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#33

GENDER BASED VIOLENCE IN TWO INFORMAL SETTLEMENTS IN NAKURU COUNTY, KENYA

MIDRIFT HURINET
Haki Kwa Wote

DIGNITY
DANISH INSTITUTE AGAINST TORTURE

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GENDER BASED VIOLENCE IN TWO INFORMAL SETTLEMENTS IN NAKURU COUNTY, KENYA

By Jessica E. Lambert and Bridget Michael

Field study prepared in collaboration with Midrift Hurinet and Digital Divide Data

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Abbreviations

CHV- Community health volunteer

GBV- Gender-based violence

MHPSS- Mental health and psychosocial support

PTSD- Posttraumatic stress disorder

EXECUTIVE SUMMARY

"As long as a substantial part of the world's population is oppressed, abused and even murdered with impunity by their own family members, the promises of the Universal Declaration of Human Rights and the Sustainable Development Goals will remain a far cry from reality. Consequently, though domestic violence may occur in the private sphere, it must be regarded as a global governance matter of inherently public concern."[1]

Introduction

Gender-based violence (GBV) is a significant problem worldwide. Domestic violence, i.e., violence perpetrated by a family member, is especially common. Globally, approximately 30% of women have been affected, with country estimates ranging from 15 to 70%. Although historically regarded as a private matter, there has been increasing recognition among international human rights bodies that it must be addressed as a human rights issue. Most recently, the United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment argued that domestic violence should be considered a major human rights issue of public concern that requires examination from the perspective of the prohibition of torture and ill-treatment.[1]

Population-based research in Kenya has indicated 39 to 45% of women have experienced some form of GBV, with intimate partners being the most frequent perpetrator. Few studies have specifically examined the experiences of women in living in informal settlements, commonly referred to as "slums." However, existing research suggests rates of GBV may be even higher in these contexts Swart, 2012; Winter et al., 2020).

This report is the result of a collaboration between DIGNITY- The Danish Institute Against Torture and Midrift Hurinet. The purpose of the study was to examine the prevalence and impacts of GBV among women living in informal settlements in Nakuru County. We also evaluated help-seeking attitudes and behavior. The study was designed to inform the development and implementation of a mental health intervention in the local communities.

1 UN Special Rapporteur on Torture & Other Cruel, Inhuman or Degrading Treatment or Punishment (2019). Relevance of the prohibition of torture and other cruel, inhuman or degrading treatment or punishment to the context of domestic violence, A/74/148. **Retrieved from** https://undocs.org/pdf?symbol=en/A/74/148

Method

The study was conducted in two informal settlements in Nakuru county, Rhonda in Nakuru Town, and Karagita in Naivasha. These districts were chosen because of ongoing projects in the areas, and information from key informants that GBV, including domestic violence, is a common problem in the communities. Systematic random sampling was used to recruit eligible participants, i.e., women over the age of 18 who were currently married or living with a partner in one of the target communities. Fifteen trained enumerators collected data using structured questionnaires administered in an interview. A total of 301 participants were interviewed.

Key findings

Key findings are summarized below.

- Our findings are consistent with prior research showing that violence against women is more pervasive in informal settlements than in the general population in Kenya (Corburn & Hildebrand, 2015; Swart, 2012; Winter et al., 2020). Winter et al. (2020), for example, found 66.2% of women living in an informal settlement in Nairobi had experienced abuse from their husband in the past year, whereas Swart (2012) found 85% of women had a lifetime exposure to interpersonal violence.

- 61.5% of women reported the violence from their husbands or partners significantly affected their mental or physical health, and nearly half reported the violence hindered their ability to work.

- Lifetime exposure to other potentially traumatic events was also high. Women who reported abuse from a caregiver were twice as likely to report physical violence from husbands/partners.

- Most of the sample reported elevated symptoms of PTSD and depression, as well as impaired functioning. Economic stress, number of traumatic events, and physical violence from husband/partner were significantly correlated with symptoms of depression and PTSD.

- Among women who reported some form of violence from their husband (*N* = 235), 43.5% had consulted a religious leader for help with the violence, 35.7% visited a hospital and 25.2%, consulted a village elder. Most reported these consultations were helpful. Only one woman sought help from the police and only one from a mental health professional.

- Approximately 40% of participants reported they were not aware of service available to survivors of GBV. More than half of the women were not aware of MHPSS services. A vast majority (85.5%) reported they would seek help from a mental health provider for an emotional problem if one was available. Most also stated they would be likely or very likely to seek help from a religious leader (80.8%) or community health volunteer (66.8%).

Future Directions

Results show the pressing need for both GBV prevention and MHPSS services for survivors in these communities. Specific recommendations for organizations working in the region are listed below.

