parents separated, 39.7% had their parents separated by death and 23.5% said that their parents divorced. The remaining 16.2% gave other reasons for their parents' separation, namely, work-related reasons, health care seeking reasons, drunkenness or "just single mother".

5.3.1.2 Parents' Level of Education

Asked about their parents' level of education, of the 285 participants, 83.2% (237) knew about their fathers' level of education. Slightly less than a half (47.7%) of fathers were reported to have attained post-secondary level of education, 29.1% reached secondary level of education, 17.3% were reported to have upper primary level of education, and 3.4% of the fathers had attained a lower primary level of education. Fathers who had not gone to school represented 2.5%.

On the other hand, of the 285 participants, 90.2% (257) knew about their mothers' level of education. Mothers reported to have post-secondary level of education accounted for 34.6%, followed by mothers who have attained secondary level of schooling (33.9%). Mothers with

upper primary level of education represented 20.2% and those with lower primary level of schooling accounted for 5.4%. Nearly 6% of mothers had never gone to school.

5.3.1.3 Exposure to Substance Abuse and Domestic Violence

On substance abuse, alcohol was reported to be consumed in 30.9% of homes while smoking and drugs consumption in only 16.5% and 1.1% respectively. The respondents, who reported having witnessed domestic violence in their families, accounted for 25.6%.

Table 5.5: Distribution of the Respondents According to Family Settings

Family Settings	Number	Percent (%)
Persons Living With (N=285)		
Both Parents	107	37.5
Father only	14	4.9
Mother only	38	13.3
Husband	59	20.7
Alone	13	4.6
Others	54	19
Family Structure (N= 285)		
Separated Parents	68	23.9
Not Separated Parents	217	76.1
Reasons for Separation (N= 68)		
Death	27	39.7
Divorce	16	23.5
Work related reasons	7	10.3
Health care seeking	1	1.5
Other reasons	3	4.4
Don't Know	14	20.6
Fathers' Level of Education (N=237)		
None	6	2.5
Primary	49	20.7
Secondary	69	29.1
Post-Secondary	113	47.7
Mothers' Level of Education (N=257)		
None	15	5.8
Primary	66	25.7
Secondary	87	33.9
Post-Secondary	89	34.6
Exposure to Substance Abuse at home (N = 285)		
Alcohol	88	30.9
Smoking	47	16.5
Drugs	3	1.1
Domestic Violence Exposure (N = 285)		
Witnessed domestic violence	73	25.6

5.3.2 Sexual Violence by Family Settings

Bivariate analyses were carried out to determine the relationships between family settings and the occurrence of sexual violence. The results are displayed in **Table 5.6.**

5.3.2.1 Family Structure and Sexual Violence

The participants who were cohabiting and those who stated that they live with both parents were characterized by the highest percentages of sexual violence victimization (87.5% and 81.3% respectively), followed by those who reported living alone (76.9%). Those who were married were found to be much less prone to sexual violence (55.9%). There was no statistically significant association between person living with and sexual violence (χ^2=14.849, p=0.062).

The respondents whose parents were not separated and who experienced sexual violence accounted for 73.2% while those who live in a one-parent family and underwent sexual violence accounted for 72.1%. No statistically significant association was found between family structure and sexual violence victimization (χ^2=1.144, p=0.564).

When asked about the family structure of survivors of sexual violence, all key-informants said that *"some survivors of sexual violence are from a one parent-family and others live in a two-parent family."* One key informant respondent from the KNH/GBVRC specified that *"certain survivors of sexual violence are orphans, and thus cared for by their extended families whose members sometimes sexually abuse them".*

5.3.2.2 Parental Level of Education and Sexual Violence

Analyses were done to determine the association between the parents' level of schooling and sexual violence. Proportions of sexual violence were higher among fathers with low standards of education. However, the difference was not statistically significant (χ^2=2.698,

p=0.746). Similarly, there was no statistically significant association between mothers' level of education and sexual violence (χ^2=3.124, p=0.681).

5.3.2.3 Exposure to Substance Abuse at Home and Sexual Violence

The research also tried to establish whether there is a relationship between substance abuse by the parents/partners and sexual violence experienced by their daughters/wives/girlfriends. The respondents whose parents/partners take alcohol were more likely (78.4%) to undergo sexual violence than the ones whose parents/partners do not (70.1%). However, the difference was not statistically significant (χ^2=2.138, p=0.153). Respondents whose parents/partners smoke were found to be at greater risk (76.6%) than those whose parents/partners do not (71.8%). There was no statistically significant association between having parents/partners who smoke and experiencing sexual violence (χ^2=0.445, p=0.593). Sexual violence among the participants whose parents/partners consume drugs was estimated at 33.3% while it represented 73% among those who said that their parents do not use drugs. However, there was no statistically significant association between having parents who take drugs and experiencing sexual violence (χ^2=2.356, p=0.183).

5.3.2.4 Domestic Violence Exposure and Sexual Violence

The respondents who reported having witnessed domestic violence in their families were found to be more vulnerable to sexual violence (79.5%) compared to those who did not (70.3%). However, there was no statistically significant association between witnessing domestic violence and the occurrence of sexual violence (χ^2=2.297, p=0.170).

Table 5.6: Sexual Violence by Family Settings

Family Settings	Sexually Violated	%	χ^2 - Value	p-value
Persons Living With (N= 285)				
Both parents (n= 107)	87	81.3		
Father only (n= 14)	9	64.3		
Mother only (n= 38)	28	73.7	12.896	0.115
Husband (n= 59)	33	55.9		
Alone (n= 13)	10	76.9		
Others (n= 54)	33	61.1		
Family Structure (N= 285)				
Separated P. (n= 68)	49	72.1		
Not Sep. P. (n=217)	124	73.2	1.144	0.564
Father's Level of Education (N= 237)				
None (n= 6)	3	50		
Primary (n= 49)	38	77.5	2.698	0.746
Secondary (n= 69)	50	72.5		
Post-Sec. (n= 113)	82	72.6		
Mother's Level of Education (N= 257)				
None (n= 15)	10	66.7		
Primary (n= 66)	52	78.7	3.124	0.681
Secondary (n= 87)	61	70.1		
Post-Sec. (n= 89)	62	69.7		
Exposure to Alcohol at home (N= 285)				
Alcohol (n=88)	69	78.4	2.138	0.153
No Alcohol (n=197)	138	70.1		
Exposure to Smoking at home (N= 285)				
Smoking (n= 47)	36	76.6	0.445	0.593
No Smoking (n=238)	171	71.8		
Exposure to Drugs at home (N= 285)				
Drugs (n= 3)	1	33.3	2.356	0.183
No drugs (n= 282)	206	76		
Exposure to Domestic violence (N= 285)				
Witness (n= 73)	58	79.5		
Did not W. (n=212)	149	70.3	2.297	0.170

Key: Separated P. = Separated Parents; Not Sep. P = Not Separated Parents

Post-Sec. = Post-Secondary; Did not W. = Did not Witness

5.4 Influence of High Risk Social Behaviors on Sexual Violence

5.4.1 High Risk Social Behaviors

Descriptive statistics were conducted on high risk social behaviors of respondents in order to address their role in sexual violence.

The respondents when asked about their sexual debut, 211 (74%) of them reported having been initiated to sex. In this group, the age at sexual debut varied between 13 and 24 years. Seven (3.3%) respondents reported having been initiated to sex between the age of 13 and 15 years; 126 (59.7%) between 15 and 19 years and 78 (37%) between 20 and 24 years. Of the 211 respondents, 38 (18%) said that peers influenced their decision to be initiated to sex.

Of the 285 respondents, 225 (78.9%) reported being in a dating relationship, of whom 175 (77.8%) reported to be sexually active. Of those respondents who were sexually active, 21 (12%) stated that they had more than one sexual partner.

Asked about substance abuse, 13% of the total study population reported use of alcohol, 3.2% reported tobacco smoking and 0.7% reported abuse of drugs.

Table 5.7 presents the distribution of respondents according to high-risk social behaviors.

