THE HIJABI
MENTORSHIP PROGRAM
We are the Catalyst for Change

ADDRESSING SEXUAL REPRODUCTIVE HEALTH AND RIGHTS AND GENDER-BASED VIOLENCE IN UNDERSERVED COMMUNITIES IN KENYA

END TERM EVALUATION REPORT

CASE OF KWALE COUNTY

MARCH 2022

TABLE OF CONTENTS

LIST OF FIGURES

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 its success. Our sincere thanks is equally expressed to Utafiti Data Hub for their technical assistance, our Board of Advisors, Our Partners, The Ministry of Health, Kwale County and National Government Department of Gender and Youth Affairs for their support throughout this evaluation process. A big thank you goes to the Kwale Community for their time and participation in this study and project.

Nimah N'zani Kassim,
Founder,
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 Organization
WB	World Bank
KNBS	Kenya National Bureau of Statistics
KPHC	Kenya Population Housing Ceusus

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 form 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 in 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.

In response to the above The Hijabi Mentorship Program (THMP) a community-based organization operating in Kwale County embarked on a one-year GBV and Sexual Reproductive Health and Rights (SRHR) project from March 2021 with a view to intervene on key concerns therein. The goal of the project was to : strengthen institutional mechanisms i.e. police & local administrators who women and girls trust so that they can report acts of GBV and Human Rights violations safely, confidentially & with no fear of reprisal. Another objective was to increase access to relevant, timely and appropriate information about sexual and reproductive health rights and GBV for young men and women in Kwale County. The last objective was to influence an increased budgetary allocation towards sexual and reproductive healthcare services in Kwale County.

This project began with a baseline survey to establish the status of GBV and SRHR in the County with a view to understand the impediments therein but most importantly suggest recommendations on how the status could be improved.

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 379 was engaged out of the 400 targeted.
The one-year project officially ended in March 2022 and with the intent to establish the achievements of the same, an end project evaluation survey was done. This report is a collection of the observations made, breakthroughs and challenges established as a result of the project.

A quick comparison of what was established during the baseline and the end survey of the project noted some sizable improvement in many areas: among them was the improved community knowledge on what GBV and SRHR entailed but also services available.

Thirty-three (33%) of the respondents, up from 15% during the baseline survey, could explain what SRHR was. They further explained family planning and its relevant information including the necessity, the different methods of family planning as well as their views on the same. Community's knowledge of the services provided by the county Government improved tremendously compared to what they had during the baseline survey. Similar improvement was noted on GBV understanding where 55% of the respondents up from 30% at the baseline were able to explain what GBV meant.
Some of the areas that still needed interventions included stereotypes, religious misconception and bias on GBV, SRHR and family planning. Although on a reduced scale, there were still a section of respondents who chose not to engage on the matter because of faith reasons. This was noted from 11 (3%) respondents who chose not to comment on the matter. Equally was the misconception on contraceptives with some members of the community noting their side effects and thereby choosing not to advocate for the same.

Community confidence in Government departments, the chief and police registered notable improvement from the findings at baseline survey. Police and chiefs have been rated by 73% and 65% of the respondents as key service providers from the findings at baseline where they were at 19% and 12% respectively. Notable concerns were related to integrity (corruption) and poor Civil relationship with complaints of harassment (harsh treatment) of survivors and/or those who accompany them to police stations.

From analysis of the findings of the survey a set of recommendations have been made in this report pointing to continued community health education and stakeholder coordination.

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 form of human rights violations. Despite the overwhelming support at Global, Regional and National levels: GBV still remains a scourge in many communities. Although there could be many factors attributing 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.

> In some countries, violence against women is estimated to cost countries up to 3.7% of their GDP

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 the informal/traditional justice system, 30 percent preferred formal justice systems while 10 per cent were unaccounted for. This is because the traditional justice system is easily accessible. It is also perceived to deliver justice and the process does not take long.

1.1 Program Overview

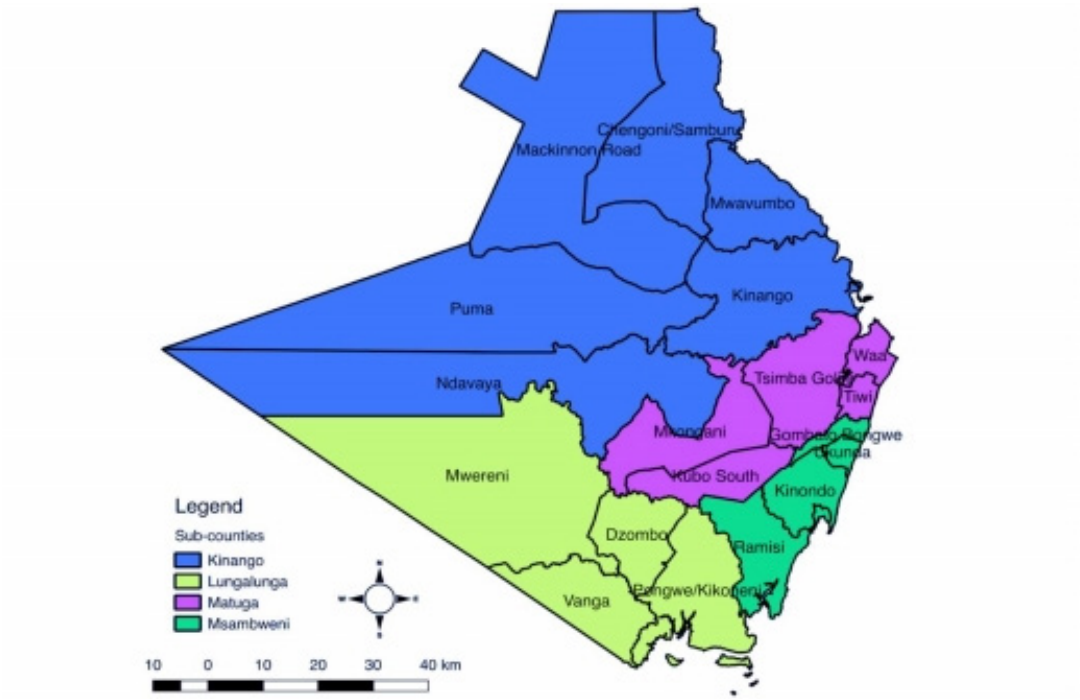
The Hijabi Mentorship Project (THMP) is a registered Community Based Organization that champions for gender equality in underserved communities in Kwale. They address: Sexual Reproductive Health and Rights (SRHR), Gender Based Violence (GBV), Peace and Conflict Resolution and promotes Economic Justice for women and girls 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 on the 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 Digo and Duruma who are numerically the majority. 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).

> The goal of the project was to: strengthen institutional mechanisms

Figure 1. 1 Overview of Kwale County (Administrative boundaries)



1.3 Population.

The County's population is estimated at 866,820 persons (425,121 males and 441,681 females, 18 intersex). The county has 173,176 households with an average household size of 5. (KNBS-2019 KPHC Volume 1)

1.4 Overview and purpose of this survey.

The primary outcomes for this survey focused on Increased access to high quality and affordable sexual and reproductive healthcare information and services, a strengthened mechanism of justice for prompt, just and effective remedies against GBV for young women and girls in Kwale that they can trust so that they can report acts of Gender Based Violence violation safely, confidentially and with no fear of reprisal. The study serves as an end of project evaluation following a one-year Community sensitization project conducted in Kwale County. 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 government to establish progress made from the one-year project. strengthen institutional mechanisms i.e. police & local administrators who women and girls trust so that they can report acts of GBV and Human Rights violations safely, confidentially & with no fear of reprisal. Another objective was to increase access to relevant, timely and appropriate information about sexual and reproductive health rights and GBV for young men and women in Kwale County. The last objective was to influence an increased budgetary allocation towards sexual and reproductive healthcare services in Kwale County.

1.5 Survey objectives.

The broad objectives of the survey were to:

1. Establish level of improvement of community understanding on GBV and SRHR: The Hijabi Mentorship Program conducted a series of activities targeting increase in knowledge and access to information throughout the 1 year project. These included : Community dialogues, Social Media Dialogues and Media Engagements.

