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Exploring Gender-Based Violence Management in Nairobi

Kirsten Dimovitz

SIT Graduate Institute - Study Abroad, kdimovitz@gwmail.gwu.edu

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Kirsten Dimovitz

SIT Study Abroad, kdimovitz@gmail.com

Advisors: Dr. Jama and Dr. Karama

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ABSTRACT

Awareness about the prevalence of gender based violence is on the rise around the world. Citizens, governments and international organizations are beginning to see the vast impacts this issue has not only on the afflicted survivors but also on their families, friends and communities. However, less research is often done on a city or community level which leaves wide gaps in varying social, cultural, economic, and situational indicators. This also leads to many broad statements about the reasons why gender-based violence is so high in a particular areas. In developing countries the code word is often, poverty. This study takes a deeper look at the issue, by selecting one unique focus area, Nairobi and especially its informal settlements, and then examines the intricacies of the similarities and differences among the data to establish specific, evidence-based risk factors. Among poorer areas there is also the issue of accessing services. This study will ask what can be done to reach the most vulnerable in addition to looking at technology's effect on access.

1. INTRODUCTION

1.1 Background:

Gender-based violence is the most widespread, socially tolerated human rights violation in the world. It kills, disables, and harms more people (women) than cancer, malaria, traffic injuries and *war* combined.¹ The violence can take many forms physical, sexual, psychological and economic. Those who survive their attacks suffer psychological and physical scars, but often do not bring it to the attention of family, friends, health workers or authorities either because of stigma, shame, the belief that nothing can be done for them, and perceived/real lack of ability to

¹ UN Resources. "Ending Violence Against Women and Girls." *UN News Center*. UN, n.d. Web. 1 Nov. 2015.

access services. A recent study found that between 20-66% of women never tell anyone about what happened to them, and 55-80% never seek services from anyone at anytime.² Because many face challenges with stigma and reporting, they never receive help, and are thus, forced to live with their scars.

1.2 Definitions

In this study, the definition and usage of **gender-based violence** will mirror the definition used by the World Health Organization: “A violation of human rights and a form of discrimination against women that result in physical, sexual, psychological or economic harm or suffering to women.” When gender-based violence is referenced throughout the paper, it should be seen to mean sexual and physical violence against women, as opposed to other forms of gender-based violence including, female circumcision, emotional abuse, and economic abuse. Sexual Violence officially includes “any sexual act, attempt to obtain a sexual act, unwanted sexual advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting.”³ For the purpose of this study, the definition of coercion does not regard the degree of force, as it can mean physical force, psychological intimidation, blackmail, intoxication or other threats which may occur when the person is unable to give consent. Sexual violence in this context will be seen to mean completed rape, other forms of assault involving coerced contact, the attempt to do so, and gang rape. This study would also like to recognize, that although sexual violence knows no geographical, ethnic or cultural boundaries, researchers have found that it is exacerbated and increased to extreme levels by poverty, conflict and disaster.⁴ These conditions can be found all

² Ombwori, Fredrick. "Status of Gender Desks at Police Stations in Kenya - A Case Study of Nairobi Province." Institute of Economic Affairs - KENYA, 2009. Web. 2 Nov. 2015.

³ Krug EG et al., eds. World report on violence and health. Geneva, World Health Organization, 2002

⁴ "Violence against Women." World Health Organization. November 1, 2014. Accessed September 22, 2015.

over the world, but the common characteristics that generally constitute “poverty” are often concentrated in high levels in the informal urban settlements or the slums.

This study acknowledges that while the term “slum” may be used in this paper, there is no one definition of urban informal settlements and that the term “slum” can inappropriately and incorrectly label a community as dirty and unhealthy. As researchers have shown using data from the Mathare informal settlement in Nairobi, Kenya, environmental conditions can vary greatly within the same slum.⁵ However, this study will use the term slum with the intent to mean the same as the United Nations Human Settlements Programme (UN-Habitat) definition: “an area with inadequate access to safe water, inadequate access to sanitation and other infrastructures, poor structural quality of housing, overcrowding, and insecure residential status.”⁶ It is with this definition in mind that this study will refer to an area as an informal urban settlement or as a slum.

1.3 Study Setting:

Because of the aforementioned high risk of violence in the clearly define informal urban settlements, this study focuses on Nairobi, Kenya. A place, not unlike many others around the world, where sexual violence is extremely prevalent, and where there is a vast number of informal urban settlements stretching across the capital city. Nairobi province is home to around 3 million with 40% of them living below the poverty line. It has the highest reported number of GBV cases in the country, despite having the largest concentration of non-governmental,

⁵ Jason Corburn and Chantal Hildebrand, “Slum Sanitation and the Social Determinants of Women’s Health in Nairobi, Kenya,” *Journal of Environmental and Public Health*, vol. 2015, Article ID 209505, 6 pages, 2015. doi:10.1155/2015/209505

⁶ “The Challenge of Slums: Global Report on Human Settlements 2003.” *Preventionweb.net*. April 16-20, 2007. Accessed September 22, 2015.

community-based, and faith-based organizations.⁷ The Gender Violence Recovery Centre in Nairobi reports that 45% of women between ages of 15 – 49 have experienced either physical or sexual violence, and the rate of violence is increasing.⁸ Additionally, it is reported that one in every three women and one in every five men experience at least one episode of sexual violence, abuse or defilement before reaching the age of 18 – an experience that not only can affect their physical and emotional health and safety immediately, but can also shape their futures in terms of their attitudes towards violence, their adoption of risky behaviors and their ability to perform normal daily functions.

Globally this phenomenon is not new, researchers have proven that violence is generally worse in urban centers and in unplanned settlements. It has been estimated that one third of the urban population in developing countries today live in overcrowded and unserved neighborhoods, often situated on marginal and dangerous land.⁹ In Kenya, these kinds of conditions can be seen in areas like Mathare, Huruma, Kangemi, Kawangware, Korogocho, Dandora and Eastleigh to just name a few. In these areas, violence is reported to be significantly higher than in surrounding middle class, formalized areas of Nairobi. According to a study in Nairobi's Kibera slum, over 36% of female residents report being physically forced to have sex (compared to 14% of all Kenyan women) and over 30% of women reported being forced to perform other sexual acts (compared to 14% of all Kenyan women).¹⁰ It is in areas like this, that

⁷ Ombwori, Fredrick. "Status of Gender Desks at Police Stations in Kenya - A Case Study of Nairobi Province." Institute of Economic Affairs - KENYA, 2009. Web. 2 Nov. 2015.

