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THE HIJABI MENTORSHIP PROGRAM

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Addressing Sexual Reproductive Health and Rights and Gender-Based Violence in Underserved Communities in Kenya

Case of Kwale County

RESEARCH REPORT

RESEARCH CONDUCTED BY: THE HIJABI MENTORSHIP PROGRAM
APPROVED BY: THE HIJABI MENTORSHIP BOARD OF ADVISORY

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Acknowledgement

We are grateful to the Gates Foundation (Bill and Melinda Gates) for supporting this study. We equally express our gratitude to everyone who contributed towards it's success. Our sincere thanks is equally expressed to our Board of Advisor, The Ministry of Health, Kwale County and National Government Department of Gender and Youth Affairs for their support throughout this research process.

A big thank you goes to the Kwale Community for their time and participation in this study.

Nima N'zani Kassim
Ms President, The Hijabi Mentorship Program

Forward

We are delighted to publish this report which presents findings of the Status of Gender Based Violence and Sexual and Reproductive Health Rights in Kwale County, Kenya. The study was made possible with the assistance from the Gates Foundation (Bill and Melinda Gates).

This report presents key recommendations whose implementation are geared towards improving the status of GBV and SRHR in the County of Kwale. This report will be of great use to the Ministry of Health, the various institutions advocating for SRHR and protection against GBV as well as the general community in and beyond Kwale County. The understanding of the SRHR and GBV status in the County will go a long way in informing the gaps therein but most importantly inform the appropriate SRHR and GBV interventions.

Nima N'zani Kassim
Ms President, The Hijabi Mentorship Program

Acronyms

COVAW	Coalition for Violence Against women
CIDP	County Integrated Development Plan
GBV	Gender Based Violence
NGEC	National Gender and Equality Commission
SPSS	Statistical package for social scientists
STI	Sexually Transmitted Infections
SGBV	Sexual and Gender Based Violence
SRHR	Sexual and reproductive Health Rights
THMP	The Hijabi Mentorship Program
WHO	World Health Organisation
WB	World Bank

Executive Summary

According to the World Bank (2019) Gender-based violence (GBV) is a global pandemic that affects 1 in 3 women in their lifetime. The numbers could vary from regions but generally point out to at least 35% women having experienced either physical and/or sexual violence from an intimate partner. Additionally, at least 7% of women have been sexually assaulted by someone other than a partner while as many as 38% murders of women are committed by an intimate partner. Female genital mutilation which falls among the physical forms of Gender based violence has been experienced by at least 200 million women globally.

This issue is not only devastating for survivors of violence and their families, but also entails significant social and economic costs. In some countries, violence against women is estimated to cost countries up to 3.7% of their GDP – more than double what most governments spend on education. Failure to address this issue also entails a significant cost for the future. Numerous studies have shown that children growing up with violence are more likely to become survivors themselves or perpetrators of violence in the future.

According to the Kenya National Gender and Equality Commission, GBV is one of the most widespread and socially tolerated forms of human rights violations, cutting across nationality, race, class, ethnicity, and religion. It is a major source of inequality in Kenya today. It has a profound social and economic impact on families, communities, and the entire nation, as well as serious ramifications on national security.
The question of Sexual and Reproductive Health Rights has often gone unaddressed in many occasions despite its importance in any society. UNESCO 2011 notes that young people face numerous health challenges during their transition to adulthood. These challenges include, among others, limited access to sexual and reproductive health (SRH) information and services. Unmet SRH needs among adolescents may contribute to sexually transmitted infections (STIs), including HIV, and unintended pregnancies. Additionally, poor sexual and reproductive health outcomes can especially impact the status of young women, as they may face stigma from the community as well as diminished educational and employment opportunities. It is worth noting that when these unmet needs escalate even at their adulthood and older ages, the effects on the health of the women but also their psychological wellbeing can be irreversible.

In response to the above The Hijabi Mentorship Program (THMP) a community-based organisation operating in Kwale County carried out a baseline survey in the County to establish the status of GBV and Sexual and Reproductive Health Rights in the County with a view to understand the impediments therein but most importantly suggest recommendations on how the status could be improved. This is part of THMP's project addressing sexual reproductive health and rights and gender-based violence in underserved communities in Kwale supported by the Bill and Melinda Gates Foundation as part of the Generation Equality movement.
This survey was conducted in the 4 sub counties of Kwale County: Matuga, Msambweni, Lungalunga and Kinango over a period of 6 weeks engaging both the general community as well as resource persons through structured and key informant interviews. A total respondent population of 371 was engaged among them 351 from general population and 20 as key informants.

The survey established very pertinent information regarding the status of GBV and SRHR in the County. Among key findings of the survey was;

- the inadequacy of knowledge and information by the community on what GBV and SRHR entailed but also services available.

- Majority of the respondents could not explain and/or chose not to comment on what GBV, SRHR entailed while a section of the same attributed this (not commenting) to their faith, i.e. as clergy

these were matters that they could not discuss openly.

- The community's tendency to remain silent (as exhibited from a number of respondents abstaining to respond to some questions) could be a pointer to the lack of information, ascription to cultures that consider such discussions as taboo or mere dissatisfaction on the status and response.

- The perception of the community on sources of help for GBV was equally sought; noting very non-obvious findings with the police, healthcare workers, religious leaders and chiefs ranked as most helpful among a continuum of many others. It was worth noting however the setbacks within these help sources where corruption, out of court settlement, religious mis conception (clergy's fear of being la belled as radical) was noted as key gaps.

- The status of service delivery in the County painted some gaps; partly because of the community's knowledge on the existence of such services or lack of the services. Although reports from relevant County Government offices noted some good efforts towards GBV-SRHR response, this could not be easily confirmed from the discussants engaged implying the ur gent need for community sensitization on the services available.

This report concludes by pointing to some important suggestions on how the situation could be improved including intense community mobilization and awareness creation, stakeholders' coordination as well as improved service delivery.

Whilst acknowledging the good work that the County Government is doing, it remains imperative that their services are known to the public. The human rights dimension on SRHR, GBV is also an important area that this report recommends on. The need to address the justice issues is paramount. Evidence from this survey noted a scot-free environment for most GBV perpetrators. This does not only leave the survivors with life-time hurt but encourages the perpetuation of the abuse.

1.0 INTRODUCTION

The 1979 UN Convention on the Elimination of all Forms of Discrimination against Women was a call to ending GBV as one of the most common forms of human rights violations. Despite the overwhelming support at Global, Regional and National levels GBV remain a scourge in many communities. Although there could be many factors attributed to this situation, the poor Gender Development Index rating in most of these communities could be a critical factor. The Gender Development Index measures gender gaps in human development achievements by accounting for disparities between women and men in three basic dimensions of human development - health, knowledge and living standards. It is important to understand the real gender gap in human development achievements as it is informative to design policy tools to close the gap.

This study was carried out in Kwale County where the Gender Development Index in 2015 was 0.63 reflecting a percentage loss in achievement across the three dimensions due to gender inequality of 63%. To improve on gender inequality, the County ought to promote gender equality and empower women through equal basic education opportunities, affirmative action and through programmes like Women Enterprise Funds. The divorce rate in Kwale is high, stemming partly from the early age at which marriage takes place. In a survey carried out by the Coalition on Violence Against Women (COVAW 2017) it was noted that cases of exploitation and gender-based violence reach the desks of law enforcement agencies, but cultural practices would compromise delivery of justice. Parents or families of victims occasionally opt for informal justice. Up to 60 per cent of the respondents preferred informal/traditional justice system, 30 per cent preferred formal justice systems while 10 per cent was unaccounted for. This is because traditional justice system is easily accessible. It is also perceived to deliver justice and the process does not take long.

According to SRHR Alliance 2019, the status of SRHR in many Kenyan communities is wanting; there is huge knowledge gap on Sexual Reproductive Health Rights but also the services available. This gap seems to be wider among communities that are marginalized; counties in the Coastal region including Kwale, Kilifi and Tana River seem to carry a significantly higher burden of SRHR violations. Investing in and prioritizing the implementation of stronger SRHR programs is a win-win for governments that seek to improve health outcomes, educational attainment and achieve gender equality. Governments should invest in national programs for SRHR, ongoing training for educators and systems for monitoring the implementation of SRHR to ensure delivery is effective, according to the Alliance.

1.1 Program Overview

The Hijabi Mentorship Project (THMP) is a registered Community Based Organization that champions for Sexual Reproductive Health and Rights (SRHR), addresses Gender Based Violence (GBV), Peace and Economic Empowerment amongst vulnerable young people, particularly women in Kwale County. Their work is in line with three of the themes of the Generation Equality Action Coalition: GBV, Economic justice and rights and Bodily autonomy and SRHR. Their plan is mainly guided by SDG1 (no poverty), SDG3 (good health and well-being), SDG4 (quality Education), SDG5 (gender equality), SDG 8 (Decent work and economic growth) and SDG 16 (Peace and Justice Strong Institutions).

1.2 Overview of Kwale County

Kwale County is located in south coast of Kenya, it borders the Republic of Tanzania to the South West, and the following Counties; Taita Taveta to the West, Kilifi to the North, Mombasa to the North East and the Indian Ocean to the East. Kwale County is predominantly settled by the Mijikenda, 85 per cent of whom are the Digo and Duruma. The Digo constitute 60 per cent, while the Duruma are 25 per cent. The Digo are associated with the coastal strip and the southern

parts of Kwale and are mainly crop farmers. The Duruma inhabit the hinterland and are primarily cattle keepers. Other ethnic groups in order of population size are Kamba, Luo, Taita, Luhya, Swahili (Shirazi) and non-Africans (Kwale CIDP, 2017).

