

Policy Brief

No. 26 June 2012



Collaborating Organizations: Division of Reproductive Health, Division of Community Health Services, Family Health Options Kenya (FHOK), Federation of Women Lawyers (FIDA).

Sexual and Gender Based Violence in Kenya: A Call For Action

Overview of Gender Based Violence:

Gender Based Violence (GBV) is any harmful act, whether it is sexual, psychological or physical, that is perpetrated against a person, and is simply based on differences between males and females [gender].¹

GBV is a violation of human rights under The Constitution of Kenya.² Article 28 stipulates that "Every person has inherent dignity and the right to have that dignity respected", and article 29 (c) stipulates that "Every person has the right to freedom and security of the person, which includes the right not to be- (c) subjected to any form of violence from either public or private sources (domestic violence)". Sexual Violence (SGBV) is one of the most serious, and life-threatening forms of GVB. It manifests itself largely in conflict situation. Marginalized groups such as those living in slum areas, not attending school, and single mothers are particularly vulnerable.

This Policy Brief revisits the issue of GBV, and more specifically SGBV in Kenya. As a point of departure from the earlier brief, it focuses on effects of SGBV on maternal and child health. It also discusses key challenges faced in dealing with SGBV and proposes a multi-sectoral approach in seeking to more adequately address this human rights issue and health problem. This Policy Brief shows that GBV is widespread with grave health and development impacts yet it has not been given the attention it deserves at all levels. It therefore strongly encourages actors to be engaged in prevention and care as well as suggests measures to improve enforcement of Sexual Offenses Act.³

Around the world, as many as one in every three women has been beaten, coerced into sex, or abused in some other way - most often by someone she knows, including her husband or another male family member. One woman in four has been abused during pregnancy (Beijing Declaration and Platform of Action, paragraph 112).

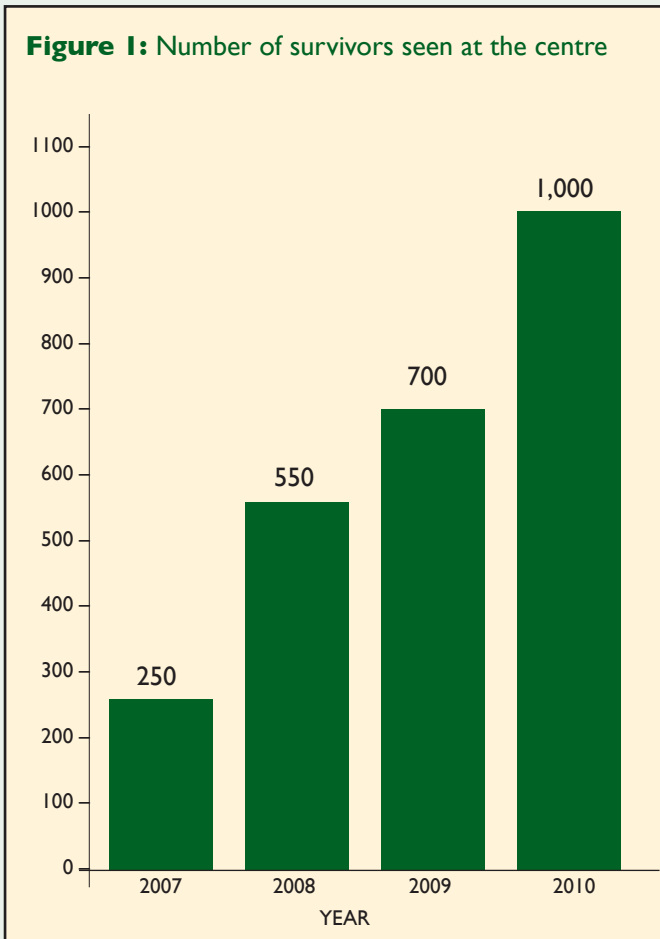
Scope of the Problem

The magnitude of SGBV is hard to determine. However, it is widely acknowledged that reported cases only represent a part of the larger picture. Even in normal situations, sexual violence will go unreported due to fear, shame, powerlessness, lack of support or unreliability of public services.

Forms of SGBV include sexual, physical and emotional violence, as well as harmful traditional practices such as early forced marriage and Female Genital Mutilation/Cutting (FGM/C). The Kenya Demographic and Health Survey,⁴ shows that 45 percent of women aged 15-49 have experienced either physical or sexual

violence, while nearly half (47 percent) of those ever married experienced either emotional, physical or sexual violence.

Furthermore, statistics at Moi Teaching and Referral Hospital (MTRH) show that there has been a sharp increase in the number of GBV survivors seen at the Centre for Assault Recovery of Eldoret (CAR-E), from 250 in 2007, to over 900 in 2010 (Figure 1).



Source: MTRH, Service Statistics 2011

A majority of survivors seen, 90 percent were female, while 70 percent of the survivors of sexual violence were aged below 18 years.