Table 5.7: High Risk Social Behaviors of Respondents

High Risk Social Behaviors	Number	Percent (%)
Sexual Initiation (N = 285)		
Not initiated to sex	74	26
Initiated to sex	211	74
Age at Sexual Debut (N = 211)		
Less than 15 years	7	3.3
15 – 19 years	126	59.7
20 – 24 years	78	37
Initiation to sex		
Influence of peers (N= 211)		
Not initiated by peers	173	82
Initiated by peers	38	18
Dating Practices		
In the last 12 months (N =285)		
Not in a dating relationship	60	21.1
In a dating relationship	225	78.9
Sexual Activity (N = 225)		
Not sexually active	50	22.2
Sexually active	175	77.8
Number of sexual partners in		
The last 12 months (N = 175)		
One	154	88
More than one	21	12
Substance Abuse by Respondents (N =285)		
Alcohol	37	13
Smoke	9	3.2
Drugs	2	0.7

5.4.2 High Risk Social Behaviors and Sexual Violence

In order to relate high risk social behaviors to sexual violence, bivariate analyses were done. On sexual debut, it was observed that the earlier females were initiated to sex, the more vulnerable they were. Besides, there was a statistically significant association between early sexual initiation and sexual violence (χ^2=8.678, p=0.013). Certain survivors of sexual violence handled by the KNH/ GBVRC are said to *"have been initiated to sex very early"*. The respondents who reported to have been initiated to sex by peers were found to be at higher risk of being subjected to sexual violence than those who were not (84.2% vs 72.8%). However, the difference was not statistically significant (χ^2= 2.207, p= 0.154). Qualitative data obtained from all the key informants corroborate these findings as they stated that *"young victims of sexual violence are often influenced by peers.* The two key informant respondents from the KNH/GBVRC specified that *"peer pressure is higher especially when adolescents and youth are in boarding school)"*.

The respondents who said that they were in a dating relationship, were found to be more likely to undergo sexual violence than those who were not (74.7% vs. 65%). However, there was no significant difference in the occurrence of sexual violence by dating practices (χ^2= 2.227, p= 0.145). Female adolescents and youth who reported to be sexually active have been found to be more vulnerable (74.9%) than those who were not (73.6%). But the difference was not statistically significant (χ^2= 0.035, p= 0.858).

Respondents with many sexual partners were found to be at greater risk of experiencing sexual violence (95.2%) than those who have only one or none (77.9% vs 67.3%). However, there was no statistically significant association between the number of sexual partners and the occurrence of sexual violence (χ^2= 7.075, p= 0.132).

Relationships between substance abuse and sexual violence were also determined. The respondents who take alcohol were found to be more vulnerable than those who do not (81.1% vs 71.4%). However, there was no statistically significant association between alcohol consumption and sexual violence (χ^2= 1.527, p= 0.242). Similarly, tobacco smoking and drug taking were found not to be significantly associated with sexual violence (respectively χ^2= 0.124, p= 1.000 and χ^2= 0.519, p= 1.000).

Table 5.8 below presents the relationships between high-risk social behaviors and the occurrence of sexual violence.

Table 5.8: High Risk Social Behaviors and Sexual Violence

Behaviors	Sexually Violated	Percent (%)	χ^2 - Statistic	p-value
Age at Sexual Debut (N=211)				
Less than 15 years (n= 7)	7	100		
15 - 19 years (n= 126)	102	81	8.678	0.013
20 – 24 years (n= 78)	51	65.4		
Initiation to sex:				
Influence of peers (N= 211)				
Initiated by Peers (n= 38)	32	84.2		
Not Initiated by Peers (n=173)	126	72.8	2.207	0.154
Dating Practices				
In the last 12 months (N= 285)				
In a relationship (n= 225)	168	74.7	2.227	0.145
Not in a relationship (n=60)	39	65		
Sexual Activity (N= 225)				
Sexually Active (n= 175)	131	74.9	0.035	0.858
Not sexually active (n= 50)	39	73.6		
Number of sexual partners Within the past 12 months (N= 285)				
None (n= 110)	74	67.3		
One (n= 154)	120	80	7.075	0.132
More than one (n= 21)	20	95.2		
Alcohol Consumption **(N= 285)**				
Take alcohol (n= 37)	30	81.1		
Do not take alcohol (n= 248)	177	71.4	1.527	0.242
Tobacco Smoking (N= 285)				
Smoke (n= 9)	7	77.8		
Do not smoke (n= 276)	200	72.5	0.124	1.000
Drugs Consumption (N= 285)				
Take drugs (n= 2)	1	50		
Do not take drugs (n= 283)	206	72.8	0.519	1.000

5.5 Influence of Cultural factors on Sexual Violence

5.5.1 Cultural Factors

The cultural-related factors considered for this study included forced early marriage and female circumcision. Out of the 285 participants in the study, 63 (22.1%) declared that they were married, of whom 19.05% reported to have been forced into marriage. When asked whether they were circumcised, only 6.3% of the 285 participants answered in the affirmative.

Table 5.9 presents the distribution of the respondents according to cultural factors.

Table 5.9: Cultural Factors

Cultural Factors	Number	Percent (%)
Forced Early Marriage (N = 63)		
Forced into Marriage	12	19.05
Not forced into marriage	51	80.95
Female Circumcision (N = 285)		
Circumcised	18	6.3
Not Circumcised	267	93.7

5.5.2 Cultural Factors in Relation to Sexual Violence

Further analyses enabled the researcher to establish the relationships between cultural factors and sexual violence.

The respondents who stated that they were forced into marriage were more prone to sexual violence than those who were not (66.7% vs. 55.8%). There was a statistically significant association between forced marriage and the occurrence of sexual violence (χ^2=9.700,

p=0.008). The participants who reported having been circumcised were found to be much less vulnerable (66.7%) than those who were not circumcised (73%). However, there was no statistically significant association between female circumcision and the occurrence of sexual violence (χ^2=2.974, p=0.226).

Table 5.10 presents the relationships between cultural factors and the occurrence of sexual violence.

Table 5.10: Sexual Violence by Cultural factors

Cultural Factors	Sexually Violated	Percent (%)	χ^2 - Statistic	p-value
Forced Early Marriage (N= 63)				
Forced (n= 12)	8	66.7	9.700	0.008
Not forced (n= 51)	29	55.8		
Female Circumcision				
Circumcised (n= 18)	12	66.7	2.974	0.226
Not circumcised (n=267)	195	73		

5.6 Logistic Regression Analysis

Logistic regression analysis was performed in order to identify whether the independent variables that were found to be significantly associated with sexual violence during the cross-tabulation analyses would remain so when they are all regressed against sexual violence in the same model. The variables found to be significantly associated with sexual violence prior to controlling for confounding factors, included marital status, early sexual initiation and forced early marriage. From the logistic regression analysis, all the three variables were

found not to have any statistically significant effect on occurrence of sexual violence. The risk of sexual violence was almost equal for married and unmarried study subjects. This was the same for those forced into marriage and those not forced into it. In addition, the rate of sexual violence was more or less same for those subjects who had early sexual initiation case and those who did not.

The results of the logistic regression analysis are presented in **Table 5.11**.

Table 5.11: Results of Logistic Regression Analysis

Variables	β	Wald's Statistics	d.f	p-value	Odds Ratio
Marital Status	0.109	0.022	1	0.881	1.116
Forced Marriage	-0.108	0.023	1	0.879	0.898
Early Sexual Initiation	-20.779	0.000	1	1.000	0.000

CHAPTER 6: DISCUSSION

The results of this study have shown that all aspects of sexual violence are highly prevalent, with an overall prevalence of sexual violence of 72.6%. The prevalence is so high even where the independent variables are compared and statistical significance demonstrated. However, this study constitutes an important entry point towards addressing the worrying problem of sexual violence, as insight into the magnitude of the problem has been examined and quantified, and hopefully interest created at the social, policy and political levels.

Based on the socio-demographic findings, female adolescents and youth who undergo sexual violence were more likely to be less than 20 years, to have high standards of education, to be engaged in economic activity, unmarried and to reside in an urban centre such as Nairobi. Female adolescents are more at risk for sexual violence than female youth. This might be the case as adolescence is a time of multiple developmental challenges surrounding normative body changes, psychological and emotional expression and social milestones such as dating and others influencing factors from outside the family (places frequented, peers seen as an important source of reinforcement and modeling concerning value and belief systems. These results corroborate findings from studies carried out by Petersen *et al.*'s (2005) and by Smith *et al.* (2003). Age was found not significantly associated with different forms of sexual violence. This implies that female adolescents and youth in the studied age range are more or less equally at risk of sexual violence victimization. This may also be the case given that the age range was small for participating subjects.

This study also observed the highest proportion of sexual violence in girls with no education. This may be explained by lack of awareness among those who have not been educated. Those girls are often very much influenced by cultural beliefs and myths that make them comply

with the fact that males constitute the superior sex, which make them submit to men. They are therefore victims of dating violence, domestic violence and rape which are very much linked with stigma (Wood *et al.*, 1998). On the other hand, proportions of sexual violence tended to increase with higher standards of education. This finding corroborates that from Resnick *et al.* (2004) who observed that more educated women constitute a great target of sexual violence.

