KENYA GENDER-BASED VIOLENCE SERVICE GAP ANALYSIS

at the County Level

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ACKNOWLEDGEMENTS

This work was led by Patricia Fernandes (Senior Social Development Specialist), Verena Phipps (Senior Social Development Specialist) and Lisa Schmidt (Social Development Specialist). The report was prepared by *Social Development Direct* under the leadership of Catherine Müller and Victoria Schauerhammer. Data collection was conducted by a team of field researchers from *Forcier* led by Caroline Morogo.

Guidance, inputs and comments from the following county focal points are gratefully acknowledged: Sylvia Chidodo (County Executive Committee Member Public Service and Administration, Kwale County), Shadrack Musyoka (Deputy Director Culture, Gender and Social Services, Kitui County), Rosemary Otieno (Chief Officer Gender, Kisumu County) and Chirchir Wesley (Deputy Director Gender, Bomet County).

The results of this research were discussed during a stakeholder workshop in October 2019, with representatives from the study counties, the State Department of Gender Affairs and the National Gender and Equality Commission (NGEC).

The study was funded by the Kenya Accountable Devolution Program (KADP).

ABBREVIATIONS

AMPATH	Academic Model Providing Access to Healthcare
CBO	Community-Based Organization
CHVs	Community Health Volunteers
FBO	Faith-Based Organization
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender-Based Violence
GoK	Government of Kenya
IPV	Intimate Partner Violence
KII	Key Informant Interview
LGBTI	Lesbian, Gay, Bisexual, Transgender, and Intersex
LVCT	Liverpool (Voluntary Counselling and Treatment) Care and Treatment
NGEC	National Gender and Equality Commission
NGO	Non-governmental Organization
KDHS	Kenya Demographic and Health Survey
PEP	Post-exposure Prophylaxis
PWD	People with Disabilities
SOPs	Standard Operating Procedures
STIs	Sexually Transmitted Infections

EXECUTIVE SUMMARY

This report summarizes findings from a gender-based violence (GBV) service gap analysis undertaken in four counties of Kenya (Bomet, Kisumu, Kitui and Kwale) in October and November 2018. The research was conducted to assess current gaps in services and provide concrete operational recommendations to strengthen awareness, access and quality of GBV prevention and response services that can inform key sectors that are looking to integrate GBV prevention and response services.

The main findings of the research show that:

1. There are high levels of awareness and recognition of the different forms of GBV among surveyed groups. At the same time, physical, sexual, verbal abuse and economic acts of violence are widespread and largely accepted.
2. Typically, violence that occurs frequently and amongst married couples – including marital rape – is considered 'normal', and results in little or no reporting or help-seeking behavior. It is usually managed at family or community level.
3. Generally, only severe violence or beatings that lead to physical injuries, and violence perpetrated by strangers are not accepted and may result in reporting and formal help-seeking.
4. The number of comprehensive formal support and response services for survivors are limited, and awareness of such available services is moderately low - particularly in rural areas.
5. Socio-cultural barriers which affect the willingness and ability of victims and survivors of GBV to report violence and access services are related to: a lack of awareness of their rights, lack of knowledge of existing services and/or their location, the high level of acceptance of more 'moderate' types of violence, stigma around reporting violence, fear of retaliatory violence by perpetrators, fear of service providers, and local power dynamics and relationships.
6. Structural barriers to help-seeking include the availability, accessibility and quality of services, defined by the availability of infrastructure, resources, human capacity, geographical distances, as well as social and gender norms which affect how service staff treat service users and choose to handle presented cases.
7. Recent progress has been made – notably with the prioritizing of GBV cases by health providers, increased (but not yet systematic) GBV training across different sectors, and GBV-specific processes by some service providers.
8. However, the institutionalization of protocols seems to be lagging behind, with the majority of service providers not making reference to any formal protocols or guidelines for their sector.
9. There is also considerable room for improvement related to making services more accessible and less discriminatory, for example by reducing financial barriers to services, improving the quality, effectiveness and accountability of services, raising awareness of existing guidelines and protocols, and providing better resources and infrastructure to service providers.

Recommendations for the future work relate to three main areas of work: (1) addressing socio-cultural and socio-economic barriers to help-seeking; (2) addressing institutional barriers to help-seeking; and (3) supporting GBV prevention efforts at the community level:

(1) Addressing socio-cultural and socio-economic barriers to help-seeking

- Invest in awareness raising activities on women, men and children's right to a life free of violence as part of community mobilization efforts to change the acceptance of GBV and other social norms around GBV.
- Invest in efforts to sensitize women and men on the importance of help-seeking and destigmatize reporting as part of community mobilization efforts to change social norms affecting help-seeking behavior.

- Support the communication and awareness of available services and referral networks within communities.
- Support the establishment of community-based support initiatives for survivors of GBV, including financial support to access services.

(2) Addressing institutional barriers to help-seeking

- Support efforts aimed at reducing access barriers by increasing the coverage of service provision, reducing direct service costs, and increasing the accessibility of services to key vulnerable groups, such as people living with disabilities.
- Support efforts that increase accountability across the justice and health sectors and the police. This could include, for example, testing the effectiveness of different modes of monitoring staff conduct and providing complaint mechanisms not tied to the service providers, and incentive schemes for service providers to encourage case handling in conformity to existing laws and standards.
- Support efforts to strengthen existing referral networks and better coordination among service providers across all sectors – including through greater cooperation between formal service providers and civil society organizations; and instituting an oversight/coordination mechanism to manage cases from start to finish across different service providers.
- Support the design, implementation and monitoring of regular trainings and refresher courses for service providers, including continued capacity building in empathetic care.
- Ensure that a minimum standard of skill sets and gender balance among staffing is implemented in all programmes supported.
- Support efforts that facilitate the monitoring of key resourcing challenges across sectors.
- Support local organizations that provide key services that are missing or lacking in government provision, such as shelters, and individuals filling gaps in referral and follow up mechanisms.

(3) Supporting GBV prevention efforts at the community level

- Invest in prevention initiatives that are co-located with support for response through improved service provision.
- Invest in proven community initiatives aimed at tackling harmful gender norms, destigmatizing help-seeking, promoting healthy relationships and non-violent behavior, and nurturing trust between communities and service providers.
- Support livelihoods and economic empowerment initiatives which promote women's economic empowerment alongside gender transformative work with women and men to address risk factors for GBV.

1. INTRODUCTION

This report summarizes the main findings of research centered around the:

- availability and quality of GBV prevention and response services,
- community perceptions and attitudes towards GBV that influence service-seeking behavior, and
- operational recommendations to strengthen awareness, access and quality of GBV prevention and response services in Kenya.

Primary qualitative research was conducted in the four counties of Bomet, Kisumu, Kitui and Kwale in October and November 2018. This was preceded by an inception phase (between June and July 2018), which included a literature review on the experiences and attitudes towards GBV across Kenya, as well as the policy framework and the state of GBV service provision to inform the selection of counties for in-depth study and data collection tool design.

Before diving into the results, this section briefly describes the main findings of the literature review with regards to types and prevalence of GBV, community perceptions and attitudes influencing service seeking behavior, and GBV service provision in Kenya. Section 2 lays out the methodology of the study, and Section 3 presents and discusses the findings, on which the recommendations in Section 4 are based.

1.1 GBV in Kenya

GBV is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed gender differences. The term GBV stems from the 1993 United Nations Declaration on the Elimination of Violence against Women, which defined violence against women as **'any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women'**. While GBV disproportionately affects women and girls across the globe, men and boys can also experience GBV and these acts are highly stigmatized and often stay hidden and unreported.

While significant evidence and data gaps persist, the 2014 Demographic and Health Survey (KDHS, 2015), and a number of additional (largely qualitative) studies, e.g. Njeri and Ogola (2014), show that GBV is widespread across Kenya. Key findings from the Kenya DHS include:

- Almost half (47%) of all ever-married **women in Kenya have experienced at least one form of intimate partner violence (IPV) in their lifetime** (emotional, physical, or sexual);
- **Physical violence is the most commonly experienced form of violence** in Kenya with 45% of women aged 15-49 having experienced physical violence at some point in their lives since age 15; and 20% having experienced physical violence within the 12 months prior to the DHS survey in 2014;
- **Fourteen (14%) of women age 15-49 reported having experienced sexual violence** at least once in their lifetime in 2014, mostly within intimate relationships;
- **Women often report multiple forms of violence**, particularly in spousal relationships, where physical violence is often accompanied by psychological abuse and sexual abuse;
- **There has been a steady, long-term decline in rates of FGM/C** since the early 1980's to about 21%; however, prevalence rates vary substantially across the country;

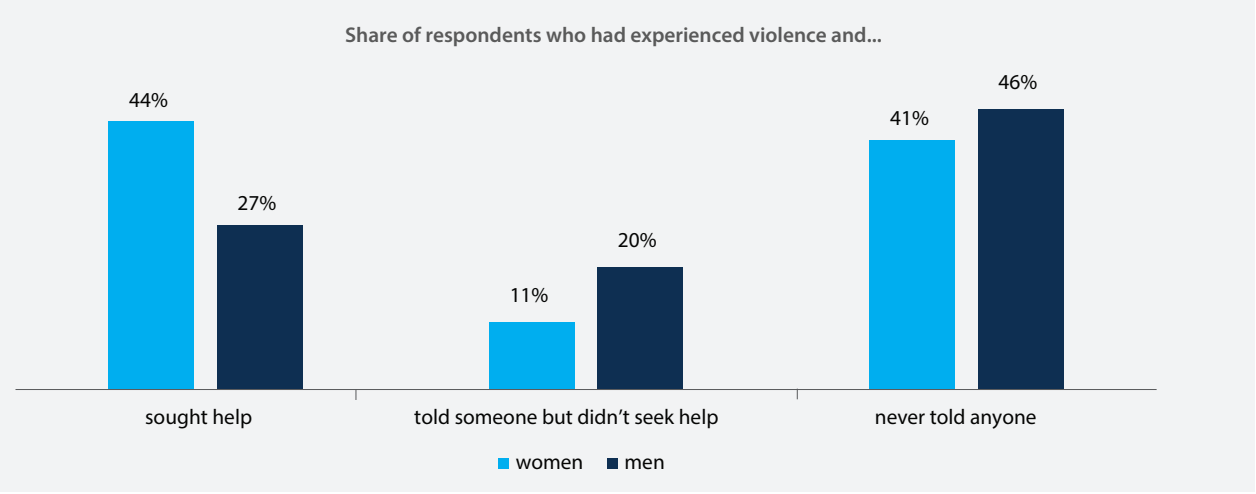
- **Men report significant experiences of interpersonal violence, often perpetrated by teachers, parents and other men,** with 44% of men aged 15-49 having experienced physical violence over their lifetime and 12% over the last 12 months; and 6% of men aged 15-49 having experienced sexual violence and 2% in the last 12 months

Women and girls who are particularly vulnerable to GBV in Kenya include: children and adolescent girls (and boys), especially orphans; minorities and marginalized groups and communities, e.g. indigenous women; older members of society; people with disabilities (PWDs); refugees; and lesbian, gay, bisexual, transgender, queer and intersex (LGBTI) communities (NGEC, 2016; Biemba, 2009; CISP, 2017; Young, 2012; Hossain, 2018; Human Rights Watch, 2015).

Processes of socialization result in low reporting rates of GBV (ACORD, 2009). For example, 44% of women and 36% of men aged 15-49 across the country believe that wife beating is justified in some cases (KDHS, 2015). Higher acceptance levels of wife-beating amongst women hints towards an internalization of underlying social norms by women in abusive relations, as observed in other country contexts (see for example Takyi and Mann, 2009). Other barriers to reporting and help-seeking behavior include perceived impunity for perpetrator, lack of awareness of or access to available services, cultural beliefs, fear of losing children or getting the offender in trouble, fear of retaliation, distrust of healthcare workers, and discriminatory attitudes towards victims among security and justice officials (Palermo et al, 2014).

This acceptance of GBV at a sociocultural level perpetuates the cycle of violence and limits help-seeking behavior. For example, just 44% of women and only 27% of men who reported having experienced physical or sexual violence from anyone have sought help from any source to stop the violence (see Figure 1 below, based on KDHS, 2015).

FIGURE 1: Women's and men's help-seeking behavior in response to physical or sexual violence



Stigma also appears to play a large part in influencing reporting behavior. For example, ACORD (2009) observe that women who seek support through the Kenyan police are often embarrassed, ridiculed and verbally abused. Njeri and Ogola (2014) underline that most cultures in Kenya consider it inappropriate and scandalous to report rape to the police; and men and boys too are reluctant to seek social services, due to a widely held belief that boys and men can't be victims of GBV. Help-seeking is further influenced by a range of background characteristics, which are similar for women and men (see Box 1; based on KDHS, 2015).

Overall, formal routes are seldom sought: only 7% of women who reported seeking help in KDHS (2015) went to the police, 2.9% went to see medical personnel or a doctor, 1.7% to a social work organization, 0.5% to a lawyer. The most common sources of help among women are their own and their husband's families (65% and 31%, respectively). Among men, the most common sources of support are their own family (49%), followed by the police (19%) and others (17%) (Ibid.).

BOX 1: Socio-economic characteristics found to influence the likelihood to report GBV in Kenya

Which women are more likely to report?

- women who have experienced both physical and sexual violence (59%),
- women aged 30-49 (49%),
- women who do not report any religion (66%),
- women in rural areas (46%),
- women in the former Eastern region (54%),
- women who are divorced, separated, or widowed (61%) and
- women with more children (e.g. 52% among those with five or more children.

Which women are less likely to report?

- never-married women (34%) and currently married women (43%),
- unemployed women (34%),
- women with no education (34%), and
- women in the highest wealth quintile (38%).

1.2 GBV legislation, policies and services in Kenya

1.2.1 Legislation, policies and standards

Kenya has made significant progress with regards to the development of standards and guidance around addressing GBV and providing support to its survivors. For example, within the country's new legislative framework, the Government of Kenya (GoK) has developed several laws which are relevant to addressing GBV, including expanding the criminalization of abuse, and an explicit statutory duty by the police and identified government departments to ensure that survivors are provided with medical services and protection. While loopholes and gaps remain in terms of the full comprehensive coverage of the legal framework (see Annex A), there is an impressive and relatively progressive framework in place to hold duty bearers and the state accountable if standards are broadly not upheld.

At the national policy level, a number of standards have been developed, such as the **National Policy for Prevention and Response to Gender Based Violence (2014)** which outlines a strategy to facilitate a multi-sectoral approach to addressing GBV through prevention and response interventions; the **National Guidelines on the Management of Sexual Violence (2014)**, which details the management of sexual violence and outlines the steps for the treatment of sexual violence survivors, including the preservation of evidence and issues of psycho-social support; and the **National Monitoring and Evaluation Framework towards the Prevention of and Response to Sexual and Gender Based Violence in Kenya (2016)** which sets out indicators for monitoring and evaluation of the different sectors supposed to prevent and respond to sexual violence.

Various standards have been developed at the national sectoral level, such as the **National Health Sector Standard Operating Procedures on Management of Sexual Violence in Kenya 2014** which outlines the minimum procedures for the management of GBV in the health sector and related referral mechanisms for psychosocial, legal, and other social support services; however, the roll-out of standards and procedures articulated at the national level remains limited at the county level.