1.3 Population.

The County's population is estimated at 820,199 persons (397,841 males and 422,358 females). The youth (15 - 29 years) are estimated at 239,744. With regards to education, the County's Secondary School Age (14 - 17 Years) population in this age group is estimated at 77,665 with only 34% enrolled in 54 secondary schools. The low transition rate from primary to secondary school is as a result of a combination of factors including poverty, cultural and religious factors.

1.4 Overview and purpose of the Survey

The purpose of this survey was to measure knowledge on SRHR and GBV, assess levels of access to justice for GBV victims, level of community awareness of the SRHR and GBV services provided by the County and National government and to provide a base against which improvements could be made/recommended.

1.5 Survey objectives

The broad objectives of the survey were to:
1. Establish community understanding on Gender Based Violence and Sexual and Reproductive Health Rights
2. Ascertain the status of GBV/SRHR situation in the County including access to related services in hospitals, access to relevant information, access to justice for GBV victims
3. Identify capacity gaps among the police and administrators who are the first port of call for victims of GBV or SRHR violations.

1.6 Methodology of the Survey

The survey was conducted in the 4 sub counties of Kwale County, namely Kinango, Matuga, Msambweni and Lungalunga. Respondents were identified from 2 main sections; general community which included women, youth, and men and key informants who included Ministry of Health officials, Religious leaders, police officers and local administration officers (chiefs). A total sample size of 371 was drawn consisting of 351 from general population and 20 key informants. Data was collected through focused group discussion, Key informant interviews and open-structured interview. The data was analysed using SPSS.

2.0 LITERATURE REVIEW

2.1 What is sexual and gender-based violence?

The understanding of gender-based violence differs with legal context, community, and country therefore there is no single definition that is acceptable universally.

However, a widely embraced definition of the term gender-based violence refers to the physical, emotional or sexual abuse/violations of an individual. The sexual element of this definition is usually the primary focus of many GBV studies, but the management of the situation touches on the emotional and physical aspect. The World Health Organization defines gender-based violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work". This report adopts this definition by the World Health Organization. However, it expands the scope to include child sexual abuse, rape experienced by both sexes, and forced sex region (Population Council, 2008).

Gender based violence is used synonymously to sexual violence. Essentially, it is used to demonstrate the gender inequality that exist in the society and is the root cause of the violence witnessed. However, in as much as majority of the victims of gender-based violence are women, in this report, the term sexual and gender based violence will be inclusive of men, children, and women region (Population Council, 2008).

2.2 Prevalence, consequences and risk factors associated with GBV

2.2.1 Prevalence

Gender-based violence is prevalent in the east African region. In Kenya, 43% of 15–49-year-old women reported having experienced some form of gender-based violence in their lifetime, with 29% reporting an experience in the previous year; 16% of women reported having ever been sexually abused, and for 13%, this had happened in the last year (KNBS and ICF Macro, 2010).

2.2.2 Consequences

Gender-Based Violence (GBV) is a major concern because of the consequences associated with it such as poor reproductive health. GBV studies conducted in various settings indicate that women and girls, who at one point in their lives experienced rape or sexual coercion, are more likely to develop genital tract infection problems, go through unsafe abortion, and experience unplanned pregnancy. These women have been found to lack sexual autonomy and as a result, they are under threat of violence, and this increases their exposure to sexually transmitted infections.

GBV contributes to, and is exacerbated by, the economic and socio-political discrimination experienced by women in many countries. Women's lack of economic empowerment is reflected in lack of access to and control over economic resources in the form of land, personal property, wages and credit. Power, and the lack of power, is a recurring factor in all types of violence: the powerlessness of survivors, whether women, men or children, is also manifest in their relative lack of resources and access to support institutions (Population Council, 2008).

2.2.3 Causes and Risk Factors

According to the World Health Organization, the following are critical causes and risk factors for GBV; traditional gender norms that support male superiority and entitlement, social norms that tolerate or justify violence against women, weak community sanctions against perpetrators, poverty and high levels of crime and conflict in society more generally.
Studies also show that the risk is higher among

young women of age between 15 and 19. Gender based violence has been identified as one of the main reason why women would opt for divorce. According to a report by the World Health Organization, most divorced women normally cite GBV as the cause of their divorce or separation (WHO, 2005).

2.2.4 SRHR in Kwale County

It is estimated that 3 percent of the youth ages 15-24 are HIV positive in Kenya. Young women in this age group are more vulnerable to HIV infection than men of the same age. Despite these challenges, many young people in need of sexual reproductive health (SRH) services are embarrassed to seek services because of fear of being seen. Kwale like many counties in Kenya is facing challenges, delivery of health services delivery is poor. In 2015, Kwale County contributed to 2% of the total new HIV infections in Kenya. SRHR is a concept that though taken for granted by many has had adverse effects in most of populations especially the vulnerable among them. (SRHR Alliance 2019).

The Kenya Girls Advocacy Alliance project in Kwale County notes with concern the escalating cases of child pregnancies which is a precursor to unsafe abortions. Sexually transmitted infections are equally a common phenomenon among many sexually active young boys and girls. The project is designed to cover six community clusters from Matuga, Msambweni and Lungalunga Sub-Counties. The Girls Advocacy Alliance (GAA) was a 5-year joint project (2016-2020) led by the Dutch offices of Plan International, Terre des Hommes and Defense for Children – ECPAT and funded by the Ministry of Foreign Affairs.

2.2.5 Ethical considerations for researching SGBV

The subject material was highly regarded as sensitive and traumatic which created the need to uphold strong ethical standards. Authorities in GBV research agree that conceived or implemented research may have dangerous consequences for the respondents and/or interviewers therefore research designs have to consider issues of confidentiality, problems of disclosure, and the need to ensure adequate and informed consent (Ellsberg & Heise, 2005). The basic ethical principles that guided this research that involved human subjects included Respect for persons (including respect for confidentiality, the need to protect vulnerable populations, and respect for autonomy), No maleficence (minimizing harm), Beneficence (maximizing benefits), Justice and voluntary participation.

3.0 FINDINGS OF THE SURVEY

3.1.0 Socio-Demographic Characteristics of Respondents

I. Age of respondents

Majority of the respondents were of ages 18-25, at 40% followed closely by those of ages 26-40 and ages 41-55. Respondents of ages 55 and beyond were the least making up 5% of the respondents.

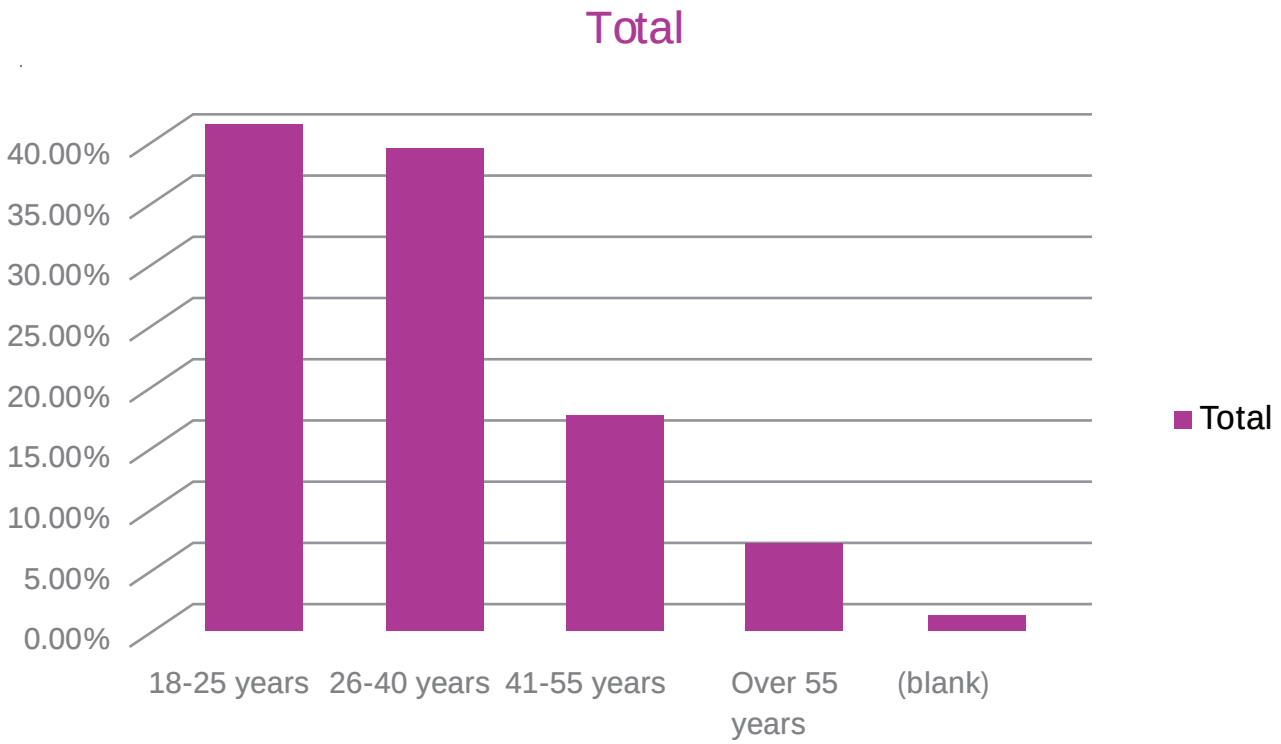

Figure 3. 1 Age of respondents

II. Sex of respondents

The survey engaged an equal number of 175 male and 176 female respondents.