A majority of respondents were unemployed. This may be the case given that most of the respondents were still very young and therefore not in a position to be employed. Study participants engaged in economic activity were found to be more likely to experience sexual violence compared to those who were unemployed. Resnick *et al.* (2004) found the same and described women economic empowerment as a factor that increases women vulnerability to sexual violence. Although research in the field of sexual violence (St Mars and Valdez, 2007; Petersen et al., 2005 and Vanwesenbeeck, 2008) demonstrated that sexual violence supportive attitudes are promoted by the correlation sex-poverty, with sexual violence being condoned because of economic needs, this study found that there was no statistically significant association between employment status and sexual violence.

The results of this study indicate that, whether married or not, female adolescents and youth experienced some form of sexual violence. These incidents could have happened in contexts that may have encouraged the occurrence of sexual violence.
Sexual violence can actually happen within marriages in form of sexual abuse (insults) or domestic violence with beating, hitting and intimate partner sexual assault. Within marriage, physical force is sometimes used by one spouse, typically the husband, in an effort to maintain complete dominance over his wife. Contrary to popular belief, sexual assault is a

common tactic used by men within the realm of marriage to affirm their power over their wives (www.google.co.ke/ findarticles.com, April 2010). With regard to those who are not married, sexual violence can happen in any context, and mostly in a context of a date. Sometimes sexual violence might be meted out by ex-boyfriends as a means of revenge as demonstrated by Petersen et al. (2005) and Brady et al. (2008). Therefore, sexual violence spares no female, whether married or not.

Respondents who were living in Nairobi were found to be more vulnerable than those who live in other places although there was no statistically significant association between the place of residence and the occurrence of sexual violence. A correlation between different factors such as risky behavior, type of acquaintance, places frequented and low parental monitoring could explain the fact that Nairobi's girls were found to be more vulnerable than their fellow girls living in other places. Nairobi being the capital, and thus a very cosmopolitan city, might keep parents busy by work or other activities which would enable them to provide for their families. Therefore, they might not have enough time to monitor their adolescent children. Moreover, parents in the city might be helpless in front of negative influence from media, that of their children's acquaintances, as well as that of places such as discotheques, bars, cinemas, where adolescents and youth interact and escape parental monitoring.

Considering the wide scope of sexual violence for this study, the prevalence of sexual violence is alarmingly high in all the contexts that have been examined. For example, in a study conducted by Rickert *et al.* (2004), it was highlighted that the prevalence of sexual violence ranges from 20% to 68% among female adolescents and youth. This finding confirms that sexual violence is a universally serious problem. According to a survey carried

out by the NGO Liverpool VCT in 2006 in Kenya, women who reported having experienced sexual violence in 2006 accounted for 29% (Mwangi and Jaldesa, 2009).

Violent practices against women continue to emerge as a critical public health issue worldwide. This and other studies (for example those of Wood *et al.*, 1998 and Wu *et al.*, 2003) have shown that most of victims of sexual violence know their perpetrators. In this study, it was evident that the victims were mostly attacked by people well-known to them. However, it has not been possible to ascertain details about the nature of the situations in which sexual violence occurs. The lack of reporting might certainly be linked to the fact that victims know their attackers and thus want to avoid the embarrassment and the shame related to the incident which was found to occur in a wide range of places (e.g. home, school, bar, etc) which can be considered sexual violence black spots. Whereas home is supposed to be the safest place, in the context of this study it appears to be the most dangerous one, situation which confirms that the victims of sexual violence know their attackers. Schools, among other places, were also incriminated. The fact that teachers also commit sexual violence against their students has led the Teachers Service Commission (TSC) to issue new school guidelines that aim to protect students (from nursery to university) against sexual harassment and sexual abuse perpetrated by their teachers (Sunday Nation, May 2, 2010, pages 4 and 5). Based on these findings, there is no safe place for females. Therefore, sexual violence can occur in any environment, as long as it encompasses factors that might encourage that crime to be perpetrated. Poor reporting of sexual violence might also be linked to lack on knowledge of sexual violence among the victims. Survivors of sexual violence may be unaware that health facilities or trauma counselors who handle them are committed to give them support and to help them cope with their emotional and physical suffering. Victims of

sexual violence may also not know that services provided by gender based violence recovery centres are free of charge and that the trauma counselors will ensure confidentiality.

Consistent with other studies (Symons *et al.*, 1994; Rickert *et al.*, 2004), certain respondents stated that either they or their assailants were under the influence of alcohol when they got sexually violated. Alcohol is well-known to increase aggressive impulses and to compromise one's ability to recognize and safely negotiate situations in which violence may occur. With regard to the victims, alcohol might have caused the misinterpretation of their behaviors as sexual invitations and those girls might have had diminished coping responses. Moreover, under the influence of alcohol, one might be unable to ward off any eventual attack. As for perpetrators, they might be out of control after taking alcohol.

Sexual violence exposes survivors to psychological sequels as well as to sexual and reproductive health problems such as unwanted pregnancies and even HIV/AIDS, the prevalence of which in Kenya is about 7.4%. Nevertheless, this study has not examined the effects of sexual violence on the respondents' health.

A majority of respondents reported to live with their parents. Considering the age bracket targeted in this study, the respondents are actually expected to still be living with their parents or by force of circumstances, to be living with guardians. In this study, living in a one-parent family or in two-parent family provides an equal risk of experiencing sexual violence. The respondents who reported to live in a one-parent were found to be less vulnerable to sexual violence. This could be the case given that single parents might be faced with the bigger challenge of raising their daughters with greater discipline, thus providing them with a more protective environment. However, this finding is inconsistent with a study carried out in

South Africa in 1998, where Wood *et al.* found that living in a two-parent family prevents from sexual violence.

Sexual violence was not associated with parental level of education. To my knowledge, no other study related parental level of education to the occurrence of sexual violence. Prevalence of sexual violence was alarmingly high no matter what parental education level was. Parents often lack skills in educating their daughters on sexuality and its hazards. In Africa, sexuality is regarded as taboo and as an "adult affair" and thus prevents parents (and educators) from providing their children with the necessary information that would help them develop self-protection skills against sexual violence and its consequences.

The respondents who reported that their parents/ partners take alcohol were found to be more vulnerable compared to those whose parents/ partners do not. Alcohol may then cause poor and/ or neglectful parent-child relationships, which render children more vulnerable to engaging in high-risk behaviors, therefore increasing the likelihood to experience sexual violence as observed by Petersen *et al.* (2005).

Previous studies (Symons *et al.*, 1994; Smith *et al.*, 2003) found that observing parental aggression increases the likelihood of sexual violence. Inconsistent with those findings, this study has found that there was no statistically significant association between witnessing domestic violence and sexual violence. However, the proportion of sexually violated respondents was higher in those who reported having witnessed domestic violence in their families. Domestic violence affects children's psychological health and sometimes makes them seek emotional shelter in friends, family members or family friends; situation which increases influence of factors outside the family, and therefore vulnerability to negative peer

influences. Seeking comfort from outside the family when frequently exposed to parental aggression also promotes the fact that some people may be ill-disposed towards children (especially females), take unfair advantage of their emotional distress.

Considering the above findings, it is easy to agree with Symons *et al.* (1994) and Borowsky *et al.* (1997) that "*family factors that potentially contribute to sexual violence need further elucidation*".

Looking at the correlation between sexual initiation and sexual violence, most of the respondents reported that their first sexual encounters occurred at a young age, mostly between 15 and 19 years, but as young as 13 years, which is too early and worrying. In this study, from the bivariate analysis, early sexual initiation was a significant determinant of sexual violence. These findings corroborate those of Wood *et al.* (1998) who carried out a survey in South Africa in 1998 and found that early sexual initiation was strongly associated with sexual violence. When parents are kept very busy by their work or businesses, they may become mindless of their children; a situation which might be harmful to both parent and child especially when those children are adolescents i.e. exposed to all sorts of negative influence. Lack of parental control over their acquaintances, negative peers influence and media influence might encourage girls to engage in sexual activity too early.

In the majority of cases, respondents reported to have been initiated to sex by intimate partners while other respondents stated that peers influenced their sexual initiation, thus making them more vulnerable than the others as observed by Wood *et al.* (1998). Adolescents whose peers are sexually active are more likely to be sexually active themselves. Negative peer influence definitely misleads adolescents and youth, who are at a critical stage of their lives and very much influenced by various factors from outside the family. The peer context

in which adolescents are situated appears to reinforce the pressure to engage sexually. Sometimes, adolescents helplessly engage in sex as a strategy to avoid peer ostracism, which increases their vulnerability to sexual violence.