A recently established **County Government Policy on Sexual and Gender Based Violence, 2017** and its accompanying **Model Legislative Framework on Sexual and Gender Based Violence for County Governments** launched in November 2017, provide a framework to support the implementation of laws, policies and, programmes for prevention and response to SGBV for county governments, and help the development of a **County Sexual and Gender Based Violence Act** setting out each county's commitment. It is important to note that the policy specifically refers to the need to "ensure that the framework is actionable, well-coordinated and sufficient resources are allocated for its implementation at County level" (NGEC, 2017: 13).

However, whilst the county policy is a significant step towards operationalizing the legal and policy framework at local level, there is limited visibility of the specific provisions that are in place (or under development), in terms of specific and localized law, policy, standard operating procedures (SOPs), and guidance documentation for service providers.

The **implementation of both the legal and policy framework, including identified measures and procedures, remains inconsistent and weak** due to a number of wide-reaching factors, including a **lack of human and financial resources at the duty bearer level** such as skill levels of the service providers, gaps in systems, tools, and supplies, and physical and societal attitudinal barriers that hinder effective provision and access of GBV prevention and response services (World Bank, 2017). In addition, the lack of **comprehensive guidelines for the roles of survivors, communities, health care workers and the police in the handling of forensic evidence** "contributes to delays in prosecuting, or even a failure to prosecute sex offenders" (Ajema et al., 2011: 11).

UN agencies and actors from the wider implementing space have developed supplementary procedures and processes, to address perceived gaps, and **a number of organizations have developed their own standards and SOPs**. For example, as part of the 'Improving Community Security (ICS) Programme' implemented by Coffey International, NGEC data management systems (SGBVIS) have been operationalized in 4 counties (16 stations), and GBV standard operating procedures (SOPs) have been developed by a multi-agency committee and rolled out to the 30 pilot police stations. Organizations such as LVCT Health have also developed specific SOPs for survivors of child sexual violence (World Bank, 2017).

1.2.2 GBV services

Despite the number of legislative and policy commitments in place, GBV service provision seems to vary substantially across counties and sub-counties. Related, it is not clear to what extent a selection of coordination bodies – put in place to support the functioning of these multiple services and mechanisms – fulfil their functions effectively. Furthermore, there is limited data on individual and community perceptions of the functioning and efficacy of GBV service provision in the Kenyan context.

A common theme across the scarce available literature is the lack of technical capacity and resourcing (both human and financial) across GBV services, such as personnel, skills and facilities for handling cases, with particular gaps around the provision of psychosocial support (ACORD, 2009), and the collection of forensic evidence (NCPD, 2012).

Another challenge frequently identified is cooperation between GBV services, particularly: the limited development of shared standards and procedures to support the uniformity and roll-out of provision; a lack of coordination between national and county institutions (Njeri and Ogola, 2014; NCPD, 2012); and a lack of coordination and feedback between sectors and institutions (ACORD, 2009), including a lack of mainstreaming of GBV across line ministries nationally and at the county level (Odotte et al., 2016).

Much more effective cooperation has been observed between non-state actors, who have formed alliances and networks to strengthen their support of service provision. For example, shelters are mostly run by civil society organizations (CSOs) and faith-based organizations (FBOs), which have limited capacity.

Existing service delivery models largely serve emergency rape or sexual assault needs and overlook care for more chronic forms of violence, such as intimate partner violence (Mak'anyengo et al., 2012). One-stop centers (OSCs), which have become increasingly popular in East and Southern Africa including in Kenya (see Keesbury et al, 2012; Samuels et al, 2015), rarely provide the complete range of medico-legal and psychosocial services (Keesbury et al, 2012), and are not considered financially sustainable given that 90% of such centers depends on external donor funding (HECTA Consulting, 2016).

Beyond formal service provision, there is some discussion of **traditional mechanisms** across the Kenya specific literature. Njeri and Ogola highlight that traditional instruments of justice tend to **disadvantage women and children**, including the specific handling of cases of defilement, which are "prohibited" in most cultures and are "resolved" through processes of ritual (2014: 12).

1.3 Study objective

The objective of this study was to:

1) Assess the availability and quality of GBV prevention and response services;

2) Assess community perceptions and attitudes towards GBV that influence service-seeking behavior; and

3) Make concrete operational recommendations to strengthen awareness, access and quality of GBV prevention and response services that can inform key sectors that are looking to integrate GBV prevention and response services (e.g. health, education, justice and policing, livelihood-focused interventions).

2. METHODOLOGY

2.1 Data collection methods

Qualitative data collection took place **in four counties – Bomet, Kisumu, Kitui, and Kwale** – in the form of:

- **60 key informant interviews** with service providers from the justice, health, protection sectors, and with individuals who can provide insight on the cultural norms, perceptions, attitudes relating to gender-based violence, as well as cultural barriers hindering access to support and services within communities and counties; and
- **40 focus group discussions** (approximately 400 participants) with potential community service users to complement and triangulate findings from the literature review and key informant interviews.

Figure 2 provides an overview of the data collection methods for this study.

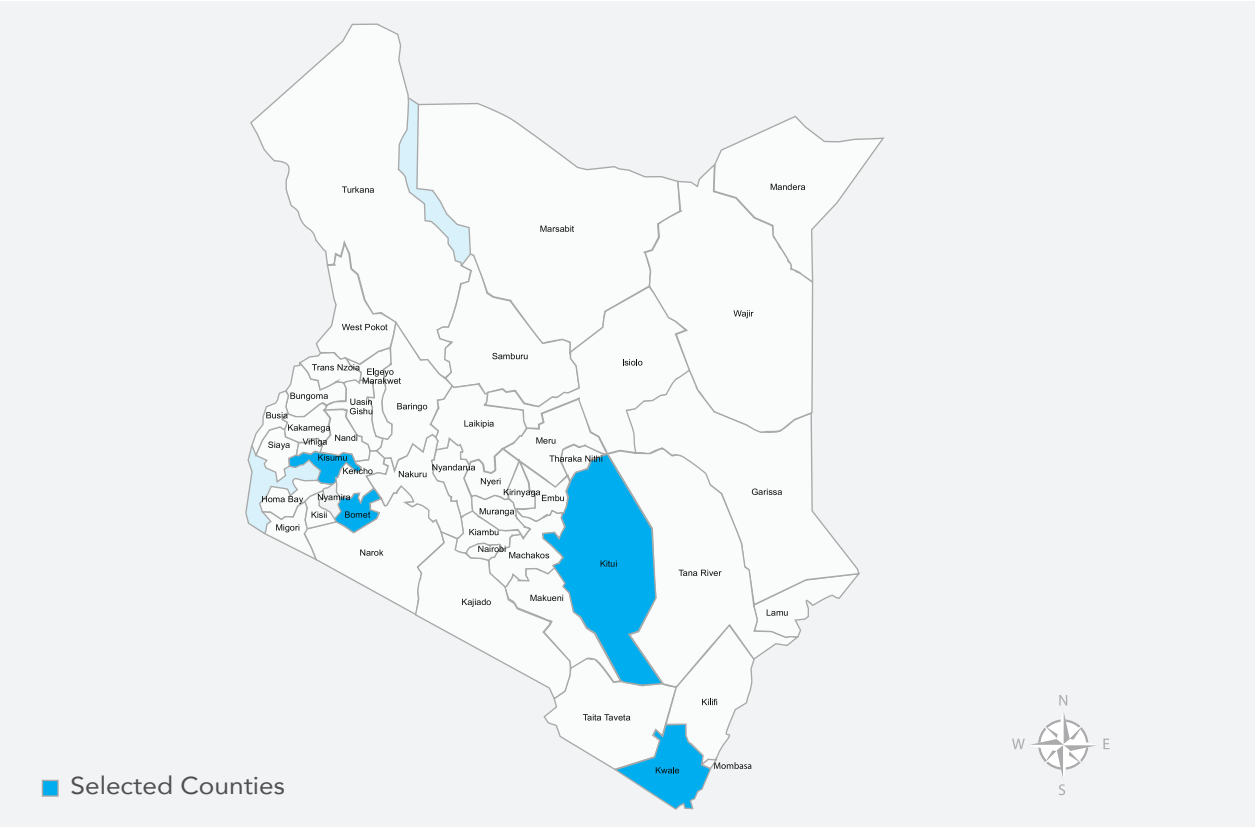
FIGURE 2: Overview on research tools and their main aims

2.2 Sampling

Choice of counties

The four counties were chosen based on a number of criteria including: prevalence of examples of good practices for prevention and response services; buy-in from counties to ease access for data collection; geographical coverage; and other ongoing programs in the area.

FIGURE 3: Selected counties for data collection



Choice of communities

Following the final choice of counties, a quick scan of county background information[1] was conducted. The purpose of this was to inform sampling of areas within counties and conflict and gender sensitivity before data collection. This information fed into the choice of final locations for data collection, with a view to facilitate access to services and key stakeholders and to get a varied view on the perception and use of services by the population in one rural and one urban community in each county.

Choice of respondents/participants

Key stakeholders were purposively selected per county for 15 key informant interviews (KIIs) and for two focus group discussions (FGDs) with social workers, paralegals, and village health team professionals. For FGDs with potential service users, the researchers were assisted by county-level gender focal point officials, service providers, local NGOs and/or community leaders/officials. The use of different contacts in each county (opposed to using service providers only) ensured that the FGD participants would include potential beneficiaries as well as people who had experienced GBV and accessed service providers.

8 FGDs were conducted with community members and potential service users (6 with women and 2 with men) in each county,[2] each with around 8-12 participants, split by age. One FGD was conducted with 'younger' women, one with 'older women', one with mixed ages and one with mixed-age men. The chosen age 'cut off' for younger and older groups was decided upon during the training with the data collectors who have previous experience working in the counties and recommended using the national cut off age for 'youth' which is 35 years.[3]

[1] This included population characteristics; any potential sensitivities that could affect data collection and should be taken into account from a conflict and gender sensitivity perspective; and listings of active GBV service providers and potential key stakeholders from government, communities and civil society organizations as existing points of entry.

[2] Thus, four in each rural and urban location within the counties.

[3] Thus, younger women or men's groups would be comprised of individuals aged 18-35, and older groups of individuals aged 35 and above.

Annex B gives an overview on the total number and types of KIIs and FGDs conducted across the counties.

2.3 Safeguarding procedures and ethics

In order to ensure safety and well-being of all study participants and researchers, several measures were put in place during different stage of the research, following WHO's ethical and safety recommendations for research on domestic violence against women (WHO, 2001). For example, only qualitative researchers with experience in gender research, and who were known to the local data collection partner Forcier from past projects, were selected and trained for this research. All the researchers originated from the research counties, thus enabling them to fully utilize their local knowledge and language throughout the data collection process.[4]

The training entailed specialized issues around GBV, ethics and safeguarding. Furthermore, the researchers were trained on referrals, i.e. what to do in case they need to refer women or men requesting assistance to available local services and sources of support. In order to reduce the risk of referring research participants to services that had not been quality assured, the KIIs with service providers and key county-level gender focal points, health workers, local NGOs were conducted before the FGDs with potential service users. This allowed to ask specific questions regarding procedures and to get an impression on the quality of services first before referring anyone to them.[5]

When engaging with study participants, the research team ensured that the participants understood the purpose of the research and gave a clear outline of their rights to anonymity, respect and voluntary participation before obtaining consent. Annex C gives an overview on SDDirect's "Ethics and Safeguarding" guidelines which were also shared with the research teams during the training, before the data collection.

[4] Their knowledge of local communal dynamics was tested, as well as their knowledge of conducting sensitive qualitative research.

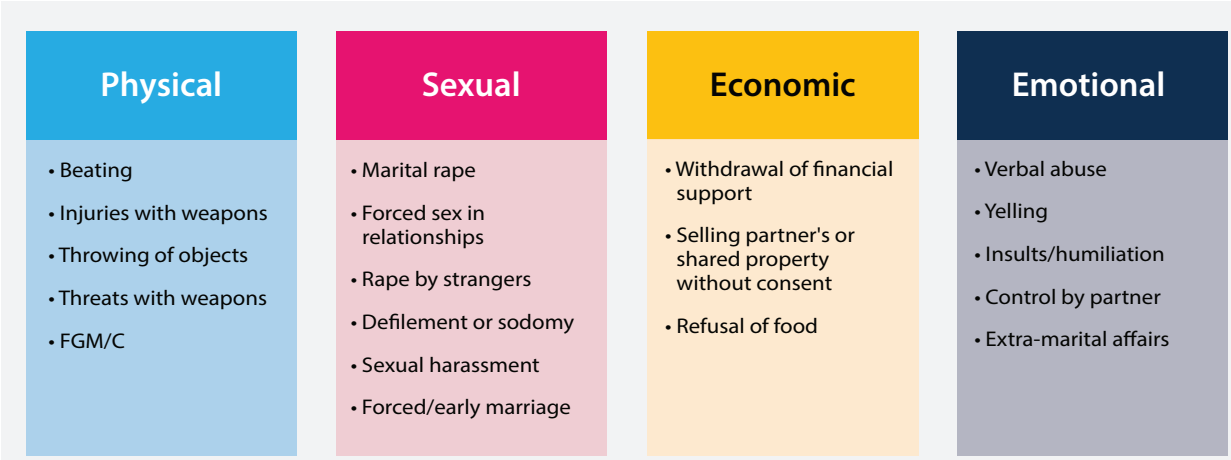
[5] However, during data collection, none of the research participants asked for/needed referrals whilst the data was collected.

3. FINDINGS

3.1 Experiences and perceptions of GBV

The dialogues with research participants in the communities across the four counties showed that the **awareness of different forms of GBV is generally high**, which was exemplified by the number and range of acts of GBV that were identified as part of the free listing exercise during the FGDs (see Figure 4 below).

FIGURE 4: Frequently named types of GBV



These **acts and types of violence are widespread and largely accepted** across the four counties and across different groups. Typically, violence that occurs frequently and amongst married couples – including marital rape – is considered normal. Only severe violence or beatings that result in physical injuries and violence by strangers is not accepted and considered as going 'too far'. This is perpetuated by observations of marital violence as the norm within communities as well as by 'advice' passed across generations:

> *"We have been brought up knowing that all our marriages have to work out even if one is being violated by the husband. This has really made us to stay and put up a brave face despite the suffering." (KII, frontline health worker, Kisumu)*

> *"Acts of violence also become normal when the people around you are also violated." (KII, health facility manager, Kisumu)*

> *"In almost every family, there are reported cases of wife beating. This makes the act common and normal." (FGD, older women – rural, Kitui)*

The three most **commonly experienced and accepted forms of GBV** across female respondent groups in the four counties include:

- Beating by male partners, as long as it does not leave bruises or injuries (this is often used as a way to discipline someone for their mistakes, and seen as an 'act of love'),
- Verbal abuse, and
- Marital rape/ forced sex in relationships (often not considered rape or wrong).

Forms of violence against children, in particular child sexual abuse (generally referred to as 'defilement' for girls and 'sodomy' for boys), are reportedly widespread. While not the focus of the research, some respondents in Bomet reported defilement and sodomy as unacceptable forms of GBV and it was anticipated that those affected would receive support by seeking care from hospitals, provision of security, investigation and arrest. Respondents in Kitui highlighted the widespread prevalence of such violence, and key informants and FGD participants in Kisumu and Kwale shared the view that the obstruction of justice and lack of punishment allows for such violence to thrive – as well as the considerable stigma surrounding it (discussed in Kwale).