The community dialogues targeted 2500 beneficiaries around Kwale county in the four sub-counties namely Msambweni, Kinango, Matunga and Lungalunga . 91 community dialogues took place across the county . They included 48 women dialogues reaching 1440 women, 19 youth dialogues reaching 376 youth and 24 Intergenerational dialogues reaching 720 youth and elders. A total of 2528 participants were reached in the four sub-counties hence increasing our target with 28. A total of 48 social media engagements were conducted. They included 17 Instagram live, 13 twitter chats, 8 Facebook live and 10 dialogues on Zoom and Google Meet. These social media campaigns helped reach the people who could not attend the physical dialogues especially the youth. The reach for social media dialogues was an approximate of 56,576 , which surpassed their initial target of 10,000 young people on social media. THMP had a target of 16 Radio Talk Shows. The Radio Shows were aired on Radio Kaya and Radio Ranet, the most listened to local FM stations in Kwale and the whole Coast region at large with a reach of over 250,000 listeners.

2. Determine the progress made towards access to related services in hospitals, access to relevant information, access to justice for GBV victims : Throughout the project, THMP had conducted 10 stakeholders engagement in the four sub-counties whereby they held 2 stakeholders engagement in lunga lunga ,2 in msambweni 3 in matuga and 3 in kinango reaching a number of 120 stakeholders around kwale county which included County government officials. The main aim was to have a collaborative and a good networking system with the stakeholders in handling GBV issues and having support and cooperation in issues dealing with GBV in the county. The stakeholders are the ones who determine the budgetary allocations including allocations towards sexual reproductive health and rights and GBV services. THMP scheduled round tables with them to present and discuss the baseline findings regarding SRHR/GBV in the county, budgetary allocations to SRHR/GBV, the level of access to SRHR information, services in health institutions within the County.
3. Assess the level of trust and confidence established between community members and sources of information or help. e.g police and administrators who are the first port of call for victims of GBV or SRHR violations: Through the Generation Equality Project, THMP team organized two administrators' training (per sub-county) for local leaders making a total of 8 training sessions for the four sub counties. The trainings targeted public health officers, area chiefs, social service officers, ward and village administrators, police officers, children's departments and other local administrators. In total, 40 local administrators were trained, 10 per sub-county. The main purpose of the training was to ensure leaders take up roles in ensuring issues of GBV and SRHR are addressed appropriately at individual, community and organizational levels. The objective of this activity was so that they're all at a better capacity to handle cases of GBV and SRHR violations in a sensitive and humane manner and facilitate victims' access to justice. They also received psychosocial training so that they can provide psychosocial support to the victims who come to report abuse.

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 sects;1. General community which included women, youth, boda-boda riders and 2. Key informants included MOH officials, Religious leaders, police officers and local administration officers (chief). A total sample size of 379 was drawn out of which 349 were the general public and 30 key informants. Data was collected through focused group discussion, Key informant interviews and open-structured interviews. The data was analyzed 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 universally acceptable. Prevalent definition of gender-based violence does not include children. Similarly, since there is a general lack of a clear and commonly accepted language, development of databases and reporting systems is inhibited. As a result, efforts of advocacy, monitoring, and prevention are restrained in the region (Betron and Doggett, 2006).

A wide definition of the term gender-based violence may refer to the physical, emotional or sexual abuse of a survivor. 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).

Physical abuse could be defined as any deliberate and unwanted physical contact. Emotional abuse on the other hand could be any abuse which could not be physical and may include verbal aggression, intimidation, manipulation and humiliation which often results in anxiety, depression, suicidal thoughts and post-traumatic stress disorder. (Pacific, 2022)

Sexual violence may also be used to represent behaviors that fall under scope of abuse, assault, and violation in relation to sex. Such activities or behaviors may include harassment and voyeurism. Gender based violence is used synonymously to sexual violence. Essentially, it is used to demonstrate the gender inequality that exists 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 in the form of forced sex are highly 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).

Women and girls living within Kwale county experience many social, cultural and religious norms that infringe their rights. Historically, women in Kwale never went to school, because of the belief that education is 'haram' (forbidden). Thus, Kwale County lags behind the rest of Kenya in education terms. It is regarded as normal for girls to drop out of school at a young age. This is often due to arranged marriages. In addition, lack of education limits women from accessing employment opportunities and engagement in gainful livelihoods (ILO, 2016).

This ultimately limits their options and possibilities in life. Due to this illiteracy, these women and girls lack proper understanding and appreciation of their basic human rights.

Gender Based Violence (GBV) is prevalent in Kenya and in Kwale County too. A study by The National Crime Research Centre shows that 49% of women aged 15-49 have experienced physical violence, 38% of ever-married women aged 15-49 have ever experienced physical violence committed by their husband/partner, 64% of GBV cases occur within the homes of survivors. One police station in Kwale reported 30 cases of gender-based violence every day in 2019. Violence against women and girls has serious short- and long-term consequences on their physical, sexual, reproductive and mental health as well as on their personal and social well-being. The health consequences of violence against women include injuries, unwanted pregnancy, sexually transmitted infections including HIV, female genital mutilation, pregnancy complications, and chronic conditions. Many barriers exist to receiving dependable, confidential services such as mental health care in marginalized communities in Kenya. Kwale is one of the historically marginalized Counties in Kenya.

Kwale County had amongst the highest prevalence of teenage pregnancies at the Kenyan Coast, standing at 24% higher than the national average of 18%

Tourism, the main economic activity in Kwale County compounds the challenges for young women because of child sexual tourism, and easy access to alcohol and drugs. According to the United Nations Population Funds (UNFPA) 2019 data, Kwale County had amongst the highest prevalence of teenage pregnancies at the Kenyan Coast, standing at 24% higher than the national average of 18%. Data from the Kenya Demographic and Health Surveys show that almost 2 out of 10 girls between the ages of 15 and 19 in Kwale are reported to be pregnant or have had a child already. This trend has been consistent over the years with little change in prevalence proving to be a major challenge for the socioeconomic development among women.

2.2.2 Consequences

Sexual gender-based violence (SGBV) is a major concern because of the consequences associated with it such as poor reproductive health. GBV studies conducted in various setting indicate that women and girls, who at zone point in their lives experienced rape or sexual coercion, are more likely to develop genital tract infections problems and Sexual Transmitted diseases like HIV and AIDS, go through unsafe abortion, and experience unplanned pregnancy. This is primarily due to their unlikely hood of using condoms. These women have been found to lack sexual autonomy and as a result, they are under threat for violence, and this increases their exposure to sexually transmitted infections. Studies have also found that sexual violence is high in the homes among partners. If women do not have sexual autonomy and the power to negotiate for safe sex within the homes, they can easily contract genital tract infections (Betron and Doggett, 2006; Population Council, 2008).

Sexual and gender-based violence both 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).

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.

2.2.3 Causes and Risk Factors

According to the World Health Organization, the following have been supported by evidence to be critical causes and risk factors including 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 years. Gender based violence has been identified as one of the main reasons why women would opt for divorce. According to a report by the World Health Organization, most divorced women normally cite cases of gender based violence that lead to the divorce or separation (WHO, 2005). Previous experience of sexual abuse, drug consumption, and alcohol use also correlate with sexual violence among adulthood.

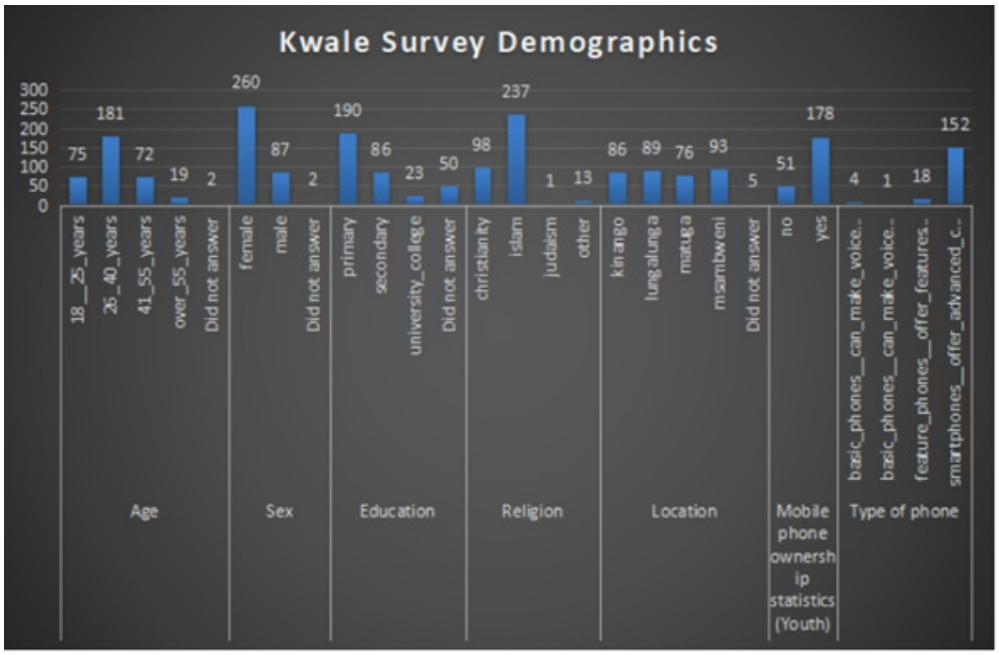
2.2.4 Ethical considerations for researching SGBV