On dating practices, respondents who reported to have had only one sexual partner within the past twelve months were found to be less vulnerable compared to those who reported to have had many. Having more than one sexual partner is a situation that sometimes leads to quarreling because of jealousy and unresolved problems. Research reported that severe dating violence was related to higher numbers of dating partners and higher dating frequency among the teenage and youth populations (Symons *et al.*, 1994; Smith *et al.*, 2003; Brady *et al.*, 2004, Resnick *et al.*, 2004; Ashley and Foshee, 2005).

With regard to sexual activity, sexually active respondents were found to be more at risk of sexual violence than those who were not, as observed by Kotchik et al. (2001), though sexual activity was not significantly associated with sexual violence. Sexually active young girls may behave in a manner which could be misinterpreted by men and which may be conducive to sexual violence.

Alcohol consumption, tobacco smoking and drug taking were found not to be significantly associated with sexual violence. However, respondents who stated that they take alcohol and smoke recorded higher proportions of sexual violence than those who did not. Such behaviors may make men perceive women engaged in substance use as more sexually available than women who do not. Contrary to other studies of gender-based violence conducted by Wu *et al.* (2003) and Champion *et al.* (2004), this study did not examine substance abuse as a consequence of sexual victimization. Nevertheless, it is worth noting that some survivors of

sexual assault might turn to substance abuse in attempt to cope with the emotional suffering and physical pain caused by assault.

With regard to cultural factors, forced early marriage was found to be significantly associated with sexual violence from the bivariate analyses. Despite the seriousness of the outcomes associated with forced early marriage, only one study (to my knowledge) conducted by Johnston T. (March 2003) described forced early marriage as a form of sexual violence. In this study, the prevalence of sexual violence among those who were forced into marriage was higher compared to those who were not. Forced marriage undermines both the personality of the female and her ability to make decision within marriage settings. Most women who are forced into (arranged) marriage completely submit to their husbands and end up becoming victims of violent sexual acts. They are most often married to older men who have authority, power or money, which entices parents to arrange their daughters' marriage. They are subsequently warned not to do anything that might bring shame to the family (e.g. refusing to marry the chosen husband, disobey him within the marriage). Young brides who are stubborn or rebellious often undergo all forms of humiliation and even sexual violence as punishment or as a means to make them surrender and subject themselves to the husband chosen for them. On the other hand, whether circumcised or not, female adolescents and youth are vulnerable to sexual violence.

The above findings suggest that regardless of the females' socio-demographic characteristics, family settings and social behaviors and irrespective of cultural related factors, they are equally subjected to sexual violence, the most predominant factor appearing to be the environment that hosts them and that might encourage its occurrence.

CHAPTER 7: CONCLUSIONS

Based on the results of this study, several conclusions can be made:

7.1 The prevalence of sexual violence, both overall and among the various socio-demographic categories of respondents selected at KNH, is alarmingly high. All socio-demographic categories of female adolescents and youth are predisposed to sexual violence, though females who are more educated and economically empowered (work/ business) were greater targets for sexual violence.

7.2 The prevalence of all forms of sexual violence is alarmingly high, considering all forms of sexual violence; situation which clearly indicates that female adolescents and youth need to be considered as a vulnerable group needing protection. Sexual abuse appeared to be the major form of sexual violence. In addition, there was poor reporting of sexual violence.

7.3 Family settings do not influence the high prevalence of sexual violence, which is suggestive of the problem of sexual violence being a more universally prevalent problem. However, the proportions of sexual violence were higher in those whose parents were involved in substance abuse as well as those who witnessed domestic violence in their families.

7.4 Although early coital debut significantly increases risks of suffering sexual violence, the prevalence of sexual violence among all age-at-sexual-debut categories remains alarmingly high. Moreover, the respondents who were engaged in high risk social behaviors recorded the highest proportions of sexual violence.

7.5 Whereas forced marriage further predisposes to sexual violence, the prevalence is high whether or not marriages are forced. At the same time, whether females complied with cultural factors or not, they were vulnerable to sexual violence.

In summary, female adolescents and youth are at risk of experiencing sexual violence as long as their environment allows that crime to be committed.

CHAPTER 8: RECOMMENDATIONS

Based on the results and the conclusions of this study, the following recommendations can be made:

8.1 Parents need to be sensitized on the advantages of providing their children (especially their adolescent and youth daughters) with more:

- Discipline and structure, in form of parental monitoring which should not be lessened by work, business, substance abuse or any other reasons.
- Support through a positive and highly protective parent – child relationship and encourage them to open up in case they are sexually violated.
- Information by communicating more openly about sexual matters so that their children discipline themselves and develop self-protection skills against sexual violence.

8.2 Community leaders and women's groups should join hands to:

- Help in stigma reduction as they make the population understand that sexual violence is a crime and therefore must be reported as early as possible.
- Sensitize men on the effects of forced early marriage in relation to sexual violence so that they can help in its reduction..

8.3 Civil Society Organizations (CSOs) and women's groups are requested to:

- Encourage and enable girls and women to have access to sexual knowledge.
- Increase awareness of women's rights through brochures and the use of media (e.g. documentaries).

8.4 Education and Gender Ministries would play a major role in combating sexual violence by:

- Developing school-based adolescent and youth protective protocols through which students will be sensitized on the necessity to reduce gender disparities.
- Enforcing the new school guidelines which were issued by the Teachers Service Commission (TSC) in April, 2010.
- Incorporating in school rules adequate measures for reporting and all forms of support for affected students.
- Severely disciplining teachers who fail to comply with the TSC guidelines.
- Strengthening and effectively implementing gender based violence programmes to address issues on sexual violence.
- Turning men into allies through massive sensitization campaigns so that they help reduce/ end unequal power relations and become more protective towards the female sex.
- Informing the population about the services provided by the Gender-Based Violence Recovery Centres countrywide (e.g. at KNH), making them aware that those services are free of charge and reassuring them about the strict confidentiality of the information provided.

8.5 The Judiciary System should be much more severe with the perpetrators of sexual violence in order to discourage them from harming others.

8.6 Recommendations for Further Research

- Given the alarmingly high prevalence of sexual violence, it is recommended that further research critically examines the effects of sexual violence among female adolescents and youth, using analytical studies, preferably case-control studies.
- As the focus of this study was on survivors of sexual violence, further research could focus on sexual violence perpetrators, enabling this serious public health problem to be better understood. Thus, effective interventions will be developed and implemented and hopefully, the destructive cycle of sexual violence controlled and interrupted.
- It's worth noting that sexual violence against men also occurs, although it unfairly draws less attention. Therefore, it is strongly recommended that future research develops interest in sexual violence against men, as well.

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APPENDICES

APPENDIX 1: QUESTIONNAIRE FOR THE PARTICIPANT

(FEMALE ADOLESCENT AND YOUTH AGED 14 – 24 YEARS)

Instruction (*Maelezo:*): This questionnaire is to be carried out in an appropriate environment. The area should be private, safe, and ensure confidentiality (***Swali hili liulizwe mahali panapofaa. Mahali pawe pa pekee, salama na pa siri***).

DATE (***Tarehe***): ...../...../..... **SERIAL N°** (***Nambari ya kitaburisho***) : N°.....

PARTICIPANT(*Mshiriki*):

1. **In-patient** (*Mgonjwa aliyelazwa*): **1. Yes** ☐ **2. No** ☐
2. **Out-patient** (*Mgonjwa wa nje*): **1. Yes** ☐ **2. No** ☐

SECTION A: SOCIO-DEMOGRAPHIC DATA (*HABARI THABITI YA JAMII*)

1. Date of Birth (*Tarehe ya kuzaliwa*): ------- dd (*Siku*) / ------- mm(*Mwezi*)/ -------- yy (*Mwaka*)

2. How old are you (Una umri gain)? --------- (Years / *umri katika mwaka*)

3. Level of Education / *Kiwango cha elimu* (Tick /Alama):

1. Nil (*Hakuna*) --------
2. Lower Primary (Mwanzo wa shule ya msingi) --------
3. Upper Primary (*Sehemu ya pili ya shule ya msingi*) --------
4. Secondary (*Shule ya upili*) --------
5. Post-secondary (*Baada ya shule ya upil*) --------
6. Unknown (*Haijulikani*) --------

4. **(a)** Do you do any paid work (*Unafanya kazi yoyote ya malipo*)?

1. Yes ☐ **2. No** ☐ **3. N/A** (*Haihusu*) ☐

(b) If yes, which one (*Kama ndio eleza*) (specify/ *Fafanua*)?