- **Develop an intervention to prevent domestic and other forms of violence.** Results clearly demonstrate the need for a preventive intervention. A variety of programs for women and men in low-and-middle income countries have shown promising results (Ellsberg et al., 2015). It would be beneficial to coordinate with community organizations in Kenya already engaged in GBV prevention efforts gain knowledge on implementation of programs in the local context.

- **Conduct awareness campaign to increase the knowledge on mental health and MHPSS.** Most women did not know where they could go to for help with a variety of psychosocial problems; a public awareness campaign about new and existing services is warranted. Efforts should involve religious leaders and village elders in addition to stakeholders in the health system, given that many women consult these individuals when they experience difficulties.

- **Strengthen access to MHPSS for survivors of GBV through a community-based psychosocial intervention.** Given the size of the population in the communities and the limited number of mental health professionals, training Community Health Volunteers to provide a low intensity, evidence-based intervention will allow more individuals to gain access to MHPSS. Most women in this study reported willingness to consult a CHV, suggesting they are trusted in the communities. It is also important to strengthen the referral pathways so the most severely distressed are identified and referred for specialized mental health treatment.

BACKGROUND

DIGNITY has been working in partnership with Midrift Hurinet in Nakuru County, Kenya since 2014 on the Intersectoral Prevention of Urban Violence Project, focused on building trust between the police and civil society (Worrall, & Kjaerulf, 2019). This project shed light on the problem of domestic and other forms of gender-based violence (GBV) in the informal settlements in Nakuru County and the need for mental health and psychosocial support (MHPSS) in these communities. To respond to this need, DIGNITY developed a pilot project aimed at strengthening access to MHPSS for individuals affected by GBV.

As part of the pilot project, DIGNITY and Midrift Hurinet conducted a field study to assess the prevalence and impact of GBV and other potentially traumatic events on women living in the informal settlements. The study was designed to inform the development and implementation of an MHPSS intervention at the community level, taking into consideration the context-specific challenges of Nakuru County.

GBV, defined as any act of violence that is perpetrated against a person's will and is based on gender norms and unequal power relationships, is a problem worldwide. Domestic violence, one form of GBV, is extraordinarily widespread. Domestic violence involves physical, psychological, sexual, and/or financial abuse among family members. Survivors of domestic violence can be male or female; however, women are disproportionately affected across cultures. On average, 30% of females have experienced violence from an intimate partner at some point in their lives (Garcia-Moreno et al., 2013). Depending on the country, between 15 and 70% of the female population has been affected (Garcia-Moreno et al., 2005).

Recognizing the widespread problem and prevalence of domestic violence, the United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (2019) recently argued that it can no longer be regarded as a private matter but must be considered a major human rights issue of public concern that requires examination, from the perspective of the prohibition of torture and ill-treatment.

In light of the consensus that GBV is a human rights concern, it is necessary to recognize the obligations of States to take effective measures, both general and individual, to prevent further violence and respond to the needs of survivors. As such, this study is relevant not only to inform DIGNITY and Midrift's future interventions, but also as evidence for engaging in dialogue with relevant duty-bearers and stakeholders to jointly find sustainable solutions.

In their 2018 report, the Committee on the Elimination of Discrimination Against Women specifically highlighted the need to address the problem of GBV in Kenya, in both the private and public spheres. Nationally representative studies have found 39 to 45% of women in Kenya experience at least one episode of violence in their lifetime, with partners being the most frequent perpetrator (Kenya National Bureau of Statistics et al., 2015). Research specifically examining the experiences of women living in informal settlements is scant; however, there is some evidence that violence is even higher in these contexts. In a study of women in the Kibera slum in Nairobi, for example, 86% of women reported some form of GBV (Swart, 2012). It is important to better understand

the prevalence and impact of GBV in these communities given that approximately 56% of Kenya's population lives in informal settlements (Jones & Kimari, 2018; UN HABITAT, 2015).

GBV poses a significant public health problem (Garcia-Moreno et al., 2013). Among other health concerns, women exposed to GBV are at heightened risk for developing posttraumatic stress disorder (PTSD) and depression, (Garcia-Moreno et al., 2013; Rees et al., 2014) and have a higher risk of suicide attempt (Devries et al., 2013). Women living in poverty are likely to have been exposed to other potentially traumatic events including community violence, accidents, and disasters (e.g., flooding, fires). Exposure to multiple traumatic events may have a cumulative effect, increasing the likelihood of PTSD and/or depression. Trauma-related distress potentially impairs one´s ability to engage in income generating activities and effectively care for children. As such, it is important to both prevent violence and address its consequences.