It is important to note that the acts of violence experienced by men in the home, reported by men as recounted in the FGDs, are largely non-physical and mostly include verbal abuse and humiliation in public, refusing to cook food or clean, and extra-marital affairs, together with threats with weapons and beatings that result in temporary or permanent injuries. It is important to clarify that these reported experiences of violence do not necessarily constitute acts of GBV, but were perceived as such by male respondents.

Participants in the FGDs and KIIs reported that **experiences of different forms of violence cut across <u>all</u> social groups**, regardless of rural/urban location, sex, age or other socio-economic factors, for example:

> *"In my area here, the kind of violence a poor woman goes through is the same violence the rich women also go through. Like the wife battering happens to all women whether rich, beautiful, poor, working or not, religious or coming from a wealthy ethnic group, it doesn't matter." (KII, community leader, Kisumu)*

Boys and men also experience varying forms of violence, including child sexual abuse and physical violence**, but were less likely to report unless the violence was severe.** This is due to shame, stigma, and a belief that men and boys do not have the same protection as women and children or suitable services to meet their needs, for example:

> *"When you have been beaten brutally like a dog and your limbs broken and you end up in the hospital, that's when you decide it has gone too far and that makes you report. Or being raped so bad you can't walk." (FGD, men, mixed ages – rural, Kwale)*

> *"Most men will keep quiet because the law protects mostly women and children and there is no place for men. Women and children's issues are taken seriously. It is embarrassing to report to parents or police and if you do, no action is taken, there is nowhere you can go." (FGD, men, mixed ages – rural, Kwale)*

While experiences of violence are similar across the counties, some distinct geographical differences stood out. For example,

1. **Boda boda drivers** have been identified in particular as perpetrators of violence such as sexual harassment and assault, including of girls, often resulting in early pregnancies, transactional relationships and forced sex with girls to fulfil 'agreements'. This particular threat has been **mentioned in all counties except Kitui.**

> *"They take advantage because these young girls in the most cases, stay with their grandmothers, aunties, so no one takes care of them very well, so if it's forced sex, if it is rape, because there is no consent, so they can experience that, it's mostly done by the bike riders they give her lift, they buy her something and later ask for favour." (KII, local council authorities, Kwale)*

2. Violence seemed particularly widespread and **not related to underlying 'reasons' or patterns in Bomet**. Whereas in other counties financial disputes, jealousy, and disagreements were common triggers, the analysis of FGDs in Bomet showed that 'any reason is good enough', perhaps best exemplified by the account of respondents in a mixed age group in rural Bomet, who shared:

   "My husband hits me whenever he finds me."

   "I think a violent man is just a violent man. My husband started hitting me from the week we got married".

   Furthermore, **FGM/C**[6] is a significant issue in Bomet, according to female respondents. For women to be accepted as adults in this community, they have to undergo FGM/C. While the practice is reportedly decreasing on the whole, it seems it is still prevalent and there is extensive shame around it, so help is rarely sought – and when it is, survivors often have to wait with everyone else to be seen to.

BOX 2: FGM/C in Kenya

Out of the four counties surveyed, FGM/C as one form of GBV was highlighted mostly in Bomet. However, given that there is little evidence to suggest that prevalence rates in Bomet are higher than in the other counties (see footnote 6), this could be suggestive of a higher sense of awareness around this issue amongst the female FGD participants in this county, or a greater willingness to speak about it.

With the government ban of all forms of FGM/C in 2011 (and making failure to report cases to authorities unlawful), this practice has likely become more hidden. Despite a criminalization of discriminating against women who have not undergone FGM/C, in practice, social pressure for women to do so is still high and it has been argued that the practice may be on the rise again, due to an increased hidden medicalisation (28TooMany and Thomson Reuters Foundation, 2018; Parsitau, 2018).

3. In **Kitui**, **land disputes** were more frequently mentioned as a key reason for conflict than in other counties.

   "Land disputes are the mother of most violence. Like you find people fighting, threatening each other or even revenging in a way that is violent."(KII, county level court official, Kitui)

   Furthermore, **violence appears to be more varied and severe**: For example, it was the only county where mention was made of *"someone's limbs being chopped off"* as part of the free-listing of acceptable and unacceptable types of violence in the FGD with community members, and having *"gouged eyes"* and not being able to physically get to a service provider due to these and other physical injuries was named as a barrier to seeking help. Rape of girls by their fathers was also commonly mentioned.

4. In **Kwale, forced early marriage of girls** by parents to obtain dowry, **girls being forced into prostitution by their mothers,** as well as girls being **raped within families (including by their fathers and step-fathers)**, were frequently mentioned in FGDs and KIIs. Rape cases such as these are considered highly shameful to the family since the perpetrator cannot marry the victim (unlike for rape perpetrated by non-family members). There are also accounts of older women being raped and of a widow being raped by her own sons. Child labor (where girls are forced to abandon their education and contribute to their family's income) is also an issue.

[6] There is little to suggest that prevalence rates of FGM/C in Bomet are significantly higher than in the other three surveyed counties: The prevalence rates of the former provinces Rift Valley (where Bomet is situated) and of the Eastern region (Kitui) are both 26.9%; the prevalence rate of Nyanza (Kisumu) is 32.4% and only that of the Coast region (Kwale) is considerably lower with 10.2% (KDHS, 2015).

There are concerning accounts **of male FGD participants justifying sexual IPV, and marital rape in particular**. For example, FGD participants observed that if wives deny husbands their 'conjugal rights', men feel they are forced to rape them ("*the husband has no option but to force himself on the woman*" *(FGD younger men - rural, Kisumu))*. At the very least, a wife's refusal of sex is often perceived as an infliction of violence on the husband, who find it *"very disturbing";* and can result in "*serious physical fights*", as such a refusal is linked to the assumption that if men are being denied their conjugal rights, their wives must be *"definitely getting it from somewhere else" (FGD, men, mixed ages, rural – Bomet)*.

Many problems seem to be 'solved' through domestic violence (including marital rape), with frustration and conflict feeding into it. For example, men being rejected by their partners/others are likely to rape a stranger to "*release his frustration*" (KII, local council authorities, Kisumu). Where a wife is violent herself, a suggestion from friends or family may be for the husband to retaliate using violence against her, so that she stops *(FGD younger men – rural)*.

This seems to be related to a strong entitlement by men to sex, as can be seen in the following quotes*:*

> *"When a man is annoyed, they get relief by having sex and they can do it with whoever is around … even if [it] is his step-daughter." (KII, local council authorities, Kitui)*

> *"Girls can be killed in case they do not give in." (KII, frontline health worker, Kitui)*

As will be seen later, the community's perception of such violence affects help-seeking:

> *"When it is the women, they think that is the duty of the husband to perpetrate this kind of an act, and the community perception is that you are antagonizing the family by reporting. Some people even do away with incest because if you report you will be discriminated by the community." (KII, county level court official, Kwale)*

Furthermore, children seem to be exposed to violence – even if 'only' as witnesses – to a considerable extent, as can be seen in this excerpt:

> *"If your husband hits you in private then you are lucky, my neighbor will hit his wife and even force her into having sex right in front of the children. He beats his children and his wife so bad that some men in our area took it upon themselves to go and warn him that if he did not change, then they would have to deal with him themselves." (FGD, women, mixed ages – urban, Bomet)*

3.2 Existing services and support

3.2.1 What services are available?

Annex D lists all the services and organizations mentioned by respondents as part of KIIs and FGDs in the research locations. As such, this list is neither representative of all the counties, nor is it necessarily comprehensive as there is large variation in the awareness around service providers – particularly in rural areas. While these tables show that a number of services exist to respond to GBV from a health, justice, security, psychosocial, shelter and other support perspective, there are some key observations regarding the availability of services, as perceived by respondents:

1. **The number of formal support and response services for survivors are limited, and more prevalent in urban areas**. More comprehensive health and counselling services for GBV are available in urban centers such as Nairobi (Nairobi Women's Hospital, where a number of GBV cases in Kisumu, Kitui and Kwale are referred to) and Kisumu (GBV Recovery Centre at Jaramogi Oginga Odinga Teaching and Referral

Hospital). Furthermore, there are gender desks at police stations in urban Kisumu, Kitui and Kwale; children's department/child protection services in Kitui and Kwale, and a number of promising civil society interventions, such as efforts of social workers and CHVs in Bomet, Kitui and Kwale; as well as a range of NGO GBV initiatives.

2. **There are notable gaps in service provision in rural areas,** and across all counties, a key barrier mentioned by both FGD and KII respondents is the long distance to services, combined with challenging transport conditions and associated costs.

3. **Awareness of available services is quite low in some of the research locations and dependent on type of service**. Community members' awareness of available services and their location, as well as access to existing services (local government, healthcare, police, and legal assistance) were generally limited in the study sites, particularly in rural areas where services are located far away. For example, one focus group with men of mixed ages in urban Kitui mentioned they may want to report unsatisfactory service provision to the *"anti-corruption offices although we don't know where they are".* Box 3 shows the service providers that were most frequently mentioned across the 25 different KIIs and FGDs in each county when asked about available services. In most cases, this includes services mentioned at least five times, with others being mentioned even less than that. However, given the overall number of services available in each county (as can be seen in Annex D), this shows a clear lack of visibility of available services.

4. **Awareness of police stations is generally high, yet police presence varies in the counties** – for example, a local council authority in Bomet said the nearest police station is 30 km away. In Kitui, there are gender desks at sub-county level police stations, but staffing has been a problem because of high turnover.

5. **The provision of health services in rural locations is facilitated by local health clinics and dispensaries,** but referrals to hospitals for more specialized services can be difficult due to shortages in ambulances and otherwise often challenging transport conditions.

6. **Access to formal justice services is limited**, due to high cost, restricted availability, and a common practice to resolve cases at a local level: While awareness of county courts is generally good (potentially due to paralegals/social workers' presence at a local level), it is one of the least accessed types of services. This is likely due to a shortage of lawyers, and a common practice to resolve cases at a family/community level – often through the use of contested local "kangaroo" courts in Bomet, Kitui and Kwale:

   "You may find that when a mother has been beaten by her husband and a child has been raped, the village elders form a court and talk on what should be compensated to solve the issue." (KII, local NGO, Kwale)

   Further factors are lengthy court procedures, to some extent existing misconceptions at a local level of how the legal system works, and the high cost of legal fees:

   "Since we are a poor community we cannot talk about legal support because it is rarely a need and the expenses that come with it is too much." (KII, religious community leader, Kisumu)

7. **Some crucial components of GBV response services are notably missing and under-resourced**: In Bomet, there are no shelters at all, while across the other three counties there is also a widely perceived lack of shelters – likely a reflection of the overall scarcity of shelters rather than a complete absence of them.[7]

[7] There seems to be some contention regarding the provision of shelters; for instance, whether shelters are part of an essential GBV services. However, referral to shelters are included in the National Guidelines for Management of Sexual Violence (2014) as part of the Minimum Post Rape Care Package and their establishment is also included as policy objectives in the National Gender and Equality Commission's model county policy on SGBV (NGEC, 2017).

Table 1 below gives a quick overview of service availability and gaps mentioned by type of sector across the counties, and Box 3 lists the most frequently mentioned services in FGDs and KIIs.

TABLE 1: Overview on the existence of key GBV services for the population across the counties as mentioned by respondents

Sector and level/ type of service	Bomet	Kisumu	Kitui	Kwale
Health				
County hospital				
Sub-county hospital				
Health centers				
Other				
Justice				
County-level				
Sub-county level				
Community level	^			
Other				
Security				
County-level				
Sub-county level				
Community level				
Other				
Psychosocial support/ counselling, shelter and other social support				
Psychosocial support				
Shelter				*
Other social support (CBO, FBO, NGO)				
Other				

Notes:

^ While two services were mentioned here, one referred to 'kangaroo courts', an inadequate mechanism for responding to GBV (as reflected by government efforts to discourage such courts to take on GBV cases)

* While three services were mentioned here, two out of these were described are children-focused only.

3 or more different service providers mentioned

2 different service providers mentioned

1 service provider mentioned

No service provider mentioned

Box 3: Available services most frequently mentioned by FGD and KII respondents across the counties

Kisumu: GBV Recovery Centre at Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH) for health care and psychosocial support; LVCT for health and psychosocial support; police for security and legal support; and the NGOs Nyabende and FIDA for psychosocial and other social support and legal support, respectively

Bomet: Longisa Referral Hospital for health care and psychosocial support; police for security; Bomet courts for legal support (with acknowledgement of existing gaps); church-based groups for informal support and psychosocial services; informal support from chiefs, elders, family and friends

Kitui: Kitui Level 5 General Hospital for health care and Kitui Level 4 Referral Hospital for health care and psychosocial support; CARITAS for psychosocial support; chiefs, police and elders for security and legal support; paralegals and local advocates for legal support; AIC Church for psychosocial and other social support

Kwale: Lunga Lunga hospital for health care and psychosocial support; children's services/ children's rights office; police for security; chief and local community leaders such as village elders for legal support and other social/ informal support; Plan International for legal support and other social support.

3.2.2 How do services work together?

The perception of whether there is an organized referral network between the different sectors, and how it works, varies considerably between and within surveyed counties, with an understanding and perceived level of accessibility depending on the interviewed stakeholder. While some respondents assessed referral structures to be functional (such as in Kwale), **most key informants said there is a weak or a lack of an organized referral network structure**, with many services appearing 'scattered' and uncoordinated. For example, it appears there are a number of entry points to initially report cases of GBV and obtain access to referrals for and to services, but there does not seem to be a consistent structure. For example, in Kwale, CHVs are often a first point of contact for GBV, although cases are also first reported to the chief, local police, or area advisory councils. Cases are then escalated to different stakeholders, such as village elders, the "children officer" (likely the child protection officer), police, or peace committee (ranging from county/sub-county level to the village level) – who then individually or together decide which hospital a client should be taken to, and who will undertake the follow-up (illustrating how complex it may seem to someone trying to navigate this system).

Problems with referral systems were noted in all counties. For example, **in Kisumu,** one key informant said that despite an existing referral network between police, hospitals and CBOs and NGOs, *"I don't think there is a clear pathway between the police and the courts. They don't share victims' information among themselves"*. Another informant (a health facility manager) emphasized that **referrals within different structures** (from pro bono to government, health to legal or police services) **pose a challenge** – once fees are involved (i.e., transitioning from free, government-provided services to those services incurring a fee), clients often drop out of the system due to a lack of funds. There also seems to be a lack of clarity and information around which services are supposed to be provided for free, which explains differing accounts of users and providers. Apart from P3's and emergency contraception, which are both to be provided for free for survivors of sexual violence according to the National Guidelines (Ministry of Health, 2014a), no documentation has been found that provides information on what costs to expect for which kind of service. However, the costing study of 218 GBV survivors by NGEC (2016) estimates that the "average cost of medical-related expenses per survivor and family amounted to KES 16,464 [KES 3,417 after removing outliers];[8] reporting the incident to a chief and community structures cost KES 3,111 [and] reporting to police cost KES 3,756" in 2015, in addition to productivity losses.[9]

In Bomet too, the **existing referral network does not work well,** and according to one key informant, referral processes from one service sector to another are not always accurate, with cases reported to police not matching those of health facilities. Referral processes depend on informal support among individuals of different institutions, but it was noted that particularly in rural areas where referrals can be hampered by duty bearers or inadequate resources, cases are often taken back to the community level through "kangaroo" (local) courts.

