

**ASSESSMENT OF AWARENESS OF AVAILABLE GENDER BASED
VIOLENCE INTERVENTIONS AMONG WOMEN OF REPRODUCTIVE
AGE IN KIBERA SLUMS NAIROBI**

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Q139/CE/22273/2012

**A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF
SCIENCE (PUBLIC REPRODUCTIVE HEALTH) IN THE SCHOOL OF
PUBLIC HEALTH OF KENYATTA UNIVERSITY**

APRIL, 2021

DECLARATION

This thesis is my original work and has not been submitted in any other university either in part or as a whole.

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DEDICATION

To the Lord God almighty who has been my firm foundation and Ebenezer.

To my family for your prayers and support in every way. Thank you for the encouragement.

Special dedication to my dad who has been a source of strength but went to be with the Lord as I was just about to finish this project. Thank you for all the sacrifices made.

ACKNOWLEDGEMENT

Special thanks to my supervisors Professor Margaret Keraka and Dr Michel Mutabazi for the expert guidance through out this project from the beginning to the end.

I also appreciate the Kenyatta University Research Ethics Review Committee for approving my proposal.

My appreciation also goes to Dr Judy Mugo for her moral support and encouragement.

I wish to thank my lectures in this course for having taken us through the coursework.

I also appreciate the clients who agreed to take part in this study because without them this project would not have been a success.

My appreciation also goes to Dr Redempta Mutisya for your input during correction.

Last but not least the graduate school for having spearheaded our presentations despite the difficult times of covid 19 to ensure that the project was completed.

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ABBREVIATIONS AND ACRONYMS

AIDS	-	Acquired Immune Deficiency Syndrome
CBO	-	Community Based organization
CREAW	-	Centre for Rights Education and Awareness
FIDA	-	Federation of Women Lawyers
GBV	-	Gender Based Violence
HIV	-	Human Immunodeficiency Virus
ICPD	-	International Committee on Population and Development
IGWG	-	Interagency Gender Working Group
IJGO	-	International Journal of Gynaecology and Obstetrics
IPV	-	Intimate Partner Violence
IRC	-	International Rescue Committee
KDHS	-	Kenya Demographic and Health Survey
MDG	-	Millennium Development Goals
MOH	-	Ministry of Health
SDG	-	Sustainable Development Goals
SPSS	-	Statistical Package for Social Sciences
STI	-	Sexually Transmitted Infections
UN	-	United Nations
UNIFEM	-	United Nations Development Fund for Women
USA	-	United States of America
USAID	-	United States Agency for International Development
WHO	-	World health Organization

DEFINITION OF OPERATIONAL TERMS

- Gender :** These are roles that are socially constructed, attributes, activities and behaviors which the society considers appropriate for both men and women. Male and female are sex categories. Masculine and feminine are categories of gender.
- Domestic violence :** Use of threats which can be exercised physically, psychologically, and/or use of emotional violence. Any force used against individuals intended to inflict harm or to exercise power and control over them.
- Violence :** This is using physical power and force to threaten or actions intended to cause injury, psychological harm, death and mal-development or deprivation. This widens the conventional understanding of violence to include acts that result from a power relationship, threats and intimidating individuals.
- Gender based violence:** This is any physical force, coercion, verbal action or life-threatening deprivation, to a person due to her or his gender role in a society which can cause physical, psychological harm or to deprive liberty and cause subordination of an individual considered to be inferior to the perpetrator.
- Gender based violence interventions :** This is a systematic process of assessment and planning employed to remediate or prevent violence.
- Access to gender based violence interventions :** This is a right or privilege to successfully get or obtain help when an individual has suffered any form of violence in a facility that is assigned the role to provide the required professional assistance.
- Battering :** To hit heavily and repeatedly with violent blows.

ABSTRACT

Dealing with violence against women is key for achieving sustainable development goals (SDG) for equality of gender and empowering women and SDGs 3, 4 and 5. Globally, GBV prevalence accounts for 10-35%. In the year 2014, 45% of Kenyan women aged 14-49 years have reported some form of gender-based violence in their lifetime. About 29% of the women reported to have had experienced it in the previous year. About 16% of these women, reported sexual abuse and 13%, of them had it happen in the previous year. The study assessed awareness on available GBV interventions to women of reproductive age in Kibera. It also identified the types of interventions which were offered to survivors. Descriptive cross sectional study was used (which involved collecting and analyzing both qualitative and quantitative data) and this was conducted in Kibera slums. A sample size of 390 women of the reproductive age was conveniently selected from Kibera which has 13 villages hence 30 women from each village. The respondents were interviewed to obtain the required information using structured questionnaires which had both closed and open ended questions. SPSS version 20 was used for statistical analysis. Chi square tests was carried out to assess awareness of available GBV interventions. Descriptive analysis was used. This study confirms that there is a gap between the variable age where the p value is 0.001 which is less than the level of significance of 0.05 where the younger an individual is, the lower the level of awareness on available GBV interventions. The higher the education level, the lower the level of GBV as per the findings where the variable education had a p value of 0.001. The study found challenges in accessing health care for victims of GBV where survivors felt they could not report the perpetrators most of who were the breadwinners hence legal measures was the least taken form of intervention accounting for only 4.3% of the study participants had sought legal redress. Verbal abuse was the most rampant form of abuse accounting for 24.4%. A 49.1% of the interviewees did not seek any help for the abuse faced. About 10% of the interviewees had faced more than two forms of abuse. Sexual abuse accounted for 18.7% which is higher than what had been reported by KDHS in Kenya in the year 2014 which was at 16%. The rape cases were at 3.3% which is a higher number considering this was just done in one slum area in Kenya which when compared to South Africa that reported a prevalence of 11% of rape cases. Affordability of interventions, accessibility, acceptability of legal measures and cultural factors all have a p value of less than 0.05 meaning that these factors affect awareness of the available GBV interventions. Out of the clients interviewed, 28.7% were not aware about any type of interventions offered. The study also found that majority of the cases occurred from their partners or people within the household. Sexual harassment rate was high as well as verbal abuse accounting for 15.4% and 24.4% respectively. The findings of this study if applied will assist in raising awareness on the available GBV interventions in Kibera Slums.

CHAPTER ONE

1.1 Introduction

Gender-based violence is the most widespread, socially tolerated human rights violation in the world. It kills, disables and harms more people especially women. The violence can take many forms to include: physical, sexual, psychological and economic (UN Resources 2015).

The survivors suffer psychological and physical scars, but often do not bring it to the attention of family, friends, health workers or authorities either because of stigma, shame, the belief that nothing can be done for them, this can be perceived or real (UN Resources 2015).

1.2 Background to the Study

Worldwide, gender-based violence is quite prevalent with domestic violence being voiced as the most common (WHO, 2014). The WHO states that 35 percent of women in the world have had an experience once in a lifetime of either sexual and /or physical non-partner or IPV sexual violence (WHO, 2012).

Weatherburn (2011), states that various European countries have had a lifetime prevalence of IPV of between 10% and 36%. A WHO study done on multiple countries which studied women's health and domestic violence which was launched in 2005 and was the first of its kind showed that the prevalence of intimate partner violence increased by fourfold. This is from 80 to more than 300 in 2008 (Benagiano G, Carrara S, Filippi V, 2010). Another study which was based on prevalence of intimate partner

violence in more than 90 countries, revealed that some regions like the Middle East and West Africa having scarce data.

There are many initiatives that exist presently in order to address issues of domestic violence but the Kenyan communities have not yet managed to stamp out or reduce significantly the cases of GBV. This manifests as physical abuse and or sexual violence, to subtle violations like entitlements, verbal abuse and deprivation in the family (FIDA, CREAM, 2011). These were like giving low status society to the women, policies condoning violence, poor legal frameworks and ignoring the prevalence and this increases cases of domestic violence.

In the year 2000, Kenyan government developed the national gender and development policy which forms the framework to address several critical areas that includes; the economy, sustainable livelihoods, law, political participation and decision making, poverty, resource mobilization, education and training, media, population and health and policy implementation framework. The framework was to safe guard the welfare of girls and women's through provision of a safe ground so as to prevent as well as respond to gender based violence issues (FIDA, 2011) .

A study which was done in Kenya revealed that the discriminated women were unable to meet their basic needs and thus they are unable to take charge of their lives and sexuality. This then increases the possibility of them being mistreated causing life impingement about their social status, causing loss of control of reproductive rights, health and destiny (FIDA, 2011) .

Kibera slums was purposively selected because of its high prevalence of GBV,

especially sexual and physical violence against women.

A study done in Nairobi's Kibera slums, shows that 36% of the female residents reported of being physically forced to have sex (in comparison to 14% of all the Kenyan women) and more than 30% of women reported being forced to perform other sexual acts (in comparison to 14% of all the Kenyan women) (Jason and Chantal, 2015). This forms a baseline for comparison with the findings of the study. In Kenya however, access to GBV interventions have not fully met the needs of the women in our health facilities hence need to look into ways how the survivors of GBV can be helped. In Kibera we find that the victims of violence do not follow up especially the legal cases since they take time from a span of three years or more and this can also be costly to the victims who mainly rely on others for monetary help. Some of the survivors have also been affected by the violence physically hence constantly need to seek help from hospitals due to ill health which is quite costly (KDHS, 2014).