⁸ Johnson, Kirsten et al. "A National Population-based Assessment of 2007–2008 Election-related Violence in Kenya." Gender Violence Recovery Center. 2014. Accessed September 17, 2015.

⁹ "Chapter 1: Development Context and the Millennium Agenda." In *The Challenge of Slums: Global Report on Human Settlements 2003: Revised and Updated Version* (April 2010), edited by Michael Kinyanjui, 3. UN Habitat, 2010.

¹⁰ Jason Corburn and Chantal Hildebrand, "Slum Sanitation and the Social Determinants of Women's Health in Nairobi, Kenya," *Journal of Environmental and Public Health*, vol. 2015, Article ID 209505, 6 pages, 2015. doi:10.1155/2015/209505

this study examines deeper for the underlying causes of such high rates of gender-based violence.

2. STATEMENT OF THE PROBLEM

2.1 Impacts of Gender-Based Violence

According to the Kenyan Police Annual Crime Report “43 per cent of 15-49-year-old women reported having experienced some form of GBV in their lifetime, with 29 per cent reporting an experience in the previous year; 16 per cent of women reported having ever been sexually abused, and for 13 per cent, this had happened in the preceding year (2009). The Police Annual Crime Report (2010) showed an increase of 8 per cent in rape cases, 19 per cent in defilement cases and 22 per cent in cases of incest from the previous year (2009).” Moreover, it is important to highlight that although these numbers are high, the real statistics must be even higher, as in Kenya and most areas of the world, the true extent of GBV has been stigmatized to the point of low reporting. These experiences not only harm survivors physically but emotionally as well. While cuts and bruises can be healed, the mental scars cannot, especially in situations where no one is told and services are not sought out.

There are also grave consequences in public health. Adverse public health effects of gender-based violence include exposure to sexually transmitted infections, gynecological fistula, unwanted pregnancy, psychological sequelae, chronic pain, physical disabilities, substance abuse and of course the initial physical damages like cuts, broken bones, bruises and pains.¹¹ Sexual and physical violence not only leaves lasting health issues, but it also reduces the range of

¹¹ Palermo, Tia, Jennifer Bleck, and Amber Peterman. "Tip of the iceberg: reporting and gender-based violence in developing countries." *American journal of epidemiology* 179, no. 5 (2014): 602-612.

choices open to women and girls in almost every sphere of life; from who they can trust, to where they can work, to where they can live, to if they can leave the house.

2.2 Costs

For children, these consequences can be even more serious. And they are particularly vulnerable to violence, especially sexual abuse.¹² The physical, emotional and psychological scars of violence often rob children of their chance to fulfil their potential. Because defilement cases are often perpetrated by fathers or relatives, children may not develop with any sense of security or ability to trust those around them. Many may be more reserved and lead lives of seclusion and pain. Physical deformities are also very common as children are being abused before they have even reached puberty.

Not only does sexual violence have severe mental and physical health implications, but it also perpetuates poverty, illiteracy and early death for victims. Moreover, studies have found that members of communities where sexual violence is high suffer deeply as well. Thus, the argument must be made that although sexual violence affects women and girls disproportionately, it cannot be an issue regarded as just a “women’s issue” or an issue of the poor. It must be an issue that everyone takes a stake in solving.

Economies are also affected and GDPs are lowered as a result of high levels of sexual violence. Although hard to quantify, several studies have calculated the economic costs of a rape, accounting for medical and victim services, loss of productivity, decreased quality of life, and law enforcement resources. It is estimated in the US, the cost exceeds US\$5.8 billion per year: US\$4.1 billion is for direct medical and health care services, while productivity losses

¹² Kenya National Bureau of Standards (KNBS). (2010). Kenya Demographic and Health Survey (KDHS) 2008-09. Nairobi, My Action Counts 43 An Assessment of Gender Based Violence Responses in nine Counties of Kenya Kenya: KN

account for nearly US\$1.8 billion.¹³ And these high costs only take into account reported cases in the context of the US where violence is lower than it is in the informal urban settlements of Nairobi.

3. OBJECTIVES

1. To explore the risk factors of sexual violence in Nairobi communities
2. To explore the access of services open to sexual violence survivors and their communities in Nairobi
3. To explore the impact of communication technology on access to resources and care

4. LITERATURE REVIEW

4.1 An Assessment of Gender Based Violence Responses in Nine Counties of Kenya

In 2014, the International Rescue Committee partnered with USAID and three main Kenyan organizations (Sauti Ya Wanawake Pwani, Rural Women Peace Link and Coalition on Violence against Women) undertook a study to establish, prevalence of GBV issues in the nine counties; interventions in place (both government and nongovernmental) to respond to the issues; the services offered and their effectiveness, and accountability of office bearers at the two levels of governments in addressing GBV. The study also looked at coordination mechanisms among the different actors. The study took a participatory approach involving the key players in GBV management in each county. The findings included: 1.) GBV cases are on the rise across the country, both in nature and in diversity. Types of GBV cases that have been considered unnatural and unacceptable in African culture, such as incest, sodomy and child defilement were reportedly

¹³ "United Nations Secretary-General's In-depth Study on Violence against Women." UNite to End Violence Against Women. 2006. Accessed September 22, 2015.

on the rise. 2) There is a glaring absence of support to survivors of GBV, as the chain of support right from reporting to the police, through to healthcare and the judicial process is slow, ineffective or hardly in place. This emboldens the perpetrators and increases the vulnerability of the survivors. 3) Various forms of GBV are accommodated, justified and even institutionalized in certain Kenyan communities and cultures.