In Kitui, respondents reported **the formal referral network is generally haphazard and can be difficult to access;** however, service providers do appear to share case information with each other to provide more specialized and continued care through referral notes and registers, and **circumvent existing gaps through individual cooperation.** A local council representative outlined using informal channels such as WhatsApp to keep on top of emerging cases and referrals. According to one NGO respondent, the Center for Health Solutions is leading on the process of forming a committee to share what different organizations are doing on GBV and how cases are processed; and a technical working team (consisting of police, judges, social workers, lawyers, NGOs) holds meetings at sub-county level to 'institutionalize collaboration', with plans to establish gender desks in every ward to escalate cases from village to county level. However, oversight of support remains a challenge: CHVs say at times they refer clients to organizations they do not know well or have not engaged with. For

[8] The study team notes however, that the treatment related expenditure should be "interpreted cautiously, because the majority of the respondents were accessed through GBV recovery centres where GBV survivors are provided with GBV and related services for free", i.e. survivors who are not treated in recovery centers might face higher costs or are not treated because they couldn't afford these costs to start with.

[9] On July 31, 2015, 1 US$ equalled 102.38 Kenyan Shillings (https://www.exchange-rates.org/Rate/USD/KES/7-31-2015).

example, for psychosocial support, one group of CHVs said they refer clients to an organization which, based on the research team's assessment, seems to focus on labor law rather than the provision of counselling. Being directed to facilities unable to provide the promised services can be discouraging for survivors and risk doing harm – and it is unclear if the CHVs are keen to simply provide some kind of referral or whether they are missing the needed overview.

In Kwale, it appears that **there is a good network between the health, security and justice sectors at the county level, but at a lower administrative level, coordination is quite weak.** A court level official outlined how the system is supposed to work: A case is reported to the nearest authorized office, such as the police or chief. The decision on whether to prioritize medical care or reporting to the police first is dependent on each case; but in either case the client is escorted to the next facility, data is shared with service providers that clients are referred to, and appropriate follow up steps taken. When a case goes to court, any counselling required by the client will be provided simultaneously. In a contrasting perspective, an NGO informant asserted that for their work, an organized referral network *"doesn't exist. I think everybody is running their show. No organizational level. … We don't have a structure that brings CSOs and the government together",* illustrating a potential weakness in the cooperation between government and civil society services.

It should be noted that within each sector, referral structures seem clearer. For example, health services in a sub-county of Kwale (Matuga) are coordinated by a Medical Health Officer, who oversees 26 facilities: most GBV clients are seen at the hospital level, and those clients who have their first contact in other facilities are referred to the sub-county hospital, which provides services for wide-ranging GBV. In Kwale's health system more broadly, each point of care is reported to use referral forms, and patients are often referred with the assistance of a staff member to ensure continuity in services.

However, service providers noted a lack of transparency and knowledge gaps in data sharing across sectors. An NGO informant in Kitui said required information for their work is not easily accessible and service providers lack insight into which services are provided by others and the number of cases of GBV reported to each (and comparisons across years to see changes). **There are requests for existing data on GBV and available services to be shared more widely.** A local council authority respondent in Lunga Lunga, Kwale requested that existing data be used to influence the sensitization efforts they are undertaking. On data collection and analysis, another respondent said: *"we need to know the trends, we need to know who the perpetrators are, we need to know which groups we should be talking [to] …. we have a huge gap when it comes to data" (KII, health facility manager, Kwale).*

These gaps in data sharing are further compounded by a **lack of coordination and capacity building on reporting mechanisms on services across sectors:**

> *"When it comes to GBV we do not have proper coordination on availability [of] reporting tools, training of our staff to collect the data and upload it. If we strengthen data collection it will help a lot because then we will have a fixed point of data that we can use to compare with what the police have, or the children's [department] have." (KII, health facility manager, Kwale)*

There is also a perceived level of disconnect with the government. Providers noted that **the data they have shared with the government appears not to be monitored, as they do not receive any feedback from the government**. Some stakeholders are unsure that the data are processed correctly:

> *"We are never sure if the data that we submit reach the destination without further errors and bias … I would request for a trained data clerk in every department of the facility so that we can be in a position to receive well and authentic data that has not been tampered with." (KII, frontline health worker, Kisumu)*

And finally, at the local level, there is also **a sense of lacking government accountability**:

> *"We are perceived as people who don't know much, and no one feels like they owe us any accountability .... as a community I feel this is very unfair … because we are the tax payers, and we should hold the government accountable for anything they do." (KII, traditional community leader, Kisumu)*

3.3 Help-seeking behavior

Analyzing the responses across all FGDs, it seems that help-seeking behavior by survivors of GBV depends mainly on two questions:

1. Whether or not the violence is considered 'normal', and
2. Whether or not the survivor has injuries and needs medical attention.

Violence that is considered normal – often violence perpetrated by family members – results in little or no reporting or help-seeking behavior. This is in contrast to violence perpetrated by strangers, which is considered much less acceptable and often results in reporting to the village elders, religious leaders,[10] or the chief (less often the police) to punish the perpetrator. Sexual abuse, violence and rape still incurs considerable stigma and shame, particularly if perpetrated by a family member – girls and young women may also not report sexual violence out of fear that they will be killed or kicked out of their home.

Most violence is managed at a family or community-level: When help is being sought, most survivors rely on their family **for mediation and reconciliation**. Even for long-standing intimate partner violence, most respondents suggested drawing on the partner's as well as one's own parents or extended family for solving any issues. However, this is usually with the objective of reconciling the marriage rather than to address the violence experienced – many respondents suggested that violence is 'just a part of marriage' that needs to be endured.

Survivors consider seeking more formal help only when the family and community-level mechanisms do not result in long-term improvements or – more significantly – **when violence 'goes too far' and poses serious threats to health and life**:

> *"When death threats come in, that is where most people take violence at home as a serious issue. It is not that barriers do not apply to them, they just decide to sacrifice their time and little money to put perpetrators behind bars for their own safety and the community." (KII, shelter manager, Kisumu)*

Where more formal services are sought, **the most important services** to clients are very similar across the counties: **medical care** for treatment of emergencies and injuries; **counselling** for incurred trauma and long-term mental wellbeing; and **legal support/justice and/or security** to hold perpetrators accountable and ensure due punishment for their actions, and to allow victims and survivors or GBV to move on with their lives while feeling safe again.

However, there is still a preference for seeking help from stakeholders that are easily reachable and that they know well, particularly in rural areas. This is largely related to a number of barriers such as accessibility, stigma and trust, as put by one community leader who outlined that people prefer to help each other out:

> *"[GBV survivors] believe that the networks are always very complicated, and they .... discriminate against people who are not learned and since most of the community members did not go to school, they prefer handling their issues with people who understand them." (KII, community leader, Kisumu)*

[10] However, this is not accessible to all, e.g. according to social workers in Kwale those in "come we stay arrangements" cannot seek help from religious leaders, only couples who are officially married.

In addition to the factors above, we also observed that **help-seeking behavior further depends on the sex, age, and often the marital status of the survivor** – very much founded in prevailing gender norms:

- **Women and girls, despite considerable socio-cultural and economic barriers to reporting and seeking help, are still significantly more likely to do so compared to boys and men.** This is related to perceived lack of tailored services, discrimination and stigma, as discussed in more detail below. Many men "*feel like health workers will discriminate them … many men who experience GBV will not seek help and will not talk about the violence they have experienced. If they go to hospital, they will not disclose what happened to them.*" *(KII, county and community level gender or GBV focal points, Kisumu)*

- **Gendered help-seeking behavior also depends on perceptions of how accessible and responsive** a service provider or community/traditional leader is. For example, men in rural Bomet reported seeking the local chief as the second most important source of support *("for punishment and mediation")* whereas women reported the chief to be the least likely person to talk to, together with the police and in-laws. In rural Kitui, however, chiefs were amongst the least likely chosen sources of support for men, whereas all three female FGDs revealed that women chose chiefs most frequently. Although the observation of such dynamics is perhaps not surprising, it does hint towards the importance of investigating local relationships and of influencing local power holders in order to change awareness and attitudes around GBV and service provision. Other barriers and facilitators of help-seeking will be discussed in section 3.4.

- **Younger respondents were more likely to seek help generally, but also from formal services.** This is generally attributed to being reached by information at a younger age in schools. For example, women in urban Bomet perceived older women less likely to report as younger women *are "still confident ... still have energy ... they know they can report" (FGD, women, mixed ages, urban - Bomet)*. In rural Bomet, younger women were also perceived to be more likely to share experiences of violence, but it depends on the type of violence: for example, rape or FGM/C are more sensitive topics women might be more *"shy"* to talk about than about *"being hit" (older women, FGD, rural - Bomet)*. At the same time, young people were less likely to report if they lacked information on *how* to report, combined with a fear of being judged by their peers and/or community (in this case, parents often report for them). Furthermore, there was a perception that *"people might get tired of you if you tell them everyday that you were hit" (women, mixed ages FGD, urban - Bomet)* and that older women will likely be made to feel ashamed of not knowing how to 'handle their marriages' by now *(older women, FGD, urban - Kisumu)*.

- **Help-seeking by younger groups may also be affected by other factors:** In Kwale, young people were less likely to seek services if they wanted to "settle things themselves" with others, and were also said to be afraid of attending health services if these were not youth-friendly services ("*you know if they go to a health facility, and there is no a specific place for the youth and the children, so they are forced to sit with women who have come for clinics they feel the women will suspect there is something going on with them… they are scared of that stigma" (KII, local NGO, Kwale)*.

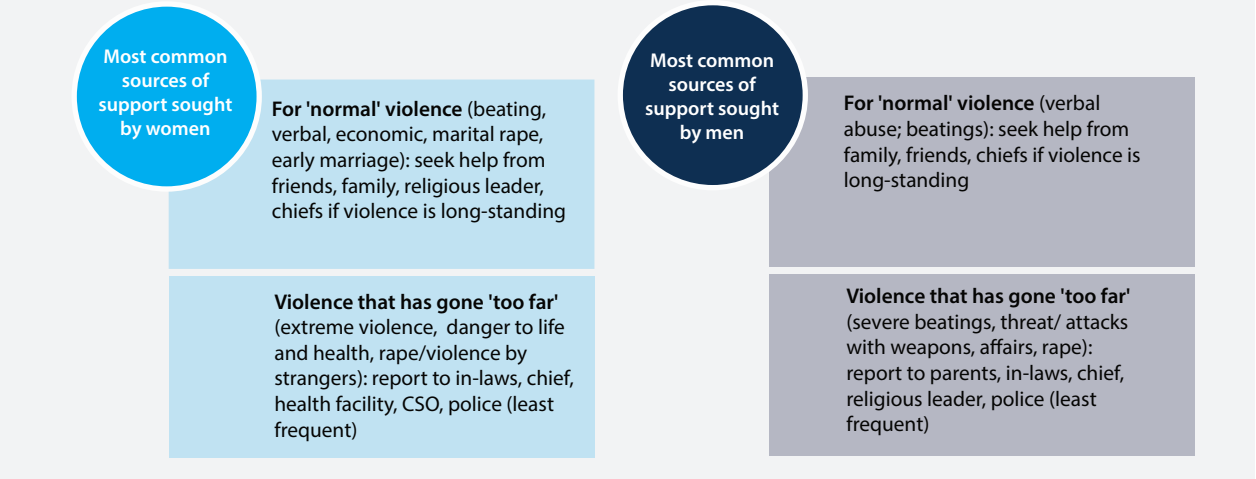
- Generally, **if older respondents sought help, they would do so by reaching out to traditional structures and informal sources** (e.g., family, trusted friends, elders or religious leaders) – whose advice was often characterized by an emphasis on "persevering' and reconciliation with a violent partner. Younger women, especially without children, were often perceived to be more easily able to walk away or return to their parents and start anew. Older men, while much less likely to seek help and instead being silent about the abuse, also seemed to focus on 'persevering' in their marriages – however, men noted a risk of suicide if severe violence went on long periods of time without any help provided.

- **Marital status has two main implications, depending on local norms.** It can factor into a decision on whether to report or not, when disclosing the experience of GBV affects the social status and therefore the ability to marry. In that case, older women have less fear to report than younger women, as they are likely to be less concerned with their ability to marry. Making it similarly less likely to report – or affecting the choice of where to report – are cases of early marriage where reporting to the police would place girls' or women's parents and husbands at risk for having engaged in the practice of early marriage, as discussed in an FGD with younger women in urban Kwale. The choice then if the girl or woman wanted to report would be seek help from the children's rights office instead or not report at all.

Socio-economic profile is also a key factor for help-seeking: Being educated (i.e. having good knowledge of one's rights and available services) seemed to increase the likelihood of seeking services, although at the same time a higher wealth status and/or being well-known in a community (so a higher risk of shame) can reduce the likelihood of reporting, as observed by key informants in Kitui. Reference was also made to women with disabilities as being particularly unlikely to report as they would likely need assistance to get to services – probably assistance by people who, more often than not, may be the perpetrators of the violence.

Figure 5 below gives a brief summary overview of the most commonly used sources of support for violence that is considered 'normal' and 'too far' (and so is no longer accepted by the community).

FIGURE 5: Most common sources of support sought by women and men

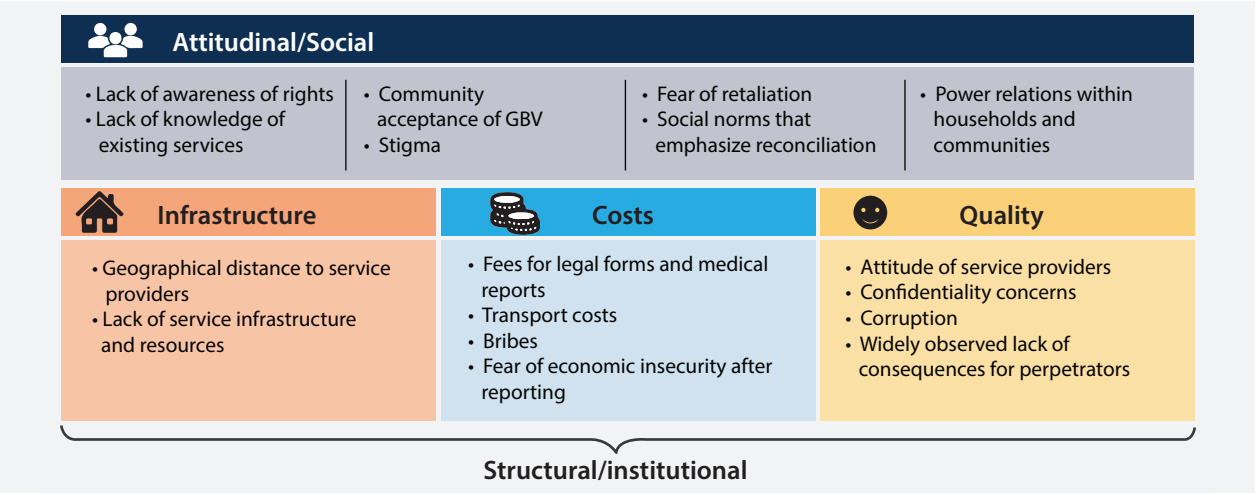


3.4 Barriers to help-seeking and service delivery

There are numerous barriers which affect the willingness and ability of victims and survivors of GBV to report violence and gain access to the services they require. These can broadly be split into socio-cultural barriers and institutional (or structural) barriers, as outlined in the sections below. The perceptions around barriers to help-seeking both from a service provider and service user perspective were interrogated in order to understand to what extent these diverge and overlap.

