ANNEX 9

A RAPID ASSESSMENT OF GENDER-BASED VIOLENCE DURING THE POST-ELECTION VIOLENCE IN KENYA

CONDUCTED

JANUARY – FEBRUARY 2008

"When you go back to your daily work at the UN, do not forget to look very deeply into the issues of women, because it is very difficult, especially for us women…where the clashes affect us after every election." ~ Woman, Kuresoi

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EXECUTIVE SUMMARY

In the last twenty years, the humanitarian field has increasingly recognized gender-based violence (GBV) as a serious global health, human rights, and development issue. While GBV is prevalent in all societies, crisis situations can exacerbate the extent and incidence of the problem, particularly sexual violence involving female survivors and male perpetrators.

> "If you don't move, we are going to rape the women."
>
> ~ Threat in Timboroa

Recognizing Kenyan women's and girls' vulnerability to violence stemming from the post-election upheaval, an inter-agency rapid GBV assessment was initiated in mid-January 2008 in selected sites in North Rift Valley, South Rift Valley, the Coastal Region, Nairobi and Central Province. The assessment examined the nature and scope of sexual violence occurring during flight, as well as within the internally displaced persons (IDP) camps and alternative settlements. Additionally, the assessment evaluated the capacity of both community and camp-based programmes to prevent and adequately respond to cases of sexual violence in order to recommend strategies for strengthening gender and GBV programming in IDP camps and in surrounding communities.

Nature and Scope of Violence

The preliminary findings of this assessment confirm initial reports from Nairobi-based hospitals that sexual violence has increased during the post-election crisis that began December 30, 2007. Evidence suggests that perpetrators are exploiting the conflict by committing sexual violence with impunity, and efforts to protect or respond to the needs of women and girls are remarkably insufficient.

Sexual violence is not only occurring as a by-product of the collapse in social order in Kenya brought on by the post-election conflicts, but it is also being used as a tool to terrorize individuals and families and precipitate their expulsion from the communities in which they live. Investigation into sexual violence which occurred during flight yielded anecdotal reports from all regions, but in particular from Mombasa, Nairobi, and parts of the North Rift, of threats of sexual violence being used as a fear-instilling tactic, in so far as women were told they and their children would be raped if they did not vacate their property within a designated timeframe. As is detailed in this report, in many instances these threats of rape were actualized, sometimes comitted by gangs of men and accompanied by physical brutality, such as inserting objects into the victim's genatalia.

Risks of sexual violence are on-going for women and young girls seeking sanctuary in IDP settlements. During focus groups, encamped women repeatedly expressed fears of sexual violence as a result of makeshift sleeping arrangements in the sites, where males and females (not of the same family) were forced to sleep together under one tent or out in the open. They also voiced concerns about lack of regulations in the camps allowing men from the outside to enter unchecked by camp officials and, in Nairobi in particular, women reported fears about sexual victimization linked to camp design and services, including lighting, water/sanitation facilities, and availability of firewood.

Despite efforts by the Kenya Red Cross Society (KRCS) and other humanitarian actors to introduce some basic protective mechanisms, cases of sexual assault in the IDP camps appear to be on the rise. Exact numbers, however, are impossible to ascertain, not only because the encampments do not have standardized reporting mechanisms, but also because of challenges associated with acknoweldging victimization, including availability of services, the level of awareness about the value of medical assistance, the degree of trust in police and other security-related issues, as well as the cultural acceptability of disclosing rape.

Sexual exploitation is also a major concern amongst the IDPs. Both women and humanitarian actors across multiple sites reported cases in which women and girls are coerced into exchanging sex for basic resources, such as food, sanitary supplies, transport, etc. Perpetrators were identified as men from the encamped population, the community and, in some cases, security personnel. Some reports suggest that sexual exploitation "rings" are being organized by profiteering men from the camps and/or host communities.

Other Gender and GBV Concerns Among the Displaced

While the assessement detailed herein primarily focused on issues of sexual violence, other gender and GBV concerns continuously surfaced throughout site visits. Domestic violence was identified as an issue among the encamped population due shifts in traditional spousal roles, idleness among the men, stressors associated with camp living, etc. Increased rates of divorce and separation were also noted--sometimes occurring along tribal lines--often leaving women as the sole caretaker of their children.

Commonly reported concerns for young girls include early marriage and trafficking for domestic labor due to increased poverty and the inability of parents to provide for their children. Another concern for girls echoed throughout the camps was withdrawal from school due to security risks or because mothers need the assistance of girls to manage increased domestic responsibilities.

These risks to women and girls are compounded by a general failure to promote inclusion of women in camp decision-making and coordination processes. Equal participation of women as compared to men in IDP camp management committees was

not evident in any of the sites visited. Similarly, camp-based services—such as reproductive health services--designed to meet the specific needs of women and girls, including acces to antiretroviral drug therapy (ATRs) were almost non-existentin the majority of camps. In addition to the lack of health services, women are in need of basic necessities such as underwear, sanitary napkins and contraception.

Prevention and Response Programming

The assessment focused on two broad "areas" when investigating prevention and response programming related to GBV: 1) camp-based programming; and 2) community-based programming. In both contexts, and in virtually all settings, efforts to address GBV are restricted by lack of resources and inadequate capacity across all service-delivery sectors.

Camp-based programming. Basic camp security provisions--such as appropriate lighting in areas frequented by women and girls, sex-separated toilets and bathing areas with locks on the inside of the facilities, and patrols of wood collection routes--have not yet been incorporated in many of the camps, especially the smaller, more informal encampments. Investigations suggest that police units protecting the camps—where they exist--have not been adequately trained on response to sexual violence or on codes of conduct related to sexual exploitation and abuse.

While the health sector has made an effort to quickly establish camp-based services, they remain unable to adequately respond to survivors of sexual violence. For example, none of the camps visited had post-exposure prophylaxis (PEP) or emergency contraception on site, and staff had not been trained on responding to survivors of GBV or the medical management of rape. Teams of psychosocial workers have moved very quickly to provide support services to the encamped populations since the initial phases of response. However, with the exception of two counselors working in Eldoret, it was not evident on the ground that any of the psychosocial actors had specific expertise in responding to sexual violence.

The KRCS has been coordinating all camp-related activities and interventions, but as of yet, no focal points have been identified to ensure that GBV-related issues in each of the camp settings are addressed through camp-based coordination mechanisms or through larger district, provincial, and national level multi-sectoral (eg. health, protection, water and sanitation, camp management and coordination etc.) coordination mechanisms. Thus far, the government has also not taken up the issue: although Eldoret and Nakuru both have coordination committees facilitated by government representatives as well as a protection cluster that is engaged around GBV issues, the Ministry of Gender, Sports, Culture and Social Services has not been activated in these or any other regions to promote monitoring of gender and GBV-related concerns among the displaced.

Community-based services. Due to limitations in camp-based services, as well as the non-permanent nature of the camps, it is essential that the displaced have access to services within the host communities. Comprehensive post-sexual violence health services are available in Nairobi; however, with the possible exception of Nairobi Women's Hospital, these services are not widely known and are therefore under-utilized. Limited capacity and resources remain a problem for health service providers in other urban areas. In Mombasa and Eldoret, for example, the government hospitals have privately-funded gender violence recovery centres equipped to provide PEP, emergency contraception, and other essential response services, but these centers are understaffed and services are only available Monday through Friday, from 9am-5pm. In rural areas, health services for survivors of sexual violence are virtually non-existent.

Even though women's and children's desks exist in many of the police posts in some of the larger urban areas and towns, interviews with police suggest that there has not been widespread training on general GBV issues and/or appropriate response to sexual violence, nor do police have the resources to ensure that all sexual-violence related complaints are investigated. Even if a police officer has a heightened awareness and sensitivity about sexual violence, lack of resources may make it particularly challenging to ensure the safety and security of survivors.

> "the police do not take [rape] seriously…"
>
> ~ Nairobi-area women

Despite the progress that has been made in legal sector reforms, particularly in terms of the adoption and implementation of the Sexual Offenses Act, there are a number of challenges to assuring survivors' access to legal justice. Informants revealed that funding limitations make witness transport to/from police stations and courts difficult. Investigations often last longer than the 24-hour limit to detain a suspect before arraignment, and this period often does not even allow for the conclusion of the medical report findings given that an official Medical Examination Report must be completed by a certified doctor, of whom there are few. Even when a Medical Examination Report is successfully completed, it often takes as long as a year for a case to go through legal proceedings, and many survivors lose hope or lack financial resources to continue. Moreover, the legal aid community has not yet been widely activated to address the particular concerns of the displaced.

These issues of poor capacity within the key service-delivery sectors are compounded by lack of coordination across the sectors. In the absence of pre-existing national coordination mechanisms to address sexual violence, a GBV sub-cluster has been established by UNFPA and is co-chaired by KRCS to coordinate multi-sectoral action related to the Kenya crisis among the health and social services actors, and the legal, human rights and security sectors. The sub-cluster is focused on strategic planning, gathering information and resources, capacity building, policy development, data

management, resource mobilization, and maintaining effective action for both prevention and response. While the GBV sub-cluster was developed in response to the IDP situation in Kenya, it is anticipated that the responsibilities of the group can be transitioned to the appropriate government bodies when the crisis has diminished and will therefore be a sustainable mechanism to lead GBV coordination nationwide.

The Way Forward

A detailed set of "camp-based" and "community-based" recommendations are provided at the conclusion of this report. The recommendations aim to guide all relevant actors in Kenya to: a) deliver a set of minimum interventions to prevent and respond to sexual violence during emergency response that are in line with international and national policies, resources, and guidelines and; b) transition humanitarian interventions to national government and non-government structures (NGOs/FBOs/CBOs) to enable the shift from humanitarian to development actions, as displaced populations move to transitional settlements in some areas and home in others. Key areas for emphasis in the recommendations include:

- Provide support to the relevant Government of Kenya ministries and institutions, especially the Ministry of Gender, Sports, Culture and Social Services, to integrate prevention of gender-based violence and gender equality concerns into their emergency plans of action and improve their capacity to address the problem of sexual violence amongst girls and women in Kenya.
- Introduce coordination mechanisms for prevention and response programming at the provincial and district levels, and ensure their linkages with national coordination mechanisms (especially the GBV sub-cluster).
- Train all camp-based staff in GBV prevention and response standards as well as on the Secretary General's Bulletin on Protection from Sexual Exploitation and Abuse by UN Staff and Partners and establish mechanisms for reporting and service-delivery.
- Ensure sufficient police presence in the camps, including female police, and allocate technical and financial resources to security personnel to address violence against women and girls.
- Improve multi-sectoral prevention and response to GBV at the community level, through sustained support to key sectors including health, legal/justice, security, and psychosocial, with a special focus on gaps such as availability of forensic examiners, legal aid services, and expedient judicial response.
- Conduct widespread community education aimed at prevention and ensuring survivors know how and where to access services.
- In recognition of the new peace agreement and the hope that most Kenyans will be able to return to their homes, mechanisms to protect returnees must be institutionalized.

LIST OF ACRONYMS

AAR:	Africa Air Rescue
ACK:	Anglican Church of Kenya
AIDS:	Acquired Immune Deficiency Syndrome
AMPATH:	Academic Model for the Prevention and Treatment of HIV/AIDS
AMREF:	African Medical and Research Foundation
ANPPCAN:	African Network for the Prevention and Protection against Child Abuse and Neglect
ART:	Antiretroviral Therapy
ASK:	Agricultural Society of Kenya
CAR-E:	Centre for Rape-Eldoret
CCF:	Christian Children's Fund
CCR:	Centre for Conflict Resolution
CLAN:	Child Legal Action Network
COVAW:	Coalition of Violence against Women
CRADLE:	CHILD Rights Advisory Documentation and Legal Aid Centre
CRN:	Children's Rights Network
CWSK-MSA:	Child Welfare Society of Kenya, Mombasa
DNA:	Deoxyribonucleic Acid Test
ECODEV	Economic and Development Centre
FEMNET	African Network for the Prevention and Protection Against Child Abuse and African Women's Development and Communication Network
FIDA-K:	Federation of Women Lawyers-Kenya Chapter
GBV:	Gender-based Violence
GCN:	Girl Child Network
GSU:	General Service Unit
GVRC:	Gender Violence Recovery Centre
HIV:	Human Immune Deficiency Virus
IASC:	Inter-Agency Standing Committee
ICRH:	International Center for Reproductive Health
IDP:	Internally Displaced Persons
IEC:	Information, Education and Communication
INGOs:	International Non-Governmental Organization
IOM:	International Organization of Migration
KAARC:	Kenya Alliance for the Advancement of Children
KAPC:	Kenya Association of Professional Counselors
KNH:	Kenyatta National Hospital
KRCS:	Kenya Red Cross Society
MAP:	Medical Assistance Programs
MGSCSS:	Ministry of Gender, Sports, Culture and Social Services
MISP:	Minimum Initial Service Package

MoH:	Ministry of Health
MSF:	Medecins Sans Frontieres
NCCK:	National Council of Churches in Kenya
NDOP:	National Disaster Operations Centre
NFIs:	Non-food Items
NGOs:	Non-Governmental Organizations
NWH:	Nairobi Women's Hospital
OCHA:	Office of the Coordinator for Humanitarian Affairs:
PCEA:	Presbyterian Church of East Africa
PEP:	Post-exposure Prophylaxis
RHRC:	Reproductive Health Response in Conflict Consortium
SOWLIDI:	Solidarity of Women Living in Distress
STIs:	Sexually Transmitted Infections
TBAs:	Traditional Birth Attendants
UNHCR:	United Nations High Commission for Refugees
UNIFEM:	United Nations Development Fund for Women
UNPFA:	United Nations Population Fund
WHO:	World Health Organization
WRAP:	Women's Rights Awareness Program
YWCA:	Young Women's Christian Association

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I. Background

On December 30, 2007, the Republic of Kenya general election results were announced, followed by an eruption of violence in various parts of the country resulting in injuries, deaths and displacement of hundreds of thousands of Kenyans. As of February 5, 2008 Kenya Red Cross Society (KRCS) estimated the number of internally displaced persons (IDPs) at 325,775, and the number of camps at approximately 300. Ten days later, the National Disaster Operations Centre (NDOP) estimated the IDP population had decreased to 200,468. The emergency situation is fluid and the number of people displaced, as well as the number of camps, continues to fluctuate.[1]

Ongoing population movement, roadblocks, transport delays and an unpredictable security environment have created significant challenges to relief efforts. Despite these challenges, the KRCS and other humanitarian aid agencies have made considerable progress in providing the encamped populations with essential services, especially in larger sites such as the Agricultural Society of Kenya (A.S.K.) Showgrounds in Nakuru and Eldoret. Nevertheless, significant humanitarian response challenges remain in meeting the needs of those who have been displaced and/or affected by the post-election violence and are either living in smaller informal encampments or with family and friends in the wider community.

II. Rationale for the Gender-based Violence (GBV)[2] Rapid Assessment

Increased global attention in the last ten years to the issue of sexual violence committed during conflict has confirmed its widespread nature. Kenya is no exception: initial post-election data from Nairobi-based hospitals identified cases of rape occurring as a direct result of civil unrest, in some instances committed by roving gangs targetting specific ethnic groups. In response, an inter-agency team was deployed in mid-January 2008 to conduct a rapid assessment in affected areas throughout Kenya to evaluate the magnitude of sexual violence and availability of services for survivors.

[1] On February 28, 2008 a peace agreement was negotiated which has significant implications for the future of Kenya and GBV-related response efforts. For further on-going and updated information on the situation go to: http://ochaonline2.un.org/Default.aspx?tabid=10370

[2] A list of standardized definitions related to GBV are in Annex IV of this report. According to the Inter Agency Standing Committee GBV Guidelines, gender-based violence "is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females." Because around the world females are the primary victims of GBV, the focus of this assessment is on women and girls; however, any information obtained during the investigative process about sexual violence against men and boys is included in the report.

III. Aim of the Rapid Assessment

The assessment primarily aimed to broadly understand the nature and scope of post-election-related sexual violence, including rape and sexual exploitation, occurring during flight, within the IDP camps, and in settings where groups of IDPs are living with friends or relatives, and also attempts to identify other common vulnerabilities displaced women and girls face such as domestic violence. In addition, the assessment sought to evaluate the capacity of humanitarian actors and host communities to provide services to survivors of sexual violence and exploitation and to institute protective mechanisms to prevent additional incidents from occurring.

A secondary but no less important objective of the assessment was to raise humanitarian actors' awareness during site visits about the risks for women and girls of sexual violence and exploitation, and to encourage utilization of key guidelines and resources to ensure rapid implementation of prevention and response programming.

IV. Methodology of the Rapid Assessment

An interagency team led by UNFPA and including GBV experts from UNICEF, UNIFEM, and Christian Children's Fund (CCF) initiated the rapid assessment during the second week of January.[3] Thus far, investigations have been undertaken in selected IDP sites in North Rift Valley, South Rift Valley, and the Coastal Region. In Nairobi, the assessment was conducted in the slums as well as in several of the larger IDP sites. One IDP site was assessed in Central Province. Security permitting, the assessment will continue to Nyanza and Western Provinces in the coming weeks and information on sites investigated will be published in an addendum to this report.

Several internationally recognized resources informed the assessment focus and methodology. The Inter-Agency Standing Committee (IASC) *Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on prevention of and response to sexual violence in emergencies (2005)* provide a standard for assessing sexual violence issues in emergency assistance in so far as these guidelines delineate standards for planning, establishing, and coordinating humanitarian interventions to prevent and respond to sexual violence during the early phase of an emergency. The IASC Gender Handbook in Humanitarian Action: *Women, Girls, Boys, and Men: Different Needs - Equal Opportunities* (2006) guided the team in assessing the integration of gender issues into the humanitarian response. This handbook details strategies to enhance protection for populations affected by humanitarian emergencies through promoting the basic human rights of women, girls, boys, and men equally.

[3] Contact information for the assessment team is included in Annex I of this report.

Specific GBV assessment tools (e.g. situational analysis and focus group guidelines) were taken from the Reproductive Health Response in Conflict Consortium's *Gender-based Violence Tools Manual for Assessment and Program Design, Monitoring and Evaluation (2004).* In addition, the assessment team followed the methodological standards set forth by the World Health Organization, *WHO Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies (2007).* [4]

Investigative methods primarily included key informant interviews with provincial and district government partners, humanitarian field workers, and representatives of agencies working in the legal, security, health, and psychosocial sectors. Wherever possible, meetings were held with male and female IDP camp representatives and focus groups were conducted with displaced women and men.[5]

V. Limitations to the Rapid Assessment

Due to the brevity of the field visits (a maximum of three days in each site) the assessement team focused almost exclusively on those living in encamped settings , forgoing investigations of the large numbers of Kenyans who have been affected by the crisis but are not living in IDP settlements (with the exception of the Nairobi slums). In addition, interviews with stakeholders were brief and there were key representatives within each site who were not available during the visit, further limiting the scope of information collected.