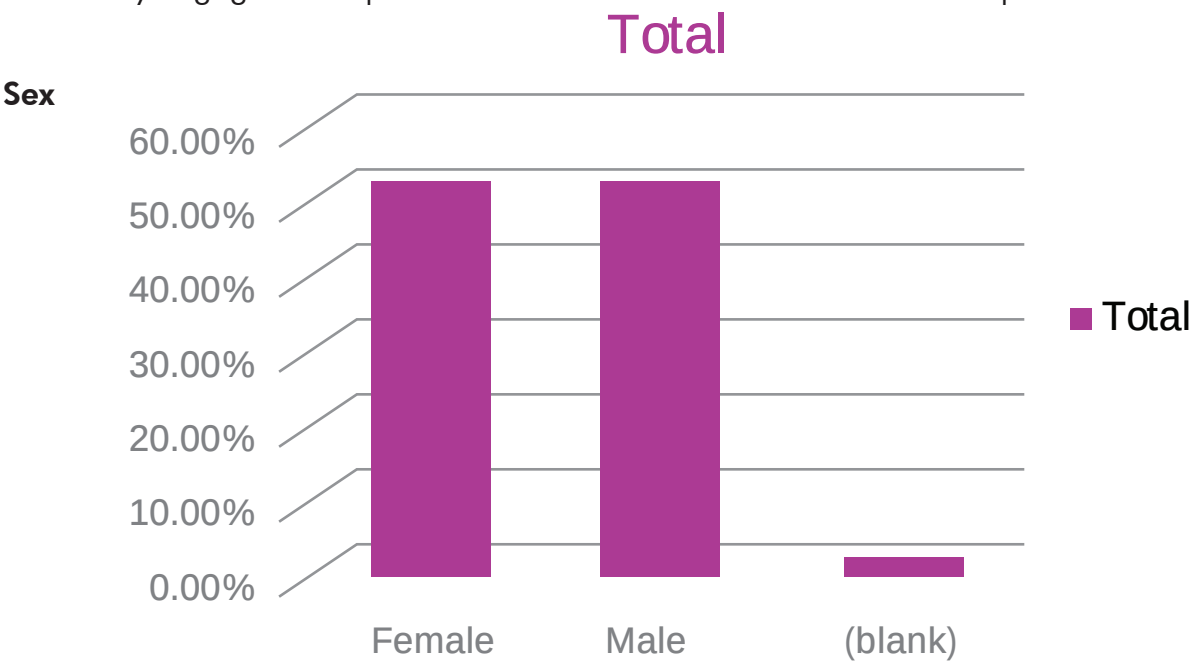

Figure 3. 2 Sex of respondents

III. Location/Residence of Respondents

Majority of the respondents were from Matuga sub county followed by Msambweni. Kinango and Lunga Lunga sub counties had equal number of respondents.

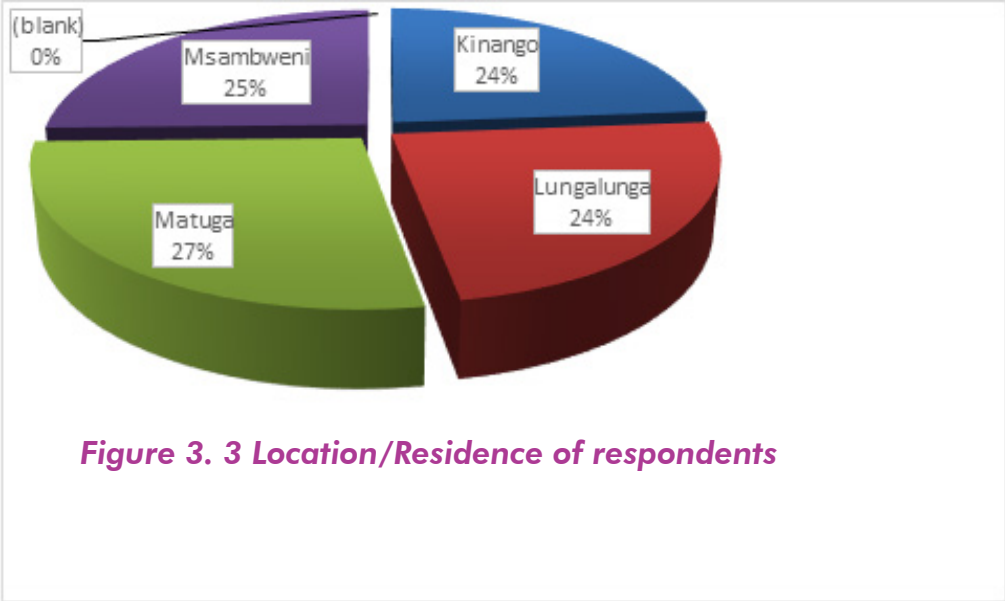

Figure 3. 3 Location/Residence of respondents

V. Religion of Respondents

Respondents of Islamic faith were the majority at 68% followed by Christians at 29%. respondents professing other faiths made up the remaining 3%.

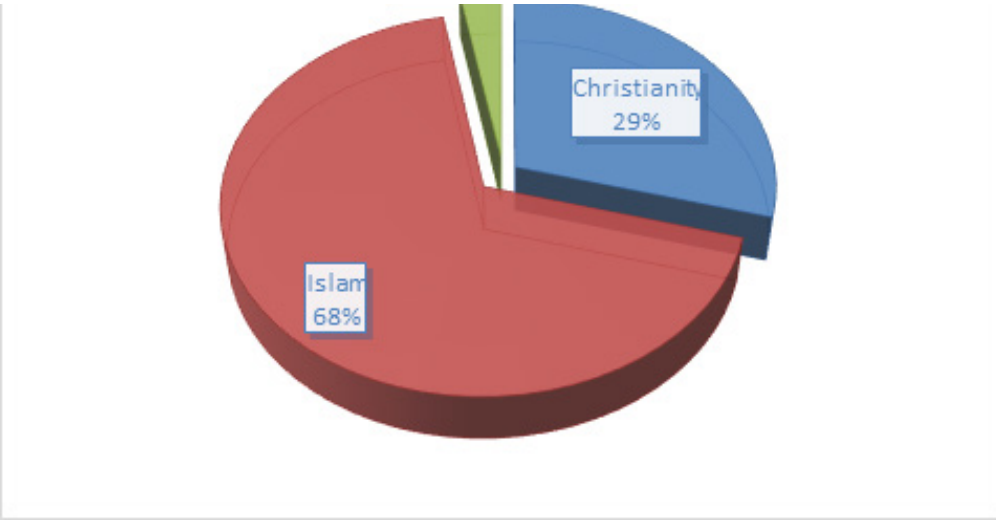

Figure 3. 5 Religion of Respondents

3.1.1 Findings from Structured Interviews with General Public

The findings of this survey are presented based on the set of questions and responses from 351 persons who participated in the General Public Interviews.

3.1.2 Participants' Understanding and Perception on Gender Based Violence.

The respondents from general public had varied definitions of Gender Based Violence:. 170 respondents confined the definition to either physical, sexual and/or psychological harm against women. The two dimensions which featured strongly are the physical and sexual dimensions at 64 and 70 respectively.

Table 1 below summarises the responses:

Community definition of GBV

Physical harm6	4
Sexual Harm	70
Psychological harm	0
Sexual and Physical Assault2	3
Sexual and Psychological Abuse	3
Sexual, Emotional, and Psychological Harm1	0

Table 3. 1 Community definition of GBV

On the other hand,100 respondents believed that it is a form of human rights violation regardless of gender. 66 respondents either had no response completely or were not aware of the subject matter. Another 15 of respondents defined GBV as harm inflicted on children. From the responses there was a demonstration that the members of the community are not very keen on psychological dimension of GBV, with none defining GBV as such.

3.1.3 Participants' opinions on interventions for Gender Based Violence.

Participants expressed divergent views on recommended interventions for GBV. 50 respondents recommended punitive measures to be taken against perpetrators of GBV. Twenty-five (25) respondents felt that community sensitization for behaviour change would better address the menace. 196 respondents expressed their concerns/fears highlighting the social, cultural and economic negative impact of GBV such moral decay, creating stigma, increasing divorces and creating stigmatizing the victims. A total of 80 respondents did not have any response, either due to lack of knowledge or voluntary decided not to contribute.

3.1.4 Participants Knowledge of GBV survivors in their community.

Asked if they knew of any persons who have experienced GBV in their community, 186 respondents reported to have this knowledge while 165 denied any knowledge of GBV survivors in their community.

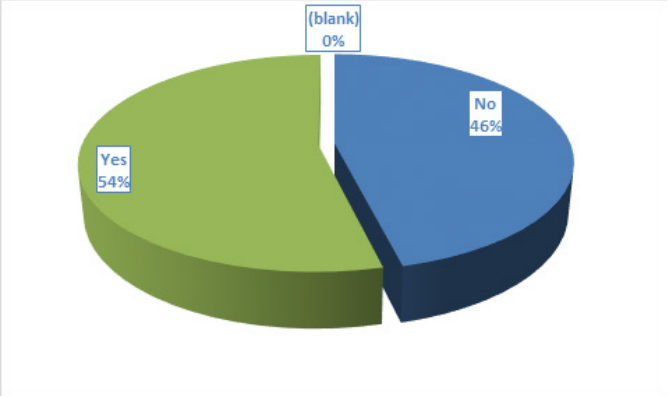

Figure 3. 6 Participants Knowledge of GBV survivors in their community.

To establish the effects of GBV to survivors, participants were requested to share experiences on what happens to survivors of GBV in their communities. The findings revealed that GBV has a number of social and psychological impacts on the victims.

Community definition of GBV

GBV Actions on VictimsF	emaleM	aleN	ullG	rand Total
They are shamed, they are stigmatized, Other (Specify)	2	1	0	3
Other(Specify)4	4	51	1	96
They are stigmatized	42	35	0	77
They are stigmatized, Other(Specify)5		2	0	7
They get justice4	6	33	0	79
They get justice are they shamed	0	1	0	1
They get justice, they are shamed, they are stigmatized	2	2	0	4
They get justice, Other(Specify)0		1	0	1
They get justice, they are stigmatized	1	2	0	3
Null	11	12	0	23
They are shamed	15	24	0	39
They are shamed, they are stigmatized	7	10	0	17
They are shamed, Other(Specify)1		0	0	1
Grand Total	176	174	1	351

Table 3. 2 GBV effects on Survivors

The findings revealed that GBV has a number of social and psychological impacts on the survivors. 79 respondents reported positive feedback on attainment of justice. The findings illustrated that stigma is one of the major effects of GBV as reported by 170 of the respondents. As reported by the respondents, it is important to note that in some instances GBV survivors have multiple experiences which were however very insignificant e.g. combination of attainment of justice and stigmatization cited by less than 5 respondents. 97 respondents were reluctant to report on any experiences.

