A STUDY OF IMPEDIMENTS TO ADDRESSING THE SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF GENDER BASED VIOLENCE SURVIVORS CARRIED OUT IN NAIROBI

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DECLARATION

This study is my own original work. It has not been submitted to any other university for a degree

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This work has been submitted for examination with my approval as a University Internal Supervisor

Isaac Amboseli Were

28.11.08
Dedication

The report is dedicated to my family and my friends; for their support, not only in the course of the research, but in other walks of life as well.

The work is also dedicated to all those who share my commitment to ending Gender-Based Violence (GBV), plus those who share my interest in protecting and promoting the rights of children and women, and in making a difference in the lives of women and children who have been subjected to violence.
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Abstract

Gender refers to the "socially determined ideas and practices of what it is to be female or male." Such ideas are sanctioned and reinforced by a host of cultural, political, and economic institutions, including the household, legal and governance structures, markets, and religion (Meinzen-Dick et al., 2005 pp 4). Gender-Based Violence, therefore refers to violence that targets individuals or groups of individuals on the basis of their gender (Esplen, 2007; 23). However, the term gender is generally assumed to be synonymous with women; and, as for Gender-Based Violence, the term is more commonly applied in relation to violence against women and girls. The unequal power relations between females and males in society are the root cause of Gender-Based Violence. The legitimised subordination of women in patriarchal societies, including the treatment of women as the property of men through practices such as payment of bride price, perpetuates violence against women and girls (Okumba et al, 2005; 65-66). Whether violence between men and violence men experience related to sexual orientation, can be included within 'gender based violence' is a further complication (Kelly, 2006; 10). Therefore, for the purposes of this study, Gender-Based Violence refers more to violations against women and girls.

Violence against women and girls continues to be a global epidemic that kills, tortures, and maims—physically, psychologically, sexually and economically. It is one of the most pervasive of human rights violations, denying women and girls their equality, security, dignity, self-worth, and their right to enjoy fundamental freedoms. Violence against women is present in every country, cutting across boundaries of culture, class, education, income, ethnicity and age (UNICEF, 2000; 2).

As well as emergency medical needs arising from violence, survivors of Gender-Based Violence frequently suffer longer-term complications and chronic conditions which, more often than not, are not addressed due to such factors as lack of access to health care, or the inability by women and girls to access reproductive health services due to factors such as poverty/lack of financial support and lack of decision-making capacity by women and girls to make critical decisions to seek medical attention when the need arises.

The research intended to establish the extent of long-term reproductive health concerns amongst survivors; that is Sexual and Reproductive Health concerns beyond the immediate medical and counseling. The Sexual and Reproductive Health needs of Kenyan women and girls resulting from
Gender-Based Violence and the constraints survivors of violence face accessing reproductive health services were the other area of study that the researched focused on. Other areas of study included to find out whether there was any relationship between Gender-Based Violence (GBV) experienced and any reproductive health complications cited by the participants; and to get subjective views on the causes and consequences of GBV disaggregated by age; socio-economic status; residential area; and gender. The study also purposed to identify and document community-based approaches to "healing" or offering psycho-social support to the survivors in the long-run.

The study was done in collaboration with Women's Rights Awareness Programme (WRAP)*, whose administrative records were availed to the researcher, especially for the purposes of studying case histories of GBV survivors. Sampling of GBV survivors for individual and group interviews was done in the neighbourhood of Kibera, mostly from within the informal settlements. The GBV survivors were requested to involve their daughters in the study. Another sample of GBV survivors was taken from the Oromo Refugee Community, which tries to keep culture and tradition alive. Several men from the Oromo Refugee Community were also requested to participate in the study.

*WRAP is a non-governmental human rights organization which provides alternative safe and secure accommodation for GBV survivors. WRAP also provides various GBV-related supportive services, directly or through referrals. The organization also addresses itself to the advancement and protection of women's and children's rights through such strategies as awareness creation and advocacy. Programme implementation also involves some element of research; at least some baseline survey or rapid appraisal to aid in project planning and implementation, and evaluative research to assess impact of the interventions put in place. This information goes into WRAP's administrative records, besides data on clients seeking GBV-related supportive services.
CHAPTER ONE
INTRODUCTION

1.1 Introduction

Gender refers to the "socially determined ideas and practices of what it is to be female or male." Such ideas are sanctioned and reinforced by a host of cultural, political, and economic institutions, including the household, legal and governance structures, markets, and religion. Gender roles vary among cultures and over time, and are crosscut by a multitude of identities (e.g. ethnicity and class). Despite this the gender division of labor usually finds men and women relegated to the public and private spheres, respectively; the women as caregivers in the household and in community management activities; and the men as providers of material needs to their families by participation public activities and in political institutions (Meinzen-Dick et al, 2005; 4). However, the term gender is generally assumed to be synonymous with women, while the term Gender-Based Violence is more commonly applied in relation to violence against women and girls (children). Gender-Based Violence is defined as any violence that targets individuals or groups of individuals on the basis of their gender (Esplen, 2007; 23). Whether violence between men and violence men experience related to sexual orientation, can be included within 'gender based violence' is a further complication. (Kelly, 2006; 10) Therefore, for the purposes of this study, Gender-Based Violence refers more to violations against women and girls.

The unequal power relations between females and males in society are the root cause of Gender-Based Violence. The legitimised subordination of women in patriarchal societies, including the treatment of women as the property of men through practices such as payment of bride price, perpetuates violence against women and girls. Females and males are socialised differently: the females to serve and reproduce society, the men to lead and be served. Females are perceived and even socialised to believe that they are weak, inferior and needing direction, guidance and disciplining. Further, they are socialised to believe that they exist for the sole purpose of satisfying men’s needs and desires. Males are socialised to demand and expect services from women and to treat them as inferior. Traditions, customs, beliefs and attitudes are used to justify the subordination and violation. Inadequate legal provisions to meet the commitments and women’s and general societal ignorance of their rights and the responsibilities of governments and society in combating violence, are the other contributing factors to entrenching gender-based violence in society. Lack of access to legal services, justice, protection for victims and their properties is a
major factor in denying women their rights; the perpetrators of violence often go away unpunished, while out-dated laws, negative attitudes of prosecutors, magistrates, judges, court clerks and others in the law enforcement sectors leave victims of violence traumatised even further (Okumba et al. 2005; 65-66).

Women are generally dependent on men, both in meeting of physical needs and on matters of “social organization.” Thus, besides physical, psychological and sexual violence, women are open to another form of violence: economic violence. “Economic violence has been cited as one of the subtle forms of violence that is perpetrated on women because of their economic dependence. Women and girls suffer the worst humiliation and violation because men can give or withhold financial support. Deprivation of necessities such as food and basics like clothing and school fees for girl children is a manifestation of economic violation. The denial of the right to work, forced surrender of women’s incomes to husbands or male friends and grabbing of widow’s property by relatives of the deceased husband are commonly experienced in many African countries” (Okumba et al. 2005; 66).

There is no universally accepted definition of violence against women. Some human rights activists prefer a broad-based definition that, besides physical, sexual, psychological/emotional and economic abuse, also includes "structural violence" such as poverty, and unequal access to health and education. The United Nations (1993) definition refers to the gender-based roots of violence, recognizing that "violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men." It broadens the definition of violence by including both the physical and psychological harm done towards women, and it includes acts in both private and public life (UNICEF, 2000; 2). Violence against women is an obstacle to the achievement of the objectives of "equality, development and peace. Violence against women both violates and impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms. In all societies, to a greater or lesser degree, women and girls are subjected to physical, sexual and psychological abuse that cuts across lines of income, class and culture. The low social and economic status of women can be both a cause and a consequence of violence against women (Kelly, 2006; 7).

Violence against women is a deeply pervasive practice in Kenyan society and manifests itself in the private and public space. There are a number of factors that cause violence against women
and girls in Kenya. At the root, however, is the implicit and explicit discrimination against women and girls in cultural and religious arrangements; in social development processes; in access to economic resources; in the family and community settings; in decision-making; in national legislation; and in the justice system. Violence against women and girls takes on many forms such as physical, sexual, and psychological violence in the family, community or perpetrated or condoned by the State, wherever it occurs. These acts include spousal battery; sexual abuse, including of female children; dowry-related violence; rape, including marital rape; female genital mutilation/cutting and other traditional practices harmful to women; non-spousal violence; sexual violence related to exploitation; sexual harassment and intimidation at work, in school and elsewhere; trafficking in women; and forced prostitution.

Violence against women is a public health problem that often overlaps with the AIDS epidemic. Violence or fear of violence has also been implicated as a barrier to women seeking HIV testing and to disclosure of HIV status. Many women in developing countries choose not to disclose their HIV status to their partners, though status disclosure is important for ensuring that HIV positive individuals are able to access a range of services including prevention of mother to child transmission (PMTCT), anti-retroviral treatment (ART), and psychosocial support.

Even though most societies proscribe violence against women, the reality is that violations against women's human rights are often sanctioned under the garb of cultural practices and norms, or through misinterpretation of religious tenets. Moreover, when the violation takes place within the home, as is very often the case, the abuse is effectively condoned by the tacit silence and the passivity displayed by the state and the law-enforcing machinery (UNICEF, 2000; 2).

Debate regarding the magnitude of the problem is also clouded by the fact that domestic violence or gender-based violence is a crime that is under-recorded and under-reported. When women file a report or seek treatment, they may have to contend with police and health care officials who have not been trained to respond adequately or to keep consistent records. On the other hand, shame, fear of reprisal, lack of information about legal rights, lack of confidence in or fear of the legal system, and the legal costs involved make women reluctant to report incidents of violence (UNICEF, 2000; 4).
1.2 Background

GBV, as an area of study, is quite wide for it also encompasses abuses and violence against children, and also economic, psychological and/or emotional abuse of men by women. However, the picture forms in the minds of many on hearing the term GBV is rape and, to some extent, domestic or intimate partner violence, in most cases characterized by women being on the receiving end. Though the study's focus was on Implications of GBV on Women's Sexual and Reproductive Health, it is still a very wide area of research as there many factors, including experience of violence in childhood, socio-economic status (SES), education, income, faith, culture, age, poor versus non-poor households, rural versus urban settings, and various others, that could be impacting negatively on women's and girls' sexual and reproductive health rights, including their access to reproductive health services. There exists the need to examine how such factors come to play at the individual, the community and the societal levels, and to establish specific influences by various the various communities on gender perceptions in the country.

GBV studies touch on issues such as human rights, poverty alleviation, governance, urban development, conflict, the family, gender equality, and others, which directly or indirectly on GBV. As it is basically a human rights issue, therefore the framework that is most appropriate to GBV studies is rights-based approach; for it holds that someone, for whom a number of such human rights as the right to food, health, education, information, participation, etc remain unfulfilled, is poor. Poverty is thus more than lack of resources – it is a manifestation of exclusion and powerlessness. However, the Gender Analytical Framework is also relevant; the advantage of this approach being that it includes men, and questions the assumption embedded in established institutions and procedures. Men have power in wide-ranging situations; from personal and family decisions to policy and programme decisions taken at all levels of government. The gender analysis approach recognizes that men's role in supporting women's rights, including their right to sexual and reproductive health is fundamental.

While undertaking a rapid appraisal in order to develop the study, the researcher could not help but notice that many of the women suffering as a result of GBV lack awareness of their rights, or are unaware of the fact that some of the abuses perpetrated against them are actionable. Thus, she chose to have questionnaires structured so as to provide information to respondents (residents of informal settlements hardly have access to resource material on GBV and other issues). By so doing, quite a number of parameters were added to the study; rather than whittle them down; the
research was carried out as an Exploratory Study, whose findings would help identify further areas of research.

The challenge posed by the study’s limited time frame and financial constraints was coming up with substantial findings and critical considerations. A cocktail of research methods was adopted to mitigate this, involving detailed questionnaires and working in collaboration with Women’s Rights Awareness Programme, WRAP *(which provides alternative, safe and secure accommodation, including other related support services to GBV survivors)* and also with community-based women’s groups. In reviewing data at WRAP, the research team found that clients were from almost all parts of the country, but some regions seemed not to have women seeking GBV-related supportive services at all. This raised many questions; possible areas of research which, however, could not be explored due to limitations; the study’s main limitations being basically, time and finances; to enlarge the scope of the study to include collaboration with other institutions and research agencies and corroboration of data from the local to the national level, in order to enable holistic analysis of the issue of women’s sexual and reproductive health, without “replicating studies” or choosing an area of research that might have already been explored by another, but whose resulting findings were not widely published.

The research team members were carefully selected and received briefing before they commenced on the interviews, which were conducted in private. As WRAP’s staff has had their capacity in research processes, monitoring and evaluation built, this did not pose a major obstacle. The questionnaires were drafted so as to also provide information to participants and to ensure that ensure that the findings are properly interpreted, especially by WRAP, which routinely collects data to improve service provision and to advocate for appropriate policy and legislation. Violence questions were drafted so as to give survivors an opportunity to make some positive statements about their partners, the aim being to reduce any possible distress of re-visiting painful experiences *(Jewkes et al, 2000; 94-97)*.

In her review of existing records, the researcher did not face any obstacles in accessing data at WRAP. Though medical practitioners have not, as part of the treatment, been documenting the possible relationship between gender-based violence and the reproductive health complications that manifest themselves on their patients, it would still have been the researcher’s wish to access data from hospitals, especially hospitals which have a specialized wing or department that
specifically deals with GBV cases like the Nairobi Women’s Hospital’s Gender Violence Recovery Centre (GVRC) without compromising the Hippocratic Oath, ethics or doctor-client confidentiality. Health care providers are strategically placed to identify women at risk and to respond appropriately to a disclosure of experiences of gender-based violence. The health professionals are in a unique position to change societal attitudes about violence against women (Bott et al, 2004; 3-4).

1.3 Statement of the Problem

Initial analysis of WRAP’s client case histories suggests that, as well as emergency medical needs, survivors of violence frequently suffer longer-term complications and chronic conditions arising from violence. For many victims; the process of getting a medical report as a result of GBV in a public hospital is considered tedious, time consuming and embarrassing. The consequences are far reaching and include the erosion of self-esteem, self-worth, physical, mental and psychological health, loss of productivity, costs of health care, unwanted pregnancies and infections, legal and judicial costs (Okumba et al, 2005; 62). The stigma associated with the gender-based violence is also a contributing factor to non-reporting of GBV by many victims. Many women are unable to disclose the cause of their injuries to anyone and continue to suffer in silence from the violence, leading to some of the women even losing their lives.

Examples of ongoing long-term sexual and reproductive health conditions arising from abuse include unwanted pregnancies and complications from unsafe abortions, HIV and other sexually transmitted infections, vaginal bleeding or infection, fibroids, decreased sexual desire, genital irritation, pain on intercourse, chronic pelvic pain, urinary-tract infections, traumatic gynecologic fistula as a consequence of sexual violence, obstetric fistula and complications during pregnancy. In many cases, these conditions are not diagnosed or treated within the 72 hours; which affects the survivors’ ability to earn a living, their mental health and their well being. In short, such complications not only result in restrictions on women’s mobility, but they also impact negatively on socio-economic and political participation.

The impact of violence on women’s mental health also leads to severe and fatal consequences. Battered women have a high incidence of stress and stress-related illnesses such as post-traumatic stress syndrome, panic attacks, depression, sleeping and eating disturbances, elevated blood pressure, alcoholism, drug abuse and low self-esteem. For some women, fatally depressed
and demeaned by their abuser, there seems to be no escape from a violent relationship except suicide (UNICEF, 2000; 9).

In line with the globalization process, the government of Kenya adopted Structural Adjustment Programmes resulting in the introduction of cost-sharing or user fees in public hospitals, health centres, dispensaries and clinics; the social effects of policy reform include negative impact on the health status of the population by affecting government expenditures on health services (Baehr et al., 1994; 63). The utilisation of the health facilities is low due to high cost of health care coupled with poverty (Toroitich, 2004; 24). Prior to the Structural Adjustment Programmes, getting treatment for gender based violence was not a priority issue for many victims; thus, the introduction of cost sharing in hospitals and other medical centres has impacted negatively on women's access to reproductive health services due to feminization of poverty. This has led to an increase in the number of cases of gender based violence going unreported and untreated.

The Nairobi Women's Hospital *Gender Violence Recovery Center* (GVRC) is the only known center that is operational and running. and that solely addresses itself to treating survivors of gender violence in the country at no cost; particularly victims of sexual and physical violence. One of the main motivating factors that lead to the setting up of the GVRC was the realization that women traumatized by GBV had nowhere to go, and that treatment of GBV in private hospitals was way beyond the reach of the average Kenyan woman.

However, this treatment is limited strictly to the violence having occurred within 72 hours, and to emergency medical (and psychological) needs of the survivor. The centre does not look into pre-existing conditions, which are related to the violence; neither does it follow up on chronic long-term reproductive health problems. After 72 hours, most patients who go to the Nairobi Women's Hospital *Gender Violence Recovery Center* are requested to pay for the services. As a result of this, women who are suffering from chronic long-term reproductive health complications have nowhere to turn to for affordable reproductive health services.

1.4 **Objectives of the Study**

1. To identify the causes and consequences of sexual and gender-based violence.

2. To establish whether gender based violence survivors are aware of their sexual and reproductive health rights, and are able to link current reproductive health complications to the violence they have suffered in their lives.
3. To establish if there is any correlation between patriarchy and the inability of women to address their sexual and reproductive health needs.

4. To find out the services available to survivors of GBV, including community-based approaches and strategies to GBV-intervention, and to examine how socio-economic status determines access to such services

1.5 Research Questions

1. What reproductive health complications are experienced by Kenyan women and girls as a result of gender based violence? How do such complications impact on women's productivity?

2. What reproductive health services are available for survivors of gender based violence? What are the constraints faced in accessing such Sexual and Reproductive Health services?

3. What are the implications of gender based violence for Sexual and Reproductive Health and sexual behavior?

4. To what extent are the cultural norms and socialization processes that result in patriarchal gender constructs responsible for gender based violence?

5. Are women able to connect the reproductive health complications they suffer to the gender based violence they experience in their lives?

1.6 Research Hypotheses

1. Sexual and Gender-Based Violence is a function of gender roles as defined by cultural norms

2. Women and girls in Kenya are ignorant and unaware of their rights, in particular their sexual and reproductive health rights; age, level of education and marital status being the variables;

3. The inability of women to address their sexual and reproductive health needs stems from patriarchal beliefs, retrogressive cultural norms and socialization processes;

4. Reproductive Health services are adequate in the country, but chronic and long-term reproductive health complications resulting from violence are often ignored and left untreated by women due to lack of financial resources and information.

1.7 Justification of the Study

Women make more than 50% of the population of Kenya, are over-represented among the extreme poor; have the least incomes and assets; have the biggest burden of disease; and have
the least formal education and training (Gituto, 2007; 19). Despite the burden of disease, women’s access to healthcare is severely curtailed by feminization of poverty. The right to health is of central importance to the enjoyment of various other rights. Ill-health is both a cause and a consequence of poverty and an obstacle to human rights enjoyment; the sick are more likely to become poor, while the poor are vulnerable to disease and disability because their “capabilities” for pursuing and attaining higher level “functionings” are severely limited (KNCHR, 2005; 76). This is not the reality for many survivors of violence; in most countries there are few, if any, victim Support Services. Even where they exist, the services are far away and victims cannot easily or cheaply access them (Okumba et al, 2005; 67).

Despite gender-based violence being primarily a human rights and a health issue, the researcher also purposed to adopt a gender perspective in analysing the barriers faced by GBV survivors in accessing support services. A gender perspective broadens the meanings of poverty and health. For women, who are often excluded from the cash economy, a broader measure of well-being, including health, may be more accurate definition of poverty. Feminist views on women’s health emphasise the need for a holistic approach which includes self esteem, personal autonomy, freedom from violence, and sexual choice. Inequality and powerlessness are also increasingly seen as being important root causes of ill health (Oxaal; Cook, 1998; 10). Such factors as women’s ability to acquire information; their ability to decide (based on information acquired); and their ability to act on the information also determine women’s access to, and use of sexual and reproductive health services (Blanc, 2001; 189-191).

Gender-based violence violates several human rights, including the right to bodily integrity, security, freedom of expression, health, life, economic welfare and reproductive choice, to mention a few. It is a costly affair that costs the individual, community, country and the whole world a lot as the victims suffer physical, psychological, mental and economic harm, while perpetrators face revenge, legal punishments and economic losses (Okumba et al, 2005; 40). As most survivors of GBV are women and girls, findings from a study that focuses on the subjective experiences of GBV survivors can be used to advocate for the establishment of structures for a holistic approach to GBV prevention, involving proactive primary prevention programmes that will target the root causes identified by sensitizing and building capacities of communities; and supportive secondary and tertiary prevention programmes involving coping mechanisms for survivors that will address their immediate and their long-term needs. Such data can also be used to challenge retrogressive
gender stereotypes and harmful traditional practices, which are some of the underlying or causal factors that perpetuate GBV and discrimination against women. Prevention of violence is one of the most effective ways of eliminating it (Okumba et al, 2005; 81). Culture is not static, and newer forms of cultural norms need to be developed that respect women and promote their dignity and safety (UNICEF, 2000; 15).

1.8 Scope of the Study

Implications of GBV on Women's Sexual and Reproductive Health is a very wide area of research as there many factors, including experience of violence in childhood, socio-economic status (SES), education, income, faith, culture, age, poor versus non-poor households, rural versus urban settings, and various others, that could be impacting negatively on women's Sexual and Reproductive Health Rights, and especially on women's and girls' access to Reproductive Health services. However, such a scope is very wide and would require collaboration between relevant institutions and research agencies, and corroboration of data from the local to the national level, in order to enable holistic analysis of the issue of women's Sexual and Reproductive Health without "replicating studies".

