



NO END IN SIGHT

2013 Sexual and Gender Based Violence (SGBV) in Kenya status brief.

ABSTRACT

Recent studies show that SGBV is prevalent in all parts of Kenya. Yet Kenyans remain largely ignorant of its magnitude, impact and longer term socio-economic and health impact.

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TABLE OF CONTENTS

Acronyms	2
Executive Summary	3
Introduction	7
Who Perpetrates GBV and who is affected?	8
Where does it occur?	12
What causes GBV?	14
What is the prevalence?	15
What happens after GBV?	18
At what cost?	19
What is in Place to deal with GBV?	22
Where are the gaps?	24
References	27

ACRONYMS

COVAW- Coalition on Violence Against Women

CREAW- Centre for Rights Education and Awareness

CSO – Civil Society Organization

FIDA - Federation of Women Lawyers (FIDA) Kenya

GBV -Gender Based Violence

GVRC - Nairobi Women's Hospital Gender Violence Recovery Center

IDP – Internal Displaced Person

KDHS- Kenya Demographic Health Survey

KPCDR- Kenya Police Crimes Data Report

NGEC - National Gender and Equality Commission

NPSCR- National Police Service Commission Report

ODM – Orange Democratic Movement

PEV – Post Election Violence

SGBV- Sexual and Gender Based Violence

UNFPA – United Nations Population Fund

UN Women- United Nations Agency

VACS - Violence against Children Survey

Executive Summary

United Nations Population Fund (UNFPA) defines Gender based Violence (GBV) as any harmful act that is perpetrated against a person based on socially-ascribed (gender) differences between males and females. It includes physical and psychological abuse, sexual violence, verbal abuse and deprivation.

Who is affected?

All studies show that women and girls make up the majority of GBV victims and survivors. That notwithstanding, the number of reported cases of boys affected mostly by sodomy abuse are on the rise. According to the 2008/9 Kenya Demographic Health Survey (KDHS) among other studies the most vulnerable categories of women include, unemployed women, women whose spouses drink heavily and those whose spouses show controlling traits. It is noteworthy that women who are more involved in decision making at home and those generally in positions of authority and control with, or relative to men experience less violence, while women and girls, who are largely voiceless, are less informed and may not have the strength to counter assault are more likely to suffer one or more forms of GBV (KDHS). Available data shows that the prevalence of GBV is not significantly affected by both education level and wealth status of women.

KDHS 2008/9 and *Kenya Violence Against Children Survey* (VACS) 2010 report reveal that men are the main perpetrators of violence in their different roles; as intimate partners of women and girls, as close relatives and as persons with authority over women and girls such as employers and teachers. In the FIDA (2008), study 79.2% of respondents identified men as perpetrators compared to 14.6% who cited female spouses as perpetrators. Those who mentioned in-laws and parents as perpetrators accounted for 4.1% and 2.1% respectively (FIDA).

How prevalent?

The KDHS 2008/9 provides the only comprehensive national data on prevalence of GBV showing that it has a significant presence throughout the life cycle of in particular of women and girls. During childhood, 32% of females and 18% of males experience sexual violence¹. 60% of females report age of first abuse at 6-12- 24% between 13 & 19 while 25% of 12-24 lost virginity through force. Overall 83% women/girls report 1 or more episodes of physical abuse². The likelihood of experiencing physical violence increases with the age of women, from only 11 percent of those ages 15-19 to 29 percent of those ages 40-49. More recent 2013 data from Gender Violence Recovery Centre that was specific to GBV in families largely confirms KDHS

¹ The 2010 Kenya Violence against Children Survey (VACS)

² Kenya Demographic and Health Survey (KDHS 2008-2009)

2009 findings but shows higher levels of prevalence overall and significantly so in Nairobi, giving the impression that GBV is on the rise in families. More recent police data on sexual violence also shows a rise in the number of sexual offences from 3525 in 2007 to 4703 in 2011³.

The KDHS data shows that GBV varies across cultures, and regions. Regions ranked from the highest to lowest showing women experiencing physical and sexual violence are Nyanza (54.1%), Western (50.1%), Rift Valley (39.8%), Central (35.1%), North Eastern (32.8), Eastern (31.5), and Nairobi (24.6%). This may call for different strategies both to understand cultural determinants of GBV and to target specific causes of GBV in different areas.

Where does it occur?

The Nairobi Women's Hospital Gender Violence Recovery Center (GVRC) 2013 study shows majority of GBV cases (64%) occur within the survivor's homes compared to 20% that occur in dark places and hidden areas⁴. **The finding appears to go against prevalent belief that homes are safe spaces for women and girls which also calls for strategies to make homes safer.**

What causes it?

Most studies attribute GBV largely to gender masculine norms that regard women as weak beings meant to serve men and to women's low socio-economic status. Police sources list drunkenness, substance abuse, unemployment, poverty, families living apart and HIV status of the as leading causes. Other sources show adultery and alcoholism cited with 41% and 28.2% scores respectively, financial position 20.5% and the HIV status of spouse 10.3%⁵. It is notable that even when causes other negative masculinity are cited, men are still by far the leading perpetrators of violence against women and girls when intoxicated.

What happens after GBV?

The main finding of most studies is that up to half of the survivors remain silent after the event making campaigns to "break the silence" as well as initiatives to make reporting worthwhile priorities for current programming. KDHS 2009 reveals that close to half (45%) of survivors never seek help or tell anyone. The practice is that women who experience both sexual and physical violence (52%) are more likely to seek help as compared to only physical (35%) or only sexual violence (14%). Older women separated and widowed women are more likely to seek help than younger and currently married women (55% compared to 37%). Among those who sought help, most sort from their family (64%) in-laws(40%), friends(17%)Even fewer(14%), community

³ National Police Service Annual Crime Report 2011

⁴ *Baseline Survey Report: Assessing the Prevalence of GBV in Kenya- The Case of Nyanza and Nairobi Regions*. Gender Based Violence Recovery Centre (GVRC) February 2013.