.....

5. Marital status (Please, **Tick**) /*Hali ya Ndoa (Alama)*:
   1. N/A (*Haihusu*) ----
   2. Single (*Kapela*) ----
   3. Married (*Alieolewa*) ----
   4. Cohabiting (*Wanaoishi pamoja*) ----
   5. Divorced (*Aliyetalikiwa*) ----
   6. Widowed (*Aliyefiwa*) -----

6. Where do you live (*Unaishi wapi*)? ----------

SECTION B - FAMILY STRUCTURE (*FAMILIA*)

7. Whom do you stay with at home (Tick) / *Unaishi na nani nyumbani*? (*Alama*)
   1. Mother only (*Mama pekee*) -----
   2. Father only (*Baba pekee*) -----
   3. Both parents (*Wazazi wote wawili*) -----
   4. Brother / Sister (*Kaka/ Dada*) -----
   5. Grandparents (*Nyanya na Babu*) -----
   6. Boyfriend ("Come-we-stay-together") -----
   7. Husband (Partner) ------
   8. Other(s) (Please specify - *tafadhali fafanua*) ----------

8. **(a)** If you live in a one-parent family, are your parents separated (*Kama unaishi na familia yako, unaishi katika*)? **1. Yes** ☐ **2. No** ☐

   (b) If yes, why did they separate (*Kama ndiyo, kwa sababu gani walitengana*? (Tick/Alama))
   1. Don't know (*Sijui*) -------
   2. Work-related (*Kazi*) --------
   3. Health-care seeking (*Afya*) --------
   4. Divorce (*Talaka*) --------
   5. Death (*Kifo*) --------
   6. Other reasons, please specify (*Sababu zingine, tafadhali fafanua*) ---------

9. The questions that follow are about your family (*Maswali yinafuata winahusu*):

9.a Does (do) your Partner / Parent(s) have a car (*Je Mzazi / Wazazi wako ana / wana gari*)? **1.Yes** ☐ **2.No** ☐

9.b A television set at home (*Runinga nyumbani*)? **1.Yes** ☐ **2.No** ☐

9.c Do you usually have enough money to get food? (*Nyinyi huwa na pesa za kutosha za chakula?*) **1.Yes** ☐ **2.No** ☐

9.d Do you have enough money to buy clothes? (*Una pesa zakutosha kununua nguo?*) **1.Yes** ☐ **2. No** ☐

9.e How many meals does your family have per day? (*Familia yako hula mara ngapi kwa siku?*)

Only 1 Meal ☐ **2 meals** ☐ **3 Meals** ☐ **4 Meals** ☐

10. What's your parent(s)'s level of education -TICK (*Mzazi / Wazazi wako wamesoma hadi kiwango gani - Alama*)?

1. Father's level of education (*Elimu ya Baba*):
   1. Nil (*Hakuna*) --------
   2. Lower Primary (Mwanzo wa shule ya msingi) --------
   3. Upper Primary (*Sehemu ya pili ya shule ya msingi*) --------
   4. Secondary (*Shule ya upili*) --------
   5. Post-secondary (*Baada ya shule ya upil*) --------
   6. Unknown (*Haijulikani*) --------

2. Mother's level of education (*Elimu ya Mama*):
   1. Nil (*Hakuna*) -------
   2. Lower Primary (Mwanzo wa shule ya msingi) --------
   3. Upper Primary (*Sehemu ya pili ya shule ya msingi*) --------
   4. Secondary (*Shule ya upili*) --------
   5. Post-secondary (*Baada ya shule ya upil*) --------
   6. Unknown (*Haijulikani*) ---------

11. Does (do) your Partner / Parent(s) care (*Mzazi / Wazazi wako wanajali*):

11.a When you go out? (e.g: do they want to know where you are going; who you are going to see, etc) **1.Yes** ☐ **2.No** ☐
(*Unapoenda nje? (wanapenda kujua unaenda wapi ; unaenda kuona nani; utarudi nyumbani saa ngapi, n.k*)?
11.b When you come back home late (*Unaporudi nyumbani umechelewa*)?
1. Yes ☐ **2.No** ☐

12 (a) *Does (do) your Partner / Parent(s) (*Mzazi / Wazazi wako*):

1. Take alcohol (*Wanakunywa pombe*)?	**1.Yes** ☐	**2.No** ☐
2. Smoke (*Kuvuta*)?	**1.Yes** ☐	**2.No** ☐
3. Take any sort of drug (*Wanameza madawa yoyote(ya kulevya)*)?	**1.Yes** ☐	**2.No** ☐

(b)* Do you (yourself):

1. Take alcohol (*Wanakunywa pombe)*? **1. Yes** ☐ **2. No** ☐
2. Smoke (*Kuvuta*)? **1. Yes** ☐ **2. No** ☐
3. Take any sort of drug (*Wanameza madawa yoyote(ya kulevya)*? **.Yes** ☐ **2. No** ☐

13. Do you witness any domestic violence in your family?
(Wewe hushuhudia hali ya mapigano katika jamii yako)? **1. Yes** ☐ **2. No** ☐

SECTION C: SOCIAL BEHAVIOUR RELATED DATA

THE QUESTIONS THAT FOLLOW ARE PERSONAL AND YOU MAY FEEL UNCONFORTABLE IN ANSWERING THEM (*HABARI THABITI KUHUSU TABIA ZA JAMII - POLE, LAKINI MASWALI YAFUATAYO NI YA KUTATANISHA.*)

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE EXTENT YOU FEEL COMFORTABLE (*TAFADHALI JIBU MASWALI YAFUATAYO KIKAMILIFU VINAVYOKUFAA*)

14. *Introduction to the question*: "Some girls/young women of your age are openly seeing someone" (*Wasichana wengine / wanawake vijana wa umri wako wana marafiki wavulana wazi au wanaona mtu Fulani).*

QUESTION: Are you seeing someone too (during the past 12 months?) (*Wewe u katika hali ya mapenzi au unaona mtu pia)*?

1. Yes ☐ **2. No** ☐

15. If yes, for how long have you been seeing your Boyfriend/Husband (*Umekua ukimwona mwenzako kwa mda upi)?*
(how many?) -------- **Days (*Siki*)/ -------Weeks (*Wiki*)/ ------Months (*Miezi*)/ ------Years (*Miaka*)**

16.a) Do you have sexual relations with the person you are seeing (*Je una uhusiano wa kimapenzi na mwenzako*)? **1. Yes** ☐ **2. No** ☐
b) If yes, do you use condoms? (*Nyinyi hutumia mipira kamwe?)* **1.Yes**☐ **2. No**☐

Tick/ Alama. **Always (*Kila mara*)..... Sometimes (*wakati mwingine*)..... Never (*hatutumii*).....**

c) How old were you at your sexual debut (*Ulikuwa na umri gani ulipo anza kufanya mapenzi?* ----------**(Years)**(*Miaka*)

d) Who initiated you to sex (*Je ni wenzio waliokuhusisha kufanya mapenzi*)?

* Peers	**1. Yes** ☐	**2. No** ☐
* Partner / Boyfriend	**1. Yes** ☐	**2. No** ☐
* Husband	**1. Yes** ☐	**2. No** ☐
* Nobody	**1. Yes** ☐	**2. No** ☐

17. Are there other person(s) you are dating (*Wewe una ni mwaminifu kwa rafiki yako*)?
1. Yes ☐ **2. No** ☐

18. a) How many sexual partners do you have (*Una wapenzi wangapi*) Please TICK (*Alama*)?

***One (*mmoja tu*)** ☐/ **Two (*wawili*)** ☐ **/Three (*watau*)** ☐ **/ More (*zaidi*)** ☐/ **NONE** ☐ **?**

b) If you have more than one sexual partner, is any of them aware that you are seeing another (other) man (men) (*Mwenzako anajua una rafiki/ marafiki mwanaume au wanaume wengine*)?

1. Yes ☐ **2. No** ☐ **3. N/A (*Haihusiki*)** ☐

c) Do you sometimes quarrel **over that situation** (*Nyinyi hukosana kuhusu hali hii*)?