The objective of this study was to document the prevalence of exposure to domestic violence and other potentially traumatic events, as well as the degree of psychological distress and impaired functioning among the population of women living in two informal settlements in Nakuru County, Kenya. We also aimed to better understand the help-seeking attitudes and behaviors of women in these communities to inform the development and implementation of an MHPSS program.

METHOD

Ethical considerations

Approval was obtained from the Strathmore University Institutional Ethics Review Committee in Kenya and from DIGNITY´s Ethical Review Committee prior to the start of data collection. Enumerators were community health volunteers (CHVs) familiar with the local area who took part in a 5-day training by DIGNITY. Training covered ethical considerations in research, including how to ensure confidentiality of participant responses. Respondents were informed during the consent process that taking part in the study was voluntary, they could refuse to answer any questions they did not wish to answer and could stop the interview at any point. Enumerators reminded respondents of their right to decline response or withdraw prior to starting sections of the interview with sensitive questions (e.g., exposure to violence and trauma). Respondents were offered information about how to seek psychosocial support at the conclusion of the interview.

Study design and procedure

Data were collected over a two-week period in July 2019. The field research was supervised by personnel from a local research company, Digital Divide Data. Fifteen trained enumerators (14 females and 1 male) went door-to-door in the two study

sites, Rhonda in Nakuru Town and Karagita in Naivasha, to recruit participants. Households were selected using systematic random sampling. Specifically, each enumerator was assigned a separate street. Starting from a landmark, she or he walked on the left side of the street, skipping five houses and knocking on the sixth door. If the person at the house was not eligible or willing to participate, the enumerator went to the next house. Almost half of the interviews (48.5%) were conducted with participants contacted on the first attempt, 23.6% were conducted on the second attempt, 12% on the third, 7% on the fourth, and the remainder on the fifth to tenth attempt. A total of 632 households were approached to obtain the final sample of 301 participants. Forty-nine women declined participation, 78 did not meet study criteria, and there was no one home at 204 of the households.

Eligible women i.e., those who were at least 18 years of age and currently married or living with a partner, were invited to participate in the study. Those who consented took part in interviews lasting approximately one hour. The interviews took place in the respondent´s home, or another location selected by her, where privacy could be ensured. Enumerators recorded responses electronically using tablets. At the end of each day, responses were uploaded to a master file and reviewed by the field supervisor. Interviews were conducted over a period of two weeks. To reduce burden on enumerators, each conducted no more than two interviews per day.

MATERIALS

Translation and cultural relevance

All questionnaires other than the General Help Seeking Questionnaire (GHQ) had been previously validated in Kiswahili. The consent form and GHQ were translated by certified translators in Kenya. Prior to the start of the study, the interview protocol was reviewed by the local data collection team. Modifications to localize questions were made based on consensus in group discussion.

Exposure to domestic violence and other potentially traumatic events

Exposure to psychological, sexual, and physical violence from one´s partner was assessed using selected items from *World Health Organization Violence Against Women Instrument* (Garcia-Moreno et al., 2005). Respondents are asked to indicate whether they have experienced a specific behavior from their partner e.g., “Has your partner ever threaten to hurt you or someone you care about?” and “Has he kicked you, dragged you or beaten you up?” The measure also includes items about whether women have sought help for the violence.

Exposure to other potentially traumatic stressors was assessed with the *Brief Trauma Questionnaire* (BTQ; Schnurr, Spiro, Vielhauer, Findler, & Hamblen, 2002). The BTQ is a 10-item questionnaire; respondents are asked to indicate whether they have experienced a series of traumatic events, as defined in the DSM-IV e.g., sexual violence, serious accident, life threatening illness. The BTQ was translated and validated among a sample of urban low-income individuals in Nairobi by Hung et al. (2019).

Psychological symptoms and functioning

Symptoms of posttraumatic stress disorder (PTSD) were assessed using the 20-item *PTSD Checklist for DSM-5* (PCL-5; Blevins, Weathers, Davis, Witte, & Domino, 2015). Symptoms of depression were assessed with the 15-item depression scale from *Hopkins Symptom Checklist* (HCL; (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974). Both measures were previously translated and validated with the population (Hung et al., 2019). Functioning was assessed with three items from the *WHO Disability Assessment 2.0 Short-Form* (WHODAS 2.0; Ustun, Kostanjsek, Chatterji, & Rehm, 2010), selected by our research team as relevant in the present context.

Help-seeking

We used a modified *General Help Seeking Questionnaire* (GHQ; Wilson et al., 2005) to assess the likelihood that women would seek help from a mental health provider and other community members (religious leader, village elder, community health volunteer, etc.) if she were experiencing a problem. We also asked women if they were aware of local resources for survivors of GBV, individuals with emotional distress, or general psychosocial support services.