⁵ *Gender Based Domestic Violence in Kenya*. FIDA

leaders and administrators, police(8%) doctors or medical personnel (2%) lawyers (.3%) or social service organizations (.1%) **At what cost?**

GBV adversely affects a survivor's mental and physical health: injuries and/or death (28.9%), financial problems (26.3%), separation/divorce (21.1%) sexual abuse (15.8%)(and emotional depression (7.9%), according to the FIDA (2008) report. Cost of managing loss due to uncompensated fatal and related ailments such as headaches, back pain, abdominal pain, fibromyalgia, gastrointestinal disorders, limited mobility and poor overall health absorbs resources that could have been utilized for more productive purposes. **Children who grow up in violent families may suffer a range of lifelong behavioural and emotional disturbances.**

Existing policy/legal support:

Kenya has enacted laws and policies to counter SGBV such as: Constitution of Kenya that outlaws all forms of discrimination, the Penal Code, the *Children's Act 2003*, *The Sexual Offences Act in 2006*, and its implementation framework under *Multi Sectoral Standard Operating Procedures for Prevention of and Response to Sexual Violence in Kenya*- comprehensive document focusing on protection, care and treatment of sexual violence victims and on prevention of sexual violence as well as management of sex offenders. This notwithstanding- among the preferred law review and formulation actions is the review of the Sexual Offences Act to remove "claw back" clauses that condone marital rape as well as review of the penal code to be gender specific in its application, to include specific gender based crimes such as occur under "domestic violence" and to be in tandem with recent legislation such as the sexual offences act and the constitution. The marriage bills need to be enacted in the form that conforms to constitutional requirements of equality in marriage. It will also be necessary to enact specific legislation that shall seek to counter domestic violence. In recognition of the growing body of evidence programs targeting men and boys can influence their attitudes, behaviours and their role as agents of change in the achievement of gender equality policies should be reviewed to be *gender transformative* and *gender synchronised* to ensure they do not reinforce negative societal values and stereotypes and instead aim to address negative gender norms through active participation of men and boys.

Coordination

In spite of limitations within the policy and legal frameworks Kenya has a firm foundation to manage GBV; however the biggest problem remains weak coordination of remedial actions which in turn tends to compromise implementation. All GBV legal policy frameworks/action plans anticipate a multiplicity of cross sector linkages, however most fall short of outlining but more critically putting in place workable protocols and procedures for exchange of information

and referrals across different service action points even among government sectors and in particular health, law enforcement and social service. Perhaps a worse scenario obtains among CSO GBV players who more often than not act independent of one another without structured and timely feedback mechanisms to even inform on what is in place, where, when and how it is progressing if at all. This tends to defeat the intention to promote synergy and offer holistic services.

Data

While acknowledging contribution of the few government and CSO agencies towards availing data to inform policy and action on GBV there is no central and systematic mechanism for collecting data on GBV at the state level to help systematize, standardize, coordinate and synchronize collection and analysis of GBV data. A related gap is the limited use of data and research by most stakeholders to enhance GBV ethical and evidence-based programing including monitoring and evaluation and in particular identification and sharing of best practices, lessons learned across agencies. Borrowing from the practice in better centralized data collection in other sectors it is prudent for the National Bureau of Statistics to take up the mantle. An anticipated contribution of such a centralized national data collection would be working out a standardized formula for calculating/determining the socio-economic cost of GBV. Additionally it would facilitate formulation of strategies appropriate to prevailing local conditions particularly at county and community levels.

Introduction

Gender Based Violence (GBV) refers to harmful acts that are perpetrated against a people based on gender differences; these include physical and psychological abuse, sexual violence, verbal abuse, threats, coercion and deprivation of liberty in public or private life. The heinousness of GBV in Kenya came to the fore in the 2008 Post Election Violence (PEV) when thousands of women and girls and some men and boys underwent horrendous violations within a relatively short time. Even though there was unusual spotlight on the violations, a 2013 UN women publication notes that “During Kenyan election periods, electoral gender based violence is consistently meted out to women by communities, families, political party members, candidates, supporters and the media who seek to discredit female candidates in the eyes of society”⁶. Studies also reveal that GBV is a continuous menace- what happens during political upheaval such as 2008 is an escalation of what already exists on a steady but less alarmist scale. The 2008 shock should therefore help us to focus more systematically on “business as usual” GBV that goes on all the time discussed below.

All recent studies show that GBV is prevalent in all parts of Kenya. Yet Kenya remains a largely ignorant nation of the magnitude and impact of GBV with many associating it with a few criminal elements ignorant of its long term socio-economic and health impact. Available data from the comprehensive Kenya Demographic and Health Survey (KDHS 2009) and FIDA Kenya (*Gender Based Domestic Violence in Kenya*. 2008) – among other sources shows that women and girls are disproportionately affected by GBV as up 1 in 2 women report having experienced violence at one point in their lives⁷. The data shows a worrying trend of up to a quarter of the girls (ages 12-24) having lost their virginity through different forms of forced intercourse. Overall 60% report age of first abuse at ages 6-12 while 24% between 13 and 19. All these data shows that GBV starts early in the lives of girls who have to live with the effects for the rest of their lives. Even more worrying is the fact that despite the high incidence the magnitude of the problem is often not easily apparent because most survivors suffer in silence. Available 2009 KDHS data shows that only 12% of women who had been physically or sexually abused report to someone in authority. Data collected from health facilities also confirms the worrying magnitude of the problem: Nairobi women’s hospital for instance receives on average 18 cases of rape and incest daily⁸. Latest reports show that reported cases of rape increased from 332 in 2012 and 297 in 2011 between January and May to 383 within the same period in May 2013⁸. The implication for GBV actors is that “Breaking the silence” still remains a relevant awareness creation endeavor to ensure that GBV is moved from the closet to the socio-political platform for it to receive the due attention.

Who Perpetrates GBV and who is affected?

All data on GBV show that men are the main perpetrators of GBV and their victims are mostly women and girls of all ages. GBV affects women and girls throughout their life cycle; pre-birth, infancy, girlhood, adolescence and adulthood and old age. The table below shows occurrence of

⁶ Electoral Gender Based Violence in Kenya UN Women 2013 Page 7

⁷ Kenya Demographic and Health Survey 49% / FIDA 48% 8 UNAIDS Report 2013.

⁸ Reported in The Standard August 15 2013

GBV by predominant specific type of violence at the different stages to mainly women and girls, but boys also face GBV at the different stages that is similar or different to that faced by women and girls:

Table 1 GBV during life cycle stages

Stage	Physical GBV	Psychological GBV
Pre-birth (Effects on parents & unborn children)	<p>*Women: Effects of assault during pregnancy, denial of resources/time to access pre-natal care and appropriate nutrition,</p> <p>*Very few men report violence from spouses due to mood swings</p> <p>* Children born with birth defects due to pre-birth violence.</p>	<p>*Stress due to mistreatment and related anxiety effects to unborn baby</p> <p>* Men report stress coping with partners moods and anxiety/fear of fatherhood</p>
Infancy	<p>*Girls: FGM, Child marriages, denial of education & care, defilement, sexual harassment, child labor, trafficking * Fewer boys suffer defilement/sodomy</p>	<p>Stress due to mistreatment and missed opportunities/anxiety about her future</p>
Adolescence Girlhood	<p>* Girls: Sexual violence-defilement, incest & rape, FGM, forced marriage, trafficking, sexual harassment, child prostitution, child labor, overload of domestic chores, denial of education opportunities, assault at home and in community corporal punishment in school, abduction</p> <p>*Very few boys report defilement- but also expose themselves to violence in order to prove their “manhood”, a number are involved in wage related child labor</p>	<p>*Worries about unwanted pregnancy, fear of abuse, stress due to not meeting numerous assignments and not being allowed to be children</p> <p>* Boys are stressed by not appearing to meet expected physical standards of manhood and also work related stress for those in child labor- who also miss opportunities for education.</p>
Adulthood	<p>* Women: Beatings, scalding, insults in relationships-courtship/dating/marriage, rape, economic coercion, marital rape, bride-price abuse, widow cleansing/inheritance, forced pregnancy, murders, in-laws interference/mistreatment,</p>	<p>Stress due to fear of violence arising from threats, fear of general welfare</p> <p>* Abused men are stressed by the community attitudes towards men in their situation that is considered</p>
	<p>loss of income to spouse/relatives, separated from children or left to maintain children without spouse support.</p> <p>*very few men report being abused in similar manner above by their spouses</p>	<p>analogous to women.</p>