The challenges of time constraints typically associated with conducting a rapid assessment were compounded in the Kenya assessment process by numerous additional issues, including the relative lack of coordination inherent in the early stages of emergency response, the ongoing movements of the displaced, the large number of informal encampments, security and logistical issues limiting access to certain sites, and the availability of translators to facilitate focus group discussions.

Moreover, because the assessment was initiated within the first weeks of an evolving crisis, some of the findings from the early site visits are now outdated. For example, humanitarian services in Nakuru have scaled up significantly since the assessment there; notably, reports of sexual violence, exploitation, and trafficking of girls in Nakuru have also increased since the assessement team conducted its field visits.

[4] The resources noted here are available, along with the report, at the GBV Sub-cluster website on the OCHA Kenya website, ochaonline2.un.org/kenya

[5] A list of key stakeholders from each region interviewed during the assessment process is in Annex II of this report.

As a result, the information provided herein is not comprehensive; rather it is meant to provide an overall impression of key GBV-related concerns in order to stimulate rapid prevention and response efforts by humanitarian actors mandated with protecting all those affected by the Kenyan crisis.

VI. Findings

This report is the initial output of the assessement process[6]; it contains a brief overiew of GBV-related concerns across all sites, followed by highlights of findings from each region. Although the assessment findings described herein are preliminary, they confirm that women and girls in Kenya have been and continue to be exposed to sexual violence and exploitation as a result of the post-election crisis. The findings further illustrate the urgent need for strengthening existing services and for developing new policies and programming to mitigate risks for women and girls and to ensure that GBV survivors have access to comprehensive and ethical services.

A. Nature and Scope of Sexual Violence

1. Sexual violence preceding and during flight

Sexual violence is not only occurring as a by-product of the collapse of social order in Kenya brought on by the post-election conflicts, but it is also being used as a tool to terrorize individuals and families and precipitate their expulsion from the communities in which they live. Investigation into sexual violence which occurred during flight yielded anecdotal reports from all regions, but in particular from Mombasa, Nairobi, and parts of the North Rift, of threats of sexual violence being used as a fear-instilling tactic, in so far as women were told they and their children would be raped if they did not vacate their property within a designated timeframe. Women were further threatened in the temporary shelters to which many fled; those who intially sought refuge in houses in Timboroa, for example, were told *"if you don't move, we are going to rape the women."*

In many instances, these threats were actualized: in Nairobi, the majority of adolescent girls in a focus group held in Kibera (Nairobi's largest slum) reported knowing someone who had been raped in the days following the election outcomes. Rates of displacement-related sexual violence were also reported as high by women seeking sanctuary in Tigoni, about 25-30 kms outside of Nairobi. Some of these rapes, according to profiles of rape survivors receiving services at the Nairobi Women's Hospital, were comitted by gangs of men and were accompanied by physical brutality, such as

[6] Additional outputs will include findings from Western and Nyanza provinces, as well and information gleaned from other assessments, to be posted to the OCHA Kenya GBV Sub-cluster site at ochaonline2.un.org/kenya.

inserting objects into the victim's genatalia. In Burnt Forest, women reported similarly widespread and brutal rapes. A Red Cross worker in Eldoret Showgrounds had reportedly heard so many details of sexual assault from the displaced women in the camp that *"he was overwhelmed – the stories were too difficult to hear."*

In settings where returns have been initiated, such as the Coast Province, threats are on-going; a mother in Mombasa was told by her neighbors they would rape her two adolescent daughters if she she returned to her apartment, saying *"these girls have never been with men; we want them."* Thus, the risk of targeted violence by men against women in their communities of origin is still present; in one recent case in Nairobi, a woman who briefly returned to her home in the Mathare slum to salvage her personal items was gang raped by eight men.

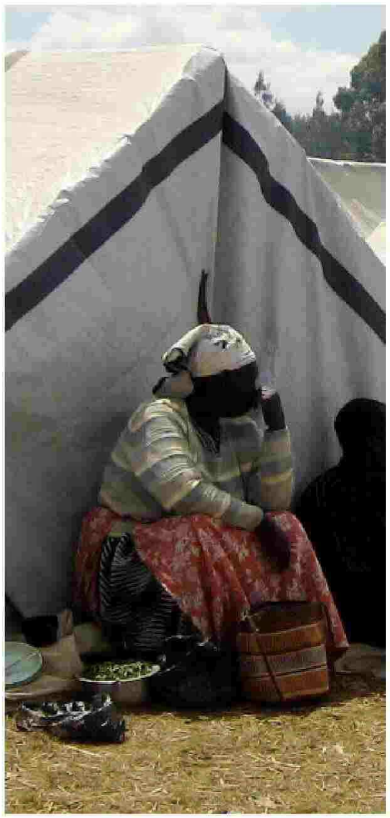
Evidence suggests that perpetrators are exploiting the conflict in order to commit sexual violence with impunity. And yet, the actual extent of rapes committed is difficult to determine. Service-delivery statistics from the Nairobi Women's Hospital and the Coast General Hospital give some indication of the scope of the problem in those settings: both hospitals have reported an upsurge in the numbers of women and children seeking treatment for rape since late December. At Nairobi Women's Hospital alone, over 300 women and children sought treatment for sexual assault in the first six weeks of the crisis.[7]

While useful, service statistics are certainly not a definitive indicator for rates of sexual violence. In other health centers located in settings where post-election violence was rampant, such as the Kitale District Hospital, Nakuru Provincial Hospital, and the Moi Teaching Hospital in Eldoret, the numbers of women and girls seeking medical care for sexual assault has declined in the last two months. Health care providers have attributed this decrease to the challenges women and girls face in accessing services during flight and in the current circumstances of displacement. (Notably, the use of all services at the hospitals has decreased since the elections, and up to 25 percent of health centers have been closed since the crisis due to staff shortfalls.)

> "Women will not say anything because your husband will leave you and the community will laugh..."
>
> ~ **Local NGO representative**

[7] Basic data from the Nairobi Women's Hospital is released regularly and is available on the GBV Sub-cluster site at ochaonline2.un.org/kenya.

There are a number of other reasons why women—particularly those living in rural areas--may not report. In Nairobi, where there has been widespread sensitization related to sexual violence and where health services for sexual assault survivors are comparatively accessible, many focus group participants frankly discussed their own experiences of being attacked and sexually assaulted during flight and within the camps when questioned generally about issues of personal security. Outside of Nairobi, revelations in focus groups conducted during the assessment about exposure to sexual violence were less consistent: in the majority of rural settings, women maintained that sexual violence was not a component of their displacement.



At the same time, women suggested that even if a woman was raped, there would be significant impediments to disclosing the assault. In Burnt Forest, women thought it highly unlikely that a survivor would report an incident because reporting would not be viewed as a priority compared to other immediate concerns such as security, food, caring for children, etc.: *"in a crisis like this, your first thought is to care for your children, get settled down, you don't even think to report…you are trying to figure out how to live."*

In Eldoret, a female camp management representative who related that there were significant numbers of rapes of women displaced from Kapsabet to Eldoret explained that women who tried to report were told by the Kapsabet police *"this is an emergency situation and this is not the time to think about these issues."* Women in a focus group in Kuresoi further explained that fear of abandonment by family members or other forms of stigma would likely discourage women from telling anyone about a case of rape.

"in a crisis like this, your first thought is to care for your children.. you don't even think to report…you are trying to figure out how to live."

~ Women in Burnt Forest

Those providing humanitarian response repeatedly echoed women's claims about the veil of silence surrounding sexual violence. The pastor assisting IDPs in his church in Munyaka (Eldoret) noted that there were threats of sexual harassment and rape during displacement, *"but here for someone to say that they have been raped would be really difficult."* In Rongai (near Nakuru), one local humanitarian worker suggested the limited reports of crisis-related sexual violence in that region were because *"women cover it up, but like the flower*

farms here in Rongai, sexual violence is rampant, at all levels." According to one expert working on violence against women in Kenya, if a woman's victimization were made public, *"her husband would divorce her outright."*

Identifying the prevalence of sexual assault is difficult in any circumstances: rape is one of the most underreported crimes in the world. In the Kenya context, the availability of services, the level of awareness about the value of medical assistance, the degree of trust in police and other security-related issues, as well as the cultural acceptability of acknowledging victimization in the different regions are each important considerations when attempting to identify the scope of sexual violence within and across geographic areas. The number of rape reports—especially in the earliest stages of an emergency, when women's focus may be on survival--should not, in itself, be an indication to the humanitarian community of the need for instituting protections for women and girls.

2. ***Sexual violence and sexual exploitation among the encamped populations***
Historically, IDP camps have posed significant risks for women and girls in terms of exposure to sexual violence and sexual exploitation. As the following summary illustrates, this is certainly the case for IDPs living in camps in Kenya.

a. Sexual Violence
During focus groups, encamped women—especially those in the larger camps such as the A.S.K. Showgrounds in Eldoret and Nakuru and in camps in Nairobi-- repeatedly expressed fear of sexual violence as a result of make-shift sleeping arrangements in the sites, where males and females (not of the same family) were forced to sleep together under one tent or out in the open. They also voiced concerns about lack of regulations in the camps allowing men from the outside to enter unchecked by camp officials and, in Nairobi in particular, women reported fears about sexual victimization linked to camp design and services, including lighting, water/sanitation facilities, and availability of firewood.

Even as women in the Eldoret and Nakuru A.S.K. Showgrounds were predicting assaults due to camp conditions, several humanitarian workers interviewed in these sites dismissed any potential problems related to sexual violence among IDPs. Some acknowledged its occurrence outside the camps, but stated that security was sufficient--particularly in the larger camps where police or other security were on patrol--to address risks. Most others were simply not considering the issue in the early stages of camp development. Not surprisingly, the number of sexual assaults in these larger camps appears to be on the rise: at

"women fear violence at any moment"
~ Women in Nairobi

the time of the assessment only one report of sexual violence had been received by camp officials at the Nakuru showgrounds but in the following week three more cases were reported.

Since then, incidents of camp-based rapes have been documented in all of the larger IDP encampments (Jamhuri in Nairobi, and the A.S.K. Showgrounds in Nakuru and Eldoret), and concerns have been raised by multiple humanitarian actors about the risks and prevalence of sexual violence amongst the IDPs. (Specific numbers, however, are still impossible to obtain because there is no central reporting mechanism in the camps for documenting cases of sexual violence.) During a recent assessment in Huruma Chief's Camp in Nairobi, one focus group participant remarked *"women fear violence at any moment";* another stressed that women were at even greater risk of attack than men. Indeed, in the night prior to the assessment visit, four women had been raped in the Huruma Chief's Camp. In Noigam, Transnzoi District, the night preceding the assessment visit was also frought: men in the camp reportedly tried to "grab" girls for sex, but were stymied when police fired shots into the air.

Several of the smaller, more informal and significantly less organized encampments investigated during the assessment presented a slightly different picture. In these settings—particularly those outside of Nairobi--humanitarian workers were more likely than the women themselves to highlight the risk of sexual violence. In Pyrethrum Camp in Molo Town, for example, KRCS and representatives from the National Council of Churches Kenya (NCCK) reported that incidents of sexual violence had been perpetrated by men in the camp against women and girls. By contrast, when interviewed about key safety issues, women themselves did not identify sexual violence as a significant concern; instead, they focused on water, food, and other essentials, as well as concerns about alchohol consumption by men in the camp. KRCS and NCCK attributed this discrepancy to the reluctance of women to acknowledge issues of sexual violence to the assessment team due to cultural taboos. Non-reporting on sexual violence may also have been related to the relative lack of humanitarian response in the camp and the priority given in focus group discussions to highlighting the dire need for basic services.

In Mombasa, a KRCS representative identified at least three cases of sexual violence occuring amongst the encamped IDPs, but the assessment team did not receive any reports from women during the interview process—perhaps in this instance because the assessment team arrived after the camps had been disbanded and the threat of camp-based sexual assault was no longer relevant. As reported above, however, women in Mombasa were very concerned about the risk of rape to women and girls returning to their communities of origin.

b. Sexual Exploitation

Across almost all sites, women freely acknowledged concerns about the risk of sexual exploitation of girls within the camps and by the host community. Even in the earliest stages of the assessment, incidents of sexual exploitation were already occurring, but in most instances were not being addressed by humanitarian workers. In Kamwingi II in Kipeklion District, a female camp representative stated that several girls in the camps were exchanging sex for biscuits and other food offered by men living in the camp. In the absence of any security or other support, the camp representative had taken it upon herself to counsel the girls to *"have good morals."* Mothers in Burnt Forest reported that their daughters were *"becoming spoiled"* – they were sleeping with men in the camp in exchange for resources.

In Burnt Forest, as in several others settings, security personnel were identified as potential perpetrators. Concens for younger girls about sexual exploitation by camp security were so great in Burnt Forest that, in the day prior to the assessment visit, women had convened a meeting to discuss the issue, but were discouraged by some in the group from making their concerns public. In Kuresoi, women stated that fears of sexual harassment by the police who were tasked with escorting them to collect firewood prevented them from leaving the camp. Additional concerns were raised in Noigam about the newly introduced contingent of military security, who the women felt posed a risk for girls in the camp.

The host community was also identified as perpetrating sexual exploitation. In Noigam, stories were related about girls leaving the camp during the day with men from community; some would miss camp curfew and stay the night in town. In the Eldoret showgrounds, women stated that girls were being seduced to leave the camp by men in the community with the promise *"to eat something sweet."* It was suspected these men were themselves exploiting the girls and/or engaging the girls in informal prostitution. In the early stages of camp development at the Nakuru showgrounds, girls were reportedly taken from the camp by community members to serve as domestic help, likely increasing their risk of sexual exploitation. While camp security attempted to address this issue by increasing

"people are doing things they would not normally do because they have to, it's about surviving and taking care of our children."
~ Women in Eldoret when discussing sexual exploitation

monitoring of community members entering and exiting the camp, several weeks later reports surfaced through the media of 30 children being taken under false pretenses from the camp, with girls being promised jobs but then being exploited for sex.[8]

While the focus of women's concerns related to sexual exploitation was primarily on girls, some female interviewees in the Eldoret showgrounds acknowledged that adult women were also exchanging sex for money—the forest around the showgrounds was reputedly littered with used condoms. Women stated that they were not being forced; rather they felt compelled to respond to an offer of payment for sex because *"we have to feed our children; if we don't do it, our kids won't eat."*

The men offering money in exchange for sex in the Eldoret showgrounds were identified as those who were able to go outside of the camp during the day and engage in casual labor, as well as those being paid by the KRCS for casual work related to camp development and maintenance. Although women stressed that rape—as it is classically understood in terms of forced intercourse—was not yet prevalent in the camps, they conveyed fears that *"in the future, men who do not have money will force us; we are very afraid because we don't know what will happen – what they will do to young ladies and even to us women if they are used to it [having sex], but do not have money?"*

Similarly, in Burnt Forest, it was reported that, *"people are doing things they would not normally do because they have to, it's about surviving and taking care of our children."* In Jamhuri Park, women described how men demanded sex from them in exchange for being allowed to warm themselves by nighttime fires.

3. Sexual violence and exploitation amongst the non-encamped

Investigations into the conditions of the non-encamped were unfortunately limited to the slums in Nairobi and, by virtue of the government-mandated closing of camps in the days prior to the assessment visit, in Mombasa. As reported above, several IDP women interviewed in Mombasa were reluctant to return to their communities of origin for fear that security was insufficient to prevent neighbors from carrying out threats of sexual violence. In Nairobi, men in Dandora concurred that *"no one, especialy women and girls, are safe at night."* In Kibera, security was also mentioned as a signficant problem contributing to sexual violence, with police officers identified as among the perpetrators.

Humanitarian workers and affected women in Nakuru, Mombasa, and Nairobi also repeatedly expressed concerns that commercial sexual exploitation will increase as displacement continues. In Nakuru during the prior displacements in 1992 and 1997, the number of commercial sex workers reportedly spiked in Nakuru Town. In Mombasa, where commerical sex work is already a significant problem, women

[8] *The Nation*, February 8, 2008.

suggested that transactional sex was already occuring amongst women and girls who lost homes and livelihoods during the post-election violence-- and was expected to increase--with concommitant increases in girls dropping out of school, early pregnancies, and STIs. Also in Mombasa, women identified sexual exploitation as a potential risk for all those children being sent "up-country" to be cared for by relatives who may not have the resources to protect them.

In Kibera, women expressed concerns about how sexual exploitation is becoming more frequent amongst their daughters, and girls themselves suggested that those without family were selling sex for as little as 20 shillings (about .30 USD) per intercourse. Interviewees in Dandora also acknowledged that women and girls who have lost their shops or stalls stalls may resort to transactional sex in order to survive.

B. Other Gender and GBV Concerns Among the Displaced

While this assessment primarily investigated issues of sexual violence and sexual exploitation, other gender and GBV concerns were continuously highlighted throughout all site visits, as briefly noted below.

Lack of participation in camp decision-making processes

Equal participation of women as compared to men in IDP camp management committees was not noted in any of the sites visited. In most sites, camp management committees had not yet been established; in fact, this failure to promote IDP representation and participatory processes was a point consistently raised to the KRCS and others during the assessment visits. In some settings, such as those in Nairobi and Nakuru, women clearly articulated that their lack of participation in decision-making processes was leading to problems in camp design, food distribution, and allocation of non-food items (NFIs) and other resources. Such problematic situations include, but are not limited to: overcrowding in shelters; communal bathing facilities with little to no privacy, forcing women and girls to bathe after dark; poorly lit facilities and pathways; lack of latrine and/or shower doors and, where they exist the inability to latch doors from the inside; risks associated with firewood collection; and men's and women's facilities located too close together, not clearly marked, or too far from shelter structures. Women also stressed the need for representation of those who were most vulnerable, including single mothers, elderly women, disabled women, and young girls.

> *"If a woman was beat by her husband and injured, you would go to the doctor and tell him it was an injury, like you fell or something. You don't say that he did it, or where will you go home to?"*
> *~ Woman, Kuresoi*

Lack of camp services specifically designed to meet the needs of women and girls, including reproductive health services

In almost all the camps visited, women had given birth and/or births were anticipated. However, appropriate services for pregnant and lactating women and ante/post natal services for mothers and their newborns are not consistent. In rural areas, many women who do not have access to adequate healthcare in the camps may be too afraid to leave the camps to go to local health centers; while many of these women may not typically give birth in health centers in any case, they do utilize them for antenatal and postnatal care. At the time of the assessment, clean delivery kits had not been widely distributed, and in smaller camps traditional birth attendants with minimal supplies were assisting women with childbirth. In some sites, maternal and/or infant deaths had already occurred. In more urban areas, pregnant women and mothers have better access to adequate services at nearby health centers. In addition to the concerns mentioned above, in virtually all the sites visited, women continue to be in need of other basic supplies such as underwear, sanitary napkins, and contraception, including pills, injectables, and condoms.