1.3 Problem Statement

Worldwide, at least one in every three women has been forced into sex, beaten, or abused by a man in their lifetime. About 20 % of women or more have reported being abused by the men they live with. Sexual and gender-based violence has impact in all areas of health and social programming: survivors of sexual violence have experienced increased rates of mortality and morbidity, violence increases HIV transmission, as well as other health conditions (IGWG of USAID, 2006).

In Kenya, the women aged 15-49 years about 45% reported having experienced various forms of gender-based violence in their lifetime out of these, 29% women reported

having had the experience in the previous year; 16% women had experienced sexual abuse in their lifetime, and 13% of the women had it in the previous year (KDHS, 2014).

The level of unawareness on GBV in the community is high and the service providers working around GBV also lack knowledge, we also have persisting cultural practices and socialisation of GBV thus significantly impairing prevention of GBV. There are weak programmes on GBV prevention and response at both national and county levels. This occurs due to limitations of geographic scope, short-term nature of the solutions, service providers are not well resourced and services for GBV survivors are varied in terms of quality.

There is weak partnership on efforts to prevent and respond to GBV that is evident through duplication of activities, inadequate use of existing data on GBV, and lack of correct monitoring and evaluation framework at both national and county level.

Slow Prosecution of GBV cases due to poor investigations, absence of legal aid to survivors, inadequate capacity and resources to law enforcement agencies that would enable to effectively discharge their mandate (Joint Programme on Prevention and Response to Gender Based Violence 2017-2020).

There is impunity in the government and society in treatment of GBV survivors which dehumanizes them since their concerns are usually trivialized by the society which is the main player both socially and economically. This hence increases the suffering of women physically and psychologically by battering, dispossessing, murdering, maiming and verbal abuse in intimate relationships which are violent (Annual report on the legal status of Kenya women 2011).

There is a higher rate of specific types of GBV in Kibera slums among women than in the Kenyan general population like in public places violence is reported almost 4 times more. A survey conducted in Kibera showed a higher rate of GBV among the women in Kibera than the general Kenyan population; leading to an urgent need for interventions in Kibera (Swart, 2012).

Due to lack of support to the GBV survivors, the chain of reporting to the healthcare and police, then the judicial process becomes slow, ineffective and lacks intergration. This then strengthens the perpetrators and thus increases the survivors' vulnerability (UN, 2006).

This study thus assessed awareness of available GBV interventions among women of reproductive age in Kibera slums.

1.4 Justification

The rate of violence in Kibera is almost as twice as high as that of the general population in Kenya. A survey conducted in Kibera showed a higher rate of violence in public places in Kibera slums among women is reported almost 4 times more than in the Kenyan general population. Few studies have been carried out on assessment of availability of GBV interventions among women of reproductive age in Kibera slums (Swart, 2012). This study thus identified education as a challenge for aimed at dealing with assesment of awareness of available GBV interventions by women of reproductive age in Kibera.

There lacks comprehensive national policy on GBV prevention and response. Few shelters and safe houses have been established and limited coordination of stakeholders working on GBV prevention and response. The health, security and justice sectors have limited capacity and resources to effectively respond to GBV and implement anti-GBV programmes. Inadequate focus on programmes that address GBV in the public and private sectors. Enforcement of legislation to curb GBV due to lack of a policy framework is limited. Weak data management and a poor monitoring and evaluation framework for GBV management. Weak utilization of existing research to inform policy and programming. Rehabilitation and reintegration programmes targeting GBV perpetrators is limited. Misconception that GBV unduly focuses on girls and women at the expense of men and boys. We have low documented evidence on what works for primary prevention in the country as well as interventions (National Policy for Prevention and Response to Gender Based Violence November, 2014).

Hence the study findings will enable policy makers to make informed decisions when formulating policies on how to improve availability of GBV intervention.

1.5 Research Questions

- i. What are the types of GBV reported among women of reproductive age in Kibera slums?
- ii. What are the types of GBV interventions offered to women of reproductive age in Kibera slums?
- iii. What is the level of awareness on the GBV interventions available to women of reproductive age in Kibera slums?

- iv. What are the factors associated with awareness availability of GBV interventions among women of reproductive age in Kibera slums?

1.6 Hypothesis

- i. There is no association between socio-economic and socio-demographic factors and awareness of available GBV interventions.

1.7 Objectives

1.7.1 Broad Objective

To assess awareness of available GBV interventions among women of reproductive age in Kibera slums.

1.7.2 Specific Objectives

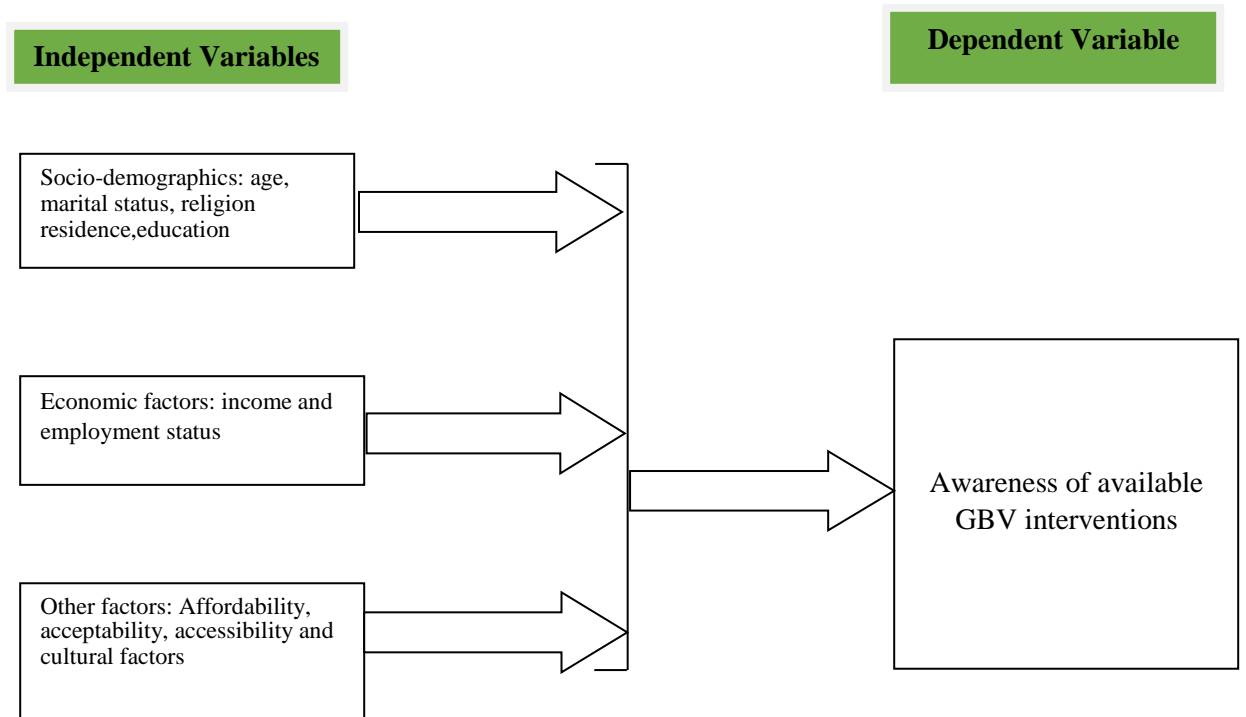
- i. To identify the types of GBV reported by women of reproductive age in Kibera slums.
- ii. To identify the types of GBV interventions offered to women of reproductive age in Kibera slums.
- iii. To determine the level of awareness on the available GBV interventions among women of reproductive age in Kibera slums.
- iv. To determine the factors associated with awareness of available GBV interventions offered to women of reproductive age in Kibera slums.

1.8 Significance

This study was important as it was able to fill the purpose of family income, age and education associated with reduced awareness on the available GBV interventions for

women of reproductive age in Kibera. This hence will be useful to make policies by policy makers hence reduce the low turn out so as to access the available facilities.

1.9 Conceptual Framework



Source: Westoff and Ochoa (1991)

