Kenya

Kenya is situated in the East of Africa and has an area of approximately 580,000 km_2. It is bordered by Uganda, Somalia, Ethiopia, South Sudan and Tanzania. The population of Kenya is estimated at 41,070,937. The total female population is estimates at 20,596,278 (50.15%) The rate of infant mortality in Kenya is high, 52.29 births in 1,000 result in the death of an infant. This can be contributed to a number of factors including female genital mutilation and poor health infrastructure. For similar reasons maternal mortality is also extremely high when compared with the global average. There are 530 maternal deaths per 100,000 births. This places Kenya with the 26th highest rate of maternal deaths globally. In addition 16.5% of Kenyan children under the age of five are underweight. Kenya has a high HIV prevalence at about 6.3% however in poorer areas this prevalence is even higher, in Kibera (Nairobi's largest slum) it stands at around 14%. It is estimated that 1.5 million people are living with HIV/AIDS in Kenya today. Women are disproportionally affected by the epidemic. The female prevalence is around 8% while male prevalence is around 4.3%. This Disparity is even greater in the 15-24 age group with females being four times more likely to contract the disease than males. This can be contributed to the high rate of sexual violence against women in Kenya.

Sexual Abuse

Sexual abuse is rampant in Kenya and permeates all sectors of society. Sexual abuse takes many forms and includes harassment, unwanted touching and rape. According to a UN-Habitat report one in every seven women in Nairobi experience sexual abuse. Out of every five cases of sexual abuse three involve rape. One out of every four cases of rape is a gang rape, this is a higher rate than in Metropolitan South Africa where 13% of rapes involve multiple rapists. For twenty per cent of these women the sexual abuse occurs on an on-going basis. One quarter of sexual abuse cases result in an unwanted pregnancy and one in twelve women who are sexually abused contract the HIV virus. One third of survivors remain in regular contact with their abuser. UN-Habitat notes that women experience sexual abuse in all areas of their lives: at home, at work, on the streets and in educational facilities. This has the effect of causing women to live in continual fear.

Sexual violence in Kenya can begin from a young age. US-AID notes in the 2008 Kenya Demographic and Health survey that 12% of women aged 15-49 state that their first sexual encounter was forced. Furthermore UN-Habit stated that out of sixty six women they interviewed who had admitted to having been sexually abused eleven women reported that they had been abused as children. Overall two thirds of these women were abused by somebody they knew: 36% by a family member and 27% by a neighbour. It was noted that women who experience sexual abuse as children are more likely to suffer from all forms of abuse when they reach adulthood.

There have been significant instances of betterment sex reported in Kenya. This refers to women being coerced into having sex in order to gain some sort of advantage or service. This can be found in the work place, educational institutes and even in the camps where internally displaced persons found themselves after the 2008 violence. Amnesty International notes in its Alternative Report to CEDAW that many women working in the slums find it difficult to find employment. Most women who have work find it as casual workers or domestic aids in higher income areas, however while this employment brings much needed income to the women it also exposes them to a higher risk of sexual violence. Amnesty International conducted a focus group with fifteen women who resided in the slum area of Mathare but worked in the surrounding higher income areas. Many of these women reported that they had to put up with sexual and other forms of harassment in order to retain their jobs. Two of the fifteen women had been raped by their employers, one becoming pregnant and infected with HIV in the process. These women did not report the harassment or abuse to the police because they felt certain their employers would be able to bribe them. UN-Habitat recounted stories of street venders who were asked by Nairobi city council guards for sexual favours. If they refused they were arrested and placed in cells. During the time they spent in the cell these guards brought in street boys who raped the women and sodomised the men. It was considered by many to be better to supply the guards with the sexual favours they asked for than to experience a night in the cells. UN-Habitat also shows how women are subjected to sexual abuse within the educational system in Kenya. 8% of women they interviewed reported that they had been asked by a teacher or lecturer to supply sexual favours in return for better grades. Betterment sex became survival sex following the 2008 violence in Kenya. Many women who found themselves in camps set up for internally displaced persons. Women and girls were often forced to

exchange sexual favours for supplies such as food. In addition during the period of violence many women were forced to leave their homes under the threat that either they or their children would face sexual abuse. Often these threats were realised if the women refused to leave.