Domestic Violence

During several focus groups, women discussed increased risks of domestic violence that they attribute to frustrations men are experiencing as a result of being idle, not being able to provide for their families and not being able to regularly have sex with their wives because of cramped living arrangements as well as stress-related lack of desire among the women. According to women in Mombasa, *"when sexual desire has gone down, physical violence goes up."* Other women agreed that in the camps, a father *"is as good as a child"* and *"when the husband is not working, he becomes part of the children"* for whom the women are responsible. In at least three camps incidents of domestic violence requiring police intervention had already been noted.

Loss of Livelihood

Women repeatedly identified loss of livelihood as a serious concern, and yet there is little programming aimed at helping the most vulnerable rebuild small businesses that were destroyed during the post-election violence. Without support to reinstate or initiate income-generation activities, women are at increased risk for sexual exploitation. According to one woman, *"Young girls and some women need money so they accept offers from men; they have nothing to do to make money and need money for necessities."* During interviews, both women and men expressed frustration with being dependant on aid: *"We are business people, we are not used to begging and living off of relief--what we really need is someone to help us restart our busineses so we can get our lives back together."*

Divorce

In a number of settings, women, men, and humanitarian actors have expressed concerns about increased separation of husbands from their wives: some men send their wives and children to other areas for safety, and some intertribal spouses have

separated along tribal lines, usually leaving the women to care for the children. The reasons for separation appear to differ by region, but it was consistently noted by men and women alike that women's and children's separation from their husbands increased their vulnerability.

Early Marriage
Increased rates of early marriage have also been identified as a possible outcome of displacement. A number of stakeholders projected that the displacement and its economic ramifications could increase the number of parents who struggle to provide for their children and decide to marry their girls at a young age. For similar reasons, humanitarian actors and women stated girls are at an increased risk for being trafficked for domestic labor.

School drop-out
Several female leaders expressed concerns that girls would be discouraged by their mothers and/or fathers to attend school due to parents' fear for their safety, because school fees, if available at all, would be prioritized for boys, and/or because mothers needed the assistance of girls to manage the challenges of cooking, childcare, etc. while displaced. In addition, many of the camps do not have schools on-site and local schools often do not have the capacity to incorporate additional students, and even if they do have space, many families cannot replace school uniforms lost during displacement, such that school attendance in general is a concern.

Forced male circumcision
In various locations (Nairobi and Tigoni in Central Province) both service providers and camp beneficiaries mentioned incidents of forced circumcision of male children. Young boys under age 11 and small male children under 5 were rudimentarily cut with blunt objects such as broken glass.

C. Prevention and Response Programming

> "If a woman was raped and it was during the day, we would take her to the hospital, if not, we would wait, we will not go out at night."
> ~ **Woman, Burnt Forest**

1. Standards for Prevention and Response
One of the most essential responsibilities of the humanitarian commmunity – if not *the* most essential--is to protect civilians affected by conflict. And yet, throughout most of history, sexual violence has been largely ignored as an inevitable byproduct of wars and other forms of state and civil unrest. In the last ten years, however, significant advances have been made in highlighting the extent and impact of sexual violence during conflict, and in developing standards for humanitarian response aimed at redressing and reducing violence against women and girls.

In 1996, for example, the Inter Agency Working Group published a *Field Manual on Reproductive Health in Refugee Situations,* which provides the humanitarian community with a standardized set of actions, known as the MISP (Minimum Initial Service Package), to be implemented along with other first steps in an emergency response. Included as a health services standard in the 2004 edition of the *Sphere Project Humanitarian Charter and Minimum Standards in Disaster Response*, the MISP focuses on the prevention of and response to sexual violence, together with preventing maternal mortality and preventing HIV transmission, as priority reproductive health interventions in the acute phase of an emergency.

In 2003, UNHCR produced *Sexual and Gender-based Violence against Refugees, Returnees, and Internally Displaced Persons: Guidelines for Prevention and Response*, which identifies some of the overarching frameworks—such as the multi-sectoral approach—for instituting prevention and response programming in humanitarian settings. In 1995, the Inter-agency Standing Committee released *Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*. These IASC guidelines detail minimum standards for humanitarian actors working within and across multiple sectors (such as health, water and sanitation, shelter, site planning, etc.) in the prevention and response to sexual violence in the acute stages of an emergency. More recently, in 2006, the IASC published *Women, Girls, Boys, and Men, Different Need-Equal Opportunities*, a gender handbook that underscores, among other important issues related to promoting and protecting human rights, that addressing sexual violence requires understanding the underlying gender inequities that are at its core. [9]

As was mentioned in the introductory section to this report, these key resources form the basis of the assessment focus: gaps in sexual violence prevention and response were measured against the standards promoted by all of these guidelines. In particular, and taking into account the Kenya context, the assessment focused on two broad "sites" for prevention and response: 1) camp-based programming; and 2) community-based programming.

2. *Camp-based Programming*

Despite all of the activities that have been initiated by a number of local and international organizations, programming focused on prevention of and response to sexual violence remains inadequate in the camps. Some of the key concerns are highlighted below and elaborated in more detail in the site-specific summaries.

[9] All of the resources listed here are available at the www.rhrc.org/gbv and are also posted on the ochaonline2.un.org/kenya GBV sub-cluster site.

Camp Design, Management and Coordination
In the initial phases of emergency response, gender equality and GBV issues were not widely taken into account in the design and delivery of camp-based services. In the larger camps, such as the A.S.K. Showgrounds in Nakuru and Eldoret, efforts by the KRCS and other humanitarian actors have been scaled up rapidly and strides are being made to improve security and services within the camps. In the more rural areas and in some areas around Nairobi, where camps are smaller in size and populations are more transient, the humanitarian actors have faced more significant challenges in organizing response, and protections for women and girls remain poor.

In particular, basic camp security provisions--such as appropriate lighting in areas frequently used by women and girls, sex-separated toilets and bathing areas with doors and locks on the inside of the facilities, and patrols of firewood collection routes--have not yet been incorporated in many of the camps. In one camp visited in Nairobi, for example, women reported being sexually assaulted when going to get water because they had to leave the camp, and again while going to the latrines due to inadequate lighting.

The KRCS has been coordinating all camp-related activities and interventions, but as of yet, no focal points have been identified to ensure that gender and GBV-related issues in each of the camp settings are addressed through camp-based coorindation mechanisms or through larger district, provincial, and national level multi-sectoral (eg. health, protection, water and sanitation, camp management and coordination etc.) coordination mechanisms. Thus far, the government has also not taken up the issue: although Eldoret and Nakuru both have coordination committees facilitated by government representatives as well as a protection cluster that is engaged around GBV issues, the Ministry of Gender, Sports, Culture and Social Services (MGSCSS) has not been activated in these or any other regions to promote monitoring of gender and GBV-related concerns among the displaced.

Camp Security
Investigations suggest that police units protecting the camps have not been adequately trained on response to sexual violence, Sphere standards for disaster response, or codes of conduct related to sexual exploitation and abuse. In Nairobi, survivors have expressed reluctance to report threats or incidents of sexual violence to police because of their failure to offer a basic level of security. When discussing the process of reporting with a police officer in one camp in Nairobi, he stated that if a woman came to report, she would need to bring something that contained blood for evidence. In Nakuru, a police officer explained that if a woman was raped, she would be taken to the hospital with the perpetrator, where the validity of the accusation would be determined. More promisingly, a police officer interviewed in Eldoret appeared to have some training on response to sexual violence, in that he discussed the need for

confidentiality, privacy during interviews, and the importance of not blaming the survivor. At the time of the assessment, only one of the sites visited had female police officers.

Camp-based Health Services
The health sector has quickly responded to address a number of the basic needs of the encamped population. However, response to sexual violence is still limited in the majority of camp settings: of the fourteen camps visited and detailed in this report, none had adequate medical services available on-site to respond to an incident of sexual violence. Although post-exposure prophalyxis (PEP) kits were procured by UNFPA to cover 400,000 people, there were delays in distribution such that the majority of camp-based health centers and mobile clinics are not able to administer post-exposure prophalyxis (PEP) to prevent HIV, nor can they administer emergency contraception or treatment for STI's, and they do not have established referral systems. If access to sexual violence services is obtained in an IDP site around Nairobi, it is generally facilitated by St. John's Ambulance service or through camp visits by Nairobi Women's Hospital.

In addition to a lack in health services for survivors in the camps, there is limited awareness among the displaced population about where to report and the need to report within 72-hours of an incident so that PEP can be administered. Therefore, even in areas where there are governement hospitals capable of responding to cases of sexual violence, most women are unaware of how and when to acccess these services.

Camp-based Psychosocial Services
Teams of psychosocial workers have moved very quickly to provide support services to the encamped populations since the initial phases of response. Counselors have been deployed to many of the larger camps and there are ongoing efforts to expand psychosocial support to rural areas. Women in Nakuru and Eldoret reported taking full advantage of these services and appreciate the quality of care given by the psychosocial workers. With the exception of two counselors working in Eldoret, however, it was not evident on the ground that any of the psychosocial actors had specific expertise in responding to sexual violence. During subsequent discussions with Nairobi Women's Hospital, it was suggested that there were additional counselors with training on GBV issues who had been deployed to the field, though actual numbers where not available. Moreover, in some settings there are no tents for counselors, such that services may be provided in the open, compromising confidentiality.

3. Community-based programming
Due to limitations in camp-based services, as well as the non-permanent nature of the camps, it is essential that the displaced have access to services within the host communities. The multi-sectoral model is used herein as a lens when considering the support that should be available to survivors in the wider community. A basic premise

of the multi-sectoral approach is that GBV cannot be sufficiently addressed through the provision of services within a single sector, but rather should the outcome of coordinated activities between the constituent community, health and social services, and the legal and security sectors. Multi-sectoral programming is limited across Kenya, but even moreso in the rural areas where few, if any, services are available to survivors.

Health services

Comprehensive post-sexual violence services are available in the Nairobi area through the Kibera South Médecins Sans Frontières (MSF)/Ministry of Health (MOH) Health Centre, MSF Blue House (Mathare), National Kenyatta Hospital Gender Violence Recovery Center (GVRC), Nairobi Women's Hospital GVRC, MSF and the Ministry of Health Riruta Health Centre (with support from Liverpool VCT), but these services, except for those of Nairobi Women's Hospital, are often unknown and under-utilized. The catchment area of Nairobi Women's Hospital is therefore extremely large, such that the hospital is inaccessible to many women and girls, especially those from many of the informal settlement areas. Referrals are also often made to clinics that do not actually provide sexual violence response services, which may dissuade some survivors from ultimately seeking health services that they need.

Though some sexual violence response services do exist in the urban areas outside of Nairobi, their capacity and resources are limited. For example, in Mombasa and Eldoret, the government hospitals have privately-funded gender violence recovery centres[10]. Both of these facilities lack resources to employ sufficient staff. The services are only available from 9am-5pm, Monday through Friday, and one nurse runs each facility--the rest of the staff is pulled from the hospital when a case is presented. These staff have reportedly not been trained on how to respond to survivors, confidentiality, or the medical management of rape.

Psychosocial Services

Based on the assessment, it seems that the encamped population is receiving psychosocial support from within the camps—no participants interviewed reported receiving psychosocial support from within the community. However, in the urban areas there are psychosocial services reportedly available, though it is unclear how many providers have been trained on GBV issues. For example, in Eldoret, Academic Model for Prevention and Treatment of HIV/AIDS (AMPATH), a collaboration among Moi University School of Medicine, Moi Teaching and Referral Hospital and the IU-Kenya Partnership, provides psychosocial services focusing on HIV/AIDS, but they have not been trained extensively on responding to GBV.

[10] Gender Violence Recovery Center at Coast General Hospital in Mombasa and Center for Rape-Eldoret at the Moi Teaching Hospital

Several agencies around Nairobi provide counseling related to GBV. However, most of these services appear to be drop-in centers outside of the slum areas, which may not be easily accessible to many of the individuals directly affected by the crisis. A number of agencies also provide shelter services in Nairobi, but these tend to be focused more on children than women.

Community education and awareness programs related to GBV appear to be extremely limited in scope. Yet, there are some health care facilities in Nairobi, such as the Nairobi Women's Hospital, that are engaged in community awareness activities to ensure that people are informed about their post-rape care services.

Security Services
Even though women's and children's desks exist in many of the police posts in some of the larger urban areas and towns, interviews with police suggest that there has not been widespread training on general GBV issues and/or appropriate response to sexual violence, nor do police have the resources to ensure that all sexual-violence related complaints are investigated. Even if a police officer has a heightened awareness and sensitivity about sexual violence, lack of resources may make it particularly challenging to ensure the safety and security of survivors. During an interview in Tigoni, a police officer explained how she had to take a survivor to her home to ensure her safety because there were no other options for safe housing available in the community.

Legal Services
Due to time constraints, in most regions outside of Nairobi, the legal sector was not extensively examined. This lack of information may also have been compounded by the fact that the legal sector has not yet been widely mobilized to work directly with the displaced. However, a number of agencies are engaged in law and policy reform related to GBV, and an even larger number provide legal aid services for women and children, particularly in the Nairobi area (including: the African Network for the Prevention and Protection Against Child Abuse and Neglect, Child Legal Action Network, Coalition of Violence Against Women, the Child Rights Advisory Documentation and Legal Aid Center, the Federation of Women Lawyers and Girl Child Network).

Due to the strong efforts of the organizations listed above there are many promising aspects of the Kenyan Legal System with regard to GBV. At least in Nairobi, specialist magistrates exist in each court. One magistrate is responsible solely for sexual violence cases. Those court personnel who are regularly assigned sexual violence cases are required to undergo special training on the Sexual Violence Act. All rape survivors, including children, can testify *in camera*, and the courts employ specialists trained in working with children and targeting questions to the developmental stage of the child. As of 2003, the complainant is considered by law to be the victim of a crime of sexual violence-- such crimes are no longer considered by law to be crimes against the state,

allowing for the decision about pursuing prosecution to be left with the survivor. Domestic violence is also covered under the penal code, as opposed to the civil code, and cases of domestic violence can be withdrawn should a survivor change her mind during the process. Lastly, Kenya's Law of Succession Act treats matters of inheritance quite fairly for women and recognizes even traditional/common law marriages, something that may be of great importance in the current crisis for women of mixed marriages who have been abandoned by their husbands.

Yet, despite the progress that has been made in legal sector, whether in rural or urban settings there are a number of challenges to assuring survivors' access to legal justice. Informants revealed that funding limitations make witness transport to/from police stations and courts difficult. Deoxyribonucleic acid (DNA) samples are often useless because there is no appropriate forensics lab in the country, and the Government Chemist that is often used for testing DNA samples often does not have all of the chemicals needed to preserve the samples.

Moreover, investigations often last longer than the 24-hour limit to detain a suspect before arraignment, and this period often does not even allow for the conclusion of the medical report findings given that an official Medical Examination Report must be completed by a certified doctor, of whom there are few. Even when a Medical Examination Report is successfully completed, it often takes as long as a year for a case to go through legal proceedings, and many survivors lose hope or lack financial resources to continue.

Coordination

There was no evidence during the assessment that any specific coordination bodies exist for addressing sexual violence at the provincial or district levels. Since then, GBV issues have been incorporated into the protection cluster meetings held weekly in Eldoret and Nakuru. At the national level a GBV sub-cluster has been established by UNFPA and co-chaired by KRCS to coordinate multi-sectoral action related to the Kenya crisis among the health and social services actors, and the legal, human rights and security sectors. The sub-cluster is focused on strategic planning, capacity building, gathering information and resources, policy development, data management, resource mobilization, and maintaining effective action for both prevention and response. The sub-cluster also aims to establish district- level GBV working groups to better monitor and address issues affecting the IDPs. While the GBV sub-cluster was developed in response to the IDP situation in Kenya, it is anticipated that the responsibilities of the group can be transitioned to the appropriate government bodies when the crisis has

diminished and will therefore be a sustainable mechanism to lead GBV coordination nation-wide.[11]

VII. Highlights from Regions Investigated[12]

A. Nairobi

In the Nairobi area, the assessment was conducted in five IDP sites (of approximately 34 in total) in and around five of Nairobi's largest slum areas (Dandora, Kibera, Korogocho/Kariobangi, Huruma, and Mathare) that have been most directly affected by the post-election civil unrest.

The IDPs in the greater Nairobi area have been displaced both long and short distances, often less than one kilometer. Some lost everything in the post-election violence, while others have retained possession of their houses and/or personal belongings. Large numbers of IDPs are living in mostly informal IDP sites, while an untold number of individuals and families are living with friends and relatives. Most IDP sites are located in the Eastlands area of Nairobi, which includes the informal settlements of Korogocho and Mathare, where post-election violence was particularly intense. The slum areas assessed were known for high rates of violence, including GBV, even preceding the elections.

1.) Nairobi Area IDP Camps

a.) Jamhuri Park (Kibera area) February 7, 2008

At the time of the assessment on February 7, 2008 the population sleeping at Jamhuri Park consisted of approximately 2,300 persons from various ethnic communities, mainly residents of Kibera and Kawangware slums around Nairobi, and from Burnt Forest and Kajiado in Rift Valley Province. During the visit it was difficult to identify those who are currently residing at the site as many were observed wandering around, and volunteers noted that the number of people sleeping at the site is significantly lower than the number receiving assistance.

[11] The terms of reference for the GBV Sub-cluster is attached in Annex III of this report. The sub-cluster has developed matrixes of programming and training activities being undertaken by its members to address the gaps identified in this report. All the GBV sub-cluster meeting minutes, reports, matrixes of activities etc. are available at the OCHA website, ochaonline2.un.org/kenya.

[12] The OCHA website has maps available to identify key provinces and districts in Kenya covered in this assessment.

Nature and scope of sexual violence

- St. John's Ambulance Service has transferred seven cases of rape (6 adults and 1 child) to Nairobi Women's Hospital from this site.
- Two girls have approached the camp-based children's centre to complain about sexual assault at the site during night hours.
- Anecdotal reports were made of men demanding sex from women in exchange for letting them sit near nighttime fires to warm themselves.

Other gender and GBV concerns

- A system of organized security was not apparent at the site. Several women mentioned that they do not feel secure in the camp. Women reported that bathing and latrine facilities are not safe for them or their daughters due to their proximity to those of men. Other characteristics of the campsite including many long, dark and isolated pathways, wooded areas, small empty buildings, and lack of safe recreational spaces for children bring up other security concerns.
- While it is important that non-camp residents who have been displaced from Kibera have access to needed services, the proximity (10 minutes) to Kibera, and the porous camp borders are a security concern, which may allow opportunities for those who created havoc in Kibera to enter the site. One resident reported feeling unsafe because she had seen some of the people who were perpetrating violence from Kibera in the site.