1. Yes ☐ **2. No** ☐

19. Please, check if you have experienced or been involved in any of the listed activities: (*Tafadhali angalia kama umekua au umehusika katika mambo yafuatayo*)

SEXUAL ACTIVITY (*UTENDAJI*)	
Kissed anybody (*Busu Mtu*)	**1.Yes** ☐ **2.No** ☐
Massaged (*Kanda mtu*)	**1.Yes** ☐ **2.No** ☐
Touched nipples, breasts, or sex organs by a partner or someone else.(*Guza Ncha Za Matiti, Matiti, au se za Nyeti na mwenzako au mtu mwingine*)	**1.Yes** ☐ **2.No** ☐
Had a sex talk with somebody (*Kuwa na mazungumzo kuhusu mambo ya mapenzi na mtu*)	**1.Yes** ☐ **2.No** ☐
Rubbed bodies together (with or without clothing) with someone (*Kugusana kimwili pamoja (mkiwa uch na nguo) na mtu*).	**1. Yes** ☐ **2. No** ☐
Watched or read sexual images, films, or magazine (*Kuangalia au kusoma picha, filamu au majarida yanayohusu mapenzi.*)	**1. Yes** ☐ **2. No** ☐
Had sexual intercourse with a partner or someone else (*Kufanya mapenzi na mwenzako au mtu mwingine*)	**1. Yes** ☐ **2. No** ☐
Had oral sex with a partner or someone else (*Kufanya mapenzi ya mdomo na mwenzako au mtu mwingine*)	**1. Yes** ☐ **2. No** ☐

20. Within the past 12 months, have you suffered from (*Ushawahi pata ugonjwa wa zinaa (STD), uchungu kwa fupa la nyonga, au kutoka usaha sehenu za nyeti katika miezi (12) iliyopita*:

* Sexually Transmitted Disease (STD)	**1. Yes** ☐	**2. No** ☐
* Pelvic pain	**1. Yes** ☐	**2. No** ☐
* Vaginal discharge	**1. Yes** ☐	**2. No** ☐

SECTION D: **SEXUAL VIOLENCE (*UTUMIAJI WA NGUVU KATIKA MAPENZI*)**

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE EXTENT YOU FEEL COMFORTABLE (*TAFADHALI JIBU MASWALI YAFUATAYO KIKAMILIFU VINAVYOKUFAA)*

21. a) What do you think about sexual violence?

i. It is tolerable (*Inavumilika*) **1. Yes** ☐ **2. No** ☐

ii. It is normal within a relationship *(Ni jambo la kawaida katika uhusiano)* **1. Yes** ☐ **2.** ☐ **No**

iii. Other opinions (Specify)/ *Sababu zingine (tafadhali, fafanua)*----------
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b) What do you people around you think about violence? (*Wenzako hufikiria nini kuhusu utumiaji wa nguvu kufanya mapenzi)?*

i. It is tolerable (*Inavumilika*) **1. Yes** ☐ **2. No** ☐

ii. It is normal within a relationship *(Ni jambo la kawaida katika uhusiano)* **1. Yes** ☐ **2. No** ☐

iii. Other opinions (Specify)/ *Sababu zingin (tafadhali, fafanua)* ----------
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c) Is sexual violence a problem within your community?

1. Yes ☐ **2. No** ☐

22. Do you have bruises or burns on your body (*Je una alama za urembo, pigo au kuun mwako*)?

1.Yes ☐ **2.No** ☐

23. Does anyone, e.g. your partner/Husband or someone else (Who? ----------) calls you names (*Kuna mtu mwingine k.m. mwenzako au mwingine (Nani?-----) hukuitamajina)*?

1.Yes ☐ **2.No** ☐

24. Have you ever been forced to have sex against your will?
(Umeshalazimiswa Kufanya mapenzi bila kupenda kwako)?

1.Yes ☐ **2.No** ☐

25. Has your partner (or someone else; Who? ------) ever hurt you or threatened to hurt you *(au mtu mwingine; Nani?.....) ameshakuumiza au kutisha kukuumiza)*?

1.Yes ☐ **2.No** ☐

26. Have you ever had a dating situation become violent with hitting or force used *(Ushawahi kupata matumizi ya nguvu au kugongwa unapokuwa na mwenzako)*?

1.Yes ☐ **2.No** ☐

27. Kindly respond to the following (*Tafadhali, Jibu yafuatayo):* Have you EVER (*Wakati wa miezi 12 ilio pita ume)* . Check all that apply *(angalia yanayo husu)*

Been threatened by a weapon and/or force (*Tishwa kwa silaha na / au kwa nguvu?* **1.Yes** ☐ **2.No** ☐	
Been verbally harassed (*Tishwa kwa maneno)?* **1.Yes** ☐ **2.No** ☐	
Undergone Unwanted touching (of a sexual nature) (*Umeguswa visivyo faa (kimapenzi)?* **1.Yes** ☐ **2. No** ☐	
Been Hit, Kicked, Pushed, Injured, or thrown down (*Gongwa, pigwa teke, sukumwa, umizwa au kuanguswa chini)?* **1.Yes** ☐ **2.No** ☐	
Has anyone tried to sexually abuse you ?(*Shuhudia majaribio ya mapenzi ya nguvu / hasa)* **1.Yes** ☐ **2.No** ☐	
Have you Ever been sexually assaulted (raped)(ushawahi Kunajisiwa)? **1.Yes** ☐ **2.No** ☐	
Experienced Sexual Harassment (*Shuhudia kutishwa kimapenzi)?* **1.Yes** ☐ **2.No** ☐	
Undergone intimate partner abuse (*Kutumiwa vibaya na mwenzako)*? **1.Yes** ☐ **2.No** ☐	

NB: *** If "YES" to any in Q.27, please proceed with Q.28 – 33. Else, please SKIP to Q.34 in SECTION E.**

28. If ever been harmed, was/were the perpetrator(s), or person(s) who harmed you (*Walio anzisha au walio kuumiza*):

a) Male (*Wanaume*)? **1.Yes** ☐ / **2. No** ☐ How many (*wangapi*)? ----------

b) Female (*Wanawake*)? **1.Yes** ☐ / **2. No** ☐ How many (*wangapi*)? ----------

c) Male & Female (*Wanaume na wanawake pamoja*)

1. Yes ☐ / **2. No** ☐ How many (*wangapi*) ----------

29. Who was/were the person(s) who harmed you (*Alikuwa au walikuwa Nani?(Thibitisha)*? (check all that apply)

Acquaintance (*Marafiki*)	
Your own Mother (*Mama yako*)	
Your own Father (*Baba yako*)	
Parent – adoptive (*Mzazi wa kambo*)	
Foster parents. (*Wazazi wasaidizi*)	
Classmate (*Mwanafunzi mwenzako*)	
Co-worker (*Mfanyikazi mwenzako*)	
Family friend. (*Rafiki wa familia*)	
Care-giver. (*Msaidizi*)	
Teacher (*Mwalimu*)	
Partner (boyfriend, girlfriend, husband, wife) or Former Partner (*Mwenzako (rafiki mvulana, msichana, mume,mke) au rafiki wa awali.)*	
Stranger (*Mtu usiye mjua*)	
Family member (please specify) (*Mmoja wa familia (tafadhali fafanua)*	
Employer (*Mwajiri)*	
Clergy/priest (*Mchungaji/Padre*)	
Unknown (*Asiyejulikana*)	

30. Where did the incident occur? (Please, tick) (*Tukio lilitokea wapi)?*

A. School. (*Shule*) -------
B. At home. (*Nyumbani)* -------
C. Night club/Disco. (*Kilabu cha usiku/ Disco*) -------
D. Hotel. (*Hoteli)* -------
E. Road (*Njiani*) ------
F. Bar (*Katika Baa*) -------
G. Motor Vehicle (*Ndani ya gari*) -------
H. Other (Please specify) (*Kwingine(Tafadhali fafanua)*----------

31. Has this incident been reported (*Tukio hili limeripotiwa*)? **1. Yes**☐ **2. No**☐

If reported, to who? ----------
If not reported, Why (*kama halijalipotiwa kwa nini*)? ----------

32. Had the perpetrator consumed alcohol or drug prior to incident
(*Je, wewe au mwenzako mlikua mmetumia pombe au madawa kabla ya tukio hili)*?

1. Yes ☐ **2. No** ☐ **3. Unknown (*Haijulikani*)**☐

33. Did you consume alcohol or drugs without your knowledge prior to incident(*Ulikua umekunywa pombe au kuchukua madawa bila ya wewe kujua*)?

1. Yes ☐ **2. No** ☐ **3. Not sure** ☐

SECTION F: **CULTURAL FACTORS** (*MAMBO YA UTAMADUNI*)

34. If you are married, were you forced into marriage (***Kama umeolewa ulilazimishwa ndoa***)?

1. Yes ☐ **2. No** ☐

35. Have you been circumcised (*Umetahiriwa*)?

1. Yes ☐ **2. No** ☐ **3. Unknown** (***haijulikani***) ☐

THANK YOU VERY MUCH FOR YOUR PARTICIPATION. MAY GOD BLESS YOU (*ASANTE SANA KWA KUSHIRIKI, MUNGU AKUBARIKI*)

INTERVIEWER: ..... **DATE:** .....