Figure 1.1 Conceptual Framework

1.10 Theoretical Framework Summary

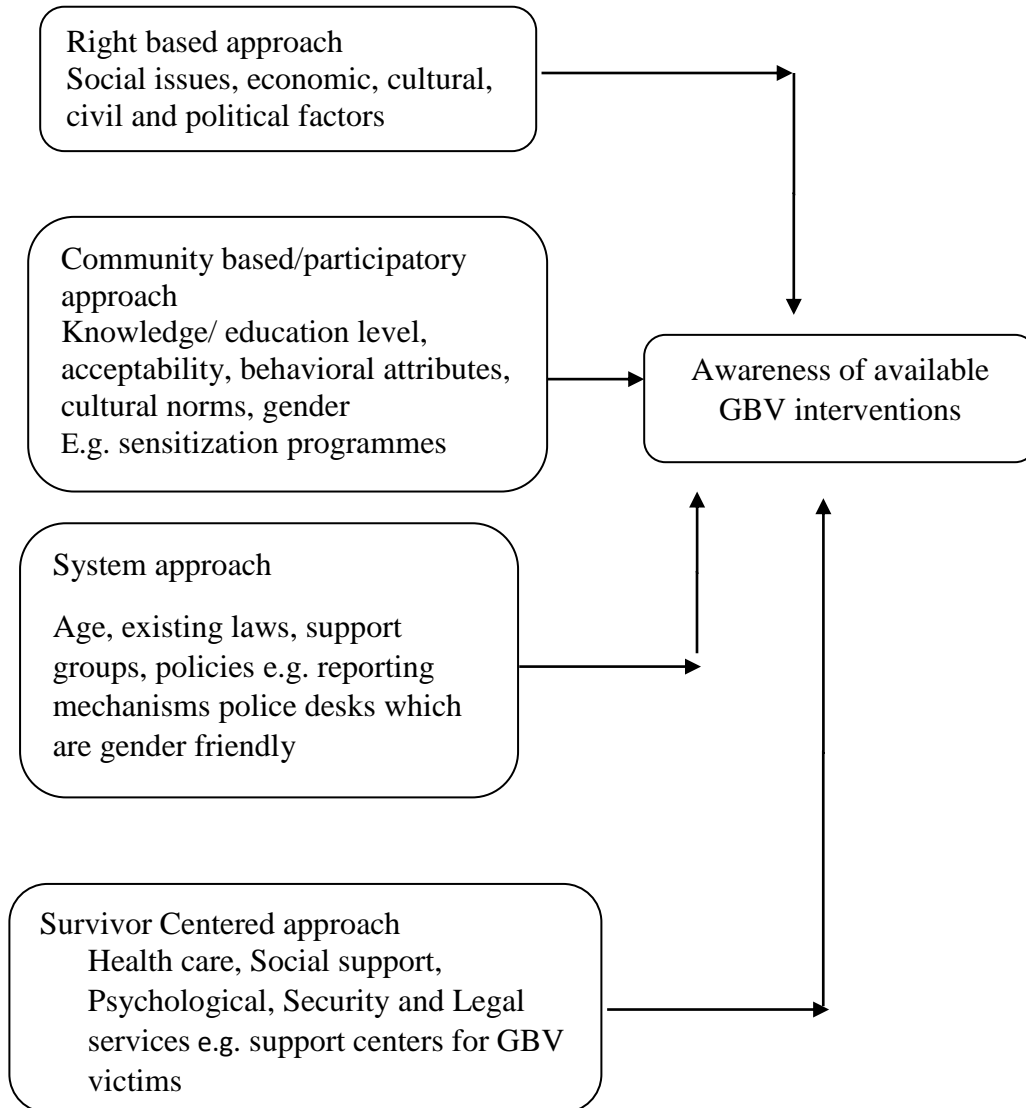


Figure 1.2 Theoretical Framework

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Gender-based violence (GBV) is a human rights concern worldwide and a public health concern (WHO, 2010). GBV is also known as domestic violence in the family. It affects the social, economic and gender issues.

Violence against women is a serious public health problem, as shown above. It impacts on ability of individuals in achieving the highest attainable health standard both in the physical and mental aspect. It impinges on human rights and women's reproductive rights as stated in the International conference on population and development (ICPD). Violence against individuals usually is complex and driven by many factors at various levels which include: the individual woman, family, perpetrator, and the community (Washington DC Internationa Journal, 2009).

A study by Marianne *et al* (2010), states that there many consequences of violence which cause devastation to a woman's health and life as well. These affect the sexual and reproductive health issues and human rights. Violence against women may take many forms to include; physical, emotional and sexual. It may occur in the homes, community, or institutions of the state. These can be perpetrated by strangers, acquaintances or intimate male partners. Sexual violence is exacerbated more by poverty, disaster or conflicts and knows no geographical, ethnic or cultural boundaries (WHO, 2014).

World Health Organization defines it as the intentional use of physical force, threats, power or actions that can cause injuries, death, mal-development, psychological harm or deprivation. When "power" is used, this broadens "the understanding of violence which include actions that may result from power relationship, threats and intimidation" (WHO, 2010).

The impact of GBV is felt in every sector in all countries including; health, social, economic and education sectors affecting the country's ability to achievement of the development goals. The toll of violence on women's health worldwide exceeded that of road traffic accidents and malaria combined (WHO, 2012).

In Tanzania, 47% of ever-partnered rural women have already experienced physical violence by their partner, 31% have also experienced sexual violence (WHO, 2010). GBV is inclusive of verbal, life-threatening deprivation or physical force, coercion which is directed to an individual woman/girl leading to physical or psychological harm, humiliating her, or arbitrary depriving her of liberty aimed at making her to become subordinated to the perpetrator (Ansara and Hindin 2009).

GBV is defined as threatening an individual or use of physical and/or emotional violence to exercise psychological control. It is also force against a person intended to inflict harm, controlling and exercising power on them. Perpetrators usually know the survivors "domestic environment": They maybe an intimate partner, spouse, former intimate partner, friends, family member or acquaintances (MOHP, 2012).

In Asia mostly, about 60 million women, are "missing". They are killed using abortion, infanticide, or deliberate mal-nutrition as well as denying them access to health care

(WHO, 2010). Each year, about 2 million girls between 5 to 15 years are introduced to commercial sex industry by human trafficking. Women who are victims of domestic violence are 12 times more likely to attempt suicide than the women who have not experienced violence (UNFPA, 2012).

So as to achieve the Sustainable Development Goal (SDG) 3 which deals with women's empowerment and gender equality as well as SDGs 4 and 5 it is key that we address violence against women (WHO, 2011). Many women experience psychological and/or physical violence in their intimate relationships which causes serious health problem to them (WHO, 2010).

A study by Sanjel (2013) shows that the magnitude of violence is not documented but can only be assumed, since the women who are affected hardly talk of their experiences and hardly ask for help. This is due to shame, fear or guilt, family tradition and perceptions of marriage. Notifying the police is rare in domestic violence cases which makes the unknown cases estimate to be high since most of the cases are unrecorded and the epidemiological data which is reliable is scarce.

The most common forms of GBV is domestic violence. It is estimated that 10 to 35% of women have experienced it once in their lives. Police are rarely notified by survivors of domestic violence. This causes the estimated number of unknown cases to remain high but most remain unrecorded making the reliable epidemiological data to be scarce (Jamieson, 1999).

A study done by WHO in 10 countries having diverse cultures, and in different geographical regions in urban/rural settings (Ethiopia, Bangladesh, Peru, Brazil, Japan,

Namibia, Samoa, Thailand and Tanzania, Serbia and Montenegro), stated a high rate of violence against women by the intimate partners, Weatherburn (2011).

GBV has progressively eroded social and human capital causing individuals to succumb to consequences. Other indirect costs of GBV include value of foregone earning caused by absenteeism and fear for seeking economic opportunities. Due to the insufficient attention which has been given to GBV in Kenya, there has been significantly delay in realization of the vision 2030 goals (USAID, 2009).

2.2 Forms of Gender-Based Violence

Physical abuse such as hitting, slapping, destroying of her property, biting/ shoving, using weapons or other objects that threaten or hurt her, denying her access to get health care. Emotional/ psychological abuse like threatening to take children from her. Verbal abuse like name calling and biting or shoving by your spouse.

Sexual abuse like being forced into unwanted sexual acts, forcing her to get pregnant or abort or infecting her with STI. Spiritual abuse like belittling her faith, denying her the freedom of attending the place of worship of her choice. Economic abuse like limiting her access to the family finances, denying her funds and basic needs, also by controlling her access to health care as well as employment, denying her to participation in making economic decisions. Forced marriages, women trafficking and female genital mutilation and (Marianne, 2010; MOHP, 2012; Sanjel, 2013 & Weatherburn, 2011).

2.3 Magnitude of Gender Based Violence

GBV can occur in different forms like sexually, psychologically and physically among others. This is a global problem affecting all stages of a woman's life cycle (Christina, 1994).

In the world, one in every three women has faced some form of violence in their life time even in childhood. Some cases led to serious injuries or death about one to two third of them were 15 years or less (WHO, 2005).

JAMA (1999) did a community based survey in the developed countries and the prevalence in USA showed that at least 20% of the adult ladies, 15% of those attending colleges, 12% adolescents had an either experienced sexual abuse or assault during their lives. These teenagers that participated in the study who were about 21-38% were involved in a relationship which was either physical or sexual.

In USA, a random survey done on women in Barbados, Netherlands, Canada, Norway and New Zealand showed that 27 to 34% were abused sexually in childhood (Handwerker 1993). Researches done in several nations on sexual assaults prevalence in women attending colleges showed rate of between 19% and 27% of violation which is high. The women who were surveyed in Canada, New Zealand, UK, Korea, and USA reported being survivors of attempted or completed rape cases during their lifetime. Five institutions including Costa Rica university students showed that 32% women had report sexual abuse in a retrospective study (Handwerker 1993). A national survey done in Switzerland on 3,993 girls who were aged 15-20 years in professional training and schools showed that 19% of had reported sexual abuse (Swiss, 2010).

A study done by WHO in several countries, showing a prevalence of physical or/and sexual violence the lowest was in Japan at 5%, Peru had 61% and highest was in Ethiopia at 71%. Non-partner physical violence was also highest in Samoa at 62%, in the city it was at 32% and the province and Peru at 28% (WHO, 2011).

The prevalence of GBV in Sub-Saharan Africa was between 20-71% (Heise *et al*, 1994). A Nigeria study revealed 15% young women had reported being forced to penetrative sex and 27% reported attempted rape, 44% reported unwanted touches. A study which was done in Cape Town, South Africa on adolescences showed 11% of rape cases and 72% reported to have had forced sex. A survey also done in other areas of South Africa showed there was a high incidence of forced sexual initiation of young ladies of 28 to 30%. Another survey done in Southern Johannesburg on young women also showed 20% of them reported sexual abuse cases by the eighteenth birthday (Andersson *et al*, 2000). A study retrospectively done in 2006 on young women aged 18 to 24 years from Kenya, Uganda and Ethiopia showed that majority of these young women were sexually abused before their eighteenth birthday, 85.2% in Kenya, 95% in Uganda and 68.5% in Ethiopia (Africa Forum 2006).