Older age	<p>*Women-Marital rape, widow inheritance, disinheritance of property on death of husband or husband taking possession of her property/denying her of joint ownership, witch-hunt assaults, denial of livelihood by family interested in her property, looking after grandchildren with little means</p> <p>*Some older men abandoned by their spouses after loss of employment or retirement and some report being neglected by families when sick and weak</p>	<p>*Women suffer stress related to basic survival and dangers faced because of vulnerability related to how people around her take advantage of her age</p> <p>* Men are stressed by fear of destitution or situation of the same and loss of authority due to effects of old age.</p>
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	Intimate Partner/partner	Family Member	Community	State	Perpetrator not identified	Data N/A	Total
Physical Violence							
Punching/Kicking	596	106	86	0	0	30	818
Abduction	1	5	1	0	2	4	13
Sexual Violence							
Rape	135	357	1677	4	796	298	3267
Wife Inheritance	60	79	8	0	0	12	159
Sexual Harassment	37	14	36	0	0	7	94
Indecent Assault	8	8	15	0	0	2	33
Attempted Rape	5	10	29	0	0	4	48
Early Marriage	1	2	1	0	0	3	7
Sodomy	0	1	20	0	10	2	33
Psychological Violence							
Threats	514	177	107	0	0	27	825



Below is: *Table 2 on number of violence acts in Kenya by type of violence and perpetrator⁹*:

A large rectangular grey box used to redact the content of Table 2, which would otherwise show the number of violence acts in Kenya by type and perpetrator.

⁹ Reproduced from No Way To tell UNIFEM 2009

Deprivation of Basic Needs	580	94	41	0	0	23	738
Verbal /Shouting	452	132	49	0	0	24	657
Intimidation	325	148	69	0	0	25	567
Denial of Access to Children	250	197	33	0	0	24	504
No Communication	333	65	33	0	0	18	449
Denial of Custody	190	38	13	0	0	17	258
Confinement	74	18	20	0	0	3	115
Economic Violence							
Control of Finances	317	41	21	0	0	9	388
Denial of Right to Work	231	41	25	0	0	14	311
Termination of Employment due to pregnancy	11	0	6	0	0	2	19
TOTAL	4,120	1,533	2,290	4	808	548	9,303

Men get access to women and girls in their different capacities and relationships that include; as intimate partners of women and girls, as close relatives or persons with authority such as teachers. A 2009 UNIFEM research consolidation report confirms that majority of perpetrators are known to the victims¹⁰. The report reveals that majority of perpetrators are men over 25 years of age with the highest levels in the 35 to 39 age group. Men represented 38.8% of the identified perpetrators while 2.3% were females. Further, family members represent 60.8% of the perpetrators, among whom 44.3% are intimate partners or ex-partners and other family members, 16.5%. The community (as perpetrators) was responsible for 24.6% of reported cases.

Men are also identified in studies as opportunistic attackers' of women and girls they may not necessarily be acquainted with. The latter attacks may occur in situations of political or civil strife or abduction and rape of women in "lonely" places. Such was the case in the 2007/8 post- election violence (PEV) during which (researcher) Wanyeki observes that in the early stages of the conflict, cases of sexual violence against women were believed to be largely opportunistic — related to the general breakdown of law and order and the upsurge of criminality of all kinds¹¹.

The breakdown of law and order during the 2008 PEV made women in particular vulnerable to GBV which led to the situation where male perpetrators took advantage of the situation to violate women and girls. The Nairobi Women's Hospital Gender Violence Recovery Center¹² noted that altogether they attended to over 650 cases of GBV related to the post-election crisis. Between late December 2007 and end of February 2008, GVRC treated a total of 443 survivors of (S)GBV of

¹⁰ No way to tell: a secondary data research project on violence against women in Kenya UNIFEM, 2009

¹¹ (L.M. Wanyeki *Lessons from Kenya: Women and the Post- Election Violence* PDF www.feministafrica.org).

¹² The Nairobi Women's Hospital Gender Violence Recovery Center, Kenya's pioneer health institution specialized in women's health issues

which 80% were rape/ defilement cases, 9% were physical assault cases, 7 % were domestic violence cases and 4% were indecent assault (CREAW, 2008, p 5). Gang rape constituted about 90% of the rape cases the hospital faced during the political crisis. The CREAW study on sexual and gender based violence in Kenya's 2007 post-election crisis indicated indecent assault as the most prevalent form of sexual violation even, if such cases were not reported as often as incidences of gang rape because women are not aware of it being a sexual offence and a crime¹³.

The rampant occurrence of indecent assault only points to a situation where otherwise ordinary law abiding men and boys turned violators in the absence of law enforcement and subsequent vulnerability of women and girls. Different forms of vulnerability that include age as minors, economic situations such as of feminized poverty, unemployment as well as poor physical conditions of employment and work environment that opens women to security risks makes it possible for men to take advantage and subject women to violence. The most vulnerable categories of women include, unemployed women, women whose spouses drink heavily and those whose spouses show controlling traits. It is noteworthy that women that are involved in decision making at home and those generally in positions of authority and control with or relative to men are less vulnerable and as a result experience less violence (2009 KDHS). This finding means that empowering women to make decisions at all levels leads to a reduction in violence.

Even though women and girls with low socio-economic status constitute the majority whose vulnerability attracts violence, men and boys may also experience violence when in similar conditions or within conditions of break- down of law and order such as was the case in the PEV. Wanyeki points out that during the PEV sexual violence included not just the rape of women, but also the forced circumcision (and, in some instances, castration) of Luo men, (who traditionally do not circumcise) making her conclude that the outbreak of sexual violence seems to have been facilitated by the general breakdown in law and order, but the forced circumcisions of women and men believed to be ODM supporters seems more specific. She points out that similar acts were perpetrated during the counter-offensive of the *Gikuyu* (Mungiki) militia moving from Nairobi into the south Rift¹⁴. Categories of perpetrators may also include both female and male family and community members.

