SEXUAL AND GENDER-BASED VIOLENCE[1] GOOD PRACTICES FROM KENYA

HIGHLIGHTS

Kenya Red Cross Society (KRCS) with the support of the International Committee of the Red Cross (ICRC) implemented a sexual and gender-based violence (SGBV) project from January 2016 to June 2018, having been preceded by a three-month assessment in 2015. The project was executed in Nairobi at Starehe sub-county in Mukuru Fuata Nyayo and Mukuru Kayaba - Nairobi through a multi-partner approach. The partners included KRCS, ICRC, Ministry of Health (MoH), department of Community Health Development Unit (CHDU), Reproductive Health and Maternal Services Unit (RHMSU), Mental Health Unit (MHU) and Nairobi County **The project aimed to ensure access to health care for survivors of sexual violence and other forms of violence in the informal settlement and to reduce their vulnerabilities to mental health issues.**

FIGURE 1 *A view of part of Mukuru slums where the SGBV project was implemented. A young boy standing looking at the view of the Mukuru slums.*

SGBV in Mukuru:

Sexual violence in form of rape, forced sexual relations with family members; child sexual exploitation and abuse; defilement

Gender based violence in form of emotional, psychological, verbal, economic, dowry, sexual and physical domestic violence; early marriage.

BETWEEN 2016 AND 2018:

A total **191 documented cases of SGBV identified and referred**: intimate partner violence 117 (61%); child abuse/ neglect 42 (22%); Rape 25 (13%, whose 20 < 18yrs), early/forced marriage 7 (4%) The data is from records with the Ministry of Health. The documentation was done by the KRCS and the Nairobi City County, Case management was done by the Community Health Volunteers (CHV) with the help of the Community Health Assistants (CHA). The CHV identified cases of SGBV, documented and referred survivors. They also followed-up with survivors individually throughout the process to ensure they get the services they require and deserve.

1 IFRC and ICRC Background Report on Resolution 3 "Sexual and gender-based violence: joint action on prevention and response", October 2015 defines SGBV as follows: *Sexual and gender-based violence is an umbrella term for any harmful act that results in, or is likely to result in, physical, sexual or psychological harm or suffering to a woman, man, girl or boy on the basis of their gender. Gender-based violence is a result of gender inequality and abuse of power. Gender-based violence includes but is not limited to sexual violence, domestic violence, trafficking, forces or early marriage, forced prostitution and sexual exploitation and abuse.*

IFRC Kenya Red Cross Norwegian Red Cross ICRC

7104 people sensitized in households, men, women and children groups and over **200 community** sensitization sessions on SGBV, its consequences and the referral pathway were held. CHVs are part of the communities and therefore worked in areas they themselves live in and there worked and supported sensitization forums, identified and referred cases and followed-up.

40 CHVs and five CHAs were trained by master trainers from the Ministry of Health on SGBV and Mental Health and Psychosocial Support (MHPSS) focusing on prevention and response to SGBV cases in their different community sites. They were equipped with several awareness raising tools and outreach techniques. CHVs for example learned specific communication techniques for how to conduct community outreach sessions and learned skills to engage do door to door awareness creation. The CHAs cascaded the knowledge to the CHVs who they then supervised. KRCS worked with counselors and psychologists from other partners. Some of the partners were Faraja foundation, Mukuru promotion Centre and a volunteer counselor from KRCS.

Referral centers identified: KRCS together with the partners first identified already existing referral pathways and strengthened individual componenets. Then KRCS brought together all the partners, identified in the referral pathway, in monthly review meetings. This enabled the different partners to share information on their role, to keep contact details updated and to continusly adapt the plan on referrals and how ensure its functioning.

For medical care: Mater Hospital, MSF clinic and its satellite clinics.

For MHPSS: Mater Hospital, Faraja Foundation.

For Legal aid: Kituo cha Sheria, Police station at Industrial area

For Protection: Mukuru Promotion center, Children officer, District children officers and Voluntary children officers. Chief (only for administrative purposes).