Some of the persistent issues included the fact that despite the high number of cases prevalence of GBV and acknowledgement of the gravity of its impact by all key leaders; the issue has neither been addressed in the legislative agenda of county assemblies nor are there budgetary provisions for the same, particularly in regard to the county service delivery plans. Additionally, there is a relationship between poverty and GBV as those in the lowest income brackets are more susceptible to it. Almost none of the counties have safe houses, while psychosocial support for GBV survivors in health facilities is “negligible” across the country. The findings also included the fact that taking cases of incest or defilement to court is prohibited in most cultures. In fact, most cultures consider it an abomination to report rape to the police. The National Police Service is greatly incapacitated in the collection of forensic evidence. Without this vital information required for successful prosecution of GBV cases, most cases collapse. Worse still, most police stations lack gender desks, and even where they exist, their efficiency and effectiveness is limited. The study found that, “it is no wonder, therefore, that in most counties, the Kenya Police Service was cited as the weakest link in the chain of referral mechanism.” Moreover, “in many societies, including Kenya, women have been generally socialized to accept, tolerate, and even rationalize domestic violence and to remain silent about their experiences.” out that the average time taken for conclusion of GBV court cases is three years. This is a very long time to wait, and in most counties visited, the support mechanism for

survivors and witnesses was very weak. This makes the cost of accessing justice prohibitive for most GBV survivors and often leads to aborted justice.

4.2 Communications and Technology for Violence Prevention

In 2012, Katherine M. Blakeslee, Deepali M. Patel, and Melissa A. Simon, Rapporteurs Forum on Global Violence Prevention Board on Global Health engaged in a workshop on Violence Prevention. Their paper is the culmination of that workshop. The workshop was focused on exploring the potential applications of ICT to violence prevention. The main problem stated was that, “the past 25 years have seen a major paradigm shift in the field of violence prevention, from the assumption that violence is inevitable to recognition that violence is preventable. Yet the prevalence of sexual violence and GBV is still high and low- and middle-income countries bear 90 percent of the burden of violence.”

To address these issues, participants discussed the fact that technology is no longer used only to send out information, but is instead used as a two-way communication channel and for the creation of dialogue among multiple parties. “Social media are affecting societies and lowering barriers and, in the process, disrupting the status quo of hierarchical structures.” This could thus be a great tool in reaching out to survivors, potential survivors, and community members to discuss the issue, to disseminate resources, and to lowering barriers to access. The study also found that coalition building is instrumental in success violence prevention. Effective collaboration between public health agencies, members of law enforcement, social services providers, educators, and other actors can have huge impacts. It is also especially important to link those who work on prevention and treatment as treatment practitioners can use their data and expertise to inform better education programs. Dr. Rosenberg from the workshop also cited the need for establishing connections between the officials who can respond to a problem and the

people who are reporting the violence as well as the need to incentivize participation and reporting.

Participants cited “the potential of information and communications technology (ICT) to help in violence prevention efforts is great and that SMS is the most common platform for mHealth. They noted that “SMS and geocoding technologies can be used to display incidents of violence in real time, which can be particularly effective in combating sexual violence.” This use of technology could be a way to break the silence that surrounds the issue, and it helps empower vulnerable groups of women in this geographic area.” Others noted the effect on women: “Providing women with access to mobile devices allows them to move toward economic independence, which reduces their vulnerability to violence.”

4.3 Mapping of Sexual & Gender Based Violence Services in Kenya

In 2010, the National Commission on Gender and Development identified services, gaps and developed approaches to institutionalize and strengthen gender-based violence response and prevention through coordination and policy advice. The study was carried out in response to post election gender-based violence which demonstrated the need to have a national mapping of services to strengthen and upscale referrals. The study covered 5 regions including Nairobi, Rift Valley, Nyanza, Western and Coast. There findings included learning that there is a higher rate of GBV than service providers can currently handle. The study concluded, that factors sustaining violence include cultural institutionalization of gender violence, weak GBV response and protection mechanisms and socio-economic and education issues. The study also found GBV hotspots, yet there are no known pre-existing anti-GBV programmes in these hotspots. Is this the case the hotspots were large counties. The Government also praised itself for “establishing” gender desks, but acknowledged gaps in district and sub district clinics that do not have

personnel or facilities for such cases. Many facilities have a shortage of PEP, only one trained person in whole facility, and inadequate counselling. There is also limited community cooperation and in community led policing.

4.4 Research Gap

This study sought to fill the gaps in sexual violence research, especially in this area. Because no community is exactly the same, it is important to have area specific data to implement evidence-based solutions. The first major gap identified was that of the lack of specific research on poverty as a risk factor, as something that exacerbates levels of sexual violence. This study seeks to discover what specific factors within the broad category of “poverty” contribute to these high levels of sexual violence. Thus, this study examines risk factors, especially those related to informal urban settlements in Nairobi. Additionally, examining access in a particular area is vital. This study will look very specifically at Nairobi, and women coming from informal urban settlements. Can they reach facilities? Do they know where they are? How do they get there?

Also, embedded in the objectives above is a desire to discover the usage and impact of new technologies to deal with these issues. Change in the field of sexual violence has been slow, and increasingly implementers are looking towards new trends and options to improve access, services and prevention. Within the last 15 years, there has been an growth of affordable and reliable information and communication technologies all over the world. Some organizations are harnessing this technology and using it to invent new ways to address old, persistent challenges. Around the world, the challenges being mitigated range from maternal and neonatal mortality to HIV and TB adherence. Innovations like SMS reminders about pregnancy visits and HIV medication appointments are increasing adherence and treatment by empowering the user with

information. In different countries throughout the world, programs are popping up and are finding their way into the sexual violence space. Recent monitorization and response programs include SMS connection to local authorities, community-based violence tracking platforms, and 24/7 anonymous hotlines.

Some organizations and experts argue that sexual violence could be managed better by utilizing such technologies. Others believe while the world used to face a shortage of information, it now is overloaded, and many organizations lack the proper infrastructure to sift through the data, analyze it, and corroborate it. Furthermore, there is still much debate about whether the use of better technologies leads to earlier action, appropriate response and increased aid of vulnerable populations. The answer is still unknown. This paper asks about the technology access of citizens living in informal urban settlements and the impact tools have on better management of sexual violence. This will be done by filling in the gap among the research and discovering how communities regard such technologies, their ease of use and levels of uptake, their effects on the populations being served, and their ability to enhance earlier action, access and improved response.

5. METHODOLOGY

The methodology for this study consisted of observations of study sites, development of questionnaires, data collection, quality control of data, data processing and ensuring ethical values. The study was qualitative in nature and sought to answer the research objectives outlined in the introduction, but was not confined to only those results. The study took place over the course of November and December 2015.

5.1 Study Setting and Sample Design

The city of Nairobi was selected purposively because of its high prevalence of GBV, especially sexual and physical violence against women, its housing of gender violence recovery centres and its presence of GBV organizations. Information was gathered from 25 survivors through combination interview, 239 survivors through already collected GVRC data, 4 key informants, 2 local online counsellors, and 2 gender violence recovery centres.