During periods of security upheaval such as the 2008 PEV state law enforcement organs may also perpetrate violence as a UN Women report (among other similar accounts in the media and elsewhere) witnesses that among SGBV “perpetrators were state security agents from administration police, Kenya police and General Service Unit”¹⁵. It is also apparent that during Kenyan election periods women candidates and women in general suffer electoral GBV meted out by communities, families, political party members, candidates, supporters and the media¹⁶. Studies have consistently established that GBV targets are the vulnerable members of society who are more likely to be voiceless, have less information and may not have the physical strength to block assault, and especially physical assault. However, it is important to mention that from 2009 KDHS

¹³ CREAW Study, 2008, P.23

¹⁴ Wanyeki says Mungiki's leaders deny being involved, although they admit that they had been approached by PNU politicians interested in the 'self-defence' effort.

¹⁵ *Electoral Gender Based Violence in Kenya* UN Women 2013 Page 51

¹⁶ *Electoral Gender Based Violence in Kenya* UN Women 2013 Page 51

data men (11%) and boys (5%) were also targets of GBV, as well as 4% reporting that even the elderly are targets of GBV.

Where does it occur?

Recent studies by Gender Violence Recovery Centre confirm earlier 2009 KDHS and other surveys' finding that most GBV (64%) occurs mainly within the survivor's homes as opposed to 20% reportedly occurring in dark and hidden areas. Put another way, women and girls and to a



lesser extent boys are more exposed to GBV in the “safety” of their homes than say on a dark urban backstreet. The irony of the situation is even more pronounced when we consider that most people will think of an evil stranger attacking women and girls, mostly when they venture from the safe home environment to the streets or farmlands.

Part of the reason why the stranger attacks are more prominent is because survivors have no prior attachment to perpetrators and may not harbour sympathy to prevent them from reporting. Such cases are therefore much better reported and are therefore more visible. It may also be that the protection that perpetrators enjoy within homes as heads of households, prized male family members, husbands and family disciplinarians privileges them at the expense of survivors.

During periods of political and social upheaval that compromise existing mechanisms of keeping law and order, the locus of violence may shift to a certain extent partly because of displacement of women and girls from their usual places of residence. The COVAW report on the 2008 PEV notes that Women in slum areas of Kisumu suffered an increase in all forms of violence during the conflict and in particular sexual violence from youth formations that were supposed to be

protecting them¹⁷. Women reported being: raped¹⁸- violated by male youth even in public places. The youth stripped them, touched their private parts or generally shouted obscenities at them. They reported increased beatings by militia, boyfriends and husbands/relatives who were said to be in a constant state of agitation. The militia also, restricted them from going to work or earning a living through petty trade or alternatively forcing them to pay them a fee for “allowing” them to work. Businesses by women were also looted and stock stolen or destroyed. A long similar experiences in more public areas Wanyeki’s study reveals that Gikuyu militia that moved into the South Rift, enforced the ban on women wearing trousers in Naivasha and Nakuru towns and ‘punished’ — through gang rape and other violence — Gikuyu women found to be involved with men from other communities or sheltering those from other communities (Wanyeki P. 6). The COVAW¹⁹ study quoted women/girls reporting that the worst time with regard to sexual and gender based violence (SGBV) was when they were evicted and during movement to the IDP camps²⁰. Most women and girls suffered SGBV attacks before arriving at the camps. Still even during conflict situations such as 2008, considerable cases of GBV were reported at home; a UNWomen reported that “rapes and gang rapes targeted mostly poor women in their homes by gangs numbering up to 20”²¹.

It is notable that accounts of GBV survivors during “peacetime” such as testimonies collected in a then (1998) peaceful Mt. Elgon district bear an uncanny similarity to PEV accounts²². In her testimony, Margaret remembers “a recent occurrence when a woman was forcefully circumcised despite her resistance”²³ She goes on to relate another case involving a man “against his wife’s circumcision, and he was thoroughly beaten until he was admitted to the hospital while the wife was taken to the operation that very day”²⁴. Margaret’s among other accounts relate forceful circumcision of the *Iteso* men and women then living among the local Sabaot even though they do not traditionally undergo circumcision. In all the cases related, nobody was prosecuted for the crimes and the tone of the narrators is one of bemusement rather than horror at such occurrences.

What causes GBV?



Available data attribute GBV to largely gender masculine norms and women’s low norms include prescriptions for ways to act tough as a man, to stay in control, and attitudes such as women should be home keepers and look after children, men should prescribe

ps in Western Kenya- Kisumu, Kakamega and Kisii Coalition on Violence Against Women (COVAW) Kenya January

ers- by who largely felt helpless to stop the militia doing it,

²⁰ Ibid P.14

²¹ *Electoral Gender Based Violence in Kenya* UN Women 2013

²² *Voices from the Mountain-Personal Life Histories from Mt. Elgon* Masheti M and Okombo. O, 1998.

²³ Page 26

²⁴ Page 27

the correct dress code and general conduct for women. Such gender norms often encourage men to respond to problems with violence; to abuse alcohol; to believe it is acceptable for men to control and dominate their partners; and to discourage men from

seeking help or expressing feelings of fear or vulnerability. It is therefore important to work with men and women to change the social norms perpetuating GBV, including providing alternative and non-violent role models for young men and boys, and supporting men to take a stand against GBV.

Because women constitute the majority of the poor in Kenya they face situations related to their survival and that of their children/families that predispose them to male violence. In most rural areas where livelihoods are secured by family land usually owned by men, women are forced to acquiesce to male control as the only way to secure access to the land and with it their livelihood. The formal



work environment as well as the more lucrative informal job market favours skills attributed to masculinity which gives men the upper hand. It is also established that women are more likely to earn less for the same job as men in the formal and informal sectors or occupy lower positions that attract less remuneration and benefits. The fact that women take on the role of baby and childcare both in relationships with men and as single mothers tends to intensify their low economic status since the role greatly compromises their capacity to engage in economic activities. These among other unfavorable economic factors that minimise options that women have for economic empowerment drive them to develop high tolerance for GBV and suffer the consequences often in silence without seeking available avenues of assistance for fear of losing what they consider to be enabling them to get by in life. Cultural norms reinforce the silence and inaction in the face of violence.

Police sources list drunkenness, substance abuse, unemployment, poverty, families living apart and HIV status of the man as leading causes. This is supported by a 2008 FIDA study that ranks conflict over adultery 41%, alcoholism 28.2%, financial position 20.5% and the HIV status of spouse 10.3%. According to the FIDA study findings, a male spouse who is HIV positive tends to be more aggressive and harsh owing to frustrations borne out of stigma and discrimination. It may appear that by their gendered socialization, men tend to gravitate towards GBV as a show of “manhood”.