This study's main limitations were, basically, time and finances; both factors were key in determining the scope of the study. Sampling of GBV survivors 18 years and over was done from the neighbourhood of Kibera, with most of the respondents being from the informal settlements in the area. These were identified through a community mobilizer who at one time had been a Social Worker with WRAP it had been based near Kibera. Most participants had, at one time or the other, sought GBV-related support services at WRAP. These were requested to involve their daughters in the study, as a result of which 30 adolescent girls were identified through their mothers. 15 of the girls participated in individual interviews, with the others joined their colleagues for group discussions. 2 other minors, clients of WRAP, were interviewed within the premises of WRAP's shelter home, which provides alternative safe and secure accommodation for survivors of GBV, particularly to women and children. A Social Worker and a Legal Officer at WRAP were identified to act as key informants for the study, besides whom male and female teachers from mixed primary schools were also identified to act as key informants.

In sampling from members of the community, both women and men were targeted, with the sample being taken from the Oromo Refugee Community, which is still cohesive, and tries to keep
patriotism, culture and tradition alive in the host country. The intention was to examine culture influences on women's sexual and reproductive health, besides finding out whether any community-based GBV intervention strategies have been adopted by the community.

24 cases of GBV survivors were selected at random from WRAP’s database and sorted out into cases involving minors (9) and cases involving adults (15). These case studies provided information on survivors from poor and from non-poor households alike, as well as information of survivors from other urban areas and the rural setting; the intention being to enhance the representativeness of sample and the generalizability of the findings.

1.9 Definition of Terminologies

Perpetrator: a person, group or institution that directly inflicts, supports and condones violence or other abuse against a person or group of persons. Perpetrators are in a position of real or perceived power, decision-making and/or authority, through which they exert control over their victims (Esplen, 2007; 23).

Abuse: misuse of power through which a perpetrator gains control or advantage of the abused; through actual or threats of physical and psychological harm (Esplen, 2007; 23).

Power: capacity to make decisions; misused to dominate, restrict, prohibit and make decisions on behalf of another in relationships (Esplen, 2007; 23).

Gender-Based Violence: Violence that targets individuals or groups of individuals on the basis of their gender (Esplen, 2007; 23).

Violence: "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" (Okumba et al, 2005; 60).

Violence against Women: "any gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" (Okumba et al, 2005; 60).
Child Abuse: gender-based violence that affects children and young people, and which, "in the context of a relationship of responsibility, trust or power, includes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect, negligent treatment, or commercial or other exploitation, resulting in actual or potential harm to the child’s health, survival, development, or dignity (Betron; Doggett, 2006; 11).

Sexual Violence: any act or attempt or threat of a sexual nature that results, or is likely to result in physical, psychological and emotional harm (Esplen, 2007; 23).

Domestic Violence: violence within the family; exclusion of women and girls from the public arena increases their vulnerability to this form of violence (Esplen, 2007; 23).

Gender: culturally specific and socially constructed characteristics assigned to men and women that define the identities, status, roles, responsibilities and power relationships of any society or culture (Esplen, 2007; 23).

Culture: refers to beliefs, attitudes, values, behaviours and traditions that are learned and shared by virtue of membership and socialization in groups. Since these constituents of culture are not ascribed or sacrosanct, they are dynamic and are therefore prone to changes at the individual or group level as a result of exposure to new information and contexts, or acquisition of new needs or goals. Some among the most determinative groups include the family, ethnic, religious and national groups (UNFPA, 2005; 1).

General Development Needs: needs that affect men and women equally, e.g. the need for roads, transport and water (Wanyeki et al, 2003; 23-26).

Women's Special Needs: needs that arise from biological or sex differences, e.g. the need for maternity hospitals and antenatal care (Wanyeki et al, 2003; 23-26).

Gender Gap: is an observable gap between men and women on some important socio-economic indicator, e.g. ownership of property, access to land, enrolment at school, etc (Wanyeki et al, 2003; 23-26).

Gender Discrimination: is the differential gender treatment that cuts off women and girls from access to opportunities, facilities and resources, thus causing a gender gap (Wanyeki et al, 2003; 23-26).
Patriarchy: is the system of beliefs that serves to legitimize male domination/sexism and gender discrimination (Wanyeki et al. 2003; 23-26).

Coercion: whether domestic or institutionalized, is the more ugly side of male domination that relies on violence against women to "keep women in their place" (Wanyeki et al. 2003; 23-26).

Social Exclusion: describes a process by which certain groups are systematically disadvantaged because they are discriminated against on the basis of their ethnicity, race, religion, sexual orientation, caste, descent, gender, age, disability, HIV status, migrant status or where they live. Discrimination may be open, for example through laws and policies; or unofficial, such as through institutionalised discrimination reflecting social prejudices; or simply reflecting a lack of awareness of needs (Payne; Nelville, 2006; 6).

Capabilities: such as individual assets as education, health, skills, savings, and such other assets as housing that enhance one's ability to achieve desired states (Gituto, 2007; 62-64).

Functionings: achievement of such desired states as being well-educated, having good health, participating effectively in public life; etc (Gituto, 2007; 62-64).

Gender Analysis: systematic gathering and examination of information on social relations in order to identify, to understand and to redress inequalities based on gender (Reeves; Baden, 2000; 2).

Gender Equality: implies women having the same opportunities in, public and in private life, as men (Reeves; Baden, 2000; 2).

Gender Equity: implies equivalence in life outcomes for women and men by recognizing respective needs (Reeves; Baden, 2000; 2).

Empowerment: the process and end result of improvement in autonomy through various means such as access to knowledge, skills and training; it improves women's economic self-reliance and ability to lead comfortable lives away from violent relationships (Okumba et al, 2005; 11).

1.10 Conclusion

Gender-based violence violates several human rights, including the right to bodily integrity, security, freedom of expression, health, life, economic welfare and reproductive choice, to mention a few. It is a costly affair that costs the individual, community, country and the whole world a lot as the victims suffer physical, psychological, mental and economic harm, while perpetrators face
revenge, legal punishments and economic losses. Relatives of both the victims and the perpetrators may themselves be violated to prevent disclosure or in retribution. Additionally, important individual and family assets like certificates, houses, furniture and equipment are destroyed with far reaching effects on those who depend on them. Societal peace is breached, social relations are disturbed and important economic resources are diverted (Okumba et al, 2005; 40).

For the fulfilment of human rights, it is urgent that men as well as women strive to change the prevailing culture of masculinity leads to violence against women and girls and puts the healthy development of the next generation at risk; those gender roles and relationships that define men as superior, entitled to use force, and women as inferior, for whom violence is to be expected. These have been identified as the root cause of violence against women and girls (Hayward, 2001; 1). Although gender-based violence is a common and increasingly growing problem, it is not an inevitable part of the human condition, nor is it an intractable problem that cannot be overcome. Humanity has over the centuries overcome and subdued such problems as slavery and apartheid, and could overcome gender-based violence with determination and concerted action. Violence is predictable and preventable, especially by tackling the factors that perpetuate it. Prevention of violence is one of the most effective ways of eliminating it (Okumba et al, 2005; 81).
CHAPTER TWO
LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Definition

There are various definitions of gender-based violence. Some human rights activists prefer a broad-based definition that, besides physical, sexual, psychological/emotional and economic abuse, also includes "structural violence" such as poverty, and unequal access to health and education. The United Nations Declaration on the Elimination of Violence against Women (1993) broadens the definition to include acts in both private and public life. The Declaration goes on to define physical abuse such as slapping, beating, arm twisting, stabbing, strangling, burning, choking, kicking, threats with an object or weapon, and murder. "Cultural Violence" includes traditional practices harmful to women such as female genital mutilation and wife inheritance; that is the practice of a widow being required to get married her dead husband's brother, and relinquish control of her late husband's property to the brother. The definition of sexual abuse includes coerced sex through threats, intimidation or physical force; forcing unwanted sexual attention on another; or forcing one to have sex with others (UNICEF, 2000; 2).

Psychological and emotional forms of abuse target one's mind – to induce guilt, rouse to anger, or destroy confidence - and one's feelings; and include behaviour that is intended to intimidate and persecute. Such abuse takes the form of threats of abandonment or abuse, confinement to the home, surveillance, threats to take away custody of the children, destruction of objects, isolation, verbal aggression and constant humiliation. When a person who normally provides for another's upkeep deliberately fails to fulfill such an obligation, it is classified as economic abuse. It includes acts such as the denial of funds, refusal to contribute financially, denial of food and basic needs, and controlling access to health care, employment, etc (UNICEF, 2000; 2).

As per the definition advanced by that line of thought, acts of omission would also be included as a form of violence against women and girls. When gender bias discriminates in terms of nutrition, education and access to health care, it amounts to a violation of women's rights. It should be noted that although the categories above are listed separately, they are not mutually exclusive. Indeed, they often go hand in hand (UNICEF, 2000; 2).
2.2 Extent and General Outcomes

GBV is, perhaps, the most compelling manifestation of unequal power in sexual relationships, and has a multitude of negative effects on women's Sexual and Reproductive Health (SRH). Results from almost 50 population-based surveys worldwide show that between 10% and 69% of women reported being physically harmed by a male partner at some point in their lives, and these numbers do not include psychological or sexual abuse. Statistics from Kenya indicate that 42% of 612 women surveyed in one district reported having been beaten by a partner; of those, 58% reported that they were beaten often or sometimes (UNICEF, 2000; 5).

Gender-based violence violates several human rights, including the right to bodily integrity, security, freedom of expression, health, life, economic welfare and reproductive choice, to mention a few. It is a costly affair that costs the individual, community, country and the whole world a lot as the victims suffer physical, psychological, mental and economic harm, while perpetrators face revenge, legal punishments and economic losses. Relatives of both the victims and the perpetrators may themselves be violated to prevent disclosure or in retribution. Additionally, important individual and family assets like certificates, houses, furniture and equipment are destroyed with far reaching effects on those who depend on them. Societal peace is breached, social relations are disturbed and important economic resources are diverted (Okumba et al, 2005; 40).

Violence against women is a global problem that has serious consequences which are far reaching and include the erosion of self-esteem, self-worth, physical, mental and psychological health, loss of productivity, costs of health care, unwanted pregnancies and infections, legal and judicial costs. Effective strategies for dealing with gender-based violence can only be developed when the concepts, forms, consequences, factors and the impact of violence are understood (Okumba et al, 2005; 62).

Between 6 and 47% of adult women worldwide report being sexually assaulted by intimate partners in their lifetime, while between 7 and 48% of girls and young women age 10-24 years report their first sexual encounter as coerced. These statistics do not include sexual violence by people other than one's intimate partner; stranger and non-stranger alike (WHO, 2002; 2).

Physical assaults result in injuries, ranging from bruises and fractures to chronic disabilities such as partial or total loss of hearing or vision, and burns may lead to disfigurement. The medical
complications resulting from female genital mutilation can range from haemorrhage and sterility to severe psychological trauma. In extreme cases, domestic violence can result in death. On the other hand, sexual assaults and rape can lead to unwanted pregnancies, and complications as a result of illegal abortions. Girls who have been sexually abused in their childhood are more likely to engage in risky behaviour such as early sexual intercourse, and are at greater risk of early pregnancies. Women in violent situations are less able to use contraception or negotiate safer sex, and therefore run a high risk of contracting sexually transmitted diseases and HIV/AIDS (UNICEF, 2000; 9).

Violence in institutions of learning also constitutes a major area of concern. A study of 202 female students done at the Chancellor College in Zomba, Malawi shows that 12.6% of those who responded to the study had been raped on campus, some of them (48%) by their boyfriends. 67% reported having been sexually harassed in campus, and 62% being harassed elsewhere. Violence in public places is also a common feature of women's lives almost everywhere in the world. In public transport, recreation centres, streets and markets, women and girls are shamelessly abused by perverts and other social misfits who know that the victims have no recourse for such abuses; men rationalise violence against women and girls by insisting that the way they dress, behave and react provoke the increased cases of rape and violation of women's freedoms. This argument confirms that men consider it their right to determine what is good for women. (Okumba et al, 2005; 68-69)

Health outcomes of violence against women are divided into fatal outcomes and non-fatal outcomes. Fatal outcomes include homicide, suicide, maternal mortality, and AIDS-related outcomes, while non-fatal outcomes are further divided on the basis of effect on physical health (e.g. injury, functional impairment, poor subjective health, severe obesity); negative health behaviors (e.g. smoking, alcohol and drug abuse, sexual risk-taking, physical inactivity, overeating); chronic conditions (e.g. chronic pain syndromes, irritable bowel syndrome, gastrointestinal disorders, fibromyalgia); reproductive health (e.g. unwanted pregnancy, sexually transmitted infections/HIV, gynecological disorders, unsafe abortion, pregnancy complications, miscarriage/low birth weight, pelvic inflammatory disease); and effect on mental health (e.g. post-traumatic stress, depression, anxiety, phobias/panic disorders, eating disorders, sexual dysfunction, low self-esteem, substance abuse) (Bott et al, 2004; 11).
2.3 Psychological Violence
The intangible nature of psychological abuse makes it harder to define and report, leaving the woman in a situation where she is often made to feel mentally destabilized and powerless. Repeated humiliation and insults, forced isolation, limitations on social mobility, constant threats of violence and injury, and denial of economic resources are some of the subtle and insidious forms of violence that can be perpetrated for the specific purposes intimidation and control; the woman may seem free to leave, but is held prisoner by fear of further violence against herself and her children, or by lack of resources, and lack of family, legal or community support. Psychological violence is harder to capture in quantitative studies. thus the full picture of its deeper and more insidious levels defies quantification. Survivors report that ongoing psychological violence – emotional torture and living under terror, with mental stress leading to a high incidence of suicide and suicide attempts – is often more unbearable than physical brutality (UNICEF, 2000; 4).

The impact of violence on women’s mental health leads to severe and fatal consequences. Battered women have a high incidence of stress and stress-related illnesses such as post-traumatic stress syndrome, panic attacks, depression, sleeping and eating disturbances, elevated blood pressure, alcoholism, drug abuse, and low self-esteem. For some women, fatally depressed and demeaned by their abuser, there seems to be no escape from a violent relationship except suicide (UNICEF, 2000; 9).

2.4 Violence in Private Life/Domestic Violence
The family is often equated with sanctuary – a place where individuals seek love, safety, security, and shelter. But the evidence shows that it is also a place that imperils lives, and breeds some of the most drastic forms of violence perpetrated against women and girls. Violence in the domestic sphere is usually perpetrated by males who are, or who have been, in positions of trust and intimacy and power – husbands, boyfriends, fathers, fathers-in-law, stepfathers, brothers, uncles, sons, or other relatives. Domestic violence is in most cases violence perpetrated by men against women. Women can also be violent, but their actions account for a small percentage of domestic violence. Even though several countries now have laws that condemn domestic violence, “when committed against a woman in an intimate relationship, the attack is often tolerated rather than prosecuted as violations of such laws”; offenders are prosecuted less vigorously and punished more leniently than perpetrators of similarly violent crimes against strangers” (UNICEF, 2000; 8).
Therefore married women remain vulnerable to marital rape, which remains unrecognized in many countries (Ilkkan; Jolly, 2007; 11).

Cultural ideologies - both in industrialized and developing countries - provide 'legitimacy' for violence against women in certain circumstances. Religious and historical traditions used to sanction the chastising and beating of wives; particularly sanctioned under the notion of entitlement and ownership of women. Male control of family wealth inevitably places decision-making authority in male hands, leading to male dominance and proprietary rights over women and girls. The concept of ownership, in turn, legitimizes control over women's sexuality, which in many law codes has been deemed essential to ensure patrilineal inheritance (UNICEF, 2000; 8).

For these and other reasons, women and children are often in great danger in the place where they should be safest: within their families. For many, 'home' is where they face a regime of terror and violence at the hands of somebody close to them - somebody they should be able to trust. Those victimized suffer physically and psychologically, are unable to make their own decisions, voice their own opinions or protect themselves for fear of further repercussions. Their human rights are denied and their lives are stolen from them by the ever-present threat of violence (UNICEF, 2000; 1).

Sexual abuse too, including rape by an intimate partner are not considered a crime in most countries; women in many societies do not consider forced sex as rape if they are married to, or cohabiting with, the perpetrator. The assumption is that once a woman enters into a contract of marriage, the husband has the right to unlimited sexual access to his wife. Surveys in many countries reveal that approximately 10 to 15 per cent of women report being forced to have sex with their intimate partner (UNICEF, 2000; 4).

A study on Women and HIV, sponsored by the International Center for Research on Women was carried out amongst women in Bombay. The research project revealed a profound pattern of physical, emotional and sexual abuse by intimate male partners. Sixteen of the thirty-five women interviewed experienced regular beatings and sexual violence; and all the women reported at least one significant instance of abuse. Despite the misconception that people living in slums would know more about sex as a result of their lack of privacy, most of the women in the study were largely ignorant about sexual relations between men and women until they learned of it on their wedding nights. They described their first sexual encounter as rape and subsequent sexual encounters as traumatic, unwanted and forced. The trauma of sexual initiation for these women
was generally exacerbated by the man's own lack of sexual knowledge and the woman's young age. They acquiesced to sex to avoid being beaten or abandoned (Heise, et al, 1998; 12-13).

Other significant factors cited in abusive family relationships include the unjust distribution of property and goods/services among family members; children's upbringing; a husband's unwillingness to repay loans which his wife has taken from self-help and other groups; a husband's involvement in antisocial activities; and a wife's inability to satisfy her husband's physical needs accusations; some husbands ignore such factors as menstruation, or the need for a woman to heal after giving birth, or that child brides not mature enough physically for sexual intercourse, resulting in painful situations as wives are forced to fulfill the physical needs of their husbands at those times (Datta; Gupta, 2004; pp 89).

2.5 Sexual Violence

The Ministry of Health in Kenya defines sexual violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting including but not limited to home and work". Rape/sexual violence can result in serious physical injuries, profound psychological trauma, unintended and unwanted pregnancy, and infection with HIV and sexually transmitted infections (STI's). Care of rape survivors needs to address all of these as well as legal and forensic issues. Comprehensive care includes counseling, treatment and management of injuries; emergency contraception and treatment of sexually transmitted infections; Hepatitis B Prevention; and Post Exposure Prophylaxis (PEP): the administration of one type of, or a combination of Anti-Retroviral drugs (ARV's) for 28 days after exposure to risk of HIV infection (Ministry of Health, 2004; 1-3).

A key determinant of sexual violence is the issue of coercion; it need not involve physical force, but can also involve psychological intimidation, blackmail and threats. Coercion also includes the threat of physical harm, of being dismissed from a job or of obtaining a job, or occur when the person aggressed is unable to give consent, e.g. when drunk, drugged, asleep, or mentally incapable of understanding the situation. (UN OCHA/IRIN, 2005; 148) The offence of sexual harassment in the workplace is further compounded by the fact that it strikes at the heart of women's economic self-sufficiency (UN OCHA/IRIN, 2005; 157).
Man's structural capacity to rape and woman's corresponding structural vulnerability are as basic to the physiology of both our sexes as the primal act of sex itself (Ruth, 1990; 204). One grave outcome of violent sexual assault, including rape, mass rape, and the forced insertion of objects into a woman's vagina is traumatic gynecologic fistula; an injury that occurs due to direct traumatic tearing of the vaginal tissues. A woman or girl who sustains this injury is rendered incontinent of urine and/or feces. Together with the horrible physical consequences of her condition, she must also bear the psychological sequelae of sexual assault, as well as the double social stigmatization due both to her unpleasant incontinent state and to her socially undesirable status as a victim of sexual assault (The ACQUIRE Project, 2005; vii).

2.6 Violence against Women in Kenya

Physical and sexual violence are the most common form of violence against women in Kenya. According to Kenya Demographic Health Survey (KDHS) 2003, approximately 49% of women reported having experienced violence since attaining 15 years of age; the violence occurred both in the public and the private spaces, and majority of the perpetrators were known to the survivors: 57.8% of the perpetrators were husbands; 38.3% were parents; and 26% were teachers. The survey also found out that 75% of the perpetrators of sexual violence against children are relatives. The survey also established that social perceptions of both men and women revealed an ignorance of women's sexual and reproductive health rights, thus creating an environment in which the violations occur with impunity. Approximately 29% of the women and 25% of the men surveyed considered a husband justified in meting out violence on his wife if she refused to have sex with him; while 43% of women and 35% of men advocated FGM as a means of safeguarding a girl's prospect for marriage (ActionAid, 2007; 5-6).

While the causal relationships between available statistics on sexual violence and the reporting of and actual rates of sexual violence in Kenya is yet to be determined, what cannot be disguised is the fact that sexual violence is one of the leading violations of women's and girls' rights in Kenya, and that it is taking new forms every day. A study by UNICEF revealed a deep collusion of hotel workers, bar attendants and parents, which has resulted in approximately 3,000 young girls being lured into transactional sex with tourists and Kenyans at the Kenyan coast; with some of the girls starting when 12-13 years old (ActionAid, 2007; 7)!
Police statistics in Kenya indicate an increase in the reporting of sexual violence between 2004 and 2006; however, it is not possible to determine whether this is as a result of an increase in the incidences of sexual violence, or whether it is as a result of increased awareness on the part of the survivors and their families. Figures from Civil Society Organizations and from the Nairobi Women’s Hospital Gender Violence Recovery Center also mirror the same trends of increasing numbers of survivors of sexual violence. Some of the organizations feel that the figures available are only a tip of the iceberg; they do not reflect the real extent of sexual violence being perpetrated against women and girls (ActionAid, 2007; 7).

2.7 Cultural Perspective to Gender Based Violence

Culture, defined as the totality of socially transmitted behaviour patterns, arts, beliefs, institutions, and all other products of human work and thought, has for a long time worked against women. Kenya is composed of more than 42 tribes, or ethnic communities; each with its own unique way of living. But, clearly shared among virtually all ethnic communities is the culture in which gender roles were and still are prescribed by society on the basis of patriarchy, which considers women and children as lesser beings who, therefore, should serve the men (Toroitich, 2004; 12-17).