5.2 Study Questionnaires

A set of three questionnaires were developed for GBV survivors, key open leaders and the SMS counsellors. The KOL questionnaire, which was also used for interviews with organization leaders and specialists, included primarily open-ended and follow-up questions designed to capture relevant data. Each questionnaire was also designed to uncover NGO activities as well as perceptions on the issue from hands on work.

5.3 Data Collection Process

No research assistants were used or trained for this study as there was only time and need for one principal investigator (PI). The PI studied best practices for interviewing and working with sexual violence survivors and tried to employ relevant tools for handling sensitive situations, questioning and listening skills, maintaining respect of the respondents, observation skills, dealing with difficult situations, objective observation, and debriefing.

(a) Secondary information – Secondary information collection comes partly from research conducted with the help of the Kenya National Human Rights Commission Library, published work by Kenyan government ministries, and the work of field leaders (e.g WHO / UN). Secondary data collection was undertaken in order to provide context and knowledge of

contemporary issues on gender violence in Kenya and what others were doing in terms of research.

(b) Primary Information - The other half of this study data comes from primary research conducted in the field including; formal and informal interviews with specialists and thought leaders, patient surveys both in both questionnaire and informal interview form, historical data collection through the Gender Violence Recovery Center Patient database and recovery center observations. The field assessment took place from mid-November to early December.

Formal interviews were conducted with Dr. Kizzie Shako - Forensic Examiner for Sexual Violence and pathologist from the Police Surgery Unit at the Nairobi Traffic Headquarters, Lorraine Ochiel - Programme Officer from Federation of Women Lawyers FIDA Kenya, Evelyne Ofwona from the joint study on sexual violence with the Kenyan Ministry of Health and the The Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Roselyn Nkirote from the Gender Violence Recovery Center, and Kennedy and Edwin the Mathare Youth Sports Association SMS counseling hotline. Their answers were created from their personal experiences working with patients, and not from organizational statistics (Appendix D&E).

At the Gender Violence Recovery Center - Adams Branch, historical data was collected on the 32 new patients from September 2015 to October 2015. This data helped uncover demographic data and similarities to illuminate risk factors. The principle investigator was also able to sit in on counselling sessions and record observations about the facility and personnel. At the Gender Violence Recovery Center - Hurlingham Branch, historical data was collected from the September 2015 and October 2015 report of over 200 patients as well as observational data of the main headquarters. Here counselor, Roselyn Nkirote was formally interviewed, as were

other staff members in a more informal way. In-depth formal questionnaires were given to 5 sexual violence survivors, 3 in English and 2 in Swahili (Appendix A - English) (Appendix B - Kiswahili). The PI and counselors were there to help the survivor fill the questions. Counselors also collected their own data through their sessions which was then merged with the questionnaire (Appendix C). Additionally, from December 1st to December 5th, 20 new patients came to the Hurlingham branch. With the help of counselors extensive data was collected on the patients' situations.

5.4 Data Processing and Analysis

Primary data consisted of field notes from interviews and questionnaires. Some of the data was processed using Excel software methods, but as the nature of the study was qualitative most information came from finding patterns in questionnaires and interview answers. This allowed for the study to develop an idea of the situation in Nairobi. The results are presented by in relation to core objectives with additional interesting and possibly insightful information on demographic trends, hot spots, and other information provided by interviewees.

5.5 Ethical Consideration

Given the sensitivity of gender based violence, the ongoing of recovery centres were observed before research as conducted. The PI spent one day at each center collecting historical data and observing counselling sessions before any questionnaires or current survivor data was collected. Every possible step was taken to ensure the respect of interviewees and their well-being while obtaining responses. Special attention was paid to survivors to ensure that questions are not too prodding, the questions are not triggering, and that they were in an emotionally and physically safe and secure place before proceeding. If survivors appeared to struggle with simple demographic questions, more sensitive ones were skipped. No names or identifying factors were

taken from patients to to the sensitive nature of their situations. Instead patients and questionnaires were identified by date and time of arrival. In addition, permission to undertake the study was sought from the administration of the Gender Violence Recovery Center - Adams after discussion and consensus on the questionnaires. A copy of the authority letter was used for identification while gathering information/data from sampled individuals, groups and institutions.

6. STUDY FINDINGS

This segment describes the findings of the study with special emphasis on information relevant to key objectives stated above. However, additional interesting related information to the issue of GBV in Nairobi is included below.

6.1 Risk Factors Objective

The study found that the biggest risk factor is being a woman. The study found that in September male adults and male children made up 14% of cases whereas women made up 86%. Additionally, male children were most affected making up 67% of male cases. In October, the data was similar, with males making up 10% of cases. 100% of those cases were perpetrated by either one or two other men. Women made up September, 88 new cases of women came to the GVRC center seeking services, and in October, there were 122 female patients.

Of these respondents, most were women residing in informal urban settlements or slums areas of Nairobi. The top three areas of an October data collection at the GVRC center were from Kangemi, Kawangware, and Kibera. The PI's research of the 25 patients from December 1st - 5th found that 25% of survivors lived in Kawangware, a slum area 15km from the city center

housing about 800,000 people, most of them living on less than \$1 a day; 65% are children and youth.



Additionally, the study found that 65% of all cases were from areas which are considered informal urban settlements. With another 13% from poor farming areas, 13% from middle class areas, and 9% unreported.

In terms of ages, sexual violence affects women across the spectrum. The study found cases as young as 2 years old, and as old as 53. GVRC counselors reported having cases less than a year old, and as old as a hundred. Clearly this is an endemic issue that can affect women of all ages. However, the study found that women between the ages of 12 and 39 were most at risk. Girls between the ages of 12-18 presented 33% of cases, and women between the ages of 19-35 accounted for 38% of cases. The next most affected age group was 5 - 11 years with 11% of the burden. Overall, children, mainly girls, accounted for 49%, of cases.

Additionally, the study found that most respondents made between 0 and 2,000 ksh and many had “vulnerable jobs.” **Vulnerable jobs** are defined as informal employment like own-account workers and contributing family workers. They are less likely to have formal work arrangements, and are therefore more likely to lack decent working conditions. Vulnerable employment is often characterized by inadequate earnings, low productivity and difficult conditions of work that undermine workers’ fundamental rights.