According to UN Women, the “culture of impunity” that informs and sustains GBV exacerbates GBV suffered by women candidates during elections²⁵. Women are routinely subjected to intimidation, insults and physical violence to stop them from competing with men for political power. Such violence is caused by the plot by men in general and male candidates in particular to preserve elective political power to themselves and employ violence to keep women out.

²⁵ *Electoral Gender Based Violence in Kenya* UN Women 2013

What is the prevalence?

All Kenya GBV studies show high levels of prevalence throughout the life cycle of women and girls in particular which means that there is not time in their lives that they are free from violence. 2009 KDHS shows that overall as many as 83% women and girls reported one or more episodes of physical abuse. The children specific 2010 *Kenya Violence against Children Survey (VACS)* indicates that violence against children is a serious and growing problem in Kenya. Levels of sexual violence prior to age 18 are 32% for females and 18% for males and 66% of females experience at least one incident of physical, emotional or sexual assault as children. 13% of females and 9% of males experienced all three types of violence during childhood.



An earlier KDHS study shows 60% of females reporting age of first abuse at 6-12 years while 24% say it is between 13 & 19. 25% of girls aged 12-24 lost virginity through force. The data raises the urgency of designing gender and age specific strategies and tools to address violence at appropriate levels. Below is a more detailed table showing rates of GBV against women and girls by age that shows that the likelihood of experiencing physical violence increases with the age of women; from only 11 percent of those ages 15-19 to 29 percent of those ages 40-49.

Table 3: Physical or sexual violence by age (2009 KDHS)

Status-Age	Physical or Sexual violence	Sexual violence
15-19	29%	8.5%
20-29	37.5%	14%
30-39	40.1%	15.2%
40-49	42.7%	15.5%

Studies also show that GBV incidence varies across cultures and regions in Kenya. Women experiencing physical and sexual violence in Nyanza (54.1%), Western (50.1%), Rift Valley (39.8%), Central (35.1%), North Eastern (32.8), Eastern (31.5), and Nairobi (24.6%). Studies also show that there are regional and local variations of incidence and types of GBV that should be taken on board when programming (KDHS)

Table 4: Physical or sexual violence by Region 2009 KDHS

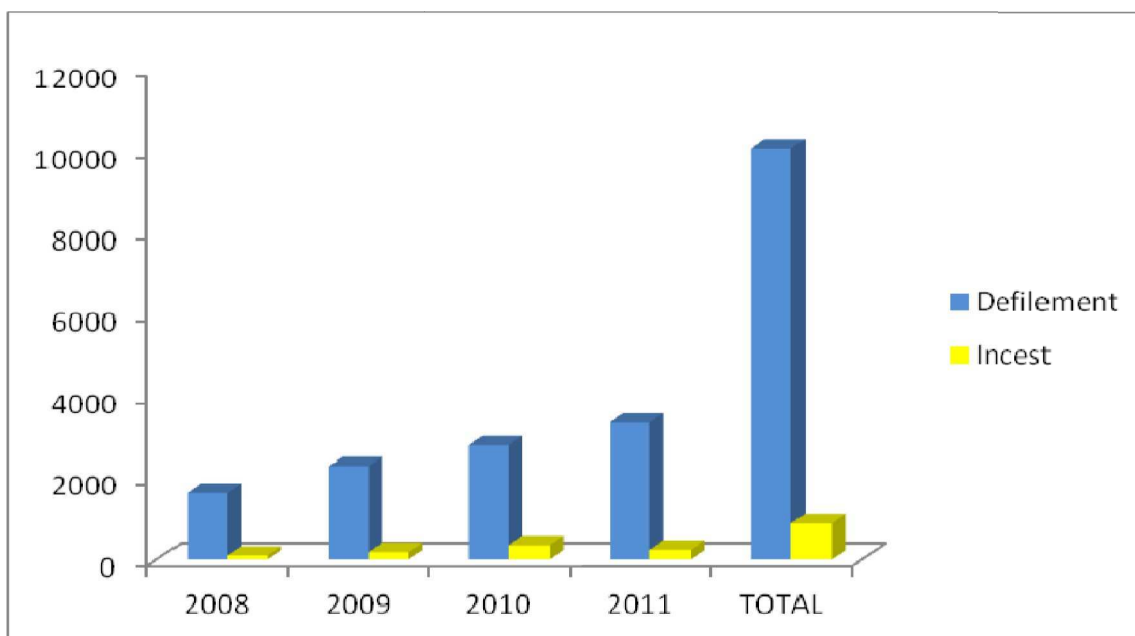
Region	Physical violence	Sexual Violence
Nyanza	54.1%	21.6%
Western Central	50.4%	17.6%
Rift Valley Coast	39.8%	15.3%
Central	35.1%	10.4%
North Eastern	32.8%	2.7%
Eastern	31.5%	12.5%
Coast	29%	13.2%
Nairobi	24.6%	8.2%

The analysis reveals that the rate of incidence of physical violence signifies relative similar levels of violence in all regions except North Eastern which has a very low incidence of sexual violence but averagely high physical violence. The discrepancy may also be attributable to possible higher levels of stigma against victims of sexual violence who most likely suffer in silence and do not contribute to known statistics. High incidence of over 50% physical violence and over 15% sexual violence could be an indicator of cultural norms supportive of GBV.

A more recent (2013) study by GVRC: *Assessing the Prevalence of GBV in Kenya- the Case of Nyanza and Nairobi Regions*, found GBV prevalence within Nairobi neighbourhoods stood at 78% and 79% for Nyanza. The rate of prevalence at family level corresponded with prevalence at community level. This is a major worry point, especially that about half of Kenyan families experience GBV. Nairobi had a much higher percentage of that 53% reporting that GBV is prevalent in their own families while Nyanza reported 47%. The consolidated data puts physical assault (58%) as the leading GBV issue followed by rape (32.5%) within communities. This are higher percentages of GBV reported in the two regions since the 2009 KDHS and may be proof that GBV is on the rise even in areas such as Nairobi that had previously reported lower incidence. However, whichever way one takes looks at it, the survey strongly showed that GBV is a massive issue at family and neighbourhood level. More evidence of a rise in GBV is from police data on sexual violence that shows a rise in the number of sexual offences from 3525 in 2007 to 4703 in 2011(NPSCR). The table and bar chart below shows consistent increment in numbers between 2008 and 2012:

Table 5 Trends in sexual offences

Type of GBV	2008	2009	2010	2011	2012
Defilement	1,626	2,285	2,808	3,352	
Incest	100	185	363	247	308



Such a trend in consistent increment of sexual violence victims may be a pointer to the corresponding failure of law enforcement and other measures in place to combat GBV.

What happens after GBV?