During the period of violence in the aftermath of the 2008 elections women faced a wide range of sexual threats. The Waki Commission (the commission set up to investigate the post electoral violence) has acknowledged that sexual violence was the crime most often perpetrated in the turmoil which ensued after the election. Women who fled to IDP camps were subjected to sexual violence at a number of levels. Often the makeshift sleeping arrangements put women in a vulnerable position as women were housed with unknown men in the same tent. This led to a number of rapes and other forms of abuse. In addition the level of screening of who could get into the camps was insufficient. Often men could enter the camp under the guise of being a volunteer. This put already vulnerable women at even greater risk. Many women contracted STIs and HIV as a result of the sexual abuse. Other women report that they were raped despite telling their rapist that they were HIV positive, thus resulting in a number of new infections. The imposed curfew from 6pm to 6am each day led to a large numbers of women being sexually abused by security forces. There are no exact figures for the numbers of women who have experienced sexual abuse during the violence and its aftermath.

Women who live in slums are at a particularly high risk of being subjected to sexual abuse. High unemployment levels mean that as women go about their daily routine they are often faced with large groups of loitering youths. One woman who was quoted in an Amnesty International report describes the abuse she suffered at the hands of one such group:

> "it was about 7pm when I had gotten to the latrine only to encounter a group of four young men – including one who was my neighbour and well known to me… Without saying anything two of them held my hands as one hit me on the face and I partly lost consciousness… I shouted asking them to leave me and I could feel them undress me and one of them say that they would teach me a lesson on why I should not be out at that time… I am sure that they were about to start raping me

> when a few people responded to my shouting and came to my rescue and these men ran away…"

This highlights an issue which puts many women in daily danger. Most women living in Kenyan slums do not have direct access to a toilet. Only 24% of people living in slums have a private toilet this means that women often have to walk for five to fifteen minutes to reach their nearest public toilet. This puts unaccompanied women at great risk. It is clear that the fear of sexual assault and rape greatly impacts the standard of living for Kenyan women living in slums.

Beading

Beads that are worn among the Samburu tribe in Kenya's Eastern province are traditionally symbolic of Kenyan nationality however they are also symbolic of abuse against women. When beading occurs a man presents a young girl's parents with a set of traditional beads. This means exchange entitles him to have sex with the girl, whether or not she gives her consent. As the man generally comes from within the girls own village it is probable that he will be a relative such as her uncle of cousin. Beading has occurred with girls as young as six. As these men rarely use contraception these young girls are vulnerable to contracting the HIV virus. In addition girls who have reached puberty are at risk of falling pregnant. While Samburu culture allows for the practice beading it does not allow girls who have had a baby as a result of the practice to marry. Thus many girls are forced to undergo crude abortions which may permanently harm their health. Girls who manage to have their pregnancy go undetected are allowed to give birth but the baby is then killed or given to another family for adoption.

Domestic violence

According to an Amnesty International report domestic violence is the most common type of violence experienced by women in slums and informal settlements. However UN-Habitat finds in its report on abuse in Nairobi that women from all socio-economic groups and areas within the city are equally likely to experience abuse. Tellingly this report found that many of the women they interviewed found

their own home less safe than their broader residential area. A study by the Federation of Women Lawyers in Kenya attributes to factors 'ranging from the low status society accords to women, to poor policy and legal frameworks that condone or ignore the prevalence and perpetuation of domestic violence'. In its report to CEDAW the cited a COVAW report which stated that 48% of all crimes reported by women are related to domestic violence, when considering this figure we must remember that majority of all domestic abuse cases are not reported. According to this same report the most common form of domestic abuse is physical abuse; this is followed by emotional abuse, sexual abuse and neglect.