There are inessential but harmful practices that hurt the very lives of women and girls in Kenya and constitute an infringement of their human rights. The practice of Female Genital Mutilation (FGM) is a classic example. FGM messes up with other priorities including education, health care and other important aspects of the family; the ceremony is very expensive, forcing families to sell assets and other property in order to raise enough money to pay the circumciser, and to buy food and local brew for rite, whose duration could be weeks. Other traditional beliefs that have proved harmful to women and girls are wife inheritance and forced or early marriages. As harmful as they are, the traditions have been worsened by the advent of HIV/AIDS. Women’s property rights closely relate to wife inheritance and cleansing rituals, in that women cannot stay in their homes or on their lands unless they are inherited or cleansed. Early marriages have dire consequences for children including denial of education; health problems, including premature pregnancies higher rates of maternal and infant mortality, and vulnerability of teenage girls to sexually transmitted infections, including HIV/AIDS; and spousal abuse (Toroitich, 2004; 12-17).

Once girls undergo FGM, they are often partnered with older men in marriage and, as a result of power differentials in age and wealth, and due to cultural inhibitions, they are unable to negotiate
safe sex. The young girls' reproductive systems are not yet fully developed resulting in bruising, even with consensual sex; this increases the chance of HIV infection from positive partners. Cultural practices such as wife inheritance and the "sexual cleansing" affects the property rights of women, despite fuelling the spread of HIV/AIDS in the communities where wife inheritance is practiced (ActionAid, 2007; 12-13)

Around the world, women and girls suffer the harmful and life-threatening effects of traditional and cultural practices that continue under the guise of cultural and social conformism and religious beliefs. Female Genital Mutilation (FGM) is one such example; it has been estimated that nearly 130 million women worldwide have undergone FGM and that approximately two million undergo the procedure every year. (UNICEF, 2000; 6)

Significantly, sexual conquest and potency appear as repeated themes in many cultural definitions of manhood, placing women at increased risk of coercive sex. One way to feel unambiguously male in many cultures is to dominate women, to behave aggressively and to take risks. Starting at a very young age, boys get the message that males are expected to be strong, brave, self-reliant, all-knowing, emotionless, aggressive and competitive. When masculine ideals are associated with violence, virility and power, one can easily see how male sexual behavior might emerge as coercive and aggressive. (Heise, et al, 1998; 25)

Anxiety about appearing masculine and powerful may inhibit men and adolescent boys from seeking information about or treatment for sexually transmitted infections. This puts heir partners at risk as it might impact negatively on their reproductive health, resulting in infertility, miscarriages or stillbirths (Blanc, 2001; 198)

In a survey of crime in 31 countries, men accounted for about 87 percent of all arrests, and 90 percent of arrests for homicide between 1962 and 1980. If men commit the majority of violent acts, does this mean that men are inherently more violent than women? Does men's penchant for violence result from biology, social conditioning or a combination of both? And perhaps of most interest, if men's propensity for violence has a biological component, does this mean it is somehow "natural" and therefore impossible to change? Two other studies of wife abuse cross-culturally (Levinson, 1989, Counts, Brown and Campbell, 1992) unearthed additional examples of cultures in which gender-based violence is absent or exceedingly rare. In his ethnographic review of 90 peasant societies, Levinson (1989) identified 16 that could be described as "essentially free or
untroubled by family violence." The existence of such cultures - even if few in numbers - stands as proof that violence against women is due to "male conditioning," and not the "condition of being male". (Heise, et al, 1998; 21-24)

2.8 Myths about Gender-Based Violence

Common myths and assumptions related to sexual violence are shared the world over. They often reflect and reinforce social attitudes and customs that aggrandize male aggression while at the same time purporting female passivity. Ideas about what constitutes “unacceptable” sexual behaviour more often serve to protect the status quo of male dominance. The volition, perceptions, and feelings of the woman or girl are amazingly absent from most cultural definitions of violence. Such delimiting characterisations of sexual violence support impunity for the average rapist because they blame the victim (UN OCHA/IRIN, 2005; 147-148).

A study involving troubled youth in the US also revealed the existence of many myths concerning coercion; for example, boys are supposed to be sexual initiators; girls like guys who take control when it comes to sex; girls want sex as much as boys, but they have to say "no" to maintain their reputation, therefore, when a girl says "no," she really means "maybe" or "yes"; girls want to be persuaded and are expected to struggle a little bit, even tears are a part of the act (Heise, et al, 1998; 28).

Violence against women and girls is couched in many myths that are used to justify or rationalise violent behaviour, or to exonerate perpetrators. Some of the myths are justified by culture, with violence being equated to masculinity; some by saying that women’s behaviour and revealing clothes provoke men to rape, batter or abuse them. Other myths define violence as an expression of a man’s love, and view rapists as psychopaths or crude, uncultured and uneducated men; such a view also holds that commercial sex workers cannot be raped, and that marital rape is not possible. Another myth that is often heard is that women say “No” when they mean “Yes” (Okumba et al, 2005; 69-70).

2.9 Gender-Based Power

Gender-based power defines men as the initiators of sex; married men claimed they were having sex outside their marriage because of being bored with their sex lives at home in a project aimed at promoting safer sex among married couples in Mozambique. They said that would change should
sex at home become better. The women were of the opinion that they are never consulted about their sexual needs, and are therefore reluctant to fulfil their husbands' sexual fantasies (Esplen, 2007; 23). Gender-based power in sexual relationships affects access to, and use of Sexual and Reproductive Health services. Gender-based power is either power to enjoy a higher degree of sexual freedom/determination or power over the wishes/goals of another. It is typified by greater sexual freedom and rights of self-determination for men than for women. Women usually have less power than men. Gender-based power is determined by the type of relationship (marriage; cohabitation; commercial; or casual) and levels of communication between partners and is directly linked to the issue of women's Sexual and Reproductive Health; domination and control of women by male (intimate) partners through violence or threats of violence impacts negatively on women's ability to acquire information; ability to decide (based on information acquired); and ability to act (on the information). In turn, such factors limit most women's access to, and use of Sexual and Reproductive Health services. This focus on gender-based power does not imply that other types of power differentials such as those based on age or wealth, for example, are unimportant (Blanc, 2001; 189-191).

Where men generally control resources and women's mobility, women may have difficulty using Sexual and Reproductive Health services when they need them, and when they get to use such services, they may find it hard to make choices that are appropriate for their situation. This circumstance does not mean that men are purposely denying women health care. The ignorance of women's reproductive health may lead them to make uninformed decisions. Women's secret use of contraceptive methods is one of the clearest examples of the potential consequences of unequal power in sexual relationships (Blanc, 2001; 197).

2.10 Networking to Minimize Violence

The isolation of women in their families and communities is known to contribute to increased violence, particularly if those women have little access to family or local organizations. On the other hand, women's participation in social networks has been noted as a critical factor in lessening their vulnerability to violence, and in enhancing their ability to resolve domestic violence. Such networks could be informal, involving family and neighbours, or formal, involving community organizations; women's self-help groups; or affiliations to political parties. From local, collective action, women have transformed their struggle against violence into a global campaign (UNICEF, 2000 pp 15-16).
GBV survivors also a connection to existing networks of women. It is clear that when victim-survivors have the opportunity to interact with other women experiencing the same problems, they are able to escape their isolation, shame and fear, and are able to rebuild their lives at a faster pace (UNICEF, 2000 pp 18).

"... The decrease in the incidence and severity of domestic abuse has been linked to the greater organizational strength of both the male and the female groups, and the income-earning ability of housewives. The highest reduction of abuse has been observed in the incidence of physical torture compared to the incidence of verbal abuse or the deprivation of basic needs." Over time lot women have begun to resist physical abuse through various concerted actions, including: discussing issues with other group members; arranging shelter for the victims (abused women) in other houses; and women’s group members intervening to help resolve the crisis (Datta; Gupta, 2004 pp 88-89).

2.11 Poverty and Access to Reproductive Health

The right to health is of central importance to the enjoyment of various other rights. Ill-health is both a cause and a consequence of poverty and an obstacle to human rights enjoyment; the sick are more likely to become poor, while the poor are vulnerable to disease and disability because their “capabilities” for pursuing and attaining higher level “functionings” are severely limited (KNCHR, 2005; 76). Accessibility to health care is quite low in Kenya, with 42 percent of the population living within 4 kilometres of a health facility, and 75 percent within 8 kilometres. The utilisation of health facilities is low due to high cost of health care coupled with poverty (Toroitich, 2004; 24).

Women, who make more than 50% of the population of Kenya, are over-represented among the extreme poor; have the least incomes and assets; have the biggest burden of disease; and have the least formal education and training. Women also constitute an absolute majority of those who are unemployed; in 1999, one man for every three women were unemployed (Gituto, 2007; 19). A combination of cultural and institutional barriers is implicated in the root causes of poverty, reproductive ill-health and indicators of the poor socio-economic status of women. Gender is structured hierarchically with men dominating the public domain, senior positions and reaping most benefits, while women predominate in the domestic domain and lower ranks at the same time as carrying a disproportionate share of burden and responsibility in social reproduction. These unequal and inequitable gender norms are internalized by both men and women, often accepted as
‘natural’ and therefore sacrosanct, and are manifested in all spheres of life. Sexual and reproductive health is strongly affected by these hierarchical norms (UNFPA, 2005: 7-9).

Thus, sexual and reproductive ill-health is both a cause and a consequence of poverty; sexuality can also lead to poverty for social as well as health reasons. In many places marriage is vital to economic survival, particularly for women. Women’s failure to marry may limit their access to land, housing, inheritance and social networks. Yet if women do marry, they may enter into a family unit which distributes resources such as food and income unequally, and demands they give more than they get, limiting their livelihood opportunities (likkaracan; Jolly, 2007: 5).

Gender-based violence is known to occur amongst all socio-economic groups and in all cultures; it cannot be said to be caused solely by poverty. However poor women may be less likely to have the resources to leave violent relationships; their heavy work burdens and the significant opportunity costs of time spent in seeking care may prevent access to health services (Oxaal; Cook, 1998: 12). Women may use all of their labor power to work in their homes, producing goods and services that are absolutely necessary for their families without receiving a salary in exchange for their labor. Much of a dependent wife’s work is deemed as personal or private or even as “non-work”; she is always being given a word of caution on spending the husband’s money, has to ask for money for personal effects, and cannot save what she is given as it might be deemed as being deceitful (Ruth, 1990: 238-9).

Inequities in access to services and low quality care have been identified as problems in health service provision for poor people, which, it is argued, is biased towards higher income groups. (Oxaal; Cook, 1998: 1) A gender perspective broadens the meanings of poverty and health. For women, who are often excluded from the cash economy, a broader measure of well-being, including health, may be more accurate definition of poverty. Feminist views on women’s health emphasise the need for a holistic approach which includes self esteem, personal autonomy, freedom from violence, and sexual choice. Inequality and powerlessness are also increasingly seen as being important root causes of ill health. This has gender implications as women are commonly less powerful in their societies/communities than men. Low self-esteem, related to a low status, can lead women to neglect of their own health needs. Poor education and lack of self-esteem may lead to women being unaware that they are suffering from a condition which can be successfully treated, particularly with reproductive health problems (Oxaal; Cook, 1998: 10).
The link between violence and economic dependence is circular; on the one hand, the threat and fear of violence keeps women from seeking employment, or, at best, compels them to accept low-paid, exploitative labour. And on the other, without economic independence, women have no power to escape from an abusive relationship. The reverse of this argument also holds true; women's increasing economic activity and independence is viewed as a threat, which leads to increased male violence (UNICEF, 2000; 6).

In a study, "Domestic Abuses against Housewives in haor Areas of Bangladesh", common poverty-related abuses were beatings and verbal abuse; perpetrated when housewives failed to do household chores on time or to take care of male family members. In contrast, in recent years housewives have not only been involved in household activities, but have also, in most cases been directly involved in income-generating activities. However, because household chores also increase her workload, sometimes the working woman might become bad-tempered with the husband or other family members, often resulting in domestic violence. (Datta; Gupta, 2004; 87)

Another study shows that socio-economic change in rural and urban East Africa; - unemployment and consequent inability of fulfilling social roles and expectations - has increasingly disempowered men, resulting in low self-esteem. Multi-partnered sexual relationships and sexually aggressive behaviour seem to have become essential to strengthen the masculinity and self-esteem (Silberschmidt, 2001; 5)

2.12 Barriers Faced by Survivors in Accessing Support Services

Shame, blame, social ostracism; - these are powerful inhibitors to seeking assistance, let alone justice. A survivor courageous enough to report her rape runs the risk of being re-victimised by the very same beliefs that facilitated the rape. A girl raped by a friend of the father in Lagos, Nigeria, for example, was accused by her father of being a prostitute; her parents ostracized her instead of protecting her. Another girl from Zambia said she was scared of reporting the priest of her local church to the police for raping her; she said no one would believe her, and that some might hold her guilty. A sexual assault victim in India was asked by a police officer whether she knew the meaning of the word rape, while another was told that "women like her never get raped"; that "she must have enjoyed it." In conservative Islamic cultures, a woman who cannot produce four Muslim witnesses to prove she was raped may be imprisoned or publicly stoned to death for having committed adultery (UN OCHA/IRIN, 2005; 148).
In most countries there are few, if any, victim Support Services. Even where they exist, the services are far away and victims cannot easily or cheaply access them. Long distances from courts, health facilities and police stations are a major obstacle to combating gender-based violence. In most rural areas, chiefs, religious and traditional leaders are the only source of support for victims. Invariably, they are mostly men, governed and influenced more by patriarchy than by social justice (Okumba et al, 2005; 67). For decades, women seeking reproductive health services in Kenya have been suffering serious human rights violations, including physical and verbal abuse and detention in health facilities for inability to pay. The situation at Pumwani Maternity Hospital, Kenya’s largest public maternity hospital where clients are amongst the youngest and poorest women in Kenya, vividly illustrates the Kenya government’s failure to take responsibility for severe human rights violations in health facilities (FIDA-K, 2007; 7-8).

The WHO Global Strategy for Health, 2000 states, “There is a health baseline below which no individuals in any country should find themselves." Among the core elements identified, which relate directly or indirectly healthcare, and which every state must guarantee to provide under any circumstances include maternal and child health care, including family planning (KNCHR, 2005; 78). According to the 2003 Kenya Demographic and Health Survey (KDHS, 2003), only 39% of married women practice contraception; in addition, the survey states that 20% of births in Kenya are unwanted, and another 25% are mistimed. Clearly, the family planning needs of Kenyan women are not being fulfilled. The harmful consequences of unwanted pregnancies are myriad; in the face of restrictive abortion law in Kenya, the only option for many women are risky, unsafe and illegal abortions (FIDA-K, 2007; 15).

Apart from user fees, other barriers to meeting the sexual and reproductive health needs of women and girls in Kenya include stock outs of essential drugs in public health facilities, which make access to healthcare including contraception to be too expensive for most women. In a survey of family planning facilities in 2004, it was found out that only 41% of the facilities had all necessary items for infection control such as soap, water, latex gloves, disinfecting solution; 48% of the facilities lacked disinfecting solution, while 28% had no soap. Other vital equipment to conduct pelvic examinations were harder to find; not many facilities had a private room with a bed and light for pelvic examination: only 27% of the facilities had a vaginal speculum, and only 22% had a spotlight. Only 8% of the facilities met all the conditions for proper pelvic examination, while a mere 3% possessed all items necessary for infection control and pelvic examinations. Although some of
these facilities treat victims of sexual violence, only 11% of the facilities surveyed offer emergency contraception. Lack of comprehensive family planning information that results in violations of women's informed consent about surgical contraception has been a long-standing problem; the 2003 KDHS found that 10% of the women had not been told that the procedure was permanent; 81.2% had not been told of the side effects or potential problems; and only 21.3% had been informed of alternative contraceptive methods (FIDA-K, 2007; 19-23).

Health care providers are strategically placed to identify women at risk and to respond appropriately to a disclosure of experiences of gender-based violence. The health professionals are in a unique position to change societal attitudes about violence against women. However, many women do not disclose experiences of violence to health care providers unless they are asked. Health programs can contribute to this effort by equipping staff to discuss violence with clients because they can reframe violence as a health problem rather than merely a social custom. Conservative elements of society that tolerate or justify violence against women sometimes change their views when health professionals demonstrate the negative consequences of gender-based violence for women's and children's health (Bott et al, 2004; 3-4). Unfortunately, many health professionals share the norms, beliefs and attitudes of the broader society in which they live. Negative attitudes toward women in general and toward victims of violence in particular can inflict additional harm upon victims and may prevent health professionals from providing adequate medical care. Improving provider attitudes and beliefs about gender-based violence should therefore be considered a responsibility of every health organization; however, this is a challenging task that requires a long-term approach (Bott et al, 2004; 14-15).

2.13 Inter-generational Effects of Violence

Sexism is the first form of oppression learned by children (Ruth, 1990; 24). Witnessing domestic violence and experiencing physical and sexual abuse during childhood, have been identified as factors that put children at risk violence, as it can also result in a child internalizing violence as a form of conflict resolution. Violence may be learnt as a means of asserting manhood by boys who have witnessed or experienced domestic violence. Girts who witness their mother being abused may be more likely to accept violence as the norm in a marriage (UNICEF, 2000; 12). In many societies, children learn that males are dominant and that violence is an acceptable means of asserting power and resolving conflicts. Women too perpetuate violence by socialising girls to
accept male dominance throughout their lives. Mothers particularly teach their daughters to persevere in order to ensure their sexual and social acceptance in the community (Okumba et al., 2005; 63).

Coerced sex also takes place against children or adolescents, the vast majority of whom are girls (Heise et al., 1998; 12). The shame and stigma that child sexual abuse survivors experience leave them feeling vulnerable, unloved and unable to say "no" to things they do not want to do, such as having sex or using drugs. They do not feel worthy or capable of undertaking self-protective behavior, such as contraception, thus increasing an individual's chance of contracting HIV or other sexually transmitted diseases. A recent study of adolescent mothers in the U.S. state of Washington found that young women who had been sexually abused during childhood began intercourse on average a year earlier than non-victimized mothers. They were also more likely to use drugs and alcohol and less likely to practice contraception. Another U.S. study confirmed that women survivors of childhood sexual abuse are nearly three times more likely than non-victimized youth to become pregnant before the age of 18 (Heise, et al, 1998; 9).

Considering the taboo in most countries that surrounds incest or the sexual abuse of children and adolescents within the family, this is one of the most invisible forms of violence. Because the crime is perpetrated most often by a father, stepfather, grandfather, brother, uncle, or another male relative in a position of trust, the rights of the child are usually sacrificed in order to protect the name of the family and that of the adult perpetrator. However, studies have shown that from 40 to 60 per cent of known sexual assaults within the family are committed against girls aged 15 years and younger, regardless of region or culture (UNICEF, 2000; 6). Children who have witnessed domestic violence or have themselves been abused, exhibit health and behaviour problems, including problems with their weight, their eating and their sleep. They may have difficulty at school and find it hard to develop close and positive friendships. They may try to run away or even display suicidal tendencies (UNICEF, 2000; 6).

A study in a South Africa township involving young men ages 13-25 found out that some of them trick young girls into sex; lie about the use of condoms; and use physical violence against women, since they view violence against women as a socially sanctioned extension of male authority in the private realm. In focus group discussions, some young men spoke of violence as a means to make a woman "understand"—essentially as a means of discipline. The most commonly reported motive
for using violence against a woman is infidelity, proven or suspected. Another motive was a woman refusing to have sex. As a young man in Uganda related, it would be acceptable to use violence against a woman, in this case "a slap," at "times when you take her out have negotiated and then she refuses." Among many of the young men interviewed in Nigeria and Uganda, a slap, for the most part, is seen as acceptable, whereas exceeding that could be dangerous, both because it could seriously harm the woman and also because it might bring reprimand (from the elders or the official authorities). Some studies show that boys and girls might interpret the use of violence due to infidelity as reflecting the level of emotional investment; that is, when a man uses violence against a woman, it shows that he is emotionally invested in the relationship or cares for her. In focus groups in Uganda, several young men mentioned how women will think a man does not love her if he does not hit her (World Bank, 2005: 22-3).

2.14 HIV/AIDS and Gender Based Violence

Violence against women and girls has been one of the leading factors triggering higher infection rates amongst women and girls in Sub-Saharan Africa. It is also a consequence of HIV infection taking on dimensions such as physical abuse, property disinheritance and social and economic discrimination within the community and employment sectors. A total of 1.2 million Kenyans are living with HIV/AIDS; 720,000 of these are women (ActionAid, 2007; 1).

Today, half or more of the 40 million people infected with HIV in the world are women. Millions of those infected with HIV are young people aged 15-24 years who now account for half of all new infections. In sub-Saharan Africa, young women account for 75% of HIV infections and are approximately three times more likely to be infected than young men of the same age. The high rates of HIV infection in women have brought into sharp focus the problem of violence against women. There is a growing recognition that women and girls' risk of and vulnerability to HIV infection is shaped by deep-rooted and pervasive gender inequalities - violence against them in particular. Studies conducted in many countries indicate that a substantial proportion of women have experienced violence in some form or another at some point in their life (WHO, 2002; 1).

Women's vulnerability to HIV/AIDS is also influenced by gender-based power; - women are often expected to be ignorant about sex and passive in sexual interactions, making it difficult for them to be adequately informed about risk-reduction strategies. Even for women who are informed, unequal power within sexual relationships reduces their ability to negotiate protection from disease,
to express their concerns about sexual fidelity, and to say “no” to (unwanted) sex. In cultures where
virginity is highly valued, girls and young women may be persuaded or coerced into engaging in
such practices as anal sex to preserve their virginity, placing them at a higher risk of infection.
When women become infected, the norms surrounding their virginity and sexuality can make them
reluctant and ashamed to seek treatment. Women’s economic dependence on men reinforces their
vulnerability to disease by increasing the likelihood that they will exchange sex for money or for
favors. Women who have few alternatives for economic survival are likely to fear abandonment and
will therefore hesitate to leave a risky relationship. Furthermore, the threat or fear of violence may
impel women to engage in risky sex as preferable to more immediate physical harm (Blanc, 2001;
198-9). Poverty drives women to work in hazardous environments. A very direct link can be seen
between women’s work and woman’s health in the case of sex workers and the prevalence of
STDs including HIV/AIDS among this group. This is exacerbated by poverty where women may be
driven into sex work, or into sexual relationships for economic reasons, and therefore may not feel
able to insist on condom use (Oxaal; Cook, 1998; 11).