It should be noted that the above **factors often overlap and interact to form a complex set of barriers**. For example, older women in rural Bomet noted that they felt discouraged from seeking help by the fact that services were far away and hard to reach, and that once you got there you may get harassed and have to wait for a long time to be seen by service providers – even if someone has injuries sustained by FGM/C or rape.

TABLE 2: Barriers to help-seeking and service delivery



3.4.1 Common socio-cultural barriers to accessing care, support and justice

Many respondents – while aware of different forms of GBV – did not seem to be **aware of their right to live free from violence**, and that they should seek help to receive treatment and legal support to demand their rights and pursue justice:

> *"People are not even aware that they are being violated, to them it's very normal." (KII, county/community level police, Bomet)*

The main socio-cultural barriers are related to a lack of awareness about their rights and lack of knowledge of the existing services – where to find them, what they do, how to approach them; the high level of acceptance to 'low' and 'moderate' types of violence; the stigma around reporting violence; the fear of retaliatory violence by perpetrators and fear of service providers, as well as local power dynamics and relationships.

Furthermore, **many respondents do not have a full awareness of the services available to them**. Many community members said they don't know what services are there; even for the services they have heard of, they don't know what they do or where they are located, or they don't understand the process. As put by one focus group discussant:

> *"I don't think that there is a proper reporting mechanism in place in the community, and if there is one, then I don't know how it functions. The reason why I am saying this is because, if you go the chief to report, the chief will tell you to go to the police, if you go to the police they will tell you to go to the hospital first, and if you go to the hospital they will tell you to go to the police, so this going in cycle will make the client feel very unhappy with the services but nowhere to report." (FGD, younger women – urban, Kisumu)*

In addition to this lack of awareness and knowledge, the widespread **community acceptance of a number of 'moderate' types of violence** poses a significant barrier:

> *"Some people feel like it is okay for them to be roughed up. In some cultures, around here, it is a taboo for a woman to stand up against a man no matter what, so the women never seek help even if their life is at risk." (KII, health facility manager, Bomet)*

This is related to **stigma and a fear to report due to complex social and gender norms**. Many respondents, male and female, across counties cited stigma and a fear of embarrassment within their communities after reporting. Women fear that they will be blamed for the violence that they have experienced and further victimized for reporting. Whilst there is increasing recognition and admission that men experience varying forms of violence, including physical and sexual assault, norms dictate that men must deal with problems on their own.

> *"Women will wonder what they will be told when they report while men fear they will be asked about how they could be beaten by a wife. Culture limits the way one can access the services." (KII, local NGO, Kitui)*

Related to these gender norms are barriers imposed by family and social networks, for example when they exert pressure on girls and women not to report incidents perpetrated by family members, including husbands and fathers, thus reinforcing existing cultural norms. For example, **reconciliation is widely viewed as preferable among married couples**, particularly where there are children involved, which is at times perceived to be the only thing binding couples together. In many cases, it is also likely linked to discriminatory inheritance laws for women and their children. This can be seen across the counties, e.g.:

> *"Most women just take in the beatings for the sake of the children. If you decide to leave, children will not get inheritance, so you decide to stay." (FGD, older women – urban, Kwale)*

> *Even for violence that goes 'too far', such as the practice of wife inheritance, no action is taken "since the woman is weak and poor. They just accept the situation for the sake of the children." (FGD, younger women – urban, Kitui)*

Other barriers imposed by family and social networks relate to **power relations within communities and between perpetrators and service gatekeepers/providers**, as mentioned above in section 3.3, with the example of the relationships between chiefs and women/men in communities and the related likelihood to resort to them for support in times of need. This relationship also comes into play where chiefs moderate access to services by having to provide letters of referral to access services and was also noted in key informant interviews, e.g.:

> *"You can't just go to the police without having a letter from the chief telling you to do so." (FGD, older women – rural, Kwale)*

> *"We have an issue with chiefs interfering with the access to justice." (KII, county and community level gender or GBV focal points, Kisumu)*

> *"What we do not get is justice for the mistreatment we receive. Sometimes you may go to the village elder who is a friend or a relative to your husband, obviously he will not give you much help, rather as soon as you leave, he will tell your husband that you were there and by the time you get home he will be waiting to beat you again." (FGD, women, mixed ages - rural, Bomet)*

In addition to the points above, **survivors of violence often fear retaliation and further violence**. Across counties, many women spoke about their fears of renewed or escalating violence by their partners if they reported them – often these fears were 'fed' by perpetrators explicitly threatening victims with hurting them more or killing them if they report.

Across the FGDs there was also considerable fear that the simple act of reporting violence – potentially combined with a high awareness of corruption and susceptibility to bribes from perpetrators – would result in being arrested and/or jailed. This theme was particularly prominent in Kisumu.

3.4.2 Common structural barriers

The main themes of structural barriers touch upon the availability, accessibility and quality of services. These in turn are defined by the availability of infrastructure, resources, human capacity and geographical distances, but also social and gender norms which underlie socio-cultural barriers and define how service staff treat service users and handle presented cases.

3.4.2.1 Availability and accessibility

A major barrier to service access is the **geographical distance to service providers**. Rural areas are particularly underserved, and many community members and service providers would welcome to extend existing services to under-served areas in response. In some cases, e.g. parts of Bomet, geographical barriers are significant. A combination of poor road networks and distance to hospitals often force people to settle for traditional doctors. Furthermore, with the nearest police station 30 km away in one particular study site, formal protection and ways of seeking justice are almost impossible, especially when taking into account associated travel costs.

This is compounded by a **lack of service infrastructure and resources**, such as staff shortages leading to reduced or restricted opening hours for service providers – a particular problem at night *"when violence happens and there is no means of transport" (KII, health facility manager, Kisumu)*. This often also results in gaps in operating services. For example, in many places there were widespread requests for counselling services to be close by.

Gaps in staff capacity pose additional barriers to the provision of quality services. These gaps in capacity are both GBV-specific (including responding to or examining children who have experienced GBV), and relate to more general skills and staff resources (including to bridge physical barriers and gaps in being able to communicate for people with disabilities). These were mentioned by a large number of service providers. For example:

> *"At night there is just one emergency officer to attend to patients, tests and counselling only done during the day." (KII, frontline health worker, Rural Training Health Centre, Kwale)*

> *"They are not adequately trained on how really to deal with GBV issues, particularly on psychosocial aspects after assault." (KII, health facility manager, Kitui)*

Another major barrier is the **costs associated with services**. These costs include **fees for legal forms and medical reports** reported by many KIIs, as well as **transport costs** to services and – although more reported by community members than in key informant interviews – **bribes**. Costs of fees in particular can be quite substantive and unaffordable for poor people. In addition, as mentioned above in section 3.2.2, there is a lack of clarity and consistency in the charging of fees. For example, survivors are charged up to 1000 Kenyan Shillings for the filing of legal forms (P3) at the police or hospital, and fees for filing divorce cases were quoted to be around 300 Kenyan Shillings in Bomet. A registration fee for government-provided health care which is supposed to be free is charged at around 300 Kenyan Shillings, while *"some nurses or medical officer insist to be paid" (KII, frontline health worker, Kitui)*. Service providers' understanding of how much of a barrier fees are for potential users is lacking, for example one health facility manager did not see a 'facilitation fee' as a barrier:

> *"Yes, we have a fee of about 1,000 Kenyan Shillings, but usually it's just a facilitation fee, just to facilitate movement." (KII, health facility manager, Bomet)*

Some providers were unsure what happens when survivors are unable to pay for services. However, poverty and inability to pay fees for services are a key barrier for reporting and the above fees are substantial to a lot of people

> *"If you don't have money, you'll never get justice." (FGD, women, mixed ages – urban, Kwale)*

This is particularly the case for poor people who often face trade-offs between seeking help and other essential items, and for women who are financially dependent on their husbands. For example, participants in Bomet outlined how almost everyone in the area is so poor that they cannot afford help:

> *"Sometimes someone is raped over and over and never goes to the hospital because they do not have the money to take themselves to the hospital and to pay for the treatment." (FGD, women, mixed ages - rural, Bomet)*

Another type of 'cost' is the **fear of economic insecurity after reporting**. Women financially dependent on their husbands and/or with children often fear the potential social or economic consequences from reporting their husbands to local authorities, including being left without financial support and losing their children's inheritance in the case of separation. It appears that perpetrators are aware of this risk, as violence in these scenarios is often more severe:

> *"Those who have low income, or the poor are the ones who experience most violence because the perpetrator is mostly the breadwinner." (KII, religious community leader, Kwale)*

Another fear is that one's husband would go to jail. A county level court official in Kwale outlined how even **when women seek services for domestic violence cases, they want to limit the severity of legal consequences for their husband**. When they understand the full repercussions of reporting, they proceed to ask for reconciliation rather than wanting an arrest (*"they don't want the other part especially the legal part, they fear the legal part" (KII, county level court official, Kwale))*. This may be due to a fear of losing the family's main source of income as outlined above, children losing access to their father, or a generalized fear of the legal system and what happens once someone has been arrested and jailed.

Furthermore, it is important to recognize that **many survivors of violence are highly restricted in their movements and interactions with other people**. For example,

> *"Most of the violated women are not allowed to even interact with people or leave the family compound by their husbands, so you find that it is not easy for them to know where to get help or even if they know they cannot reach them." (FGD, women, mixed ages – rural, Kitui)*

Women in Kitui also shared examples where survivors were physically unable to seek help due to their severe injuries, or where a perpetrator held the victim captive for 72 hours so that the window for collecting evidence had passed.

3.4.2.2 Quality of services

Whilst a more detailed account of the quality of services is provided in chapter 3.5, this topic and concerns about the drivers (e.g. resources, capacity) as well as expressions of it (such as the treatment of service users and cases) were widely shared and are crucial to understand the barriers to help-seeking and therefore already described here.

By far the largest and most widely shared expressions of barriers to service provision centered around the treatment by staff, the lack of confidentiality (which interplays with shame and stigma around experiencing GBV) and the lack of consequences for perpetrators, which renders reporting "a waste of time, energy and money" as summarized by older women in a FGD in urban Kisumu.

Attitude and treatment by staff, including treatment of confidentiality. The issue of treatment by staff including not treating complaints and requests for support as confidential came out much more as a barrier in FGDs. It was however also acknowledged by many key informants amongst service providers. This not only relates to shaming and blaming of survivors (mainly by the police) but also to general rudeness and breach of confidentiality:

> *"There is nothing like rape in marriage ... it demoralizes anyone that wants to report" … "They ask you why you were dressed provocatively to attract rapists and then before you know it everyone knows that you were raped, and you are looked at as an outcast. Nothing is done about any of the violence cases hence it is regarded as normal"… "Police seem to only act in cases of death, otherwise they will dismiss the case." (FGD, older women – urban, Kisumu)*

> *"Some of the workers are rude to the survivors and results in the client not going back there or the worker is big mouth; the client feels that if I tell my issues, the worker will tell everyone in the community." (KII, frontline health worker, Kitui County Referral Hospital)*

However, the issue of confidentiality can also arise due to a lack of adequate infrastructure (lack of privacy) and the nature of processes. For example, as accounted by one key informant, GBV court case hearings are open to the public:

> *"The case is heard in the open by everyone ... imagine these people getting to know what survivors have gone through. It's humiliating. If I know I will report these cases to be heard by everyone I will not." (KII, county and community level gender or GBV focal point, Kitui)*

At one county police station in Bomet, facility observations noted that staff do not keep cases fully confidential and there were **no private rooms or other privacy measures for clients**. Furthermore, researchers heard police officers talking about cases as they were waiting to undertake their key informant interviews.

Village elders too may not always offer confidentiality or accountability: one account of a woman who trusted her village elder who always counselled her to return home and solve her 'family problems', then shared her personal experiences of GBV in the community *(FGD women, mixed ages - urban, Bomet).*

In addition, women find that in many instances, their **accounts are dismissed and not believed**:

> *"If the woman reports a man, the woman's claims are dismissed as illness or amnesia. The woman therefore decides not to bother with seeking for any help." (KII, local council authorities, Kisumu)*

> *"We have one [woman] who is being beaten by her sons, who are drunkards. When they come home drunk, they demand for food from her and most of the time rape her. When she reports no one takes action since these men claim that they take care of their mother. They say that it is only that she has become old that is why she is speaking like that, so those men have turned their old mother into their wife." (FGD, women, mixed ages – rural, Kitui)*

Similar to women, men find humiliation when reporting:

> *"They feel like health workers will discriminate them …. health workers are not usually understanding and supportive when someone who has been raped or physically attacked seeks care from health facilities. They often tend to be judgmental." (KII, county and community level gender or GBV focal points, Kisumu)*

> *"To the police, if you go to report as a man that your woman is beating you, they will not take it seriously. They can even laugh at you and fail to help you." (FGD, men, mixed ages – urban, Kitui)*

Another issue affecting people's trust in and willingness to access services revolves around the accountability of service providers, specifically with respect to the **widely observed lack of consequences for perpetrators**. The lack of follow up and inefficiencies was also mentioned by many service providers – often in relation to the police specifically:

> *"Some will hesitate to seek help because even when they do, no action is taken against the perpetrators, especially when it comes to family where matters are normally solved "kinyumbani" (at home)." (KII, frontline health worker, Bomet)*

> *"It's a waste of time, energy and money … nothing will be done, you will hurt alone and continue suffering and nobody cares." (FGD, older women - urban, Kisumu)*

There were also accounts of people needing help with filling in forms due to low levels of education and staff being 'unwilling' to help – however, it is not possible to ascertain whether this is indeed due to lack of sensitivity on the side of the service provider or due to a lack of time in view of low numbers of staff. One frontline health worker in Kwale requested that:

> *"The filling of the P3 should be made compulsory for all staff because most of them normally refuse to fill these forms." (KII, frontline health worker, Kwale)*

One issue related to both attitudes of service providers and economic barriers to help-seeking is the issue of **corruption**. The police are by far the least frequently sought source of help; although health services (as described above when discussing the payment of fees) and legal services are reportedly also affected by corruption. However, whereas the corruption by health and legal services 'only' poses economic barriers, some members of the police are being 'paid off' by perpetrators and subsequently mishandle or do not pursue cases.