APPENDIX 2: GUIDE FOR KEY INFORMANT INTERVIEWS

Introduction (Orally)

I, **Carmen N. D. SOHOUENOU-TOGBETO**, am a post-graduate student in the Department of Community Health, pursuing a degree programme in Public Health. As part of my program, I am supposed to carry out a study.

My research topic is:

"FACTORS ASSOCIATED WITH SEXUAL VIOLENCE AMONG FEMALES AGED 14 - 24 YEARS AT KENYATTA NATIONAL HOSPITAL"

SEXUAL VIOLENCE

- Is it a problem in the Kenyan society? Reasons for responses (Examples, if any).
- Who in the community or population do you think is affected? Why do you think so? EVIDENCE
- How many cases do you get daily? Weekly? Monthly? What's the prevalence of sexual violence in your clinic? In Kenya?
- When does the incident occur?
- Under which circumstances is sexual violence often perpetrated?
- Who are the perpetrators?
- Is the incident often reported for meaningful actions to be taken?
- If so to whom?
- If no, what are the reasons?

FACTORS ASSOCIATED WITH SEXUAL VIOLENCE

- Could you tell me what might be the causes of the occurrence of sexual violence?
- What age group is the most targeted?
- Did they by any chance experience any prior victimization?
- What do you know about the victims' social behavior? Are they eventually influenced by peers? Involved in juvenile delinquency?
- Do they consume alcohol / any sort of drug / Tobacco?

- Do you have an idea of the Family structure of the victims you give assistance?
- What kind of health disorders are they prone to after having experience sexual violence?
- What services do you provide to the victims of sexual violence?
- What is the cost of those services? Is it affordable?
- Are those services always available and acceptable by the patients?
- How much do you think the community is concerned about this public health problem?
- Do you closely work wit the Police in order to provide the victims with the care and support they need and also to contribute to the reduction of this problem?
- What would you recommend to the persons, especially the adolescents and young women who experience sexual violence?
- What can you recommend to the authorities?
- Are you approached to help develop programmes and implement policies that aim at preventing and reducing sexual violence in Kenya?

CONCLUSION:

I WOULD LIKE TO TAKE THIS OPPORTUNITY TO THANK YOU VERY MUCH FOR ACCEPTING TO PARTICIPATE IN THIS STUDY.

MAY GOD BLESS YOU!

APPENDIX 3: INFORMED CONSENT EXPLANATION & FORM FOR THE PARTICIPANT

I, **Dr. Carmen SOHOUENOU-TOGBETO**, am a post-graduate student in the Department of Community Health, pursuing a degree programme in Public Health. As part of that programme, I am supposed to carry out a study. My research topic is:
"FACTORS ASSOCIATED WITH SEXUAL VIOLENCE AMONG FEMALES AGED 14 - 24 YEARS AT KENYATTA NATIONAL HOSPITAL"
The purpose of the study is to determine factors associated to sexual violence among females aged 14 – 24 years at Kenyatta National Hospital.
It has been observed that sexual violence among females in on an increase. And therefore, this study aims at identifying factors that influence the occurrence of such incidents in this age group, especially among females.
In order to achieve the objectives of my study, I need some information from persons like you. You may not directly benefit from the study, but the results of the study will be communicated to the policy makers so that they can implement preventive measures. Thus, there will be a reduction of sexual violence among female adolescents and youth.
There are no major risks for participating in this study. The only risk you may undergo is that some of the questions are personal. If during the process of interviewing, you opt to discontinue, you are free to do so without any penalty and you will still receive the services you were seeking. The responses that you provide will be kept confidential and anonymous. Your names will not appear in the questionnaires. You will just be assigned a code. The data collected for this study is only for education purposes. If any publication should be done, no participants' names will appear.
If you are aged less than 18 years, you will be asked to have your parents/ guardians read and sign the consent forms on your behalf. Your parents/ guardians will also be asked to answer a few questions included in the questionnaire.
You will be required to remain with one copy of the signed consent form.
For any problem or questions related to the study, you can contact me on the 0725 430 786, or the secretary of KNH / UoN – ERC (Tel: 726300-9 or P.O Box 20723, Nairobi.)

CONSENT FORM FOR THE PARTICIPANT

I, **(CODE – No name please)**..... have been explained the purposes of this study, risks involved and benefits for participating in the study and I here-by:

* agree to participate in this study.
* don't agree to participate in this study.

SIGNATURES:

Participant: .....Date: .....

Researcher: .....Date: .....

NYONGEZA 3: MAELEZO YA MAKUBALIANO NA FOMU

Mimi, **Dr Carmen SOHOUENOU-TOGBETO**, Mwanafunzi wa chuo kikuu, daraja ya upili katika idara ya afya ya jamii ninatarajia kuendesha uchunguzi kama sehemu ya (name venue) kutimiza,"shahada ya Master of Public Health Degree''

Sababu ya uchunguzi huu ni kuhakikisha/ kuthibitisha mambo yanayohusiana na mapenzi ya nguvu kati ya wanawake kati ya umri wa miaka 14-24 katika Kenyata National Hospital.

Imetambulikana kwamba mapenzi ya nguvu kati ya wanawake yanaendelea kuongezeka. Kwa hivyo uchunguzi huu unakusudia kuonyesha mambo yanayosababisha matukio haya kati ya wanawake wa umri huu.

Ili niweze kutimiza uchunguzi huu, ninahitaji maelezo kutoka kwa watu kama wewe. Huenda usifaidike na uchunguzi huu mara moja lakini matokeo ya uchunguzi huu yatawasilishwa kwa viongozi wa serikali ili waweze kuweka juhudi za kupunguza mapenzi ya nguvu kati ya wanawake wabalehe na vijana.

Hakuna hatari yoyote kushiriki katika uchunguzi huu. Hatari iliyoko ni kwamba maswali yaliyomo ni ya ubinafsi sana. Wwakati wakujibu maswali, iwapo utakata kauli kutoendelea, wewe una uhuru wa kutoendelea bila adhabu yoyote, na utaendelea kupata huduma unayo hitaji.

Majibu unayotoa yatawekwa siri na bila majina. Majina yako hayataonekana katika majibu. Utapewa herufi ya siri. Habari zote zitakazo patikana ni za sababu ya masomo tu. Kama habari yoyote itachapishwa, hakuna majina ya washiriki yatakayo tokea.

Kama una miaka chini ya 18 utahitaji ruhusa ya wazazi/wasimamizi wako, wasome na waweke sahihi ya kukubali katika fomu kwa niaba yako. Wazazi/ wasimamizi wako pia wataulizwa wajibu maswali machache yaliyo katika uchunguzi huu.

Kama kuna shida yoyote inayohusu uchunguzi huu unaweza kuwasiliana nami kwa nambari ya simu 0725 430 786, au Katibu wa KNH/UoN-ERC (simu: 726300-9 au SLP 20723,Nairobi)

FOMU YAKUKUBALI

Mimi **(tafadhali andika nambari ya kitambulisho- usiandike jina tafadhali)**---------- ---- nimeelezwa sababu ya uchunguzi huu, hatari zinazohusika na faida ya kushiriki katika uchunguzi huu nami *ninakubali kushiriki katika uchunguzi huu
*sikubali kushiriki katika uchunguzi huu

SAHIHI:

Mshiriki.....Tarehe.....

Mtafiti.....Tarehe.....

APPENDIX 4: INFORMED CONSENT EXPLANATION & FORM FOR THE PARENTS/ GUARDIANS (FOR PARTICIPANTS AGED LESS THAN 18 YEARS)

I, **Dr. Carmen SOHOUENOU-TOGBETO**, am a post-graduate student in the Department of Community Health, pursuing a degree programme in Public Health. As part of that programme, I am supposed to carry out a study. My research topic is:
"FACTORS ASSOCIATED WITH SEXUAL VIOLENCE AMONG FEMALES AGED 14 - 24 YEARS AT KENYATTA NATIONAL HOSPITAL"
It has been observed that sexual violence among females in on an increase and therefore they are at risk of many problems, such as, unwanted pregnancies, STIs including HIV/AIDS, and school drop-out among others. There is need to identify factors that influence the occurrence of such incidents in this age group, especially among females. Therefore, I am proposing to conduct a study in order to determine factors that are associated with sexual violence among females aged 14 – 24 years at Kenyatta National Hospital.
In order to conduct the study I need to collect data from female adolescents and youth like your daughter. And that is the main reason why I have identified your daughter to participate in the study. She may not directly benefit from the study, but the results of the study will be communicated to the policy makers so that preventive measures can be implemented. Thus, there will be reduction of sexual violence among our female adolescents and youth.
There are no major risks for your daughter participating in this study. The only risk she may experience is that some of the questions to be asked are personal. The responses that are provided will be kept confidential and anonymous. Names will not appear in the questionnaires but only codes will be assigned. The data collected for this study is only for education purposes. Should any publication be done, no participants' names will appear anywhere in the document. In case you decline for your daughter to participate in this study, she will still continue to receive the services she is entitled for.
You will be required to remain with one copy of the signed consent form.
Should any problem or questions related to the study arise, you can either contact me on Cell: 0725 430 786 or the Secretary of KNH / UoN – ERC (Tel: 726300-9 or P.O Box 20723, Nairobi.)