A WHO study finds that the greatest risk of HIV infection for many women comes from a regular
partner, and is heightened by an unequal relationship that makes it difficult, if not impossible, to
negotiate safe sex. For these women, sex is not a matter of choice. A study of women aged 18 and
over in one province in Zimbabwe found that 26 per cent of married women reported being forced
to have sex when they did not want to. It is widely acknowledged that, even when a woman is
aware that her partner has other sexual partners, or is HIV infected, she may not be in a position to
insist on condom use or monogamy. For these women, sex is not a matter of choice. Thus, the
greatest risk of HIV infection for many women comes from a regular partner, and is heightened by
an unequal relationship that makes it difficult, if not impossible, to negotiate safe sex. They feel that
any attempt to discuss such measures would provoke yet more violence; practices that see women
being considered as the ‘property’ of men (UNICEF, 2000; 9). Often the disclosure of HIV infection
by a woman is met with violence at home (ActionAid, 2007; 1).

Other studies have found that the spread of HIV/AIDS in some parts of Africa is being exacerbated
by practices that see women as the ‘property’ of men. The tradition of wife or widow inheritance, for
example, is fairly common in eastern and southern Africa. When a woman’s husband dies, his wife
and property are often inherited by his eldest living brother. In western parts of Kenya, women
have been forced to marry, even when their husbands have died of AIDS, when they themselves

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are infected, or when their future husband has AIDS. There are no laws to address this practice in Kenya. Sexual cleansing, practiced within extended families in western parts of Kenya, Zimbabwe and parts of Ghana, is a more recent phenomenon, resulting from, and contributing to, the spread of HIV/AIDS (UNICEF, 2000; 9).

2.15 Consequences: Calculating the Costs of Violence

Such medical problems as injuries to the limbs and sexual organs, physical and psychological trauma and sexually transmitted diseases are some of the consequences of gender-based violence. Beyond this, there are additional issues related to denial as well as delayed justice from the legal system including police or local administration; lack of material support from estranged spouses; lack of support for the upbringing of children; lack of alternative shelter; possibility of HIV infection; unemployment; and continued harassment from the estranged husband. Post-Rape Care in private health institutions costs around 26,000 Kenya shillings, while at the Nairobi Women's Hospital Gender Violence Recovery Center it costs 15,000 Kenya shillings on average to treat one survivor of sexual violence, including providing emergency contraception, treatment of sexually transmitted infections. Post Exposure Prophylaxis or the administration of Anti-Retroviral drugs (ARVs) for 6 weeks to guard against HIV infection, and individual and group trauma counseling. Reconstructive surgery to repair damaged sexual and internal organs can cost between 95,000 and 130,000 Kenya shillings (ActionAid, 2007; 9).

Countries cannot reach their full potential as long as women's potential to participate fully in their society is denied. Data on the social, economic and health costs of violence leave no doubt that GBV undermines progress towards human and economic development. Women's participation has become key in all social development programmes, be they environmental, for poverty alleviation, or for good governance. By hampering the full involvement and participation of women, countries are eroding the human capital of half their populations (UNICEF, 2000; 9).

Thus, calculating the costs of violence is a strategic intervention to make policy-makers more aware about the importance and effectiveness of prevention. In 1993, the World Bank estimated that, in industrialized countries, health costs for domestic violence and rape accounted for nearly one in five disability adjusted life years lost to women aged 15 to 44. The health costs of domestic violence and rape are the same in industrialized and developing countries, but because the overall burden of disease is high in developing countries, a smaller percentage is attributed to GBV. In
developing countries, depending on the region, estimates range from 5 to 16 per cent of healthy years lost to women of reproductive age as a result of domestic violence (UNICEF, 2000; 12).

The Inter-American Development Bank (IDB) divides the costs of violence into four categories:

**DIRECT COSTS:** which take into account expenditures on psychological counseling and medical treatment; police services - time spent on arrests and responding to calls; costs imposed on the criminal justice system; housing and shelters for women and their children; and social services (GBV sensitization, training prevention and advocacy programmes).

**NON-MONETARY COSTS:** which do not draw upon medical services, but in themselves take a heavy toll on the victim-survivors by way of increased morbidity and mortality through homicide and suicide, increased dependence on drugs and alcohol and other depressive disorders.

**ECONOMIC MULTIPLIER EFFECTS:** include, for example, decreased female labour participation and reduced productivity at work, and lower earnings. In the United States, it has been reported that 30 per cent of abused women lost their jobs as a direct result of the abuse. Another effect under this category is the potential impact of domestic violence on the future capacity of children to obtain adequate employment. Apart from the loss of human capital, there are direct costs on the school system as children from violent homes may perform badly and have to repeat grades.

**SOCIAL MULTIPLIER EFFECTS:** include the inter-generational impact of violence on children, erosion of social capital, reduced quality of life and reduced participation in democratic processes. These effects are difficult to measure quantitatively, but their impact is substantial in terms of a country's social and economic development.

It is clear that all sectors of society are deeply affected by, and bear the consequences of, violence against women. A major knowledge gap also exists on the cost-effectiveness of interventions for domestic violence. This is an important area of research that would provide guidance on effective, workable and replicable programmes, and thereby help channel resources and energy in the right direction (UNICEF. 2000; 12-13).

### 2.16 Theoretical/Conceptual Frameworks

#### 2.16.1 Human Rights Framework

Gender equality was included as one of the human rights principles in the United Nations Charter at its formulation in 1945. Since then, gender equality has evolved as one of the key agendas of
the United Nations and is now included as a mainstream issue in most deliberations and activities of the United Nations. The Commission on the Status of Women (CSW) is the organ responsible for sustaining the gender equality debate and action within the United Nations system. The UN Conferences of the last 30 years were fundamental to the conceptualisation, development and implementation of strategies for the elimination of all forms of discrimination against women and the progress towards gender equality. The key outcome is that over these years, gender became a key human rights and development issue, integrated in most sectors of the global and national development agenda policies and programmes (Okumba et al, 2005; 21).

The 1993 World conference on human rights in Vienna, acknowledging that human rights should apply broadly to the areas of sexuality and reproduction, affirmed that women’s rights should not be subordinated to cultural or religious traditions. The 1994 International Conference on Population and Development in Cairo created a comprehensive framework to realize reproductive rights and health. And the 1995, fourth World Conference on Women in Beijing took holistic rights based focused view of health and the social, political and economic factors that affect it (Ilkcarakan; Jolly, 2007; 13-14). Sexual and reproductive health rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements, which include: the right of all persons, free of coercion, discrimination and violence, to the highest attainable standard of sexual health, including access to sexual and reproductive health care services; to seek, receive and impart information related to sexuality; to sexuality education; to respect for bodily integrity; to choose their partner decide to be sexually active or not; to consensual sexual relations; to consensual marriage; to decide whether or not and when, to have children; and to pursue a satisfying, safe and pleasurable sexual life. The responsible exercise of human rights requires that all persons respect the rights of others (Ilkcarakan; Jolly, 2007; 10). In the past, human rights protection was interpreted narrowly – state inaction to prevent and punish violations was not viewed as a failure in its duty to protect human rights. The concept of state responsibility has now developed to recognize that states also have an obligation to take preventive and punitive steps where rights violations by private actors occur (UNICEF, 2000; 10).

The analytical framework of a rights-based approach aims to capture the root causes of the perpetuation of poverty, exclusion, discrimination and power relations that sustain inequity, as they all impact negatively on women’s reproductive rights and health. The framework aims to strengthen duty bearers to fulfil their obligations and empowering right-holders to claim their rights. A rights-
based approach holds that someone, for whom a number of human rights remain unfulfilled, such as the right to food, health, education, information, participation, etc., is a poor person. Poverty is thus more than lack of resources – it is a manifestation of exclusion and powerlessness.

There are 6 key principles that are derived from international Human Rights instruments to offer normative clarity and a road map to policy makers:

a **Universalism and inalienability**: every woman, man and child is entitled to enjoy her/his rights by virtue of being human;

b **Equality and non-discrimination**: all persons enjoy equal access to the available goods and services that are necessary to fulfill basic human needs;

c **Indivisibility and inter-dependence of human rights**: thus the call for affirmative action as a remedy for marginalization;

d **Participation and inclusion**: all persons are entitled to participate in society using their maximum potential;

e **Accountability**: rights imply duties; duties demand accountability;

f **Rule of law**: aggrieved rights-holders require access to competent, impartial and independent judicial processes to invoke their rights to institute legal proceedings for appropriate redress (Donnelly, 2003; 23-37).

### 2.16.1.1 Limitations of Human Rights Frameworks

The Human Rights Framework relies upon assertions of universality, commonalities and setting boundaries, yet there is no consensus about the most basic measures, and the search for transnational indicators is proving difficult. Initial conceptions of Human Rights applied only to states and state actors, but have gradually been extended to encompass civil society and private actors in certain contexts. But it is still not accurate to claim that human rights law exists to "eliminate all forms of violence against all people" for, as it emerges, Human Rights protect the individual from the state in traditional liberal tradition, in which the private sphere was excluded from consideration as being without the reach of the state. Therefore, at the end of the twentieth century, Human rights have become more normative and vaguer, meaning that they are in some ways more limited in scope than civil rights under national law – especially relevant to violence. Women's Rights have also for many decades regarded as too trivial, and the abuse of women
regrettable but cultural or private and "too pervasive to be of concern to mainstream human rights activism" (Kelly, 2006; 2-6).

2.16.2 Gender Analytical Frameworks

WOMEN'S OR LONGWE EMPOWERMENT FRAMEWORK: Its proponent is Sara Longwe; its relevance to this study is that it views the empowerment of women as being central to the development process. It recognizes that gender inequities do not merely arise from differences in gender roles, but from the gendered division of labor and the allocation of benefits and resources. The framework operates at five levels: the Welfare or zero level of empowerment in which women are the passive recipients of benefits from a "top-down" approach; the Access or first level of empowerment - women improve their own status, relative to men, by increased access to resources; the Conscientization or second level of empowerment - women realize and understand the underlying causes of their problems and, motivated, attempt to identify strategies for action; the Mobilisation or the third level of empowerment - motivated by their awareness, women opt for collective action in analyzing and identifying discriminatory practices and in formulating collective and strategic action to remove these discriminatory practices; and the Control or final level of empowerment - reached when women have taken action towards greater gender equality in decision-making over access to and control of resources; women are no longer given resources merely at the discretion of men, or at the whim of patriarchal authority (Wanyeki et al., 2003; 26-32).

The main limitation of the Women's Empowerment approach is that it does not take into account women's biological roles and the "unrecognized role they play in family, child, and community welfare". To compensate for the limitation, the researcher also made reference to two other frameworks found within the gender approach: the SOCIAL RELATIONS APPROACH developed by Naila Kabeer at the Institute for Development Studies, which conceptualizes development as the achievement of human well-being through three basic principles: survival, security and autonomy; and the MOSER/DPU FRAMEWORK, developed by Caroline Moser at London University's Development Planning Unit, which describes women's roles as triple roles, which includes productive, reproductive, and community management. Practical gender needs and strategic gender interests are taken into account with this framework. (Reeves; Baden, 2000; 6)
CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Target Population: The target population was categorized into 4 sub-populations; these were:

i. GBV Survivors who had sought services from Women's Rights Awareness Programme (WRAP) 6 months to 1 year before the study was undertaken;

ii. Adolescent Girls living in a low-income neighborhood;

iii. Members of the Community from poor households; and

iv. Key Informants: comprising of SRH Service Providers and Teachers.

Secondary data collection was effected by means of reviewing existing (client) records at WRAP.

3.2 Sample Size: - 55 GBV Survivors and 17 Adolescent Girls were sampled for individual interviews and group discussion. Only 4 men participated in individual interviews as Members of the Community. The Key Informants comprised 2 members of WRAP staff and 4 teachers from mixed primary schools. Case Studies involved 24 client histories selected at random from WRAP’s client records for reviewing; 15 of which were case histories of adults, and 9 were case histories of minors.

3.3 Sampling Techniques

Snowball Sampling: was used for GBV survivors in Kibera slums. Former clients of WRAP were asked to invite colleagues experiencing, or who had experienced abuse to participate in the research. This sampling technique also applied for the sub-population of adolescent girls living in a low-income neighborhood; participants were requested to involve adolescent daughters in the study.

Convenient Sampling was used with the Oromo Refugee Community: WRAP held workshops to educate refugee communities on gender, Human Rights, GBV, advocacy and Women and Girls in Leadership, so it was relatively easy to mobilize participants from that community. Besides attending the afore-mentioned workshops, women from the Oromo Refugee Community had sought various services at WRAP as GBV survivors. Convenient sampling was also used to identify key informants, while Random Sampling and Purposive/Judgment Sampling were used for the case studies; client histories were selected at random, care being taken to ensure that the cases so sampled involved both child clients/minors (9) and adult clients (15).
3.4 Research Design: The study is exploratory as it lacks random assignment of participants to an intervention and a control group, thus its basic design is "Quasi-Experimental", a design commonly used in evaluating social programs. As fieldwork was done within a time-frame of one month, the study is also "Short-term Study", or a "One-Shot Case Study, involving a "One Group Posttest Only Design". Both the "Quantitative" and the "Qualitative" aspects of research designs also apply, since the study sought to generate data on survivors who suffer long-term sexual and reproductive health complications, though more emphasis was laid on the participants' subjective experiences or perceptions of GBV (Frankfort-Nachmias; Nachmias, 1996; 145-148).

3.5 Research Ethics: Research assistants were carefully selected; criteria being background in basic counseling or social work; all were actively involved in, or had prior experience of working with GBV survivors. As members of WRAP's staff have had their capacity in research processes built, it was from there that the research team was assembled. The research team comprised the principal researcher and 3 research assistants: 2 female members of WRAP's staff (a social worker and an intern – a young undergraduate student majoring in social work) and a male volunteer. The research assistants received briefing before commencing on the interviews. WRAP has an ongoing counseling programme for survivors of violence that helped cope with trauma as a result of re-visiting or re-living extremely distressing events in their lives during the interviews. Any other traumatic impacts from answering questions about violence were to be addressed through WRAP's linkages with other service-delivery and community-based advocacy organizations (Jewkes et al, 2000; 94-97). Making the young intern to be part of the research team was an added advantage in that the adolescent girls opened up more to her. The exercise also added to her experience, and will improve her résumé (Kirby, 2004; 7).

The study involved participants reliving extremely distressing events in their lives; a situation of vulnerability, which if not handled sensitively can lead to women being further traumatized with feelings of blame, hopelessness, and the feeling of a lack of self-worth being reinforced. WRAP staff regularly handles traumatized clients and has been trained in information-giving in situations of distress; thus the issue did not pose a major challenge in the course of the study. The research team put into practice basic counseling skills, especially listening, and referred women suffering longer-term complications and chronic conditions as a result of violence to available sources of
support that is besides providing for immediate counseling needs and legal advice at WRAP (Jewkes et al, 2000; 94-97).

Besides voluntary participation and informed consent, protecting confidentiality was essential, to ensure not only the safety of participants and researchers, but also of data quality. Consent for the minors was sought from their parents, though the research team also sought assent from each of the minors who participated in the study (Frankfort-Nachmias; Nachmias, 1996; 81). Data collection protocol included assigning letter and number codes to participants to ensure confidentiality, or anonymity. No names or addresses were recorded on the questionnaires. (Frankfort-Nachmias; Nachmias, 1996; 335-336) Before the interviews were conducted, participants were reminded of their right to terminate the interview session at any time, and for any reason; it was not imperative for them to participate. The safety factor was put into consideration, since interviews involving GBV survivors and adolescent girls from Kibera were conducted within the precincts and privacy of a church hall, while those involving the refugee community and 2 minors (former clients, but whose cases were still on-going) were conducted within the premises of WRAP’s shelter home.

One of the ethical principles of research is *beneficence*: that is "What is in it for the interviewee?" Thus, all participants received some "monetary token of appreciation"; to compensate for time spent in the study. The sub-population of GBV survivors was referred to WRAP for counseling; referrals were also made to other available sources of support (Jewkes et al, 2000; 94-97). As finances made the option of workshops as a tool of data collection not to be feasible, the questionnaires were structured so as also to provide participants with information related to women’s Sexual and Reproductive Health Rights.

### 3.6 Data Collection Procedures

As much analysis as is possible was done by reviewing existing records at WRAP; that is the data routinely recorded during service delivery to clients. 24 cases were selected at random; 9 of the cases involved minors and 15 adults. This helped to minimize the need for using additional research methods, besides minimizing the risks to informants and participants. As researching violence with children under 18 involves particularly complex risks, analysis of the Sexual and Reproductive Health impacts of violence on this age group was by use of routine client data, with the consent of the partner organization WRAP.
In-depth individual interviews were conducted for all respondents of the four respective sub-populations, besides the Plenary or Focus Group Discussions by the GBV survivors (divided into 4 groups, one of the groups being comprised of women leaders from Kibera) and adolescent girls (around 30 participated in group discussions, though only 15 in individual interviews). The key informants were given questionnaires to fill in their own time.

Some of the questions posed to participants during individual interviews were also used for group interviews and focus group discussions; the respondents were more “expressive” in group discussions as opposed to in individual interviews. Translation services were required for the Oromo Refugee Community, from which the four men were also sampled.

3.6.1. Structuring Questionnaires for Use in Interviews

The questionnaires were semi-structured, so as to give the research team room to re-frame the questions depending on the emotional state and degree of openness or level of communication of each respondent. Factual questions were used to elicit objective information such as the age and other background information of the respondent. Questions about subjective experiences: beliefs, attitudes, feelings and opinions, were of 2 types:

Closed-ended questions or statements were used to express explicit points of view on various issues. Respondents were to agree or disagree with the stated point of view. In this category of questions “contingency questions”, were asked based on the way respondents answered the preceding question; then referred to as a “filter question”. Closed-ended questions with more than 2 choices or “matrix questions” were also used.

Open-Ended Questions were used for a variety of reasons: - to learn how respondents arrived at a particular point of view; to test respondents’ level of information on the topic in question; to give respondents an opportunity to think through an issue; to assess the ease with which respondents communicate content of the issue; and to find out the extent of respondents’ motivation to communicate on the topic (Frankfort-Nachmias; Nachmias, 1996; 251-160).

3.7 Challenges and Limitations

The researcher had originally intended to work with 75 GBV survivors randomly sampled from WRAP’s database, however, as the feedback loop in WRAP’s intervention programmes is still to be effectively developed, it was not possible to get in touch with many of WRAP’s former clients.
Sampling of GBV survivors, therefore, was done from the neighbourhood of Kibera; most of the respondents were from the informal settlements in the area. These were identified through a community mobilizer who at one time had been a Social Worker with WRAP it had been based near Kibera. Most participants had, at one time or the other, sought GBV-related support services at WRAP.

As for the sub-population of adolescent girls, the original intention had been a sample of 30 girls, of 18 years of age and over, for the purposes of consent from a Form IV class in a Secondary school situated in a low-income neighbourhood; 2 teachers from the same school were to act as key informants. However, as the study was carried out when schools were on holiday, it was difficult for the research team to seek clearance with the education Ministry. 30 adolescent girls were therefore identified through their mothers, who participated in the study as GBV survivors. 15 of the girls participated in individual interviews, with the others joined their colleagues for group discussions. 2 other minors, clients of WRAP, were interviewed within the premises of WRAP’s shelter home, which provides alternative safe and secure accommodation for women and children who are survivors of GBV. As for teachers to act as key informants, male and female teachers from a few mixed primary schools were identified. Besides the teachers, a Social Worker and a Legal Officer who work with GBV survivors were also identified to act as key informants for the study.

Regarding the sub-population of community members, the researcher’s intention had been that justified sampling on the basis of age and gender be done from two community-based GBV intervention groups that WRAP had helped set up in its GBV prevention programmes; one from a middle-income residential area and the other from an informal settlement. A sample of 8 persons was to be taken from the 18-25 age group; another 8 from the 26-44 age group; and 8 persons aged 45 years and above. 2 out of the 8 persons in each group were to be men. The contact person in each respective community was to be the 25th member of the group. However, violence in the informal settlement – Mathare – displaced the originally identified people, while a certain religious denomination that was influential in the middle-income residential area was against the study.

Therefore, the sample of members of the community was taken from the Oromo Refugee Community, with both women and men were targeted, with being. The intention was to examine culture influences on women’s sexual and reproductive health, besides finding out whether any
community-based GBV intervention strategies have been adopted by the community. 24 cases of GBV survivors were selected at random from WRAP's database and sorted out into cases involving minors (9) and cases involving adults (15). These case studies provided information on survivors from poor and from non-poor households alike, as well as information of survivors from other urban areas and the rural setting; the intention being to enhance the representativeness of sample and the generalizability of the findings.
CHAPTER FOUR
PRESENTATION OF FINDINGS

4.1 Introduction
This chapter presents the findings of the research. Based on the response of each participant, the interviewers were to note and indicate the interviewee's degree of cooperativeness; level of interest; level of understanding; level of participation in group discussions; and the conduciveness of venues to the process of interview. All respondents were cooperative and their understanding of the issues at hand fair. The venues; a Salvation Army Church Hall in Kibera, and the premises of WRAP's shelter home {which provides temporary alternative and safe accommodation to GBV and child abuse survivors} were convenient for such a study, for they offered privacy and a sense of security to the participants, besides which there was minimal distraction.

Coding had been done for the different sub-populations: GBV Survivors were given Code G; Adolescent Girls – Code A; Community Members – Code C; and Key Informants – Code K. More resources and time were committed to gathering information amongst the sub-population of GBV Survivors, with significant attention also being given to the sub-population of Adolescent Girls; the bulk of the finding is from the two sub-populations. 30 questionnaires were selected at random from the interviews of the sub-population of GBV Survivors: 19 of these were from interviews of GBV survivors in Kibera, and 11 were from the Oromo refugee community. Information from these 30 questionnaires was combined with information from the random sample of 15 adult case histories. Information from the 17 questionnaires used in interviews of the sub-population of Adolescent Girls in Kibera was combined with information from the random sample of 9 case histories of minors.