Children were found to be most at risk if they lived in these low-socioeconomic areas as well. However, the time of the attack in these areas differed. Whereas women were most targeted at night, children were most likely to be assaulted during the day. Key opinion leaders cited the nature of low-socioeconomic areas in Kenya as the problem. Because most women have vulnerable jobs, they must go to work every single day, and almost none of the resources to higher and pay for a nanny or house help. Thus, young children remain at home unattended or in the care of an older sibling. An anecdotal example given from one respondent was that a 3 year old child was left in the care of a 6 year. This leaves children vulnerable. Houses do not have gates or in some cases even doors. Additionally, the crowded nature of the community allows everyone to know when the mother is home, and when her children or young girls are alone.

More over the nature of housing leads to increased violence. Often there are many people living in one small room. This can include extended family or multiple families in one space, without partition walls. Many people living in these areas, especially men, are unemployed and said to be “idle”. Which respondents attributed to high levels of sexual violence? Additionally, some believed that sexual violence is simply another form of crime, and in areas where there are high rates of crime, there will naturally be higher levels of sexual violence because of the nature of the violent population.

6.2 Access Objective

Although there are high rates of violence in informal urban settlements, no clear answers could be obtained on the cause of this phenomenon. Looking at the specific example of Kawangware, when discussed with counsellors, it could not be determined whether or not this was because of a higher incidence rate in Kawangware, because of its proximity to the center, or because of local population's awareness. However, when examining access, the PI took into consideration these comments and investigated the "closeness" of this area. The PI took a trip to the center of Kawangware which was 6.5 km away, and discovered a bus ride takes around 40 minutes without traffic and closer to 70 minutes with mild traffic. Besides the bus route running directly along the road from Kawangware to the GVRC Center - Hurlingham, one could conclude that it is not exactly accessible. Additionally 100% of respondents answered that they walked or took the bus to arrive to the center; making any journey for help somewhere between 40 and 90 minutes.

Furthermore, when a patient finally reaches the facility, they often do not stay there for long. The average counselling sessions last between 5-15 minutes, and offers advice on where to go next. After the survivor receives treatment, if they would like to pursue justice, they must travel to different sites around the city by bus or by foot. This process is reported to create high attrition rates in access to justice, because survivors do not have the time, resources, or willpower to navigate the system.

Additionally, all of the KOLS excluding Dr. Shako, cited police mistrust and mismanagement as a barrier to access. They described many survivors feeling their cases would not be taken seriously. However, all mentioned that both these perceptions and actions of police officers are slowly changing. Dr. Shako indicated that low resources, officer redistribution, and

lack of training funding, are the main problems afflicting police officers and thus their work ethic or perceived work ethic. When a gender-based violence case is delegated to officers to collect the survivor or perpetrator, Dr. Shako said it takes time, because officers cannot find vehicles to bring them or their posts do not believe it is a priority. Yet, at the GVRC, the study found that police were involved in referring cases. About 28% of the time, survivors arrived at the center because of police referral; demonstrating that police can have a positive impact on survivors accessing resources if they are trained and able to handle cases properly.

Police are just one piece in a long line of bureaucratic processes. Outside of legal services there are other barriers to seeking services and help. Some of these include: living environments, threat from perpetrators, low income and stigma. Living environments can be a higher barrier to survivors as they are often living either with the perpetrator, in the proximity of the perpetrator or in situation that allows the perpetrator to still have access to them. Generally, respondents said that about 90% of perpetrators are known to survivors. Study data found that number to be more around 69%. However, because some data was collected on new patients many left it unreported or the results of perpetrator details were left unknown. A breakdown of the October data, found that the makeup of known perpetrators was 23% friends, 28% spouses/partners, 19 known person, and 13% neighbor. Additionally, security in these areas is not conducive to survivors' mental and physical safety. Almost all of the respondents surveyed reported feeling still threatened by the perpetrator, with only a few reporting being unsure of how they felt. When a survivor feels threatened by the perpetrator thus may stop them from seeking legal action. It may also be a very valid fear, and thus, their safety is again at risk as statistically perpetrators are likely to perpetrate again, if they either do not understand what they are doing is wrong or have

no regard for the law, either because of weak laws or because of social acceptability and thus belief that no action will be taken against them.

Moreover, it is much harder for survivors to access services if they are in a socio-economic disadvantage because of cost and because of breadwinner situations. Some may have simple misconstrued perceptions about the cost of services in addition to the real cost of transport to and from compiled with the financial hits a woman would take when she misses a day of work. Having limited income can greatly affect survivors, especially those who have vulnerable day to day jobs and must provide for their families. On the other hand, women living in traditional breadwinner situations where the man makes all the money can be detrimental as well. Some women visiting GVRC noted that their partner made the most money and that they also withheld or controlled money. These situations make it hard for women to leave abusive partners or fathers or family members. If a woman cannot provide for herself, and afford a place to live she cannot help her children or herself leave the situation.

Community members, families and chiefs can reinforce these fears, and further damage the survivors if they are able to convince them not to seek help, report or pursue justice. This is often caused because of social stigma against the issue. Many communities discourage talking about sex or any aspect of it, and this makes talking about a horrible experience in this category even more difficult. Moreover, KOLS cited problems with socialization. They reported that Kenya is still very much a patriarchal society, even though it is slowly changing. However, many men and women believe that men are the ones who hold power over women's bodies and choices. This makes domestic violence, intimate partner violence and even unwanted sexual activity or coercion difficult to discuss. Additionally, many believe it is not something that could seriously damage the well-being of the victim or something that should be thought of as a human

rights violation. Moreover, communities like to settle this issue through traditional means, as it is often seen to be inappropriate to talk about in public and therefore inappropriate to take to court. This also harms the survivor as family members often disassociate or look down on women who decide to report. However this is changing slowly, especially with the rise in media coverage on defilement. Parents always accompanied their children to the GVRC. Thus, it can be lightly concluded, as Dr. Shako did, that access to justice is slightly easier for children, as society is beginning to view this violence against children negatively.