3.1.6 Sources of help/support for GBV victims.

The research findings were keen to understand where victims of Gender Based Violence seek help. A gender analysis on the findings noted that both men and women almost on equal measure seek for help on GBV matters. Only 1 respondent reported the contrary view i.e. victims not seeking any help. Majority of the respondents reported that GBV victims sought help from the police station. The police station was followed by the Chief's office. Women were reported to be more comfortable to seek help from the chief's office compared to their male counterparts. The hospital came in third. More women than men are willing to go to the hospital for help in case of GBV.

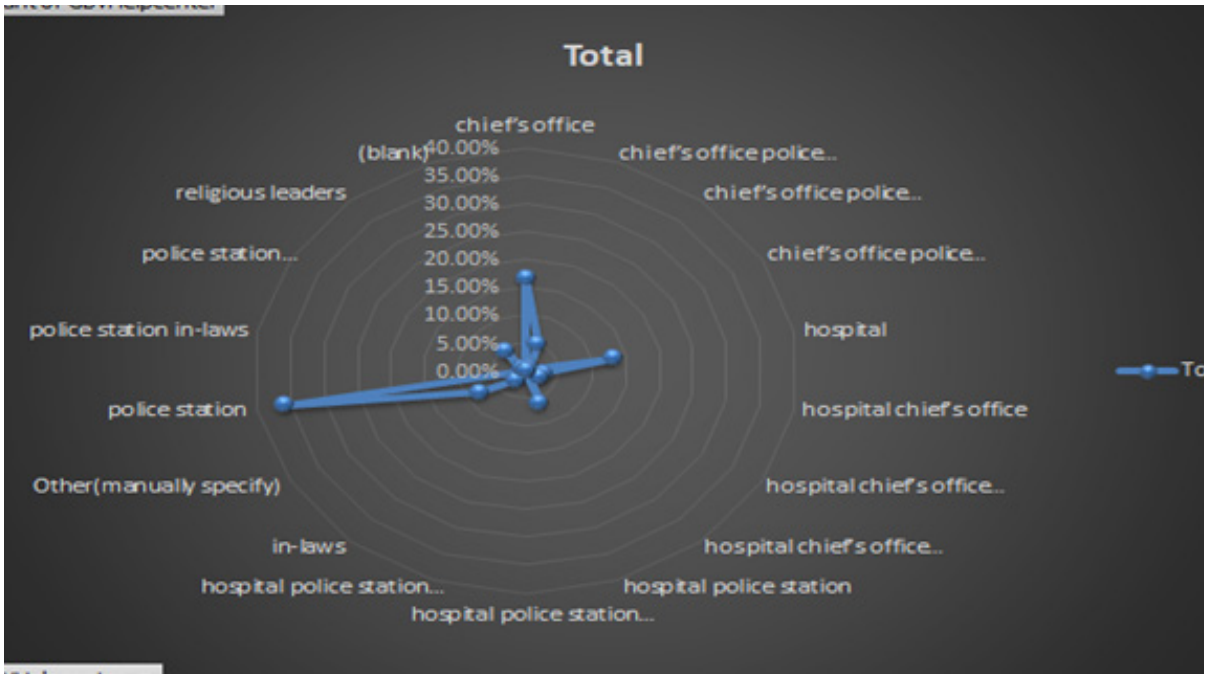

Figure 3. 7 GBV Help Centres

The religious leaders were ranked fourth. Women are least interested in seeking help from religious leaders. The lowest point of intervention was the family unit (in laws). The likelihood of seeking intervention from more than one institution was minimal. This is demonstrated by chief office and police station cited by only 17 respondents. The more the points of intervention increase the more the numbers of respondents' decrease.

3.1.7 Type of help obtained.

In Addition to the places where GBV survivors got help, the survey sought to establish the kind of help obtained. Those who went to the hospital expressed needs for medical treatment or check-ups. Those seeking help from the chief's office and police station expressed needs of seeking attainment of justice and protection. The expectation from religious leaders and family unit was to seek alternative dispute resolution mechanism and counselling, as more trusted sources than friends and/or professional counsellors.

3.1.8 Assessment of GBV help sources.

Participants were asked to share their views on the capacities of the help sources to address GBV/support the GBV survivors, following were their responses:

Police: The police service enjoy high level of confidence from the community in regard to their capacity to dealing with GBV cases with 257 respondents acknowledging so. Half the respondents pegged this on their punitive nature in dealing with the perpetrators. The second reason attached to this rating was their capability to help victims find justice. The rest of the respondents admitted that they have confidence with capacity of the police but could not attach any reason to this association. On the other hand, the major reason given by those who saw police as a weak point was due to fear of corruption which was seen as a setback to victims finding justice.

Health care workers: Health workers follow the police officers in terms of high rating in their knowledge and capacity to handle GBV, denoted by 246 of the respondents. All the respondents alluded this to their ability to offer care, treat-

ment, maintain high levels of confidentiality and counselling to victims of GBV victims.

Religious leaders: Religious leaders came third in terms of their capacity and knowledge in handling GBV cases, reported by 230 respondents. This was partly attributed to their soft power approach in terms of using spirituality to educate their followers and their capacity to provide trauma healing through spiritual counselling. Respondents are attracted to religious leaders by a collection of attributes such as being role models in the society which gives them a niche over the other institutions. Trust is also another attribute in favour of the religious leaders. This is critical because Tthese communities regard GBV as a sensitive matter associated with shame, stigma, stereotyping, prejudices, or rejection which for the sake of protecting victims should be concealed.

Chiefs: The chief's office was rated fourth. Respondents cited confidence in attainment of justice through this office via alternative dispute resolution or through the law courts. Additionally, the ability of the chief's office to convene and sensitize communities on GBV was another important attribution on the capacity and knowledge to handle GBV cases.

3.1.9 Participants' knowledge of GBV support provided by the County Government.

Out of the 351 respondents, 241 were of the opinion that County Governments do not provide any GBV services. On the other hand, 110 respondents acknowledged county Government service delivery on GBV. The services they outlined varied from collaborations between County Governments and NGOs, building children's homes for victims, counselling, and other forms of support through the Gender and children offices. Even for the respondents who acknowledge service delivery by County Government were not in a position to explain or even mention a single service offered. This points to the possibility that the county government's role on GBV could be very minimal or the respondents are not aware of service provision by County Governments on GBV.

3.2.0 Sources of information regarding GBV in the community.

Asked on ways, places of getting information regarding help or report GBV case participants outlined varied sources including Chief office, Police Station, County Offices, Hospitals, Local Radio, Local TV Stations, Community Outreach, Barazas, Local Groups Eg Youth Groups, Women Groups.

3.2.1 Participants additional view on the subject of GBV

Asked if they had additional comment on GBV in their community, 150 of the respondents recommended on preventive measures i.e., more sensitization programs, respect for human rights and a more inclusive approach in tackling GBV. The findings based on the previous questions have portrayed that these communities perceive GBV to be a challenge exclusively for women, girls and children. Additionally, 50 respondents emphasized on putting mechanism in place to support victims to obtain justice.

3.2.2 Participants' definition of sexual and reproductive health

Asked about their understanding of Sexual Reproductive Health and Rights (SRHR), 250 respondents could not define SRHR. A total of 71 could only attach one or two variables to the meaning out of the 4 variables comprising the standard definition of SRHR and only 30 could give full definition with all key components of the standard definition i.e. safe, satisfying sex life, capability to reproduce, freedom to decide if, when and how often to do so).

3.2.3 Community Understanding of Contraceptive

On community understanding of contraceptives, 280 respondents had a very good understand-

ing of contraceptives as a birth control measure. A minimal number (less than 5) did not have the slightest idea of contraceptives. Nearly half of the respondents assign gender roles to family planning, confining the role exclusively to women and girls. It also emerged that there are existing myths and biases on contraceptives specifically linking it to unwanted pregnancies and not general birth control.

3.2.4 Contraceptive Pick up Points.

Asked where in their community they would find contraceptives, it emerged that there are four main pick-up points for contraceptives, the local hospitals topping the list, followed by chemists. Some 30 respondents did not of the pick-up points. The instances of respondents picking contraceptives from multiple sources was minimal with a combination of chemist and hospital highest while a combination of hospital and local kiosks at the lowest.

3.2.5 Contraceptive Information Centre.

Asked where they get information on contraceptives, majority (250) of the respondents cited hospitals, clinics, dispensaries, outreach centres as their main information centres. This was followed by chemist, radio and barazas.

3.2.6 Participants' views regarding contraceptive.

The participants had varied views regarding contraceptives with the majority defining them as birth Control measure. On the Side effects of contraceptives, respondents cited cancer, hormonal imbalance and infertility. On non-use of contraceptives, respondents identified not being allowed by religion/culture, causing infertility, do not prevent sexual transmitted diseases/infections as the reasons.

3.2.7 Participants' definition of Sexually transmitted infections

Asked to define STIs in their own words, an overwhelming majority of the participants defined STIs as Sexually transmitted diseases.

3.2.8 Whether STIs are common in the community

On the magnitude of STIs in terms of whether they are common or not in the community, a total of 183 participants responded to the affirmative, noting that STIs are common while 168 thought they are not. In terms of the reasons behind the prevalence of STIs in the community, 133 respondents attributed it to unsafe sex while 50 attributed it to cases of multiple sex partners. Unwillingness to disclose sexual health status by a section of the members of the community due to stigma and other reasons that might lead to being disowned by community was also a reason attributed to the high cases of STIs. Ignorance was also blamed for the increase of STIs cases in the community.