CONTEXT

National statistics indicate that 14 % of women and 6% of men between 15-49 years have experienced sexual violence at least once in their lifetime. In the case of physical violence these figures increase to 45% and 44% respectively.[2] Kenya ranks 135 on the gender inequality index and has a 30% rate of child marriage. Based on a need's assessment conducted in 2015 in Mukuru informal settlement, it was evident that there was a gap in SGBV/MHPSS services at the community level. This informed the startup of the SGBV project. The assessment in addition revealed that while Kenya through the MoH and other Government Ministries has made progressive strides in laying down legal frameworks and protocols which guide SGBV response[3], the implementation is still lacking behind. The referral pathways were not clear and not monitored, survivors did not know what services to access or how to access them. Community support for survivors is weakened by high levels of stigmatization, labelling, normalization of violence, lack of knowledge about SGBV and limited information on the needs of survivors. Confidentiality mechanisms are not rigorous among the community care givers and the community at large. Provision of holistic care for SGBV survivors is minimally provided by the state, most facilities provide only start doses of prophylactic post exposure treatment. Finally, protection for survivors is hampered by weak enforcement of laws and limited resource for protection actors like the police. Very few temporary shelters exist, in poor conditions, poor chain of custody, capacity gaps, limited forensic equipment and materials, and inconsistent documentation.

2 Kenya Demographic and Health Survey, 2014 pg. 15 accessed at https://www.dhsprogram.com/pubs/pdf/sr227/sr227.pdf on 22 October 2019
3 National Guidelines on management of sexual violence in Kenya, 2014 accessed at https://www.law.berkeley.edu/wp-content/uploads/2015/10/Kenya_Natl-Guidelines-on-Mgmt-of-Sexual-Violence_3rd-Edition_2014.pdf on 13 Nov 2019.

PROJECT OVERVIEW

Based on the joint assessment carried out by KRCS, ICRC and an external consultant between March – May 2015 in five urban informal settlements in Nairobi including Huruma, Mathare, Mukuru, Dandora and Korogocho, a Community Health strategy was identified as the entry point for the project. Community Health Volunteers (CHV) were defined as a critical workforce in the strategy as they are involved in improving access of community members to health care services. However, their participation in SGBV and other related cases was limited and unstructured. They lacked systematic training, supervision and follow up support. **In this regard the project applied a bottom up approach through capacity building, system strengthening and support by engaging CHVs, Community Health Assistant (CHAs), school social workers, health facilities, counsellors for close supervision.** The main aims of the project were 1) to ensure that survivors of SGBV living in the informal settlements of Nairobi have access to healthcare including MHPSS and 2) capacity building to CHVs to be able to create awareness in their communities, identify, respond and properly refer survivors.

INSTITUTIONAL COORDINATION	AWARENESS/SENSITIZATION	HEALTH AND PSYCHOSOCIAL RESPONSE
Referral Pathway: KRCS first mapped and assessed the existing referral pathway, then worked together with ICRC and national health institutions to set-up a referral path. The holistic response now includes: **Medical care:** Mater Hospital and MSF clinics; **MHPSS:** Mater Hospital and Faraja Foundation. **Legal aid-** Kituo cha Sheria, Police station and **protection through** Mukuru Promotion center, Children Officers, as well as Voluntary children Officers. KRCS together with the partners held several community sensitizations session and all partners involved would share with the community their respective roles and how their services can be reached. The community members got a chance to interact directly with the different stakeholders to ask questions, share difficulties and challenges. This was key to finding joint solutions and to improve the referral pathway. **National SGBV Training manual:** This is the first national training manual on SGBV for the MoH community work force developed with support of KRCS and IFRC. This Manual formed the basis for the CHV trainings.	**Community:** 7104 people were sensitized at household and community level targeting men, women, community groups and children. Over 200 sensitization sessions were conducted by CHVs to improve awareness on SGBV at the community and household level and information was given on existing services. This enabled the community to be more aware of the referral pathway. KRCS supported the CHVs by giving them monthly stipends to ensure they can conduct community sensitization sessions, identify and refer SGBV cases. The stipend was a god incentive for CHVs as most of them invest a lot of time supporting survivors. CHVs and KRCS volunteers live in the targeted communities in Mukuru kwa Reuben and have been working there for some time and are trusted. This ensured that they reached most of their community members. At the same time, CHVs were able to work closely with the local administration to support further case management for SGBV survivors, especially when protection risks, such as threats by perpetrators/an or family members arose. This increased the trust in the community, as some perpetrators were arrested and more SGBV survivors felt they could disclose.	**Health:** Through continued community awareness CHVs received cases of SGBV and referred the survivor to the nearest health facility in the referral pathway. They worked to ensure that the survivor gets medical assistance within 72 hours and continues with follow up visits. The CHVs were well known in the health facilities and were thus able to support the survivors through the referral pathway and to ensure they got the information they need and access the services they require. **MHPSS:** KRCS volunteers, CHVs, as well as Community leaders were trained on SGBV, existing services and how to refer survivors to MHPSS support. **Supervision: ICRC closely supervised the CHVs.** In a regular meeting forum CHVs reflected on their work and personal experiences while responding to SGBV at the community level. Feedback was given through peer support and professional support from health staff. Seven support supervision sessions for the 40 CHVs were conducted within the project period. CHVs reported feeling more empowered, enlightened and having more self-awareness. The CHVs identified with psychological needs were referred for specialized interventions. Post-knowledge testing showed CHVs were more aware of SGBV cases, referral pathway and multi sectoral follow up at the community level.