Prevention and Response

Gender-based violence prevention and response services are virtually nonexistent in Jamhuri Park. While abuse reports are being made, there is no system in place to report abuses, and despite the appearance of many active organizations--including the NCCK, African Network for the Prevention and Protection Against Child Abuse and Neglect (ANPPCAN), Childline, CRADLE-The Children's Foundation, Book of Hope Kenya, and the Dagoretti Volunteer Children's Officer--no organization is focused on the provision of GBV services except St. John's Ambulance service, which assists in transferring sexual violence cases to Nairobi Women's Hospital.

Medical Assistance Programs (MAP) International is coordinating six organizations in the provision of medical assistance, yet women do not have access to reproductive health care at the site. Neither condoms nor PEP kits were available at the time of the assessment, likely due to difficulties in distribution of the supplies procured by UNFPA. While a significant amount of counseling is provided on an ongoing basis by volunteers who are predominantly from church-based organizations coordinated by the NCCK, these services are not specialized to meet the needs of GBV survivors or address other reproductive

health concerns camp residents might have. When a volunteer counselor was asked about the availability of condoms at the site, she stated, *"No! Condoms will encourage immorality. I'm a Catholic, I don't believe in condoms."*

b.) Huruma Chiefs Camp[13] (Huruma area), February 4, 2008

The IDPs at this site are from Mathare and were originally displaced to a makeshift camp outside of the Moi Airbase. When that site was closed they were relocated a few kilometers away to an area beside the Huruma Administration Police Station. The number of IDPs sleeping at the site at night is approximately 215 (169 female/46 male). During the day the numbers may swell to over a thousand.

Nature and scope of sexual violence

- During an initial visit made to the camp women reported rape and sexual abuse in their trips to fetch water or use the latrines. They reported that groups of men with *pangas* have entered the camp at night and have raped women.
- Women also reported rapes perpetrated by camp residents, adding that four rapes had taken place the night before. Although these rapes were not reported to the police, IDP women said that the survivors had received medical treatment at a nearby clinic.
- During the visit, one assessment team member was talking to a group of women and as the men drew near, she heard them say that if they said anything they (the women) would be attacked later.
- During a second visit to this camp, a report surfaced of a gang rape by eight men of a 35-year-old woman who had returned to her house in Mathare to see if she could salvage anything. This case was treated at Nairobi Women's Hospital, but when the woman initially tried to report the incident and seek support from the police she was told by the police officers, *"if she does not know the men who raped her, she should 'just' go to the hospital."*

Other gender and GBV concerns

- Access to livelihoods was highlighted as key towards helping women and girls recover from incidents of violence. One woman stated, *"Women need to be able to plan for their future, to be able to move forward and to start a new life. They need to be able to take care of themselves, to do business."*
- Security issues were also noted as problematic in this site, as the camp is open on two sides. One woman, aged 42, stated *"women fear violence at any moment."*

[13] This camp is sometimes referred to as the Huruma/Mathare Chief's Camp since both Chiefs have their offices here and given that it is near a border area.

- Discriminatory practices based on tribe were emphasized as problematic, especially for women. Several women stated that they were often left out of distributions, something that may leave them more vulnerable to sexual exploitation and abuse.
- Women are not involved in camp decision-making. Many women voiced frustration with the way their voices were left out of decisions that impact them directly.

Prevention and Response
Availability of GBV-related response services is limited in the Huruma Chief's Camp. The Ministry of Health has assessed the situation at the site, and St. John's Ambulance Service has assisted at least one survivor in accessing services at Nairobi Women's Hospital. A tent was set up to provide medical care, but when passing the camp a second time the tent was no longer there. The MSF-Belgium Blue House is said to be a referral option for the area, where ARTs and comprehensive sexual violence services can be obtained.

"If she does not know the men who raped her, she should 'just' go to the hospital [and not to the police]."
~ Nairobi police officer about a woman who was gang-raped by 8 men

Despite the fact that reports have been received in this camp, in some instances, camp staff was apprehensive about acknowledging the issue of sexual violence. Initially the KRCS/Mama na Dada (a local NGO based in Nairobi) volunteers working in the camp did not report problems, but one later confirmed that rapes have happened. Meanwhile the camp chief denied the problem outright, stating that there are *"no"* problems of security and/or rape at the site.

Fear and stigma were acknowledged as issues that keep women from reporting violence and seeking assistance. Women stated that they were not prepared to report the rapes or even to talk about the issue amongst themselves for shame and also because they are afraid the perpetrators will target their daughters.

c.) Hope Star of Academy/Soul Winning School (Mathare area) February 5, 2008
The IDPs at this site are from Kijiji Chachewa in Mathare North. This site, a private school, hosts 249 adults and 56 children. In an earlier assessment 750 persons (600 adults, 150 children) were taking refuge at this site, many of these have now left – either to other camps for the displaced or out of Nairobi.

Nature and scope of sexual violence

- Though it was not possible to obtain hard data on case reports, during the GBV assessment visit and an initial Child Protection assessment visit women reported that rapes were widespread during the burning and looting of Kijiji Chachewa: One woman stated that during the attacks *"police were telling people to rape, brute [sic], pillage, but don't kill."*

Other gender and GBV concerns

- Tension and fear were expressed by women in the camp. During the day, they would only move around outside the camp in groups. After dark they said it was too dangerous.
- Women, both young and old, reported that they go in groups to collect firewood because they are *"afraid of being snagged and raped or slashed."*
- Treatment, care and proper nutrition for HIV-positive residents, especially women, were also highlighted as obstacles in this camp.
- There is only one toilet for all 305 camp residents, posing additional security, hygiene and sanitation risks for women and girls.

Prevention and response

A few camp residents reported that three organizations were providing psychosocial counseling. No health workers were identified at the site, despite the fact that Soul Winning School has been identified as one of the Nairobi Women's Hospital sites that offers medical and psychosocial support for survivors of sexual violence.

2.) Nairobi Settlement Areas[14]

a.) Dandora Area (Phase 4 Awendo) February 6, 2008

> ***"No one, especially women and girls, is safe at night"***
> *~ Man, Nairobi*

Dandora is a high-density slum area in the eastern part of Nairobi, with elevated crime and unemployment rates. The area is most recently known as the place where slain Mr. Melitus Mugabe Were, a freshman member of Parliament, grew up and where he served as a councilman.[15] As a small indication of the level of destruction this slum has incurred, men and women were interviewed by the GBV assessment team directly across from a sizeable apartment building that was completely burned during post-election rioting.

[14] Note that for this section covering Nairobi settlement areas, the prevention and response recommendations are presented at the end of the entire section rather than within the summary of each site since many of the prevention and response activities overlap sites.

[15] Jeffrey Gettleman, "Would-Be Peacemaker Killed in Kenya", *The New York Times*, January 30, 2008.

Nature and scope of sexual violence

- Women reported that many women and girls have been raped in the area since the election.
- The Provide International health clinic in the area reported that they received three cases of rape during the post-election period, one case involved an 11-year-old girl and two involved women above 18 years.
- Transactional sex is becoming more common due to the crisis. Women reported that many have lost their shops or stalls where they made their living, leading more women and girls to sell their bodies for money or food.

Other gender and GBV concerns

- Both men and women reported major concerns of security and fears related to moving too far from where they were currently staying with friends or family. One man stated *"no one, especially women and girls, are safe at night."*
- The women underscored that they want to play an active role in peace building, but cautioned that, *"they need security to be peace builders."*

b.) Katwekera, Kibera, February 8, 2008

As many as one million people live in Kibera slum, one of Africa's largest informal settlement areas. Kibera has residents coming from all the major ethnic backgrounds, and is known for on-going small ethnic conflicts. Since displacements started in the Nairobi area, there have been approximately five "official" (meaning recognized and served by the humanitarian community) IDP sites identified in this area, housing approximately 2,821 people: Dagoretti, Kawangware, Riruta Orthodox Church, Riruta Satellite, and Jamhuri Park.

Nature and scope of sexual violence

- Security issues, including rape, were mentioned repeatedly by women and girls in Kibera. They emphasized that, *"things are not ok*!" Women reported they cannot venture out to engage in their small businesses, afraid that they might be killed, brutalized, or raped at any moment.
- One woman stated that she cannot sleep at night because she hears voices: *"The Mungiki are coming [to rape]."*
- The women and girls confirmed that many of their peers had been raped during the worst of the violence, and that they still remain at risk. They mentioned that police officers are often the perpetrators. One woman stated, *"If you tell GSU [General Service Unit or Police] you are HIV positive, they will beat you and still rape you."*
- Economic hardships women and girls are faced with due to the conflict are putting them at increased risk of sexual exploitation and abuse:

- The older women voiced concerns about how sexual exploitation is becoming more of a problem for their daughters. Higher commodity prices mean that girls have to sell their bodies to shopkeepers to meet their basic daily needs.
- The girls revealed concerns for their peers who do not have any relatives around (of which there are many) and are forced to *"keep bad company"* – meaning selling sex for as little as 20 shillings per intercourse.
- The girls said that since the conflict, they also struggle more with peer pressure to obtain "nice things" such as fancy clothing, body lotion, and hair oil.

Other gender and GBV concerns

- Women and female and male youths pointed out that security in the slums is a pressing issue for everyone, but especially for women and girls.
- The current economic hardship is making access to the basic needs challenging for women and girls. With little to no money to obtain basic supplies such as sanitary towels, girls reported having to resort to humiliating and unsanitary tactics such as using paper or newspaper to absorb their menses.
- Condoms are also difficult to obtain, and women underscored concerns about their daughters being at increased risk of STIs including HIV. They stressed that more money given by a man for sex means no condom, whereas less money means a condom can be negotiated on the part of a girl during transactional sex.

c.) Huruma Settlement Area, February 4, 2008

Huruma is an informal settlement area that houses about 6,500 people and borders the Mathare slum area. Since population movements in Nairobi started, there have been about three major "official" and "unofficial" (meaning no camp management system) IDP sites identified in this area, housing approximately 2,616 people: Huruma Lions Police Post; Central Ghetto Slums and Kiamiko.

i.) Kiamiko Road Area and Ghetto Village

Many people affected by the displacement in this part of Huruma are thought to be displaced within the community and residing with neighbors or friends. In one site approximately 850 adults and 1,400 children are still living in a walled- off area to prevent the community from further pillaging.

Nature and scope of sexual violence

- Of children involved in the Christ Chapel Centre, two cases of defilement have occurred post election: one 11 year old and one 8 year old. Both child survivors were referred to NWH.

- Women noted that sexual violence perpetrated against women and girls was a major part of the post-election clashes.
- Women revealed significant concerns for their security. One woman reported there is "*no security*" for women in this area, and that women even more than men are under threat by individuals from other tribes. They also reported that some women fear attacks by their male community members when they are forced to sleep in the open since their homes were burned down.

Other gender and GBV concerns

- Women in this area voiced concerns about many women being HIV-positive who are having trouble accessing ARTs.
- Women reported fears about losing their children and husbands in future incidents of violence, and that similar fears about their own safety make them reluctant to leave their small fenced-in areas. Distress symptoms such as inability to sleep, headaches, and loss of appetite were reported.
- Due to these fears of leaving their living area, women reported that maternity services were difficult to obtain, and they relayed concerns about having a shortage of food and firewood for cooking soon. Currently they burn wood remnants from their destroyed homes.
- While women reported that there are supply distributions in various locations they could access, they stated they usually did not receive information on time, so that when (male) members of their community go to access the distributions, resources are frequently depleted.

e.) Mathare Settlement Area, February 5, 2008

Mathare is a collection of slums in Nairobi with a population of approximately 500,000 people. This area has a history of violence, largely due to tensions between rival Luo (Taliban) and Kikuyu (Mungiki) gangs. Following the presidential elections Luo gangs reportedly burned more than 100 Kikuyu homes.[16] There have been about seven small IDP sites in this area serving approximately 2,487 people: Mathare 4, Mathare Police Post, Match Camp, Nairobi Mosque Camp, Moi Air Base Environ, Stare of Hope Academy/Winning Soul School; and Presbyterian Church of East Africa (PCEA) Church.

Nature and scope of sexual violence

- While the women said they felt safe in this location and that they had not experienced any harassment, when asked why they were not staying at the nearby Huruma/Mathare Chief's camp, they replied that it was because rape occurs there.

[16] Jeffrey Gettleman, "Disputed Vote Plunges Kenya Into Bloodshed", The New York Times, December 31, 2007.

- At the time of the assessment, Mathare North Health Center reported that they had received three cases of rape since the election—a number they considered high for their facility.
- MSF Blue House in Mathare reported that they had only received about 4 cases since the election—a number that they considered low given the common perception among staff and other service providers in the area that sexual violence has been a major problem during this period of unrest.
- MSF France also received one case of sexual violence that was perpetrated by two men against a woman over 35 who was dragged out of her house and raped in front of her husband.

Other gender and GBV concerns

- In this area several women reported they were HIV-positive and having trouble accessing the ARTs and/or that they do not have enough food to take their drugs.
- Women in this area reported that they are unable to access health services because they have no money to pay the required fees.

3.) Nairobi Settlement Area Prevention and Response

Comprehensive post-sexual violence services are available in the Nairobi area through the Kibera South MSF/Ministry of Health (MOH) Health Centre, MSF Blue House (Mathare), MSF France, National Kenyatta Hospital Gender Violence Recovery Center (GVRC), NWH GVRC, and the Ministry of Health Riruta Health Centre (with support from Liverpool VCT).

Marie Stopes Kenya also provides post-rape care that includes provision of emergency contraception and STI prophylaxis treatment aside from PEP, through six clinics: Eastleigh, Kencom City, Kenyatta Market, Kibera, and Kagemi. For PEP, Marie Stopes Kenya makes referrals to one of its HIV partners.

NWH is by far the most widely known referral site for sexual violence services in spite of its inconvenient location for many slum-based patients. From Dandora and Korogocho, for example, women stated that it might take them an hour and a half to two hours by car. Still, referrals to NWH continue to be made because service providers are largely unaware of the alternatives listed above.

In some instances women and girls are mistakenly referred to facilities that do not provide sexual violence response services. For example, during assessments in Mathare and Dandora women stated that they thought many survivors had received services from Provide International. However, in a follow-up visit to one of the Provide International clinics in Dandora, staff reported that they had only received three cases since the election and that survivors of sexual violence are always

referred to NWH. Such confusion has the potential to dissuade some survivors from seeking health services. Community members and service providers alike need better information on facilities that offer comprehensive post-sexual violence care and treatment.

During health center visits to Provide International and Mathare North it was difficult to gain a clear understanding of the protocols used to medically manage the needs of survivors (including the provision of first aid and referral), indicating a need for capacity-building to ensure that multiple health centers throughout Nairobi can provide comprehensive sexual violence medical management services. Another major concern is that most medical services are not free in many facilities, if they are offered at all, except at Kenyatta National Hospital and NWH.

Service providers from a variety of sectors reported that they know that sexual violence has been a major part of the post-election violence, but that actual reports/cases they have received have been low. Interviewees believe that a significant number of rapes that occurred early after the post-election crisis have likely not been treated because many women in the slum areas are still fearful of moving around. It is also possible that many of these women may have been referred to health facilities (such as Provide International) that do not treat sexual violence cases.

Both women and girls revealed low levels of knowledge on what to do after a rape occurs. Only one woman was able to articulate the steps to her peers in the group; another woman suggested that they should gather women together to talk about what to do and where to go if they are attacked.

When asked if they think that a woman who has been exposed to rape would usually seek medical services, many women expressed doubt, in particular due to a woman's fear of the police finding out because police are among the perpetrators. Women and girls in the Nairobi settlement areas repeatedly voiced concerns about making reports of sexual violence to the police, making such statements as, "*No! Women are afraid to go to the police.*" According to some women, "*the police do not take [rape] seriously,*" making dismissive statements such as, "*do you know who the perpetrator is? Well, what do you have to tell us then?*" One solution offered in interviews to change police behavior was to bring in female police officers.

A number of agencies are engaged in law and policy reform related to GBV, and an even larger number provide legal aid services for women and children in the Nairobi area (including: the ANPPCAN, Child Legal Action Network, Coalition of Violence Against Women, the Child Rights Advisory Documentation and Legal Aid Center, the Federation of Women Lawyers (FIDA) and Girl Child Network. While

none of these agencies focus on service provision for IDPs, many are taking the initiative to engage in outreach activities in some of the Nairobi area IDP sites.

Consistent with reports in the health sector and in the communities, many of the legal sector service providers interviewed, including FIDA and WRAP, reported seeing a decreased caseload during the post-election period. However, they noted that slowly, as things begin to settle down, they are beginning to receive reports related to gang rapes and cases where women in mixed marriages have been abandoned or sent away. In their opinion the decreased reporting is not linked to a decrease in violations, but rather to heightened safety and security concerns.

On the criminal justice side, assessment findings draw upon visits to Pagani, Mathare, and Nairobi Area Traffic Posts and the Makadara Law Courts. The Nairobi Area Traffic Post was chosen because this is the official location of the only certified Police Doctor in all of Nairobi, the only doctor qualified to sign off on a "P3" official Medical Examination Report Form in the entire city. The assessment team made three unsuccessful visits over the period of six days to find the doctor at his post. This Police Doctor is responsible for testifying in all crimes where an individual has been physically harmed (e.g. rape, physical assault, traffic accidents). Thus, he is nearly always busy, either seeing people waiting to have their form verified, or testifying in court. On each occasion of the visits, it was possible to observe long lines of people queued for the eventual return of the doctor.

Many survivors may be dissuaded from pursuing justice in a sexual violence case due to the sheer inconvenience of obtaining the Nairobi Police Doctor's signature. This systemic disincentive is only compounded by a related problem observed in the course of this assessment: whether or not a survivor reports first to the police or to a health care facility, she/he may have to be examined twice-- once by the health facility and once by the Police Doctor. It was also possible to witness failure of the system to maintain the safety, security and confidentiality of a survivor. Individuals often have to state their issue aloud in front of a queue of people.

Several agencies around Nairobi provide counseling related to GBV. However, most of these services appear to be "drop-in" centers located outside of the slum areas, which may not be easily accessible to many of the individuals directly affected by the crisis. This list includes, but is not limited to: Amani Counseling Center, Childline, Child Life, and Kenya Association of Professional Counsellors Association, FIDA and Women's Rights Awareness Programme (WRAP).