3.2.9 Sources of help for patients with Sexually Transmitted Infections

Asked where persons with STIs would go for help, respondents cited hospitals.

3.3.0 Protection from STIs

To protect themselves from STIs, respondents had the following suggestions: abstinence (131), safe sex (164) and avoiding multiple sex partners (38).

3.4.0 Feedback From Key Informant Interviews

The 20 key informants were drawn from health facilities, local administration as well as the clergy. Their views on what GBV is were quite varied with a sizeable proportion noting the physical component of GBV. Majority of them felt that GBV incidences were not common. In terms of types, they identified defilement, domestic violence, sodomy and rape. They noted the lack of service awareness by community underscoring the need to improve on the same.

3.4.1 Location distribution.

Residents' Locations/Residence

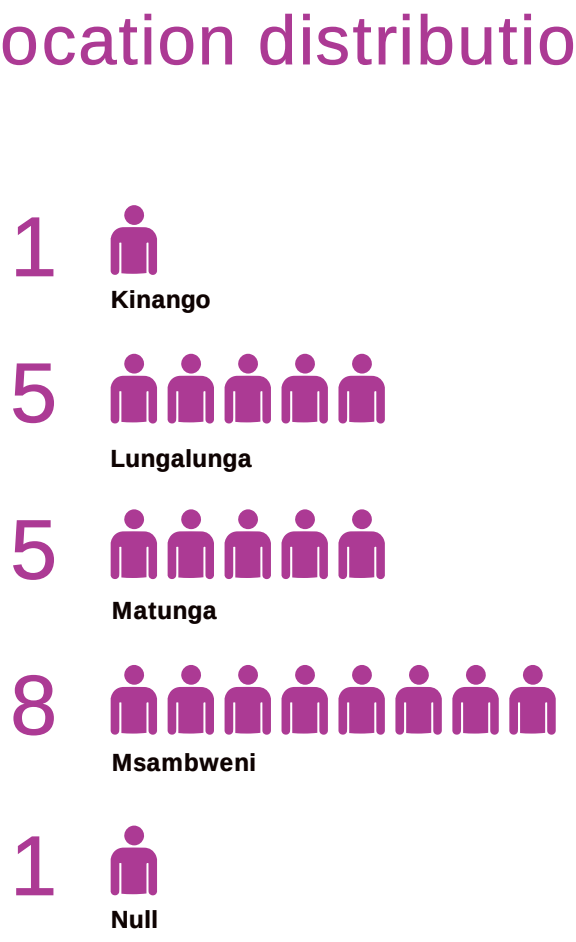

Figure 3. 8 Residents' Locations/Residence

Institutions where Key informants came from

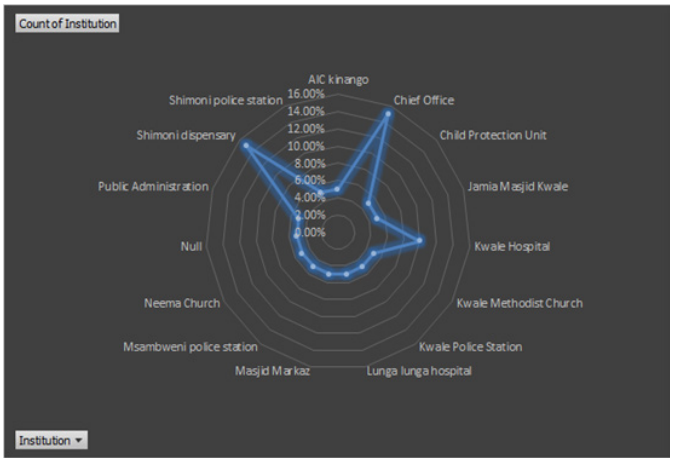

Figure 3.9 Institutions where Key informants came from

Designations of Key informants

Key informants were 16 professionals from key administrative and health departments as well as clergy.

Designations	Number Interviewed
Doctor1	
Nurse	1
Police Officer in Charge	1
Pastor1	
Public Health Officer	2
Reverend 2	
Social Worker	1
Village Chair2	
Vice Chair3	

Table 3.3 Designations of Key informants

3.4.2 Participant's definition of Gender Based Violence

As presented below, the respondents definition of GBV presented varied opinions perhaps based on experience or the happenings within the community. Majority of the Key Informants (at 30%) defined GBV as physical assault or sexual abuse of one gender by the other followed closely (at 20%) by those who felt that it is violation of one's rights based on gender. A similar proportion of the respondents (at 10%) defined GBV as violence of all types against women but also conflict or misunderstanding in a marriage. A proportion of 5% of the participants defined it as mistreatment of both gender of their rights, and another 5% one gender violating the other gender physically, sexually sometimes even emotionally.

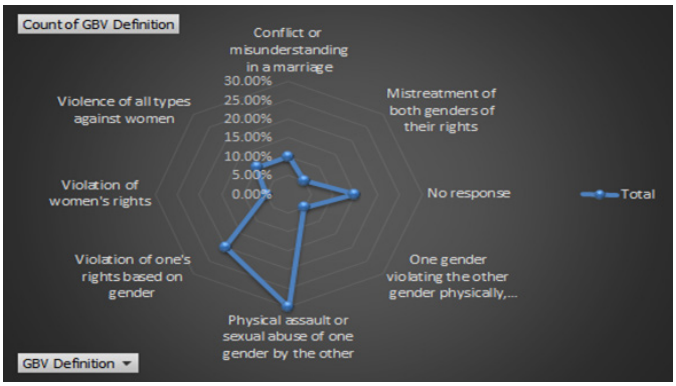

Figure 3.10 Participant's definition of GBV

3.4.3 GBV Incidences in the community

Asked on the incidences of GBV in the community, 30% of the respondents noted that GBV is common, 10% thought it was very common while 60% argued that it was less common.

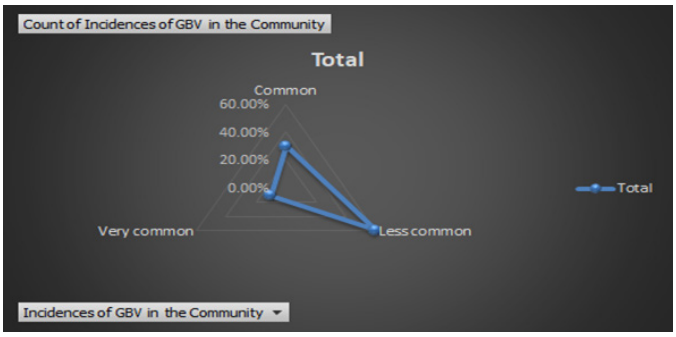

Figure 3.11 GBV Incidences in the community

3.4.4 Common types of GBV in the community

The most common type of GBV in the community are defilement, domestic violence, sodomy and rape (at 70%). The next type of GBV was said to be rape and child labour which was also rated at 10% where rape was considered singly.

Figure 3. 12 Common types of GBV in the community

There was a section of respondents (at 5%) who reported not to be sure of the common types of GBV while a similar proportion (5%) identified forced marriage and domestic violence as the common types of GBV in the community.

3.4.5 Typical GBV survivors in the community

The respondents felt that the typical GBV survivors in the community were women, girls and children at varied ages and proportions.

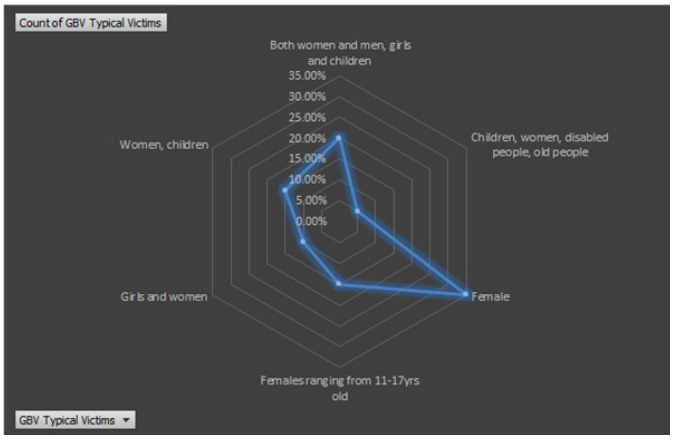

Figure 3.13 Typical GBV survivors in the community

3.4.6 GBV remedies available to survivors in the community

The respondents felt that the Kadhi service offered most in terms of GBV remedies given the 20% score. This was followed closely by police station at 15% where administering of emergency medication including counselling and guidance happened similar to the hospitals. The least rated remedy was counselling and Medicare (at 5%) while a similar proportion (5%) felt that there was no service/remedy available for GBV in the community.

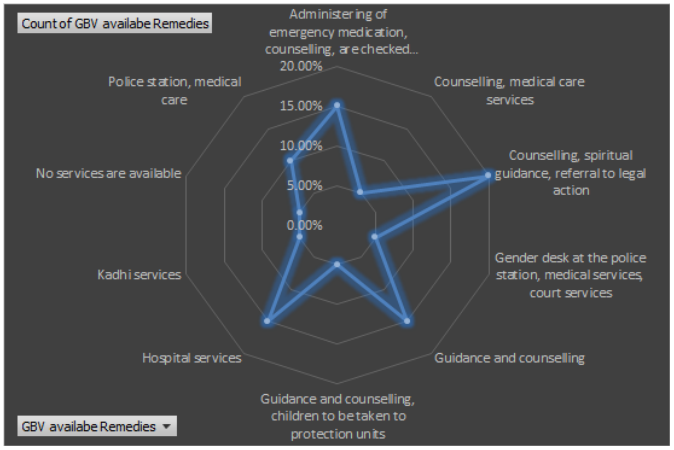

Figure 3. 14 GBV remedies available to survivors in the community

3.4.7 GBV remedy Gaps for survivors in the community

There was overwhelming dissatisfaction from the respondents who noted that there are still gaps in GBV response and support, this was the response from 95% of the respondents.
Explaining the rating, the respondents had this to say: majority (15%) lamented that perpetrators of GBV are not apprehended and they go hiding.

