



Violence against women in Kenya: A public health problem

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Abstract

Violence against women (VAW) in all its various forms is now widely accepted as a serious social and public health problem in many parts of the world. Rigorous efforts are being made by governments, non-governmental organizations (NGOs) and other stakeholders to combat the menace and help the survivors. In Kenya, VAW is not a new problem, what is new is the recognition that it has detrimental health consequences for the survivors and that the public health sector has great potential to contribute to the prevention of VAW and mitigation of its health sequelae. The focus of this paper is on violence against women in Kenya. It examines the health specific impacts on victimized women and efforts within the public health sector to end the violence. The paper argues that the establishment of gender violence recovery centres in both private and public health facilities has not only contributed to reducing incidents of gender violence but also provided the survivors with much needed support. However, the scourge is yet to be eradicated because of a number of challenges. The paper recommends that to effectively address the problem of VAW the public health sector resources need to be allocated resources and its practitioners trained on how to tackle the problem. Even though not exhaustive, it is hoped that this paper might help to disseminate knowledge which could provide a starting point for further dialogue and possible action on this critical public health issue.

Keywords: Gender-Based Violence; Violence Against Women; Public Health; Consequences; Kenya

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1. Introduction

Violence against women (VAW) also known as gender-based violence (GBV) is a silent social crisis that occurs daily with impunity behind closed doors in many homes around the world. It is one of the most pervasive of human rights violations and pressing public health problems in the world today (UNICEF, 2000; WHO, 2017). The problem affects both men and women irrespective of their social, economic, cultural and political backgrounds (UNICEF, 2000; Ondicho, 2013; NGEC, 2016). While there is no reliable statistical estimate on the magnitude of the problem in the world, studies from different parts of the world have highlighted its incidence and prevalence. A multicountry study reported that all but 30% of the women in the world have experienced physical and sexual violence perpetrated by a current or previous male partner and 7% have been assaulted sexually by a man other than their intimate partner (Garcia-Moreno et al., 2013). UNICEF (2000) estimates that between 20 and 50% of women in world have experienced at least one form of male violence (rape, battering, sexual or emotional abuse) in their lifetime. The World Health Organization (WHO, 2017), estimates that about 1 in 3 (35%) of all women in the world and one third (30%) of women who have been in an intimate relationship have experienced at least one form male violence in the course of their lives. Studies from more than 50 countries indicate that between 10% and 60% of women who have ever been married have been physically abused by their current or previous intimate partner (Ellsberg and Heise, 2005). This figures confirm not only that VAW is frightening problem but also that the brutalized women are more likely to be injured or killed (UNIFEM, 2012; WHO, 2017). While VAW is a global problem, it is more widespread in Sub-Saharan Africa, where poverty and deep-seated cultural norms continue to influence the lives of many people and render women and girls vulnerable to male violence (UNICEF, 2000; Rumbold, 2008).

VAW is believed to be a major course of many negative social, medical, physical and psychological problems among women and girls of reproductive age. Scholars (Evans, 2007; Chebogut and Ngeno, 2010; Garcia-Moreno et al., 2013) state that VAW is one of the most important risk factors for a wide range of detrimental health problems among women. Research at first undertaken in Western Europe, New Zealand, Australia and North America, and now emerging from many developing countries indicate that violence against women is a major source of morbidity and mortality among women of reproductive age (Colombini et al., 2008; Dahlberg and Mercy, 2009; WHO 2017). Women exposed to violence are said to be more likely to experience a multiplicity of health problems compared to women who have no history of violence in their lives (Heise et al., 1996; WHO, 2002; Garcia-Moreno et al., 2005). Generally, women exposed to violence tend to experience more physical and emotional impairments, chronic mental, sexual and reproductive health problems (UNICEF, 2000; Garcia-Moreno et al., 2013). Moreover, women exposed to male violence are likely to exhibit more behavioural deviations and to adopt behaviours such as problematic substance use and alcohol abuse, suicidal tendencies and physical inactivity which can further affect their health (WHO, 2002; Evans, 2007). Women experiencing violence are also at a higher risk of contracting sexually transmitted diseases including the Human Immune Deficiency Syndrome (HIV) and subsequent victimization (Colombini et al., 2008; Dahlberg and Mercy, 2009; WHO, 2017).

The public health sector is assumed to have huge potential not only to curb violence against women but also to mitigate its health sequelae. The (UN, 1989; WHO, 2002; WHO, 2013) predict that the medical practitioner within the public health care system is usually the first formal source of health that a victim of violence will approach and many survivors are likely to spend more time visiting doctors and staying in hospitals, and also to be intensive long-term users of health services. This demonstrates that scholars and practitioners are convinced the public health care system has a crucial role to play and an effective public health sector is needed to curb violence against women. Indeed, the public health sector has since 1996 when the World Health Assembly (WHA) adopted Resolution WHA 49.25 been in the nerve centre of international efforts to address the problem of violence against women in the world. The resolution which was titled 'Prevention of violence: a public health priority' declared violence, particularly against women and girls 'a leading worldwide public health problem' that without delay required to be addressed by governments and health organizations (WHA, 1996; Krug et al., 2002). The WHO was subsequently requested to initiate and promote public health activities internationally to tackle the problem at all levels. The WHO produced the first world report on 'Violence and Health' in 2002 thus giving international recognition of the significance to public health action in the prevention of VAW (WHO, 2002).