6.3 Technology Objective

This objective proved hard to meet. When questioned about hypotheticals regarding technology, survivors were hesitant and unsure how to respond. When asked which they would prefer between in person, online and over the phone counselling, every participant answered “in person.” Which could lead the study to conclude that Kenyan survivors prefer in person counselling and that this would make utilizing technology to break down barriers mute. However, when asked why, they chose the answer they did, respondents replied with vague answers highlighting either a misunderstanding of the question or traditional views on counseling. This is definitely a point for further study. However, respondents did utilize forms of technology in relation to other aspects of their experience. About half called a hotline and even more called a friend or relative for advice before visiting the center. Thereby, it appears that the most utilized form of technology and possibly the best entry point for new practices is with the cell phone. Additionally, no respondents reported searching for information online which was an interesting finding compared to US statistics where many people look to the internet for information first.

While the information from survivors was hard to discern, some insight from local SMS line counselors illustrated that a hotline of such kinds may be useful for younger generations both in terms of prevention and response. The SMS line is operated through the Mathare Youth Sports Association which runs programs for over 20,000 local kids. The hotlines placement within an already existing organization gives it strategic capability to reach vast numbers of youth. The general consensus was that the SMS hotline broke down barriers to accessing information and discussing individuals' concerns especially among youth. It was also highlighted that the service has given the users an opportunity to share their pressing issues anonymously which they believe has increased willingness to disclose information. However, it was about half and half. There are individuals who will prefer to have one on one (face to face) with other counselors and others who just prefer texting. Yet, counselors do believe that if the SMS service did not exist, many youth with pressing issues would not have an opportunity to be assisted and probably be depressed or engage in risky behaviors.

7. RECOMMENDATIONS

This study faced huge time constraints. As to no fault of the Gender Violence Recovery Centre, the authorization to conduct research took more time than the PI had initially planned. Given the short amount of time available for conducting research, the time spent waiting for the permit was virtually wasted. This was unfortunate for the study and must be incorporated into future study plans. Once the clearance was through, endless data and opportunities were available. If future studies would have these doors open to them sooner, extensive, comprehensive studies could be created. In order to overcome these limitations, the PI attempted to be both flexible and definitive in interviewing and collecting data during short time of the study. Although the PI did encounter changes in schedules and cancellations, she was flexible

and grateful for any and all time given. The team also used opportunistic sampling to follow up on new leads from interviews and take advantage of unexpected opportunities.

In the future, to better study the role of technology, research should be conducted using an experimental design. The PI realized it was difficult to ask hypothetical questions to survivors in reference to technology, especially as this form of counselling was a foreign concept to them. It would be better in the future, to build a technology or service after doing extensive intake on the community's issues and needs. Then, the study could research the effect of the posed technology effectively. Additionally, studies which examined women's empowerment programs, rescue centers, and security systems and their relation to sexual gender-based violence would be beneficial for the field, especially in terms of recovery. One could ask, do such programs enable enhance survivor reporting, access to justice and overall recovery? Moreover, many respondents highlighted "culture" or socialization as reasons for high rates of gender-based violence. A useful study would be one that looked at best practices for behavioral and mindset change in terms of prevention methods.

Additionally, if the study had more time, it would be crucial to take into consideration the sensitivity of the issue and specifically select patients who are coming in for follow-up sessions, instead of including patients who are coming for the first time, often traumatized. The study also would have interviewed community members, of the "hotspot" of most affected area, interview government officials to learn more about their initiatives and funding, interview informal settlement specialist to discuss what can be done after an area becomes a "slum" and a crime specialist to discuss the correlation between general crime and gender-based violence.

8. CONCLUSIONS

Even though this study faced many hurdles, many conclusions can be drawn about best practices and future steps. One of the first and biggest ones would be to partner with the government and other local organizations to create One Stop Centers. These centers would cut down on bureaucracy and high attrition rates of accessing justice by locating every step of the process in one location, targeting and serving the most vulnerable and provide quality controlled services. Currently the journey from the so called “nearest” informal settlement is between 40 and 70 minutes and 6.5km. A journey that by the Kenyan government standards would not pass for accessible: according to the government guidelines, a health center must be within 4km of a patient’s house. By bringing together legal, medical, psycho-social, economic empowerment, safe house services, and prevention education Kenya could drastically change the way survivors are treated, mentally/physically recover, achieve justice and change their lives. The addition of rescue centers is a critical conclusion, as KOLs and the study identified living conditions as a major hurdle. This could provide a safe place for vulnerable children, adolescents, teens and adults as they try to break away from their current living situations.

Other suggestions include continued research so better statistics can be used to lobby the government. Despite the large numbers of affected, there still has not been a major rehabilitation or call for GBV programs. Organizations should work together to share and make publically accessible statistical data. Moreover, funds should be shared to have more frequent and more extensive programming, including prevention/education workshops and supplies and services offered in treatment centers. The study found that community dialogues sometimes happen but very rarely because so many organizations are just trying to keep up with demand. A commitment from the government could increase donors confidence across all fields because sexual violence is so pervasive. If persuading officials through just the goodwill of their hearts of

presented evidence is not enough, then it could be lobbied through a development lens with emphasis on the economic and social implication that affect society.

In addition to more funding from the government, police officers who participate in trainings could be incentivized as well as combining those who excel with better resourced gender desks. Awareness about gender desks need to be better publicized in tandem with the actual improvement and implement of these centers. While police redistribution may be a bigger problem than this study knows how to solve, organizations could combine funding and work to be involved in immediate new officer training, and the government can help by mandating that all those seeking to be officers go through gender-based violence sensitivity and case management training. Although it could initially take more resources to retroactively train officers, in the future it will increase trust between community members and officers, increase the ability for survivors to get help, and improve the police/government image as they work to fight corruption. Gender desks could ask be instrumental in awareness creation about the issue and about the services which are available. This could also work to decrease sexual violence incidences and deter people as society begins to see perpetrators accused and jailed. Thereby instilling the idea from a young age that beating your wife, girlfriend, any woman, or forcing them to engage in sexual activity with yo is a form of gender-based violence, a crime, and a violation of their human rights.

In addition to improved gender desks, it is crucial to create and support women's empowerment programs. These could be housed in one stop centers, already existing GBV organizations or eve organizations with seemingly different missions who want to improve local communities. Even without the lens of fighting GBV, women's empowerment programs could be started and supported by service providers. If women could gain control of their finances or

make enough money, they could potentially with guidance leave their partners/ family members or dangerous living situations. Co-ops of women could band together to pay for security guard, fences, nannies and other essential security needs. If a woman is not accepted into such a program, does not make enough money, or otherwise cannot find a means to protect her children, day care centers should be made available. They can be housed in churches or other religious institutions. They can be created by groups of neighbors or supported by local NGOS with after school programming. The day care centers could be community libraries with extra space or a yard where one volunteer/employee looks after children. This is vital as children and adolescents are especially vulnerable during the day when they are home alone.