The data is presented in both tabular and narrative form.

4.2 Background Information of Target Population Sampled

4.2.1. Table 1: BACKGROUND INFORMATION OF GBV SURVIVORS

<table>
<thead>
<tr>
<th>AGE</th>
<th>18-25 years</th>
<th>26-44 years</th>
<th>Over 45 years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>10</td>
<td>33</td>
<td>2</td>
<td>45</td>
</tr>
<tr>
<td>Percent</td>
<td>22.2%</td>
<td>73.3%</td>
<td>4.5%</td>
<td>100</td>
</tr>
<tr>
<td>Range</td>
<td>Mean</td>
<td>Median</td>
<td>Mode</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>--------</td>
<td>--------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td>18 - 46 years</td>
<td>27.5 years</td>
<td>28 years</td>
<td>28, 29, 32 years</td>
<td></td>
</tr>
</tbody>
</table>

**EDUCATIONAL BACKGROUND**

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Primary School</th>
<th>Secondary School</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>7</td>
<td>23</td>
<td>15</td>
<td>45</td>
</tr>
<tr>
<td>Percent</td>
<td>15.6%</td>
<td>51.1%</td>
<td>33.3%</td>
<td>100</td>
</tr>
</tbody>
</table>

**OCCUPATION**

<table>
<thead>
<tr>
<th></th>
<th>Unemployed</th>
<th>Casual work</th>
<th>Self-employed</th>
<th>Student</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>18</td>
<td>12</td>
<td>14</td>
<td>1</td>
<td>45</td>
</tr>
<tr>
<td>Percent</td>
<td>40.0%</td>
<td>26.7%</td>
<td>31.1%</td>
<td>2.2%</td>
<td>100</td>
</tr>
</tbody>
</table>

**TYPE OF RELATIONSHIP**

<table>
<thead>
<tr>
<th></th>
<th>Unmarried</th>
<th>Married</th>
<th>Separated</th>
<th>Widowed</th>
<th>Cohabitation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>2</td>
<td>17</td>
<td>12</td>
<td>3</td>
<td>11</td>
<td>45</td>
</tr>
<tr>
<td>Percent</td>
<td>4.4%</td>
<td>37.8%</td>
<td>26.7%</td>
<td>6.7%</td>
<td>24.4%</td>
<td>100</td>
</tr>
</tbody>
</table>

**NUMBER OF CHILDREN**

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>1 Child</th>
<th>2 Children</th>
<th>More than 2 Children</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>3</td>
<td>11</td>
<td>7</td>
<td>24</td>
<td>45</td>
</tr>
<tr>
<td>Percent</td>
<td>3.3%</td>
<td>26.7%</td>
<td>15.6%</td>
<td>53.3%</td>
<td>100</td>
</tr>
</tbody>
</table>

**MEMBERSHIP TO SELF-HELP GROUPS**

<table>
<thead>
<tr>
<th></th>
<th>Non-member</th>
<th>Member: Welfare oriented groups</th>
<th>Member: Social support groups</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>15</td>
<td>19</td>
<td>11</td>
<td>45</td>
</tr>
<tr>
<td>Percent</td>
<td>33.3%</td>
<td>43.3%</td>
<td>23.4%</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Fieldwork 2007

4.2.2. Table 2: BACKGROUND INFORMATION OF ADOLESCENT GIRLS/MINORS

**Age of Respondent**

<table>
<thead>
<tr>
<th>Range</th>
<th>Mean</th>
<th>Median</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 - 18 years</td>
<td>14.5 years</td>
<td>16 years</td>
<td>14, 17 and 18</td>
</tr>
<tr>
<td>Family Background</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lives with mother</td>
<td>Lives with both biological parents</td>
<td>Lives with father and step-mother</td>
<td>Lives with guardians</td>
</tr>
<tr>
<td>31.2%</td>
<td>35.6%</td>
<td>7.7%</td>
<td>17.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of siblings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range</td>
</tr>
<tr>
<td>0 to 11 siblings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Decision-making at home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children excluded from decision-making</td>
</tr>
<tr>
<td>59%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender roles at home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eldest sister; other children</td>
</tr>
<tr>
<td>5.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Background</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussion with parents/guardians on RH-related issues</td>
</tr>
<tr>
<td>Never</td>
</tr>
<tr>
<td>53%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mentor at puberty (onset of menstruation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elder sister</td>
</tr>
<tr>
<td>23.5%</td>
</tr>
</tbody>
</table>

Source: Fieldwork 2007

4.2.3. BACKGROUND INFORMATION OF THE OTHER SUB-POPULATIONS

The ages of the four men interviewed from the Oromo refugee community ranged from 23 to 61 years. Only one had attained a level of education equivalent to Form IV; two were educated to the 9th Grade (Form II equivalent), and one was uneducated. They were all unemployed. As regards marital status one was in a monogamous marriage with 3 children; another was polygamous, having 4 wives and 14 children, while the other 2 were unmarried.

The two key informants representing service providers were sampled from the civil society (WRAP). Their average experience of intervening in GBV-related incidences is 4 years. Both
<table>
<thead>
<tr>
<th>Topic</th>
<th>Yes</th>
<th>No</th>
<th>%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religion and tradition sanction chastising of wives</td>
<td>20</td>
<td>3.3</td>
<td>76.7</td>
<td>100</td>
</tr>
<tr>
<td>Wife need not know destination of husband's income</td>
<td>-</td>
<td>10</td>
<td>90</td>
<td>100</td>
</tr>
<tr>
<td>Husband is family's sole breadwinner</td>
<td>3.3</td>
<td>3.3</td>
<td>93.4</td>
<td>100</td>
</tr>
<tr>
<td>Husband should make decisions on fertility issues</td>
<td>6.7</td>
<td>10</td>
<td>83.3</td>
<td>100</td>
</tr>
<tr>
<td>Marriage gives men &quot;absolute&quot; sexual access to their wives</td>
<td>20</td>
<td>-</td>
<td>80</td>
<td>100</td>
</tr>
<tr>
<td>Wives do not raise the issue of contraception fearing abuse by husbands</td>
<td>40</td>
<td>6.7</td>
<td>53.3</td>
<td>100</td>
</tr>
</tbody>
</table>
indicated that intrinsic motivation is what keeps them going as funding is often too low to provide "reasonable" monetary incentive.

The mean teaching experience of 4 teachers (sampled from a primary school in which over half of the 1,000 pupil population is comprised of girls) was 20 years and 3 months.

4.3 The Experience of Violence: Cause, Effect and Reproductive Health Implications of GBV
Participants' responses to questions were used intended to identify patriarchal and other beliefs, retrogressive cultural norms and socialization processes that contribute to GBV at the intimate partner level, and at the community or societal level (be it abuse/violence by next-of-kin or by strangers). Though the Adolescent Girls said they had experienced of GBV, their experiences are grouped together with their beliefs, attitudes and practices; though experiences from the case histories of the minors are grouped apart. The data is presented in both tabular and narrative form.

4.3.1 Table 3: BELIEFS, ATTITUDE AND PRACTICES OF GBV SURVIVORS

<table>
<thead>
<tr>
<th></th>
<th>I agree</th>
<th>It depends</th>
<th>I disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent</td>
<td>Percent</td>
<td>Percent</td>
<td>%</td>
</tr>
<tr>
<td>Marriage vital to economic</td>
<td>30</td>
<td>10</td>
<td>60</td>
<td>100</td>
</tr>
</tbody>
</table>
Psychological abuse is better than physical assault/abuse

Marriage is a private affair between man and wife

Source: Fieldwork 2007

From group discussions, the participants’ beliefs and opinion were similar on most of the issues discussed, save for the view that the family ought to be a “private sphere under male control, for which the group of women leaders responded in the affirmative, citing religion and tradition to support the view. The adolescent girls’ focus group and one of the women’s focus groups were also of the opinion that marriage should not be a private affair between a man and his wife; the couple, especially the wife, should be in a position to consult and share so as to improve on the marriage. The two groups also felt that GBV is not strictly an outcome of patriarchy; substance abuse, jealousy and insecurity are other factors that contribute to the violence. The two groups also concurred on the issue of sexual relations; the adolescent girls said that the contemporary culture exposes children to matters of sexuality at an early age. The girls’ groups also refuted the idea that men are supposed to initiate sex, since women are supposed to be sexually naive, citing the ever rising incidences of teen pregnancies, especially those that involve girls who everyone had presumed to be “innocent”.

4.3.2 Table 4: SUBJECTIVE EXPERIENCES, BELIEFS, ATTITUDE AND PRACTICES

<table>
<thead>
<tr>
<th>EXPERIENCE OF VIOLENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why violence against women and girls happens</td>
</tr>
<tr>
<td>Women and girls are perceived to be weak</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incidences of violence experienced or witnessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnessing of domestic violence</td>
</tr>
<tr>
<td>23.5%</td>
</tr>
<tr>
<td>Physical</td>
</tr>
<tr>
<td><strong>Sexual harassment: Incidences experienced</strong></td>
</tr>
</tbody>
</table>
### At School
- Neighbourhood: 65%
- In Church: 29.5%
- Public Places: 71%
- By Next-Of-Kin: 23.5%
- By Peers: 65%
- None: 6%

### Avoiding sexual assault: precautions
- Avoid isolated spots when on your own: 23.5%
- Avoid alleys and unlit streets: 11.75%
- Talk to people you do not know well in public places: 17.5%
- Walk in the company of others: 29.5%
- All afore-mentioned precautions: 35%

### BELIEFS, ATTITUDE AND PRACTICES

#### Career versus family
- Career: would not like education go to waste: 46.7%
- Family: not to delay the joys of motherhood: 13.3%
- Strike a balance between the two: 33.3%
- Upbringing and behavioural history will determine choice: 6.7%

#### Personal attributes in choosing an intimate partner
(17 girls responded; they ranked the attributes; frequencies are presented for choices 1 through 3)

<table>
<thead>
<tr>
<th>Faithful, Trusting</th>
<th>Feelings of love</th>
<th>Kind, Supportive</th>
<th>Finances, Success</th>
<th>Honesty, Openness</th>
<th>The person's</th>
<th>Source: Fieldwork 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>8</td>
<td>2</td>
<td>5</td>
<td>8</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2nd</td>
<td>3rd</td>
<td>1st</td>
<td>2nd</td>
<td>3rd</td>
<td>1st</td>
<td>2nd</td>
</tr>
</tbody>
</table>

4.3.3 Table 5: GENDER BASED POWER OF GBV SURVIVORS

<table>
<thead>
<tr>
<th></th>
<th>%</th>
<th>%</th>
<th>Total Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living with in-laws</td>
<td>Yes</td>
<td>53.5%</td>
<td>46.5%</td>
</tr>
<tr>
<td>Choice of husband</td>
<td>Yes</td>
<td>77%</td>
<td>23%</td>
</tr>
<tr>
<td>Age difference between spouses</td>
<td>Small</td>
<td>54%</td>
<td>46%</td>
</tr>
<tr>
<td>Education difference with husband</td>
<td>Small</td>
<td>46.5%</td>
<td>53.5%</td>
</tr>
<tr>
<td>Wife's ability to acquire information</td>
<td>Autonomous</td>
<td>46.5%</td>
<td>53.5%</td>
</tr>
</tbody>
</table>
Almost all GBV survivors were in agreement that living with in-laws sometimes limits the wife’s decision-making ability and degree of autonomy. It also opens her to psychological and emotional abuse by the in-laws. Forced or arranged marriages are against a woman’s or a girl’s right to choose her partner, and make her more vulnerable to abuse by the partner she did not know. These are issues of gender based power, which allows the husband’s immediate family or next-of-kin to live with the couple.

The adolescent girls’ focus group also brought up the issue of gender based power as they discussed why current AIDS control efforts largely fail to stem the epidemic in women and girls and cited sexual violence as being one of the reasons that make girls and young women to be more vulnerable to HIV infection. The girls felt that boys are socialized to believe that being macho involves multi-partnered sexual relationships; this results in unfaithful partners who abuse and exploit the trust and naivety or innocence of young girls. Another factor contributing this negative outcome is that women have limited control of property and other resources, which forces some women to turn to commercial sex for a livelihood. Men also take advantage of the situation by sexually exploiting economically vulnerable women even in exchange of services which are the women’s right. The other main factor is lack of policy framework to provide schools with specially trained female teachers to help protect girls/children from abuse, especially child sexual abuse, and regulation in the job market to protect female employees from sexual harassment/exploitation by male colleagues at their workplace.

### Table 6: SUBJECTIVE EXPERIENCES OF GBV SURVIVORS

<table>
<thead>
<tr>
<th>Experiences of violence before 16 years of age</th>
<th>Within the family</th>
<th>By strangers</th>
<th>By peers</th>
<th>Other</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>36.7%</strong></td>
<td><strong>6.7%</strong></td>
<td><strong>13.3%</strong></td>
<td><strong>3.3%</strong></td>
<td><strong>40%</strong></td>
<td></td>
</tr>
</tbody>
</table>
# Experiences of violence since attaining 16 years of age

<table>
<thead>
<tr>
<th></th>
<th>By intimate partner</th>
<th>By strangers</th>
<th>By next-of-kin</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>56.7%</td>
<td>33.3%</td>
<td>26.7%</td>
<td>13.3%</td>
</tr>
</tbody>
</table>

## Type and incidence of abuse/violence

<table>
<thead>
<tr>
<th>Type of Abuse/Violence</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td>70%</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>76.7%</td>
</tr>
<tr>
<td>Psychological/Emotional</td>
<td>53.3%</td>
</tr>
<tr>
<td>Economic abuse</td>
<td>56.7%</td>
</tr>
<tr>
<td>None</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

## Type of Reproductive Health complication/chronic condition

<table>
<thead>
<tr>
<th>Type of Condition</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical trauma</td>
<td>60%</td>
</tr>
<tr>
<td>Reproductive Health Complications</td>
<td>56.7%</td>
</tr>
<tr>
<td>Psychological trauma</td>
<td>43.3%</td>
</tr>
<tr>
<td>None</td>
<td>10%</td>
</tr>
</tbody>
</table>

## When the Reproductive Health complication was first noticed

<table>
<thead>
<tr>
<th>When First Noticed</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 2 years ago</td>
<td>57%</td>
</tr>
<tr>
<td>5 - 10 years ago</td>
<td>38%</td>
</tr>
<tr>
<td>15 years ago</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: Fieldwork 2007

While discussing behaviour experienced, almost all GBV survivors noted that their intimate partners used to express verbal and physical intimacy at the onset of the relationship, pointing out that such appreciation ceased after the birth of the first or the second child. Cessation of such appreciation was accompanied by more restriction of movement and association:

- 74% of the respondents, for example, have to consult partner before accessing health care. Many women said that their intimate partners have a say on their employment status, and that they are made to account for money they earn.
- 82% of the respondents said that they are or have been forced by their intimate partner to have sex without consent; most said they acquiesce to diminish violence, as their spouses see nothing wrong with that.
- Up to 75% of the respondents reported that they do or have experienced psychological, emotional and economic violence by their intimate partner. Some of the experiences they cited include: threats of abandonment; being confined to the home; being put under surveillance; being issued with threats that custody of children will be taken away; destruction of objects of sentimental value; being constantly subjected to verbal aggression and humiliation; and being denied finances to meet cost of purchase of food and basic needs.
### Table 7: CASE STUDIES: EXPERIENCE AND CONSEQUENCE OF GBV

#### ADULTS’ SUBJECTIVE EXPERIENCES

<table>
<thead>
<tr>
<th>Conjugal Fidelity</th>
<th>Economic Abuse</th>
<th>Psychologic Abuse/Emotional Abuse</th>
<th>Abuse by In-laws</th>
<th>Bigamy</th>
<th>Denied Access to Children</th>
<th>Physical Abuse/Assault</th>
</tr>
</thead>
<tbody>
<tr>
<td>46.7%</td>
<td>26.7%</td>
<td>53.3%</td>
<td>20%</td>
<td>13.3%</td>
<td>13.3%</td>
<td>80%</td>
</tr>
</tbody>
</table>

#### Further Violation of Rights

<table>
<thead>
<tr>
<th>Locked out of Matrimonial Home</th>
<th>Curtailed Movement/Social Associations</th>
<th>Expectant Boyfriend Turns Out to be Married</th>
<th>Expectant Jilted for Not Aborting</th>
<th>Denied Documents of Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.7%</td>
<td>33.3%</td>
<td>6.7%</td>
<td>6.7%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

#### Abuses That Started before 18 Years of Age

<table>
<thead>
<tr>
<th>Married as a Minor</th>
<th>Taken From Rural Home, Employed as a Minor</th>
<th>Forced Marriage as a Minor</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.3%</td>
<td>6.7%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

#### Associated Trauma/Complications

<table>
<thead>
<tr>
<th>Contracted HIV</th>
<th>Premature Deliveries</th>
<th>Depression</th>
<th>Unceasing Migraine</th>
<th>Constant Physical Pain</th>
<th>Drug and Alcohol Dependency</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.7%</td>
<td>6.7%</td>
<td>6.7%</td>
<td>6.7%</td>
<td>6.7%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

#### MINORS’ SUBJECTIVE EXPERIENCES

<table>
<thead>
<tr>
<th>Gang-Rape</th>
<th>Physical Abuse</th>
<th>Forced Prostitution</th>
<th>Defiled</th>
<th>Aggravated Assault</th>
<th>Child Labour</th>
<th>Emotional Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>22.2%</td>
<td>11.1%</td>
<td>11.1%</td>
<td>66.6%</td>
<td>11.1%</td>
<td>22.2%</td>
<td>11.1%</td>
</tr>
</tbody>
</table>

#### Associated Complications and Further Violations

<table>
<thead>
<tr>
<th>Urinary tract infection; Syphilis</th>
<th>Infected with HIV</th>
<th>Arrested on trumped up charges</th>
<th>Attempted suicide</th>
<th>Pregnancy terminated</th>
<th>Caesarian delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1%</td>
<td>22.2%</td>
<td>11.1%</td>
<td>11.1%</td>
<td>11.1%</td>
<td>11.1%</td>
</tr>
</tbody>
</table>
4.3.6 Table 8: FACTORS THAT COULD HAVE LED TO VIOLENCE

<table>
<thead>
<tr>
<th>Factors</th>
<th>Yes %</th>
<th>No %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control of the partner's liberty/movement/visiting friends</td>
<td>92</td>
<td>8</td>
</tr>
<tr>
<td>Distribution of property and goods/services among family members including next of kin</td>
<td>83.3</td>
<td>16.7</td>
</tr>
<tr>
<td>Issues related to children support and up bringing</td>
<td>85</td>
<td>15</td>
</tr>
<tr>
<td>Being forced to fulfill the physical needs of the husband without regards of a woman's RH concerns</td>
<td>83.3</td>
<td>16.7</td>
</tr>
<tr>
<td>Financial autonomy for working wives</td>
<td>87</td>
<td>13</td>
</tr>
<tr>
<td>Alcohol/substance abuse</td>
<td>93</td>
<td>7</td>
</tr>
<tr>
<td>Destination of the man's income</td>
<td>92</td>
<td>8</td>
</tr>
<tr>
<td>Conjugal fidelity</td>
<td>92</td>
<td>8</td>
</tr>
<tr>
<td>Contraceptive use</td>
<td>79</td>
<td>21</td>
</tr>
<tr>
<td>Initiating sex</td>
<td>84</td>
<td>16</td>
</tr>
</tbody>
</table>

Source: Fieldwork 2007

The men's views on probable causes of violence in the household were markedly different from those of the GBV survivors. For example, whereas almost all the women cited control of their liberty/movement/visiting of friends by their partners; none of the men saw that as being an issue. The same applied for the issue of destination of the man's income; almost all the women cited disagreement over the issue as being one of the factors contributing to domestic violence, yet only one of the men acknowledged that the issue could contribute to violence. The views also differed on the issues of conjugal fidelity; woman's willingness/ability to fulfill domestic chores; and on the issue of a wife raising controversial issues with her husband over in front of friends/family.

The men were also asked to give comments on discordant couples, especially the problems that would affect such a couple where the wife is infected and the husband is not, and vice versa. Half the men felt that there would be more problems where the wife is infected and the husband is not, although such problems would be minimal if husband and wife got tested and discussed the way forward together. One of the men said that a discordant couple is bound to experience a lot of problems, regardless of which of the partners is infected, while the fourth felt that although gender...
based power can help an infected man protect his wife from infection, it would work against him where the wife is infected and he is not.