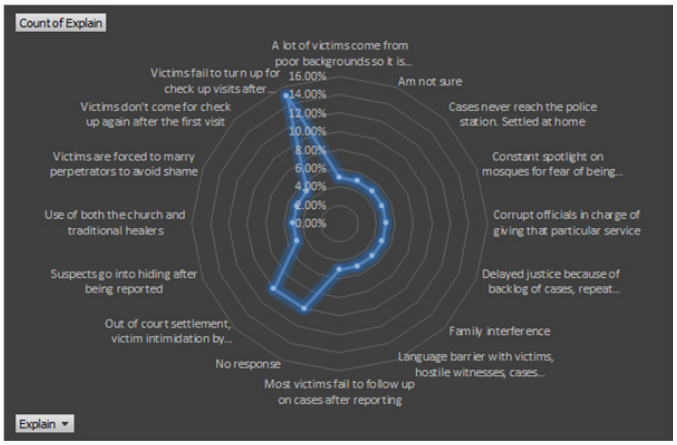

Figure 3.15 Remedy Gaps for survivors in the community

Most felt that the offenders are being left free after out of court settlements. The rest of the respondents lamented that the survivors get treated by traditional healers, the church/mosque tend to silence the cases for fear of being labelled as radicals, survivors are married off to the perpetrators, corruption in justice/police institutions among others.

3.4.8 Justice for GBV survivors in the community

This information on GBV gaps in the community was further corroborated by an overwhelming majority (70%) of respondents who felt that there was no justice for GBV survivors.

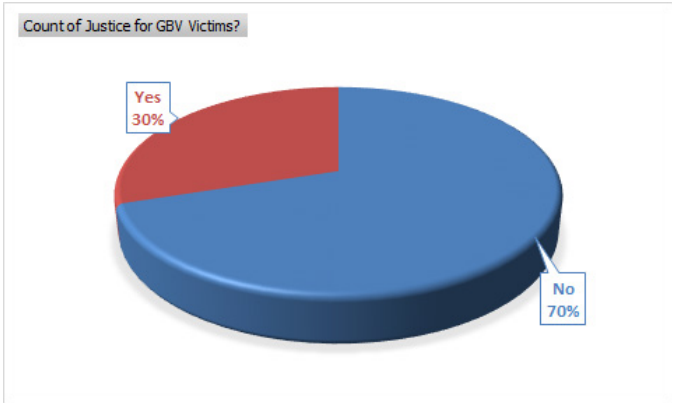

Figure 3. 16 Availability of Justice for GBV survivors in the community

A further probing on the above painted a picture on why justice for GBV survivors lacked. The respondents noted most cases are not handled to fruition because of a seemingly corrupt structure that would see a number of them handled out of court with the fear of stigma partly contributing to this. Details of their specific responses is as outlined in the figure bellow.

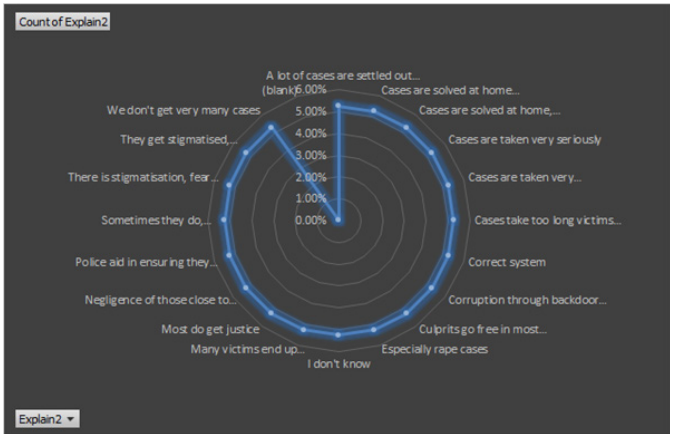

Figure 3. 17 Why Justice for GBV survivor is lacking

3.4.9 Role of Chief in GBV Protection/support

The survey went further to check if the respondents understood the role of the different institutions in providing GBV Protection/support. Among them was the chief where majority (40%) of the respondents confined their role to assisting the police officer to facilitate arrest of the perpetrators.

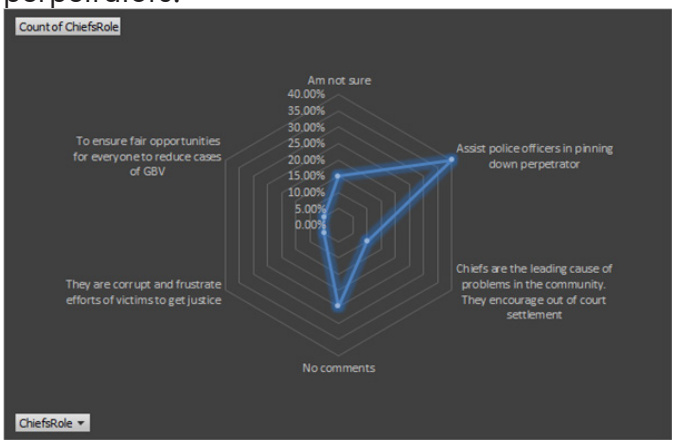

Figure 3.18 Role of Chief in GBV Protection/support

However, within the same was a complaint that the chiefs are the leading cause of GBV related problems, as they often encourage out of court settlement.

3.5.0 Role of police in GBV

Majority of the respondents (65%) attributed the role of the police to arresting offenders and gathering evidence.

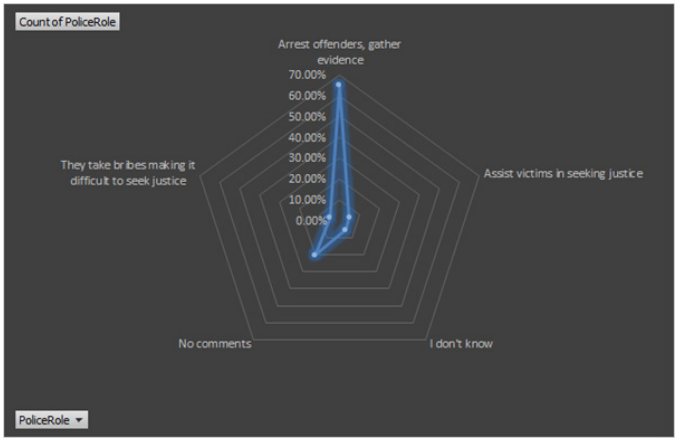

Figure 3. 19 Role of police in GBV

3.5.1 Role of court officers in GBV

On the role of the court office, majority (35%) of the respondents felt that they help to speed up cases while 30% had no comments on their role.

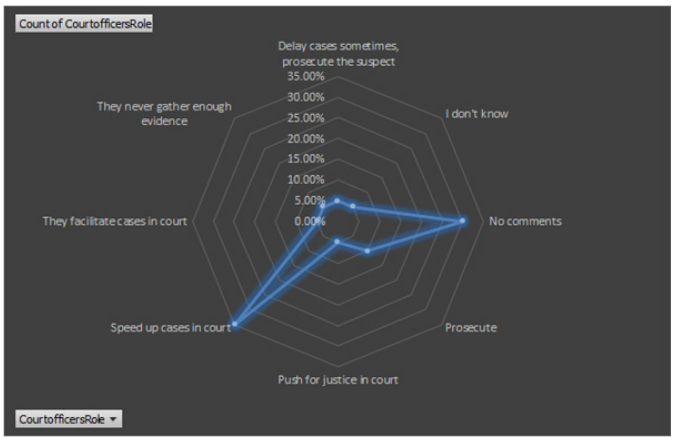

Figure 3. 20 Role of court officers in GBV

Among the respondents (10%) attributed the role of the court officers to ensuring the court procedures are being followed. The rest at (5%) noted the role of the court officers to gathering evidence.

3.5.2 Health worker's role in GBV

The role of the health worker was largely confined to assisting in investigation, treatment, and counselling by the majority (35%) of the respondents while 15% felt that they do guidance and counselling and treat victims.

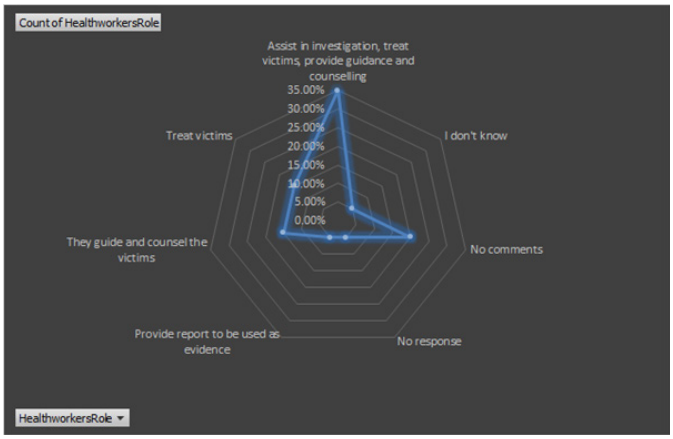

Figure 3. 21 Health worker's role in GBV

3.5.3 Definition of SRHR

Asked what the definition of SRHR is, majority of the respondents (65%) had no comments on the definition of SRHR while 15% defined it rights a woman has over her sexual and reproductive system.