Evidence from 2009 KDHS is that up to possibly half of the survivors (45%) of GBV do not seek help- choose or may be forced to keep quiet and takes no action. Documented reasons for the silence include but are not limited to; fear of the perpetrator(s), survivors' shame and selfblame for the violence by victims. Survivors feel helpless as: no one may help the situation, knowledge that duty bearers will not help, acceptance of certain forms of violence within societies and cultures, lack of basic resources to seek justice, inadequacy of appropriate services and/or insensitivity of service providers. Fear of social stigma particularly in cases of sexual assault discourages reporting and so does high tolerance for violence within given cultures.

There is however some evidence that the more severe the violence the more the likelihood of survivors reporting- for instance, women who experience both sexual and physical violence (52%) are more likely to seek help as compared to only physical (35%) or only sexual violence (14%)²⁷. The reason for severe cases help- seeking behavior may have to do with the likelihood of such attacks being noticed easily by others or such attacks resulting in such severe injuries that make survivors fear for the worst if they do not take any action. It may also be that suffering both sexual and physical violence widens options available for support which tends to motivate survivors to choose at least one option.

According to (KDHS) 2008/9 report. Age and marital status also affects help seeking habits - older women, separated women and widowed women are more likely to seek help than younger and currently married women (55% compared to 37%

Better help seeking among older women may have to do with the realization of the more severe health consequences of ignoring injuries (including of a psychological nature) resulting from GBV. Older age may also signify more self-confidence and better knowledge of psycho-social and other support ties in particular among fellow women that could motivate or make it worthwhile to seek help. Evidence of un- attached women seeking help on a higher scale than those in marriage has to do with the autonomy of the former in their single status as they do not have to seek permission or consult their usually more powerful partner in order to seek help. In the more likely event that the perpetrator is a current spouse there are higher chances that he will try to stop the survivor from seeking help either as a punishment or because of fear that such help may result in his being asked to account for the violence including to law enforcement agents. These trends in differential help seeking behavior among different categories of women calls for strategies to reach out to in particular focused upon abused women in marital relationships that appear handicapped as far as autonomy to make decisions and act upon GBV directed at them.

²⁷

2009 KDHS

Awareness of options for help should be supplemented by workable measures to reduce fear and stigma among this category of women that is associated largely with cultural expectations of gendered behaviour of women and men in marriages.

Information from studies on where or from whom help is sought by survivors shows a consistent trend that avoids making perpetrators legally accountable for their actions within the provisions of the law.

Table 6: Help seeking habits:

Where help was sort	Percentage	Nature of agency help
Family	64%	Social/reconciliatory
In Laws	40%	As above but in some cases limited non mandatory sanctions
Friends	17%	Social/reconciliatory with no sanctions
Community leaders and administrators	14%	As above but in some cases limited non mandatory and mandatory sanctions- in particular from administrators such as chiefs that may include fines and in very few cases referral to police

Doctors or medical personnel	2%	Mainly curative clinical support, limited psychological support and minimal collection of evidence for prosecution referral
Lawyers	0.3%	High likelihood of referral to justice system or legal sanctions
Social service organizations- (NGOs included)	0.1%	Moderate likelihood of referral to justice system or legal sanctions but very high likelihood of psychosocial support.

Data from 2009 KDHS

What the table (above) shows is that the help seeking trends of survivors of GBV do not focus on corrective action and in particular fail to rope in the perpetrators which means that there is little to stop them from continuing with GBV aggression. It also means that all the commendable effort that has gone into policy legal reforms, awareness, community action and service provision is yet to reach or impact on up to at the very least 50% of the survivors of SGBV.

At what cost?

GBV ramifications are felt at many levels; individual, community and national and with them associated human, social and direct financial and wider economic costs.



t the direct economic level, GBV costs money in two ways; on the one hand services that are in place for mitigating medical and psycho-social effects have a cost comparable to that of road accident victims and survivors. In both cases you are dealing with otherwise a healthy population often at the prime of its productive capacity but that is subjected to human driven and avoidable traumatic acts that seriously interfere with their productivity-cumulatively for long periods of time.

Within the time survivors undergo FGM and suffer fatal to manageable injuries, they involve costs in medication, care and rehabilitation that have to be taken from productive budgets. In second place, GBV turns otherwise healthy responsible and productive people into often net recipients of charity and support from service providers, families, communities and individuals. It is both a loss to the interventionists who sink money that could have been use more productively into reproductive care of survivors. Parallel to such costs are costs related to loss of “revenue” that is equal to would- be contribution of the collectivity of victims had they not been incapacitated by

GBV. Otherwise productive people are turned into consumers of resources that they could be multiplying by their economic contribution. The illustration below shows both direct costs of GBV such as days of absence from work by victims and wages lost as a result and indirect costs such as negative effects on child mortality and survival and treatment income used on treatment and care:

Notable psycho- social and clinical costs are that GBV adversely affects survivor's mental and physical health as shown in the table below derived from FIDA (2009) data that puts the biggest effect on direct costs to victims from managing injuries and loss of life, followed by direct loss of finances or means of getting finances:

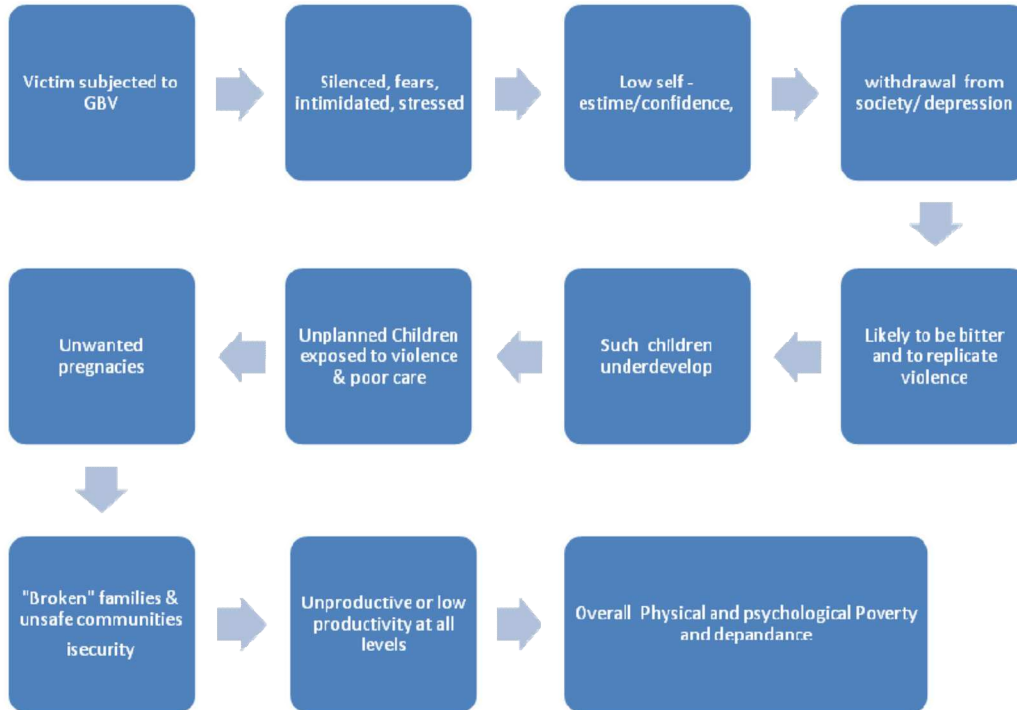
Table 7:

Effect suffered by victim	Percentage of affected
Injuries including that cause death	28.9%
Direct financial problems	26.3%
Separation/divorce	21.1%
Endured sexual abuse	15.8%
Emotional depression	7.9%

The cost of managing loss due to uncompensated fatal and related ailments such as headaches, back pain, abdominal pain, fibromyalgia, gastrointestinal disorders, limited mobility and poor overall health is enormous. Considering that the cost of GBV is "silent" and seemingly indirect to the extent that it is borne largely by individuals and families and increasingly by non- profit CSOs, most of the time it goes un-noticed at a global level government revenue and expenditure level. Where the impact is inevitably visible is the micro- family level where the gap created by the unavailability of the economic provider has multiplier effects on dependants who in most cases happen to be children and siblings. Considering that Kenyan demographics are such that many children and young people depend on the productivity of fewer older people, the fact that the incidence of violence increases with age means that many dependants are turned destitute by the effects of GBV in turn affecting their potential for fitting into the productive economy.

Other costs are indeterminate because of their long term nature; children, for instance, who grow up in violent families may suffer a range of lifelong behavioural and emotional and mental health disturbances such as drug/alcohol abuse, risky sexual behavior, and perpetration of violence (for males) and being a victim of violence (for females) attributable to exposure to violence.

Table 8: SAMPLE CHAIN OF GBV INDIRECT COST



It means that their otherwise normal development is compromised and resources have to be spent on them even when they reach the age of majority where they are supposed to be self-reliant and productive.

What is in Place to deal with GBV?

Policy/legal support:

Kenya has a relatively well developed policy legal framework for GBV. Among the highlights is that it has signed international treaties such as UN Conventions: on Elimination of all forms of Discrimination against Women, on the Rights of the Child, UN Resolution 1325 and Beijing Platform for Action. In addition, regional treaties such as Maputo Protocol provide a comprehensive framework for enactment and review of national policy and legal instruments. Such international principles are captured in National policies such as *Vision 2030* under the social pillar, *Gender Equality and Development, Sessional Paper No.2 of 2006*, and its *Plan of Action (2008 – 2012)*. Legal instruments include the Constitution of Kenya that outlaws all forms of discrimination, the Penal Code, the *Children's Act 2003*, *The Sexual Offences Act in 2006*, and its implementation framework under *Multi Sectoral Standard Operating Procedures for Prevention of and Response to Sexual Violence in Kenya*- comprehensive document focusing on protection, care and treatment of sexual violence victims and on prevention of sexual violence as well as management of sex offenders.

Police reforms

The Kenya Police Service has initiated reforms to improve its response to GBV that include: dedicated gender desks at all police stations to receive and deal sensitively and professionally with survivors, increasing its numbers of female police officers and strengthening capacity among its officers to handle GBV cases.

The main problem remains weak coordination of efforts to combat GBV in the implementation of action plans. The problem of coordination is also intensified by endemic challenges posed by implementation of

The 2010 UNIFEM *Comparative Review of Domestic Laws* lists five key challenges to women's access to the law in Kenya: lack of accountability, under-representation of women in the police force, criminalization of feminized poverty, alternatives to incarceration and structural barriers to women's access to criminal justice²⁶. Inadequate accountability has its roots in the discretion given to the police and other law enforcement agents that include decisions on identifying suspects, whether and how to record a statement, whether to prefer charges and for what offence, whether to offer (police) bond, and what evidence to produce in court among others. There are no clear mechanisms for accountability where police officers perpetrate criminal offences as in cases where they are engaged in sexual offenses against women and girls as happened during 2008 PEV. Such weak accountability mechanisms also leave police vulnerable to interference by powerful individuals as happens in rape and domestic violence cases where the powerful perpetrators are more likely to escape punishment.

Male dominance in the Kenya police service helps maintain masculine norms that work against the force being effective in the fight against GBV. It is estimated that currently women make up only 11 per cent or 8030 of the 73,000 (as of 2012) members of the police service in Kenya²⁷. This falls way below the constitutional minimum of at least one third participation of each gender. Police have acknowledged reforming the police institutions such as providing additional facilities for female trainees at the National Police Training College in Kiganjo but the impact is yet to be felt on the streets and in the communities. The numbers of police women are even lower in senior positions compromising their ability to engage with decision making and change institutional culture.

The biased male institutional police culture is visible in the criminalization of feminized poverty by law enforcement agents even when the laws do not explicitly make certain activities of largely poor women that may involve committing petty non-violent offenses such as trading in unlicensed brews, hawking, and sex work. The lack of safeguards in the penal code for handling petty 'crimes of poverty' opens mostly poor women to GBV perpetrated by the state. Even while acknowledging that reforms have been or are potentially beneficial to women's access to justice; there is need for more to counter the underlying causes of GBV. Coordination remains key with clear leadership and commitment by government.

²⁶ Promoting the human rights of women in Kenya: a comparative review of the domestic laws UNIFEM 2010

²⁷ Sex-segregated data by gender is not available publicly for the Kenyan police force

Limited (working) alternatives to incarceration still lead them to attract harsh custodial sentences often at the behest of justice officers' discretion on when to apply the Community Service Orders Act that allows for replacing custodial sentences of up to 3 years with community service or probation under the Probation Act. Structural barriers to women's access to criminal justice such as limited geographical access due to over centralization of the court system in major urban areas, social cost in the likelihood of disapproval by relatives, financial cost and fear of officers/procedures of the justice institutions obstruct women from seeking help from them. Despite the launch of the National Legal Aid and Awareness Scheme in 2008, little has changed for poor women as they may not be provided with free legal aid from government. CSOs such as FIDA provide limited legal aid in their program areas that is a drop in the sea. The proposed legal Aid scheme also ignores paralegals that are often available and accessible to women within the areas they operate making referrals to pro bono services more difficult.

Where are the gaps?