A UN-HABITAT report found that in Nairobi 60% of the women they interviewed had experienced physical abuse; most of these women had experienced the abuse within the home. More than half of these women were subjected to abuse frequently. Over 70% of them were abused on front of other people, most commonly their own children. This is a cycle which perpetuates violence as children begin to hold the understanding that it is ok to physically abuse women, the Kenyan Demographic and Health Survey found that women who whose fathers had beat their mothers were more likely to be beaten themselves in later life. From a national point of view the Kenyan Demographic and Health Survey found that about 39% of women experience physical violence. It is thought that one in seven women in Nairobi are sexually abused. Women are most likely to be sexually abused by an intimate partner or husband. According to the Kenya Demographic and Health Survey 2008-2009 only 6% of sexual abuse is perpetrated by strangers. 37% of women were abused sexually by their current husband or partner, 16% by current or former boyfriends and 13% by their former husband or partner. A woman's chance of being physically or sexually abused rises in direct relation to an increase in age and the number of children she has had. This report found that this physical or sexual abuse usually occurs with another form of abuse such emotional or economical abuse by their partner. Economic abuse can take many forms but most commonly it involves a lack of maintenance payments from a woman's husband or him taking money which she has earned. The UN-HABITAT report found 52% of women they surveyed had been subjected to economic abuse. The survey also found that approximately 57% of women were subjected to emotional abuse, 23% of these women were insulted or mocked on front of their children. Furthermore the Kenyan Demographic and Health Survey 2008-2009 illustrates that Kenyan men frequently display controlling behaviour towards their spouses and partners. Of the women surveyed 49% claimed that their former/current husbands/partners displayed jealous behaviour when they spoke to other men while 19% were repeatedly accused of being unfaithful. 37%

state that their husband or partner demands to know where they are at all times and 20% are not permitted to meet with their female friends while 14% are only allowed limited contact with their family.

While domestic violence is undoubtedly a serious problem in Kenya it has not been properly legislated for. Currently physical abuse is covered in the penal code as assault/battery however in the case of domestic violence police officers often tell victims that this does not apply to them. Furthermore they frequently ask women what they have done to instigate the violence. More often than not women are sent back to their abuser to 'work things out'. The Family Protection bill would give greater support to victims of domestic abuse, however though it has existed since 2001 it has not yet been enacted. It would recognise domestic violence as a crime and provide victims with counselling and psychological services. In addition it would allow third parties to report suspected abuse to the authorities. The bill has had such trouble because it includes a controversial clause about criminalising marital rape which is currently not an offence in Kenya. Most legislators do not accept that marital rape is a crime or that rape within marriage can even exist. Thus the bill like other gender related bills before it is having trouble being passed. The only piece of legislation which currently exists in relation to domestic violence is the Children's Act which allows that children who are exposed to violence within the home should be afforded special care.

Female Genital Mutilation

Female genital mutilation is defined by the World Health Organisation (WHO) as any procedure which intentionally alters or causes injury to the female genital organs for non-medical reasons. The Who recognises four different categories of female genital mutilation. Type I involves the partial or total removal of the clitoris and/or the prepuce. This may involve the removal of the clitoral hood or prepuce but it can also involve the removal of both the clitoris and the prepuce. Type II is defined as the partial or total removal of the clitoris and the labia minora with or without excision of the labia majora. While type III is considered to involve the narrowing of the vaginal orifice with the creation of a covering seal. This seal is created by cutting and repositioning the labia minora and/or the labia majora. There are no health benefits associated with female genital mutilation, however the WHO has issued a

long list of negative long-term and short-term health impacts which can be caused by the harmful practice.

In the immediate aftermath of the procedure a woman can suffer from severe pain due to the fact that nerve endings and sensitive tissue have been cut, this is exacerbated by the fact that proper anaesthetic is rarely used and when it is used it is often ineffective. This severe pain combined with haemorrhaging can cause the girl/women to go into sever shock. In the days after the operation women can experience difficulty when passing urine or faeces due to the swelling and pain. There is a high risk of women catching infections if the surgical equipment used during the procedure has not been properly sterilised after each use. Ultimately a girl/woman can die in the immediate aftermath of the operation due to a haemorrhage, infection, tetanus or shock. The experience can have profound psychological effects on the woman. If mistakes are made during the first genital cutting a woman may be subjected to further instances of genital mutilation.