In 2014, during the 67th World Health Assembly (WHA) 24 governments initiated a motion which led to the adoption of a resolution entitled "Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children" (WHA, 2014). The WHA resolution noted that violence was a persistent social crisis and major challenge to public health in all countries in the world. Member States were requested to ensure that all people affected by violence have timely, effective and affordable access to health services. Some governments and organizations around the world have now acknowledged violence against women as a serious public health problem and put in place mechanisms within the public health sector to prevent VAW and lessen its health impact on female survivors. However, in Kenya very little is known about the health consequences of VAW and the role of the public health sector in its prevention. The focus of paper is therefore to review violence against women in Kenya as a public health problem. The paper will include a discussion of the health consequences of VAW and the public health sector initiatives to curb the menace.

2. Definitions

There is no universally accepted definition of the concept violence against women. Different scientists, practitioners, and communities define and apply the concept differently. As such, there are as many definitions of the concept as there are those who have attempted to define it. Despite the many different definitions of VAW, some of the commonly used definitions in the literature include those by the United Nations (UN) Declaration on the Elimination of Violence against Women which defines VAW as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life' (UN, 1993). The World Health Organization (WHO) in its 'World Report on Violence and Health' defines violence against women as 'the intentional use of physical force or power,

threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation' (WHO, 2002).

Some people narrowly use the term 'violence against women' to cover incidents of sexual and psychological violence directed against women by current or previous partners. Other people use the term in a broader sense to include physical, sexual and psychological violence occurring at many levels i.e. family, community and state levels, and in many different forms. While physical violence may be the most visible and therefore identifiable, violence against women includes sexual harassment, incest, rape, forced prostitution and sexual slavery; emotional and psychological violence which includes threats of violence, insults and name calling, humiliation in front of others, blackmail and the threat of abandonment; harmful traditional practices such as female genital mutilation (FGM), denial of certain foods and forced and/or early marriage and socio-economic violence which encompasses discriminatory access to basic health care, low levels of literacy and educational attainment, inadequate shelter and food, economic deprivation, armed conflict and acts of terrorism, are also important dimensions (Commonwealth Secretariat, 2003; Ellsberg and Heise, 2005).

In Kenya, VAW has a broader and more encompassing definition than that used in the mainstream. The term violence as used in the Sexual Offences Act, 2006 describes forms of violence that include rape, defilement, indecent act, sexual assault, incest, deliberate transmission of HIV and any other life threatening sexually transmitted diseases, sexual offences relating to positions of authority and persons in position of trust, harmful cultural practices such as child and forced marriages, female genital mutilation and socio-economic violence which includes discrimination, denial of opportunities, services, resource deprivation and social exclusion. Used in this wider sense, gender based violence encompasses child abuse, violence between siblings, abuse or neglect of the elderly and abuse of children by parents as well as people in same sex relationships (Krug et al., 2002; Ellsberg and Heise, 2005; UNIFEM, 2012). Due to the fact that VAW affects women and girls, the terms Gender Based Violence and VAW are used interchangeably. However, men and boys can also be victims of GBV perpetrated by women. Sometimes, the terms intimate partner violence (IPV); family violence (FV) are also used in the literature to refer to violence against women. This paper will mainly be concern with physical, psychological and sexual forms of violence against women and girls.

3. Overview of violence against women in Kenya

Kenya, is a developing country located in the East African region. The country has an estimated population of 44 million people made up of 44 different cultural and language groups (KNBS, 2010). Independent since 1963, the country adopted a constitution which until the late 1990s allowed discrimination on the basis of sex and a legal system that did not proscribe violence against women. Over 80% of the population live in rural areas, earn their livelihood through peasant farming. Women in Kenya are disadvantaged in numerous ways relative to men and to their counterparts in other parts of the world. Economic deprivation due to lack of land rights, high levels of illiteracy and poverty among women, little independent access to cash income

and customary patterns of out-marriage as well as prevalent practices of bride-price and polygamy render women dependent on men for economic survival. This, coupled with deeply entrenched cultural beliefs about male dominance freely allow men to chastise women, particularly wives. In Kenya violence – whether sexual, physical and emotional, touches the lives of most women, even those women that are not direct victims of male violence know female relatives and friends who are survivors of male violence (UNAIDS, 2006). It is therefore possible to make generalizations about women’s experience of male violence in Kenya.