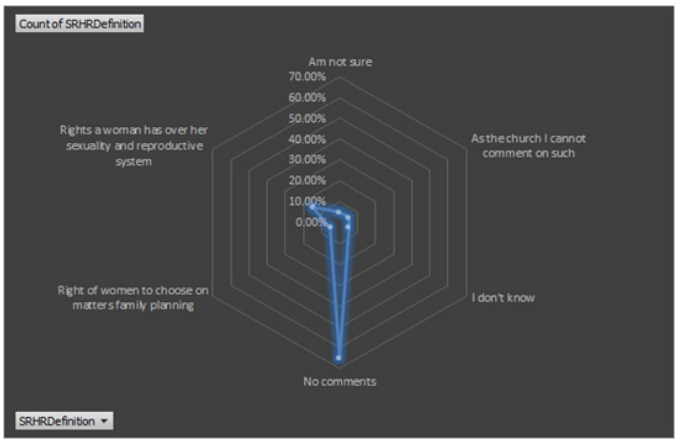

Figure 3. 22 Definition of SRHR

The rest of the participants had no idea and/ or could not comments because of their faith (church) affiliation.

3.5.4 Access to contraceptives in the community

As indicated on the chart above, majority of the respondents (65%) had no comments while 25% noted that contraceptives are easy accessible.

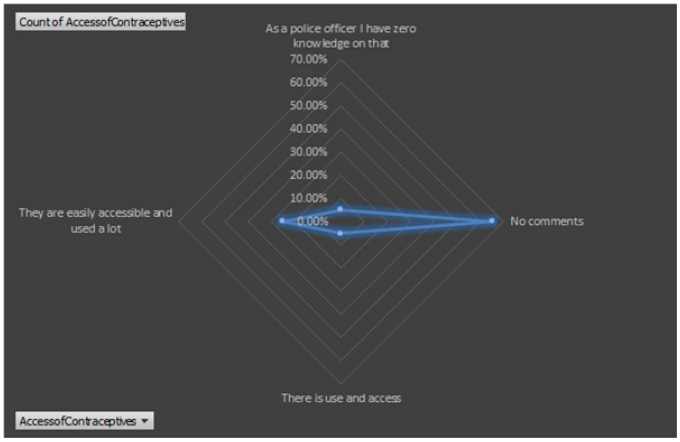

Figure 3. 23 Access to contraceptives in the community

A few of the participants (5%) reported that there was use and access to contraceptives in the community while a similar proportion expressed zero knowledge on the subject.

3.5.5 Information on Contraceptives.

Majority of the respondents (65%) had no comments while 10% noted that there is enough information on contraceptives available to public.

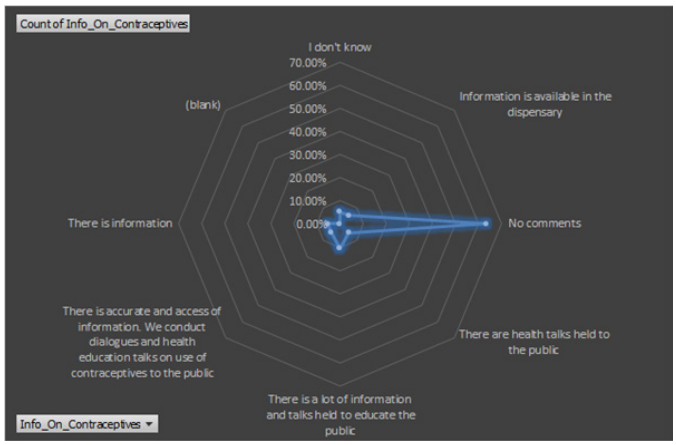

Figure 3. 24 Information on Contraceptives.

3.5.6 Prevalence of STIs in the community.

Majority of the respondents (75%) had no comments while 10% were not sure of the prevalence.

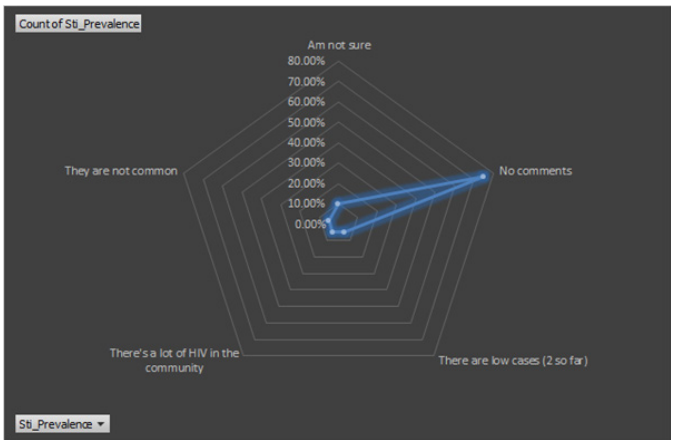

Figure 3. 25 Prevalence of STIs in the community.

The rest of the respondents felt that there are a lot of STI cases in the community.

3.5.7 Information on STI in the community

An overwhelming majority of the respondents (70%) expressed no comments on the status of STI related information in the community.

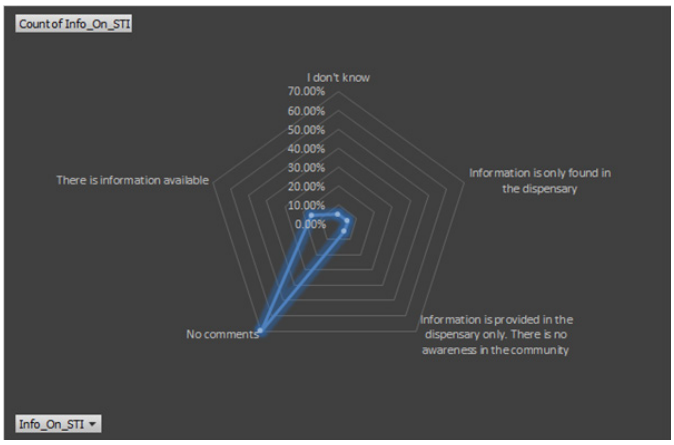

Figure 3. 26 Information on STI in the community

Those who felt there was information on STI were 15% while the others of 5% had no idea on the status of STI information, noted that information is available in the dispensary while the rest reported that there was no awareness/information on STI in the community.

3.5.8 Availability and use of antenatal services in the community

Most (65%) of the respondents had no comments on the availability and use of antenatal services in the community while 30% reported that there is 100% use of the service in the community.

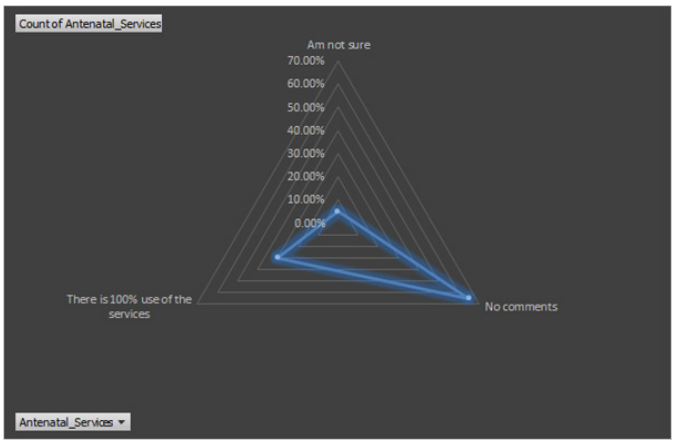

Figure 3. 27 Availability and use of antenatal services in the community

The rest of the respondents were not sure on the availability and use of antenatal services in the community.

3.5.9 Comparison between hospital and home deliveries/births in the community

When the respondents were asked to compare the rate of hospital and home deliveries in their community, 65% noted that dispensary deliveries

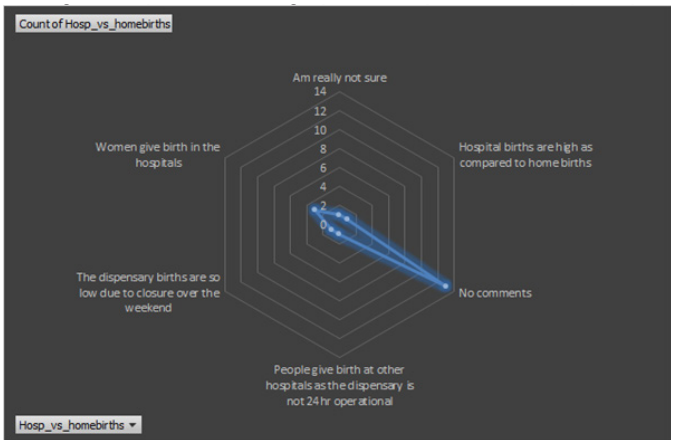

Figure 3. 28 Comparison between hospital and home deliveries/births

Another set of respondents (at 15%) thought that home deliveries are most common and preferred, this was against a proportion of 5% who felt that hospitals births were high.

3.6.0 County Government and GBV services in the community

Examining the role of the County Government in providing GBV services in the community, majority (70%) of the respondents had no comments on the subject. This was followed by a section (10%) of the respondents who felt that there is need to establish a specific department to handle GBV cases.

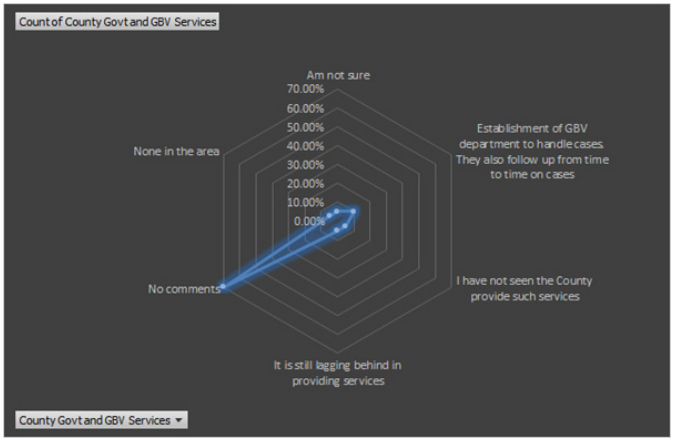

Figure 3. 29 County Government and GBV services in the community

5% of the respondents reported to have witnessed of GBV services being provided by the county Government.