Women can suffer several severe long term effects from being subjected to female genital mutilation. Chronic pain can result due to trapped or unprotected nerve endings. Women can suffer from a wide range of infections after the procedure. Dermoid cysts, abscesses and genital ulcers can develop with superficial loss of tissue. Chronic pelvis infection can result in life long back and pelvic pains. An increased risk of urinary tract infections has been noted in both women and young girls. Urinary tract infections can ascend to the kidneys potentially resulting in renal failure, septicaemia and death. It is worth noting that an increase in certain genital infections including bacterial vaginosis and genital herpes has been documented. Due to an increased risk for bleeding during intercourse there is an increased risk of catching HIV for a woman who has experienced female genital mutilation. The removal of highly sensitive genital tissue especially the clitoris may affect sexual sensitivity and lead to problems such as pain or decreased pleasure during sex. Scar formation, pain and traumatic memories can also lead to similar problems. Women who have experienced female genital mutilation are also at greater risk of experiencing problems when they are giving birth. They may need to have a C-section and the risk of having postpartum haemorrhaging is substantially increased. Whether or not a woman is circumcised also has an effect on her new-born baby. Babies born to women who have been mutilated or cut have higher death rates and a reduced Apgar score.

Despite the long list of negative health affects genital mutilation is an everyday reality for millions of women throughout the world. The WHO estimates that about 140 million girls and women are living with the consequences of female genital mutilation worldwide. 92 million of these women are resident on the African continent. The reason that female genital mutilation persists is due to the fact it is a social convention which is considered by some cultures to be necessary to raising a girl properly. It is often linked to beliefs about what the practising community consider appropriate sexual behaviour. It is believed to lower a woman's libido and therefore discourage her from participating in sexual behaviour which is considered outside the norm. In the case of type III mutilation the pain associated with opening the covering is intended to discourage a girl from engaging in sexual activities that would be thought of as abnormal by the community. If a family refuses to circumcise their daughters they may face repercussions from the rest of the community. Father's and mother's may lose their social standing and be shunned. Not having been cut can affect a girl's chance of getting married. The fact that a family would have to expect a decreased dowry should their daughter not have been circumcised may influence some families decision to subject their child to female genital mutilation.

According to UNICEF figures 32% of women and girls in Kenya have experienced female genital mutilation. However this statistic does not apply evenly to every region of Kenya. In the Western region of Kenya about 4% of women report being circumcised while this figure raises to 98% in the North East Province. This regional difference occurs due to the fact that Kenya is home to more than thirty different ethnic groups, each with their own cultural practices and beliefs surrounding female genital mutilation. Among some of these groups cutting is almost universal: Somali (97%), Kisii (96%), Kuraia (96%) Maasai (93%). It is also common among Tuitu (62%), Kalenjn (48%), Embu (44%) and Meru (42%). While it is less common among Kikuya (34%), Kamba (27%), Turkana (12%)and mijikenda (6%). It is almost non-existent among the Luhya and Luo women (<1%). The type of female genital mutilation which occurs also depends heavily on the ethnicity of the woman. Most Somali women will experience type III while type II is more frequently practiced among Maasai and Kuria and type I isused by the Kisii. Female genital mutilation affects more rural women(36%) than urban women (21%), it is worth noting that the urban figure may be skewed due to the fact women enter urban areas from the countryside in search of employment. There is also a link between the amount of education that a

woman has received and whether or not she has experienced female genital mutilation. 58% of women who have little or no education have been mutilated while this figure drops to 21% among women who have at least some secondary education.