As highlighted above there is need to continue review of laws and policies that affect GBV because they still contain gaps. We also recognize that experience with implementing existing laws policies and action plans has tended to shift focus to endemic challenges to achieving desired results. The most pressing challenges include weak coordination of efforts- meaning different government sectors such as health and law enforcement as well as CSO actors work independent of one another without even sharing experiences which makes it difficult to achieve common objectives set out in the action plans. There is also consistent slow uptake of action plans in particular by key government actors sometimes attributable to unclear reporting lines. Other gaps have to do with, weaknesses in the proposed GBV prevention actions and strategies which end up not being sufficient to address the identified problems. Closely related are gaps in data collection, data analysis, dissemination of data and its utilization for improved planning and implementation of initiatives to the extent that a number of initiatives are not based on appropriate data. It has also become the practice that GBV initiatives do not receive adequate funding and in a timely and consistent manner to sustain actions.

Law/Policy actions:

Among the preferred law review and formulation actions is the review of the Sexual Offences Act to remove “claw back” clauses that condone marital rape. This is urgent to reduce violence between intimate partners and at home that constitutes the highest incidence from the data reviewed above. In the same vain, the penal code should be reviewed to be gender specific in its description of crimes and prescription of penalties as well as general application. The penal code has to include specific gender based crimes such as occur under “domestic violence” such as wife/partner beating and to be in tandem with recent legislation such as the sexual offences act and the bill of rights in the constitution. The same review should be extended to the criminal procedure code to take into consideration gender specific needs and interests of in particular women who find themselves seeking justice or on the wrong side of the law.

The ongoing discussions on the marriage bill present graphically the need to keep the debate focused on preserving freedoms and rights already guaranteed to women and girls in the constitution while at the same time closing the yawning gap between the reality of how people enter and stay in relationships in Kenya and what the law expects in such unions. Already, a number of people, among them religious leaders, elders and even legislators have called either for dropping of constitutionally sanctioned entitlements to women in marriage such as equality at all stages or enactment of clauses that will limit women’s freedom within marriage. It is critical that civic awareness makes it clear that adoption of some of the unconstitutional views will lead to constitutional challenges in court with a high possibility of reversal of the law leading to more wasted time in correcting mistakes. The marriage bills aside, it will also be necessary to enact specific legislation that shall seek to counter domestic violence in order to position the fight against GBV on a strong legal prohibition path.

Recognizing the principle of gender equality within the constitution and going by the growing body of evidence that programs targeting men and boys can influence their attitudes, behaviours and their role as agents of gender responsive, policies in particular should be gender sensitive by

analyzing and including the roles of men and boys. “GBV policies” should be reviewed to be *gender transformative* meaning that they seek to make women and men, boys and girls agents of change. Policies should also be *gender synchronised* to ensure that they do not reinforce negative societal values and stereotypes and instead aim to address negative gender norms through active participation of men and boys at countering such negative norms.

Coordination:

All GBV legal and policy frameworks/action plans anticipate a multiplicity of cross sector linkages, however most fall short of outlining but more critically putting in place workable protocols and procedures for exchange of information and referrals across different service action points. This is so even among government sectors and in particular health, law enforcement and social services. Perhaps a worse scenario obtains among CSO GBV players who more often than not act independent of one another without structured and timely feedback mechanisms to even inform on what is in place, where, when and how it is progressing if at all. This tends to defeat the intention to promote synergy and offer holistic services.

In addition to the hitherto highlighted weaknesses in coordination of GBV programs, the current restructuring situation within the public sector appears to have slowed down even further progress of concerted interventions. The Ministry of Devolution that houses the “gender directorate” is yet to give directions on both the wider operations of the gender directorate²⁸ as well specific responsibilities for programs such as those that fall under GBV. It is not clear what the roles and responsibilities of the National Gender and Equality Commission and the gender directorate are with regard to GBV coordination, among other related responsibilities such as to do with children issues. The setting up of different and increasingly parallel commissions/ councils/ directorates is having the negative effect of duplicating bureaucracy and stifling cohesion and complementarity.

To avoid the prevailing coordination gridlock above, a specific government office (sector) has to take responsibility for coming up with a consolidated master plan for GBV in a participatory manner that involves government sector, CSO, private sector and other none state actors. The same agency/office should take on the central responsibility of coordination of the plan and in particular networking and communication/feedback mechanisms, identification and facilitation of capacity requirements of different players including advising on priority funding arrangements. It is desirable that such an office deal exclusively or at the very least put in place a well capacitated secretariat to carry out coordination roles to the satisfaction of partners and other stakeholders. Within and among government sectors, such an office should have the mandate to receive reports from across sectors without undue interference by the specific sector protocols.

Data: Even while acknowledging contribution of the few government and CSO agencies towards availing data to inform policy and action on GBV there isn’t still a central and systematic mechanism for collecting data on GBV. The state should explicitly take on this role and appoint preferably, borrowing from the practice on better centralized data collection in other sectors Kenya Bureau of Statistics should be the central repository but working closely with the coordinating office. Such an arrangement should help meet the need to systematize, standardize, coordinate and

28 That appears to have taken over the roles of the former “Ministry of Gender”

synchronize collection and analysis of GBV data. An anticipated contribution of such a centralized national data collection would be working out a standardized formula for calculating/determining the socio-economic cost of GBV. Additionally it would facilitate formulation of strategies appropriate to prevailing local conditions particularly at county and community levels. A related gap is the limited use of data and research by most stakeholders to enhance GBV ethical and evidence-based programming. It may be that the observable consistent rise in GBV cases has to do with poor planning apart from coordination bottlenecks. Timely availability of reliable data should aid adherence to the highest standards of results based logical planning.

Monitoring and evaluation of GBV programs is still a very weak area since most of the actors lack both capacity and resources to undertake M&E. As a result it is difficult to tell based on evaluation of ongoing and past programs what we are doing wrong since GBV is beating all our efforts. It is critical in particular to identify and share best practices and lessons learned across agencies to make a difference to the bad GBV incidence trends discussed above. The NGECC may come in handy since its statutory responsibilities include monitoring of implementation of “gender” initiatives. NGECC’s main contribution would be inform of regular periodic reports on SGBV status and how successful measures taken by different players are faring. It may also be of immediate interest to players in GBV programming to link up with the current ongoing efforts to set up a National Integrated Monitoring and Evaluation framework that includes CSOs and private sector -under the planning department so as not to work in isolation and for sustainability.

Other opportunities that –to improve GBV work are for instance the one third rule that guards against any gender monopolizing over two thirds of participation in any sector. The rule should immediately come in handy within the Kenya Police Service Recruitment to raise the number of women officers to at least a third as well as ensure the same balance in the hierarchy. Devolution and in particular allocation of resources to counties and with it the mandate to plan and implement more locally specific programs provides an opportunity of possible additional funding and potentially more authority by women and other stakeholders in gender equality to include GBV interventions in county plans and budgets. Increased representation by women in parliament and the newly created institutions such as county governments and legislatures provides a significant ability to push the eradication of GBV to new levels.

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