Training: 40 CHVs were trained to improve their skills on sensitization and to reinforce the community referral system on SGBV. Master Trainers from the MoH at the national level were trained as key facilitators. 20 CHAs were drawn from the project area and Kamukunji Sub county and trained by the master trainers. However, only 5 CHAs were directly involved in the project, those drawn from the project area. The 5 identified, trained and supervised the 40 CHVs from Mukuru Fuata Nyayo and Kayaba area.

KRCS CAPACITY-BUILDING:

- 2 KRCS staff were trained to improve their skills in training and supervising CHVs.
- The KRCS volunteers in the area were trained on SGBV, existing services and how to refer survivors including to MHPSS support.

WHAT WAS ACHIEVED?

1) **Comprehensive healthcare and referral for SGBV survivors.** A referral pathway for health care, MHPSS, legal and protection services was identified and established. Combined with training and sensitization of CHVs on attitudes, perceptions and biased behavior due to certain belief systems and/or cultural norms towards some forms of SGBV, identification, referral and follow-up of survivors was enhanced. As an example, intimate partner violence was said to be normal before and thus no medical services were sought.

> *"I used to have my own biases and cultural belief where I thought intimate partner violence was normal and should be resolved at family level and not involving anyone. Now, I know it is not normal, it is violence."* CHV in Mukuru

2) **Enhanced capacity of county, CHAs and CHVS to respond to SGBV.** Feedback from the county indicates the project enhanced the skills of the county workforce in relation to SGBV prevention and response. Based on the initial documentation of the needs, gaps, opportunities and challenges to work with health care personnel and CHVs, targeted training intervention were possible. The assessment also gave a more accurate picture on survivors and forms of SGBV. KRCS together with partners improved documentation and reporting of SGBV cases at the community level through the development

of a reporting system. This system based on absolute confidentiality as no names are plotted into the system, now captures all the cases reported by the CHVs in their specific areas/households. Regular supervision of CHVs was a critical part of capacity building in the project. CHVs were able to get support for difficult cases and learnt more on self-care. Working with MOH and the CHVs ensured continuity of the work even after KRCS and ICRC no longer supported the project.

3) **Strengthened interinstitutional coordination.** Inclusion of different partners at the community and county level including the MOH was one of the greatest strengths of the project ensuring buy in, participation of MOH staff, strengthened the community health system and enhanced sustainability even after the project ended in 2018. The project also triggered interinstitutional cooperation on the development of the first national training manual on SGBV for the community workforce (CHAs and CHVs).

LESSONS LEARNT

The SGBV project in Kenya demonstrates that Red Cross and Red Crescent can play an important role in complementing the efforts of state institutions in preventing and responding to SGBV challenges.

COOPERATION AND COMPLEMENTARITY	Inclusion of partners at community and county level including the MOH ensured buy in, participation of MOH staff, strengthened the community health system and enhanced sustainability. KRCS have access to the community and volunteers on the ground. ICRC was able to fund KRCS and bring in their MHPSS skills through training and supervising the CHV together with KRCS.
CHV INVOLVEMENT	CHV are a critical frontline community work force when responding to SGBV as they live in the communities where they work.
CAPACITY-BUILDING	Strong focus on capacity-building as major outcome, made monitoring of the outcomes related to survivors of SGBV after their referral difficult. This should be considered in the planning phase of an SGBV program.
QUALITY OF CARE	Limited quality and adequate MHPSS services were a high risk for the SGBV response program.
DONOR DEPENDENCY	Cooperation only worked as long as additional funds were available; the government institutions did not prioritize SGBV projects in these specific areas.
CORRUPTION	Briberies and payment requests by public officials disrupted the referral system.
DATA	Lack of previous baseline data on number and types of SGBV at county level made it difficult to measure improvement or impact for SGBV survivors in the project.

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