Very few agencies are providing outreach services related to the current crisis. Those that have been identified include: African Medical and Research Foundation (AMREF) --providing counseling sessions to women, men and children on GBV

related issues in outreach sites in Kibera; Kenya's African Women's Development and Communication Network--providing on-going counseling sessions (to both men and women) on GBV related issues in Huruma; and Women's Empowerment Link--providing counseling support in Kibera and Mathare. The vast expanses and high population density of the slums make it hard to determine how accessible these services are to individuals directly affected by the post-election unrest.

A large number of agencies provide shelter services, which are often referred to as 'rescue' services, for children who have suffered sexual violence. This list includes, but is not limited to: Childline, Child Life, Good Samaritans Home, SOS Children's Village, Mama Fatuma Children's Home, and Undugu Society. Staff informants from several of these sites stated that they had received children who were sexually exploited or abused in relation to the post-election chaos, but the majority of their cases are children abandoned or separated during the skirmishes. Shelter services for women are much harder to find in the Nairobi area. So far, WRAP is the only agency that has been identified as providing safe shelter services for women and their children.

Community education and awareness programs related to GBV appear to be extremely limited in scope. Yet there are some health care agencies sensitizing communities about their post-rape care services (MSF France, MSF Blue House, and Kibera South MSF/MOH Health Centre). As mentioned previously, a few of the legal aid agencies are also starting to make field visits to make sure that camp-based residents are aware of their services.

When describing interventions that would help them deal with the consequences of sexual violence, women and girls stressed the importance of support rather than blame and stigma. In response to inquiries about how survivors of sexual violence are perceived by the community, women and girls stated that reactions are generally negative, with girls being blamed for wearing revealing clothes. However, the girls clearly articulated that they *know* it is not a girl's fault when rape occurs, that women and girls need support from friends and family when rapes occur, that they especially need to be able to keep company with friends, and that even boyfriends need to know that survivors should be supported: *"They should know that it is not her fault."* Lastly, they indicated that women and girls need a place to be together to share their experiences and they need supportive people to talk to.

B. Central Province

Tigoni, February 2, 2008
Violence broke out in parts of Kenya, especially Nairobi and Kisumu, due to the shooting to death of Mr. Melitus Mugabe Were, the Member of Parliament in Nairobi.

In several areas, a number of deaths were reported, and there was a large influx of IDPs to Tigoni Police Station in Limuru. Within just a few days, approximately 6,000 flooded the area surrounding the police station in Limuru.

Nature and scope of sexual violence

- Women in Tigoni highlighted how threats of rape were used to displace women, and that many women were indeed raped if they did not leave their homes.
- One police officer in Tigoni reported that she knew of two rapes that had taken place during displacement to the Tigoni Camp: one 50 year old woman, and one 14 year old girl who was gang raped by three men who then attempted to forcibly circumcise a four month-old baby boy who was in her care. Due to security concerns, the officer had to take the girl and boy into her home until she could transfer them to a Tigoni children's home where they continue to reside.
- The officer also provided anecdotal reports of cases of male sodomy that had taken place. She noted that while males are known to be sodomized during normal times in Kenya, they almost never report these cases to the police, but they do seek health services.

Other gender and GBV concerns

- The women highlighted male circumcision. They reported knowledge of several cases where boys had suffered forced rudimentary circumcision.
- The police officer reported at least three cases where Luo women have been abandoned by their Kikuyu husbands.
- Site planning was identified as a major issue in this camp. Women complained that within the camp area they needed a place to bath and to defecate, and that they needed water to wash clothes.
- Women's participation was also stressed as an issue that needs to be addressed. Women explained that they were not given the opportunity to play a decision-making role in the camp, and that male leaders were simply advocating for their friends and families during distribution exercises.
- Many were tearful as they reported that they and their children had been exposed to horrible violence. They saw people getting their heads cut off, and one woman reported that someone had been paying individual Kikuyus 2000 shillings (about $30 USD) each per Luo head they decapitated.
- All group members reported that they had lost their source of livelihood and could not return to their communities of origin.

Prevention and response

Availability of GBV-related services is limited at the Tigoni campsite. While the KRCS is charged with overall coordination, the Baptist Church has set up a temporary clinic and is providing some counseling support in the form of basic medicine, psychological debriefing and follow-up sessions. Referrals are made to the

sub-district hospital located nearby. Various church groups and volunteers provide relief supplies on an ad hoc basis, as well as spiritual counseling. When asked if they thought GBV survivors had received the services they needed, they said that some of them had, but that there were many more who were afraid to talk about what had happened to them due to insecurity and stigma. During the assessment visit, women also complained of having to give birth in the open because, as yet, there was no tent set up for any reproductive health services.

C. Rift Valley Province

Assessments were conducted in specific sites in both the North Rift Valley and the South Rift Valley. The vast majority of the people displaced in Rift Valley Province are Kikuyu; there are also some Kisii and Luhya. The Kalenjin have reportedly been the primary perpetrators of violence and displacement, actively recruiting the Luo in their push to drive out the rest of the tribes. The Kalenjin consider Rift Valley to be "their land" and are telling others to leave or be killed. The tribal clashes, ethnic tension and displacement in this area date back many years, but the situation has never before reached this level of violence. As of February 15, 2008 OCHA estimates there are still 176,134 displaced persons in the Rift Valley Province.[17]

While there are large concentrations of IDPs in some of the major towns such as Molo, Nakuru, and Eldoret, there are also very many small sites dotted across the countryside with hundreds to thousands of IDPs gathered in churches, schools and around police posts, within relatively close proximity to their homes/farms. The IDPs remaining in these rural sites generally express a desire to stay. Those who are too afraid to stay have tried to make their way to the larger sites around big towns, and if they have financial means, further afield to Central Province and Nairobi.

The violent attacks, burning of homes, and alleged threats of sexual violence targeting women and children is ongoing, reportedly perpetrated by highly organized groups of Kalenjin Moran (warriors), and comprised mostly of children/youth, some as young as ten years old.

1.) South Rift Valley

Assessments in the Southern Rift Valley were conducted within specific sites in the Nakuru, Molo, and Kipkelion Districts. In the Nakuru District, assessments were completed in Nakuru Agricultural Showgrounds (Nakuru Town), Sacred Heart Boys School (Rongai Division), and a local church (Rongai). In the Molo District, assessements were undertaken at Camp Pyrethrum (Molo Town) and Baringo B (Kuresoi Division). In the Kipkelion District, Kamwingi II (dispensary) and St Kizito's

[17] Office of the United Nations Humanitarian Coordinator in Kenya. United Nations Humanitarian Update (February 11-15), Volume 4.

Londiani Catholic Church were assessed as part of a rapid assessment by an inter-agency team investigating child protection issues.[18]

The findings below focus on the camps, but it is important to note that risks for sexual violence are not limited to those living in encamped settings. In one example, a displaced girl from Eldoret seeking refuge in a family house in Nakuru was asked to go out at night to get money through commercial sex work. In previous periods of displacement (1992 and 1997) the number of commercial sex workers reportedly spiked in Nakuru town, indicating a need to anticipate and address this issue in the current crisis.

i. Nakuru District:

a.) Nakuru Agricultural Showground, Nakuru Town, January 20, 2008

Many IDPs are using the Nakuru Agricultural Showground as a transit site to organize onward movement toward their "ancestral lands"; however, there are also people who have been at the site since its inception and either have no resources to move elsewhere or are waiting to return to their communities of origin. As of January 15th, there were an estimated 3,500 IDPs residing at the site, with an additional estimate of 1,000 people passing through during the day, either in transit or from nearby areas. Of the 3,500, 2,090 are children, 560 are men and 850 are women. One month later, on February 15th, it was estimated that this number had increased to 13,000, mainly people originating from Central Province. According to OCHA, some have started to return to their ancestral areas with the government and well wishers facilitating their transportation

Nature and scope sexual of violence

- During a focus group conducted by the assessement team, women reported that men and women from the community were entering the camp to take girls for domestic work; some women expressed concerns that these girls might be sexually exploited. Several weeks later, KRCS stated that 30 children had been lured out of Nakuru Showground (boys and girls between 13-17) and that teenage girls were promised jobs and are then exploited sexually.
- There was one documented case of rape perpetrated by a local volunteer during the first week of camp development. Two weeks after the assessment, a representative from KRCS stated that five cases of sexual violence had been reported, but the perpetrators were not identified.
- A representative from the Center for Conflict Resolution (CCR), a small NGO based in Nairobi, identified under-reporting of sexual violence as a common

[18] Since the focus of the child protection visit in Kipkelion was not solely on GBV, findings for this district are less comprehensive, but are nevertheless included in this report. The inter-agency Child Protection Rapid Assesment reports are available on the ochaonline2.un.org/kenya website.

phenomenon: *"If you hear of a few cases, you know that there are many more. Women will not say anything because your husband will leave you and the community will laugh at you, so you sweep it under the carpet. Even among a group of women, they will not admit it, they are scared they will become an outcast, so it is best to keep quiet."*

- During the focus group, women expressed concerns about personal safety, reporting that they slept irregularly at night because they are afraid that men who are sleeping in the camps might accost them.

Other gender and GBV concerns

- During the initial phase of camp development volunteers could access the site without a system for security clearance or regulation, increasing the risk for sexual exploitation and abuse.
- Women reported that they had unequal access to food, stating that there was only one food line and the boys and men reportedly monopolized access to food, such that women felt they were receiving smaller portions and, in some instances, were not able to get food.
- At the time of the assessment, bathing facilities were not private so women were not able to shower during the day.
- Women reportedly feared the police in their own communities, but not within the Showground. However, women said they did not know the process for reporting a case of sexual violence or who to go to if they were facing a problem. Notably, there were no female police officers assigned to the camp.

Prevention and response efforts

There are limited medical resources for survivors of sexual violence in the Nakuru showground. The otherwise well-organized and well-staffed camp-based clinic does not have staff specifically trained in the medical management of rape or resources such as PEP or emergency contraception, and therefore refers cases to the nearby Nakuru Provincial Hospital. PEP and other services are reportedly available free of charge to IDPs at the Nakuru Provincial Hospital, but the hospital administrator said there was no protocol for forensic examinations and that several of the hospital staff with specific training on medical management had since been transferred. In the one instance of rape that had occurred in the camp prior to the assessment team's visit, the survivor was reportedly referred to Nairobi Women's Hospital for assistance.

> "If you hear of a few cases, you know that there are many more…you sweep it under the carpet. Even among a group of women, they will not admit it, they are scared they will become an outcast…"
>
> ~ Local NGO worker

Psychosocial services are provided by a volunteer group of trained counsellors and psychologists overseen by the Hope for Women's Network, and the services are widely used and appreciated among the women. The Hope for Women's Network leads women's groups and provides individual couseling sessions with members of the encamped population, in addition to distributing necessities such as sanitary supplies and undergarments. None of the psychosocial workers volunteering at the time of the assessment had undertaken specialized training in caring for survivors of sexual violence. Psychosocial workers had not received any accounts of sexual assault occurring during displacement or within the camps (with the exception of the one assault by an adolescent camp volunteer committed against an adolescent girl); however, they acknowledged that their focus was on coping mechanisms, and that *"they were not asking questions about what happened before."*

Ten police officers patrolled the camp during the day and 12 at night, none of whom were female. During an interview with the assessment team, the head of camp security initially stated that *"nobody would respect a female police officer, so there is no reason for us to put one here";* by the end of the interview, he stated that he would recruit a female officer. Notably, he felt that women and girls were not at an increased risk for being exposed to violence in the camp and he was not aware of the case involving the volunteer.

According to a representative from the CCR, although they encourage survivors to come forward and seek medical attention and legal justice, *"women often keep quiet when raped."* Cases of sexual violence are reportedly resolved within the families through remuneration to the family by the perpetrator.

NCCK in Nakuru has worked with female IDPs since the displacement during the 1992 elections, providing groups on empowerment and microfinance projects, combined with a psychosocial component. A representative from NCCK suggested that providing survivors with access to legal justice, through FIDA or paralegals, would be especially beneficial to this population.

b.) Rongai Catholic Church, Rongai, Nakuru District: January 20, 2008

This site was established because there is a nearby police post. At the time of the site visit, there were an estimated 600 people who had been staying at the church since December 31, 2007. The surrounding area is primarily inhabited by the Kalingen tribe, so the primarily Kikuyu population in the camp did not feel safe outside of the church grounds.

Nature and scope of sexual violence

- Women reported threats of sexual violence during flight, but did not report actual incidents during displacement or within the camp.

Other gender and GBV concerns

- Women would not leave the boundary of the camp, stating they would be *"chased"* by members of the community.
- An unspecified number of women had miscariages while in the camp due to the *"shock of displacement"*, resulting in the death of one woman. A dispensary is on the site but does not have delivery kits and pregnant women do not have access to the local medical clinic.
- During a female focus group, women expressed fears that their *"daughters would be affected psychologically by the displacement"* and concern that there were no psychosocial services being provided in the camp.
- In a male focus group, men stated that *"we are not fathers"* (because they can't fulfill their roles); that there is no privacy among husbands and wives; and to deal with the stress, *"we just take it inside."*
- There have not been distributions of sanitary supplies or undergarnments in the camp. Women do not have firewood for cooking, nor do they have access to clean water.

Prevention and response efforts

There were no medical services (aside from what was available at the dispensary) being provided in the camp and mobile clinics were not reaching the site at the time of assessment. As aforementioned, there were no psychosocial services being offered but women thought this would be helpful for both them and the younger girls. Women reported feeling protected by the police, but feared that if the police were not at the site they would be attacked by people in the community.

c.) Sacred Heart Boys School, Rongai, Nakuru District: January 20, 2008

The Sister managing the camp was not sure how many people were at the site, but estimated there were 250 children. At the time of the assessment, this camp was primarily comprised of woman and children. During the day, many women living at the site go to work on their farms, leaving their children behind in the care of others.

Nature and scope of sexual violence

- According to the Sister, there have not been any cases of sexual violence at the site and women are secure.

Other gender and GBV concerns

- Women were concerned that they would be attacked at the site without the police protecting them.
- There was one case of maternal/child death, and four births since the camp was established. There are no delivery kits on site.
- Women need sanitary napkins, underwear, and diapers and clothes for the newborn babies.

Prevention and response efforts

The church is providing basic medication to the displaced population. However, they are not able to respond to more complex health issues, including management of sexual violence. According to the Sister, there is a health facility nearby but they are unable to respond to cases of sexual violence. There was no evidence of psychosocial, legal, or other GBV-related services available in the wider community.

ii. Molo District

On January 19, 2008, an estimated 30,000 to 35,000 IDPs were staying in 25-30 sites in Molo District according to the District Commissioner. As with most regions, most tend to be situated around police posts, schools, churches and other facilities, e.g. a monastery and a forest station. The situation is very fluid and the numbers fluctuate every day. As of February 15, 2008, OCHA reported that the numbers of IDPs in Molo has reduced to 7,464 living in 17 Camps (2,983 women, 542 men and 3,939 children). Most of the IDPs have expressed willingness to return to their rural areas if security can be guaranteed.

a.) Camp Pyrethrum, Molo Town Center: January 19, 2008

At the time of the assessment visit, there were three sites in Molo Town, but due to time constraints, the team was only able to visit Camp Pyrethrum, where an estimated 1,500 people were living, of which approximately 80% were female. The displaced population primarily came from Nyakinua, Gorovue, Olenguruoni, Kuresoi, Kipkelion, Londiani and Mausummit.

Nature and scope of sexual violence

- KRCS gave anecdotal reports of sexual assault in the camp, stating *that "men sneak into the areas where women sleep to sexually assault them"*, but could not provide numbers.

"There is a lot of sexual violence in the camps; you cannot control the men. If they want to sneak in and assault women or bribe them for sex, they [the police] cannot stop them"
~ KRCS representative

- Sexual exploitation is reportedly a concern, according to a KRCS representative working at the site: *"At night, men go into the building where women and children are sleeping and pay for sex."*
- When asked about police protection in the camp, the same KRCS representative concluded, *"There is a lot of sexual violence in the camps; you cannot control the men. If they want to sneak in and assault women or bribe them for sex, they [the police] cannot stop them."*
- According to KRCS and NCCK, sexual violence was a significant component of displacement for women in Molo, but women would not admit their exposure. The representative of the female displaced population did not confirm the alleged rapes or sexual exploitation that occurred during flight or in the camps, but identified common fears among women of leaving the camp due to threats of sexual violence. When asked about how comfortable women might feel telling someone about an incident of sexual violence, the female camp representative stated that women *might* report eventually, but would only go immediately to the police or health services if the survivor were a young girl.

Other gender and GBV concerns

- Women's health was raised as a concern, especially for pregnant women, new mothers and their children. At the time of the site visit, five women had given birth at the camp and there were 16 pregnant women.
- Women reportedly fled before their husbands due to fear of being attacked and some husbands had been killed. The female camp representative suggested this was among the most pressing concerns for women in the camp.
- Lack of sanitary napkins, undergarments, towels, and clothing for women and infants was identified as a serious problem.
- Sanitation concerns were raised among women; the insufficient water source made it difficult for them to clean the site, putting their children at increased risk for illness.
- Women in the camp were using the surrounding fencing for firewood because of fears of leaving the camp, putting themselves at even greater security risk by taking away the protection surrounding the camp.

Prevention and response efforts

On-site medical facilities have been established by Africa Air Rescue (AAR) at a neighboring camp. The assessment team was not able to meet with AAR during the visit, so it is not clear if they are able to respond to cases of sexual violence. No psychosocial services were being provided at the time of the site visit, but the assessment team was informed that AAR would begin to provide services the following week.

Services for survivors in the wider-community are limited. The district hospital in Molo Town is offering free, 24-hour services to the displaced population, but the hospital is feeling overwhelmed by the injuries, deaths and disabilities resulting from the post-election violence. The facilities did not seem well-equipped to treat or respond to survivors of sexual violence, although PEP is reportedly available. According to the head nurse, the hospital does not have the capability to conduct a forensic exam, and staff has not been trained on the clinical management of rape. While the nurse was knowledgeable on the use of emergency contraception, she appeared to be confused on the appropriate use of PEP. The hospital did not have P3 forms (the police form necessary to report a case of rape) on site; instead, survivors must go to the police station to get the form and bring it back to the hospital. There is one nurse and one doctor trained on counseling, but this counseling appeared to focus on HIV testing, not GBV issues. At the time of the assessment, service delivery statistics on sexual violence were not available.

b.) Baringo B Site, Kuresoi Division, Molo District: January 19, 2008

At the time of the assessment there were 20 camps in Kuresoi, but due to time constraints, the team was only able to visit one site, Baringo B. On December 29th, Kalenjin warriors (Moran) began burning houses in this area and families fled to a private farm house located next to a temporary police post, Baringo B. At the time of the assessment, there were approximately 525 people living in the site (375 children and 150 adults). Most people came with their families intact from nearby farms (within a 3 km radius); many had their houses burned down completely, while others' homes had been looted. The camp itself was raided the night before the assessment by men who allegedly threw arrows into the area where the IDPs sleep, but no one was injured.