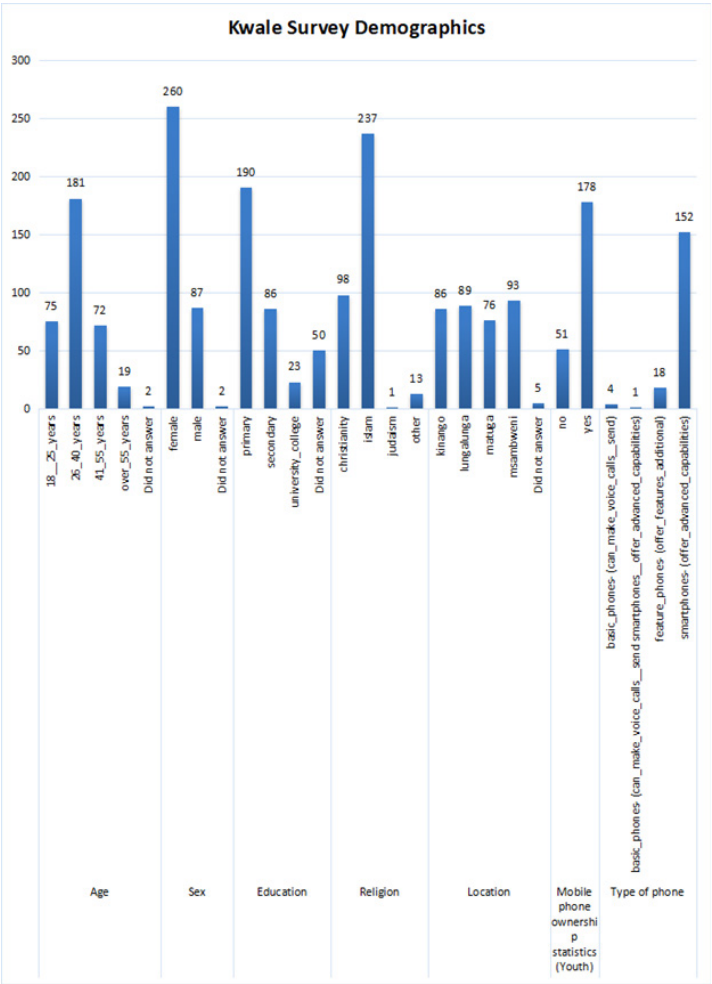
The subject material was highly regarded as sensitive and traumatic which created the need to uphold strong ethical standards. Authorities in GBV research agree that conceived or implemented research may have dangerous consequences for the respondents and/or interviewers therefore this survey ensured such ethical issues including confidentiality where the respondents' comments were not to be used for any other reasons save for the purpose of the survey only. Participants engaged with informed consent having been explained what the survey entailed. Participation was also voluntary and respondents had the liberty to engage and leave at any part of the survey with an equal choice to respond to only the questions they were comfortable with. All respondents were treated with due respect and protected from any known or perceived harm that may have arisen from their engagement in the survey.

3.0 FINDINGS OF THE SURVEY

3.1.0 Socio-Demographic Characteristics Of Respondents

Figure 3. 1 Kwale Survey Demographics





Majority of the respondents were of ages 26-40 while those above 55 years were the least. Female respondents formed 75%, 24% were male while the remaining respondents chose not to disclose their sex. Respondents with Primary level education were the majority (at 54%) followed by those of Secondary and University. At least 14% of the respondents did not disclose their levels of education. Muslims faith were the majority followed by Christians and other faiths. The respondents were almost evenly distributed in the sub counties of Kwale; Msambweni, Lunga Lunga, Kinango and Matuga following respectively. A total of 175 respondents had phones, with a majority (87%) having smartphones.

Figure 3. 2 Gender

Figure 3. 3 Location

3.1.1 Findings From Structured Interviews With Respondents

The findings of this survey are presented based on the set of questions and responses from 349 persons who participated.

3.1.2 Participants' Understanding and Perception on Gender Based Violence.

A total of 55% of the respondents were able to explain what GBV could be. This was an improvement from the initial 30% at the baseline. Findings from the respondents noted had varied definitions of Gender Based Violence with the majority confining the definition to mostly physical and sexual. Generally, the public has an idea and understands what GBV is. However, most respondents felt that GBV is perpetrated only on women, forgetting the gender aspect that it could be either. Perhaps their perception of GBV to be on women may have been influenced by what commonly happens in the community, i.e women being most affected. Majority of the respondents reported to be aware of one or two persons who are survivors of GBV.

Findings from the respondents noted had varied definitions of Gender Based Violence with the majority confining the definition to mostly physical and sexual.

Observations from the Key informants noted a total of 23 respondents using the same word to define Gender Based Violence. With this approach it was not easy to tell whether they are conversant with the term or not. Three (3) respondents were of the opinion that GBV is rape/sexual assault, 2 believe that GBV is a form of human right violation that applies to both men and women. One of the respondents did not share their response.

With regards to GBV prevalence in the community, the 23 respondents further acknowledged that GBV is very common, 3 claimed that it is common while the remaining 4 respondents viewed GBV as being less common. The informants further alluded that women, girls and children (reported by 25 respondents) suffer most when it comes to GBV. The specific age groups were not highlighted in this research; this can form one of the recommendations as this information will help in coming up with more affirmative actions for such age groups. Boys and the old are minimally affected at 4 and 1 respectively.

A close comparison between these respondents and those gathered at the baseline survey noted close similarities: where GBV is generally a vice, not welcomed in the society. It is also attributed to one's gender (perception on male/female) in the society. Further comparison established that the members of the community were still not very keen on the psychological dimension of GBV, with none defining GBV as such, just like it was at the baseline survey. At least 30% of the respondents chose not to comment on this question, further adding to the concern on whether they actually understand what GBV is.

3.1.3 What happens to survivors of GBV

Findings from the majority 48% of the respondents painted a picture that GBV survivors are yet to be fully embraced/supported in the community and seemingly there was no fair treatment unto them. Majority of the respondents noted that survivors of GBV were ashamed and stigmatized. Although there were indications of fair treatment and support to the survivors, these were only a few as reported by respondents who said that the survivors get justice.

Family interference and resorting to handling GBV cases as family affairs was an observation at the baseline with 30% respondents claiming such and corruption at 37%.

This finding was similar to that from key informants who claimed that the majority (60%) of the respondents believe that the survivors of GBV do not get justice while 13 (43%) were of the opinion that they do get justice. One of the major reasons why victims of GBV do not get justice is because almost half of these cases happen between the family set up for instance close family members, neighbors or tribesmen and to protect the family image these cases are not reported, as claimed by 15 (50%) of the respondents. Five 5(16%) respondents decried financial constraints to follow up on cases. Corruption (as reported by 6(20%) respondents) has also been a hindrance in gathering evidence and fatigue in follow up cases.

Comparing this with findings at the baseline where only 22% of the respondents felt that GBV survivors get justice, the observation below where 44% of the respondents felt that the survivors get justice is an indication for improvement.The rate of stigmatization on survivors equally showed an improvement from the previous 77% to current 10%. Family interference and resorting to handling GBV cases as family affairs was an observation at the baseline with 30% respondents claiming such and corruption at 37%.

Meanwhile, as observed during the baseline survey, shaming and blaming of GBV survivors was common in the community. Equally is the case of family interference, corruption and lack of justice for survivors.