These observations are not only made through discussions with community members but also on admission of police officers themselves:

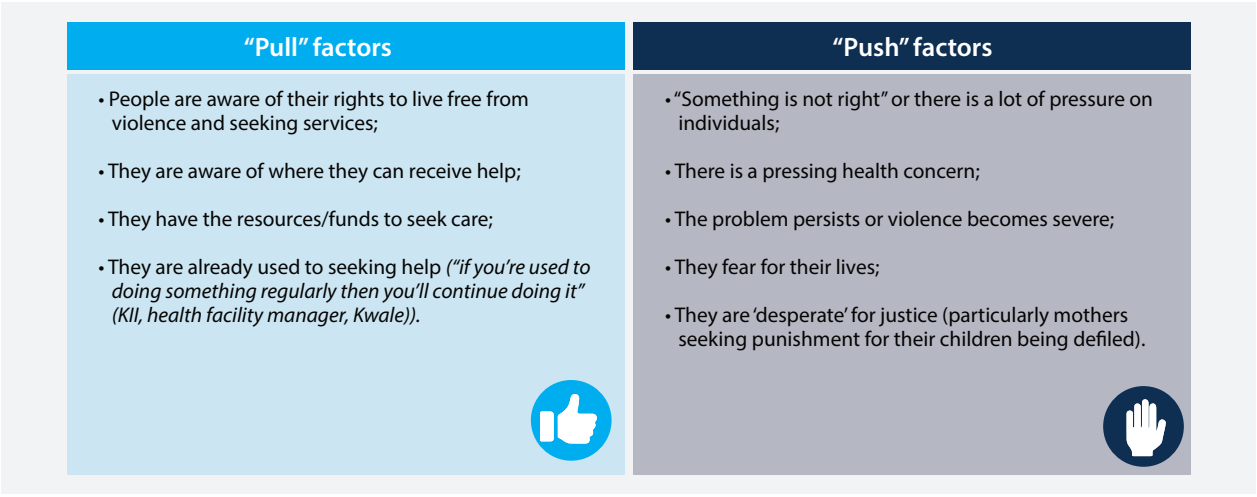
> *"The legal and police services are affected by corruption. This is because for one to have a case out of court, one can easily bribe a court official. Police are best known to be very corrupt, the criminals can bribe them, and no arrest will be made, hence the perpetrators go free." (KII, county/community level police, Bomet)*

> *"Most of the times the police need to be bribed for them to help out which in most cases they don't." (KII, local NGO, Bomet)*

In urban Kitui, one of the FGDs with women of mixed ages outlined how there is a pattern of repeatedly being told to 'come back tomorrow' until a victim becomes discouraged and gives up – this is usually when a bribe has been received from the perpetrator.

Despite the manifold barriers, respondents outlined a number of 'push' and 'pull' factors which contribute to help-seeking behavior. Figure 6 below summarizes these factors.

FIGURE 6: Contributing factors to help-seeking



3.5 Quality of existing services

3.5.1 What is working well?

Against the backdrop of the barriers to help-seeking outlined above, there are a number of issues where respondents felt that progress has been made over the last few years. For example, access to GBV services is being facilitated by **referral structures among the health care system**, and **gender desks for reporting GBV at police stations** are available at the sub-county level in Kisumu, Kitui, Kwale and Bomet.

For most of the facilities observed as part of this research, researchers noted that files were stored away, and staff kept cases confidential. However, there was more variation in observations on whether there was a private room/other privacy measures for patients when they receive treatment, care and advice (with a substantial number of services not able to provide this due to shortages).

GBV has increased in visibility among service providers, with evidence that cases of GBV are given greater prioritization. For example, a county level court official outlined that

> *"now many things have changed when you go to the hospital and say that you have gone through violence you are given a priority." (KII, county level court official, Kitui)*

One of the key informants from a rural health center in Kwale outlined how protocol dictates that GBV cases are treated as an emergency: Clients are treated separately from others and are taken to a secure room where they are examined and counselled alone, and receive differentiated treatment based on the violence experienced. It should be noted, however, that at other facilities,

> *"GBV victims have to wait in line like other patients so that they receive treatment and screening. There is no infrastructure that is there specifically for GBV cases." (KII, county and community level gender or GBV focal points, Kisumu)*

The **availability of GBV services seems to be improving**, with most health services saying they have adequate facilities to provide full medical examinations of GBV survivors, post exposure prophylaxis (PEP), emergency contraception and STI prophylaxis - usually free for GBV victims. Furthermore, **post rape care legal documentation has been made free**. Although not all GBV survivors and some service providers seem aware of this and it is not enforced everywhere, this has been a milestone implemented to reduce barriers for those survivors of violence who cannot afford legal fees. However, facilities' ability to collect forensic evidence, allow uncontaminated storage and transport, and pass evidence to the police varies significantly, affecting the usefulness of the legal documentation.

While most facilities said they offer equal services to all population groups, including for children and adults, only a few select facilities (such as the Gender-Based Violence Recovery Centre and an LVCT clinic in Kisumu) said they had **differentiated approaches to providing services to different groups** such as sex workers, LGBT, and PWDs. One NGO in Kwale also provides counselling to perpetrators, to encourage positive behavior change and prevent repeat perpetration. Many stakeholders are aware of the need to better cater to different needs of help-seekers, e.g. in Kitui numerous service providers and focus group participants were concerned that people with disabilities are excluded from services due to communication barriers related to hearing or speech impairments. In Kwale, language barriers also related to individuals from ethnic groups that do not speak Kiswahili or English.

Training on GBV (and differentiated approaches for different groups) is provided by a range of stakeholders: for example, in Kwale, NGOs are providing training on child protection and case management to health, education, justice, police, local officials and civil society. Some health centers have also benefitted from trainings on providing youth-friendly services – a lack of which is a barrier experienced by young people when they seek help. See Box 4 for an overview on the GBV training related efforts across the counties.

While this is a promising start – and it should not be forgotten that most legislation and policies have only relatively recently been issued – it is evident that these efforts seem neither comprehensive nor systematic (see Section 3.5.2), and **civil society stakeholders are stepping in to compensate for many remaining challenges.** For example, paralegals and social workers are said to be

> *"doing a commendable job of picking up the cases that have been neglected, and ensuring they are attended to, because the GBV cases are very rampant. Most of the cases are being covered in the "kangaroo courts" (local courts) in the villages and most of the people, justice is not done as expected." (FGD, social workers, paralegals and CHVs, Kitui)*

BOX 4: GBV training activities across the counties – good examples

Ongoing efforts to improve services include specifically the provision of GBV training. The following efforts across the counties were conveyed by informants:

- In Kisumu, surveyed shelters and county level police had all received continuous training on GBV and domestic violence, listening skills, domestic violence and sexual assault training – most of it in 2018. One health center reported that all staff had received a five-day training on clinical management of GBV and continue to benefit from refresher training. Some social workers, health workers, and paralegals had been trained by AMPATH on existing policies, referral and reporting pathways, paralegal training (dispute resolution, awareness creation and community mobilization), and how to record and report GBV cases. An LVCT facility provides training to data clerks within the county to report GBV data to the Demographic and Health Survey.
- In Bomet, hospital staff had generally been trained on various aspects of GBV between 2017-2018, including on domestic violence, sexual assault and handling of GBV cases (by the National AIDS & STI Control Programme (NASCOP) and Walter Reed). A few police officers had received police-specific domestic violence and sexual assault training – with new recruits receiving GBV training as part of their training camps. Some social workers, health workers, and paralegals had benefitted from one training on GBV case handling and reporting by Walter Reed.
- In Kitui, health care providers at the county and sub-county level have generally received some training on GBV – though some dated as far back as 2013, whilst others received their first ever training only in 2018. One sub-county hospital had not had any GBV-specific training at all but received a capacity building on 'sexuality mainstreaming and GBV' in 2018. Traditional community leaders reported being provided with training through seminars, e.g. on serving people and treating them well. The county referral hospital has a staff member whose role it is to provide GBV training to colleagues and undertake sensitization of chiefs and assistant chiefs on collecting evidence and handling rape cases.
- In Kwale, a county-level court official said they had received continuous training on GBV and domestic violence, listening skills just three months prior to the research. The county level police (and gender desk) had received training on GBV and domestic violence in 2017, with additional training having been received at some point (the respondent was unsure when). In Diani, police are trained on child friendly service provision. Local officials (village elders, local administration) are trained on child protection, and some community social workers reportedly receive training by GBV trainers. Local officials have benefitted from legislative trainings.

3.5.2 Areas for improvement

In view of the above, there are a number of key areas that could be improved, both in terms of filling gaps as well as improving existing services. The key factors hampering the quality of services are related to a lack of staff and inadequate resources and infrastructure; a lack of GBV capacity, inconsistent awareness and implementation of protocols and guidelines; and a lack of coordination amongst service providers.

3.5.2.1 Lack of staff, resources and inadequate infrastructure

Consistent staffing of existing service providers appears to be a challenge throughout. Gender desks at police stations across the surveyed counties are said to be only irregularly, under, or not at all staffed; health clinics often lack an adequate amount of nurses, and professionally trained GBV counselling staff (where there are some trained staff, they often only have basic counselling training); and mobile outreach health services are often undertaken at the expense of the operations within clinics. Furthermore, too few social workers covering large areas reportedly results in poor services and burnout (and, potentially, drop out from the line of service) among social workers.

Virtually all consulted service providers noted a **lack of adequate vehicles and transport resourcing**. Hospitals are missing ambulances to reach emergencies and undertake referrals to other facilities; and police stakeholders also note shortages, including sufficient funds for fuel (it is reportedly common practice that clients are asked to fund these so that cases can be attended to). Other service providers who do not have vehicles at all note the lack of funds for transport fees for both outreach efforts and referrals of clients, at times resorting to covering these out of pocket. Community-level workers with no vehicles (such as volunteers) may have to walk up to 10 km to reach cases.

Almost all service providers said they were dealing with **inadequate office equipment and supplies**, with needs ranging from computers for data entry, sharing and obtaining; to missing key supplies for the collection (GBV kits) and submission of forensic evidence (such as envelopes to preserve and submit physical evidence). Even some of the major health facilities at county level are struggling with inadequate equipment and supplies to collect, store and transfer forensic evidence, or to provide primary care. Many clinics noted their inability to provide TB prophylaxis.

The vast majority of facilities included in the research were missing crucial infrastructure: **hospitals and health centers lack sufficient size of facilities and number of rooms** to ensure privacy and quality care for different cases, while police stations also often lack sufficient rooms for privacy and GBV-specific services, as well as adequate cells for custody (one police station in Bomet has resorted to housing children and adults together).

Existing shelters face severe funding shortages and are inadequately equipped for providing adequate shelter to GBV survivors. Two interviewed shelter managers in Kisumu described a lack of funds to support operation and a consequent dependency on donations, which meant the shelters were significantly underequipped – for example, one consists of a simple wooden structure with two rooms (one as an office and one for treatment/sleeping for women and children seeking shelter), while the other is too small for existing demand (lacking enough rooms and beds, as well as running water). Some service providers make up for gaps by taking clients to their own homes, from which they often don't want to leave (*"they request to stay because they feel safer here than in their homes" (KII, shelter manager, Kisumu).* A community level police officer at a gender desk in Kwale outlined how due to a missing shelter for GBV victims, women and children are being housed in the station's prison cells for security.

BOX 5: Challenges across multiple services severely affect access for GBV survivors

Such challenges in resourcing and infrastructure across service providers has profoundly negative impacts on service quality which in turn affects help-seeking behavior. For example, one of the service providers – aiming to provide 24-hour GBV services specifically – has neither sufficient infrastructure (including vehicles, office equipment and supplies, building structures) nor sufficient of staff to maintain a consistent level of service provision in view of the high demand. P3 forms are only filed on specific days, and the supply of forensic kits is inconsistent. Forensic samples are "*lost mysteriously sometimes*" and resources to track and monitor clients are also falling short. At the same time, the county level police also deal with inadequate resourcing for protecting victims of violence: there is a lack of safe houses, lack of funds to staff investigations, and physical follow ups on cases is hindered by a lack of money for fuel and supplies, missing facilities to collect forensic evidence, and the provision of counselling throughout the process is also lacking. This is example is representative of what research respondents reported across all counties.

There were repeated requests from FGDs and KIIs across counties for one stop GBV centers (also to upgrade existing shelters) due to the pressing need for their provision. This is also supported by the often-expressed fear by women that they would experience renewed violence after reporting violence – this fear, as well as the risk of repercussions during a potential trial (a risk well-recognized by service providers), poses a significant barrier to help-seeking.

Furthermore, there is a need for better gender balance among staff, particularly in certain positions. For example, in one of the health facilities in Kisumu the only doctor trained to undertake physical examinations of GBV victims is male; and there are currently no female officers at the children's department in Kwale, which receives many cases of abuse by children and women. This can affect individuals' comfort level in opening up to the service providers regarding what has happened to them:

> *"They feel like they will not be handled properly. They also feel the same way 'akienda huko anakuta mwanaume' (when she goes there, she finds a man), they shutdown, they change the story." (KII, county level court official, Kwale)*

> *"The largest issue is opening up to an officer, with a woman it's easier." (KII, local council authorities, Kwale)*

3.5.2.2 Lack of GBV training, awareness of and implementation around protocols and guidelines

As outlined above, there are many efforts related to raising GBV capacity amongst service providers. However, many stakeholders are still in need of capacity building on GBV, and how it pertains to their specific roles.

Across the counties, it can be observed that **a number of institutions have not received training on GBV,** and those that have, either received it a few years ago with no refresher trainings, or very recently, likely as part of efforts to upgrade the current GBV response. However, the gaps in training result in concerns around the ability of recently hired staff that had not been sufficiently trained to perform their role – this applies particularly to health staff when collecting forensic evidence and filling in legal forms. In view of high demand of these services by clients this could then result in errors with far-reaching consequences. Box 6 below shows gaps and challenges related to GBV specific training across the sectors.

There is little evidence of a coordinated, systematic approach to GBV training. An NGO respondent in Kisumu expressed concern about **inefficient and irrelevant training and low use of training provided** – for example, health stakeholders receive police-specific domestic violence and sexual assault training, and police benefit from health-specific medical report writing, whereas service providers who are in actual need of this do not.

Related, the **awareness of existing protocols for addressing GBV in specific sectors is quite low**, with many informants only referring to general training they have been provided with, rather than specific guidelines they are using in their work. The overview of existing protocols also varies, for example, one of the respondents working for an NGO with extensive activities on tackling GBV (including through capacity building) did not know of any guidelines/protocols to improve quality of GBV services among police, local officials or civil society (NGO, Kisumu).

It also appears that **most institutions do not have any guidelines in place or are not implementing them** or are drawing on general conduct policies that they have created themselves. For example, according to a staff member at the Gender-Based Violence Recovery Centre in Kisumu – as an institution entirely focused on responding to cases of GBV – is lacking clear guidelines to operate *("not really guidelines, but we sometimes have meetings so that we remind ourselves what we need to do")*. There is also a sense among service providers and institutions that changes in policies are not accompanied by sufficient support to roll them out.