4.3.7 Table 9: CONSEQUENCES OF THE REPRODUCTIVE HEALTH COMPLICATIONS

<table>
<thead>
<tr>
<th>Time spent in seeking medication, or lost due to being incapacitated</th>
<th>Not affected by any serious complication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between 2 weeks and over 1 year</td>
<td>86.7%</td>
</tr>
<tr>
<td></td>
<td>13.3%</td>
</tr>
</tbody>
</table>

Impact on Income Generation and Family Welfare

<table>
<thead>
<tr>
<th>Met cost of immediate medical needs</th>
<th>Yes 37.5%</th>
<th>No 62.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner supportive in accessing healthcare</td>
<td>Yes 20%</td>
<td>No 80%</td>
</tr>
<tr>
<td>Lost job or business as a result of abuse</td>
<td>Yes 58%</td>
<td>No 42%</td>
</tr>
<tr>
<td>Children’s academic performance affected</td>
<td>Yes 93%</td>
<td>No 7%</td>
</tr>
</tbody>
</table>

How The Violence Affected The Respondents’ Children

<table>
<thead>
<tr>
<th>Bad Grades</th>
<th>Repeated a Class</th>
<th>Out of School</th>
<th>Health Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>20%</td>
<td>46.7%</td>
<td>13.3%</td>
</tr>
</tbody>
</table>

Source: Fieldwork 2007

4.3.8 Table 10: THE EXPERIENCE OF ACCESSING REPRODUCTIVE HEALTH SERVICES

<table>
<thead>
<tr>
<th>Had information on where to access Reproductive Health services</th>
<th>Yes 40%</th>
<th>No 60%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faced constraints while accessing the Reproductive Health services</td>
<td>Yes 92%</td>
<td>No 8%</td>
</tr>
<tr>
<td>Partner was supportive in access to Reproductive Health services</td>
<td>Yes 22%</td>
<td>No 78%</td>
</tr>
<tr>
<td>Respondent had the time to attend to her health needs</td>
<td>Yes 66.7%</td>
<td>No 33.3%</td>
</tr>
</tbody>
</table>

Factors That Deterred Respondent From Attending To Her Health Needs

<table>
<thead>
<tr>
<th>Transport costs</th>
<th>Time to travel to clinic</th>
<th>Long queues at clinic</th>
<th>Other factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>54%</td>
<td>25%</td>
<td>18%</td>
<td>23.3%</td>
</tr>
</tbody>
</table>

How respondent gauges the treatment of women and girls by

<table>
<thead>
<tr>
<th>The Police</th>
<th>The judiciary</th>
<th>Reproductive Health Service Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insensitive</td>
<td>Sensitive</td>
<td>Insensitive</td>
</tr>
<tr>
<td>70%</td>
<td>30%</td>
<td>46%</td>
</tr>
<tr>
<td>54%</td>
<td>46%</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sensitive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>84%</td>
</tr>
</tbody>
</table>

55
During the focused discussions, all the groups acknowledged the fact that sexual and reproductive health services available are either too few or cost-prohibitive and that GBV survivors usually lack information as to where such services can be accessed. Even where such information exists, many women can hardly access it because of the mode of dissemination, or for lack of time. The groups acknowledged that because of poverty, women do not have the time to attend to their health needs they are busy taking care of their reproductive and productive roles. Poor households rarely have a "medical float" and need every penny they can earn; thus poor women lack the means and the time to attend to their Sexual and Reproductive Health needs. Economic dependence, lack of decision-making capacity, and the role of managing the home impact negatively on women's sexual and reproductive health concerns. Where healthcare facilities are not within walking distance, transport costs, the time taken to travel thereto and long queues at poorly staffed public health facilities deter many women from following up on Sexual and Reproductive Health concerns.

The notion of the family as a private institution works against effective service provision for GBV survivors as it at times results in insensitive treatment by the police and other service-providers. Feedback about any insensitive experience gets to other women, discouraging them from following up on GBV-related incidences. The participants were also of the idea that systems based on patriarchal beliefs do not appreciate or remunerate the biological roles of women, resulting in failure to adequately plan for Women's Special Needs (arising from biological differences) as a separate and different category from General Development Needs. As it is hard for men to understand women's issues fully, there should be support affirmative action so that more women would be represented at decision-making levels. The respondents felt that men ought to play a more visible role in supporting women's sexual and reproductive health rights to lend a male dimension to proactive GBV-related strategies.

The sub-population of key informants comprising Reproductive Health service providers also spoke of noticing a link between a GBV survivor's level of education/self-esteem, level of income, and her ability to seek treatment for reproductive health problems she is suffering from. The Reproductive Health service providers also made the researcher aware that many of WRAP's clients are from informal settlements and poor households, with most of them being totally dependent on their male partners for upkeep. They get to realize that they are married to an abusive partner when the relationship has already failed, and also when they also have children; they then do not know how,
or have the means to plan for a new life; some may not even know whether and how to act on experiences of GBV from an intimate partner.

4.3.9 GBV Intervention Strategies

From the women's group discussions, it emerged that removal of a woman/child from a situation of violence to a place of safety (usually a colleague's house) is the priority in the event of any incidence of GBV. Seeking medical attention for the victim and undertaking other appropriate interventions, including involvement of the police (depending on the gravity of the incidence) is the next concern during interventions. Most of the cases usually end with reconciliation and mediation efforts; this is done by involving church and community leaders and the Provincial Administration. The GBV survivors saw the need of sensitizing the entire community on GBV and steps to take in the event of GBV; the men also concurred on this in that they proposed that communities should form committees to sensitize men on women's rights and advice and inform people on GBV prevention and intervention.

The sub-population of key informants representing RH service providers also concurred with the need of mobilizing communities to form community-based GBV intervention groups, and then building the capacity of such groups. WRAP, for example, has helped establish community-based GBV-intervention groups, which have then been empowered with information on the steps to take in the event of any GBV incidence. The groups have been furnished with contacts of relevant service providers, to whom they can refer GBV survivors, and have been guided into establishing a working relationship with the Provincial Administration and Area Chiefs, through whom they get to summon or to arrest perpetrators of GBV (though they are encouraged to take time and establish facts before carrying out an intervention). However, such groups lack offices and resource materials to be fully effective. From clients referred to WRAP, it has been established that some committee members, especially those from low-income neighbourhoods, ask for a token so as to be of any assistance to GBV survivors. Others make the survivors to pay for their transport while escorting them referral organizations. This places an extra burden on GBV survivors as they try to access SRH services.

The following table, compiled using information gathered from the client records, shows how the clients came to know of, and to access GBV-related supportive services from WRAP.
Table 11: REFERRAL OF CLIENTS TO WRAP

<table>
<thead>
<tr>
<th>GBV Survivors Adults:</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NWH</td>
<td>Area Chief</td>
<td>Media House (Radio)</td>
<td>Partner Organizations</td>
<td>Others (Peers, Strangers, etc)</td>
</tr>
<tr>
<td>11</td>
<td>11</td>
<td>6</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>24.4%</td>
<td>24.4%</td>
<td>13.3%</td>
<td>22.2%</td>
<td>15.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GBV Survivors Minors</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provincial Administration</td>
<td>Police</td>
<td>Neighbours; VCO’s</td>
<td>Area Children’s Officer</td>
<td>Partner Organizations</td>
</tr>
<tr>
<td>22.2%</td>
<td>22.2%</td>
<td>11.1%</td>
<td>11.1%</td>
<td>33.3%</td>
</tr>
</tbody>
</table>

Source: Fieldwork 2007
CHAPTER FIVE
DISCUSSION OF FINDINGS

5.1 Introduction
As prevention is one of the most effective ways of eliminating GBV, (Okumba et al, 2005 pp 81) a holistic approach to GBV prevention, involving proactive primary prevention programmes that will target the root causes identified by sensitizing and building capacities of communities; and supportive secondary and tertiary prevention programmes involving coping mechanisms for survivors that will address their immediate and their long-term needs to be adopted. Discussion of the findings was done towards such an end, and relative to the research objectives and research hypotheses. The findings were also interpreted relative to the theoretical frameworks adopted for the study, with the researcher concluding by linking the findings of the study to previous studies carried out in the same field, and by identifying areas of research that would generate much more GBV-related information.

5.2 Causes and Consequences of Sexual and Gender-Based Violence

5.2.1. Causes of Sexual and Gender-Based Violence
During focus group discussions, patriarchy, which tends to rely on coercion or violence against women, to control women and perpetuate male domination, was mentioned by the various sub-populations as the main cause of gender-based violence. Such a system marginalizes women as it pre-supposes that men are custodians of community resources; "legitimizes male domination" in decision-making process; and proscribes patrilineal inheritance of property. Some men justify beating of wives by citing such assumptions, which have their base in religion and/or tradition. This assumption, and the consequent bias in the distribution of property and goods/services among family members results in the economic dependence of women on men, in other words the feminization of poverty, which then makes women much more vulnerable to physical, psychological, economic, emotional, and sexual violence or sexual exploitation. Economic dependence also compels many women to live in abusive relationships, in which stomach all manners of abuse by their intimate partners; - to that end, wife inheritance is all about control of property or resources, and nothing about fulfilling the needs of woman. Control of the woman's liberty, movement, associations and visits to or by friends are other means that a man might use to
"subdue woman", while others intimidate their spouses by issuing casual death threats, thus making the wives live in uncertainty.

As unmarried women are undermined by society, many women are forced to live in relationships that violate their rights and limit their access to such benefits and resources as may be their right. Thus, patriarchy impacts negatively on the sexual rights of women because it accords woman a subordinate position in society, as a result of which many women are not in a position to freely express their sexuality. The participants said that "fear of husbands prevents many women from expressing their sexuality". They said that it was because some of the husbands wrongly attribute their wives' expression of desire to infidelity, and that society-at-large "frowns upon women who express their sexuality"; thus a woman who initiates the process is bound to be deemed as being loose in morals. All of the four women's focus groups concurred that women sometimes acquiesce to sex even when they do not want due to economic dependence and feminization of poverty. Another reason that may make women to acquiesce to sex even when they do not want is to avoid embarrassment in front of the children.

Almost all the GBV survivors cited conjugal fidelity as being one of the factors that led to the violence they experienced. From the findings, it can be inferred that neither their marital status, nor the type of relationship were in had any bearing whatsoever on the probability of their experiencing violence from their spouses or intimate partners on account of infidelity allegations; the percentage of those in formal marriage (customary, religious or statutory) is equal to that of women "living in cohabitation" with their intimate partners.

In contrast to this view, the male participants did not view conjugal infidelity as an issue; neither did they view the issue of destination of the husband's income as probable sources of conflict in the household. They said that cultural and religious basis of polygamous unions rule out infidelity. The man is the family's breadwinner; as long as the husband provides for the family, the wife need not know the destination of her husband's income.

Based on this observation, one might conclude that men with "multiple partners" are less likely to mete out violence on women. However, from the case studies, it is evident that polygamy does not imply that the wives will live a violent-free life, neither is it a guarantee that the husband will be faithful to his wives; a fifth of the clients were in polygamous marriages, and more than a quarter of the case histories involved husbands who were either involved in bigamy, were keeping a mistress
or who were planning to marry another wife. Economic violence was also found out to be a major feature of many polygamous unions. As one client reported, the husband told her that he had married another wife, and could not provide for her as he used to. Requests for money to meet basic needs were from then on met with violence.

The findings also indicate that an early marriage will, more often than not, impact negatively on the girl's or young woman's rights and personal liberties. From reviewing WRAP client records and from responses of the GBV survivors who were married when still minors, the much older intimate partner tends to use all manners of obvert and subvert control to "keep the minor in check". These range from use of physical violence or coercion to curtailing the minor's movement and social associations; some of the older partners even ensure that the child bride does not access documents of identification when she comes of age. Besides the age of the bride, the extended family system sometimes results in the bride living amongst "hostile" in-laws, which limits the wife's decision-making ability and degree of autonomy. It also opens her to psychological and emotional abuse of the wife by the in-laws; and might sometimes result in abuse that is sexual in nature. Forced or arranged marriages are against a woman's or a girl's right to choose her partner, and make her more vulnerable to abuse by the partner she did not know. Other factors that the survivors of violence cited as being, directly or indirectly, linked with sexual violence at the intimate partner level include the issue of financial autonomy for working wives; alcohol and/or substance abuse; the issue of conjugal fidelity; or being forced to fulfill the physical needs of the husband regardless of a woman's Sexual and Reproductive Health concerns (such as coerced sex at the time her menstrual flow, or just after delivery). The GBV survivors said it would be more practical for the woman to decide on when to have sex; otherwise the man should consult with her about the appropriate days. The GBV also survivors intimated that women who are more educated, or who earn more than their spouses become vulnerable to the various forms of GBV; the man might feel that "his woman" has taken control of the house and might therefore "struggle to wrest the control from her", or even to get back at her. The sub-population sampled from the refugee community cited political problems as being another factor that leads to GBV.

Unlike the adult respondents, the adolescent girls did not view violence against women as strictly being an offshoot of patriarchy; they cited pride or ego and such factors as alcoholism; early marriage; jealousy; and such "reasons" as making mistakes; or because there is no love amongst the people; as being some of the causes of violence. Though, in effect, what they cited could be...
termed as "products of patriarchy"; men under pressure to conform to and compete in a system that advocates for male aggression/superiority turning to violence against "the vulnerable" (mostly women and children) to vent their frustration. Asked why violence against women and girls happens, most of the adolescent girls said it was as a result of men using violence as a means of controlling women; because women and girls are perceived to be weak; and because children learn violence from their parents and from some of the social norms and cultures that prescribe wife-beating. The adolescent girls' focus group was also of the view that men and boys have been socialized to believe that being macho involves multi-partnered sexual relationships. This results in unfaithful partners who abuse and exploit the trust and naivety or innocence of young girls, besides leading to increasing levels of sexual harassment and rape.

Even in educational institutions, the effect of socialization processes that make many men be ignorant of women's and girls' Sexual and Reproductive Health Rights came to fore. A teacher in an institution with girls needs to be aware of all issues that a girl is bound to encounter as she matures physically and cognitively. This, ideally, should be the case with all teachers, male and female. The male teacher chose not to make recommendations on a policy that would address provision of reproductive health services within schools. This shows the apathy that many men have towards the issue of women's Sexual and Reproductive Health Rights, despite the fact that, as fathers, they are also supposed to provide appropriate guidance to their daughters on various issues that might touch on their sexuality.

5.2.2. Consequences of Sexual and Gender-Based Violence

HEALTH COMPLICATIONS: For those respondents who reported experiencing some form of reproductive health complication or other chronic condition, the average time spent seeking medication was between 2 weeks and over 1 year for each serious incidence of violence. Reproductive health complications manifested themselves in the form of sexually transmitted and other infections such as pelvic inflammatory disease, urinary tract infections; candidiasis; an itch; syphilis; HIV; and other conditions, which were unmanaged because of lack of cooperation by the intimate partner. Some of the survivors of violence reported pain during intercourse; while a few others said violence caused them to have a miscarriage; resulted in premature delivery, or resulted in a situation whereby the respondent can only deliver by caesarian.
PRODUCTIVITY AND ECONOMIC ABILITY: Many of the survivors of violence said that they were still experiencing difficulties as a result of violence in their lives; some said that they were still on medication; while a few others said that they still spend a lot of time visiting clinics for follow up. As a result of physical trauma, several of the respondents said that they were still in pain, as a result of which some of them can not do any strenuous work. One of the respondents reported that she can not bend as a result of an incidence of aggravated assault by her spouse. More than half the respondents said that they lost a job or business, or could not participate in income-generating activities as they used to prior to the abuse.

MENTAL HEALTH PROBLEMS: Those that reported psychological trauma cited such symptoms as depression, for which one of the respondents was hospitalized; unceasing migraines; constant physical pain: attempted suicide; forced abortion; and drug and alcohol dependency, for which another respondent had been committed to a drug and alcohol rehabilitation centre. Children too were not spared; especially from the secondary effects of violence; respondents with children of school-going age reported that the children’s academic performance had been affected; while some said that the health of their children had been affected by the violence; the issue raised being more of adjustment and mental health problems than of physical trauma.

5.2.3. Linking Complications Cited to Incidences of GBV

Only a few of the GBV survivors reported that they had reproductive health and other complications prior to the assault or violation that resulted in the current medical (or other condition). Thus, almost all the survivors of violence attributed the reproductive health complications and/or other chronic condition to violence experienced at the hands of an intimate partner; only a few had been subjected to violence by strangers. Almost all of the respondents reported that they, as a result of GBV, were experiencing or had experienced some form of reproductive health complication or physical and psychological trauma. Many of the survivors of violence noticed that they had developed reproductive health complications or other chronic conditions within 2 years prior to the date of interview. The rest had become aware of the reproductive health complication around 5 to 10 years prior to the date of interview, with only a few of the respondents saying they had become aware of the complication 15 years prior to the date of interview; implying that, for some women, the negative health outcomes as a result of GBV plague them all their lives.
The complication or chronic condition cited most by the GBV survivors, either as still being experienced or as having been recently experienced, was physical trauma. In this category, a broken arm was the physical trauma cited most by the respondents, while being kicked in the belly was cited as another common form of assault. In some of the incidences, the kick sometimes affected the uterus, causing womb problems, heavy periods and backache, which then resulted in miscarriages, or in the respondent only being able to deliver through caesarian section. One respondent had a broken leg that did not set well even after medical intervention; it still troubled her. Some long-term reproductive health complications or other chronic conditions cited by the GBV survivors, and which they linked directly to violence in their lives, include pain in the back; pain in kidneys; pain on passing stool; stomach pains; womb problem; Pelvic Inflammatory Disease and candidiasis, especially when pregnant; HIV/Aids and other sexually transmitted infections; painful sex (making one to be scared of sex); pain on passing urine, especially if held for too long; pain at start of each menstrual cycle; and severe pain under right breast (experienced for a long while, but not yet examined by a physician on account of finances). Many respondents said they were traumatized psychologically and emotionally by the experiences endured, with one respondent being hospitalized for some time on account of stress.

5.2.4. Linking Sexual and Gender-Based Violence to HIV Infection

Apart from women’s vulnerability to HIV infection due to their inability to negotiate safe sex with intimate partners, women’s and girls’ vulnerability to HIV infection is further compounded by sexual violence and child sexual abuse. Intervention involving minors who have undergone child sexual abuse, in particular, poses some unique challenges. One amongst child client histories that were reviewed best sums up the relationship between sexual violence, sexual behaviour and HIV infection. This was an on-going court-case involving the defilement of a minor that was about to be dismissed by the court at the time the research was being undertaken. The minor, going to 14 years of age then, kept on running away from home and, as a consequence, usually ended up not being there for hearings. Her HIV status was positive, though the HIV status of the man who defiled her on 3 separate occasions was negative. It is therefore presumed that she was infected thereafter; ... elsewhere. Such behaviour, which is usually associated with victims of child sexual abuse, not only makes the risk of unwanted pregnancies and contracting sexually transmitted infections higher, but it sometimes affects the quest for justice on behalf of the minor, and also impacts negatively on her being able to benefit from supportive services open to GBV survivors.
5.3 Socio-Economic Factors That Determine Access to Sexual and Reproductive Health Services

5.3.1. Services Available to GBV Survivors
As many GBV survivors lack information as to where to access reproductive health services in the event of violence, they end up assuming that they can not meet medical costs, unaware of that there are various hospitals and health facilities that provide free services to survivors of violence. Public hospitals like Kenyatta National Hospital and other government hospitals, including dispensaries and clinics that are run by local authorities do provide free or affordable healthcare for survivors of GBV. However, the long queues at such health facilities, many of which are understaffed, many from following up on Sexual and Reproductive Health concerns. The GBV survivors felt that reproductive health services in the country might not be adequate, as it is only Nairobi Women's Hospital that specifically addresses GBV. Most of the respondents cited such civil society organizations as WRAP and other "like-minded organizations" as being the "service provision outlets" that many women prefer, as they include programmes that, besides counseling of the traumatized, also provide medical and legal assistance; safe alternative accommodation; mediation services; and resettlement and re-integration. However, the capacity and reach of such organizations is limited.

5.3.2. Constraints Faced in Accessing Reproductive Health Services
Almost all the survivors of violence reported facing various constraints while trying to access reproductive health services. More than half the respondents did not have the information as to where reproductive health services can be accessed at their first experience of intimate partner violence. Apart from lacking information as to where reproductive health services can be accessed, distance was the other major constraint that was cited by most of the participants; there are not many service provision outlets within the informal settlements, thus GBV survivors must be able to meet transport costs, besides meeting the cost of medical consultation and drugs. Survivors of violence from poor households hardly have "medical floats" or monies for other emergencies. Security concerns also affect access to health services at night, more so within the informal settlements. Other constraints cited include lack of support from the intimate partner, and the fact that taking care of the children is a mother's priority, even when violence occurs. Being from poor
households, the GBV survivors reported that sometimes a woman might be too busy struggling to eke a living or struggling to provide for the family, especially when physical violence is accompanied by economic violence. Some women said that since society tends to blame women for failed marriages, victims of violence might be too busy trying to preserve their marriage by trying to seek mediation, thereby ignoring some of their Sexual and Reproductive Health needs.

5.3.3. Effect of Poverty on Access to Reproductive Health Services

All respondents, especially the sub-population comprised of survivors of violence, were from poor households. Besides reporting that service-provision outlets are few, especially in informal settlements, the GBV survivors also cited other constraints affect women's and girls' access to reproductive health services, including lack of support from male intimate partners; transport costs; the cost of medical consultation and drugs; and for the reason that taking care of the children is a mother's priority. They also said that that at the first experience of violence, many women do not know what to do; lack of information about the steps to take in the event of GBV leaves many survivors of violence unsure as whether to report GBV-related incidences that involve intimate partners or whether to just let them go.

This should not be taken to mean that women and girls from non-poor households are exempt from the experience or violence, or of violation of their rights; background information from reviewing client records at WRAP shows that majority of the GBV survivors whose cases were under study are from non-poor households (all from Nairobi, but one from another urban town). Therefore it cannot be said that GBV is caused solely by poverty. However, feminization of poverty and women's limited control of property and other resources increases their vulnerability to abuse from male intimate partners. Women from poor households and from female-headed households for example, have to toil every day for little pay to provide for their families; they rarely have anything left for savings, such that when violence occurs, there is no "medical float" to help meet immediate medical needs for the survivors of violence. The hand-to-mouth existence also leads to situations whereby women rarely have the time to attend to Sexual and Reproductive Health needs.

The GBV survivors cited long queues at public/government hospitals and the various understaffed health facilities where persons from poor households to access "affordable healthcare" as being a deterrent to many women from poor households who want to access Reproductive Health services. Poverty also affects a woman's ability to acquire information due to limitation in time; lack of
service provision outlets within the informal settlements; and due to lack of access to resource material, resource persons or resource centres. Socio-economic factors also impact on women's ability to act on such information as regards use of Reproductive Health services; women generally lack the money to cater for transport costs, and the cost of medical consultation and drugs.

The Reproductive Health Service Providers said that they had identified low levels of education and/or self-esteem as some of the factors that hinder women undergoing abuse and other rights violations from expressing themselves clearly enough for an effective solution to their problems to be identified. On the other hand, women leaders said that lack of information is a major constraint to women's access to Reproductive Health services during their focus group discussion. In their view, even where information exists, many women can hardly access it because of the mode of dissemination, or for lack of time; which implies that some of the information disseminated might not be easily understood by persons with low levels of education.