UNICEF states that although President Moi issued two presidential decrees banning female genital mutilation and the government prohibits government controlled hospitals and clinics from practising it there is no law that expressly bans the practice. The Children's Act 2001 forbids female genital mutilation on girls under the age of 18 stating that 'no person shall subject a child to female circumcision' however this does not equate to an overall ban. CEDAW expresses concern in the Universal Periodic Review of Kenya that the Children's Act will effectively mean that women undergo female genital mutilation at a later age than they previously did which could heighten the psychological impacts of the practice. However there is evidence that suggests that girls are in fact being circumcised at younger ages today than previous generations. Women aged 15-19 were on average circumcised at 13 while women now aged 19-49 were circumcised at an average age of 15. It is worth noting that some circumcisions take a place at a much younger age, in some cases infants are mutilated and among certain ethnic groups (Somali and kisii) girls under the age of ten are cut. There are several reasons why female genital mutilation may be occurring at an earlier age in Kenya. In some case poverty may be a factor with parents needing to ensure that their daughter gets married at a younger age in order for them to obtain a dowry. Another factor is the high rate of teenage pregnancy (which as of 2010 stood at 18%) parents feel that my having their daughters circumcised they will not engage in promiscuous sexual behaviour. Another worry is that parents may wish to have the procedure over before their daughters are old enough to understand their rights and the implications associated with Female Genital Mutilation. Over time the type of female genital mutilation which is practised in Kenya has also changed over the last number of decades. While 62% of women over the age of sixty experienced type II only 38 of the 15-19 age group underwent the same type of procedure, mostly they experienced type I.

As previously mentioned the government prohibits female genital in government controlled clinics. The vast majority of procedures are performed by traditional circumcisers however about 11% of girls aged 15-19 reported that they were circumcised by a trained nurse under hygienic conditions. While this reduces the risk of infections and immediate pain it does little to counter little to counter the long-term physical and psychological consequences of the practice. One such

consequence is the danger to maternal health during childbirth. Kenya has the 26th highest rate of maternal death in the world (Ireland is second) with 530 deaths per 100,000 births. Female genital mutilation also has a negative effect on infant mortality rates, Kenya also has an extremely high infant mortality rate ranking 43rd out of 220 country (Ireland ranks 201st) with 52.290 babies dying per 1,000 births. The cost of the effects of female genital mutilation also has a high impact on the health care system in Kenya it is estimated that .40% of all government spending on fifteen year old girls goes towards treating the complications that arise as a result of female genital mutilation.

Trafficking

Human trafficking is a problem in Kenya at both international and national level. At a national level women and girls are often trafficked from rural areas to urban areas, particularly to cities such as Mombassa, Kisumu, Malindi and Nairobi. Girls are lured to cities by the promise of education. In Nairobi these girls are predominantly sold as domestic workers while in more coastal areas they are sold as sex workers to the tourist industry. The case of R. vs. Hans Vreins which took place in 2011 is indicative of the type of internal trafficking which occurs in Kenya today. Mr vreins established a school in a Kenyan slum where he recruited young girls who stayed at the boarding school. He allegedly developed a list which separated the girls into virgins and non-virgins. The girls were also exposed to pornographic materials. A case was taken against him but due to poor investigations he was acquitted. He has since opened a similar school in West Kenya.

Internationally Kenya is a major source transit and destination country. The trafficking often involves women and children. Children are most commonly trafficked for illegal adoptions. Women are lured by the promise of jobs in countries such as the UK and the Lebanon. The jobs they are promised are usually in the education sector however when they reach their destination they are sold as domestic workers or into the sex industry. Due to instability in neighbouring countries such as Somalia women are frequently trafficked over the border into Kenya.

Reporting of domestic abuse and sexual violence

In recent years the Kenyan government have tried to introduce a number of measures to increase the ease at which women can report domestic abuse and sexual violence to the police. The government have set up the first police station to deal specifically with women and children; in addition desks have been established in each district to deal with instances of domestic abuse. However these reforms are inadequate and the vast majority of cases dealing with violence towards women go unreported or uninvestigated. The government established the Gender Desk Program in 2003. this program aimed to have a gender desk in each police station where a female police officer would be able to deal with the reporting of sensitive issues. The program had the dual aim of making it easier for women to report such issues and increasing the number of female police officers. However too date this program has not been very successful. This lack of success can be attributed to a number of factors. Firstly there are not currently enough female police officers to staff these gender desks. In addition the policy of transfer within the force (officers must transfer at least every three years) means that few gender desks operate with any real consistency. Finally the operation has not been well publicised and even in areas where women have access to a gender desk they may not be aware that such a service exists.