In Kenya, as elsewhere in the world, GBV against women is a glaring social problem which occurs behind closed doors and in secret (UNFPA, 2006; UNIFEM, 2012; Ondicho, 2013). However, there is no reliable statistical estimate of the incidence and prevalence of VAW as a majority of the cases remain either undocumented or unreported. Emerging statistical data from various studies in the country allow us to speculate about the extent of the problem. For example, a 2014 Kenya Demographic and Health Survey (KDHS) reported that 45% of women aged 15-49 have experienced physical violence since age 15 and 20 % of them stated that they experienced physical violence within the 12 months prior to the survey. The survey further revealed that 14% of the survey women report having experienced sexual violence at least once in their life time. Taken as a whole 39% of ever-women aged 15-49 years reported having experienced physical and sexual violence perpetrated by their spouses, that is, husband or intimate partner (KDHS, 2014). Kimuna and Djamba (2008) report that over 40% of married women in Kenya have been victims of, at least one form of family violence in their lifetime. The Kenya Federation of Women Lawyers (FIDA) in a study four Kenyan provinces found that 75 percent of the women surveyed had suffered gender-based violence within the homestead and 78 percent of these women knew others who were either frequently or very frequently brutalized by men (FIDA, 2008). A WHO study in Kenya revealed that 42% of 612 women surveyed in one district were reported to have been beaten by a partner; of those, 58% reported that they were beaten often or sometimes (WHO, 1999 in UNICEF, 2000). The Gender Violence Recovery Centre (GVRC) in Nairobi reports that 45% of women between ages of 15 – 49 have experienced either physical or sexual violence, or the rate of violence is increasing (Kirsten et al., 2014).

Wife beating appears to be the most common form of violence in Kenya. Studies by scholars (Ondicho, 1993; Njau and Kabira, 1989; Njau and Njeru, 1997; Kangara, 2014; Aura-Adhiambo, 2015) report that wife-beating in Kenya is so common that it is viewed as a normal part of a married woman’s daily life. These scholars further state that the beatings are, in most instances, severe enough to ‘leave marks on the body of the abused woman’ and to cause her pain for a long time. Such beatings are often attributed to alleged failure of a woman, especially wife, to fulfil her culturally defined households duties and roles or to be ‘submissive’ enough, ‘properly’ obedient or as a way of men venting out their frustrations in life. Several researchers have reported that wife-beating in Kenya is widely viewed as a form of ‘punishment’ to the woman for failing to do the husband’s bidding (Ondicho, 2013; Kameri-Mbote, 2000; Aura-Adhiambo, et al., 2010; Aura-Adhiambo 2015). Ondicho (2000) cites the cases of Betty Kavata who died in 1999 after sustaining fatal injuries from a beating by her husband; Mary Akinyi who in the same year was slashed by her husband for singing a long ‘a ndombolo’ tune that was being aired on radio, in front of a guest and Piah Njoki whose

eyes were gouged out by her husband for bearing him only female children in November 1983. The other regularly cited and much publicized cases in discussions of violence against women in Kenya include those of Jackeline Mwendu who in July 2016 was brutally attacked by her husband who chopped off her hands with a machete and inflicted serious injuries on her face and forehead leaving her deaf for failing to bear any children during their seven years of marriage and Judith Muendi whose hands and right leg were chopped with a machete by her husband after a domestic brawl in December 2015.

Violence against women - or wife beating as it is popularly known - is a hidden problem that takes place daily behind closed doors in many households (Ondicho, 2013). The problem is often denied, disguised, tolerated, ignored, tactfully condoned, taken lightly and/or covered up under the guise of family privacy (Wamalwa, 1987; Ondicho, 2013; NGEC, 2016). Furthermore, women are socialized to accept, tolerate and rationalize the violence in the name of cultural traditions (Kimuna and Djamba, 2008; KDHS, 2014). In fact, in many Kenyan communities violence is not only accepted as normal part of a woman's life but also is promoted by cultural practices which continue perpetuate notions of male superiority and unequal gender power relations between men and women (Njau and Njeru, 1997; FIDA, 2008). Male dominance in the cultural, socio-economic and political gender power relations reduce women to positions of emotional and economic dependency, which not only renders women vulnerable to violence but also traps them in violent relationships (Ondicho, 2013; Aura-Odhiambo, 2015). Long-standing and deeply ingrained patriarchal notions about male superiority allow them to freely exercise unlimited power over women's lives including the right chastise women or to use of violence as a tool to exert control over women (Njau and Njeru, 1997; Njau and Kabira, 1989; Ondicho, 1993 and 1997). The supposed 'legitimacy' of men beating women is further compounded by the high rates of poverty and unemployment among most women in Kenya (Ondicho, 2013; NGEC, 2016). This traditional acceptance of violence not only makes it difficult for victimized women to speak out or seek help but also undermines their ability to break the cycle of violence.