Statistics of a Gender Recovery Centre (GRC) at the Kitale District Hospital statistics, in agreement with MTRH data, shows that most cases reported involve children. In 2010, the GRC handled 547 SGBV cases between May and December. Of these, 69 percent were defilement, 18 percent were domestic violence, 8 percent were of sodomy, 4 percent rape cases and 1 percent other cases.

SGBV - Largely Violence Against Women and Children

Women's forced subordinate status (both economic and social) makes them more vulnerable to violence and contributes to an environment that wrongly accepts, excuses, and even expects violence against women.⁵

Women are also largely at risk of FGM/C, the prevalence rate in Kenya being 27 percent⁶ FGM/C involves partial or total removal of external female genitalia or injury of female organs for cultural or other non-therapeutic reasons. About 93 percent of those circumcised are children below 18 years old. In North Eastern, 64 percent of circumcised women underwent the procedure between ages 3 to 7 years, while in the Coast, the highest proportion of circumcision is performed during infancy.⁷ This happens despite recognition that FGM/C is a violation of children's rights and a harmful practice that poses great risk to the health and well being of women and girls who undergo it.



Female survivor of GBV

Photo credit: FHOK GBV Project

Furthermore, children also experience sexual violence which are usually perpetrated by persons the victims know. However, social stigma and family shame result in the knowledge of the abuse being kept within the family. At times, families are paid “damage money” to buy their silence.⁸ This culture of secrecy serves to aid the impunity of the perpetrators.

Implications of SGBV with emphasis on maternal health

SGBV has a greater impact on women and girls, as they suffer greater physical harm than men when victimized. This form of violence during or around the time of pregnancy can lead to unique consequences on maternal and child health.

Children also experience sexual violence and perpetrators are usually persons known to the victims.

According to Medical experts at CAR-E (MTRH), physical abuse may lead to pregnancy complications like miscarriage, placental abruption, premature delivery, low birth weight and fetal or infant death. Non-pregnancy complications seen include fractures and head injuries which can ultimately result in death.

Consequences of sexual abuse on reproductive health includes; STIs, HIV/AIDS, unwanted pregnancies, unsafe abortion, urinary tract infections, pelvic inflammatory disease, infertility and genital injuries including obstetric fistulae. When a woman is not able to seek proper health care in the period surrounding pregnancy or after physical abuse, the consequences can be fatal.

Psychological impact of GBV can have devastating results on the wellbeing of the mother, not only in the period surrounding pregnancy, but even years

later. Immediately after birth, bonding and attachment between parent and child may be impaired. The mental health of the mother is also affected, with a noted predisposition to depression, anxiety, post-traumatic stress disorder, eating problems, sleep disturbances and sexual dysfunctions.

Health and Psychosocial Support: Policy Framework

Kenya’s National Reproductive Health Strategy⁹ promotes “*a comprehensive and integrated system of reproductive health care, that offers a full range of services by the government, non-governmental organizations (NGOs), and the private sector (...)*”

Through the twin Ministries of Health and partnerships with various professional and civil stakeholders, the Ministries facilitated the development and approval of policy guidelines for effective administration of Post Exposure Prophylaxis (PEP), for survivors of sexual violence. However, many of these guidelines and protocols are not followed in most health facilities due to poor infrastructure and lack of budgetary allocation.

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Legal Framework

Collectively, The Constitution of Kenya 2010, the Penal Code, the Sexual Offences Act 2006, and the Children’s Act 2001 provide a secure legal framework to prosecute SGBV cases. Although the SOA was a huge positive step towards addressing sexual offences, various challenges still hinder reporting and prosecution of offenders.

Challenges With Legal Procedures in Kenya

1. Use of Legal procedures is intimidating, especially for rural women and girls who may be illiterate or poorly educated and who, because of gender roles and norms, may not be accustomed to speaking for themselves (or speaking publicly). The option of hiring a lawyer can be expensive where legal aid is not easily accessible.
2. Furthermore, court procedures prevent survivors from seeking formal legal redress due to lack of privacy. In an assessment study by FHOK, one respondent, speaking about the mentioning of a case, recalled how the clerk remarked in an open court, “*hiyo ni ile case ya rape*”.
3. Other challenges include court processes fraught with tension and numerous legal barriers. Among others, the requirement that investigations must be complete within 24 hours is most likely not attainable especially in rural areas given that an official medical examination report must be completed by a certified doctor. This factor and the long period of time it takes before a case is concluded make many survivors despair and abandon their claims.
4. Similarly, where gender desks exist, there is no standardised procedure in place to regulate their operation. The desks are meant to be confidential spaces but survivors are received at the front desk where they must explain their situation before

With the formal justice system riddled with so many hurdles, many families of SGBV survivors run to traditional justice systems that are geared towards reaching a consensus rather than securing justice for individual survivors.

being directed to the gender officer. Front desks are usually crowded and structured in such a way that one must raise their voice to be heard thus making the process insensitive to SGBV survivors.

Consequently, with the formal justice system riddled with so many hurdles, many families of SGBV survivors run to traditional justice systems that are geared towards reaching a consensus rather than securing justice for individual survivors. Traditional systems are preferred because they are faster and issues are resolved in a way to guarantee that affected families retain their place in society.