BOX 6: GBV training activities across the counties – gaps and challenges

- In Kisumu, health providers illustrated a sporadic approach to training. At the county's GBV Recovery Centre, staff had received training "sometime back", with no sign of refresher trainings. Health centers showed disparate training as well, with one health center only having one staff member trained on GBV; while at another, all staff had received trainings and continue receiving refreshers. A notable gap among surveyed medical facilities was training on medical report writing – a key requisite for legal proceedings (although an informant said this is provided in medical school or nursing college). The interviewed county level court official was unsure about any training provided. Among social workers, health workers, and paralegals, the training received varied, with some having been trained by AMPATH; and others rarely having received any training – this was particularly prevalent amongst paralegals. Although police in Kisumu are said to benefit from GBV training, a particular challenge noted was staff turnover – when police officers have been trained on GBV processes, transfers of officers often result in replacements with untrained staff.
- In Bomet, health sector stakeholders also had different levels of training. Hospital staff had generally been trained on various aspects of GBV between 2017-2018; however, training on medical report writing and listening skills was provided inconsistently. A smaller health facility had not received any training on GBV. Some institutions had benefitted from general training, but not directly related to GBV. In the security and justice sector, the county level court official was unaware of any training having been provided. Among police, it was noted that staff had no continuing training on domestic violence or listening skills (in urban Bomet, FGD respondents of women of mixed ages said the gender desks needed more training efforts to be made functional, as the they do not feel safe reporting to them the way they are now). The training that had been received by social workers, community health workers, and paralegals varied, some only knew of other workers in the county who had been trained on GBV. They emphasized that they would be able to deliver better services if they had more training and refreshers on GBV.
- In Kitui, in the security and justice sector, the county level court official said no GBV training had been provided, and the county level police also asserted that staff members did not receive any training. A local shelter had received GBV training a few years ago.
- In Kwale, training provided to health providers varied. Most government health clinics had received some kind of training a few years ago, including on domestic violence, writing medical reports and presenting cases at court. One informant at a rural health center had never heard of specialized listening skills for victims' story. A respondent at a sub-county clinic mentioned "a huge gap" in training, saying they had not received training "for a very long time".

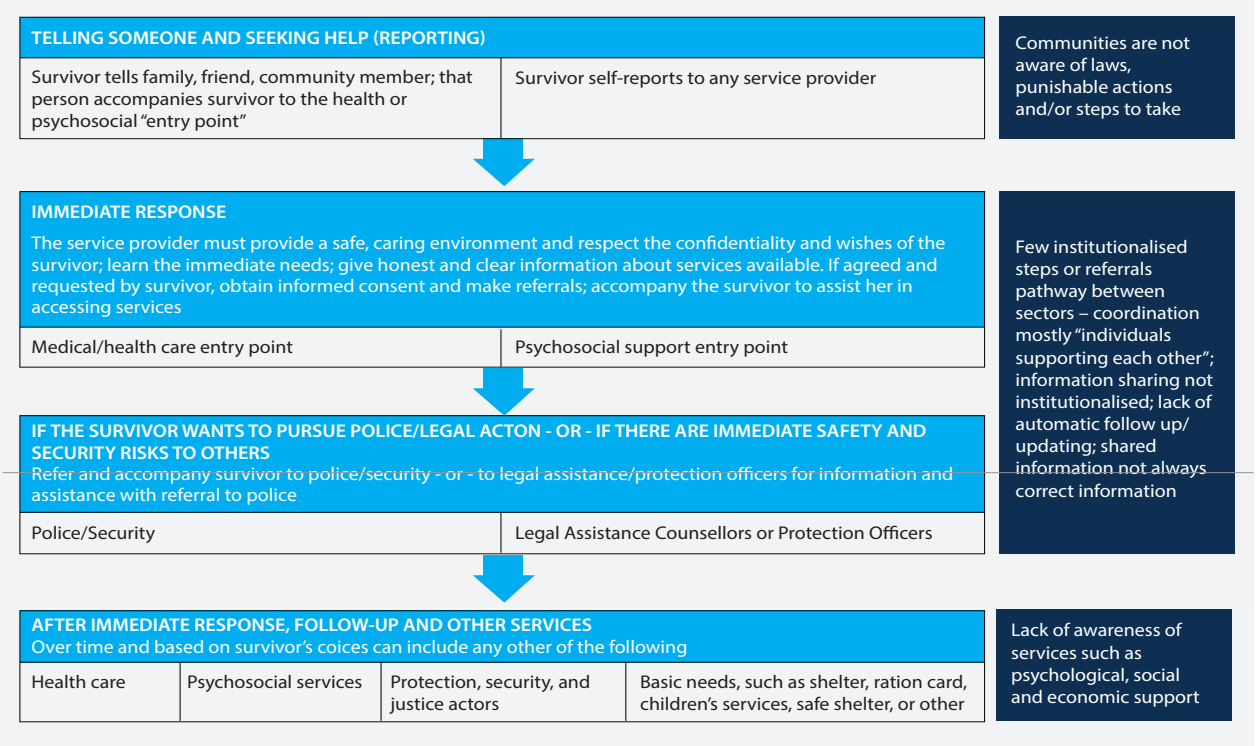
3.5.2.3 Lack of coordination amongst service providers

The provision of services responding to cases of GBV are often dependent on referrals to other facilities which can provide more specialized care. However, the required referral procedures are at times not fully executed due to challenges, including the fact that some of the referral facilities also experience shortages in services.

In addition, **the referral pathways that are in place are complex and hard to navigate** by stakeholders, particularly at the community level. This can be observed in different understandings of what the structure is supposed to be like, many potential ways of reporting and then requiring different referrals, and a widespread perception that the process can be laborious and circular. There are some accounts of clients getting 'lost' or failure to keep track of clients while they are navigating different systems of service provision – this would be remedied by strengthened monitoring of the referral process.

Figure 7 below aims to summarize the most important gaps identified by this study with reference to the pathway of help-seeking and referrals outlined in the National Health Sector SOPs on the management of sexual violence (Ministry of Health, 2014b, p.35).

FIGURE 7: Help seeking and referral pathway and most important gaps challenging effective inter-sectoral linkages and usage of services



Due to existing and well-known gaps in government structures and a prevalent disconnect between government and communities, **communities feel neglected by the government**. In response, a community leader in Kisumu outlined how **communities create their own local networks that are manageable and accessible** for them. It also contributes to the tendency to respond to GBV cases at a local level through "kangaroo" courts, which are highly biased and susceptible to mishandling.

According to a local NGO informant in Kisumu, **competition among organizations for funding (and visibility) leads to further lack of coordination of services** – here, the focus is likely to be on creating and maintaining certain services' visibility, rather than a comprehensive overview of what is available and for whom.

Specifically, in relation to coordination and cooperation amongst service providers, a more formal recognition of social workers by the government would support their efforts to see that GBV cases get processed adequately. Based on insights from Kitui, there is **considerable potential to upscale their efforts to fill gaps in the referral networks** through promoting greater visibility of these workers in communities (such as official badges provided by the government) and promoting support (such as financial support, capacity building and access to a more formal network for referral).

Related to the wider issue of cooperation and coordination is a noted need for greater efforts around data collection and sharing for better understanding of changing patterns in prevalence of cases, available response services and cases processed, as well as feedback on data submitted to higher levels of government for reporting. This feedback and the monitoring of emerging data could give an oversight of the issue at county level and inform approaches to existing challenges.

3.5.3 Feedback mechanisms

The previous sections have provided an account of the major concerns around the quality of services as well as areas for improvement. It is important to note that **the vast majority of respondents feel completely unable to raise or log complaints in the case of unsatisfactory services**.

Across Bomet, Kisumu, Kitui and Kwale, many respondents did not feel they had any possibility to complain to the service providers. Even where 'suggestion boxes' exist, very few respondents said they would log a complaint if they were unhappy with services, and if they did, they could not be sure whether these were taken up or responded to at all. Some respondents feared even more severe consequences:

> *"They just discuss it in low tones thinking that they might even get arrested for feeling unsatisfied with a service, especially the police service because that's where we go for reporting." (FGD, older women – rural, Kisumu)*

In response, they often stop seeking these services. For example, one group of women of mixed ages in rural Bomet conveyed that:

> *"the women are used to their situation and have reached a point of accepting their fate. These things are now part of us, there is nothing that can be done." (FGD, women, mixed ages - rural, Bomet)*

Both the experience of chronic violence (including emotional abuse and neglect) and not receiving help for this can have severe consequences for women and men:

> *"If you are not happy with the service, there is nothing you can do and that's why you find most people committing suicide because they have nowhere to turn to for help." (FGD, men, mixed ages – urban, Bomet)*

This resignation to not being heard is not only restricted to service users. In one county, respondents reported receiving threats in response to raising concerns about the provision of poor or weak services: *"we were told if we continue or [are] heard talking about it, we would lose our lives, so we had to remain silent".*

In addition to not reporting or resorting to informal mechanisms, a **number of respondents suggested alternative services which may offer better treatment,** such as private services in urban areas. However, private services are neither available nor affordable to many women and men; and local radio stations were named as one other alternative to report bad service, such as *Musyi FM* and Syokimau FM in Kitui. In Kwale, some respondents suggested that in case of a severe infraction, one should report the incident to a superior office (for example, if one is unhappy with the village chairman, speak to the chief, if it is the chief, speak to the police).

4. RECOMMENDATIONS

The findings from this study show a multifaceted set of socio-cultural factors and institutional barriers which affect help-seeking behavior among Kenyan women, men, girls and boys who experience GBV. Consequently, the ability to seek help and receive appropriate, quality care is affected. It is anticipated that the recommendations (based on participants' contributions and subsequent analysis of the data) provided above, as well as global findings in relation to what works to provide better GBV services and help prevent GBV, can help inform future efforts to improve the availability, quality and utilization of response services and prevention efforts regarding GBV across different service sectors, particularly in Bomet, Kisumu, Kitui and Kwale counties.

We suggest three main areas of work: (1) addressing socio-cultural and socio-economic barriers to help-seeking; (2) addressing institutional barriers to help-seeking; and (3) supporting GBV prevention efforts at the community level.

4.1 Addressing socio-cultural and socio-economic barriers to help-seeking

It is crucial that socio-cultural barriers to help-seeking – including widespread acceptance of different forms of GBV, pervasive stigma attached to reporting violence (for both women and men, and in some cases girls and boys), combined with a low awareness of available services – are addressed. The main areas of work through which this could be achieved are:

- Increasing women and men's **awareness about their right to a life free of violence**, particularly with regards to marital rape and physical violence which is still widely accepted as a 'part of life'.
- Sensitizing women and men on the importance of help-seeking and **destigmatize reporting**.
- Raising **knowledge of available services and referral networks** in all communities. This includes clear communication about:
    - The range of existing service providers
    - The services women and men can expect to have access to at these providers
    - The location of these services
    - The costs involved – if any
    - What obligations service providers have to clients and where complaints (including regarding poor treatment, bribes or corruption) can be lodged (including contact details and hours when complaint mechanisms can be accessed)
    - What support exists in order to access these services, particularly for poor people and people with disabilities; and where such support can be accessed
- Support the establishment of community-based **financial support initiatives for survivors**, e.g. an 'emergency fund' for those requiring financial support to access response services.

Ideally, the above activities should be part of multi-component community mobilization and broader programming efforts to change social norms around GBV, for the effectiveness of which there is some evidence (Fulu & Kerr-Wilson, 2015). In addition to initiatives at community level, popular local radio stations can be drawn on for all three points above, as talk shows were mentioned as a common source of information on GBV and available services across the counties, and a potential way to report complaints regarding service provision.

4.2 Addressing institutional barriers to help-seeking

Addressing the acceptance of different forms of GBV, the stigma attached to reporting violence and the moderately low awareness of available services from a service user perspective is important, but a number of barriers to help-seeking are posed by service providers and need to be addressed. As seen in the analysis, these evolve mainly around accessibility, accountability, and the quality of services. The recommendation therefore is to support initiatives that aim to:

- **Reduce access barriers.** This could include:
    - Increasing the coverage of service provision. This could be achieved by establishing more branches in rural areas or doing more outreach, such as through legal aid clinics or mobile health clinics. However, this should be undertaken with additional capacity, rather than put more pressure on existing, already often overextended staff. Alternatively, greater facilitation in terms of transport to distant facilities may be helpful.
    - Reducing direct service costs. This includes lowering or subsidizing registration, consultation and form fees, as well as a close monitoring of services that are supposed to be free.
    - Increasing the accessibility of services to key vulnerable groups such as people living with disabilities by providing specialized training of medical staff.
- **Increase accountability across the justice and health sectors and police.** Women and men report being highly discouraged from seeking help or reporting violence by the lack of respect and treatment they receive from some service providers, as well as by the broader impunity of perpetrators. Accountability could be increased by:
    - Monitoring staff conduct and providing complaint mechanisms that are not tied to the service providers themselves but are centrally, independently managed.
    - Helping establish incentive schemes for service providers that reward following up on cases in conformity to existing laws and standards.
    - Enforcing penalties for service providers/duty bearers who request bribes or 'facilitation fees', or do not act based on existing laws and standards.
- Strengthen the organization of existing referral networks and support better coordination among service providers across all sectors to avoid disruption in referral networks – including through encouraging greater cooperation between formal and informal service providers, and/or instituting an oversight or coordination mechanism to manage cases across different service sectors and providers.
- **Improve quality of services provided** through
    - Regular trainings and refresher courses for service providers covering both the breadth and depth on GBV topics generally (including a gender-transformative perspective to reduce discriminatory attitudes), as well as specific to their services. This should include regular reviews of guidelines and protocols for service providers which are often not in place or of which staff are not aware.
    - Continued capacity building on counselling among all stakeholders.
    - Paying attention to skill sets and gender balance among staffing.
    - Monitoring and addressing key resourcing challenges by regularly reviewing, keeping track of and addressing common shortages across different sectors (e.g. staffing, vehicles, office equipment and supplies, and infrastructure).
- **Provide funding for informal/non-government provided GBV services which are filling crucial gaps** but are severely underfunded, such as shelters.

Ideally, these types of activities would be informed by meaningful involvement with potential service users – women, men, boys and girls at risk of or experiencing GBV – who can bring in their perspectives of the barriers to help-seeking, reporting and access to services, as well as those civil society stakeholders which have been key actors in providing GBV services and can share their experiences and learning (Bell and Butcher, 2015).

4.3 Supporting GBV prevention efforts at the community level

In addition to the recommendations outlined above, a number of prevention efforts can be supported which help tackle socio-cultural and socio-economic barriers. This includes both the targeting of harmful social and gender norms, and the reduction of economic dependencies which respondents say keep many survivors in harmful relationships. Recommendations in this area are to support the following:

- **Invest in prevention initiatives that are co-located with support for response through improved service provision**
    - Engage on a community-wide level to raise awareness of GBV, its consequences and existing protective legislation as it pertains to GBV and related punishment for crime – while nurturing trust between communities and service providers, for example through sharing stories of success in help-seeking.[11]
    - **Invest in proven community initiatives aimed at tackling harmful gender norms, destigmatizing help-seeking, and promoting healthy relationships and non-violent behavior** – such as the promotion of healthy relationship and non-violent communication capacity building to stop violence before it starts.
    - Within this effort, reaching children and adolescents to break the intergenerational cycle of violence (and better address their current high vulnerability to GBV) will be crucial.[12]
- Support livelihoods and economic empowerment initiatives which promote women's financial independence and their ability to leave abusive relationships if they so wish, either within communities or at shelters where women are looking to start over.
- **Support economic empowerment initiatives more broadly alongside gender-transformative work** with women and men to address risk factors for GBV and reduce financial barriers of help-seeking that cut across all groups, including men and boys.

[11] Such prevention efforts are recognised by many service providers as crucial, but they often lack the knowledge and/or resources of undertaking these.

[12] Such efforts could draw on well-recognized curricula, such as the UNESCO International Technical Guidance on Sexuality Education Here, where children and young people learn about "health and well-being, respect for human rights and gender equality", and to recognize, prevent and manage experiences of GBV. The curriculum also fosters life skills such as empathy, negotiation and critical thinking, including about social and cultural norms which may cause violence (such as gender and power relations): https://en.unesco.org/news/comprehensive-sexuality-education-prevent-gender-based-violence.