Figure 3. 4 Survivors of GBV

GBV Actions on Victims	Female	Male	(blank)	Grand Total
They are_they_shamed	47	10		57
They are_they_shamed, they_are_stigmatized	10	5		15
They are_they_shamed, they_are_stigmatized other_specify	1			1
Other_specify	29	1		30
They_are_stigmatized	19	7		26
They_are_stigmatized, other_specify	1			1
They_get_justice	94	16		111
They_get_justice, are_they_shamed	1			1
They_get_justice, are_they_shamed they_are_stigmatized	3	2		5
They_get_justice, they_are_stigmatized	3			3
(blank)				
Grand Total	**208**	**41**	**1**	**250**

GBV Actions on Victims	Female	Male	null	Grand Total
They are shamed, they are stigmatized, Other(Specify)	2	1	0	3
Other(Specify)	44	55	1	96
They are stigmatized	42	35	0	77
They are stigmatized, Other(Specify)	5	2	0	7
They get justice	46	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	34	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**

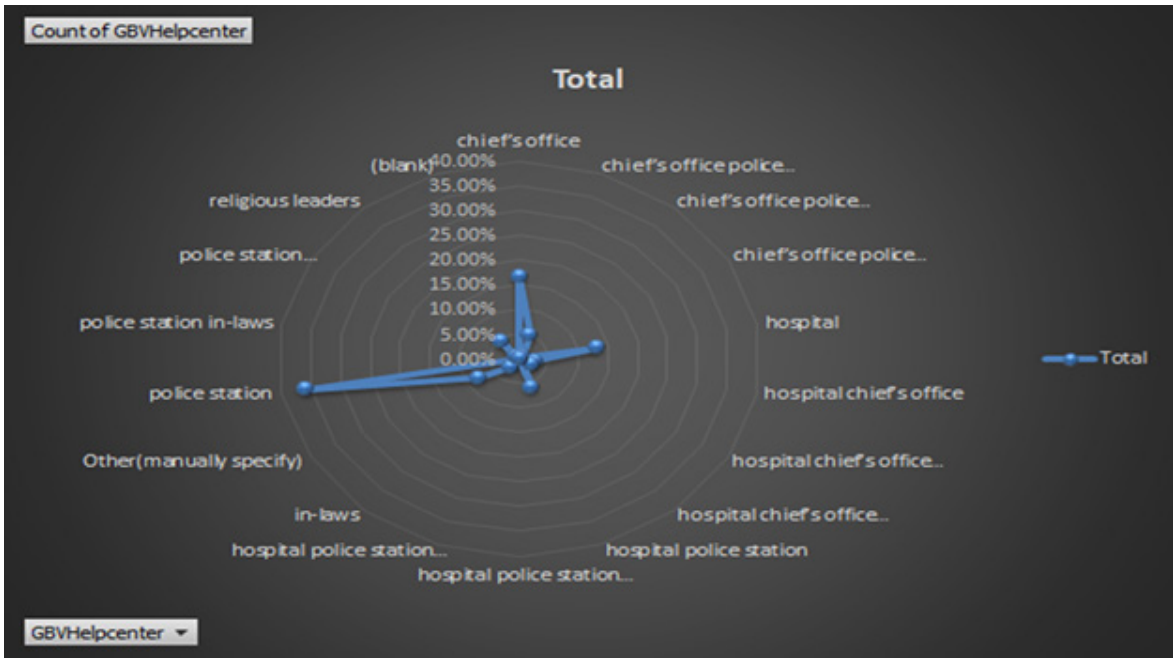
3.1.4 Sources of help for GBV Survivors

The three top sources of help for GBV survivors were mentioned as hospitals/healthcare workers, Government law enforcement agencies, the police and chief. The healthcare workers were reported as most helpful by the majority; 20% of the respondents. Government law enforcement agencies came close with police reported at 19% and chiefs following at 16%.

These findings provide some change of opinion comparable to observations at the baseline where police were rated as the most helpful source at 73%, followed by Health care workers at 70% religious leaders at 66% and lastly chiefs at 65%.

Figure 3. 5 Sources of Help for GBV Survivors

GBV Help center for survivors	Count of GBV Help Center
chief_s_office	55
chief_s_office other_manually_specify	1
chief_s_office police_station	3
chief_s_office police_station other_manually_specify	1
chief_s_office police_station religious_leaders	1
hospital	71
hospital chief_s_office	2
hospital chief_s_office police_station	10
hospital chief_s_office police_station other_manually_specify	2
hospital other_manually_specify	1
hospital police_station	13
hospital police_station in_laws	1
hospital religious_leaders other_manually_specify	1
other_manually_specify	13
police_station	70
police_station other_manually_specify	1
religious_leaders	2
religious_leaders other_manually_specify	1
(blank)	
Grand Total	**249**



GBV Help centers 2021

When the respondents were probed further to establish the kind of support offered at these offices; the hospitals were reported to be helpful in providing screening and treatment to survivors while the chief was reported to play a key role on guiding the survivors on the next steps including making referrals to relevant offices such as the police and the hospital. The police role involved making arrests and placing suspected perpetrators in custody and presenting them to court. Religious leaders would provide psychological/moral support to the survivors.

On assessment of the capacity and quality of services offered by the identified sources of help; the respondents had this to say:

On hospitals: Most, 37% of the respondents felt that the hospitals have the required capacity to handle GBV while 8 claimed that they do not have the capacity. They, however, could not explain the claims.

On police: Only 8% of the respondents agreed that the police have the capacity to offer support as far as GBV cases were concerned while 10 (3%) respondents felt that the police do not have the capacity. Further probed to explain why they felt that the police lack the capacity, only 3 of the respondents were able to explain. They claimed that the police are harsh and hardly listen to cases, and they are also corrupt

On chief: There were low (26) cases of respondents in agreement that the chief had the capacity to support GBV prevention and interventions while 9 respondents disagreed that chief had any capacity on the issue. Like above, only 2 of the respondents could justify their claims. These, like in the case of the police, attributed their claim to corruption among some chiefs.

On Religious leaders: Although reported to be helpful in providing psychosocial support, there were claims by respondents that the religious leaders lack the necessary knowledge/skills on the practice.

Analysis from key informants noted that 20 respondents reported that the survivors get their services from hospitals or seek psychological support from CSOs, religious institutions and community leaders. Five (5)

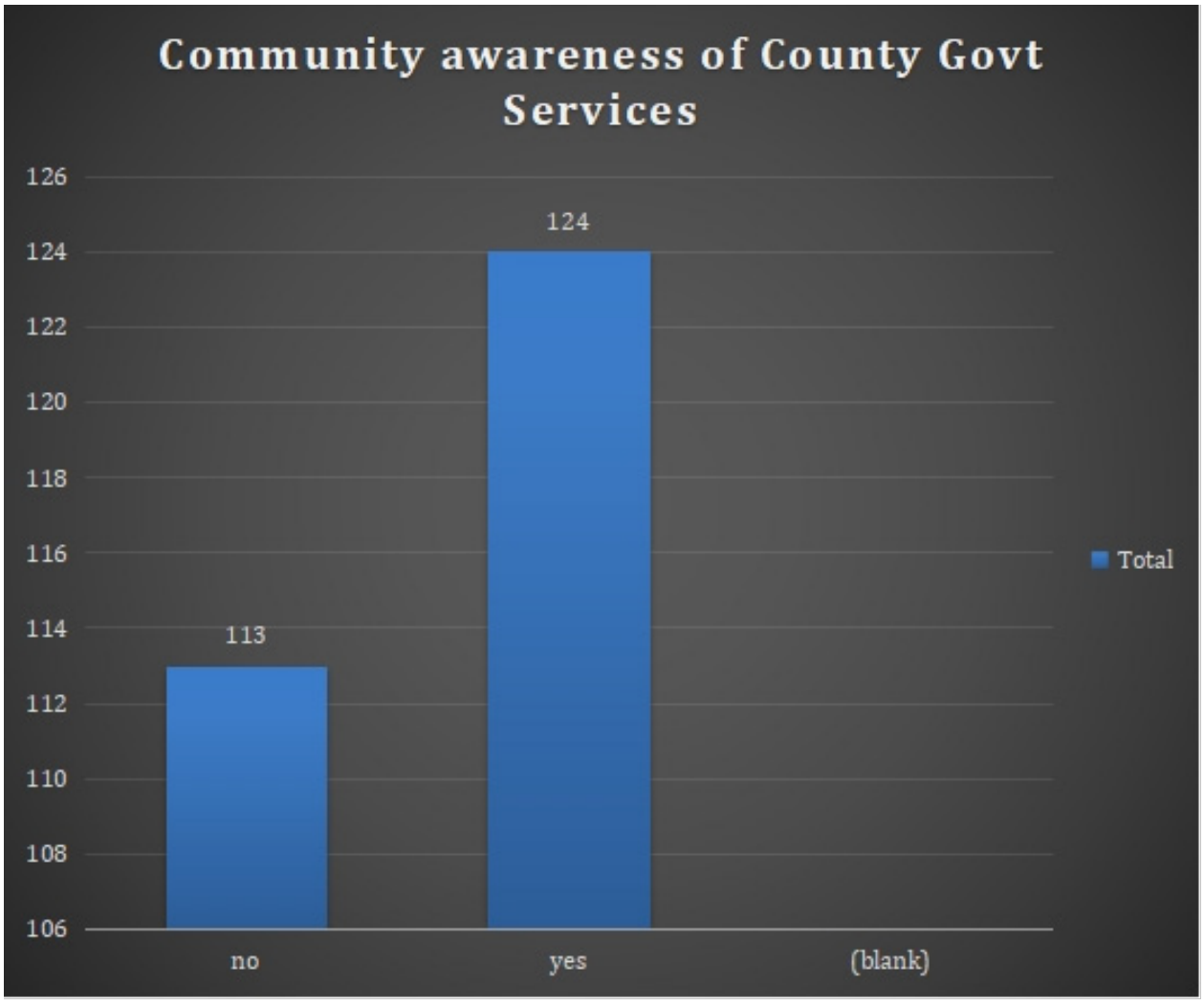
respondents noted that survivors seek the legal dispute resolution mechanism through the court or chief. On the other hand, 4 report the matter to the police and only 1 does not seek any form of support.