Violence against women in Kenya is not only associated with many negative social, psychological, physical and health problems that afflict women, their families and society as a whole but also, is a major burden to the public health care system. The KDHS (2014) and NGEC (2016) highlight that violence against women in Kenya has a detrimental impact on the economy through increased disability, medical costs, and loss of labour hours. However, because women bear the brunt of GBV, they excessively bear the health and psychological burdens as well. Since very few women speak out or seek intervention from statutory agencies, it is possible that the number of women regularly abused by men could be higher than imagined and the health consequences may be enormous. In recognition of the health impact of GBV, there has been a growing momentum to a better understanding of the health consequences of VAW and the steps that have been undertaken within Kenya's public health sector to deal with the problem of violence against women. In spite of the increasing acceptance of violence as an important risk factor for a wide range of health problems among women in Kenya, very little attention has been given to the subject, making it very difficult to understand the causes, magnitude and health consequences of such violence. As a result, the health impacts of VAW have been downplayed. Hence very little action has been taken within the public health sector to minimize the problem of violence and its health consequences. This paper attempts to review the health consequences of violence in Kenya and to understand the role of the public health sector in GBV prevention.

4. Methodology

This paper employed several methods for data collection and analysis: firstly, personal observations and interaction with key people working in organizations with a gender violence focus including those in government, NGOs, and public health sector as well as survivors of violence in Kenya. The author of this paper has been living in Kenya and teaching courses which include Gender Based Violence and Conflict Resolution for over 20 years at the Institute of Anthropology, Gender and African Studies (IAGAS), University of Nairobi. The IAGAS is devoted to research and teaching on women's participation in the development processes and the impediments to the realization of their full creative potential. Besides teaching undergraduate and postgraduate courses on Gender Based Violence and Conflict Resolution, this author has also conducted some research on domestic violence and on political conflicts in Kenya.

Secondly, data were gathered from different secondary sources including published and unpublished works on gender-based violence against women and girls in Kenya and other parts of the world. Secondary sources included research reports and other publications on violence against women in Kenya. These included government policy papers, unpublished theses, conference papers, consultancy reports, journal articles, books and book chapters, and online materials on violence against women. Key reports used include: 'Gender based Violence in Kenya: The Economic Burden on Survivors' by the National Gender and Equality Commission (NGEC), 'The Kenya Health Demographic Survey' by the Kenya National Bureau of Statistics (KNBS), Gender-based Violence in Kenya: A

Study of the Coast, Nairobi, Nyanza and Western Provinces by the Kenya Federation of women Lawyers (FIDA). Information derived from these sources include the prevalence and magnitude of the problem, the impacts of GBV, policy and other interventions to end violence against women in Kenya. Particular attention is paid to the definition, health consequences, public health interventions, opportunities and challenges associated with using the public health sector in tackling VAW. This and information from other sources provided the basis for analyzing the health consequences of VAW and public health interventions in Kenya.

This paper is basically qualitative in nature. As result, thematic and content analysis were utilized to evaluate the data and information gathered. Thematic analysis of qualitative data obtained from secondary sources about violence against women in Kenya was summarized into themes and patterns. This provided the basis for the analysis of the health consequences of GBV and public health interventions. Finally, the limited quantitative data collected were cited to illustrate the extent of GBV locally and internationally.

5. Results and discussion

Violence against women in Kenya has a wide range of short-term and long-term fatal and nonfatal physical, economic and emotional consequences on the survivors. These effects can manifest as poor health status, poor quality of life, and high use of health services (Campbell, 2002; KDHS, 2014). While, to some extent, the physical and economic impacts of GBV in Kenya have been investigated and documented in the literature (FIDA, 2008; NGEC, 2016), the health impacts have not received much research attention. Based on the

extant literature, the health consequences of violence against women and public health interventions are discussed as follows:

5.1. The health impacts of violence against women

The health consequences of violence against women are now well documented in the literature (UNICEF, 2000; Krug et al., 2002; WHO, 2005). The health impacts of violence can be fatal and non-fatal physical, emotional or psychological, and sexual or reproductive which can have significant short-term and longer-term bearing on the health and well-being of women (Chebogut and Ngeno, 2010; Ondicho, 2013; UNAIDS, 2006; NGEC, 2016). The often cited health impacts of violence are physical injuries and impairments which may range from minor bruises, pain, cuts, swelling, scratches, burns and fractures to chronic internal injuries and disabilities like broken bones, loss of vision, memory and hearing and that in the worst cases may culminate in death or the victim may commit suicide (Krug et al., 2002; Garcia Moreno et al., 2005). A study in Kenya by UNAIDS found that VAW especially rape and coerced sex, FGM, polygamy, early marriage and widow inheritance were responsible for the high levels of HIV infection and premature death among women (UNAIDS, 2006). Research has shown that in addition to the physical injuries, women who have experienced male violence exhibit acute mental and behavioral health problems including depression, anxiety, feelings of humiliation, anger, nightmares, self-blame, low self-esteem and poor confidence, suicidal ideation, eating and sleeping disorders, inability to concentrate, Post-traumatic Stress Disorder (PTSD) and stress related illnesses, which lead to an impaired quality of life (Rumbold, 2008; WHO, 2013; Aura-Odhiambo, 2015). Women who have suffered violence or abuse are also much more likely to report somatic symptoms related to panic, depression, musculoskeletal disorders and chronic pain, genitourinary disorders, and respiratory illness (Fried, 2003; WHO, 2005). Furthermore, women with such experience are more likely to misuse drugs and to attempt suicide. These consequences can have ripple effects on the everyday lives of women and girls, their families and society as a whole (WHO, 2011).