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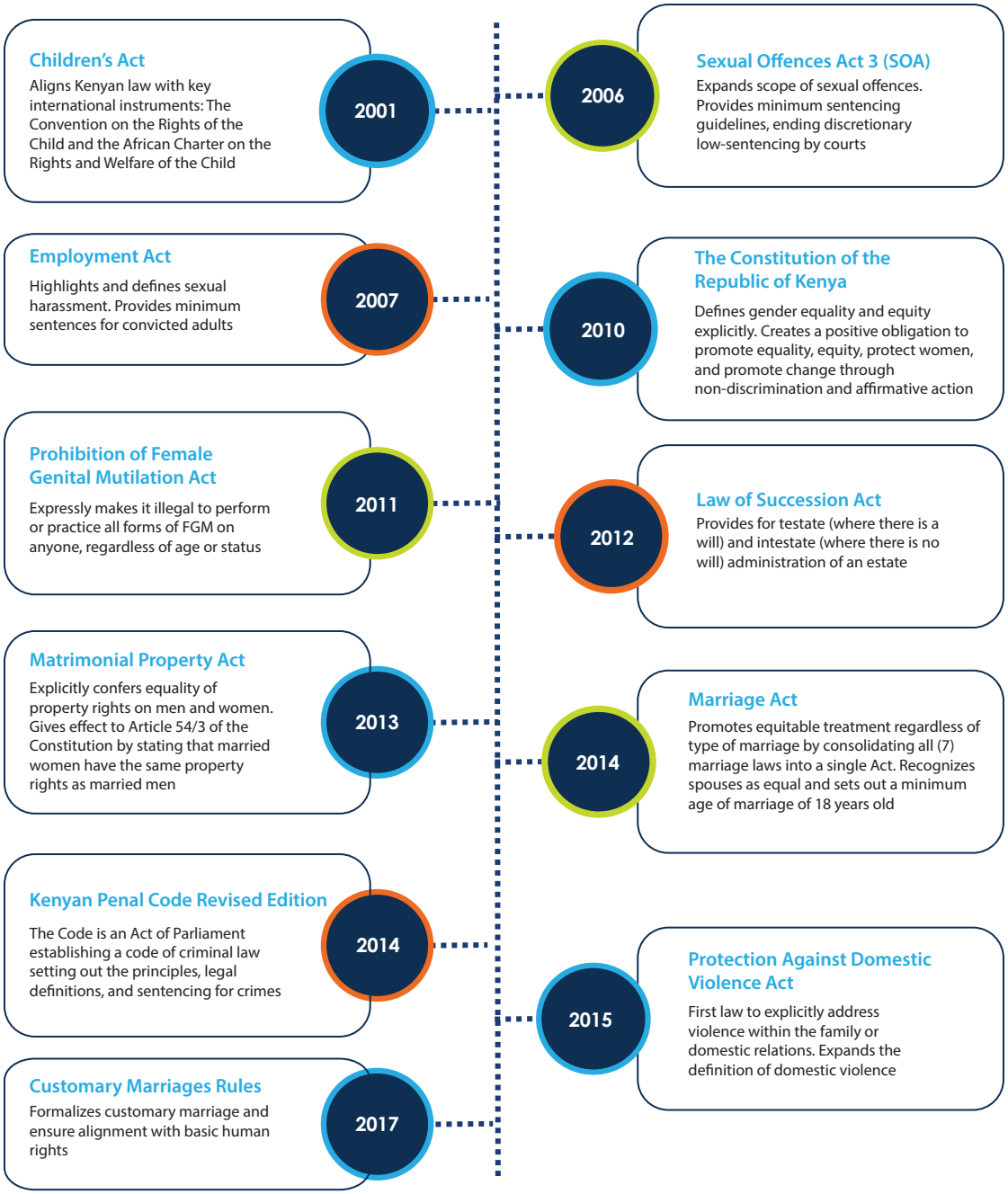
ANNEXES

Annex A - GBV relevant legislation



Annex B - Overview on number of FGDs and KIIs

Table 3: Kisumu – List of conducted KIIs and FGDs

Participants	Location
Key informant interviews	
Gender and Youth Affairs county office (GBV focal point)	Urban
National Gender and Equality Commission (GBV focal point)	
Health facility manager	
INGO representative	
Shelter manager	
Teaching and Referral Hospital manager	
Kisumu High Court official	
Sub-county hospital frontline health worker	
Local council authority	Rural
Traditional community leader	
Religious community leader	
Sub-county hospital frontline health worker	
Shelter manager	
County-level police inspector, gender desk	
NGO representative	

Focus group discussions	
Social workers, paralegals and health workers	Urban
Younger women	
Older women x 2	
Social workers, paralegals and health workers	Rural
Younger women x 2	
Older women	
Younger men	
Men (mixed ages)	

Table 4: Bomet – List of conducted KIIs and FGDs

Participants	Location
Key informant interviews	
Chief Officer Gender (County level)	Urban
NGO representative	
Government Referral Hospital manager	
Hospital frontline health worker	
Health facility manager	
INGO representative	
Women Representative office (GBV focal point)	
County-level court official	
Local council authority	
CBO/Local NGO	
Traditional community leader	Rural
Religious community leader	
County/community-level police	
Frontline health worker	
Frontline health worker	
Focus group discussions	
Social workers, paralegals and health workers	Urban
Younger women	
Older women	
Women (mixed ages)	
Men (mixed ages)	
Social workers, paralegals and health workers	Rural
Younger women	
Older women	
Women (mixed ages)	
Men (mixed ages	

Table 5: Kitui – List of conducted KIIs and FGDs

Participants	Location
Key informant interviews	
Local NGO x2	Urban
County-level gender/GBV focal point x2	
County/community-level police	
Religious community leader	
Frontline health worker	
Shelter manager x2	
County-level court official	
Health facility manager x2	
Local council authority	Rural
Traditional community leader	
KII with frontline health worker	

Focus group discussions	
Social workers, paralegals and health workers	Urban
Younger women	
Older women	
Women (mixed ages)	
Men (mixed ages)	
Social workers, paralegals and health workers	Rural
Younger women	
Older women	
Women (mixed ages)	
Men (mixed ages)	

Table 6: Kwale – List of conducted KIIs and FGDs

Participants	Location
Key informant interviews	
NGO	Urban
INGO	
Health facility manager	
County-level court official	
Shelter Manager x2	
Religious community leader	
Frontline health worker	
Traditional community leader	
Frontline health worker	Rural
Health facility manager	
County/community-level gender or GBV focal point x2	
Local council authority	
County/community-level police	

Focus group discussions	
Social workers, paralegals and health workers	Urban
Young women	
Older Women	
Women (mixed ages)	
Men (mixed ages)	
Social workers, paralegals and health workers	Rural
Young women	
Older Women	
Women (mixed ages)	
Men (mixed ages)	

Annex C - SDDirect's Ethics and Safeguarding Guidelines

1. Our work should lead to clear social development benefits in people's lives.
2. Our work is conducted to a high standard in ways that are fit for purpose and ensure only the gathering of information that is relevant to the goals of our work.
3. Harm to all groups involved in our work is avoided.
4. We are inclusive, ensure that marginalised groups are not excluded and are respectful of and informed by cultural differences and sensitivities.
5. Participants take part voluntarily, based on valid informed consent.
6. We compensate research participants for their involvement by providing refreshments at FGDs.
7. Personal information is treated confidentially, and the privacy and anonymity of participants is preserved.
8. We publish and communicate research and evaluation findings.
9. We adhere to national and local ethics approval processes within the countries we work.
10. Data collection will adhere to the common ethical standards of do no harm. Care will be taken to avoid findings being described in a way that could pertain or result in biased views on communities or groups of people.

Whilst this research study did not involve any direct engagement with children, Forcier and SDDirect had the child protection policies in place which was shared with the research team to avoid any risk of misconduct in these interactions. Forcier provided clear behavior guidance to all qualitative researchers on expectation around child safe interactions. This included provision of a written declaration that qualitative researchers have understood what is expected of them. Also, all members of the research team were briefed on the ethical principles of conducting research. While SDDirect had the overall responsibility for safeguarding in this project, at the community level, Forcier's child protection policy and reporting mechanisms was used.

Annex D - Services mapping by sector and county[13]

Health

County	County Hospital	Sub-county hospital	Health Centers	Other
Bomet	• Tenwek Mission (Referral Hospital) • Longisa Referral Hospital	• Siongiroi (Sub-county) Hospital • Ndanai (Sub- county) Hospital	• Kapkimolwo health Centre, Siongiroi Health Centre, health centers in Longisa, Bomet, Kaplong, Tenwek • Kaplong Mission Hospital	• National AIDS & STI Control Programme (NASCOP) • Community health workers
Kisumu	• Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH) – includes Gender-Based Violence Recovery Centre (GBVRC) (level 5)	• Rabuor Sub county hospital • Ahero sub- county hospital (level 4)	• LVCT clinic • Health center in Kadinda • Masogo Health Centre • Private: Jamii Thabiti Health Clinic	
Kitui	• Kitui General Level 5 Hospital • Kitui Referral Level 4 Hospital • (Nairobi Women's Hospital – referral) • Free hotline 911 - Nairobi gender desk to receive calls from survivors	• Mwingi Hospital • Migwani hospital • Mulango sub-county hospital • Katulani sub-county hospital • Kauwi sub-county hospital • Mutomo Hospital	• Primary health care center • Yanzuu Health center • Muthale Mission Hospital • Dispensary: Mulutu dispensary • Private: Nehema Hospital • Private: Jordan Hospital	• Healthcare Assistance Kenya (SGV Rapid Response System and Helpline 1195 supports survivors GBV to quickly access GBV health and legal services) • Social Workers and CHVs • Centre for Health Solution (Machakos County, but some overlap)
Kwale	• Kwale District Hospital • Msambweni District Hospital	• Lunga Lunga sub-county hospital/ Health Centre • Kwale sub-county hospital	• Health centrers in Kikoneni, Mkongani, Shimba Hills and Ng'ombeni, Kombani, Tiribe, Vindeni, Mlungunipa • Tiwi Rural Training Health Centers • Private: Pendo Medical Clinic • Faith-based: Ukunda Catholic Hospital • Dispensary: Diani Clinic, Meza Mwenye Dispensary, • Lunga Lunga Dispensary	• Afya Pwani-Ukunda

[13] Please note that this list might not be exhaustive as it only lists services that were mentioned by respondents

Justice

County	County-level	Sub-county level	Community level	Other
Bomet	• Judiciary: Bomet law courts (only 2 in county)		• Social workers • "Kangaroo" courts	
Kisumu	• Judiciary: Kisumu law courts • Director of Public Prosecution (DPP) - government entity • Kisumu Gender Technical Committee	• Ahero law courts • Court Users Committee (CUC)	• Legal support: KELIN and community paralegals • FIDA (not all areas)	
Kitui	• Judiciary: Kitui law courts • Office of the Director of Public Prosecution • (National Gender and Equality Commission)	• Court Users Committee (CUC) • Khadis' Courts (for Muslims) • Human Rights Office, Kitui town • Children's Rights Office/ Department	• Peace Workers • Social workers • Paralegals	• Kitui Cha Sheria - Legal Advice Service • Maendeleo ya Wanawake
Kwale	• Judiciary: Kwale county law courts • Gender Technical Working Group • (National Gender and Equality Commission)	• Khadis' Courts (for Muslims) • CLEAR (Mombasa) • FIDA (Mombasa) • Department of Children Services	• COVAO • MUHURI (Muslims for Human Rights) • Haki Yetu • Plan International • Social workers • Women Fighting AIDS in Kenya (WoFAK)	

Security

County	County-level	Sub-county level	Community level	Other
Bomet	• County-level police station: Bomet • Gender Desk	• Sub-county police station e.g. in Sotik • Gender Desk	• Chiefs	• Nyumba Kumi initiative
Kisumu	• County police station- e.g. Nyando, Ahero, Boya, Kabonyo, Kakola, Onjiko • Gender Desk	• Local police station - Awasi, Boya, Ahero, Katito • Gender Desks	• Chiefs	• Nyumba Kumi initiative – community policing to report cases and make community safer (works with area police)
Kitui	• County-level police station: Kitui town • Gender Desk	• Sub-county police station e.g. Itoleka, Kitui rural • Gender Desks	• Chiefs	• Nyumba Kumi initiative
Kwale	• County-level police station: Lunga Lunga, Kwale Town • Child Protection Unit • Gender Desk	• Administration Police: • Gender Desk	• Community Police Officers • Local council authorities	• Nyumba Kumi initiative

Psychosocial support/counselling, shelter and other social support

County	Psychosocial support	Shelter	Other social support (CBO, FBO, NGO)	Other
Bomet	• Tenwek Mission (Referral Hospital) • Longisa Referral Hospital • AGC Church Twenwek/ Longisa • Community health workers in Siongroi and Sigor • Kaplong Catholic Church	No shelters exist	• Local traditional leaders (chiefs, village elders) • I Choose Life • Church-based: • AGC Church Twenwek/ Longisa, • Kaplong Catholic Church • Family and community members	• Walter Reed American Research Institute (training on GBV to health facilities and police)
Kisumu	• Gender-Based Violence Recovery Centre, Kisumu • LVCT health, across county • Kemri CDC • FACES • Nyabende Support Program • Women Concern Center	• CBO-run shelter, Nyando • Shelter in Kisumu Central Constituency	• Plan International, Milimani • Mama Rhoda, Urudi • Awasi Child Fund, Awasi • Church-based: AIC Ayucha • Otheka Human Rights Organization • Nyabende Support Program, Ahero • Bernard's Vision School, Tura • Ebenezer Children's Home, Ahero • USAID DREAMS project, Ahero	
Kitui	• Private: Nehema Hospital • Private: Jordan Hospital • Girl Child Watch • CARITAS • AIC Church • KICABA • St. Eudes Rehabilitation Center • Mama Upendo Children home	• St. Eudes Rehabilitation Center • Kiria Rescue Homes • Mama Upendo Children home (for children only) • Christ Freedom Center	• Local traditional leaders (elders and chiefs) • Maendeleo ya Wanawake • Centre for Human Rights • Church-based: • Catholic Church, AIC, Redeemed Church, • Community of Mercy, Christ Freedom Center, Christian Child Fund Kitui Development Rescue Center • KICABA • African Development Services	• UNEP • Individuals provide informal shelter
Kwale	• Kwale sub-county hospital • Department of Children Services • Kids Care • Women fighting AIDS in Kenya (WoFAK) • Ukunda Catholic Hospital • Volunteering Children Officers (VCOs) • Compassion ACK Church • (Nairobi Women's Hospital – referral)	• Hennesy Childen's Home • Footprints • Simba Rescue Centre	• SCOPE (Strengthening Community on Partnership Empowerment) • Local traditional leaders - area chiefs and elders • Maendeleo ya Wanawake • Child Welfare Society of Kenya • Khadis (Muslim religious leaders) • Church-based: ACK (African Child Kenya) • Sauti ya Wanawake (The Voice of Women) • Plan International • Kwale Welfare and Education association (KWEA) • Moving the Goalposts (MTG) • Samba Sports Coaching	• Informal youth groups in communities • Activist Amina Musa (chairlady of Maendeleo ya Wanawake, GBV champion with Plan International; peace keeper etc.) leads support groups and provides informal support

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