3.6.1 County Government and provision of Family planning services in the community

Asked on the status of Family planning services provision by the county government, 65% of the respondents had no comments while 30% reported that the county government do provide such services.

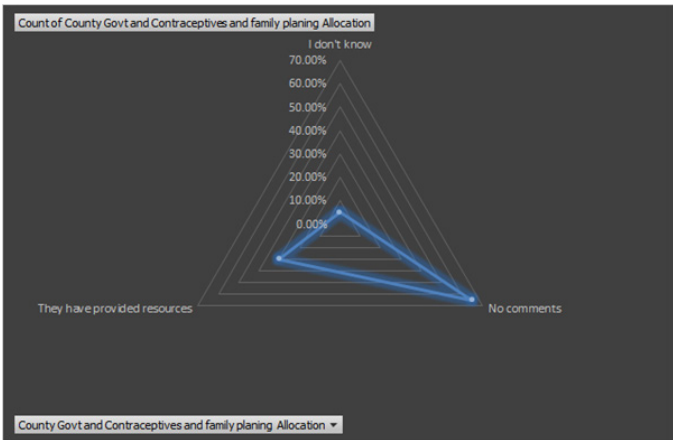

Figure 3. 30 County Government and provision of Family planning services

The remaining respondents had no idea whether the County Government provides any family planning services in the community.

3.6.2 County Government and treatment of STIs in the community.

Evaluating the support of the County Government in treating STI cases in the community, only a quarter (25%) of the respondents noted that the County Government does provide STI related support services. 65% of the respondents expressed no comments while 10% did not have knowledge on the subject.

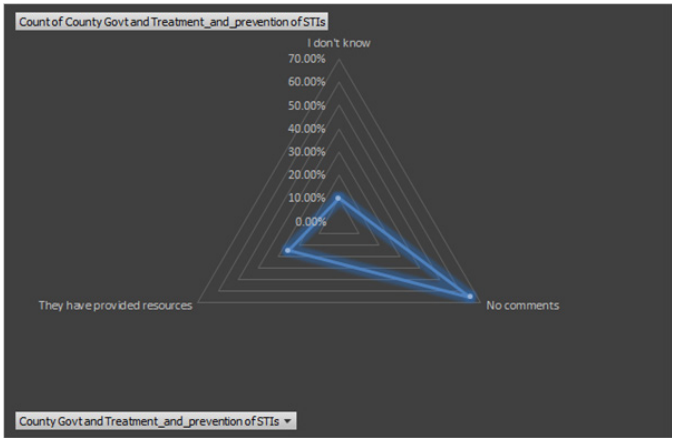

Figure 3. 31 County Government and treatment of STIs in the community.

3.6.3 County Government and provisions of Antenatal services in the community.

On the status of provisions of Antenatal services by the county Government, 30% of the respondents noted that the County Government does provide the services while 5% did not have knowledge on the subject. Majority (65%) of the respondents did not comment.

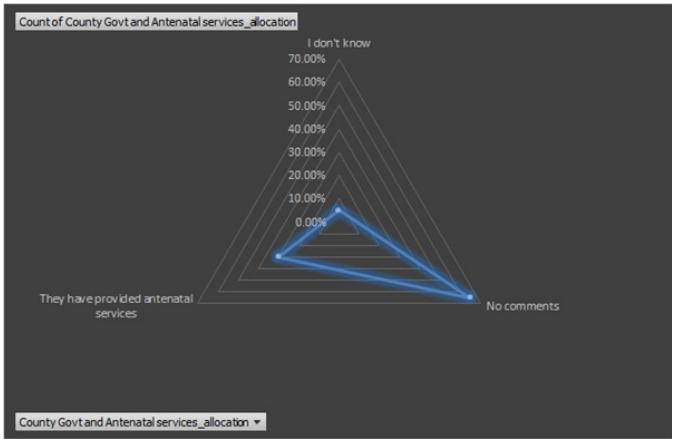

Figure 3. 32 County Government and provisions of Antenatal services

3.6.4 County Government and provisions of maternity services in the community.

On the status of provisions of maternity provision services by the county Government, 30% of the respondents noted that the County Government does provide the services while 5% did not have knowledge on the subject. Majority (65%) of the respondents did not comment.

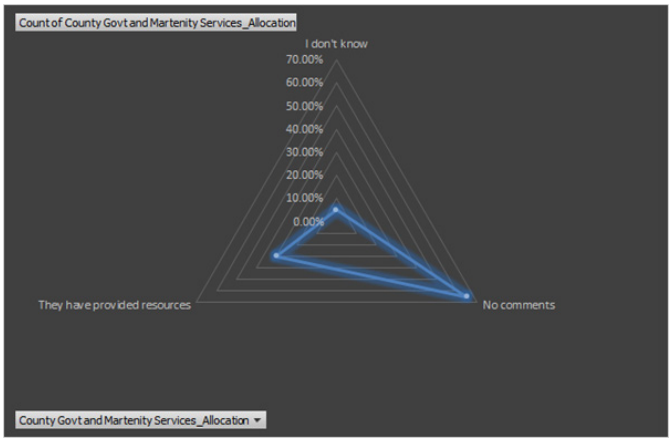

Figure 3. 33 County Government and provisions of maternity services

4.0 CONCLUSION AND FINAL RECOMMENDATIONS

In view of the findings from the respondents in the survey the following findings are key:

This question Community Understanding of Gender Based Violence was discussed in terms of the definition of GBV, knowledge of any survivors of GBV, effects of GBV as well as their opinions on the kinds of interventions and services being offered. The survey noted evidence of huge GBV knowledge gaps in the community especially in the way they defined it. The psychological component of GBV was often downplayed while majority defined GBV as a physical assault. Equally downplayed was the gender aspect where majority of the participants felt that GBV is only/mostly directed to women. Despite literature pointing out to high incidents of GBV in the area, the respondents of this survey reported to the contrary. 60% felt that GBV is not common, 30% noting it as less common with only 10% reporting GBV as very common. This contradicted with the response to the question on whether the participants had knowledge of any GBV survivor, where more than half of respondents reported to be aware of at least one person amongst them who is a survivor of GBV. On the effects of GBV, the findings illustrated that stigma is one of the major effects of GBV with women and men seemingly being affected by stigma almost on equal measure. This was the case despite the fact that some victims were able to get justice, implying stigma would still persist. The was also a majority of respondents who were reluctant to disclose their experiences/ comment on the matter.

Though constitutionally assigned like any other right, Sexual and Reproductive Health Rights are not known by many. Findings from this research have pointed to the fact that majority of the respondents could not attach meaning to SRHR or decided not to comment on the matter at all. While the reason is unclear, either a knowledge gap or cultural inclined reason (taboo), the issue of SRHR remains a huge gap whose need to be intervened on cannot be over emphasised.

In view of the above therefore this survey recommends intense community mobilization and behaviour change communication. There is need for community sensitization on what entails GBV. The question of stigma is one that needs to be addressed given the impact it is causing in the community including their choice of not being ready to discuss the subject, as evident from the many respondents who chose not to comment or expressed no knowledge of the subject.

Service delivery is another area that needs to be addressed. The service delivery programs are pertinent in identifying GBV cases and providing care to the GBV survivors. Such programs are important in documenting information critical in providing court evidence. Another area that the service delivery programs needs to be concerned with is the provision of contraception to women.

There is need for Security/police and legal programs to address the human rights dimension of the GBV. Community trust issues on police and the justice system needs to be addressed. The feeling among community members that GBV cases placed in the hands of police, justice systems are often downplayed with cases of perpetrators going into hiding or bribing their way out would tend to motivate GBV incidences in the community.

Stakeholders including faith-based organizations, opinion leaders, schools, the police, and NGOs need to take an active role in addressing GBV. Cases of denial by the clergy (that they cannot discuss GBV matters) would also cause GBV escalation if unchecked. Tendency to compromise on perpetrators and adoption of community resolution mechanisms including marrying off survivors to the perpetrators is a great violation of human rights and the CSO community need to intervene as a matter of urgency.

Coordination from all sector players; evidence from the study points to some lack of coordination among key sector players including the po-

lice, chief, health facilities, community leaders. This was partly attributed to the participants' rating of the players and opinions about their roles. The conflicting opinions among the players (for instance , the clergy resorting not to comment on the subject owing to the faith reasons) may further aggravate the situation. This study thus recommends the need to take a Multi-sectoral approach to GBV intervention by working with the other actors.

Special focus on Sexual and Reproductive Health remains a clarion call following findings from this Survey. There is evidence of huge gaps in terms of understanding of SRHR and the SRHR services available in the County. There is a need to review the County SRHR status with a view to addressing the gaps therein thus remain paramount.

Although County Government support on GBV and SRHR would seem to be an obvious aspect, findings from this survey point otherwise. The majority of community members could either be unaware of the kind of support being offered by the County Government or are unhappy/unsatisfied with the support and thus chose to report that they have no knowledge or decided not to comment on the matter. With devolution in place members of the community have constitutional rights to not only be informed of the various services available at different county Government departments but also have the right to be provided with such services.

Other findings from the survey:
There was evidence from the survey that community awareness on contraceptives, antenatal care, maternal health, family planning and SRHR is minimal. Knowledge of the types of services available and where such services are available was scanty among most of the respondents. This survey would further recommend that follow up study is conducted to specifically assess the status of the said aspects in the community.

In conclusion, the survey has established the magnitude of GBV and SRHR status, issues and challenges in the county. As a matter of public importance, this calls for joint efforts in addressing GBV and SRHR in the county.

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