These findings provide some change of opinion comparable to observations at the baseline where police were rated as most helpful source at 73% (by 257 respondents), followed by Health care workers at 70% (by 246 respondents), religious leaders at 66% (230 respondents) and lastly chiefs at 65% (228 respondents).

In view of the above, community dissatisfaction with service from the chief and police is an issue that still obtains and the need to intervene on the same cannot be overemphasized. Cases of corruption that often lead to our court settlement were still being reported. Additionally, mishandling of survivors and/or persons accompanying them at the police was still evident with some of the respondents claiming that police are harsh.

Of equal importance for consideration here is community sensitization on the steps to follow in response to GBV acts. From the responses, there is fear that survivors spend a lot of time at preliminary levels (i.e. between chief and police), an issue that predisposes them to more harm, as they delay getting medical attention but also raising the possibility of loss/deterioration of GBV evidence. Of equal importance would be the sensitization of the police on GBV and supporting them to take up an active role in the same.

Figure 3. 6 Community Awareness of the services offered by County Government



Thirty-five (35) percent of the respondents reported awareness of GBV services offered by the county Government. However, 75% of them could not articulate the kinds of services offered. They merely explained the same to include provision of support services to survivors, provision of counseling and medical support/treatment, running GBV help/recovery centers, providing sponsorship/scholarship to GBV survivors.
Thirty-two (32) per cent of the respondents denied knowledge of any service being offered by the County Government claiming that most of the services are being offered by police and the chief. Majority of them (80%) plainly claimed non-awareness of any services being offered by the county Government. The remaining 33% of respondents did not commit any response.

This finding shows some level of improvement from the 30% reported during the baseline survey on the knowledge of County Government GBV services in the community. Despite this improvement, the need for further community sensitization remains critical. This is because generally only a third of the respondents seem to be aware of the service offered by the County. In a noted case, a respondent claimed that there is not even a single shelter for the GBV victims in the whole County. It will also be key not to forget the silent majority (more than a third of the respondents) who did not commit any response. Further follow ups on them will be important to establish whether they are unaware or their silence signified some dissatisfaction.

3.1.6 Community understanding of Sexual and Reproductive Health Rights

Responses from the community painted a picture of some level of familiarity (by at least 33% of the respondents) on what SRHR is, although most of their definitions were discrete. Among the definitions included the freedom to decide when to give birth, a state of physical, emotional, mental well-being in relation to sexuality, safe sex etc. The remaining respondents could either not define SRHR or their definitions were incorrect.

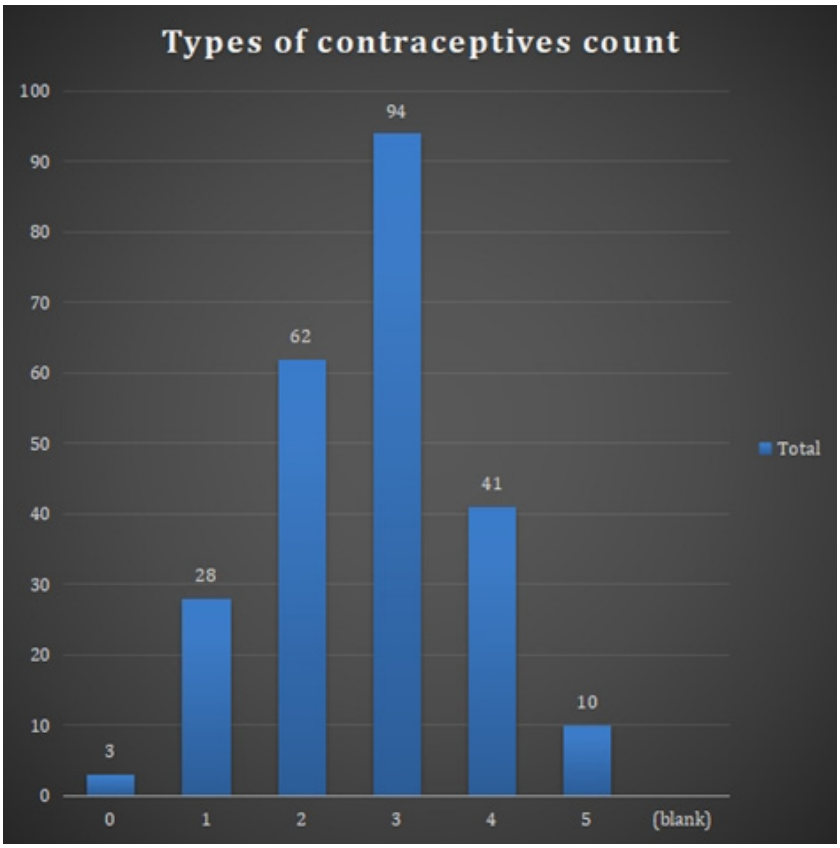
The key informants expressed correct understanding of SRHR; though with varied definitions, the respondents well-articulated the definition some of which included the right for citizens to know issues counselling, sexual reproductive health and their rights on the same, young people to be made aware of the same part of personal responsibility, right to be empowered to deliver the same as their role to educate the young people.

The finding shows that the community's level of awareness on SRHR has improved compared to the findings at the baseline survey. During the initial survey, a large proportion of the community could not explain what SRHR was. 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. The rest of the participants had no idea and/or could not comment because of their faith (church) affiliation. Despite this improvement, with two thirds unable to define SRHR, it is a call for continued public education.

3.1.7 Community definition/understanding of contraceptive

Despite their varied definitions, 72% of the interviewees could express knowledge of contraceptives.

Figure 3. 7 Types of contraceptive count



Some of their responses included methods used in family planning, preventing pregnancy, child spacing. The remaining respondents, however, could either not explain or failed to post any response

The respondents demonstrated knowledge of contraceptives. Asked on the type of contraceptive they know of, 10% of the respondent mention up to 5 types, 92% mentioned 3 types while 62% mentioned 2 types. The common types mentioned included Condom, pills, injection, diaphragm, sterilization.
On contraceptives pick -up points and contraceptive information, like the case above, all the respondents were aware of these places. The commonly mentioned pick up points included hospitals and dispensaries, pharmacies and chemists, chief's offices. Apparently, these were the same places mentioned as sources of information on contraceptives.

Observations from key informants noted that contraception services are available across all health facilities with some of the contraceptives (condoms) made available in public places and entertainment joints (guest houses and lodges). They underscored the need for heightened community sensitization.