2.4 Sites of Gender-Based Violence

2.4.1 Family

Can take many forms including confinement, forced marriage which is arranged by members of the family without her giving consent, threats, neglect and insulting her. If a woman's sexuality is controlled by forcing her to become pregnant or to abort

against her will. Violence occurring in the family and household is treated as a 'private' issue making this information to be scarce (Ansara, and Hindin, 2009).

2.4.2 Community/Society

Occurs in the family structures and power inequalities that affect the family and society. Workplace like in the governmental offices or business premises, women tend to be more prone to sexual aggression and commercialized violence for example, "trafficking women for sexual exploitation" (Ansara and Hindin, 2009).

2.4.3 State

Legitimizes the inequalities hence increasing GBV by enacting discriminatory policies, laws or by discrimination during the applications of the law (Ansara and Hindin, 2009).

2.5 Factors influencing Gender Based Violence

There is no single cause that can be pointed out as the cause of GBV but there are several risk factors as follows:-

2.5.1 Alcohol and drug use

Violence is increased in intimate partners relationships due to the behavior of the partner which increases aggression and controlling behaviors (Deardon and Payne, 2009).

Alcohol increases the chance of domestic violence. Mouzos and Makkai (2010) found out that between 2000 and 2006, 44 % of the intimate-partner homicides were also alcohol abuse related.

2.5.2 Child abuse

When an individual has had childhood experiences of violence, such women in their adulthood have one and a half times likelihood of experiencing violence. A child at the age of 15 years who has experienced violence or abuse increases their risk as adults. If a woman has experienced physical abuse, she has a two times likelihood of experiencing violence from her partner. Survivors of child sexual abuse usually report violence three times more than other people (UNIFEM, 2009).

2.5.3 At risk group

With low education status the chance of a violent partner increases. The 4% of the unemployed and the employed or not in the labor force. Women relying on pensions and allowances as their source of income source are more likely to stay in violent relationships due age, physical location, social status, disability and ethnicity (UNIFEM, 2009).

2.5.4 Younger women

The roles that gender ascribes to young women are a key factor to increasing vulnerability to violence due to inexperience, age difference and lack of access to services which makes their problems complex (UNIFEM, 2009).

2.5.5 Indigenous women

The preferred term by indigenous communities for GBV is 'family violence'. This includes all forms of violence in the family and intimate relationships and other relationships due to mutual obligation and support. Victimization is hidden from the

police and nondisclosure is higher with indigenous communities than non-indigenous (UNIFEM, 2009).

2.5.6 Women living in rural and remote areas

They experience violence but hardly disclose because in rural and remote areas, there is social control and limitation of informal sanctions and self-reliance. Women tend not to discuss family issues since they think this brings shame to their families (UNIFEM, 2009).

2.5.7 Women living with disability

Their full extent of violence is unknown but there is evidence which shows that it is higher than in other populations. They are more vulnerable to all forms of violence due to their increased dependence, social and cultural disadvantage. This includes removing of their accessibility devices, denying them their treatment and threatening them with taking them to institutions for confinement. Those with psychiatric conditions are at a higher risk of being sexual assaulted and exploited. The main caregivers are the ones who cause victims to suffer neglect, isolation, increasing their vulnerability to abuse; thus the victims fail to get help (UNIFEM, 2009).

2.6 Health consequences of Gender Based Violence

UNIFEM (2009), reveals that violence is associated with negative outcomes in health which can be mild or severe like fractures and damaged ears and eyes which may be permanent or chronic pain syndromes like pain in the pelvis, depression, mental health issues, eating disorders, anxiety, sexual and reproductive health problems like STIs and

HIV/AIDS, unwanted pregnancies which can result from sexual assault and rape. When women are unable to request or negotiate for safer sex using condoms due to actual violence, this increases the risk of unwanted pregnancies which leads to unsafe abortion, causing gynecological problems (IJGO, 2009). Half to two-third murders of women are as a result of violence by intimate partners (Beaver, 2006).

2.7 GBV Responses

2.7.1 Health sector responses

Most cases are mainly of sexual violence in nature, this makes the other forms of GBV to be classified as normal medical injuries. This masks the gravity of GBV the magnitude and character. The consequences to the survivors are not identified and may require attention and support to follow up the victims. The GBV health infrastructure in national and referral hospitals is well developed, but very poor at lower levels of the health facilities level where most GBV cases are reported (IRC, 2014).

2.7.2 Legal sector response

Most survivors do not press charges due to the pressure from their community. This affects the ability of the judiciary to deter GBV. Existence of enforcement laws like the Penal Code, Sexual Offences Act and FGM Act is usually weak. Victims give up since this takes time and can take up to 3 years and there are cost constraints leading to collapse of cases (IRC, 2014).

2.7.3 Community based efforts

Gender based violence organizations, like the CBOs increased after the post-election violence of 2008. This led to establishment of informal justice systems all over the counties but most are male-dominated. Most of the survivors reported the cases to the village elders and relatives, police are seen as a last resort. Perpetrators are arrested but parents usually decide to negotiate an out of court settlement (IRC, 2014).

2.8 GBV Intervention Approaches

2.8.1 Guiding Principles for all GBV Interventions

The GBV strategy lies in providing services for GBV survivors. The GBV Sub-sector aim is to ensure services are accessible, confidential, prompt and appropriate to survivor needs, wishes and decisions, and available in locations where there is need. GBV survivors need comprehensive and systematically addressing of various needs of a survivor. This may need different sectors for assistance. Hence a multi-sectoral model is used for holistic interventions that involves inter-agency collaboration and coordination across key sectors, including (but not limited to) psychosocial, health, legal/justice and security. They include GBV prevention, coordination response, and advocacy adhering to the following guiding principles:

2.8.2 Right based approach

This is important in GBV, and cannot be addressed when we have not worked on basic gender equality. It involves analysis of the root cause of the problem. When an avenue

for their voices is heard, it enables people to rebuild and develop solutions (UNFPA, 2015).

2.8.3 Community based/ Participatory approach

This involves decision making, accommodating the views of a community and ideas to develop programmes that prevent GBV. This is used to developed and change communities positively.

2.8.4 System approach

This is a result oriented system which is geared towards preventing GBV. Policies are made at national and international levels so as to safe guard the rights of vulnerable people.

2.8.5 Survivor centred approach

Survivors are empowered by improving access to appropriate, acceptable and good services e.g. health care, legal services and security, psychological and social support. This includes safety, confidentiality, respect, non-discrimination of the survivors. (UNFPA, 2015).

2.9 Risk factors for limited availability of GBV Services

Inconsistent efforts and inadequate resources as well as lack of access to funding indicating a lack of political will and and lack of a comprehensive and integrated approach limits access to GBV interventions at facility level.

Sexual exploitation and abuse by humanitarian workers is accepted and hidden. Lack of capacity (medical, legal, psychosocial). Laws in the country regarding abortion, emergency contraception, are not well known by the community. Not relevant in comparison to other problems like drought.

Failure to end impunity, the intersection of multiple forms of discrimination, lack of evaluation and understanding of GBV at community leadership level.

GBV being a taboo, not a priority in being a life saving issue, lack of data in terms of it doesn't happen—on populations affected, under reporting (“not in my community”) Myths versus Facts not well known by individuals and family members.

2.10 Gaps the researcher aims to bridge

The reporting of cases of GBV should be improved since most go unreported due to lack of confidence in our health care for follow up of the GBV cases as well as delay of justice. This will reduce stigma.

Aim at prosecuting of perpetrators GBV since most of them are let to go free because their family members are not willing to hand them over to authorities because most of them are breadwinners.

Aim at improving awareness to the community on the available services for survivors of GBV .

Aiming at facilitating community initiatives to prevent GBV through involvement in community watch programmes to report cases which they may come across.

CHAPTER THREE: MATERIALS AND METHODS

3.1 Introduction

The Kibera slums was purposively selected because of its high prevalence of GBV, especially sexual and physical violence against women. It is also a cosmopolitan site providing a unique setting. The site provides an extremely good site where such issues are not only a priority but can easily produce results that can be generalized to other similar areas.

The proximity of Kibera slums to the researcher was a justification for the research site. Doing the study elsewhere would have caused financial strains and could have probably put the researcher to other disadvantages like language barrier.

3.2 Research Design

A descriptive cross sectional study design was used in this study where data was collected which enabled the researcher to look into the problem, define it, clarify it, and obtain information which was useful for the study. This used a mixed method where both qualitative and quantitative data was used. The methodology for this study consisted of development of questionnaires, data collection, quality control of data, data processing and ensuring ethical values.

3.3 Variables

3.3.1 Dependent variable

Awareness of available GBV interventions

3.3.2 Independent variables

These include socio-demographics of the women of reproductive age to include: age of the interviewees, their religious background, residence, marital status. The economic status including source of income and the employment status. The affordability, acceptability, accessibility of the interventions and cultural factors to include men being allowed “to discipline their wives”, have polygamous marriages and inheritance of wives.