Nature and scope of sexual violence

- According to two representatives from NCCK who work directly with the encamped , threats and incidents of sexual violence were endemic during the displacement process.
- Women did not confirm these reports of sexual violence; they stated instead that women do not discuss sexual violence due to risk of being ostracized by their community and families. According to one, *"When there is an act of rape, if you tell your husband, he will beat you, it is like you have cheated, so the best thing to do is be quiet. You must learn to brush it*

> *"When there is an act of rape, if you tell your husband, he will beat you, it is like you have cheated, so the best thing to do is be quiet."*
> *~Woman, Kuresoi*

under the rug." Another woman revealed that, *"You only know if a girl has been raped if she is young enough to be washed. If she is older than that, you will never know because it is shameful. You would never report for her either, if it is known that she has been raped, other mothers will not let their sons marry her."*

- Women expressed additional reluctance about taking legal action in cases of sexual violence *"You have to persevere in this situation, if you have a child and you take legal steps, how will you take care of the child? It is best just to keep quiet."*
- Women in the camp expressed concerns about transactional sex increasing in the community due to the fact that their farms have been destroyed and families have lost their livelihoods. There is apparently a history of sexual exploitation of women doing casual work at flower farms in the region.
- Police reportedly harrass women when accompanying them to seek firewood, compounding women's feelings of insecurity in the camp.

Other gender and GBV concerns

- Women stated that fighting between husbands and wives had increased, but again acknowledged the secrecy attending the issue. One woman stated, *"If a woman was beat by her husband and injured, you would go to the doctor and tell him it was an injury, like you fell or something. You don't say that he did it, or where will you go home to."*
- Women fear an increased risk of early marriage among younger girls due to higher levels of poverty. Mothers fear their daughters will also be at greater risk of early/unwanted pregnancy due to idleness in the camp among the youth. One mother stated, *"When the attackers came last night we all had to flee. We don't know where the girls and boys were, but we think that the boys sexually harass the girls and try to get them to have sex with them. All of the youth sit around with nothing to do, this encourages sex."*
- Women reported being especially vulnerable during attacks since they are charged with caring for the children: *"When the camp is attacked, the men can run, we have to take care of our children."*
- Women mentioned the need for sanitary napkins and undergarments.

Prevention and response efforts

At the time of the assessment, there were no services available in the camp to prevent or respond to incidents of sexual violence and/or other GBV concerns. No mobile clinics were reaching this site to provide health services, such that even basic health needs were not being met. There were also no psychosocial services being provided to the encamped population. The NCCK member, who owns Baringo-B and was acting as camp manager, seemed concerned with security for women and children, but did not have the capacity or resources to address the issue.

Capability to prevent or respond to GBV issues in the wider community is also limited. There is no medical facility in the area, and the insecure roads restrict travel to the hospitals in Molo or Nakuru; there are also no psychosocial services available in the community. At the time of the assessment, the only security available in the area were the two police officers on site.

c.) "Mawingu" IDP Site, Kuresoi Division, Molo District: January 17, 2008[19]

At the time of the assessment, there were approximately 1,000 people living in the site (600 children and 400 adults), all Kikuyu.

Nature and scope of sexual violence

- There were mixed reports of sexual violence: some interviewees had not heard of any incidents involving sexual violence, but others spoke of rapes and sexual assaults by the Kalenjin during the initial house-burning and population displacement.

Other gender and GBV concerns

- The families in this site reported being scared of attacks by the Kalenjin and do not leave the confines of the site without police escort. There have been several attempts by large groups of Kalenjin warriors (children and youth) to attack the camp.
- Women mentioned a need for soap, sanitary napkins, and the contraceptive pill.

Prevention and response efforts

At the time of the assessment, policemen were beginning to express fear that they could not repel attacks for much longer. The inability of police to provide security puts the population at an increased risk of being attacked. No health or psychosocial services were available in the camp. The village health post has been abandoned, so there are no health services in the surrounding area. People must travel to Molo Town to seek health care; however, regular public transport is no longer running so mobility is restricted.

iii. Kipkelion District

a.) Kamwingi II (dispensary), Kipkelion District: January 16, 2008[20]

Many of the IDPs living in this site lost homes (260 were burnt), and others fled with belongings. The IDPs are mostly Kikuyu but there are also Kisii and Luhya. At the time of the assessment, there were 3,500 IDPs, 776 of them under the age of five and 1,800 ages 5-18.

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[19] Information from this site was gleaned from a Child Protection Rapid Assessment.
[20] Information from this site was gleaned from a Child Protection Rapid Assessment.

Nature and scope of sexual violence

- There are concerns that there may be some sexual exploitation of girls by men in the camp who are giving them biscuits and other goods in exchange for sex.
- Concerns were also expressed that women may exchange sex for transport out of the camp.
- A representative of the Catholic Church reported that there had been a rape in the camp, but the committee chairman said there had been none.

Other gender and GBV concerns

- While this site was remarkable in that the community had established a camp committee, there were only two women representing camp concerns on the camp committee, compared to 14 men.
- There are no delivery kits available for women; three had given birth at the site and another seven were expected to give birth in the coming weeks.
- The IDPs did not feel it was safe to leave the compound even though their farms are one to five kilometers away. There were two police officers stationed at the site but they requested more security.
- Sanitary napkins and family planning services such as contraception were identified as urgent needs.

Prevention and response efforts

Just prior to the assessment, MSF held a mobile clinic and was planning a subsequent visit the following week. The Public Health Officer from Nakuru had also visited the site. Two police officers were stationed at the site, which the community felt was insufficient. No psychosocial services were being provided at the time. There were 16 women's CBOs in the community prior to the elections, but reportedly all had been dispersed as a result of the violence.

b.) St Kizito's Londiani Catholic Church, Kipkelion District: January 16, 2008[21]

The first week after the election, there were 3-4,000 people sleeping at the church at night but at the time of the assessment, there were around 800 IDPs, predominantly women, children and elderly. The rest have returned to their homes or moved on. Those remaining are the ones whose houses were burnt down and the very poor or old. The majority of people staying in the camp are Kikuyu but there are also Kisii and Luhya coming from small villages close by.

Nature and scope of sexual violence

- A team from MSF was thought to have identified one rape case but this was not confirmed.

[21] Information from this site was gleaned from a Child Protection Rapid Assessment.

Other gender and GBV concerns

- The IDPs feel safe at the church but felt it was unsafe to leave the church compound.

Prevention and response efforts

There is a hospital near the camp, which closed for a week after the elections following threats by the attackers. Health services have been supplemented by a volunteer nurse at the Church and MSF mobile clinics. The site is next door to the police station, offering some measure of security for the encamped population.

2.) North Rift Valley

In the North Rift Valley, assessments were conducted in the Uasin Gishu District, Koibetek District, and Trans Nzoia East. In the Uasin Gishu District, sites included were the Eldoret Agricultural Showgrounds, the Presbyterian Church in Munyaka, and the Arnesan High School in Burnt Forest. In Koibatek the District Office in Timboroa was assessed, and in Trans Nzoia East, Noigam Primary School in Cherangany was visited.

i. Uasin Gishu District

a.) Eldoret Agricultural Showground, Uasin Gishu District: January 29, 2008

At the time of the assessment, the Eldoret A.S.K. Showground was hosting over 13,000 displaced people, mostly from the Kikuyu tribe. A February 15 report by OCHA stated that the number of IDPs in Eldoret Showground had reached approximately 19,400.

Nature and scope of sexual violence

- It was reported by humanitarian organizations and women's groups that sexual violence--which in some cases was accompanied by brutal acts of physical violence such as shoving spears into a women's genitalia--was a significant aspect of displacement in the North Rift Valley. One female camp representative related a story of an elderly woman (approximately 60 years old) from Kapsebit who was gang raped by three men during displacement, and the next day gang raped by two other men. When she reported the issue to the police in Kapsebit, they said there was nothing they could do, emphasizing *"this is an emergency situation and this is not the time to think about these issues."* The camp representative believed that *"once things calm down, women will start talking about these issues"* and was taking the initiative to develop support systems for survivors.
- Thirteen of the fifteen cases of sexual violence reported to the Centre for Rape (CAR-E) sexual assault treatment center at the Moi Teaching Hospital since the beginning of January were related to the current crisis. Use of all hospital

services has decreased since the elections, possibly explaining a decline in reported cases of sexual violence from 40 per month to 15 in January (as of January 29). The nurse from CAR-E stated that, of the rapes she had seen at the hospital, most perpetrators were unknown, many were gang rapes, more than 50% of the survivors were under 18, and the youngest survivor was one year old.

- During a focus group at the A.S.K. Showgrounds, women expressed concerns about sexual exploitation, stating that men from both inside and outside the camp approach young girls with the enticement, *"How would you like to eat something sweet?"* An increased rate of pregnancy among girls was identified as a major concern related to this increase in transactional sex.
- Women reported that they were also engaging in transactional sex: if they wanted to feed their children, they had no other choice than to trade sex for money or food. One woman stated *"My husband is a Pastor and we are Christian. Me, if I don't get money to support my family, it can affect my children…people are doing things they would normally not do because they have to."*
- KRCS provides men with economic opportunities in the camp, and according to the focus group, it is these men (of men living within the camp) who are among those most likely to sexually exploit women and girls. Women are not provided with equal economic opportunities, though they felt that the only job that men were doing that they couldn't do was dig latrines.
- Women expressed fears that once men no longer have money to pay for sex, they will start using force (illustrating their shared belief that rape is caused by a need for sex). Women did not know where to report if a case of sexual violence occurred.
- Women requested increased security in the camp, including screening visitors who enter the camp in order to decrease risks of sexual exploitation.

Other gender and GBV concerns

- A female representative of the camp committee identified an increase in domestic violence in the camp, reporting one case the night before the assessment which was resolved when the police beat the husband. Women in a focus group were aware of this case stating that *"it was probably the woman to blame, she did not understand her husband."* A police officer identified increased quarelling between couples from inter-tribal marriages. Another reported contributor to the increase in tension between spouses was the demands men were placing on their wives to have sex

> ***"It was probably the woman to blame, she did not understand her husband."***
>
> ~ Woman in Eldoret when discussing a case of domestic violence

despite the fact that family members were living together in small tents. Concerns were expressed that girls who were forced to leave their family tents in order for their parents to have sex would be unmonitored and more likely to be seduced by boys or older men.

- When reflecting on men's changing roles due to lack of work and idleness, women stated that their husbands *"have been reduced to the level of a child"* and that a woman must *"be careful to make sure she understand her husband in this situation and not put pressure on him."*
- IOM is distributing firewood, but supplies were insufficient, requiring women to go to the nearby woods where they feared that they might be attacked.
- Camp management and the health center contended there are enough sanitary supplies for the female population, but women disagreed. They stated that the lack of sanitary napkins was a particular problem for girls, who would be forced to stay in their tents all day when they were menstruating.

Prevention and response efforts

In general camp design promotes security for women and girls. Latrines and bathing areas are sex-disaggregated, there are floodlights at night, and there are a number of easily accessible water points. Efforts are being made by KRCS to further improve camp security, such as increasing firewood distribution and strengthening camp entry regulations. There are eight chairwomen representing the encamped population and seven of the eighteen people on the camp management committee are women.

Health services in the camp are provided by the KRCS and Ministry of Health. There are no targeted health services for survivors of sexual violence in the camp. The on-site health center does not have the resources or capacity to respond to a case of sexual violence and members of the health team have not been trained on responding to GBV.

Psychosocial services are widely available and used in the camp, but the perception of women participating in a focus group was that the psychosocial workers were meant to attend to emergency needs, such as distribution of sanitary towels. A female camp representative felt that it was unlikely that women in the camp would utilize psychosocial care to deal with sexual assault. Two psychosocial workers reportedly had specific training on GBV, but the assessment team was unable to meet with them during the site visit.

There were camp security patrols in addition to police officers from a nearby post that were tasked with responding to incidents in the camp. The police

officer on duty at the police post at the time of the assessment visit seemed to have general knowledge of the reporting system for sexual violence, but could not give numbers of cases reported, as the statistics remain with the Women's and Children's desk. An officer for this desk was not available during the assessment, so it was not possible to see what steps are actually taken when a survivor comes to the station.

The CAR-E center, located at the hospital in Eldoret, is capable of responding to survivors of sexual violence. However, their resources are limited and no staff in the hospital—including those who directly deal with survivors--has been trained on GBV or the medical management of rape. One nurse is stationed at the center. When a survivor comes to the hospital, a doctor from the emergency department is called on to respond. The center provides both immediate response to survivors and follow-up services, including support groups for survivors and their families and individual counseling sessions. The follow-up counseling services are not widely used by survivors, but most return for medical treatment.

"It is likely happening, but people will not admit it, might tell the doctor, but couldn't tell the police, they might blame or harass you...need to be silent, hidden."

~ Nurse in Eldoret

There are a few community-based organizations working on efforts to prevent and respond to GBV. In collaboration with the North Rift Empowerment Consultancy Services, Peace Link has worked in the Mt. Elgon area to provide pro bono legal services to survivors. They have not yet mobilized to work on cases related to the post-election violence, but are planning to introduce psychosocial activities in the showgrounds. AMPATH currently works on issues surrounding HIV/AIDS prevention and response, and would like to start incorporating GBV issues into their programming. Notably, AMPATH is engaged in a project with commercial sex workers in the Burnt Forest, which might be replicable in other settings where transactional sex is increasing as a result of the crisis.

b.) Munyaka Presbyterian Church, Uasin Gishu District: January 29, 2008

Munyaka Presbyterian Church is located outside of Eldoret, and most people staying at the camp are from the surrounding area. Though the population is primarily Kikuyu, there are people from the Kalenjin and Luo tribes who are married to Kikuyus residing in the camp. At the time of the assessment, about 500 were sleeping at the camp, but 3,500 were dependent on the camp to meet basic needs such as food, clothes, and transport.

Nature and scope of sexual violence

- When asked about threats or cases of sexual violence during displacement, the pastor stated, *"In our community, for someone to say that they have been raped would be really difficult."* The pastor's wife concurred: *"it is likely happening, but people will not admit it, might tell the doctor, but couldn't tell the police, they might blame or harass you…need to be silent, hidden."*

Other gender and GBV concerns

- Children and youth in the camp were not attending school. At the time of the site visit, there were 24 girls who had been accepted to a mission school in Nairobi, but did not have transportation.
- Sanitary supplies, undergarments, and clothing were identified as urgent needs.

Prevention and response efforts

Most services are lacking at this site. The pastor's wife, who was formerly a nurse, has helped with five deliveries and uses donations to purchase essential medicines for the displaced. The community must go to Eldoret to meet most of their medical needs, but roads are insecure and thus mobility is restricted. There are no psychosocial services being provided in the camp. Fifty police officers guard the camp and the surrounding area, but the encamped population reported feeling insecure and has therefore established an internal security system.

c.) Arnesan Secondary School, Burnt Forest, Uasin Gishu District: January 30, 2008

At the time of the assessment, there were 5,858 displaced people staying at the Arnesan Secondary School in the Burnt Forest, mostly from the surrounding area. Women and children slept inside of the school and men slept outside. A group of women and children were staying at a church behind the school. The population was comprised mainly of members of the Kikuyu tribe and there was a lot of anger expressed towards their *"enemies,"* the Kalenjin.

Nature and scope of sexual violence

- During focus group discussions, women shared stories about rapes which occurred during the displacement process:
    - In Nakaya, three women were gang raped during flight, one woman was burned afterwards and the others were cut. The survivors were allegedly taken to Nakuru Provincial Hospital.
    - In Ruikuni, a woman was gang raped and had her eyes pulled out; she passed away before she could get medical attention.
    - In Naruwa, a woman was gang raped by a group of youth and was cut afterwards. She was taken to Eldoret for treatment.

- Women expressed fears about current risks associated with sexual violence, especially related to leaving the camp to collect firewood and other provisions, including accessing health care. A woman from the camp management stated, *"If a woman was raped and it was during the day, we would take her to the hospital, if not, we would wait, we will not go out at night."*
- The afternoon prior to the assessment, there had been an incident of sexual violence directly outside of the camp, but nobody knew what happened to the survivor.
- When discussing the issue of reporting, a woman stated, *"In a crisis like this, your first thought is to care for your children, get settled down, you don't even think to report…it's the last thing you think about, you are trying to figure out how to live."*
- Sexual exploitation was identified as a problem--women worried the younger girls would *"become spoiled,"* meaning they would sleep with men for money or food if they did not have an alternative means to make money or if their parents are unable to provide for their basic needs. According to one woman, *"Young girls and some women need money so they accept offers from men; they have nothing to do to make money and need money for necessities."*
- The government is providing security, but women expressed concerns that their daughters were targets of sexual exploitation by the police officers since *"they came without their wives."* Notably, the week prior to the site visit, the women had met to discuss this issue and decided to warn the younger girls to be cautious about the police, but otherwise did not publicize their apprehension.

Other gender and GBV concerns

- There exists an intense fear of being attacked among the encamped population: people do not leave the camp at night and stay within a one half kilometer radius during the day. When discussing firewood collection, women described how, *"you hear screams, they [the enemy] are coming to attack you, and so you run back."*
- There is a hospital a few meters from the site, but women are too afraid to leave the camp to walk there. Traditional midwives in the camp assist with deliveries. There are no delivery kits available.
- Women are currently forced to burn the fencing surrounding the camp in order to cook, which is a security risk as this fence provides protection to the encamped population.
- Women mentioned a need for sanitary supplies and undergarments.

Prevention and response efforts

Camp management is fairly well organized, even with the limited resources available. For example, the IDP population had set up an internal security mechanism, since they felt the government security was insufficient. Health services for survivors of sexual violence are not available in the camp. A mobile

KRCS health clinic stops in the camp every few days, but they are not equipped to respond to cases of sexual violence. KRCS provides the encamped population with psychosocial services every 2 – 3 days. The team was not able to meet with the psychosocial workers as they were not in the camp the day of the site visit.

According to a UNHCR representative, the health center in Burnt Forest was vacant because the staff had fled during the post-election violence. The assessment team was unable to go to the center to confirm. Women stated that they would prefer a health clinic that is specifically for women and children in order to meet their needs. Currently, the nearest adequate health services for survivors of sexual violence is the hospital in Eldoret, but the insecure roads between Burnt Forest and Eldoret limit accessibility

ii. Koibatek District

a.) Timboroa District Office, Koibatek District: January 30, 2008

At the time of the assessment, many people were entering and exiting the camp, making it difficult to ascertain the number of IDPs staying at the site. Camp management was not available during the site visit to discuss the situation in the camp, which was visibly disorganized, with most forced to sleep on the ground under tarpaulin.