An overall comparison of these findings with what was established during the baseline survey noted significant improvement at 72%. During the baseline survey, 65% of the respondents had no comments on contraceptives. However, some key areas for follow up including the section who could not tell what a contraceptive is signals some knowledge gap in the community which needs to be addressed.

3.1.8 Community's view regarding contraceptives

The views of the respondents on the above were very varied with a sizeable proportion, 37% expressing disapproval, 24% indicating that they are not necessarily bad while a few, 15% expressing the need for additional information/knowledge on contraceptives.

Those indicating disapproval

A total of 33% of respondents claimed that contraceptives are harmful, bad, and destroy the birth timing of a woman. They also felt that contraceptives are against religion with a few noting that they shouldn't be given to young girls under 18 years.

Those who were okay

These were 22% of the respondents. According to them, contraceptives were generally good, healthy and should be embraced.

A total of 25 of the respondents argued that they needed more information on contraceptives choosing not to say explicitly their views on the same. The rest of the respondents did not commit to give any response.

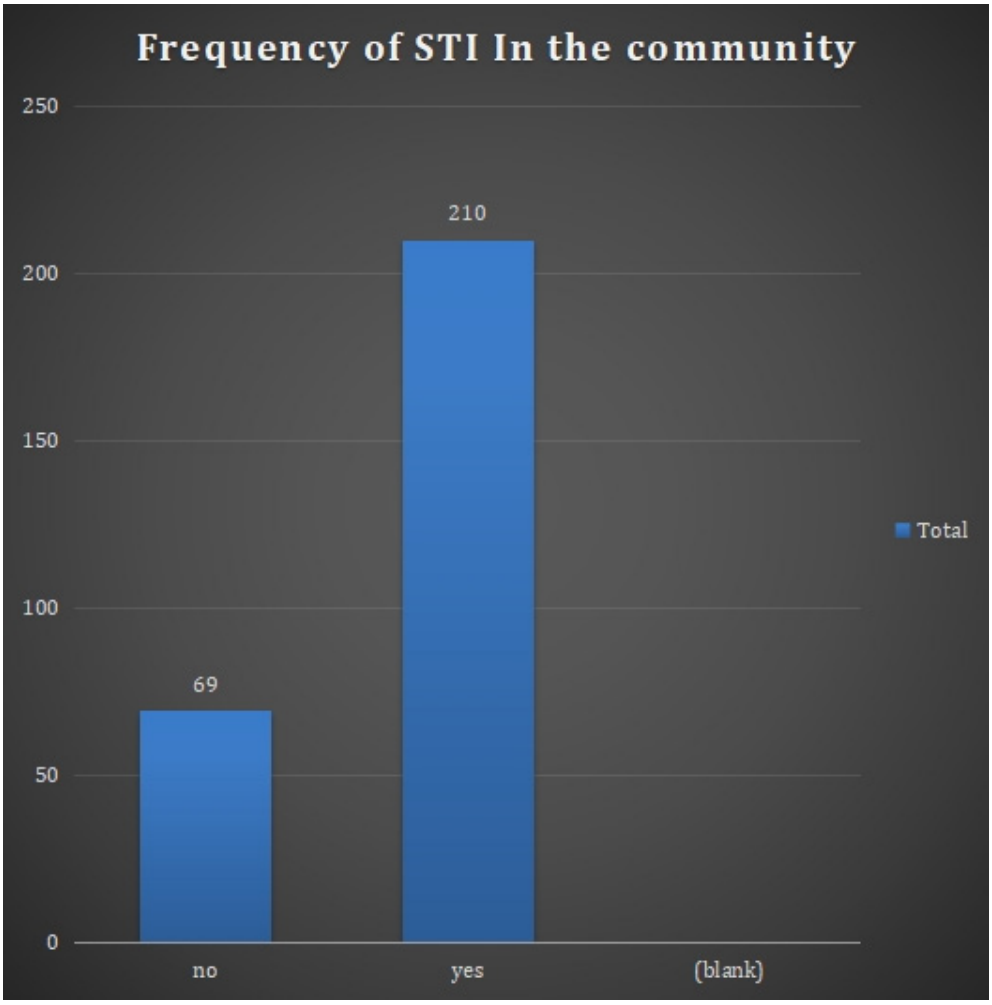
From the findings above, there is noted improvement on the community's familiarization towards family planning. Of most interest however is the need to ensure that misconceptions around the subject, as sighted above, are addressed for they could be attributed to low uptake of this service by the community.

3.1.9 Community's understanding and definition of STI

STI was defined by merely saying the abbreviation in full, as sexually transmitted infections. This was the response from 49% of the respondents. The other respondents could either not explain or give wrong definitions for STI.

It is encouraging to realize that a bigger section of the community (49%) compared to that during the baseline survey (25%) understands what STI is. At the baseline, the majority of the respondents (75%) had no comments while 10% were not sure of the prevalence. The rest of the participants felt that there are a lot of STI cases in the community while others felt that there were only a few cases in the community.
However, the mere definition of the abbreviation could call for more understanding as to what STIs entail; say some examples of STIs, how STIs manifest in terms of symptoms and/or complications, can be treated etc. This is of more importance to the section of the community who could not define the subject at all.

Figure 3. 8 Frequency of STI in the Community



Asked whether or not STIs are common in the community; 60% respondents responded in affirmation while the rest thought that STIs are not common.

When probed to justify their responses, 75% of respondents reported the presence of noticeable symptoms and complaints by suspected infected persons. Other reasons included the rise of adultery incidences and high HIV prevalence in the community. Those who felt that STIs are not common argued that most couples are faithful, they

have not heard or are not aware of any infected cases but also it was hard to know who is infected since medical records are confidential. A total of 115 of the respondents could not explain their reason for affirmation or denial of the existence of STIs in the community.

On sources of support for STI; findings from the survey noted high knowledge in the community of the places where support on STIs could be obtained. They largely mentioned hospitals, health centers, dispensaries and chemists as the most common. Noticeably few, 7% of respondents, unfortunately could not tell any sources of support for STI.

Asked what the community could do to enhance protection from STIs; abstinence, condom use, and being faithful to one partner were the most featuring ways reported by respondents. A few also noted the need for more sensitization on STIs.

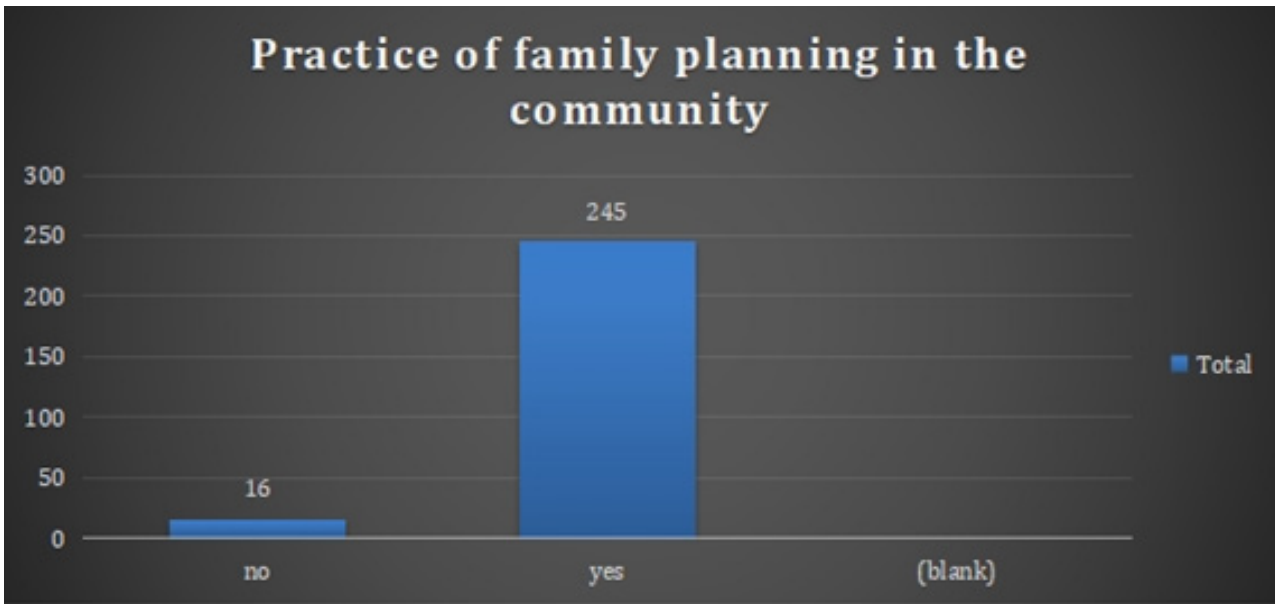
Additionally, sources from the key informants noted the availability of adequate services on STI treatment and prevention in the county. Notably were screening, treatment and counselling services that they claimed were available in the hospitals and Sub County Health Centers. According to them, through the Health services, treatment and prevention of STIs has improved -by sensitizing the community.