In conclusion, although this study offers some proposed solutions to some of its discovered problems, this is not by any means a completely comprehensive list. There are so many other possible ways to change the situation whether large or small. The importance is not on how much can be done in the shortest amount of time, but on the comprehensive plan for future. There is no evidence that this issue is going away soon. Therefore, already existing organizations need to be supported to be able to meet the demand that is currently outweighing their capacity while partners and new agents are creating new and building on existing organizations to address some of these issues. The future of this issue is unknown, but as a society huge strides can be made if people begin to see this issue as cross cutting and intersectional. It is only through collective action that society can change and it starts with a deep understanding of the issues and a willingness to change.

APPENDICES

Appendix A:

Questions For Participants - English Version

About You:

1. How old are you? < 12 12-17 18-24 25-34 35-44
 45-54 55-64 65-74 >75
2. Do you have children? Yes No
a. If yes, how many? 1-2 3-4 5-6 7-8 9 or more
3. What is your marital status? Single Married Widowed
 Divorced Separated Other
4. Whom do you live with? Partner Family Alone Other
5. What area do you live in? _____
6. Are you employed? Yes No
a. If yes, what is your job? _____
7. How much money do you earn a week? _____ KSH
8. Who makes the most money? You You Partner Other
9. Does anyone control or withhold money from you? Yes No
10. Are you currently attending school? Yes No
a. If no, did you drop out complete school
11. Do you or anyone in your family have a disability? Yes No
12. Are you or anyone in your family part of a gang? Yes No
13. Have you ever seen violence either physical or sexual between parents, friends or community members? Yes No
14. Do you know anyone else who has experienced sexual violence? Yes No
15. Do you ever feel unsafe? Yes No
a. If yes, who makes you feel unsafe? Family Friends
Neighbors Strangers

About Access:

16. How did you find out about this center? Friend Family,

Police Organization Personal Research

17. How did you arrive? Bus Taxi Walking Friend Family

18. Did you come with anyone to the center? Parents Partner,
 Family Friend Child Neighbor Alone

19. Who knows you are here? Partner Parents Family
 Friend Neighbor Perpetrator Other No One

20. Did anyone try to stop you from coming? Perpetrator
 Partner Parents Family Friend Neighbor No One

21. What services did you come for? Psycho-Social Counseling
 HIV Testing/Treatment Forensic Screening Pregnancy
 STI Testing Injury Treatment Emergency Contraception
 Legal Advice

22. What service(s) did you receive? _____

23. Would you tell others about this center? Yes No

About Technology:

24. Do you own a mobile phone? Yes No
a. If no, why? Too Expensive Do Not Want One
 Broken Stolen Getting One Soon

25. Did you search for information about sexual violence or help centers online? Yes No

26. Did you call a hotline? Yes No

27. If you searched for information online or called a hotline, did it impact your decision to come to the center today? Yes No

28. Would you rather Call a counselor on the phone Text them
 Instant message them Talk to them in person

29. Why? _____

In the Future:

30. Would you tell others about this center? Yes No
a. If yes, why? _____

Sensitive questions: If any of the questions are triggering or too hard to answer please skip them or leave them blank.

31. How long ago was the assault? Today Yesterday

- > 3 days > a week > two weeks > three weeks
 > a month > a couple months > a year ago
 > 2 years > 5 years > 10 years

32. When did the incident happen? Early Morning Morning
 Midday Late Afternoon Evening Night
33. Where did the incident happen? Home School Street
 Neighborhood Other
34. Did you tell anyone about it before visiting today? Yes No
 a. If yes, who? Partner Parent Family Friend
 Child Counselor Doctor Neighbor Other
35. Do you know your assailant? Yes No
 a. If yes, are they A Family Member A Partner A Friend An Acquaintance
 A Neighbor Other
36. Have you ever experienced sexual violence before this incident? Yes No
37. Have you ever experienced physical abuse before this incident? Yes No
38. Do you still feel threatened by the assailant? Yes No

Thank you for your time. Sharing can be difficult and your willingness to aid this study is greatly appreciated.

Appendix B:

Maswali wa Washiriki - Kiswahili

Kukuhusu:

- Una umri gani? < 12 12-17 18-24 25-34 35-44
 45-54 55-64 65-74 >75
- Una watoto Ndiyo Hapana
 a. Wangapi? 1-2 3-4 5-6 7-8 9
- Umeoa? Umeolewa? Mjane? Tumetalikiana?
 Tumeachana?
- Unaishi na nani? Mwenzio Familia Peke Yake
 Mwingine
- Unaishi wapi? _____

6. Umejiriwa / Unafanya kazi? Ndiyo Hapana
 a. Kazi gani? _____
7. Unalipwa pesa ngapi kila wiki? _____ KSH
8. Nani ni msimamizi wa bajeti ya nyumbani? Wewe Mwenzi
 Mwingine
9. Sasa unaenda shule? Ndiyo Hapana
 a. Hapana, uliacha au ulimaliza
10. Umesoma hadi darasa? _____
11. Una ulemavu wowote au yeyote katika familia yako?
 Ndiyo Hapana
12. Unahusika na uhalifu wowote au yeyote katika familia yako?
 Ndiyo Hapana
13. Ushawahi kuona tukio lolote la kimwili au kimapenzi?
 Ndiyo Hapana
14. Unashawahi kuona yeyote ambaye amepitia dhuluma ya kimapenzi? Ndiyo Hapana
15. Hua wajihisi huna usalama? Ndiyo Hapana
 a. Na kama ndiyo, ni nani anakufanya usiwe salama? Marafiki
 Majirani Wageni Familia Mwenzi Polisi

Kukuhusu Upatikanaji:

16. Je, ulifahamu vipi kuhusu hilitukio? Rafiki Familia
 Polisi Utafitii Wako Mwenyewe
17. Ulifikaje? Kwa Basi Teksi Miguu Rafiki Familia
18. Ulikuwa na nani kituoni? wazazi mwenzi
 Familia Rafiki Motto Jirani Peke Yako
19. Nani alifahamu kuwa uko hapa? Mwenzi Wazazi Familia
 Jirani Mhusika Rafiki Wengine Hakuna
20. Ulikuwa na kizuizi chochote kufika hapa? Mhusika