The day before the site visit, a building in Timboroa where displaced people were renting rooms was burned down, so they were displaced to the area surrounding the District Office. A KRCS volunteer stated that some police officers were involved in the burning of the building.

Nature and scope of sexual violence

- During displacement attackers reportedly threatened the population, saying *"If you don't move, we are going to rape the women."* Women expressed intense fear being raped and therefore do not leave the camp.
- The overall state of disorganization in the camp creates multiple vulnerabilities for women. For example, there are no tents so women are forced to sleep in the open with men in the camp.

Other gender and GBV concerns

- The encamped population did not feel safe at this site, as there was overall distrust of the police in the area.
- Undergarments, sanitary towels, and tents were identified as urgent needs.

Prevention and response efforts

Health services and psychosocial support is provided in the camp every 2-3 days by the KRCS. These mobile clinics do not have the capacity to respond to survivors of sexual violence--they do not have PEP or emergency contraception. The team also visited the Timboroa Health Centre Kiobatek TB Testing and Treatment Centre, a few hundred meters from the camp. Most of the staff has been affected by the current emergency and is displaced. No hospital staff has been trained on response to sexual violence and no rape kits were available. If a woman is sexually assaulted, she is taken 42 kilometers away to Eldama Ravine. At the time of the assessment, this road was closed. The District Officer was visiting the health center at the time, and stated there is interest at the district level in having trainings on responding to survivors of sexual violence.

iii. Trans Nzoia East District

a.) Noigam Primary School (Cherangany), Trans Nzoia East District: January 30, 2008

Noigam is a temporary camp for approximately 7,000 displaced, most of whom are Kisii. A district representative reported during the site visit that plans were underway to relocate the inhabitants close to their communities of origin. A security contingent had arrived the night prior to the assessment to facilitate this process.

Nature and scope of sexual violence

- Both health care providers and female participants of a focus group identified sexual exploitation of girls as a problem in the camp. In the night prior to the assessment, a group of men attempted to *"grab"* some girls in the camp, but were stymied when police fired bullets in the air. Other girls are reportedly being seduced out of the camp by men in the town. Some miss curfew and spend the night in town at undisclosed locations.
- Women have reportedly been harassed by police in the camp, and there were some allusions to sexual assault committed by the police, though no confirmed cases.

Other gender and GBV concerns

- Women suggested that domestic violence was a problem, especially related to husbands trying to force their wives to have sex. They worried about the impact of quarelling between husbands and wives on the children in the camp.
- While displaced women claimed that they did not have enough sanitary napkins, health care providers suspected that some were selling the napkins in town. Lack of underwear was also identified as a significant problem.

- Health care providers thought that women in particular were in need of psychosocial services; three women in the camp had reportedly developed stress-related "mental problems."

Prevention and response efforts
A pre-existing on-site health clinic was being supported to provide services for the IDPs, including STI treatment, emergency contraception, and PEP in the event of a sexual assault; however, a P3 form was only available at the Kitale District Hospital, and there was no transport should a survivor need it. No cases had been received. Police were patrolling the camp, but it was unclear whether or not the IDPs would report a case to them as some women perceived them as potential perpetrators. Other services for survivors, such as psychosocial support, were reportedly not available.

D. Coastal Region (Mombasa)

Five camps in Mombasa holding an estimated 1,500 IDPs were disbanded several days prior to the assessment. A small group of displaced persons continued to sleep at the A.C.K. Emmanuel Church. According to the head of the IDPs, approximately 65% of the dispersed IDPs are staying with families or renting a room in town, and an estimated 20% have traveled up-country. The latest reports released on February 15, 2008 by OCHA, state that there are no IDPs in Mombasa.

a.) Anglican Church of Kenya (A.C.K.) Emanuel Church, Mombasa: January 21-22, 2008
At the time of the assessment, 15 men, women, and children were staying at this church. The church was also being used as a distribution site every other week where the displaced population was able to access food and NFIs.

Nature and scope of sexual violence
- Women at the church did not report any concerns about staying there, but according to the Provincial Children's Officer, men from the community have entered the church and sexually harrassed the women.

Other gender and GBV Concerns
- Women in a focus group discussion related that domestic violence was increasing because men were idle. They predicted that divorce rates would increase.
- While KRCS has distributed rations to the IDPs, many do not have a place to cook. Moreover, for those who have returned to their homes, they felt that carrying home a large supply of food created risks for them of being robbed by their neighbors.
- Displaced children were not in school, and there were concerns that girls could be exposed to early marriage or sexual exploitation due to increased poverty and lack of education and skills.

- Both women and men are concerned that their busineses have been destroyed and question how they will rebuild their livelihoods: *"We are business people, we are not used to begging and living off of relief, what we really need is someone to help us restart our busineses so we can get out own lives back together."*
- Many of those who are HIV-positive and on ARTs fear to travel to the hospital for their treatment
- Lack of sanitary towels was identified as a serious problem, especially for young girls: *"girls do not have pads, this can make them have low self-esteem for girls who soil their dress."*

Prevention and response efforts

It is difficult to know whether the A.C.K represents the only remaining "camp" for IDPs. It is more likely that IDPs who have not returned home or found shelter with friends and family are encamped informally in several sites across Mombasa. At the church, food is being distributed to both IDPs staying at the church and displaced people residing with relatives. Psychosocial services will continue to be available every other Thursday while food is being distributed, but at the time of the assessment this had not been implemented. There are no general health services being provided in the camp, but the population has access to the hospitals in Mombasa.

b.) Mombasa

In addition to visiting the A.C.K., the assessment team held meetings with community-based organizations in order to better understand the overall situation prior to and after the disbandment of the camps. Interviews were conducted with the Provincial Children's Officer, representatives from Kenya Alliance for the Advancement of Children (KAACR), service providers at Jocham Hospital, ActionAid, Kenya Young Women's Christian Association (Kenya YWCA), Solidarity with Women in Distress (SOLWADI), Gender Violence Recovery Center (GVRC,) and The Federation of Women Lawyers Kenya (FIDA Kenya). The assessment team also participated in a meeting with the Children's Rights Network, with members from SOLWADI, Child Welfare Society of Kenya (CWSK), FOROHA, WEMA Centre for the rehabilitation of street children and community orphans, World Vision, ActionAid, and a psychologist from the Makupa Hospital. General findings for Mombasa have been extrapolated from these interviews.

Nature and scope of sexual violence

- In an assessment conducted by Kenya YMCA in the early weeks of the crisis, a total of 18 out of 51 women interviewed reported cases of physical and/or sexual attacks. However, these women did not report their victimizations because they did not know the legal procedure; they feared retaliation by the perpetrators, who in many cases were their neighbors; there was no one to turn to; and/or they thought the police would not take any action.

- Two cases of sexual violence were perpetrated against IDP girls outside a camp called "Dog Section," in which the girls were raped in public and, according to a psychosocial counselor, disappeared the next day: *"The shame was too much so they left before getting help."*
- Several women initially encamped in "Dog Section" were housed by police officers in their homes; concerns were expressed that these women may have felt compelled to have sexual relations with the officers in exchange for shelter.
- Reports of sexual violence at the Gender Violence Recovery Center (GVRC) have doubled since the elections and the demographics of perpetrators shifted from known-attackers to strangers, frequently gang rapes. The majority of reports have come from Tudor.
- Despite efforts to encourage women to report to the police, service providers at GVRC, located within the Coast General Hospital, state that women rarely report and often seek treatment secretly as they fear being stigmatized by the community. Most women do not report to the GVRC within 72-hours.
- During counseling sessions with psychosocial workers at ActionAid, women revealed both threats and incidents of sexual violence, which have resulted in intense fearfulness about returning to their homes.
- Local community-based organizations predict that unless women and girls are supported to rebuild their lives, they will be at an increased risk of entering commercial sex work.
- KAACR and the YWCA predict an increase in the number of girls subjected to commercial sexual exploitation and/or increased risks of early pregnancy due to the fact that children's homes in the area are full and are unable to provide displaced girls with a safe shelter. The YWCA is housing three adolescent IDP girls at their Likoni Center who are pregnant.

> *"The shame was too much so they left before getting help."*
> ~ psychosocial counselor, about cases of rape

Other gender and GBV concerns

- Members of SOLWADI have observed an increase in domestic violence, attributing this to men who demand more sex from their wives because they are now too afraid to leave the house to pay for sex, as was their usual custom prior to the conflict.
- According to a member from KAACR, parents' fears that their girls are at risk when walking to school will result in girl-student withdrawals.
- There have reportedly been many separations among intertribal spouses. Interestingly, KAACR representatives identified separation not only as a problem for women, but also as a risk for children, stating *"If a woman gets remarried, she is not able to take her children, the children usually go to the grandparent…this scenerio often leads to children living on the streets."*

Prevention and response efforts

The GVRC, located at the Coast General Hospital in Mombasa, has the ability to respond to survivors of sexual violence, but the facility lacks resources and the staff has limited training. There is no phone in this department and it is only open from 9am-5pm during the week. The GVRC is not marked and the hospital staff had trouble locating it for the assessment team--some staff was not aware that the center existed. The one nurse who is responsible for overseeing the center is employed by International Center for Reproductive Health (ICRH) and is very knowledgeable on responding to and treating survivors of sexual violence including PEP, forensic examination, emergency contraception, counseling, reporting, and the accompanying paperwork. All services are provided free of charge and the center offers follow-up services for both medical and psychological needs. The nurse would like to expand services to include response to domestic violence in the future.

Jocham Hospital in Mombasa also provides sexual assault services, and the nurse on staff seemed very knowledgeable about treatment protocols and client-centered interventions. However, their specialized sexual assault program was discontinued last year due to lack of funding. The hospital is actively soliciting funds to reopen their center, and though they are private they continue to provide services to survivors of sexual assault free of charge.

FIDA Mombasa is one of GVRCs and Jocham's referral partners. FIDA is interested in targeting activites to the displaced, particulary regarding facilitation of prosecution of human rights abuses, but has not yet developed a particular action plan. FIDA appears to have developed standardized procedures for supporting victims of sexual assault, and has conducted training for police in order to build their capacity to respond to a survivors and to investigate cases. Few cases are prosecuted, however, in large part because women do not access medical treatment in time to conduct a forensic examination.

There is an branch of the Kenya Association of Professional Counselors (KAPC) in Mombasa. These counselors, as well as other professional volunteers, were mobilized to work in the camps. Following the disbandment of the camps, KAPC developed a provisional plan for some counselors to make themselves available to the displaced when they receive food rations from the KRCS. However, there are no other services that are being developed to specifically target the needs of the IDPs, although YWCA hopes to scale-up counseling services to the affected population in the coming months. The KAPC stated that the counselors were struggling to deal with the *"shock"* of the camps closing precipitously, preventing them from being able to say goodbye to those with whom they had developed relationships. None of the KAPC counselors have been specifically training in caring for survivors of sexual violence

Despite significant efforts by local organizations to prevent and respond to commercial sexual exploitation, many do not have capacity to ensure widespread impact of programs. For example, the local NGO SOLWADI has had a number of success stories in assisting women to exit prostitution, but their reach is limited by a shortage of financial and other resources. Notably, members of SOLWADI felt this might be an opportune time to scale up programming aimed at transitioning women out of the sex industry because the low ebb of tourism is making prostitution less remunerative.

ActionAid hopes to implement a project working with youth to discuss how the situation is impacting them. The division officer had a meeting with young men to discuss the violence and to encourage them to be a part of the peace building process. ActionAid would like to ensure that women's voices are also being heard in the decision-making process. YWCA would also like to initiate community outreach aimed at peace-building.

The Children's Rights Network (CRN)—a coordination body for child rights and protection organizations working in Mombasa—is scaling up efforts to coordinate and target activites of network member organizations to address the needs of the IDPs, but they lack resources and capacity.

VIII. Recommendations

For effective short and long-term protection from GBV for women and girls in Kenya, interventions must take place at three levels in order that structural, systemic and individual protections are institutionalized[22]. These levels are:

1. Structural level (primary protection): preventative measures to ensure rights are recognized and protected (through international, statutory and traditional laws and policies);

2. Systemic level (secondary protection): systems and strategies to monitor and respond when those rights are breached (statutory and traditional legal/ justice systems, health care systems, social welfare systems and community mechanisms);

3. Operative level (tertiary protection): direct services to meet the needs of women and girls who have been abused.

[22] Adapted by Sophie Read-Hamilton from A. Jamrozic and L. Nocella (1998) *The Sociology of Social Problems: Theoretical Perspectives and Methods of Intervention*, Cambridge University Press, Melbourne.

Addressing GBV among IDP communities in Kenya therefore requires: measures to protect women's and girl's rights; actions for intervention when those rights are breached; and services and programs to meet the needs of women and girls who have suffered violence.

Responding to sexual violence in particular requires significant sensitivity. Whilst there is a need for information on the scale and scope of sexual violence for advocacy and program planning purposes, there are significant ethical and programmatic constraints to the way in which incident-related data is collected and disseminated. Furthermore, women's reasons for not taking up certain services post-incident must be understood and respected by all actors and all response interventions must be implemented in a manner that fully respects the confidentiality, rights, wishes, choices and dignity of survivors.

Successfully protecting internally displaced women and girls from GBV in Kenya is dependent on the active commitment of, and collaboration between, all actors, including male and female community members. Gender-based violence is a cross-cutting issue, and no one authority, organization or agency alone possesses the knowledge, skills, resources or mandate to respond to the complex needs of survivors of violence or to tackle the task of preventing violence against women and girls, yet all have a responsibility to work together to address this serious human rights and public health problem. This "multi-sectoral" requires in particular coordination of activities between the constituent community, health and social services, and the legal and security sectors.

The recommendations detailed below are meant to provide guidelines for addressing and preventing GBV within the current post-election crisis period and into the early recovery phase. They are organized in terms of both *Improving Camp-based Programming* and *Improving Community-based Programming*, with the aim of guiding all relevant actors in Kenya to:

I. Deliver a set of minimum interventions to prevent and respond to sexual violence in line with the IASC Guidelines for Gender-Based Violence Interventions in Humanitarian Settings and other international and national policies, resources, and guidelines.

II. Transition humanitarian interventions to national government and non-government structures (NGOs/FBOs/CBOs) to enable the shift from humanitarian to development actions, as displaced populations move to transitional settlements in some areas and home in others.

A. Improving Camp-based Programming

Target Area	Activities
Participation/ Access	• Ensure that the voices of women and girls are incorporated in a meaningful way into all camp-related issues, and that women and men take part equally (in numbers and consistency) in decision-making, planning, implementation, trainings and management of all camp-based programs. 50% of camp management staff members should be women and there should be 50% participation of women in camp governance meetings and other camp programming activities (protection, education, health, nutrition, hygiene etc.). • Engage camp residents (men, women, girls and boys) in a review of camp-based strengths and resources and positive coping mechanisms that can be used to promote GBV prevention and response. • Guarantee that information and awareness-raising about camp management and programming issues are provided equally to women, girls, boys, and men, and ensure that information is disseminated through the most appropriate means. • Ensure that women, girls, boys, and men can equally access all camp services and assistance. • Ensure that support is provided to women and adolescent girls and boys to strengthen their leadership capacities and facilitate their meaningful participation. • Ensure that sustainable structures and mechanisms are established for meaningful dialogue with women, girls, boys, and men. • Ensure that all camp-related employment opportunities are equally open and accessible to females and males, and aim to employ equal numbers of females and males in all programs.
Protection	• Engage camp residents, especially women and girls, in weekly safety and security audits so that protection strategies can be redefined as needed in the evolving humanitarian situation. • Ensure that there is sufficient policing by male and female police staff and camp residents that are trained on protection and response to sexual violence. • Disseminate codes of conduct to all volunteers, and other relevant local and international NGO, governement, and UN staff and ensure that the codes of conduct are understood and signed off on by each person that has contact with beneficiaries in the camp settings. • Ensure that all camp offices/worksites (health clinics, schools, distribution centers, etc.) are monitored and instances of discrimination or GBV are addressed promptly. • Develop investigative procedures for alleged breaches in conduct in camp settings. Emphasis should be

	placed on training security and camp management and coordination actors (e.g.GSU/Police, KRCS) on how to appropriately respond to incidents of sexual violence and how to manage their positions of power to promote protection for all. • Create and disseminate reporting procedures and protocols to handle cases of GBV, including referral guidelines. Develop mechanisms to monitor, report and seek redress for GBV violations (e.g. rape and other forms of sexual violence and exploitation, trafficking). • Ensure that women and girls have access to legal assistance including, court advocates to accompany them through the court system system. • Ensure that there is a comprehensive understanding of the specific risk factors faced by women and girls in camp settings and this analysis is incorporated in security provisions within the camps (e.g. appropriate lighting in areas frequently used by women and girls, patrols of fuel wood and water collection routes, monitoring of school routes). • Ensure regular observation visits are undertaken at security checkpoints. Other high-risk security areas should be monitored regularly at different times of the day (e.g. school routes for girls, video clubs at night, bars, etc.). Women and girls should always be a part of these observation visits. • Camp security and other volunteers are required to wear attire that can be easily identifiable (e.g. KRCS jacket, organization t-shirt) so that people know wear to seek help.
Training and Capacity Building	• Train relevant local and international NGO, governement, and UN staff in essentials for addressing GBV in emergencies (IASC *Guidelines on Gender-Based Violence Interventions in Humanitarian Settings*) as well as designing and implementing gender-sensitive services through site planning, water/sanitation, food, nutrition, and shelter programs (IASC *Gender Handbook in Humanitarian Action and Sphere Humanitarian Charter and Minimum Standards in Disaster Response).* • Ensure that all volunteers, and other relevant local and international NGOs, governement, and UN staff working in camps are trained on the prevention of sexual exploitation and abuse and codes of conduct. Ensure that the SG's Bulletin is distributed to all staff and partners (e.g.KRCS). • Encourage all agencies to train their staff on gender equality issues, GBV prevention and response in emergenies and the guiding principles of GBV response: confidentiality, respect, safety and non-discrimination. • Make certain that equal numbers of female and male camp beneficiaries are receiving training on camp management issues, including participatory assessments, gender, GBV prevention and response etc.