3.4 Location of the Study

The study was conducted in Kibera slums in Nairobi County. Kibera Slums is also the second largest slum in Africa. Kibera is located approximately 5 km south east of the city centre in Nairobi. Nairobi County location is at coordinates 1°17'S 36°49'E covering an area of 696km² (269 sq mi) and has a height of 1,661m above sea level ([http:// www.city-data.com](http://www.city-data.com)). The Nairobi County has a population of 3,138,295 (KDHS, 2014). The Kibera population is about 170,070 people living in 131,901 households (KBNS, 2010). It has 2,000 people per hectare and the settlement covers approximately 250 hectares. Out of these 48% are males while 52% are females. The Kibera slums has 13 villages namely ; Makina, Gatwekera, Lindi, Kisumu Ndogo, Mashimoni, Kianda, Silanga, Kambi Muru, Soweto West, Soweto East, Laini Saba, Kichinjio and Raila.

3.5 Study Population

Reproductive age women, aged 14-49 years in Kibera slums. The population for women is 52% hence women population is 88,437.

3.6 Sample Size Determination

The sample size was calculated using Kothari et al, 2004 as follows: using p of 0.45 as per KDHS (2014). Where p is the prevalence of gender based violence in Kenya which is at 45%.

$$n = \frac{Z^2 P(1-P)}{d^2}$$

$$d^2$$

$$n = \frac{(1.96)^2(0.45)(0.55)}{(0.05)^2}$$

$$= 380.3184$$

$$\text{Corrected } n = \frac{n}{1+n/N}$$

$$\frac{380.32}{1+380.32/88,437}$$

Kibera has 13 villages hence to get a sample from each village: $380.32/13=29.3$.

Hence 30 participants from every village.

Thus, 30 participants were recruited for the study from each village this ensured an equal representation from each village. Convenience sampling was used to attain the sample size desired as GBV depends on many factors but is not a stand alone factor.

3.7 Sampling Techniques

The sample population was obtained using convenience sampling due to the sensitivity of the subject at hand and security issues since the area is insecure. According to the national population census report, the population of Kibera was 170,070 people

living in 131,901 households (KBNS, 2010). It has 2,000 people per hectare and the settlement covers approximately 250 hectares. Out of these 48% are males while 52% are females. Respondents were picked from women of reproductive age in the 13 villages of Kibera. A sample size of 390 with 30 respondents from each village. Selltitz et al (1959), principle which states that one simply reaches out and takes the case at hand until the desired sample is attained was used.

3.7.1 Inclusion Criteria

Women in Kibera slums of reproductive age and those that willingly gave informed consent for the study.

3.7.2 Exclusion Criteria

The study excluded women who did not give informed consent or assent for those aged 14-17 years and those that did not give responses to questions asked.

3.8 Construction of the Research Instrument

The study employed researcher administered questionnaire. The questionnaire was constructed using both closed and open ended questions. The questionnaire was used to gather both quantitative and qualitative data. The questionnaire was divided into 3 sections. This study relied on self-reports from the respondents as these are useful and valid source of information. Questions were read by the interviewer.

3.9 Pre-testing

It was carried out on randomly selected respondents of women of reproductive age in Mathare slums. The findings of the analysis was done which addressed any ambiguity and the tool was improved.

3.10 Data Collection Technique

Researcher administered questionnaires which had both quantitative and qualitative data was used which is a mixed method using close and open ended questions to obtain better findings. Integrating quantitative and qualitative approaches helped reduce the chances of bias while at the same time maximizing the quality of data.

3.11 Data Analysis

All the completed questionnaires were assessed and then categorized before coding. Data was collected and entered into the system by recording and version 20 of SPSS was used for statistical analysis. Descriptive variables were presented as means and as percentages. Proportions and frequencies were determined characteristics of the respondents were presented in tables. Chi square tests were done using the P-value of 0.05 and a 95% confidence interval. Since the data was mainly descriptive, the researcher presented the findings in tables to ensure readers understood the report. Correlation coefficient and chi-square tests were used to identifying the baseline client's characteristics in relation to the variables (Brink, 2006 and Annan, 1999).

3.12 Logistical and Ethical Considerations

Clearance was sought from: Research Ethics Review Committee, Kenyatta University, National Commission For Science, Technology & Innovation, Kenyatta University Graduate School and approval from Nairobi City County for the research. Consent was also given to the participants which was signed upon agreeing to participate in the study for those above 18 years and assent for those between 14-17 years. There was maintainance of confidentiality for the all respondents through identifying them using by numbers but no actual names were used.

CHAPTER FOUR: DATA ANALYSIS

4.1 Introduction

This chapter presents the analysis of the data that was collected. The study sought to assess level of awareness on the available GBV interventions among women of reproductive age in Kibera. The researcher analysed 390 questionnaires.

4.2 Socio-Demographics of Respondents

Table 4.1 below shows the socio demographic characteristics of the respondents who were interviewed.

Table 4.1 Socio-demographic characteristics of the respondents

	Category	Frequency	Percentage
Age	15-24	65	16.7
	25-34	206	52.8
	35-44	108	27.7
	45-54	11	2.8
Marital status	Single	69	17.7
	Married	207	53.1
	Cohabited	65	16.7
	Divorced/separated/widowed	49	12.4
Education level	No formal Education	26	6.7
	Primary School	144	36.9
	Secondary Education	147	37.7
	College	68	17.4
	University	5	1.3
Religious affiliation	Christian	273	70.0
	Muslim	112	28.7
	Hindu	5	1.3
Family monthly income	< 5000	152	39.0
	5000-10000	158	40.5
	10001-15000	64	16.4

	>15000	16	4.1
Occupation	Farming	12	3.1
	Business	114	29.2
	Housewife	117	30.0
	Permanent Employment	33	8.5
	Casual Employment	63	16.2
	None	51	13.1
Spouse occupation	Farming	14	3.6
	Business	147	37.7
	Casual Employment	74	19.0
	Permanent Employment	21	5.4
	None	134	34.1
Number of children	0	56	14.3
	1	40	10.3
	2	124	31.8
	3	107	27.4
	4 and above	63	16.2
Types of houses they live in	Renting	350	89.7
	Own House	5	1.3
	With Relatives	35	9.0
Occupants in the house	Alone	5	1.3
	Husband and Children	254	65.1
	Children	67	17.2
	Relatives	56	14.4
	Friends	8	2.1

Table 4.1 above shows that most respondents 206 (52.8%) were aged 25-34 while respondents aged 40-49 were the least 11 (2.8%). For marital status 207 (53.1%) of the respondents were married. The respondents who had studied up to the secondary level of education were the highest with at 147 (37.7%) while the respondents who studied up to the university level were the least at 5 (1.3%). The respondents who were Christians were the highest at 273 (70.0%) while the respondents who practised Hinduism were the least at 5 (1.3%).

Results from Table 4.1 also shows that the respondents who had earned a monthly income between 5000-10000 were the highest at 158 (40.5%) while the respondents who earned a monthly income greater than 15000 were the least with at 16 (4.1%). With regard to the occupation of the respondents, the highest numbers of respondents were housewives at 117 (30.0%) followed by business women at 114 (29.2%) while the respondents who practised farming were the least at 12 (3.1%).

The highest number of respondents had spouses who operated businesses which were 147 (37.7%) while the respondents whose spouses practised farming were the least at 14(3.6%). The respondents that had no children were 56 (14.3%) while 124 (31.8%) of the respondents which was the highest number had two children. The highest number of respondents lived in rented houses at 350 (89.7%) and only 5 (1.3%) lived in their own houses. Majority of the respondents making 254 (65.1%) lived with their husband and children, while the respondents who lived alone were the least at 5 (1.3%).

4.3 The Types of GBV Reported

Table 4.2 shows the forms of GBV reported by women of reproductive age in Kibera slums.

Table 4.2 The types of GBV reported by women of reproductive age in Kibera Slums

	Frequency	Percent
Physical Abuse	34	8.7
Sexual Harassment	60	15.4
Verbal Abuse	95	24.4
Denial of basic needs	19	4.9
Rape	13	3.3
Physical and verbal abuse	39	10.0
Two and above	39	10.0
None	91	23.3

Women of reproductive age in Kibera slums have experienced many forms of gender based violence. Table 4.2 above shows that out the 390 respondents, 34 (8.7%) have experienced physical abuse, 95 (24.4%) have experienced verbal abuse, while 91 (23.3%) of the respondents have not experienced any type of GBV. Physical abuse was classified as a woman having been slapped more than once by their partner or having had any physical force used against them.

4.4 Types of Interventions Offered to Victims of GBV

Table 4.3 shows the type of interventions that were offered to victims of GBV in Kibera slums.

Table 4.3 Types of interventions offered to victims of GBV

	Frequency	Percent
Medical treatment	39	13.1
Guidance and counseling, Support groups	44	14.7
Legal measures taken towards perpetrator	13	4.3
None	147	49.1
Two or more interventions	56	18.7

As shown above, most survivors 147 (49.1%) of GBV had never received any interventions. Furthermore, 39 (13.1%) of the survivors of GBV had received medical treatment, 44 (14.7%) had received guidance and counseling and incorporated to a support group, only 13 (4.3%) had taken legal measures against the perpetrators.

4.5 Level of awareness on types of GBV interventions that can be offered to women of reproductive age in Kibera Slums.

Table 4.4 shows the level of awareness of the respondents regarding the types of GBV interventions in Kibera slums.