As it stands a woman's desire to find redress is hampered by a number of several critical issues. In most cases a woman will have to report the crime in a police station which lacks any privacy. This can be daunting as women themselves can be subjected to social stigma if they report these crimes. In addition they may fear that the perpetrator will find out, this could lead to violent retribution or if the abuser is a member of their family can leave them without economic support. In some cases police officers will see crimes that occur within a family as a 'family issue' and will send women back to sort things out within the home, effectively sending a woman back to her abuser. According to an UN-Habitat report only 7% of the women they had interviewed who had experienced sexual abuse reported this abuse to the authorities. Only 6% of women who had experienced sexual abuse reported it to the police. This report found that women instead prefer to rely on the informal support of family and friends. When questioned why they did not wish to report the abuse to the police women cited shame and the sense that nothing could be done to help their situation. The fear that nothing will be done is intensified by the fact that only 12% of reported rapes result in an arrest.

Furthermore in order to report violence women have to go through a long and complicated process. When reporting an act of violence women are required to produce three documents: a police abstract, a 'P3' form and a medical report. The P3 form poses a particular problem for many women. Until recently his form could only be obtained from police stations however it can now be found at some hospital on the internet; however most people are not aware of the existence of these forms. Despite the fact that Kenyan law does not state that there is a payment to be paid for the P3 form in practice people are expected to pay for it. Furthermore this payment is not standardised, effectively this allows police officers to charge what they want for the form. This means that people who cannot afford to pay for the form (the majority of people) are unable to access the justice system. In addition the P3 form does not allow for the same depth of information as the Post Rape Care Form (PRC1) which is not admissible in court. Most notable it does not have any place to write about the psychological state of the victim. While the PRC1 form is filled in by a medical professional the P3 form is normally completed by police officers that have little training in deal with such sensitive issues. In the case of rape women face obstacles to being able to access a medical report. In each district there is only one government doctor who is mandated to deal with incidences of sexual abuse. This doctor must carry out an examination of the patient and attend the court case. This means that many women will have to wait lengthy periods before they can see a doctor, this compromises vital evidence as women may wash or throw away the clothes they were wearing at the time of the incident. The fact that this same doctor must attend the trial means that it takes a long time for each case to be brought to court. This wait may further deter a woman from reporting incidents of sexual violence.

Women who live in slums have further difficulties in accessing redress. In most cases there is little or no police presence in Kenyan slums. In kibera, Kenya's largest slum, there are only irregular police patrols and there is no permanent police station at all. According to a 2010 Amnesty International report even when there are police patrols the police do not hold the trust of the community. In many cases the police only visit certain areas to extort money from members of the community. The situation in Kibera is echoed in other slum and poor income areas. One Kenyan NGO worker quoted in the same Amnesty International report summarises the situation:

> "Formally, the general statistics are such that there is one policeman for every 700 Kenyans and even this has been deemed insufficient.

> However, in Kibera, for an estimated 1 million residents, there is virtually no regular police post or station. In contrast, in the middle and high income areas situated on the edge of Kibera, with about one tenth of the slum's population, there are at least three police posts or stations."

Public trust in the police force has further deteriorated since the violence which followed the 2007 elections. In many cases it was the police who carried out violence and sexual abuse against women. For example in Kibera 29 women were subjected to rape and/or sexual assault from administrative police and general service officers. It is reported that these police officers would wait until the government imposed curfew to break into houses where women were known to live without adult male companions. They would then rape these women sometimes in the presence of their children. As police patrols at the time took place in groups of ten most of these women were subjected to gang rape. Due to the volatile situation at the time many the women could not seek medical care until march 2008. As a result many of the women became HIV positive and one woman fell pregnant with her rapist's baby and gave birth in October 2008. Though the identity of their attackers is known (as they were all employed by the chief's office) none of them were apprehended or convicted of any crime. It is unsurprising, therefore, that women living in poverty are slow to report instances of violence and sexual abuse to police officers.