Even though most respondents reported that time was not an issue when it came to accessing healthcare, they said that the reverse applies when violence occurs; survivors hardly have the money to seek medication – poor households do not have "medical floats" or monies for other emergencies; thus survivors of violence might be too busy struggling to eke a living or providing for the family, or they might even be busy trying to preserve their marriage by trying to seek mediation, thereby ignoring some of their Sexual and Reproductive Health needs.

### 5.3.4. Other Factors That Limit Access to Reproductive Health Services

Though trends are changing, many women are still economically dependent on their spouses. However, as poor households "need every penny they can earn", the woman joins her spouse in struggling to provide for the family. Women from female-headed households said they have to toil every day for little pay to provide for their families and rarely have savings. As a result of this, many women lack the time to attend to their RH needs. Woman's lack of decision-making capacity, from the household level to the societal level, and the socialization processes that see her solely managing the home without any "recognition", also impact negatively on women's Sexual and Reproductive Health concerns.

Respondents said that the Police and many other service providers have yet to be sensitized on women's issues, especially the issue of GBV survivors, because feedback about any insensitive experience gets to other women, discouraging them from following up on GBV-related incidences.
The participants also cited patriarchy within most socio-economic and politico-legal systems as being an obstacle to meeting the sexual and reproductive health needs of women, as it is the reason why decision-making and policy-formulation organs do not appreciate or remunerate the biological roles of women and, as such, do not adequately address women specific development needs while planning for service provision.

5.4 Linking Findings to Theoretical Frameworks

“Feminization of poverty” is more than lack of (access to and control over) resources; it is a manifestation of exclusion and powerlessness, resulting in unfulfilled needs and wants; Sexual and Reproductive Health related needs being the focus of the study. Therefore, adopting a Pro-Poor Approach to the study which, appropriately, should be based on the Human Rights Framework, would be ideal in a study that involves exclusively women since a number of their human rights remain unfulfilled, such as the right to food, health, education, information, participation, and such others are not guaranteed for many women; their rights are, at times, subject to the whims of their male partners. However, the approach requires baseline survey involving such indicators as those earning less than a dollar a day; those spending more than 70% of their income on food; etc, which was beyond the scope of the study. The researcher thus opted to focus more on the Gender Analytical Framework in analysing the findings of the study. Out of the various approaches to the Gender Analysis Framework, the Longwe or Women’s Empowerment Framework was adopted. As the Women’s Empowerment approach has a limitation - it does not take into account women’s biological roles and the “unrecognized role they play in family, child, and community welfare” – the researcher also referred to the Moser or DPU Framework and the Social Relations Approach to make up for the limitation.

5.4.1 Ignorance of Sexual and Reproductive Health Rights

Whereas the questions posed did not directly link respondents’ ages to ignorance of one’s Sexual and Reproductive Health Rights, the sub-population of key informants comprising Reproductive Health service providers spoke of noticing a link between a GBV survivor’s level of education/self-esteem, level of income, and her ability to seek treatment for reproductive health problems she is suffering from. As close to a fifth of the GBV survivors had not received any education (contrary to the right to education), and half of them had not gone beyond the Primary School level, it can be indirectly inferred that low levels of education may contribute to ignorance of Sexual and
Reproductive Health Rights, resulting in situations in which GBV survivors are not able to effectively follow up on their Sexual and Reproductive Health needs, especially given that almost half of the respondents were unaware that they suffered from a condition could be successfully treated.

Over half the respondents reported that they did not have information (contrary to the right to education) as to where and Reproductive Health services for GBV survivors can be accessed. Some got such information from their mother/parents or next-of-kin; others went to the nearest health centre, from where they got relevant advice and appropriate referrals. A quarter of the sub-population of community members (men) was uneducated and only one had attained education to a grade equivalent to Form IV. Their views were largely shaped by cultural and religious influence; only the younger member of the sub-population gave views that were more reflective of the "cosmopolitan or contemporary culture". The views of the adolescent girls, however, were more proactive in relation to those of the adult participants; they felt that there exists a need for women to share ideas and to seek relevant information, so as to avoid abuse. The adolescents also annulled the statement that the family is a "private sphere" under male control, saying; "Abuse within the family, especially of children, should be reported to the police, in accordance with the law". The girls felt that information technology; and the media have led to a change in gender perceptions; however, they expressed the need for incorporating sex education in schools' curricula to dispel ignorance on reproductive health issues.

5.4.2. GBV Relative to a Rights-Based Framework

The analytical framework of a rights-based approach aims to capture the root causes of the perpetuation of poverty, exclusion, discrimination and power relations that sustain inequity, as they all impact negatively on women's reproductive rights and health. Patriarchy affects such diverse human rights for women as the right to work, property rights, freedom of movement and association, and various others. The system also impacts negatively on women's sexual and reproductive health rights. Sexual and reproductive health rights include the right of all persons, free of coercion, discrimination and violence to...; here one must pause on realizing the subsequent rights are based on the absence of coercion, discrimination and violence in one's life. This implies that most women do not enjoy the full extent of their sexual and reproductive health rights as they experience varying extents of coercion, discrimination and violence in their lives. The
sexual and reproductive health rights are listed below, with instances cited from the responses of the GBV survivors showing how each is violated:

The right to the highest attainable standard of sexual health, including access to sexual and reproductive health care services: Reproductive health complications as a result of GBV manifested themselves in the form of sexually transmitted and other infections such as pelvic inflammatory disease, urinary tract infections; candidiasis; an itch; syphilis; HIV; and other conditions, which were unmanaged because of lack of cooperation by the intimate partner. While factors such as economically dependence; lack of time to attend to their reproductive health needs; lack of decision-making capacity; management of the home without any “recognition; not having “medical floats” or monies for emergencies; having lower levels of education and/or self-esteem relative to men; lack of information on sexual and reproductive health; and lack of support from male intimate partners all impact negatively on women's access to sexual and reproductive health care services.

- The right to seek, receive and impart information related to sexuality: The above-mentioned factors also impact negatively on women’s access information related to sexuality
- The right to sexuality education: Same factors apply
- The right to respect for bodily integrity: physical violence or coercion, curtailing of movement and social associations; same factors as above-mentioned apply.

5.4.3. GBV Relative to Gender Analytical Frameworks

Analysis of the findings relative to the Gender Analytical Frameworks is more “remedial”, as it identifies practices that create gender gaps in reproductive health rights, and proposes the way forward towards guaranteeing access to sexual and reproductive health services as being adoption and promotion of practices that will enhance gender equity and equality.

Women's/Longwe Empowerment Framework: two “variables” were isolated to help interpret the findings; these are gender inequities arising from gendered division of labor, and gender inequities arising from the allocation of benefits and resources.

GENDERED DIVISION OF LABOR: Almost half the sub-population of GBV survivors was unemployed; the rest are either self-employed or seek for casual work. The effects of gendered division of labour affect most of the respondents, especially where the woman has to generate
income to support the family, besides attending to household chores and taking care of children. The primary effect is lack of time or of the money required to join self-help groups (which are a means towards the social and economic advancement of women).

Gendered division of labour also affects decision-making: *culture gives man the prerogative, as the head of the family, to make decisions on all issues touching on the family.* This gives rise to situations in which the social and Sexual and Reproductive Health needs of the wife are compromised, especially when the husband controls movement, associations and visits to or by her friends. Most of the respondents said that they have to seek permission from their spouses whenever they had to access Reproductive Health services. Lack of decision-making for women in intimate partner relationships also impacts negatively on matters that might touch on such Sexual and Reproductive Health Rights of women as birth control. Gendered division of labour allocates the responsibility of taking care of children to women; which gets frustrating when husbands fail to provide for the children knowing well that their wives are economically dependent on them.

ACCESS TO BENEFITS/RESOURCES: Gender inequities in access to and control over resources have resulted in the economic dependence of many women on men. Patrilineal inheritance of property and the belief that a husband should be the family’s sole breadwinner make women vulnerable to economic abuse and sexual exploitation, impacting negatively on women’s Sexual and Reproductive Health Rights. More than two-thirds of the respondents had not gone beyond the Primary School level, with quite a number not having received any education at all; patriarchal beliefs result in scarce family resources being set aside for boys’ education, and not for girls (who, as a result of which, are limited in terms of individual “assets” and “functionings”).

Besides the variables above, the findings were also analysed relative to the levels of empowerment proposed by the Women’s/Longwe Empowerment Framework:

EMPOWERMENT LEVELS: The fact that most of the survivors of violence reported using contraception behind their husbands’ backs and seeking Reproductive Health services without having to seek the consent of their spouses implies that they have, at least, attained the Access or first level of empowerment proposed by this framework. All participants were either members of self-help or other social action groups, or were aspiring to join such groups; limitation being lack of the finances required for one to join, or lack of time to attend meetings. Such groups also intervene whenever incidences of GBV occur in the community. By attending awareness creation events,
and by associating with others to help cope with the effect or threat of violence in one's life, the participants actions were in line with the **Conscientization** or second level of empowerment: motivated women by themselves realize that their lack of status and welfare relative to men is not due to their own lack of ability, organization or effort, but from the discriminatory practices and rules, which give priority, access and control to men. They then attempt to understand the underlying causes of their problems, and to identify strategies for action.

As most of these women's groups also intervene whenever a colleague is experiencing violence, the measures and steps that the participants said that they take when one of them is being subjected to violence are in line with the **Mobilisation** or the third level of empowerment, which involves women acting collectively to analyze and identify discriminatory practices; and then collectively strategizing on actions or formulating solutions to remove the discriminatory practices. There exists the need to build the capacity of women, especially those poor households and the need for affirmative action in decision-making and policy-formulating organs to help women attain the **Control** or final level of empowerment.

**Moser/DPU Framework**: the needs articulated by respondents during individual and group interviews were isolated and categorized according to the productive, the reproductive and the community management roles proposed by the framework.

**THE PRODUCTIVE ROLE** involves generation of income, directly or indirectly, to help meet personal needs and those of the children/family. The **PRACTICAL GENDER NEEDS** that would enable women to fulfill this role include access to resources; access to education; access to employment opportunities; and access to information about on-going economic empowerment programmes open to women, while the **STRATEGIC GENDER INTERESTS** that would help ensure that the practical needs are met include: the need to review Laws on matrimonial property, inheritance and succession to improve women's access to and control over property, and remove gender stereotypes and discrimination from the workplace.

**THE REPRODUCTIVE ROLE** involves giving birth to, nursing of, and being primary agents of socialization for children. The **PRACTICAL GENDER NEEDS** that would enable women to fulfill this role include free round-the-clock family planning, GBV-response, delivery and general healthcare services; information as to where reproductive health services can be accessed; and information to help promote the Sexual and Reproductive Health Rights of women, while the
STRATEGIC GENDER INTERESTS that would help ensure that the practical needs are met include: formulation of policy to help "recognize" women's biological role by, for example, introducing an economic empowerment component to antenatal services for women from poor households. The police and provincial administration should also be in a position to counsel GBV survivors, besides maintaining an account to help those from poor households and other victims of sexual assault to access justice.

THE COMMUNITY MANAGEMENT ROLE involves managing the home and being concerned about the welfare of the children, the family and the community. The PRACTICAL GENDER NEEDS that would enable women to fulfill this role include capacity-building programmes to empower women within the family institution and in the society-at-large: access to offices and resource materials for women's group meetings; and increased access to marital counselors, while the STRATEGIC GENDER INTERESTS that would help ensure that the practical needs are met include: Improved access to legal systems by persons from poor households to help with pre-nuptial agreements registration of any union between man and woman so as to safeguard the rights of both parties to the union; Affirmative actions in decision-making/policy-formulation to enable women make decisions on all issues touching on the family and the society-at-large

Social Relations Approach: development is relative to the three basic principles of survival, security, and autonomy. Some of the obstacles cited by the GBV survivors as being impediments to "achievement of human well-being" for women are discussed relative to the 3 principles.

SURVIVAL: obstacles to financial autonomy and access to health arise mainly due to women's economic dependence on male partners and/or male relatives; the notion that a husband ought to be the family's sole breadwinner; and the fact that women generally use all of their labor power to work in their homes, producing goods and services for themselves and their families without receiving a money wage directly in exchange for their labor all affect financial autonomy. Lack of financial resources to cater for the cost of medical consultation and drugs, besides transport costs; the stigma associated with GBV; lack of enabling policies, programmes and laws to inform women about existing reproductive health facilities, and that make them more accessible so that all women can benefit from them; and taking care of the children/family is a priority which impacts negatively on women's need for immediate medical attention in the event of GBV
SAFETY AND SECURITY: At the community level this includes safety from harmful traditional practices such as female genital mutilation and wife inheritance; male dominance and proprietary rights over women and girls, including control over women's sexuality; and beliefs that condition men to take wife-beating or intimate partner violence for granted; while obstacles at the societal level include the high levels of poverty in society; inequities in access to services and low quality care for the poor; patriarchy, which woman to sexual and other forms of violence by intimate partner and stranger alike; and because many women lack the time and the money required to join beneficial "social networks".

AUTONOMY (Economic and Decision-Making): Limited access to land, housing, inheritance and social to networks due to patriarchy and patrilineal inheritance of property results in feminization of poverty, and leads to situations in which a man will even control the income of his working wife. Patriarchy leads to lack of decision-making capacity by women and girls both within and without the home; the "male-oriented" culture gives man the prerogative as the head of the family to make decisions pertinent to reproductive health, economic and social issues, which limits women's autonomy to acquire information; autonomy to access and to reproductive health services; and autonomy in initiating sexual interaction.

5.4.4. Community-Based Approaches to GBV Intervention

Respondents said that women depend upon "women's networking ability" when it comes to intervening in GBV-related incidences. The priority, on getting to hear of a colleague experiencing violence, or in response to a distress call, is to remove the victim from the violent situation to a place of safety, usually a colleague's house. Medical attention is then sought for the victim, and various other appropriate interventions undertaken, including involvement of the police, depending on the gravity of the incidence. The Provincial Administration is also involved, especially when issues of custody and maintenance of children arise. Religious and community leaders, on the other hand, are involved when it comes to mediation and reconciliation. The sub-population sampled from the refugee community said that they involve the host community or the Provincial Administration in matters that are beyond their capacity to intervene. All the GBV survivors said that there was need to sensitize the entire community on GBV and on the steps to take in the event of GBV. On being asked about the GBV intervention strategies they would recommend in given situations involving violence in the household, the adolescent girls, in response to an incidence in
which a child is experiencing violence at the hands of either parent, generally recommended the involvement of police and removal of the child from the violent situation. The girls also recommended a marriage counselor as another effective conflict resolution method that is applicable for parents who are involved in a quarrel, implying that many children do not like to see their parents separating.

On the other hand, the male participants' views were "not subjective"; their general response to the issue of community-based GBV intervention strategies was that elders should intervene and advice quarrelling couples, or that couples in conflict should seek advice from friends and next-of-kin. None talked of actually rescuing the woman from the violence.

5.5 Conclusion

5.5.1. Respondents' Recommendations

The GBV survivors recommended free round-the-clock health services for women, especially concerning family planning, GBV and delivery. (One of the respondents, for example, had 8 children, who were all born in hospital at a fee, despite her being economically challenged). The participants felt that medication, right from consultation, through diagnosis and prescription, to the purchase of drugs, should be at no cost, or should be "affordable". Besides the issue of finances, the participants also recommended that information as to where support for GBV survivors can be accessed should be easily available. They also proposed the establishment of more Rescue Centres for abused women all over the country, to provide a safety net for women living with abusive spouses. The survivors of violence said that Reproductive Health Service Providers should be kind and empathic so that GBV survivors can open up. Doctors, for example, should be keen when dealing with this category of patients, and should explain any medical condition clearly, besides dispensing proper medication to patients. The Police and Provincial Administration should also be in a position to counsel and to give advice to GBV survivors, besides providing for their security needs and enforcing court orders.

As regards the Criminal Justice System, the respondents felt that the Judiciary ought to mete out stiffer sentences to perpetrators of GBV. A campaign also needs to be undertaken to sensitize and encourage the community to adopt a culture of reporting GBV incidences. The Police force should be just, and should put a stop to incidences of officers asking for physical favours from women.
before assisting them. The force should also maintain an account to help GBV survivors to access justice, especially those from poor households, and victims of sexual assault, who might have lost possessions to robbers in the process.

The participants felt that women need to be sensitized on their rights and to be guaranteed access to Sexual and Reproductive Health services; while men need to be sensitized on their responsibility in marriage. Another of their recommendations was for people to be encouraged to discuss Reproductive Health issues openly from the family and intimate partner levels to the societal levels; this would help improve women’s and girls’ access to Sexual and Reproductive Health services.

The respondents said that “the marital institution is becoming increasingly difficult to maintain”, thus, they recommended that the state should empower women within the family institution (as it is the basic unit of society). There is need for sensitize couples-to-be on the need of drafting prenuptial agreements to minimize need for GBV-related services; however, this would require improved access to legal systems by persons from poor households. Another recommendation was for increased access to marital counselors; this would help those in matrimony to identify and disregard any advice that might be detrimental to the union.

An economic empowerment component ought to be introduced to Sexual and Reproductive Health services; a policy which, besides ensuring that all women can access Sexual and Reproductive Health services, would also ensure that those trapped in abusive relationships as a result of economic dependence can move on with their lives. Women need to be empowered economically to be able afford accessing quality healthcare; therefore information about on-going economic empowerment programmes and/or options open to women should be readily available at the grassroots level.

The sub-population of key informants comprising teachers recommended that policy be formulated, which will address Sexual and Reproductive Health needs and the issue of teen pregnancies within schools {anyone impregnating a girl to be fully responsible for the maintenance of mother and child, with provisions to guide cases where both parents-to-be are minors}, and the needs of other vulnerable children at all levels; policy which will incorporate sex education in schools’ curricula from class one onwards and establish a code of conduct for male teachers in girls’ schools {male teacher said Girl–Male relationship is wanting in many public schools: Girls mature earlier than boys and are more psychologically affected when they get to adolescence, some wanting to
challenge their teachers); and policy which will provide the framework for effective Adolescent Development Programmes in schools (guidance and counselling of adolescents requires a lot of commitment and patience yet teachers with the skills are few, besides which they are also involved in academic tuition).

5.5.2. Relationship to Previous Research

As the participants were mainly from informal settlements and poor households with limited access to resource materials needed to increase their awareness on GBV and Sexual and Reproductive Health-related issues, the questionnaires were structured so as also to provide information to participants, with the issues raised by the question and the various statements being drawn from literature review or from the findings and conclusions of various studies done on the same and/or associated areas of research.

The findings of this study were consistent with such findings and conclusions, the only difference being in the trends of some of the statistics generated by the research. The difference can be attributed to the fact that most of the studies that were referred to while reviewing literature involved a "general sample" of women from various neighbourhoods, whereas for this study, the women who participated were sampled mostly from GBV survivors who had sought various services from WRAP within a period of 6 months to 1 year before the study was undertaken; the focus being to establish the extent of long-term Sexual and Reproductive Health complications and other unmet Sexual and Reproductive Health needs of women and girls who have experienced violence in their lives.

5.5.3. Implications for Further Research

There exists the need to examine how such factors as experience of violence in childhood, socio-economic status (SES), education, income, faith, culture, age, and various others come to play at the individual, the community and the societal levels. This would help to establish specific influences by various cultural and social norms of Kenya's various communities on gender perceptions. Another important area of research would be to examine the cost-effectiveness of community-based GBV interventions that used to be, or which are still applied to mitigate the effects of gender based violence.
Studies could also focus on analysing feedback from the rural setting; from culturally conservative communities; and from residential areas not yet sensitized on women’s Sexual and Reproductive Health/GBV. Such studies would help identify entrenched traditions, practices and stereotypes that have a negative impact on women’s Sexual and Reproductive Health Rights, at the same time highlighting best practices that protect and promote various rights of women. Findings of the studies would not only be useful in forming or in strengthening existing community-based GBV intervention strategies, but could also be used in advocacy. Research-based advocacy would help shape policy, resulting in such law and policy changes as would guarantee every woman’s and every girl’s access to Sexual and Reproductive Health services.

Data from hospitals, especially such hospitals as deal with GBV cases like the Nairobi Women’s Hospital, would help generate data on the extent of long-term Sexual and Reproductive Health complications the in-patients suffer or are likely to suffer as a result of GBV. Collaborative research ought to be done with such institutions, to work out modalities of how to generate such data without compromising the Hippocratic Oath, ethics or doctor-client confidentiality; while longitudinal and tracer studies would help examine, for example, how various programmes aimed at sensitizing children and adolescents on gender issues (both boys and girls) would impact on women’s and girls’ SRH rights, and on conflict resolution in intimate partner relationships.

At the individual level feedback on the issue of women’s Sexual and Reproductive Health rights needs to be collected from men who have not been sensitized on women’s Sexual and Reproductive Health and GBV, and who work in jobs where personnel is predominantly or exclusively male. The assumption being, unabashed by the presence of female colleagues, respondents would give such views as would help identify ingrained patriarchal beliefs that impact negatively women’s and girls’ access to Sexual and Reproductive Health services and violate various of their sexual and reproductive health rights. Besides individual and group interviews, observation of behaviour and language of such work gangs (both in groups and individually) in the presence of female members of the research team would be some of the methodological approaches applicable to such a study.

Holistic collection of GBV and Sexual and Reproductive Health related data at a national level would require a multi-sectoral and multi-disciplinary approach whereby research teams/institutions
would work in collaboration with academic, public health, and other institutions, the legal sector, civil society rehabilitative and law enforcement agencies collate and corroborate data from the community to the national level, in order to enable holistic analysis of the issue of women's Sexual and Reproductive Health needs, without "replicating studies" (by choosing an area of research that might have already been explored by another, but with the resulting findings not being widely published).
CHAPTER SIX
APPENDICES

6.1 Time frame
The research project’s time frame is 15 months, running from January 1, 2007, to March 31, 2008. The period covers development, implementation/fieldwork and reporting of the research project, which started after submission of the research proposal in December, 2006.