Table 4.4 Awareness on types of GBV interventions

	Frequency	Percent
Provision of support to shelters facilities	47	12.1
Outreach and awareness creation	122	31.3
Training police and outreach	22	5.6
Prosecution of perpetrators	11	2.8
Provide proper protection of victims against harassment	28	7.2
Funding and cost reduction for treatment	39	10.0
Not aware of any interventions	112	28.7
Two or more interventions	9	2.3

Respondents were asked whether they were aware of any GBV interventions that could be offered to women of reproductive age in Kibera. Table 4.4 above shows that out of the 390 respondents, 47 (12.1%) said provision of support to shelter facilities, 122 (31.3%) said outreach and awareness creation, 22 (5.6%) said prosecution of perpetrators, 28 (7.2%) said the provision of proper protection of the victims against harassment, 39 (10%) said funding and cost reduction for treatment while 112 (28.7%) were not aware of any GBV interventions. As per the above findings, only 9 (2.3%) which is a small percentage had adequate awareness on the types of interventions that were available for GBV while 112 (28.7%) were not aware of any interventions.

4.6 Factors associated with awareness of available GBV interventions

Table 4.5 shows the socio-demographic characteristics that are associated with awareness of available GBV interventions in Kibera slums.

Table 4.5 Socio-demographic factors associated with awareness of available GBV interventions

	Category	Awareness of available GBV interventions		χ^2	df	p value
		No	Yes			
Age	15-24	37 (13.21%)	28 (25.68%)	17.207	2	0.009
	25-34	147 (52.5%)	59 (54.12%)			
	35-49	96(34.28%)	23(20.18)			
Marital status	Single	51(18.21%)	18(16.51%)	12.768	2	0.12
	Married	136(48.57%)	71(64.22%)			
	Cohabited	93(33.2%)	21(19.24%)			
Education status	No formal education	16(5.71%)	10(9.17%)	25.648	3	0.001
	Primary	86(30.71%)	58(52.29%)			
	Secondary	113(40.35%)	34(31.19%)			
	College	65(22.46%)	8(8.25%)			
Religion	Christian	192(68.57%)	81 (73.39%)	2.894	1	0.576
	Muslim & Hindu	88(31.42%)	29 (27.52%)			

Table 4.5 above shows that the variable age affects the awareness of the available GBV interventions ($\chi(2) = 17.207$, the p value = 0.009). The variable education status, $\chi(3) = 25.648$, the p value = 0.001, showing that there is an association between the variable education status and the awareness of the available GBV interventions. The other variables do not affect the socio-demographic factors associated with awareness of available GBV interventions.

Table 4.6 Economic factors associated with awareness of available GBV interventions

	Category	Awareness of available GBV interventions		χ^2	df	p value
		Yes	No			
Family monthly income	<5000	104(37.14%)	48(44.03%)	5.578	2	0.472
	5000-10000	112(40%)	46(41.28%)			
	10001-150000	65(22.85%)	15(15.59%)			
Occupation	Farming	90(32.13%)	17(15.59%)	34.958	3	0.001
	Business	66(23.57%)	51(46.78%)			
	Permanent employment	70(24.99%)	27(24.76%)			
	None	54(19.28%)	15(13.75%)			
Spouse Occupation	Business	112(39.99%)	49(44.94%)	20.136	4	0.065
	Casual employment	42(15%)	32(28.44%)			
	Permanent employment	32(11.42%)	7(7.33%)			
	None	94(33.57%)	22(20.18%)			

Table 4.6 above shows that for the variable occupation, $\chi (3) = 34.95$, the p value = 0.001 showing that the variable occupation is associated with awareness of available GBV interventions.

Table 4.7 Other factors associated with awareness of available GBV interventions

	Category	Awareness of available GBV interventions		χ^2	df	p value
		Yes	No			
Affordability	No influence(scale 0)	24 (8.57%)	10(9.17%)	18.251	2	0.001
	Some influence(scale 1)	70(25%)	14(12.84%)			
	Much influence (scale 2)	186(66.42%)	86(78.89%)			
Accessibility	No influence (scale 0)	48(17.14%)	21(19.26%)	11.999	2	0.017
	Some influence (scale 1)	176(62.85%)	51(46.78%)			
	Much influence (scale 2)	56(20%)	38(34.86%)			
Acceptability	No influence (scale 0)	46(16.42%)	32(29.35%)	12.264	2	0.015
	Some influence (Scale 1)	142(50.71%)	50(45.87%)			
	Much influence (scale 2)	92(32.85%)	28(25.68%)			
Cultural factors	No influence (scale 0)	15(5.35%)	18(16.51%)	24.829	2	0.001
	Some influence (scale1)	77(27.5%)	35(32.11%)			
	Much influence (scale 2)	188(67.14%)	57(52.29%)			

Table 4.7 above shows that there is an association between affordability and level of awareness of GBV interventions ($\chi(2) = 18.251$, the p value = 0.001). For the variable accessibility, $\chi(2) = 11.999$, the p value = 0.017, showing that there exists dependence between the variable accessibility and awareness of GBV interventions. The variable acceptability, $\chi(2) = 12.264$, has the p value=0.015, we conclude that the variable acceptability and awareness of available GBV interventions are statistically dependent. The variable cultural factors , $\chi(2) = 24.829$, has the p value = 0.001, hence this shows that there exist dependence between cultural factors and awareness of available GBV interventions.

CHAPTER FIVE: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the comparison of the findings of the study with other similar studies and conclusions derived from the study findings. The recommendations drawn from the study and conclusions have also been made. Areas of suggestions for further research were also made in this chapter.

5.2 Discussion

5.2.1 Socio-demographic Factors

As per the study analysis done, the p value of education is at 0.001 meaning that the education affects awareness of available GBV interventions. This is similar to a study done in Kenya by FIDA which revealed that the discriminated uneducated women were unable to meet their basic needs adequately thus are unable to take charge of their livelihoods and sexuality. This increases the possibility of mistreatment causing life impingement on their in social status, losing control of their destiny, reproductive rights and health. This hence affects the women's general health as well as the welfare of their families especially the children. This is because the women are dependent on their partners to be a source of livelihood for them. The variable age also had a p value of 0.009 whereby the lower the age of an individual, the higher the chances of not being aware of the available GBV interventions as shown by a study done by UNIFEM where young women have an increased vulnerability to violence due to inexperience and lack of access to services and do not seek help.

5.2.2 Types of GBV encountered

In Kibera slums 3.3% of the respondents had experienced rape which is a high percentage in a sample size of 390 respondents. A study done by Africa forum, showed that victims of child sexual abuse occurred before the 18th birthday.

In Kibera 76.7% of the clients interviewed, had experienced violence in a life time which is higher than that of a study done by WHO also showed that worldwide 35 % of women have experienced either physical and/or sexual IPV or non-partner sexual violence. A study done in 1994 by Heise showed that in Sub-Saharan Africa GBV had a prevalence of between 20-71%.

A study also done in Nairobi's Kibera slums by Jason in 2015, showed that over 36% of female residents had reported having had a physical force to have sex compared to 14% of all Kenyan women and the rape cases were at 3.3 % in a sample size of 390 in Kibera which is on the higher side since this is just one slum.

Verbal abuse is also seen as a way in which women are violated and this is intended to make them submit to their partners since they are the breadwinners accounting for 24.4%.

5.2.3 Types of interventions offered

Out of the clients interviewed 61% did not seek any medical advice and only 3.3% sought legal redress which concurs with the findings of a study by Sanjel in 2013 which noted that the affected women hardly talk about their experiences nor do they ask for help. Enforcement of legislation to curb GBV due to lack of a policy framework is limited. This shows that there is apathy in follow up of violence related cases. This also concurs to a study done by IRC in 2014 that found that majority of survivors report cases to their relatives, village elders and usually the police are as a last resort. When perpetrators are arrested, parents decide outside courts negotiations and majority of survivors do not press charges due to pressure from their community.

Only a small percentage of 2.3% had adequate knowledge on the types of interventions that were available for GBV. This hence means that most of the victims of GBV do not seek help and this can affect their health.

GBV health infrastructure in referral and national hospitals is fairly well developed, but very poor in health facilities at lower level where most GBV cases are reported as reported by IRC. This could be lack youth friendly services where the youth feel comfortable to report. Also due to the fact that the facilities available in Kibera are not well equipped to handle GBV cases. There is lack of comprehensive national policy on GBV prevention and response. Few shelters and safe houses have been established and limited coordination of stakeholders working on GBV prevention and response. The health, security and justice sectors have limited capacity and resources to effectively respond to GBV and implement anti-GBV programmes. Inadequate programmatic focus

in addressing GBV in the public and private sectors as stated by national policy for prevention and response of GBV in 2014.

5.2.4 Economic factors hindering awareness of available GBV Interventions

Majority had low income making 83.9% of those interviewed hence finances playing a role on their awareness to available GBV interventions. This thus concurs to a study done retrospectively in 2006 by African Forum on young women aged 18 to 24 years from Kenya, Uganda and Ethiopia that showed that majority of these women were sexually abused before they turned eighteen, 85.2% in Kenya, 95% in Uganda and 68.5% in Ethiopia. The lower the age, the education status and the income the higher the chance of GBV and unawareness on available interventions.

The highest number of respondents lived in rented houses with a percentage of 89.7% and only 1.3% lived in their own houses. This is also a reflection of the fact that most of the respondents have a low socio-economic status and this is also a factor that affects awareness on available GBV interventions.