Mwenzi Wazazi Familia Rafiki
Hakuna

Jirani

21. Ni huduma gani ambazo zilikuleta hapa? Ushauri wa Kisaikolojia
 Upimaji wa Virusi Vya Ukimwi
 Uchunguzaji wa Mauaji Ujauzito Magonjwa ya Zinaa
 Matibabu ya Majeraha Mpango wa Dharura wa Uzazi Ushauri wa
kisheria
22. Ulipata huduma gani? _____
23. Ungewambia wengine kuhusu kituo hiki? Ndiyo Hapana

Kuhusu Teknolojia:

24. Unamiliki simu ya rununu? Ndiyo Hapana
a. Hapana, kwa nini? Ghali sana Sitaki moja
 Imeharibika Imeibiwa Natarajia moja hivi karibuni
25. Je, kutafuta habari kuhusu unyanyasaji wa kijinsia au vituo vya msaada online? Ndiyo
Hapana
26. Ulipigia simu ya dharura? Ndiyo Hapana
27. Ikiwa ulitafuta maelezo kwenye mtando au kipiga simu ya dharura, je iliathiri uamuzi wako wa
kuja katika kituo hiki leo? Ndiyo Hapana
28. Ungeonelea ni afadhali kupiga mshauri simu ujumbe mfupi kumtumia ujumbe wa papo
 kuongea na wao binafsi?
29. Kwa nini? _____

Siku Za Usoni:

30. Utawambia wengine kuhusu hapa? Ndiyo Hapana
a. Kwa nini? _____

**Maswali Nyeti: Ikiwa swali lolote linaleta hisia mbaya ama ni vigumu kujibu, tafadhali
acha**

31. Shambulizi lilitokea lini? Leo Jana Siku Tatu Wiki Moja
 Wiki Mbili Wiki Tatu Miezi Kadhaa Mwaka
Mmoja uliopita Miaka miwili iliyopita

Miaka mitano Kumi iliyopita

32. Tukio lilitokea lini? Asubuhi Mapema Mchana

Alasiri Jioni Usiku

33. Tukio lilitokea wapi? Nyumbani Shule Mitaani Kwingine

34. Uliambia yeyote kabla ya kuja hapa leo? Ndiyo Hapana

a. Kama ndiyo, nani? Mwenzio Wazazi Familia Mototo
 Mshauri Daktari Jirani Wengine Hakuna

35. Unajua mshambulizi wako? Ndiyo Hapana

a. Kama ndiyo ni Jamaa Yako Mwenzio Rafiki
 Jirani Wegnine

36. Ushawahi dhulumiwa kimapenzi? Ndiyo Hapana

37. Umewahi nyanyaswa kimwili kabla ya tukio hili?

Ndiyo Hapana

38. Bado unahisi tishio lolote kutoka kwa mshambulizi wako?

Ndiyo Hapana

Asante kwa wakati wako, kutoa habari hizi ni vigumu na kujitolea kwako kusaidia katika masomo haya kumekubaliwa pakubwa.

Appendix C:

Questionnaire Given to Survivor or Completed with Counselor

1. Branch
2. Free care or Private
3. Date of presentation
4. First Name
5. Last Name
6. Sex
7. DOB
8. Age
9. Survivor's current residence
10. Survivor's nationality
11. Survivor's employment
12. Survivor's educational level
13. Survivor's marital status
14. Does the survivor have a disability?
15. Is the survivor pregnant?

16. Does the survivor have children under 18?
17. Date of violence
18. Time of violence
19. Place of violence i.e. Physical address (e.g. Karen)
20. Location of violence
21. No. of days between violence and presentation
22. Did survivor present within 72 hrs?
23. Reported to police?
24. Name of police station
25. Main nature of violence
26. Secondary nature of violence
27. Other form of violence
28. Who referred the survivor to GVRC?
29. Why was the survivor referred to GVRC?
30. Number of perpetrators
31. Known to survivor?
32. Relationship to survivor?
33. Perpetrator Age
34. Employment
35. Current residence
36. Survivor referred on to...
37. Survivor admitted to hospital (in-patient)
38. Previous violence
39. Previously presented to GVRC
40. Previously reported to police
41. Counsellor's comments
42. Additional information (especially if OTHER selected in previous answers)

Appendix D

Questions for Nairobi Women's and Children's Hospital GVRC:

1. What are your organization's main objectives and services?
2. How long have you been working here?
3. Why did you decide to work here?
4. How do people arrive at your center?
5. How do they contact or learn about your center?
6. Who pays for transport and for any hospital fees?
7. Who do they come with?
8. What are the concerns of the people who accompany them?

9. After they arrive, what is the usually process they go through?
10. What is the major concern of most GBV patients?
11. Are you able to mitigate the concerns?
12. What are the most common demographics of the GBV patients you see?
13. What are some of the biggest and most common barriers to reporting and seeking assistance?
14. What are some of the biggest challenges facing your organization?
15. What are your biggest successes?
16. What can be done better in the future and/or what can be improved upon to increase the access survivors have to your center?

Appendix E: Example Interview

12/1/2015 - 1:21pm

K = Kirsten Dimovitz, Principal Investigator

Dr = Dr. Kizzie Shako, Senior Medical Officer at Forensics and Pathology Services, Police HQ
Kenya

Recording Transcript

K: How many people do you see a day?

K: And are those all new cases or do you get follow up cases?

K: And what is the referral system like? Do you work with them?

K: For defilement cases, who are the perpetrators usually?

K: So when they come together? Who is the perpetrator usually?

K: So when they come together, is there a way that the center deals with that?

K: For rape cases is the suspect order the same?

K: So you do not see a lot of IPV?

K: So who do you think is most at risk of experiencing sexual violence?

K: and for the rape cases?

K: Do they ever ask for guidance from you?

K: when children come, who is bringing them?

K: Do the police usually handle this responsibly?

K: When come with police is it free?

K: Is the examination free?

K: What is the usual outcome? What happens next?

K: How do you think survivors find out about the center?

K: How many women versus children and versus men do you see?

K: Why do you think there is so much violence in nairobi?

K: For those who are genuine, what aspects of poverty? poverty is a broad topic.

K: In the future, what can stop the issue? what is the solution?

K: You focus on response and handling direct cases, that must be really hard. How do you do it everyday?

K: Could you ever see yourself doing anything else? What would be next?

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