This is yet another area where some level of improvement was sighted compared to the observation at the baseline survey. Observations at the baseline noted 75% of the respondents having no comments on the subject as opposed to current where this percentage (75%) expressed familiarity of the subject, moving ahead to outline some of the STI symptoms. The community is now opening up on the presence of STI and also demonstrates awareness on the sources of support for the same.

3.9.1.2 Community definition and understanding of family planning

Majority (257) of the respondents were able to demonstrate some level of knowledge of family planning. These responses largely defined family planning as the process of controlling birth, child spacing, and planned birth. The rest of the respondents could either not explain what family planning was and/or chose not to comment.

Figure 3. 9 Practice of Family Planning in the Community

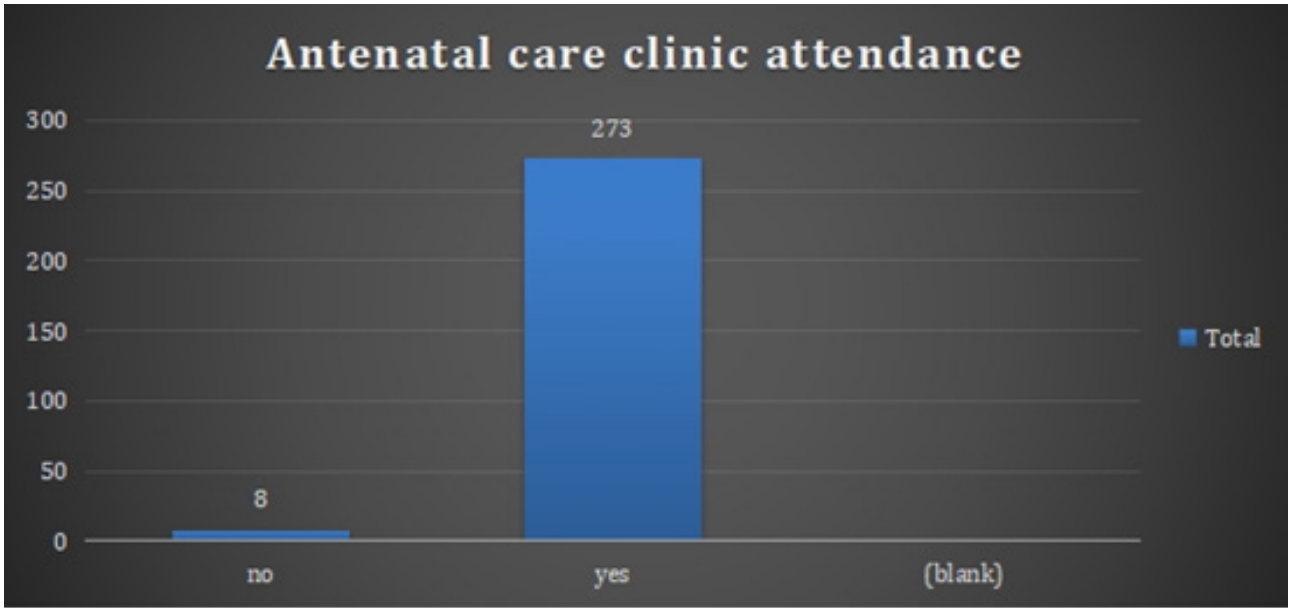


Whether family planning is practiced in the community was a question that was affirmed by the majority (261) of the respondents. Another 16 respondents denied the practice in the community while the rest decided not to comment.

Respondents had varied views on family planning but most (245) of which affirmed the practice; these included the need to provide better for a smaller family, to give time for children to grow well and healthy, to have time for a mother to recuperate and stay healthy. Other respondents who seemed not to encourage the practice attributed their reason to their faith; that religion did not allow the practice while others claim that there is nothing like child spacing.

To weigh in on the matter, the key informants noted that family planning services are highly accessible, and the County government has been putting in more facilities and that most health units are well equipped to offer maternity services. Overall community knowledge on family planning registered a rising level from 35% during the baseline to the current 74%. This could further be justified with their ability to mention some of the family planning methods.

Figure 3. 10 Antenatal Care Clinic Attendance



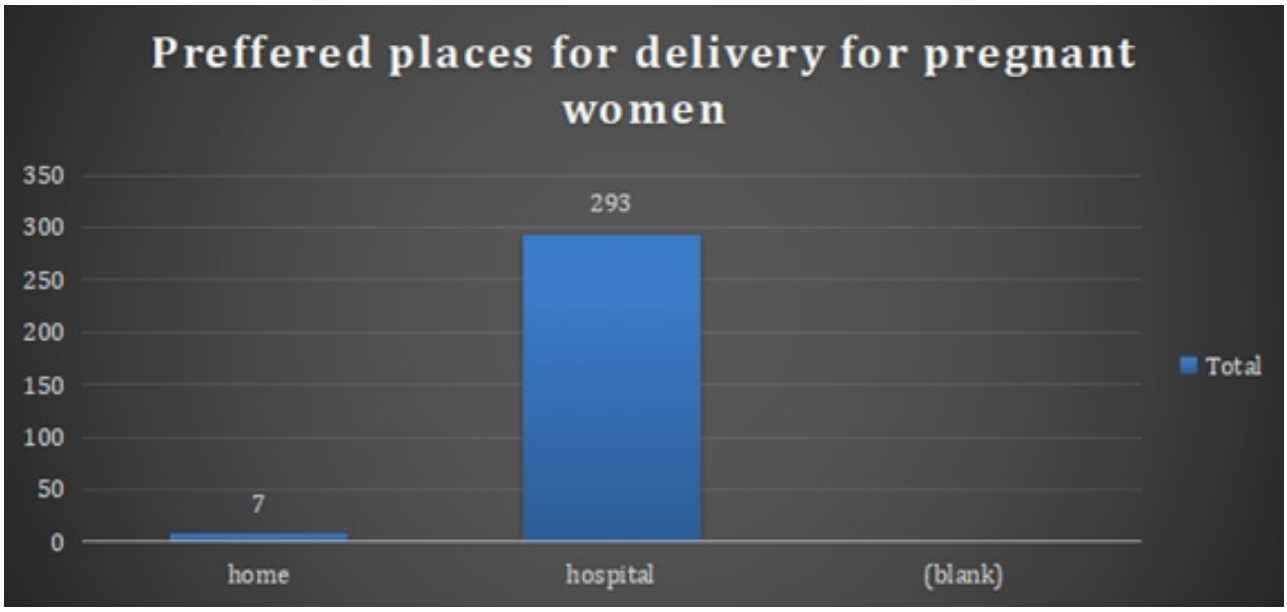
Around (273) of the respondents reported that pregnant women in the community attend antenatal care clinics while a small section of 8 reported that they don't attend. A section of the same further argued that most women only attend clinics in their third trimester. In explanation of what goes on at the clinic, the respondents mentioned broadly on medical and health education including checking on the health of the baby and the mother, knowledge on how to care for the unborn and themselves, and monitoring the development of the baby.

During the baseline, most (65%) of the participants 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. The rest of the participants were not sure on the availability and use of antenatal services in the community. Comparing this with the end of the survey where 78% of the respondents demonstrated familiarity on the subject, is a noted improvement.

The key informants observed that although the services are available, there is need for continued sensitization

to enhance attendance by expectant mothers. They decried the fact that most mothers attend in their late trimesters. The underscored the positive role played by CHVs in community sensitization but also suggested additional allocations of the commodities/services.

Figure 3. 11 Preferred places for Delivery for pregnant Women



The hospital was reported to be the most preferred place for delivery by a majority (293) of the respondents.