Challenges faced in Managing Survivors of Sexual and Gender Based Violence

1. At the **community level**, there is lack of awareness that SGBV is unlawful and should not be settled out of court. Communities also are unaware that survivors of sexual violence should seek health interventions immediately, and not later than 72 hours for purposes of administration of HIV Post Exposure Prophylaxis (PEP), STI prophylaxis, and Emergency Contraception. Arriving to hospital immediately also allows for collection of forensic evidence which helps survivors to access justice by ensuring availability of credible evidence that sexual violence actually took place, and help link the perpetrator to the crime. There is also little or no knowledge by victims on how to preserve evidence such as not bathing after assault. Besides, local leaders and community health workers lack knowledge on how to appropriately refer survivors to those involved in their guidance.
2. At the **Institutional level**, health facilities lack adequate resources, knowledge and skills on collection and lab processing of forensic evidence, as well as equipment used in the collection and processing of forensic evidence such as rape kits, laboratory reagents, and the DNA (Deoxyribonucleic Acid) analyzing machine. Inadequate drugs e.g. antiretrovirals for PEP, antibiotics for STI prophylaxis is another issue. They also lack adequate personnel at health facilities to carry out comprehensive handling of survivors.

3. Furthermore, **lack of co-ordination** among the various stakeholders involved in the management of SGBV namely the police, judiciary and health workers is a challenge. Some police stations also lack a gender desk that specifically and adequately addresses survivors of SGBV. Where gender desks exist, the police have not been sensitized on SGBV and as such do not handle survivors with the compassion, privacy and confidentiality they require.
4. In some cases, there is lack of co-operation by police. The police occasionally turn away survivors of SGBV telling them to solve their problems at home. They may also request for bribes to facilitate arrest of the perpetrator or before issuing the survivor with a P3 form.

SGBV is widespread and is a gross human rights violation that is not given the attention it deserves both at the grassroots level and by policy makers.

5. Also critical is the **lack of statistics** on SGBV at health facilities and at police stations that would facilitate planning. Similarly, very limited research has been done on SGBV.

Conclusion

1. SGBV is widespread and is a severe human rights violation that is not given the attention it deserves both at the grassroots level and by policy makers.
2. The impact of this form of violence is far reaching, affecting not only the health and well being of the individuals, but also undermines development within the community and society as a whole.
3. Most of the survivors are women from poor socio-economic backgrounds. This means that prevention of SGBV should emphasize on educating them on their rights and empowering them socio-economically.

A Call to Action

Policy brief No. 6 of 2009 suggests key policy recommendations in combating gender based violence. Using new evidence, this brief complements the initiative to further reinforce efforts to advocate on behalf of survivors, in order to enhance their protection, and bring perpetrators to being held liable.

Therefore there is need to:

- I. Raise awareness about SGBV and the contents of the SOA 2006 by:
 - Educating communities on SGBV and the legal framework through *barazas*, health talks at rural health facilities, and local media. Communities' leaders should be involved in the process of creating and implementing strategies to address SGBV.
 - Ministry of Education incorporating SGBV in guidance and counseling programs of primary, secondary and tertiary learning institutions.
 - Including SGBV in the pre-service training curriculum of health workers and the police by Ministries of Health and the Kenya Police Service respectively.
 - Disseminating the national guidelines on SGBV management and the SOA 2006 to health care facilities at all levels and to other relevant government institutions. This should be vested in the Task Force on Implementation of SOA 2006.
 - The Ministry of Gender, Children and Social Development enlisting community groups in efforts to provide sensitive community-based responses to survivors of SGBV and promptly refer them to health services and to the police.

Leaders should be involved in the process of creating and implementing strategies to address SGBV.

NCPD is a semi-autonomous government agency that formulates and promotes population policy and coordinates related activities for sustainable development in Kenya.

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2. The Government of Kenya (GoK) should establish or identify one governing body to bring together and co-ordinate activities of all stakeholders (both within the government and non-governmental organizations) that are involved in SGBV.
3. The Ministry of Medical Services, should ensure adequate supply of drugs used in the management of survivors, and the drugs should be dispensed free of charge to ensure accessibility. Other supplies for collection and processing of forensic evidence should be made available as well.
4. The Ministry of Internal Security to fully implement policy on setting up user-friendly gender desks in all police stations and police posts and train those manning the desks on SGBV.
5. Girls who have been to school are shunning retrogressive cultural practices. As such, the girls require support to be able to realise their dreams. Rescue Centres should be increased in FGM/C prone areas. The Centres should also be facilitated with adequate support to enable them to provide home to young girls running away from forced FGM/C and early marriages. On the other hand, communities still practicing FGM/C should be sensitised to enable them embrace change.



Girls who ran away to escape FGC pictured at their new home - Morpus Rescue Centre



This publication is made possible by the government of Kenya with support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of the National Council for Population and Development and do not necessarily reflect the views of USAID or the United States government.

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