5.2.5 Level of awareness on the available interventions offered to victims of GBV

This study shows that 28.7% of the respondents were not aware of any interventions offered to victims of GBV in Kibera slums. A study done previously showed rare notification of cases by victims of domestic violence to police. This made the estimate of the unknown cases remain high since most of them remained unrecorded and there is scarcity of reliable epidemiological data as per Jamieson.

Only 2.3% could be regarded as having adequate awareness on interventions of GBV and this presents a low percentage of those who have awareness on the interventions of GBV this also concurs to a research finding whereby, the national policy for prevention and response of GBV in 2014 stated that there is high levels of unawareness on GBV in community, lack of knowledge on service providers that are working around GBV, persisting cultural practices and socialisation of GBV thus significantly impairing prevention of GBV. Weak Programming on GBV prevention and response at both national and county levels as they are limited in terms of geographic scope, short-term in nature, service providers are not well resourced and services for GBV survivors are varied in terms of quality.

5.2.6 Other factors associated with level of awareness of GBV interventions in Kibera Slums

In this study, affordability, accessibility, cultural factors and acceptability of the services were also seen as factors that influence awareness of available GBV interventions. This concurs to a study done on violence against women (UN 2006), that showed GBV survivors lack support since the chain of support for reporting to the police, the healthcare providers and the judicial process being slow, ineffective and is hardly incorporated. This therefore strengthens the perpetrators causing an increase in vulnerability of the survivors.

Violence within the family and household, is treated as a 'private' issue therefore, this information is lacking as per Ansarain 2009. This also falls into cultural factors that affect GBV. Misconception that GBV unduly focuses on girls and women at the

expense of men and boys. Less documented evidence on what works for primary prevention in the country as well as interventions.

5.3 Conclusion

In Kibera all forms of violence are rampant to include physical abuse, verbal abuse, sexual abuse and harassment, emotional abuse to include denial of basic needs which accounts for 76.7% which is higher than that of the WHO which accounts for 35%.

The types of interventions given include are medical interventions, guidance and counseling as well as provision of survivor support through shelter, legal measures against perpetrators which accounts for 50.9% but 49.1% of survivors do not seek for any professional help which concurs with a study by Sanjel where majority do not seek for help.

The level of awareness on the available interventions was low where only 2.3% of respondents stated more than two forms of interventions and 28.7% were not aware of any interventions available. This concurs to a study finding where health, security and justice sectors have limited capacity and resources to effectively respond to GBV and implement anti-GBV programmes. Inadequate programme focus in addressing GBV in the public and private sectors. Enforcement of legislation to curb GBV due to lack of a policy framework is limited. Weak data management and a poor monitoring and evaluation framework for GBV management. Weak utilization of existing research to inform policy and programming. Rehabilitation and reintegration programmes targeting GBV perpetrators is limited.

Accessibility, affordability, acceptability, cultural factors, age, occupation and education status are also associated factors that influence awareness of available GBV intervention which concurs with a study by IRC in 2014 which states GBV infrastructure is very poor in health facilities at lower levels.

5.4 Recommendations

1. As per this study there is need to enlighten the community on need for reporting of the cases of GBV and protection of GBV survivors. This can be done through the survivors of GBV as well as the guardians in case of violations when the survivors are minors. Reporting should be made easy without fear of intimidation by the perpetrators even for minors. This should include provision of hotlines so as to ensure anonymity of victims as well as those who might note the vices within the neighbourhood.
2. There is need for formation of youth friendly programmes by the government which is incorporates all services under one roof to include GBV. By incorporating them the government can get more information and use the same youth to have solutions e.g. The youth for youth forums since the youth are more aware of their colleagues going through similar challenges and can be subject of the change they want to see.
3. Need for training of the health care providers and police who receive reports of violence on how to attend to cases of GBV without stigma to the survivors. This can be facilitated by government forums or NGOs. The first people to come into contact with the survivors of GBV are the police and health care providers who can make such a major impact e.g. by having hotlines which can be used by survivors where when they

are trained can have better skills of handling the victims without the survivors feeling intimidated. If this happens, then it is possible to get better outcomes.

5.5 Recommendations for Further Research

1. The study thus demonstrated high number of cases of young people who had gone through cases of GBV. Thus a study can be done on factors leading to high level of GBV among the youth.
2. This study also shows that cultural factors also hinder awareness on available GBV interventions. Thus a study can be done on how cultural factors affect GBV awareness of available interventions.
3. This study was conducted in one slum, hence can be carried out in other slums for the purposes of comparison.
4. A study on evaluation of effectiveness of past interventions in Kibera Slums can also be carried out.
5. A study to evaluate the implementation of awareness of past interventions in Kibera slums can also be carried out.

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APPENDICES**Appendix I: Informed Consent****INFORMED CONSENT FORM/ ASSENT****KENYATTA UNIVERSITY SCHOOL OF PUBLIC HEALTH****POPULATION AND REPRODUCTIVE HEALTH DEPARTMENT****ID NUMBER****Consent to participate in a research study**

Greetings! My name is Bancy Wanjohi, a student at Kenyatta University undertaking Master of Science in Reproductive Public Health. I am currently working on a project which aims to determine the factors that influence access to gender based violence interventions among women of reproductive age in Kibera slums Nairobi City County Kenya.

Procedure to be followed

This is a cross sectional study and data will be collected for a period not exceeding four weeks while individual session in responding to the questionnaires will take about 20 minutes with good cooperation.

You have the right to decline participation. This will not pose a threat because of declining.

Participation is purely voluntary and you are free to ask questions related to this study at any time.

You may refuse to respond to any question and may stop the interview at any point without any consequences.

Discomfort and Risks

Some of the questions asked are on intimate matters and may embarrass or make you uncomfortable. If this happens, you may refuse to answer these questions if you so choose. The interview may also add like 20 minutes depending on the details to be given. The study has no risks involved whatsoever as the study is non-interventional.

Benefits

If you participate in this study you will help us know how we can improve the provision of care of GBV victims without stigma.

Rewards

There is no monetary incentive or material reward for participating. Participation is voluntary with no coercion and one is free to opt out at any stage of the process and it will not affect any interaction with Kenyatta University now or in the future.

Confidentiality

Your name will not be recorded in the questionnaire. The questionnaire will be kept in a locked cabinet for safe keeping at Kenyatta University. Confidentiality and privacy will be highly maintained.

Contact information

In case of any questions, comments or concerns you are free to contact the following:

Lead investigator- B.Wanjohi 0728415119

Supervisors- Prof M.Keraka 0721817521 / Dr M.Mutabazi 0725984499

Participant statement

The above information regarding my participation in the study is clear to me. I have been given a chance to ask questions and my questions have been answered to my satisfaction. My participation in this study is entirely voluntary. I understand that my

records will be kept private and that I can leave the study at any time. I understand if I decide to leave this will not change my relationship with Kenyatta university.

Name of participant.....

.....

Signature or Thumbprint

Date

Investigators Statement

I, the undersigned have explained to the volunteer in a language she understand the procedure to be followed in the study and the risks and the benefits involved.

Name of Interviewer

.....

Signature or Thumbprint

Date

Thank You

Appendix II: Questionnaires**Date of visit:** **Study ID:** **Gender:****A. Demographic and socio-economic details**

1. What is your year of birth? _____
2. What is your marital status?
 - Single
 - Married
 - cohabited
 - Divorced/separated
 - Widowed
 - Other (Specify)
3. What is your level of education?
 - No formal education
 - Primary school
 - Secondary education
 - College
 - University
 - Other (Specify)
4. What is your religion?
 - Christian
 - Muslim
 - Hindu
 - Other (specify) _____
5. What is your family monthly income in Kshs?
 - <5000
 - 5000-10000
 - 10001-15000
 - >15000 (specify how much) _____

6. What is your occupation?

- Farming
- Business
- Housewife
- Permanent employment
- Casual employment
- Hawking
- Other (Specify) _____

7. What is the occupation of your spouse (if applicable?)

- Hawking
- Farming
- Business
- Casual employment
- Permanent employment
- Other (Specify)

8. Where do you live or which village in Kibera _____

9. How many children do you have?

10. What type of house do you live in?

- Renting
- Own house
- With relatives
- Other (Specify)

11. Who do you live with?

- Alone
- Husband and children
- Children
- Relatives
- Friends
- Others (Specify)

B: Types of GBV encountered by women of reproductive age

12. Among the following Gender based violence, which have you ever encountered?

- a) Battering
- b) Sexual harassment
- c) Verbal abuse
- d) Denial of basic needs
- e) Others (specify)

13. a) Have you ever been physically abused within the homestead?

- 1. Yes
- 2. No

b) Yes who was the perpetrator? (Explain how it happened in the first incidence).....

c) How often does such an incidence occur? (Tick one)

- 1. Once in while
- 2. Regularly
- 3. All the time

d) What circumstances often lead to such abuses?
.....
.....

14. a) Have you ever been verbally/emotionally abused within the homestead?

- 1. Yes
- 2. No

b) If yes, who was the perpetrator (Explain how it happened in the first incidence)

.....
.....
.....

c) How often do such incidences occur? (Tick one)

- 1. Once in while
- 2. Regularly
- 3. All the time

d) What circumstances often lead to such abuses? (Please narrate in detail).....

.....