CONSENT FORM FOR THE PARENT/ GUARDIAN

I, **(CODE - No name please)** ....., on behalf of my daughter/relative, have been explained the purposes of this study, risks involved and benefits for her participating in the study. Therefore, I here-by:

* agree for my daughter/ -------to participate in this study.

* don't agree for my daughter/ -------to participate in this study.

SIGNATURES:

Participant: ..... Date: .....

Researcher ..... Date: .....

NYONGEZA 4: MAELEZO YA MAKUBALIANO NA FOMU KWA MZAZI/MSIMAMIZI/MTUNZI(KWA WASHIRIKI WALIO CHINI YA MIAKA 18)

Mimi, **Dr. Carmen SOHOUENOU-TOGBETO**, ni Mwanafunzi wa chuo kikuu, daraja ya upili katika idara ya afya ya jamii. Kama sehemu ya orodha ya masomo yangu, ninatakikana kufanya uchunguzi . Uchunguzi wangu ni kuhusu mapenzi ya nguvu.

Imetambulika kwamba mapenzi ya nguvu kati ya wanawake inazidi kuongezeka kwa hivyo hatari ni nyingi na shida pia kama mimba zisizotakikana, STIs yaani magonjwa ya zinaa kama ukimwi (HIV/AIDs) na kutoendelea na masomo. Kuna haja ya kutambua mambo yanayoleta matukio haya katika umri huu hasa kati ya wanawake. Kwa hivyo ninapendekeza kuendesha uchunguzi huu kuthibitisha mambo yanayo husika na mapenzi ya nguvu kati ya wanawake wa umri wa miaka 14-24 kwenye hospitali kuu ya Kenyatta(KNH).

Ili kuendesha uchunguzi huu ninahitaji kukusanya habari thabiti kutoka kwa wanawake wabalehe na vijana kama msichana wako. Na hii ndiyo sababu nimemtambua msichana wako ashiriki katika uchunguzi huu. Huenda asifaidike na uchunguzi huu mara moja lakini matokeo ya uchunguzi huu yatawasilishwa kwa viongozi wa serikali ili waweze kuweka juhudi za kupunguza mapenzi ya nguvu kati ya wanawake wabalehe na vijana.

Hakuna hatari yoyote itakayokupata ukushiriki katika uchunguzi huu. Hatari iliyoko ni kwamba maswali yaliyomo ni ya ubinafsi(personal) sana.

Majibu anayotoa mtoto wako yatawekwa siri na bila majina bali atapewa herufi ya siri. Habari zote zitakazo patikana ni za sababu ya masomo tu. Kama habari yoyote itachapishwa, hakuna majina ya washiriki yatakayotokea.

Kama hutamkubalia msichana wako kushiriki katika uchunguzi huu, yeye ataendelea kupata huduma ambazo ni haki yake.

Kama kuna shida yoyote inayohusu uchunguzi huu unaweza kuwasiliana nami kwa nambari ya simu 0725 430 786, au katibu wa KNH/UoN-ERC (simu: 726300-9 au SLP 20723,Nairobi)

FOMU YA MAKUBALIANO

Mimi (tafadhali andika nambari ya kitambulisho- usiandike majina tafadhali)-.....kwa niaba ya msichana wangu----- nimeelezwa sababu za uchunguzi huu, hatari zinazohusika na faida za kushiriki katika uchunguzi huu. Kwa hivyo

- ninakubali/
- sikubali msichana wangu/---- ashiriki katika uchunguzi huu.

SAHIHI:

Mshiriki.....Tarehe.....

Mtafiti.....Tarehe.....

APPENDIX 5: INFORMED CONSENT EXPLANATION AND FORM FOR THE KEY INFORMANT

I, **Carmen SOHOUENOU-TOGBETO**, am a post-graduate student in the Department of Community Health, pursuing a degree programme in Public Health. As part of that programme, I am supposed to carry out a study. My research topic is:
"FACTORS ASSOCIATED WITH SEXUAL VIOLENCE AMONG FEMALES AGED 14 - 24 YEARS AT KENYATTA NATIONAL HOSPITAL"

The purpose of this interview is to:

- Deepen our understanding of the magnitude of sexual violence among our population, especially, female adolescents and youth aged 14 – 24 years.
- Discuss factors that influence occurrence of such incidences among our young female population.
- Gather stories and ideas about our experiences regarding occurrence of sexual violence among our target population.
- Discuss preventive measures against sexual violence among our target population.

You have been selected among those to be interviewed because you / your clinic handle (s) victims of sexual violence. Your opinion is therefore crucial to identify the determinants of sexual violence and thus to contribute in its reduction. The discussion will take a maximum of 1Hour to complete. The aim of having such an interview is to help me identify the reasons for sexual violence among females aged between 14 – 24 years.

You are requested to contribute freely to the discussion as the responses will be strictly confidential and your names will not be recorded. You will only be referred to by fake assigned numbers. Although the discussion will be tape-recorded this is only to ensure that I don't lose any important information discussed/contributed by you. The tapes will be destroyed once the information has been transcribed.

You will be required to remain with one copy of the signed consent form.

Should any problem or questions related to the study, you can either contact me on Cell: 0725 430 786, or the Secretary of KNH / UoN – ERC (Tel: 726300-9 or P.O Box 20723, Nairobi.)

Do you have any questions before we can proceed? Feel free to ask them.
You will have to sign the consent form before we can start. This is to indicate that you agree to be interviewed. "**Thank you very much for allowing me to interview you**"

CONSENT FORM FOR THE KEY INFORMANT

I, (**CODE – No name please**)....., have been explained the purposes of this study, risks involved and benefits for participating in the study and I here-by

* agree to participate in this study. * don't agree to participate in this study.

SIGNATURES: Participant: ..... Date: .....
Researcher..... .....Date: .....

APPENDIX 6: APPROVAL LETTER FROM THE KNH - ERC (Kenyatta National Hospital-Ethics and Research Committee)

KENYATTA NATIONAL HOSPITAL
Hospital Rd. Upper Hill
P.O. Box 20723, Nairobi
Tel 726300 ext
Fax 725272
Telegrams: MEDSUP, Nairobi
Email KNHplan@uonbi.ac.ke
November 25, 2009

Ref: KNH-ERC/A/352

Dr. Carmen N. D. SCHIOLER-NOU-TOGBETO
Dept. of Community Health
School of Medicine
University of Nairobi

Dear Dr. Carmen

RESEARCH PROPOSAL: "FACTORS ASSOCIATED WITH SEXUAL VIOLENCE AMONG FEMALE AGED 14-24 YEARS AT KENYATTA NATIONAL HOSPITAL" (P289/10/2009)

This is to inform you that the Kenyatta National Hospital/UON Ethics and Research Committee has reviewed and **approved** your above cited research proposal for the period 25th November 2009 - 24th November 2010.

You will be required to request for a renewal of the approval if you intend to continue with the study beyond the deadline given. Clearance for export of biological specimen must also be obtained from study ERC for each batch.

On behalf of the Committee, I wish you fruitful research and look forward to receiving a summary of the research findings upon completion of the study.

This information will form part of database that will be consulted in future when processing related research study so as to minimize chances of study duplication.

Yours sincerely

DR. L. W. MUCHIRI
AG SECRETARY, KNH/UON-ERC

c.c. Prof. K.M. Bhatt, Chairperson, KNH/UON-ERC
The Deputy Director CS, KNH
The Dean, School of Medicine, UON
The Chairman, Dept. of Community Health, UON
The HOD, Medical Records, KNH
Supervisors: Prof. Joyce Olenja, Dept. of Community Health, UON
Mr. Lambert Nyabola, Dept. of Community Health, UON
Prof. Kanji R. Kamau, Dept. of Obs/Gynae, UON