VAW is also associated with a wide range of sexual and reproductive health problems including unwanted pregnancy as a result of the inability to negotiate contraceptive use or unwanted sexual relations (rape), early sexual debut, and sex without contraception, late entry to prenatal, still birth, premature labor and birth, and low birth weight (WHO, 2002 and 2005; Evans, 2007). Women exposed to violence generally and young women specifically are likely to indulge in illegal abortions which greatly predispose them to chances of future infertility and risk of obstetric complications and/or gynecological disorders (Heise et al., 1994; WHO, 2002). Research has shown that the inability of women who are victims of sexual assault and rape to negotiate safer sex (condom use) places them at especially high risk of contracting sexually transmitted diseases (STDs) including HIV/AIDS (UNAIDS, 2006). Multiple studies have shown that women experiencing violence are at higher risk of committing suicide, indulging in drug and alcohol abuse and other dangerous behaviours' such as prostitution and physical inactivity which can further affect their health (Colombini et al., 2008; WHO, 2002 and 2013). Both fatal and non-fatal consequences of VAW are far-reaching health consequences on women due to the length of time that women endure such brutalities before they can seek help (WHO, 2002). Johnson et al. (2008) have argued that in extreme cases

violence against women can lead to severe disability or even death among women, but even in less severe cases, it can adversely affect the overall quality of a woman's entire life, which in turn, may impede their ability to earn a living, access education, and participate in social and political life.

VAW is not only a significant cause of female ill-health but also generates enormous socio-economic costs that have ripple effects throughout society. A 2016 study by the National Gender and Equality Commission on the economic burden of GBV to survivors and to the country revealed that the 'average medical-related cost' was KES 16,464 per survivor and family; KES 3,417 per household and the weighted annual cost per survivor and family was estimated to be KES 24,797. At the national level, it was estimated that KES 10 billion is spent annually by survivor and/or her family on violence-related medical expenses. The study further reported that productivity loss from serious injuries amounted to KES 223,476; productivity loss from minor injuries was KES 18,623; and productivity loss from premature mortality from GBV amounted to a massive KES 5,840,664 (NGEC, 2016). Victims of GBV often have severe feelings of guilt and are stigmatized and blamed by family, friends, and society (WHO, 2002). Additionally, female survivors of violence are usually numb and fatigued, and often lack the energy to do no more than basic domestic chores and child care. This, not only hinders women's ability to work inside and outside the home but also to participate in social, economic and political life. It has been demonstrated in the literature that VAW undermines the dignity, autonomy and security of the victims; and the overall social and economic development of the entire society, thereby re-enforcing gender in-equalities (Autra-Odhiambo et al., 2010; NGEC, 2016). Thus, violence denies society the full creative potential, talents and participation of women in the overall social and economic development of the entire society which in turn perpetuates poverty.

5.2. Public health sector responses

VAW is now widely accepted as an important risk factor for a wide range of health problems among women and the public health sectors is increasingly being viewed as a sector with great potential to address the problem and mitigate its health consequences. Scholars (Krug et al., 2002; Dahlberg and Mercy, 2009) state that health care professionals treat a large number of women for injuries resulting from family violence because they are usually the first formal source of help that a victim will approach. Indeed, the attention devoted to violence prevention by the public health sector has increased considerably since the 1996 the World Health Assembly adopted a resolution declaring violence 'a leading worldwide public health problem' (Krug et al., 2002). The public health sector is well placed to effectively respond to VAW because of its scientific approach, potential to work with multiplicity of other key sectors, to coordinate multi-sectoral and multidisciplinary efforts, and role in ensuring that appropriate and adequate services are available for survivors and victims. Krug et al. (2002) further predict that abused women are likely to use health services more frequently even after they are no longer exposed to male violence. Health workers and practitioners are therefore in a key position to offer critical treatment, care and support to abused women who might otherwise face violence and its health consequences for many years (UN, 1993; UNICEF,

2000). The available evidence shows that victims of GBV have more health problems, significantly higher health care costs and make more frequent visits to emergency departments throughout their lives than

those without a history of abuse. However, it is extremely difficult to calculate the precise burden of all types of violence on health care systems and delineate the role of public health sector in violence prevention in Kenya.