6.2 Budget

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount in Ksh</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Research Assistants;</td>
<td>20,000</td>
<td>They were not all given a token of equal amount, but each according to the number of days spent in the field</td>
</tr>
<tr>
<td>1 Community Mobilizer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport for Respondents</td>
<td>20,000</td>
<td>Also in appreciation of the time committed to the research; as per the principle of beneficence</td>
</tr>
<tr>
<td>Token for 2 Translators</td>
<td>4,000</td>
<td>A male and a female translator helped with interviews of Oromo Refugee community</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>20,000</td>
<td></td>
</tr>
<tr>
<td>Photocopying and Binding</td>
<td>6,000</td>
<td></td>
</tr>
<tr>
<td>Miscellaneous Expenses</td>
<td>5,000</td>
<td>This includes cost of catering for research team and some of the project participants</td>
</tr>
<tr>
<td>Grand Total</td>
<td>75,000/=</td>
<td></td>
</tr>
</tbody>
</table>

NB it would have been difficult to carry out the research on the budget, which is relatively low given the amount to human hours that went into the work; WRAP staff provided a lot of support without getting any “material recognition” for work done.

6.3 Appendix of Instruments

Primary Data Collection Instruments
Questionnaires for Individual Interview
Questionnaires for Group Interview and Focus Group Discussion

Secondary Data Collection “Instruments”
Client Records at WRAP
Pertinent Literature
### GBV SURVIVORS' INDIVIDUAL INTERVIEW

1. **Age**
   - i. 18-25 age group ____________
   - ii. 26-44 age group ____________
   - iii. Age 45 and over ____________

2. **Area of Residence**
   - ii. Mathare: Low-Income Neighbourhood/Poor Household ___________
   - iii. Kahawa West: Middle-Income Residential Area/Non-Poor Household ____________
   - iv. Other: ___________________ Poor Household/Non-Poor Household ____________

3. **Educational Background**
   - i. Primary School Level ____________
   - ii. Secondary School Level ____________
   - iii. Tertiary Education/Vocational Training ____________

4. **Occupation**
   - iv. Housewife/Unemployed ____________
   - v. Self-employed ____________
   - vi. Casual Work ____________
   - vii. Formal Employment ____________

5. **Membership to and Type of Women's/Self-Help Groups**
   - i. Non-member (reasons for not joining any group) ____________
   - ii. Welfare oriented groups (merry-go-rounds, etc) ____________
   - iii. Action oriented groups (developmental, environmental and such other issues) ____________
   - iv. Social support groups (discuss GBV-related issues/intervene in domestic violence) ____________

6. **Marital Status**
   - v. Unmarried ____________
   - vi. Married: Type and duration of relationship
     - a. civil/traditional/religious marriage; ____________; No. of years ____________
     - b. cohabitation; ____________; No. of years ____________
     - c. casual relationship ____________; No. of years ____________
   - iii. Separated/Divorced ____________

7. **No. of Children**
   - vii. None ____________
   - viii. 1 or 2 Children ____________
   - ix. More than 2 Children ____________

8. **Level of awareness on and attitude towards GBV**
   - x. Is only aware of physical violence or threat of physical violence ____________
   - xi. Is aware of sexual violence, including rape by an intimate partner ____________
   - xii. Is aware of psychological, emotional and economic violence by an intimate partner ____________

* *To determine level of awareness, participants respond to and comment on the following:*
A. Marriage is vital to economic survival, particularly for women, because women's failure to marry may limit their access to land, housing, inheritance and social networks.
I agree ____ ; It depends ____ ; I disagree ____

B. Religious and historical traditions in the past have sanctioned the chastising and beating of wives. A man therefore has reasonable ground to chastise his wife if, for example, she failed to do household chores on time or to take care of male family members.
I agree ____ ; It depends ____ ; I disagree ____

C. As the husband is the head of the family, the wife has no business with knowing the destination of her husband's income.
I agree ____ ; It depends ____ ; I disagree ____

D. As the head of the family, the husband is also supposed to be the sole breadwinner of the family. Therefore, where the husband earns enough to support the family, the wife should direct her energies to raising children and keeping house.
I agree ____ ; It depends ____ ; I disagree ____

E. The husband, as the head of the family, should be the one to make decisions on fertility issues such as whether to have sex; contraceptive use; and economic issues such as control of his own and his wife's earnings and making decisions on the purchase of major household goods. Other issues that the husband decides on include visiting family friends and choosing of meals for the family.
I agree ____ ; It depends ____ ; I disagree ____

F. Through marriage, men should have sexual access to their wives whenever and however they wanted, thus women should not consider forced sex as rape if they are married to, or cohabiting with, the perpetrator.
I agree ____ ; It depends ____ ; I disagree ____

G. Many women are afraid to bring up the issue of contraceptive use for fear of being beaten, abandoned or accused of infidelity. For such women, "No" is not an option even to unsafe sex with a husband who has multiple partners.
I agree ____ ; It depends ____ ; I disagree ____

H. A husband who constantly issues his wife with threats of abandonment or abuse, threats to take away custody of the children, threats of or actual confinement to the home, threats of or actual destruction of objects, isolation from friends/other family members, surveillance, verbal aggression and constant humiliation, besides threats of or actual denial of funds, refusal to contribute financially, denial of food and basic needs, and controlling access to health care, employment is better than a husband who physically assaults his wife.
I agree ____ ; It depends ____ ; I disagree ____

I. Marriage is a private affair between a man and his wife; neither the state, next-of-kin, nor have any business of knowing what transpires between husband and wife.
I agree ____ ; It depends ____ ; I disagree ____
9. Family structure/Gender-based power
   i. Does not now or previously, live with in-law
   ii. Age difference between spouses: Small _____ Large _____
   iii. Educational difference with husband: Small _____ Large _____
   iv. Chose husband _____ Did not choose husband _____
   v. Autonomy of partners in making decisions: Effect on wife's:
      a. Ability to acquire information; Autonomous _____ Depends on husband _____
      b. Access/use of SRH services; Autonomous _____ Depends on husband _____
      c. Initiating sexual interactions; Autonomous _____ Depends on husband _____
      d. Financial autonomy; Autonomous _____ Depends on husband _____

10. Experiences of violence before 16 years of age (Number of incidences, type and the perpetrators of the violence)
   i. Violence or threat of violence within the family
   ii. Violence or threat of violence by strangers
   iii. Violence or threat of violence by peers

11. Experiences of violence since attaining 16 years of age
   i. Violence or threat of violence by husband/intimate partner
   ii. Violence or threat of violence by next-of-kin (but not intimate partners)

12. Type and incidence of abuse/violence
   i. Physical abuse
   ii. Sexual abuse
   iii. Psychological/Emotional abuse
   iv. Economic abuse

13. Type of RH complication/chronic condition
   i. Physical trauma
   ii. Complications related to reproductive role
   iii. Psychological conditions

14. Relationship between GBV and the RH complications cited
   i. When the manifestation of the chronic long-term RH complication was first noticed
   ii. Pre-existing medical conditions as a result of GBV, or due to other factors
   iii. Respondent's awareness that she is suffering from a condition which can be successfully treated: Aware _____ Unaware _____

15. Factors that could have led to the violence
   (Interviewer takes respondent through the following issues as probable causative factors. The respondent affirms or negates, and elaborates where necessary)
   i. Control of the partner's liberty/Movement/ Visiting friends; Yes ____ ; No ____
   ii. Distribution of property and goods/services among family members including next-of-kin; Yes ____ ; No ____
   iii. Issues related to children's support and upbringing; Yes ____ ; No ____
   iv. Being forced to fulfill the physical needs of husbands without regards of a woman's RH concerns; Yes ____ ; No ____
   v. Financial autonomy for working wives; Yes ____ ; No ____
   vi. Alcohol/substance abuse; Yes ____ ; No ____
   vii. Destination of the man’s income; Yes ____ ; No ____
   viii. Conjugal fidelity; Yes ____ ; No ____
   ix. Contraceptive use; Yes ____ ; No ____
16. The experience of abuse/GBV

To compare the woman's self assessment/definition of abuse with an objective measure of what types of behaviors she had endured.

i. Did he touch you in loving ways? Yes ___; No ___

ii. Hug you and kiss you? Yes ___; No ___

iii. Did he buy you presents? Yes ___; No ___

iv. Did he ever say you look nice? Yes ___; No ___

v. Does he still show his appreciation of you in such ways? Yes ___; No ___

vi. When did he stop doing that? ____________________________

vii. Has your partner ever forced you to have sex when you didn't want to? Yes ___; No ___

viii. Do you categorize the behavior as violent? Yes ___; No ___

ix. Do you find it painful or harmful? Yes ___; No ___

x. How did you respond when your partner forces you to have sex? Yes ___; No ___

xi. Did/Does your partner intimidate you with threats of abandonment or abuse? Yes ___; No ___

xii. Did/Does he confine you to the home? Yes ___; No ___

xiii. Did/Does he put you under surveillance? Yes ___; No ___

xiv. Did/Does he issue threats to take away custody of the children? Yes ___; No ___

xv. Has he ever threatened you with destruction of objects of sentimental value? Yes ___; No ___

xvi. Did/Does he constantly subject you to verbal aggression and humiliation? Yes ___; No ___

xvii. Did/Does he refuse to contribute financially towards purchase of food and basic needs? Yes ___; No ___

xviii. Did/Does he have to be consulted when you have to access health care? Yes ___; No ___

xix. Did/Does he have a say on your employment status? Yes ___; No ___

xx. Did/Does he make you account for money that you have earned? Yes ___; No ___

17. Consequences of the RH complications on the respondent's life

i. How much time has the respondent spent in seeking medication or from being incapacitated by the RH complications resulting from the violence? What restrictions have such complications placed on the respondent's mobility and her ability to earn a living? Did the respondent meet the cost of immediate medical needs (psychological counseling and medical treatment) using the "household budget"? Yes ___; No ___

ii. Was the partner supportive in the process of her accessing health care? Yes ___; No ___

iii. Did the respondent lose her job/income-generating activity as a direct result of the abuse? Yes ___; No ___

iv. Did the violence affect children's academic performance? Yes ___; No ___

v. To what extent? Bad grades ___; Repeated a class ___; Out of school ___
ii. Did the respondent face any constraints while trying to access the RH services? Yes ___; No ___

iii. How does the respondent gauge the treatment of women and girls by the police? Insensitive ___; Sensitive ___ The judiciary? Insensitive ___; Sensitive ___; RH service providers? Insensitive ___; Sensitive ___

iv. Was the respondent's partner supportive of her need to access to RH services? Yes ___; No ___

19. Effects of poverty and economic insecurity

i. Did the respondent have the time, or was she too busy fulfilling her reproductive and productive roles to attend to her health needs? Yes ___; No ___

ii. Which other factors deterred the respondent from attending to her health needs? Transport costs ___; Time to travel to health facilities ___; Long waiting times at poorly staffed health facilities __; Other factors ________________________________

Had the respondent not been in a situation of poverty or economic dependence, would she have left the abusive relationship? Yes ___; No ___

20. Preferences for RH service delivery

6.3.1.2. GBV-RELATED SUPPORTIVE SERVICE PROVIDERS’ INDIVIDUAL INTERVIEW

1. How many years of experience with GBV survivors do you have? _______________________

2. What was your occupation prior to your current work? ___________________________________

3. What motivated you to wanting to work with GBV survivors? ___________________________________

4. Which 2 case studies would you cite to show WRAP’s successes in GBV interventions?
   i. _______________________________________________________________________
   ii. _______________________________________________________________________

5. Which 2 case studies would you cite to show some of the unique challenges encountered in service provision?
   i. _______________________________________________________________________
   ii. _______________________________________________________________________

5. In your years as a service provider, or from going through client records, have you been able to observe any trends to the types and incidences of GBV reported by clients at WRAP? That is:

   i. Abuse based on type and duration of relationship;
      a. civil/traditional/religious marriage; ____________; Duration __________
      b. cohabitation; ____________; Duration __________
      c. casual relationship __________; Duration __________

   ii. Types of abuse/violence against women at the intimate partner level
   iii. Types of abuse/violence at the community/societal level;
   iv. The sexual abuse of children and adolescents
   v. Types of abuse/violence or threat of violence by strangers
vi. Types of abuse/violence or threat of violence by next-of-kin (but not intimate partners)

7. What can you say about effectiveness of community-based interventions for GBV, such as WRAP's Neighbourhood Watch Programme, which builds the capacity of communities so that they can form committees to intervene on GBV
   i. Success
   ii. Challenges

8. From your experience is there any link between a GBV survivor's level of education/self-esteem and her ability to seek treatment for reproductive health problems she is suffering from? Yes ___ No ___
   Reason: __________________________________________________________

9. Gender-based violence is known to occur amongst all socio-economic groups and in all cultures. Therefore it cannot be said to be caused by poverty. However in situations of poverty and economic insecurity women may be less likely to have the resources to leave violent relationships. What comment can you make about this statement, especially as regards WRAP clients from poor households?

10. Women immediately recognize physical abuse as battery, but many do not classify psychological and sexual abuse as "violence." Based on the statement how would you compare the definition of abuse and self-assessment by WRAP's average client with an objective measure of what types of violence she had endured?

6.3.1.3. GBV SURVIVORS' GROUP INTERVIEW/DISCUSSION

1. Relationships between older men and young girls should never be encouraged, since young girls are traditionally bound to obey older men. True ____ False ____
   Reason: __________________________________________________________

2. Marriage is a private affair between a man and his wife; not the state, not the next-of-kin, not even a friend of the family has any business of knowing what transpires between husband and wife. True ____ False ____
   Reason: __________________________________________________________

3. Violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men - physical and sexual violence is the fallback method of control and subjugation where women's acceptance of patriarchal beliefs begins to waver. True ____ False ____
   Reason: __________________________________________________________

4. Women are often expected to be ignorant about sex and passive in sexual interactions. As a result of such beliefs, many girls/young women are largely ignorant about sexual relations between men and women until they learned of it on their wedding nights. True ____ False ____
   Reason: __________________________________________________________
5. Women frequently acquiesce to sex in order to avoid what they perceived as a more threatening outcome, such as being beaten or abandoned. True ____ False ____
Reason: ____________________________________________________________

6. Women who have few alternatives for economic survival are likely to fear abandonment and will, therefore, hesitate to leave a risky relationship. True ____ False ____
Reason: ____________________________________________________________

7. The family is a private sphere and under male control; it is, therefore, private and beyond control of the state. True ____ False ____
Reason: ____________________________________________________________

8. Men are supposed to be sexual initiators. Though a woman might want sex as much as the man, she has to say “No” to maintain her reputation. Therefore, women should wait for men to initiate and assume control when it comes to sex. True ____ False ____
Reason: ____________________________________________________________

9. Isolation of women in their families and communities is known to contribute to increased violence, particularly if those women have little access to family or local organizations. True ____ False ____
Reason: ____________________________________________________________

10. With unemployment and, and self-esteem have become increasingly linked to sexuality and sexual manifestations. Where the husband is unemployed and depends on his wife’s income, or earns too little to adequately provide for his family (thus rendered incapable of fulfilling social roles and expectations), multi-partnered sexual relationships and sexually aggressive behaviour become essential to strengthening his masculinity (male identity) and self-esteem. True ____ False ____
Reason: ____________________________________________________________

FOCUS GROUP DISCUSSIONS

1. Some of the factors due to which women and girls are unable to access reproductive health services are given here.
Give one way in which each of the points impacts negatively on the access to RH services by women and girls

   i. Reproductive health services available are either too few or cost-prohibitive for survivors of gender based violence
   Reason: ____________________________________________________________

   ii. Survivors of gender based violence lack information as to where this medical care can be accessed
   Reason: ____________________________________________________________

   iii. Because of poverty, women do not have the time to attend to their health needs they are busy taking care of their reproductive and productive roles
   Reason: ____________________________________________________________

   iv. Transport costs and time to travel to health facilities, as well as long waiting times at poorly staffed health facilities all discourage survivors from seeking health care
   Reason: ____________________________________________________________

   v. Insensitive treatment of GBV survivors by the police and other service-providers
   Reason: ____________________________________________________________

   vi. Policy-makers failing to adequately plan for General Development Needs (needs that affect men and women equally) as a separate and different category from...
Women’s Special Needs (those needs that arise from biological or sex differences).

Reason:____________________________________________________________________________

2. What 2 community-based approaches does the Neighbourhood Watch Committee need to adopt for “healing” or offering psycho-social support to GBV survivors in the long-run and in addressing the perpetrator, especially if still residing in the neighbourhood?
   i. ____________________________________________________ ___________________
   ii. ____________________________________________________ ___________________

3. The conjugal contract implies that male and female contributions are complementary. Women offer their capability of having children, household services and sexual fidelity. In turn, the man has to contribute with the resources he produces to support his spouse and children, and has to be sexually faithful. However, with increasing unemployment levels, the contract of marriage has to be drawn afresh. Suggest 2 obligations that each of the respective partners owes to the union.
   The Husband’s Obligations
   i. ______________________________________________________________________
   ii. ______________________________________________________________________
   The Wife’s Obligations
   i. ______________________________________________________________________
   ii. ______________________________________________________________________

4. Men’s role in supporting women’s rights:
   Men have power in wide-ranging situations; from personal and family decisions to policy and programme decisions taken at all levels of government and, as such, can make a tremendous contribution by using their power for positive change. Suggest 2 ways in which men can use social and gender-based to improve access to RH services for women and girls.
   i. ______________________________________________________________________
   ii. ______________________________________________________________________

6.4 List of Respondents or Intermediaries

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact</th>
<th>Interviewed as /Role Played</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs. Anne Mbuthia</td>
<td>Premier School, Parklands</td>
<td>Key Informant - Teacher</td>
</tr>
<tr>
<td>Mrs Benedicte Owino</td>
<td>Head Teacher, Muthaiga.</td>
<td>Key Informant - Teacher</td>
</tr>
<tr>
<td>Ms. Pauline .M.</td>
<td>Kilimani Primary School</td>
<td>Key Informant - Teacher</td>
</tr>
<tr>
<td>Ms. Aikar Kodawa</td>
<td>Kilimani Primary School</td>
<td>Key Informant - Teacher</td>
</tr>
<tr>
<td>Ms. Joanne Wambilyanga</td>
<td>Legal Officer,WRAP</td>
<td>Key Informant - GBV Supportive Service Provider</td>
</tr>
<tr>
<td>Name</td>
<td>Role</td>
<td>Key Informant</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Ms. Francesca Mutuku</td>
<td>Clients Manager, WRAP</td>
<td>Key Informant - GBV</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supportive Service Provider</td>
</tr>
<tr>
<td>Mrs. Rosemary Alambo</td>
<td>Community Mobilizer, Ushirika Clinic</td>
<td>Community Mobilizer – GBV</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Survivors</td>
</tr>
<tr>
<td>Mr. Tsegay</td>
<td>International Rescue Committee/ Community Mobilizer</td>
<td>Community Mobilizer – Oromo Refugee Community</td>
</tr>
</tbody>
</table>
6.5 Bibliography

Some of the literature review was done through browsing through various websites, and downloading relevant information from the internet. The web-based articles are indicated to distinguish them from literature that was available in hard copy.


2. Baehr, Peter; Hey, Hilde; Smith, Jacqueline; Swinehart, Theresa, Human Rights in Developing Countries, Yearbook 1994: A Human Rights Project, Nordic Human Rights Publications, Oslo, Norway


6. Bott, Sarah; Guedes, Alessandra; Claramunt, Maria Cecilia; Guezmes, Ana, Improving the Health Sector Response to Gender-Based Violence, IPPF/WHR Tools, 2004, produced in collaboration with PROFAMILA, Dominican Republic, INPPARES, Peru, and PLAFAM, Venezuela

7. Datta, Dipankar and Gupta, Neli Sen: - Domestic Abuses against Housewives in haor Areas of Bangladesh: Understanding the Impact of Concern’s Intervention in Reducing Abuses – April 2004, Regional Programme, Concern; Dhaka, Bangladesh (website article)


10. FIDA-K. Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities, 2007, Center for Reproductive Rights, NY, USA.


16. Jewkes, Rachel; Watts, Charlotte; Abrahams, Naeema; Penn-Kekana, Loveday; Garcia-Moreno, Claudia, Research Methodology: Ethical and Methodological Issues in Conducting Research on Gender-Based Violence in Southern Africa, 2000, Women's Health Research Unit, Medical Research Council, Cape Town, Southern Africa.


18. Kirby, Perpetua, A Guide to Actively Involving Young People in Research: For Researchers, Research Commissioners, and Managers, 2004 - Published by the INVOLVE Support Unit.


22. Miruka, Okumba; Wainaina, Njoki; Chege, Rose; Munyua, Alice and Olak, Jael, FEMNET TRAINING MANUAL ON GENDER BASED VIOLENCE, 2005 African Women’s Development and Communication Network (FEMNET)


24. Payne, Lina and Nelville, Sally, Aid Instruments, Exclusion and Gender: Background Paper for DFID’s Internal Guidance on Aid Instruments, 2006, - Social Development Direct, UK


27. Silberschmidt, Margrethe, PhD: - Male Sexuality in the Context of Socio-Economic Change in Rural and Urban East Africa Sexuality in Africa Magazine; 1998 (website article)


29. The UNICEF Innocenti Research Centre DOMESTIC VIOLENCE AGAINST WOMEN AND GIRLS; Innocenti Digest No. 6 – June 2000 (website article)

31. UNFPA, Cultural Programming: Reproductive Health Challenges and Strategies in East and South-East Asia; 2005 UNFPA Country Technical Services Team for East and South-East Asia, Bangkok, Thailand


33. UN OCHA/IRIN, Broken Bodies Broken Dreams: Violence against Women Exposed, 2005 United Nations Office for the Coordination of Humanitarian Affairs/Integrated Regional Information Networks

34. Wanyeki, L. Muthoni; Longwe, Sarah Hlupekile; Nzomo, Professor Maria; Wandia, Mary; Kaara, Wahu; Okumu, Mary; Mghanga, Hon. Mwandawiro - Perspectives on Gender Discourse: Gender Dimensions of NEPAD 2003 Heinrich Böll Foundation, East and Horn of Africa Region, Nairobi, Kenya