15. a) Does or has your spouse/partner ever given you support to better your livelihood?

- 1. Yes
- 2. No

b) If yes, please give details

.....
.....
.....

c) Has s/he ever denied you of anything that you feel is your entitlement?

- 1. Yes
- 2. No

d) If yes, Please give details

.....
.....
.....

e) What, in your view are the reasons behind such denial?

.....
.....
.....

16. a) Do you know a person who has experienced either physical or emotional or both types of abuses?

- 1. Yes
- 2. No

b) Please narrate the circumstances that led to such abuses

.....
.....
.....

c) How frequent are such incidences in your village in Kibera?

- 1. Very rare
- 2. Rare
- 3. Frequent
- 4. Very Frequent

d) What in your view underlies the frequency/rareness of such incidences?

.....
.....
.....

C: Interventions offered to victims of GBV and Level of Knowledge

17. What help did you receive when you went to a centre for GBV?

- a) Medical checkup/ treatment
- b) Guidance and counseling

c) Incorporated to survivors support groups for moral support

d) What legal action was taken towards the perpetrators by the relevant authority like the chief or police

e)Others(Specify).....
.....
.....

18. Do you have knowledge of other interventions offered to victims of GBV?

- 1. Yes 2. No

If yes, list them on the space provided below.

.....
.....
.....
.....
.....

19. a) Do you know the GBV interventions that are available for women of reproductive age in Kibera slums?

- 1. Yes 2. No

b) If yes, state them on the space provided below.

.....
.....

20. How as an individual do you deal with physical abuses perpetrated by your spouse/partner or other member of the household?

.....
.....
.....

21. a) Have you ever reported an incidence of abuse to anyone, agency or authority?

- 1. Yes
- 2. No

b) If yes, kindly give details including how the matter was resolved.

.....

.....

.....

.....

22. a) Does this community use any methods to handle GBV?

- 1. Yes
- 2. No

b) If yes, please mention them and narrate their merits and de-merits in curbing the vice.

.....

.....

.....

c) Suggest what you think are the best and most effective way of dealing with GBV in your community

.....

.....

.....

23. a) Are you aware of any initiatives/organizations that are involved in addressing GBV?

- 1. Yes
- 2. No

b) If yes, please mention them.

.....

.....

.....

c) What do you suggest would be the best way for such initiatives/organizations to approach the issue of GBV?

.....

.....

.....

d) What in your view are the major hindrances to accessing GBV intervention in Kibera?

.....

.....

.....

24. To what extent do you think the following hindrances influence the availability to GBV interventions in Kibera?

	No influence	Some influence	Much influence
1.Affordability (income)			
2.Accessibility of service			
3.Acceptability of service			
4.Cultural practices			

Appendix III: The Map of The Study Area



scale :1cm= ½ km



Appendix IV: Nairobi City County Research Authorization

NAIROBI CITY COUNTY

Telegrams: "PRO-MINHEALTH", Nairobi
 Telephone: Nairobi 217131/313481
 Fax: 217148
 E-mail: pmonairobi@yahoo.com



COUNTY HEALTH OFFICE
 NAIROBI
 NYAYO HOUSE
 P.O. Box 34349-00100
 NAIROBI

COUNTY HEALTH SERVICES

When replying please quote
 Ref. No. CMO/NRB/OPR/VOL1-2/2016/135

1st August, 2017

Wanjohi Bancy Wairimu
 C/o Population and Reproductive Health Department
Kenyatta University

RE: RESEARCH AUTHORIZATION

This is to inform you that the Nairobi City County Operational Technical Working group reviewed the documents on the study titled, "**Effectiveness of gender based violence interventions in Kibera slum, Nairobi County**".

I am pleased to inform you that you have been authorized to undertake the study in Lang'ata Sub County, Nairobi County.

On completion of the study, you will submit **one hard copy and one copy in PDF** of the research findings to our operational research technical working group.




R. K. MULI
FOR: COUNTY DIRECTOR OF HEALTH SERVICES

FOR: COUNTY DIRECTOR OF
 HEALTH SERVICES
 NAIROBI COUNTY

CC:

SCMOH - Lang'ata

Appendix V: Kenyatta University Graduate School Approval For Research Proposal



**KENYATTA UNIVERSITY
GRADUATE SCHOOL**

E-mail: dean-graduate@ku.ac.ke P.O. Box 43844, 00100
 Website: www.ku.ac.ke NAIROBI, KENYA
 Tel. 020-8704150

Internal Memo

FROM: Dean, Graduate School DATE: 26th June, 2017
 TO: Wanjohi Bancy Wairimu REF: Q139/CE/22273/2012
 C/o Population and Reproductive Health
 Department.

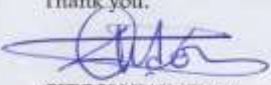
SUBJECT: APPROVAL OF RESEARCH PROPOSAL
 =====

We acknowledge receipt of your revised Research Proposal as per our recommendations raised by the Graduate School Board of 29th March, 2016 entitled "Challenges in Accessing Gender Based Violence Interventions among Women of Reproductive Age in Kibera Slums Nairobi City, County".


You may now proceed with your Data collection, subject to clearance with the Director, Ethics Office, Kenyatta University and Director General, National Commission for Science, Technology and Innovation.

As you embark on your data collection, please note that you will be required to submit to Graduate School completed Supervision Tracking Forms per semester. The form has been developed to replace the Progress Report Forms. The Supervision Tracking Forms are available at the University's Website under Graduate School webpage downloads.

Thank you.



GIDEON KAIMENYI
FOR: DEAN, GRADUATE SCHOOL




CC. Chairman, Population and Reproductive Health Department

Supervisors:

1. Prof. Margaret Keraka
C/o Population and Reproductive Health Department
Kenyatta University
2. Dr. Micheal Mutabazi
C/o Population and Reproductive Health Department
Kenyatta University

GK/rwm

Appendix VI: Kenyatta University Ethics Review Committee Approval



**KENYATTA UNIVERSITY
ETHICS REVIEW COMMITTEE**

Fax: 8711242/8711575
 Email: kuerc.chairman@ku.ac.ke
 kuerc.secretary@ku.ac.ke
 Website: www.ku.ac.ke

P. O. Box 43844,
 Nairobi, 00100
 Tel: 8710901/12

Our Ref: **KU/ERC/ APPROVAL/VOL.1 (135)** Date: 14th June, 2018

Bancy Wairimu Wanjohi
 P.O Box 312-00100
 NYERI

Dear Bancy,

APPLICATION NUMBER: PKU/743/1812 "CHALLENGES IN ACCESSING GENDER BASED VIOLENCE INTERVENTIONS AMONG WOMEN OF REPRODUCTIVE AGE IN KIBERA SLUMS NAIROBI CITY COUNTY"

1. IDENTIFICATION OF PROTOCOL

The application before the committee is with a research to "Challenges In Accessing Gender Based Violence Interventions Among Women of Reproductive Age In Kibera Slums Nairobi City County" received on 19th March, 2018 and discussed on 12th June, 2018.

2. APPLICANT

Bancy Wairimu Wanjohi

3. SITE

Kibera Slums, Nairobi City County

4. DECISION

The committee has considered the research protocol in accordance with the Kenyatta University Research Policy (section 7.2.1.3) and the Kenyatta University Ethics Review Committee Guidelines and **APPROVED** that the research may proceed for a period of **ONE year from 12th June , 2018.**

5. **ADVICE/CONDITIONS**

- xiii. Progress reports are submitted to the KU-ERC every six months and a full report is submitted at the end of the study.
- xiv. Serious and unexpected adverse events related to the conduct of the study are reported to this committee immediately they occur.
- xv. Notify the Kenyatta University Ethics Committee of any amendments to the protocol.
- xvi. Submit an electronic copy of the protocol to KUERC.

When replying, kindly quote the application number above.

If you accept the decision reached and advice and conditions given please sign in the space provided below and return to KU-ERC a copy of the letter.

DR. TITUS KAHIGA
CHAIRMAN ETHICS REVIEW COMMITTEE

I Bancy Wairimu accept the advice given and will fulfill the conditions therein.

Signature..... Bancy Dated this day of 22/06 2018.

cc. DVC-Research Innovation and Outreach

Appendix VII: National Commission For Science, Technology And Innovation Approval


REPUBLIC OF KENYA


NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION

Ref No: 593858 Date of Issue: 02/December/2020

RESEARCH LICENSE



This is to Certify that Ms. Nancy Wairimu Wanjohi of Kenyatta University, has been licensed to conduct research in Nairobi on the topic: CHALLENGES IN ACCESSING GENDER BASED VIOLENCE INTERVENTIONS AMONG WOMEN OF REPRODUCTIVE AGE IN KIBERA SLUMS NAIROBI CITY COUNTY for the period ending : 02/December/2021.

License No: NACOSTI/PI/20/7941

593858
Applicant Identification Number


Director General
NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION

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THE SCIENCE, TECHNOLOGY AND INNOVATION ACT, 2013

The Grant of Research Licenses is Guided by the Science, Technology and Innovation (Research Licensing) Regulations, 2014

CONDITIONS

1. The License is valid for the proposed research, location and specified period
2. The License any rights thereunder are non-transferable
3. The Licensee shall inform the relevant County Director of Education, County Commissioner and County Governor before commencement of the research
4. Excavation, filming and collection of specimens are subject to further necessary clearance from relevant Government Agencies
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