Public Health refers to an organised response to the protection and promotion of human health. It is defined as '...a Complete state of physical, mental and social well-being, not merely the absence of disease or infirmity' (WHO, 2013). Unlike the medical approach to health which focuses on treatment of sick or injured people, public health is concerned with the health of all people in a given locality or country and its center of attention is prevention of disease and injury, promotion of public education and health lifestyles. Public Health operates at three levels to address an array of health issues that affect individuals and whole populations. The three levels are primary, secondary and tertiary. The primary aim of prevention is to minimize the occurrence of disease by addressing its root causes or determinants. Secondly, secondary prevention seeks to lessen the escalation of disease through early detection and early intervention. Last but not least, tertiary prevention targets people who are already affected by disease and provides them services aimed at mitigating the impact of the disease, delay complications, prevent repeat and improve function of those affected. In the disease prevention model there is often some overlap between primary and secondary prevention, for example, when the cause of the problem cannot be eliminated the focus turns to modifying behaviour. The public health model for prevention has in recent years been increasingly adopted and adapted as an asset for preventing violence against women. Thus, primary prevention aims to preventing violence before it occurs; secondary prevention focus on early intervention and tertiary prevention aims to offer safety and support for the survivors of violence (WHO, 2002).

In Kenya, VAW is not a new problem however its recognition as a public health problem is relatively new and violence prevention is an emerging field in the public health sector. This recognition has been accompanied by significant policy attention. Indeed, over the last two or so decades reducing VAW has become a priority objective of the Kenyan health strategy and the Ministries of Health and sanitation as well as Medical Services have been working in collaboration with other line ministries, county governments, non-governmental organizations (NGOs) and other stakeholders to implement a public health strategy for the prevention of GBV. Policy initiatives have been driven by increasing realization of the significance of the public health approach to the prevention of VAW and in the mitigation of its consequences. The public health sector has only recently started to make substantial contribution to reducing VAW and mitigating its negative consequences. The attention devoted to violence prevention by the public health sector has increased exponentially in the last two decades. In addition to treatment, public health facilities have developed other activities related to VAW such as research, mainly in data collection and services for victims.

This recognition of VAW as a significant public health problem has been accompanied by significant policy attention. Reducing VAW is a priority of the Kenya Health Strategy which being implemented by the Ministry of Health and Sanitation and the Ministry of Medical Services. However, very little research has been conducted to establish the health consequences of VAW and role of the public health sector in violence prevention and health consequence mitigation. Sometimes it is difficult to generalize findings from these studies from the developed nations to developing countries including Kenya where socio-cultural and economic conditions are extremely different and incomparable. Some of the government initiatives to end

GBV that impinge on public health sector include the National Plan for the Elimination of Female Genital Mutilation, National Guidelines on the Management of Sexual Violence, National Curriculum on Sexuality and Sexual Health Training for Health Service Providers, Post-Rape Care Form (MoH 363) and Post-Care Register. The government has specifically developed national guidelines for the medical management of rape and sexual violence, a trainer's manual on clinical care for survivors of sexual violence and a trainer's manual for rape trauma counselors. However, it is important to state here that at the moment there is no public health facility in Kenya that can adequately provide integrated gender violence services. The services offered at most public health facilities are usually limited to basic treatment, counselling and public education. Attempts are being made to make the public health sector more responsive to the needs of the victims and survivors by engaging with the Ministry of health, county governments, training medical and paramedical personnel, and conducting and disseminating research that focuses on the health impact of GBV. However, financial and budgetary constraints continue to hamper health sector involvement in the prevention and treatment of GBV.

6. Gender violence recovery centres (GVRs)

The first Gender Violence Recovery Centre (GVR) in Kenya was founded in March 2001 as a non-partisan, not-for-profit charitable trust of the Nairobi Woman's Hospital to offer free and comprehensive medical treatment and psychosocial support to survivors of gender based violence in Kenya. Nairobi Women Hospital is one of the few private hospitals in Africa to set up such a centre whose main focus is on the prevention and management of gender based violence through the public health system. However, over the last decade other recovery centres have been set up in government health facilities in Kenya. These include: The Centre for Assault Recovery of Eldoret (CARE) established in May 2007 at the Moi Teaching and Referral Hospital in conjunction with AMPATH, Kenya Police, German Development Cooperation – DED and GTZ and the Legal Aid Centre of Eldoret. Also established in May 2007 is Gender Based Violence Recovery Centre at the Coast Province General Hospital as a public-private partnership between the Ministry of Health and International Centre for Reproductive Health. This was followed by establishment of the Gender Based Violence Recovery Centre (GBVRC) at the Kenyatta National Hospital in January 2009 as a joint project between the German Development Cooperation (GDC) and Kenyatta National Hospital. Similar centres have also been established in Taita Taveta District Hospital in Taita Taveta County and Biafra Clinic in Eastleigh in Nairobi County.