KEY INFORMANT RESPONDENTS 30
Name of institution

Figure 3. 12 Name of Institution

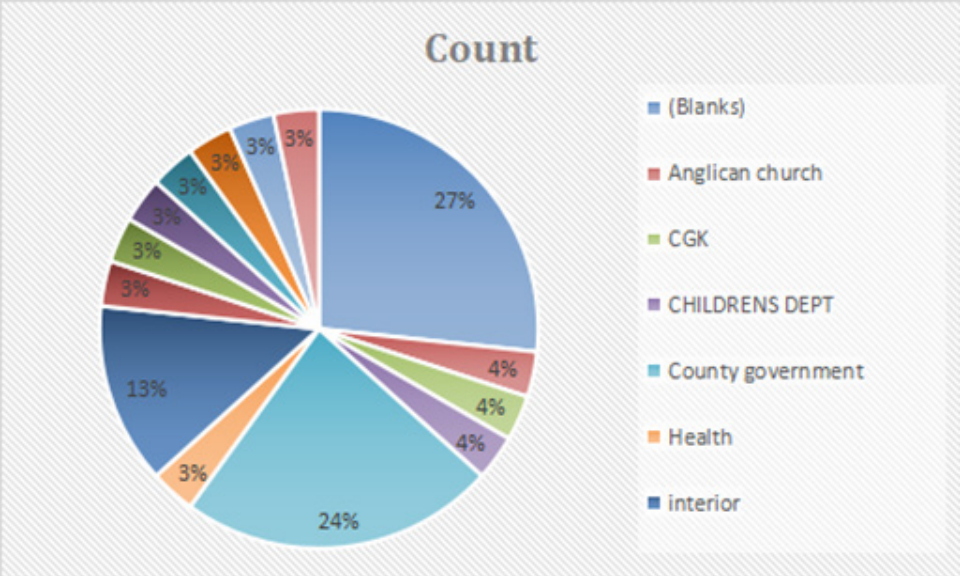


Figure 3. 13 Age

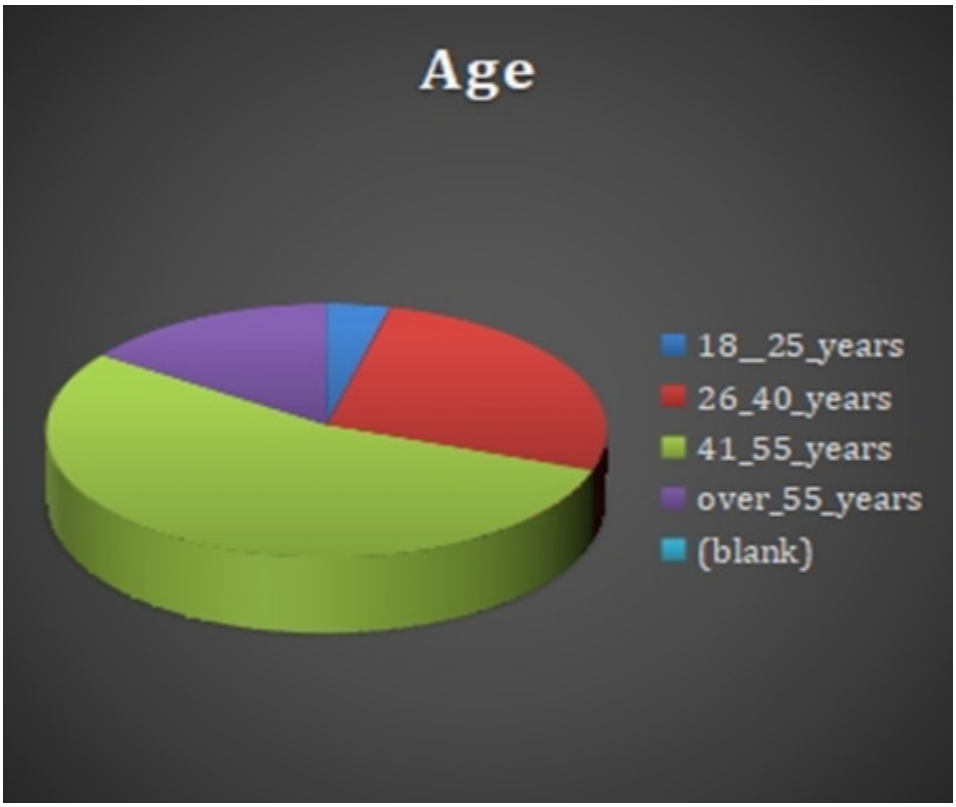


Figure 3. 14 Location

4.0 CONCLUSION AND FINAL RECOMMENDATIONS

Information gathered from relevant authorities on the subject under review and findings established both before and after the project, key achievements have been made and lessons drawn. These are summarized hereunder:

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 established improved community knowledge of GBV

Participants were able to define GBV but further outlined the sources of help/support for GBV survivors. They could also come out more openly to show that the practice is common. Incidences of denial (attributed to religion or non-familiarity of the subject) were fewer compared to what was gathered at the baseline. The **psychological dimension** of GBV however lacked in most of the definitions. An open **gender bias for GBV** being a challenge for women (only) still exists.

Sexual and Reproductive Health Rights is a subject that is slowly gaining grounds in the community. Survey findings established some level of familiarity by the community on the subject, especially through their definitions though not accurate. However, with some two thirds of the respondents unable not to define SRHR, sensitization remains vital.

Family planning & STI knowledge by the community has equally improved. Respondents were able to articulate what family planning and STI is. There were noted incidences of misconception on family planning which need to be clarified. Although most of the explanations of STI were merely the abbreviation, this was not the case at the baseline. The fact that a section of the same came out to say that STIs are common in the community attributing them to irresponsible sexual behaviors including adultery is an indication of community's readiness/potential to address the challenge.

Sources of help for GBV, Family planning & STI; Government departments including health institutions, dispensaries were mentioned as important sources of information. Personnel including the chief and police were equally sighted for the services they offer to the public. What remains important to be addressed is the lack of rapport between police and community (GBV survivors) and cases of corruption that were reported by a section of respondents. Apparently community knowledge on the services provided by the county government is much better than it was previously.

Recommendations

Community feedback mechanisms need to be put in place and/or strengthened. Evidence from the survey pointed to a section of the community which is aggrieved by the status quo. However, they may lack knowledge of where to seek justice especially where the same places that they ought to have gotten help are the ones exploiting them.

Ongoing community education and mobilization to address gaps in GBV, Family planning and STI information. The sensitization should be extended to government officials including the police and chief. Despite the presence of gender desks in some of these offices, their capacity gaps need to be addressed if the desks are to be of any positive effect to the community.

Improved justice systems; delayed/denied justice with cases of human rights violation (GBV) that go scotch-free were still evident from the survey. Out of court settlements, religious misconceptions of GBV which often result in silencing, and corruption in relevant offices were grievances that the community is still grappling with.

Holistic Stakeholder involvement; 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 same perpetrators who caused them atrocities is a great violation of human rights and the CSO community needs to intervene as a matter of urgency.

In conclusion, the survey observed a general improvement on community knowledge, perception and practice on the subject under investigation. Despite this improvement, some gaps are still obtained and thus the need for continuous stakeholder involvement beyond the project cycle.

REFERENCES

1. Betron and Doggett, 2006: Gender Differences in Relationships
2. COVAW 2017: Status of Gender Based Violence in Kenya
3. COVAW 2019: The Girls Advocacy Alliance Project- Kwale County
4. GOK: National Adolescent and Sexual and Reproductive Health Policy 2015
5. Kenya National Human Rights Commission 2012: Realizing Sexual and Reproductive
6. Health Rights in Kenya: A myth or reality?
7. Kenya National Gender and Equality Commission 2019: GBV Status, Kenya
8. Moving the Goal posts (MTGP) 2018: Situational Analysis on Sexual Reproductive Health and Rights for Female/Male In and Out of school from ages 9-25 years in Matuga Sub County (Kwale).
9. Population Council 2008: Addressing Sexual and Gender Based Violence Kenya
10. SRHR Alliance 2019: Working together to increase Access to Reproductive Health and Rights.
11. Word Bank 2019: Violence Against Women and Girl

Address: P.O. Box 367-80403, Kwale.
Kwale Town, Matuga Sub-County,
along Ziwani Street opposite the Kwale
Culture Hall Roads,
Email: info@thehijabimentorship.org
Tel: +254 (0)713 397 782