Water and Sanitation	• Ensure that camp-based staff and resident water and sanitation committees are trained specifically on gender sensitivity. • Guarantee that all water distribution sites, mechanisms and maintenance procedures are accessible to women and girls. Engage women and girls in all design and monitoring activities to ensure this. • Ensure that communal latrine and bathing cubicles are separated from those of men and boys, that they are in safe locations with lighting, culturally appropriate, and secure (with locks on the insides). Engage women and girls in all design and monitoring activities to ensure this. • Make certain that equal numbers of women and men are involved in the safe disposal of solid waste. • Ensure that equal numbers of women and men are trained in the use and maintenance of all water and sanitation facilities. • Guarantee that women's and girl's access to and control over resources for collecting/carrying water, containers and storage facilities are monitored continuously with assistance from women and girls. Ensure that any obstacles to equal access are addressed promptly and in collaboration with women and girls.
Food security/ nutrition, food and non-food distribution	• Ensure that women and girls are involved in any participatory assessment activities aimed to gather information related to the design of all food security/nutrition and NFI distribution procedures and identification of site distrubution sites. Women's and girl's access to services should always be routinely monitored through spot checks and discussions with women and girls. Inequities should be addressed promptly. • Guarantee that services are designed to reduce women's and children's time spent getting to, at, and returning from food distribution points (e.g. distribution organized at different time intervals to avoid crowds and long waiting time; to avoid travel at night/dusk; to ensure timely distribution; and to avoid long waits for food delivery). • Assure that services are designed to reduce the burden that the receipt of food aid may pose on women beneficiaries. Food distribution points should be established as close to beneficiaries as possible, and weight of food packages should be manageable for women and girls (e.g. 25 kg vs. 50 kg bags, etc.). • Make certain that sufficient water and alternative fuel for cooking is provided in order to mitigate the risk of sexual violence during collection of these necessities. Or ensure that when women and girls have to leave camps to collect these essentials they go in organized groups with trained, security accomnpainment.

	• Make sure that women and girls do not have to gain access to food and non-food items from men or from remote locations. Women should be the food entitlement holders (e.g. family entitlement cards should be issued in the name of the primary female of the household). • Guarantee that food and NFI distribution is done by sex-balanced teams. • Ensure that positive measures are adopted to redress and discriminatory issues related to the allocation of food resources (e.g. ensure that children under 5, the sick or malnourished, pregnant and lactating women, and other vulnerable groups are given priority for feeding). Any security issues and instances of abuse should be monitored continuously and addressed promptly. • Make certain that access to clothing; blankets, bedding or sleeping mats is equal among females and males. The provision of blankets and other bedding items should be sufficient to allow for separate sleeping arrangements as required. • Guarantee that women and girls have continuous access to sanitary materials and dignity kits (including soap and underwear).
Shelter, site planning and design	• Make certain that the Sphere standards are disseminated and adhered to. • Guarantee that female heads of households and single women have access to housing and shelter supplies. Inequities among females and males should be addressed promptly. • Ensure that there is allocation of space in campsites that can be used as child centered spaces, centers for youth or community centers, with an emphasis on guaranteeing that survivors of sexual violence have access to non-stigmitizing safe shelter. • Avoid problematic camp design situations including: forcing women and girls to bathe after dark; poorly lit facilities and pathways; inability to latch doors from the inside; and men's and women's facilities located too close together, not clearly marked, or too far from shelter structures. • Ensure that equal numbers of females and males are involved in the design, allocation and training for and construction of shelters and camp facilites. • Ensure that camp sites have perimeter fencing on all sides. • Guarantee that overcrowded living arrangements are avoided, as they can make women and girls vulnerable to sexual violence and abuse. Ensure that shelter conditions are routinely assessed with participation of women and girls. • Make certain that appropriate arrangements are in place to address the needs of groups, including women, girls, boys, and men living with HIV/AIDS or disabilities, single heads of households, separated and unaccompanied children, elderly women and men, etc.

	• Ensure that women and adolescent girls have equal opportunities to those of men and adolescent boys to participate in all aspects of shelter construction and remuneration for work.
Health and community services	• Guarantee that the timing, staffing, and location of health services ensure equal opportunity for women and men to access them. Any obstacles to equal access or discrimination should be addressed promptly. • Ensure that all camp-related health care facilities have basic infrastructure, with equipment, supplies, drug stock, space, and qualified staff to provide reproductive health services, including sexual violence, delivery and emergency obstetric care services (as indicated in the MISP). Both camp-based residents and host communities should have access to health facilities with health staff trained in addressing the needs of GBV survivors, including training on the Kenyan National Guidelines on Medical Management of Rape/Sexual Violence, and on communicating with survivors, counselling, and referral mechansims. • Make certain that camp-residents host communities have access to free safe 24-hour sexual violence services. • Guarantee that GBV programmes are integrated in health and community services activities. • Ensure that there are culturally relevant community-based psychological and social support for surivors in place. Camp-based psychosocial service providers should receive training on the IASC *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. • Make sure that livelihood programs are eventually developed ensuring that they do not discriminate against women or men – for example construction projects traditionally targeted only to men should be reviewed to ensure access to both women and men (e.g. receive equal compensation for equal labor). Women's and girl's access to livelihood programs should be routinely monitored through spot checks and discussions with community members, especially women. Vocational training and non-formal education programs should target the specific needs of adolescent girls and boys and provide them with practical skills that they can use, including non-traditional skills. • Ensure that women and girl's participation in community service activities is facilitated by provision of family/child care. • Ensure that all community services programs are monitored for possible negative effects of changes in power relations (e.g. rise in domestic violence as a reaction to women's empowerment).
Education	• Ensure that both boys and girls have access to safe and developmentally appropriate education activities. • Train teachers on GBV prevention and recognizing abuse. All teachers are trained on the prevention of sexual exploitation and abuse, and have signed a code of conduct

	• Guarantee equal numbers of girls are involved in child/youth participation activities. • Encourage the utilization of the Ministry of Education's Gender Policy in all camp-related education sites. Assist teachers in creating girl-friendly classroom environments and use teaching strategies to engage girls.
Coordination	• Identify key partners and GBV focal points for each camp who will participate in and be responsible for raising key issues for GBV-related protection and response at all GBV, protection, health, water and sanitation, and camp management etc. coordination meetings at the district level. • Ensure that government gender officers participate in coordination efforts to facilitate monitoring of gender and GBV issues.
Data collection	• Guarantee that data on demographics, mortality, morbidity, and health services are routinely collected and are disaggregated and reported by age and sex and a gender analysis is applied. Data collection for any program (e.g. food distribution, shelter etc.) should be sex-and age-disaggregated on program coverage. • Ensure that women and girls play central roles in all participatory assessment activities. These activities should be on-going to assess the impact of the crises on all camp residents, but especially on women and girls.
Information Education and Communication (IEC)	• Involve women, youth and men in the development of culturally appropriate messages in Kiswahili (and other local languages as needed) so that community members can be informed about camp-based and community GBV-related services. • Ensure the development of materials that address/challenge gender stereotypes and reflect new realities in society. • Make sure that there are on-going information campaigns for men and women about the health risks to the community of sexual violence, and on where and how to access supportive services. • Ensure that communication strategies are developed and implemented to highlight the specific health risks affecting women and men, as well as targeting adolescent girls. • Guarantee dissemination of the *Simplified Version of the Sexual Offences Act, 2006.*

B. Improving community-based programming

Target Sector	Structural/Primary Prevention Activities	Systemic/Secondary Prevention Activities	Direct Services/Tertiary Prevention Activities
Constituent Community and their Representatives (i.e. Ministry of Gender, Gender Commission, local women's NGOs, international NGOs engaged in women's rights, women's leaders, local women's advocates, etc.)	• Support the Gender Commission on developing a GBV policy for Kenya. • Build capacity of Ministry of Gender to monitor and address gender and GBV issues amongst the displaced • Ensure that gender and GBV are integrated into all reconstruction efforts. • Establish mechanisms for monitoring rights violations and for information dissemination for advocacy and action. • Ensure humanitarian actors and others with responsibility for protecting women and girls from violence act in accordance with international humanitarian law and standards that promote and protect women's rights, while taking into account the unique challenges faced by people with disability in relation to GBV.	• Ensure interagency and inter-sectoral training on human rights, women's rights and GBV, international standards, national laws and practices. • Develop codes of conduct for local and international NGOs etc., and policies for addressing any breach in those codes. • Education on human rights and women's rights for traditional leaders, other "duty bearers" to encourage change in practices that condone or perpetuate violence against women and girls. • Sponsor a national media campaign designed to communicate social norms that define violence against women as unacceptable. • Advocate with UN agencies/partners so that gender and human rights issues are integrated across all clusters engaged in emergency response.	• Engage communities in participatory processes to identify community-based strengths and resources, to help them prevent violence and identify positive coping mechanisms to support for survivors. • Engage in women's, men's, boys and girls human rights awareness campaigns focusing on issues of GBV, and conduct widespread community education about availability of GBV-related services, rights of access and legal frameworks. • Ensure community education about availability of GBV-related services and rights of access, as well as on the principles of survivor response.

	• Intensified community education on legislation relating to women's rights and GBV for example the Sexual Offences Act and HIV and AIDS Act.	• Build the capacity of local partners, women's organizations, counsellors and all others who could come into contact with cases of sexual violence, to address GBV, and establish a standardized protocal for counselors to improve survivor response including engagement and case management.	• Awareness-raising on human rights and women's rights for traditional leaders and communities • Involve women, youth and men in the development of culturally appropriate messages in kiswhalli (and other relevant local languages) so that community members can be invormed about community GBV-related services.
Health (Ministry of Health, health care administrators and staff, Traditional birth attendants, community health workers, etc.)	• Create policies that ensure appropriate and consistent health response to women and girls exposed to GBV. • Develop policies to ensure training on GBV in medical school and other health curricula. • Develop strategies to increase number of female doctors.	• Develop codes of conduct for all health service providers and policies for addressing any breach in those codes. • Establish integrated health, protection and psychosocial response to meet the immediate survival needs of survivors. • Train health staff to provide confidential services that include counseling, examining victims, and collecting evidence, as well as coordination with other sectors, according to the Kenyan National	• Reproductive health services starting at the ministry level should focus on the following with the end goal of making sure these services accessible throughout the country. • Screening, case management, referral, and advocacy related to GBV. • Clinical management of sexual violence according to the Kenyan National

		Guidelines on Medical Management of Rape/Sexual Violence • Train traditional birth attendants in issues related to GBV and in referral processes. • Improve upon established data collection systems at the service delivery level and monitor on-going incidents.	Guidelines on Medical Management of Rape/Sexual Violence, and follow-up. • Confidential data collection. • Community education about the health outcomes of GBV and prevention of GBV.
Psychosocial (teachers and school administrators, skills training program managers, etc.)	• Develop policies for the training of teachers on codes of conduct and school-based education on safe touch, gender, and healthy relationships. • Ensure that polices and guidelines are in place to guide the social welfare system throughout the country to respond to GBV-related issues. • Ensure that the Ministry of Education's Gender Policy is operational throughout the country. • Develop strategies to increase number of female teachers.	• Develop codes of conduct for all social welfare service actors including social workers, child services staff, teachers and administrators and skills training actors etc., and policies for addressing any breach in those codes. • Build the capacity of local partners, counsellors and all others who could come into contact with cases of sexual violence, to address GBV, and establish a standardized protocol for counselors to improve survivor response including engagement, case management and coordination with other sectors.	• Ensure that supportive counseling and case management (including confidential data collection) is available to women and girls throughout country. • Ensure that services are targeted at the most vulnerable, especially returnees, singles mothers and widows, and the disabled. • Establish income-generation activities for women and girls. Support income generation activities through

		• Education on human rights and women's rights for teachers and other "duty bearers" to encourage change in practices that condone or perpetuate violence against women and girls. • Establish integrated health, protection and psychosocial response to meet the immediate survival needs of survivors. • Ensure that actors are trained in the IASC *Guidelines on Mental Health and Psychosocial Support in Emergency Settings.* • Improve upon established data collection systems at the service delivery level and monitor on-going incidents	community-based cooperatives for training skills and information sharing on human rights and GBV. • Ensure shelter or other services for women who have been exposed GBV who do not want to return to their families. • Support school-based education on safe touch, gender, and healthy relationships.
Legal/Justice (Ministry of Justice and Constitutional Affairs, judges, magistrates, Kadhis, court officers, lawyers, traditional leaders, legal advocacy groups)	• Support law reform initiatives to promote adoption of laws that conform to international standards and promote and protect women and girl's rights. • Audit relevant national laws and practices to assess areas for possible reform.	• Develop codes of conduct for all legal actors and policies for addressing any breach in those codes. • Establish integrated health, protection, legal justice, and psychosocial response to meet the immediate survival needs of survivors.	• Ensure that survivors, in rural areas especially, have access to legal assistance. • Ensure that women have access to court advocates to accompany them through the court system.

	• Guarantee advocacy and technical support for substantive and procedural law reform. • Ensure that the process for pursuing legal justice is more survivor-centered and upholds the guiding principles of confidentiality, security, respect and non-discrimination. Ensure that the PRC1 is given more clout so that multiple doctors throughout the country can be certified to complete the P3 form. • Support review and revision of current forms used as legal documents in the prosecution of sexual violence cases. • Promote more female lawyers and judges; establish percentages for women in law schools.	• Ensure human rights violations monitoring and information dissemination for advocacy and action, and ensure the establishment of data collection systems at the service delivery level and monitor on-going incidents. • Guarantee that there is a system of courtroom advocacy in place to support survivors through the court system. • Make certain that there is on-going training for the judiciary and for lawyers on women's rights and GBV. • Ensure in-depth law school training on GBV and the rights of survivors.	• Ensure rapid and respectful judicial response. • Ensure community education about laws relating to women's rights and GBV. Dissemination of the *Simplified Version of the Sexual Offences Act, 2006* should be prioritized. • Ensure that survivors, in rural areas especially, have access to legal assistance. Use expertise of legal aid agencies based in Nairobi (FIDA, WRAP, Girl Child Network etc.) to help decentralize capacity and knowledge to the rural areas.
Police/Security (Ministry of Internal Security, police, military, etc.)	• Develop strict policies for police in responding to violations of women's rights. • Ensure adequate percentages of women within law enforcement institutions.	• Develop codes of conduct for all security actors (GSU/police, military) etc., and policies for addressing any breach in those codes. • Establish integrated health, protection and psychosocial response to meet the immediate	• Guarantee the provision of rapid and respectful police response to women reporting incidents of GBV. • Ensure same sex police officers to respond to incidents and to conduct

		survival needs of survivors. • Support the development of disaggregated data collection and monitoring within police. • Support the development of non-stigmatizing specialized police services (in all districts) to meet the protection concerns of women. • Support the coordination of police with other sectors. • Build capacity of local policing networks and train them in gender-based violence. • Ensure reporting systems are in place for a breach in codes of conduct committed by military, police, INGOs, NGOs, etc.	interviews with women and girls exposed to GBV. • Build capacity of local policing networks, train them in GBV, and ensure that they provide rapid and respectful police response to women reporting incidents of GBV. • Provide special assistance to returnees.

ANNEX I: GENDER BASED VIOLENCE ASSESSMENT TEAM MEMBERS

Name	Organization	Contact Information
1. Jeanne Ward (Consultant and Team Leader)	UNFPA, Nairobi	jeanne@swiftkenya.com 0734-916145
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4. Arjmand Banu Khan	UNIFEM, Nairobi	Banu.kahn@undp.org 0733-738471
5. Mendy Marsh	Christian Children's Fund	mendy.marsh@yahoo.com 0711971502

ANNEX II: PERSONS MET AND CONTACT INFORMATION

Some interviewees wished to remain anonymous; their names and contact information are therefore not listed below.

Key Informant Name, Title and Organization	Contact Information
Nairobi Assessment	
Peter G. Gichanga, Men for Gender Equality Now (FEMNET)	0722262337 petergichanga@yahoo.com
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ANNEX III: TERMS OF REFERENCE GENDER BASED VIOLENCE SUB-CLUSTER

Objectives
The Gender Based Violence (GBV) Sub Cluster in Kenya aims, in collaboration with and in support of the Government of Kenya, to consolidate and coordinate the activities of all relevant stakeholders to improve and support the prevention of and response to GBV amongst populations affected by Kenya's post-election violence.

Gender-based Violence as defined in the IASC Guidelines for Addressing Gender Based Violence in Humanitarian settings 'is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between male and females.'

The GBV Sub Cluster aims to consider all types of gender based violence in its coordination, planning, and advocacy activities, but will give special emphasis to addressing sexual violence in the current emergency.

Reporting – Protection Cluster and OCHA

Membership
Membership is open to all organizations, media representatives and donors working on or funding any aspects of gender based violence prevention and response in relation to the Kenya post-election crisis. Membership will/should include government representatives, international and national non- governmental organizations, the Red Cross movement, United Nations agencies and other international organizations.

Responsibilities

Cluster Chair
UNFPA, as Cluster Chair, will abide by the cluster lead mandate and responsibilities as outlined in the IASC TOR for cluster leads, including:

- Establish and maintain coordination mechanisms and chair coordination meetings and ensure that appropriate stakeholders are continuously engaged in the cluster meetings and activities (i.e. Ministry of Health, Justice, Gender, Gender Commission, Internal Affairs and Education)
- Ensure utilization of participatory and community based approaches
- Ensure mainstreaming of HIV/AIDS and gender concerns
- Ensure effective and coherent sectoral needs assessments and analysis
- Ensure appropriate planning and strategy development (identification of gaps etc)
- Ensure application of standards that exist (national protocols, existing policy guidance etc)
- Monitoring and Evaluation
- Advocacy and resource mobilization with a special focus on meeting the needs of the most vulnerable, in particular people with disabilities
- Training and capacity building as needed
- Act as a provider of last resort

Cluster Co-Chair (Kenya Red Cross)
- Will work with the cluster lead to complete the above responsibilities
- Will co-chair coordination meetings

Members
- Regularly attend Sub Cluster meeting
- Coordinate and share information about activities and the field challenges encountered
- Agree to follow guiding principles for ethical GBV programming

Confidentiality
Identifying information related to GBV cases will not be revealed in the GBV Sub Cluster meetings to ensure the right to privacy of the survivor is respected, following the principles set out in the UNHCR Guidelines on Gender-based Violence Prevention and Response Among Displaced Populations (2003).

Priorities
- Coordination in order to strengthen and formalize GBV response efforts
- Information sharing of programming activities to in order to identify gaps, build coalitions and reduce the likelihood of replication of programming
- Advocacy to stimulate support for GBV prevention and response activities
- Advocacy and capacity building efforts to ensure that media activities are not harmful to efforts related to GBV prevention and response
- Sharing of tools, training resources, awareness raising materials, studies and available research
- Facilitate gender desegregated documentation in order to identify lessons learned and best practices
- Develop a standardized response to GBV for members of the cluster
- Coordination with provincial level GBV working groups, with an emphasis on information sharing from meeting outcomes at the national level with provincial groups and vice versa.

Time and Venue
Weekly meetings to be held on Thursdays, 9am at the OCHA Regional Office

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To be put on the GBV sub cluster mailing list, please contact sub cluster secretary Julie Lafreniere, gbvsubcluster@gmail.com.