The purpose of these centres is to provide free and comprehensive one-stop diagnosis, treatment, psychological support and prevention of gender based violence. Treatment focuses on management of physical injuries, provision of Post Exposure Prophylaxes (PEP) to reduce chances of HIV/AIDS infection and emergency contraception to minimize incidences of unwanted pregnancies arising from rape and forced sex, and provision of psycho-social support through counseling services to help survivors deal with trauma. While these Centres serve mainly women and children survivors of gender violence, male survivors also make use of their services. The centres also undertake primary prevention activities through creating awareness and community education that facilitates behavioral change through capacity building and

training for various stakeholders including medical personnel and paramedics, police and judicial officers. The aim of the awareness campaigns is not only to break the silence and enable the victims of GBV to seek treatment and legal interventions but also to sensitize prevention and increase accountability in legislation and justice system to reduce impunity for perpetrators of violence. The centres also played an important role in lobbying the Ministry of Health (MOH) to establish formal programmes for victims of GBV in all government health facilities, to provide guidelines for medical practitioners working with victims of violence and to include GBV in the medical and nursing education curriculum. Indeed, the Ministries of Health and sanitation and Medical services has developed national guidelines for the management of sexual violence in Kenya (Kenya, 2009). Other activities include tracking the implementation of the gender violence legislation, research and dissemination of findings on the health impacts of GBV especially rape and battering in order to improve evidence collection and preservation, reporting, documentation, referrals and expert testimonies in court to increase statistical visibility of violence against women.

Despite some successes, the GVRCS and the public health sector in particular remain marginal and play a marginal role in national efforts to prevent VAW and to treat its sequelae. Many survivors of GBV in rural areas have very limited access to GVRC services which are primarily offered in health facilities located in a few urban centres. Most public health facilities and practitioners in the country have largely been silent, they do not have any specific programmes or budgetary allocation to aid them in the fight against women. Much of the public health sector attempts to deal with VAW have basically focused on the normal diagnosis and treatment of injuries without taking into cognizance the special nature of the health impacts of GBV. Any efforts to address GBV have come from individual practitioners working within the public health system while in some cases they have been working for NGOs sponsored programmes. While some of these health practitioners have been working with survivors of

GBV for a long time, they have received very little specialised training and education on how to handle GBV cases. In Kenya there are no courses in the medical curriculum that offer training on diagnosis, prevention and treatment of health conditions associated with GBV.

GBV programmes and activities in public health facilities, where they exist, are usually managed on shoe string budgets which limits geographical coverage, the range and quality of services given to victims of GBV. Thus, survivors of violence who come from poor backgrounds especially in urban slums and remote rural areas have limited access to such services. In addition, medical care and medico-legal support to GBV victims is not given free of charge by all healthcare providers. For survivors to get proper care free of charge s/he has to go to health facility with a gender recovery centre. However, in some cases they have to pay for the services of a "forensic expert" who is qualified to provide expert opinion valid in the eyes of the other operators in this chain (police, judiciary, and psycho-social support providers) and/or for other medical conditions /problems that are not related to the violence.

Lack of and/or inadequate resources, both human and financial continue to weaken the capacity of the public health sector in terms of dealing with GBV. Socio-cultural biases which favour men over women and the girl child have consistently continued to frustrate public health sector interventions. Traditionally, women have been viewed as lesser beings than men. This means that a man can do whatever he wishes to

the woman given that he 'bought' the woman through payment of bride price (Ondicho, 1993). Violence has thus been condoned and accepted as a socio-cultural norm within the society. Much health service providers tend to focus on the injury itself while ignoring the process and circumstances that caused it i.e. women do not tell the doctor they were abused but will complain of many health conditions including fatigue, depression, anxiety and other related complaints. The doctor usually accepts the woman's fictitious account without attempting to find out more about how the injuries were sustained (UN, 1993; Ondicho, 2000). Health service providers who suspect that the woman is a victim of abuse, prefer not to inquire closely because they do not wish to become involved in marital conflict other than fulfilling their primary mandate, treatment of the condition presented to them. Health workers often view VAW as a problem that requires legal and/or family solutions. They see the maintenance of the family unit as an important goal. They prescribe inappropriate drugs – this stems from their training which stresses individuals case history and pathology rather than a holistic approach, they treat symptoms and not an experience or situation. Inadequate response of the medical profession to wife abuse reinforces the woman victimization. Therefore, education and training programmes in the medical profession are essential in ameliorating the situation.

The minimal public health sector involvement is unfortunate, since health workers are logical advocates and supporters of women who suffer the effects of violence. Thus, all the peoples within the health care system such as nurses, doctors, traditional healers and community health promoters should be alerted to the fact that a woman may be battered or raped. Thus, these and other health care givers should be trained to identify, assess and refer the physically, emotionally or sexually abuse female survivor of GBV. Where possible, medical examination and testing, psychological counselling, and legal services should be integrated, so that the woman and her support network do not expend scarce resources on locating different agencies and service providers. Above all health services should not victimize the woman. Stories abound of the rape victims and battered women who seek help, only to be treated insensitively or ridiculed by ignorant health workers/ care providers.

Women in rural and remote areas of the country where much of GBV occurs have limited access to services offered by the recovery centres. It is also not clear yet how many medical specialists in these recovery centres provide integrated health services to the victims of GBV. The attempts to deal with the health impact of GBV has come primarily from the GVRC and a few a civil society organisations in the country. The public health sector has largely been silent and there has been limited government effort to roll out similar services in public health facilities. While some medical personnel (doctors and nurses) have been working with victims of GBV, these service providers have more often than not received any medical education as medical courses in the country do not offer training on the diagnosis, prevention and treatment of health conditions related to gender violence. While women have been targeted appropriately as beneficiary populations, medical and psychotherapeutic services still remain scarce for a large majority of the victimized women even in places where the services are available. To address GBV, there is the need for a coordinated, inter-agency, and multi-sectoral strategies that aim for prevention through policy reform and implementation of protective mechanisms and building the capacity of health, social welfare,

legal and security systems to recognize, monitor, and respond to GBV; in addition to ensure rapid and sensitive services to victims.

7. Why should the public health sector be involved in violence prevention

Dahlberg and Mercy (2009) state that there are many reasons that have contributed to the growing acceptance and recognition of VAW as a public health issue. The public health sector is openly concerned with gender based violence not only because women who are abused are frequently treated within health-care systems but also because of the significant contributions that can and should be made by public health workers in the prevention of such violence. Colombini et al. (2008) state that victimized women are regular visitors to health facilities and frequently turn to it for both primary and secondary as well as tertiary care. Fried (2003) argues that health practitioners within the public health system are uniquely placed to offer treatment and support to victims of violence throughout their lives by ensuring the availability of services for victims and its potential to coordinate multidisciplinary and multi-sectoral efforts to end violence against women.

The other reason why the public health should be involved in addressing violence against women is its focus on behavioral factors in the etiology and prevention of disease within the public health community. Dahlberg and Mercy (2009) argue that prevention of diseases such as diabetes and cancer largely depends on behavioral changes such as changing diet and exercise. One of the key paradigms within the public health sector is that prevention works better than cure. In the same vein, violence against women could be better prevented before it takes root. Public health sector's strong emphasis on evidence based approaches to problem solving could particularly be important in policy making and tackling VAW. The public health practitioners have great potential to employ a similar approach to deal with behavioral challenges underlying violence against women and achieve positive results. The public health sector has a strong emphasis on using scientific evidence when making policies and treating health conditions. Thus, if strategies to end VAW are to be successful, prevention policies and activities must be firmly grounded in science, as in other successful public health efforts. In addition, the public health sector provides critical complementary services to existing approaches to violence prevention, which are mainly reactive, by focusing on changing the behavioral, social, and environmental factors that nurture violence.

VAW prevention activities normally involve partnerships across the different stakeholders, organisations and scientific disciplines. The central role of community health workers in preventing violence against women cannot be overemphasized. Public health workers have a long-standing commitment in supporting and helping communities to deal with their own health problems. Public health workers also play an important part in linking women to appropriate services while the public health sector has a responsibility to ensure that health services are available in communities. This role can be extended to the provision of health services aiming to reduce the negative physical injuries and disabilities of women injured in violent incidents and associated psychological trauma. Emergency response and trauma systems are

therefore a critical component of comprehensive health- services approach to GBV prevention and management.

8. Conclusion

This paper has demonstrated that the health sector both public and private play an important in promoting the health and well-being of people. However, violence against women, like other forms of violence, not only impacts the health own women negatively but also imposes a heavy burden on their well-being. The broad goal of public health is ensure the safety and wellbeing of communities, health wise. The major task of all stakeholders involved in efforts aimed at combating violence against women at the global, national and community levels to persuade all the key actors in the health sectors in their respective locations to prioritize and commit themselves to this noble goal. The public health sector and officials wield enormous potential which they can use not only to build important partnerships between the various actors and sectors involved in this endeavor and lobby governments to allocate adequate financial resources to support violence prevention efforts but also to play an active role in formulating national action plans and strategies to prevent violence against women. While the public health sector has a significant role to play in combating through influencing public policy and engendering positive action, it should also be acknowledged that the public health sector cannot direct all the actions and responses to prevent to VAW. The data collected by the public health sector and other agencies, the insights and understanding developed through empirical research, and the commitment to find effective and sustainable responses to VAW are important avenues through which the public health sector can make useful contributions to the global response to VAW.

In conclusion, it should be noted that gender based violence is not only a health problem of the victims but also, a social problem for the public health system, communities and governments around the globe. A public health approach is therefore needed to tackle the problem of VAW both in the developed and developing nations. To tackle violence against women in an effective and sustainable manner there is an urgent need for collaboration between the different sectors whose activities impinge upon VAW, such as education, health, police, social and legal authorities, the church, and non-governmental organisations. Basically, VAW is a multi-sector problem requiring coordination with the community at large (e.g., neighbours, families, friends, schools, and churches), the legal system (e.g., police, prosecutors, and court system), the social system (e.g., legal aid, social services, and shelters), and the health profession (e.g., physicians, nurses, counsellors, and social workers). VAW can be prevented by ensuring that care and support services such as counseling; shelters, counselling and referral are easily accessible to victimized women and their children at the local level.

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