Demographic questionnaire

A questionnaire developed for the purposes of this study was used to gather basic demographic information about the sample including age, education level, employment, literacy, and finance related stressors. We also asked women to provide information about their husband/partner including age, education level, literacy, and substance use.

RESULTS

Demographic information

The final sample included 301 women; 204 from the more populated area of Rhonda and 97 from Karagita. The sample demographics were similar across both communities, so data from both locations were evaluated together. Demographic information for participants is shown in Table 1.

TABLE 1. PARTICIPANT DEMOGRAPHIC INFORMATION

AGE	***N*** = 301	%
18 – 25 YEARS OLD	76	25.20
26 – 34 YEARS OLD	132	43.90
35 – 41 YEARS OLD	58	19.30
42 – 49 YEARS OLD	24	8.00
50 – 65 YEARS OLD	9	3.00
ABOVE 65 YEARS OLD	2	0.70
RELIGION		
CHRISTIAN	297	98.70
MUSLIM	3	1.00
PAGAN	1	.30
READS ENGLISH		
YES	235	78.10
NO	66	21.90

WRITES ENGLISH			
YES		231	76.70
NO		70	23.30
READS KISWAHILI			
YES		281	93.40
NO		20	6.60
WRITES KISWAHILI			
YES		273	90.70
NO		28	9.30
HIGHEST LEVEL OF EDUCATION COMPLETED			
PRIMARY		134	44.50
SECONDARY		127	42.20
HIGHER		25	8.30
DO NOT KNOW		15	5.00
NUMBER OF CHILDREN			
N	MIN.	MAX.	MEAN (SD)
301	0	10	2.53 (1.65)
NUMBER OF PEOPLE RESIDING IN HOUSEHOLD			
N	MIN.	MAX.	MEAN (SD)
301	1	11	4.31 (1.63)

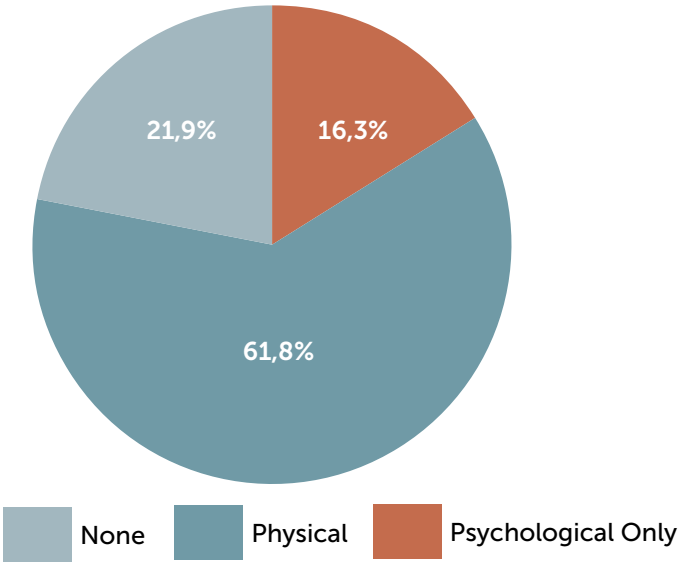
Most participants were under 35 years of age (69.1%) with one to three children. Just over half of the sample (51.1%) was employed outside of the home, primarily working in a business, or doing casual work. A majority (62.1%) reported difficulties paying for necessities like food and water.

Women were also asked to provide information about their husbands. Most husbands (89%) worked outside the home, primarily doing semi-skilled (44.2%) or unskilled labor (33.6%). Approximately 23% of women reported their husbands drank alcohol, 9% reported drug use. Of these, 32.2% reported financial problems related to the substance use and 29.2% reported family problems.

Domestic Violence from Husband

As shown in Figure 1., a majority (61.8%) of women reported at least one type of physical violence from their husbands (with or without psychological violence); the most common forms were being slapped, pushed, or forced to have sexual intercourse. Of the participants who reported no physical violence, 16.3% reported psychological abuse from their husbands (without any physical violence) including insults, intimidation, and threats.

Figure 1: Violence from husband



Figures 2 and 3 show the frequency of specific types of psychological and physical violence, respectively, including only the 235 women who endorsed some form of violence. Table 2 shows the number and percentage of women who reported physical and psychological violence disaggregated by age group and education level.

Regarding the impact of violence from partners, 61.5% reported that the violence negatively affected their physical or mental health; 47.5% reported their ability to do work in the home or engage in income generating activities was affected.

Figure 2: Psychological abuse by husband/partner (N)

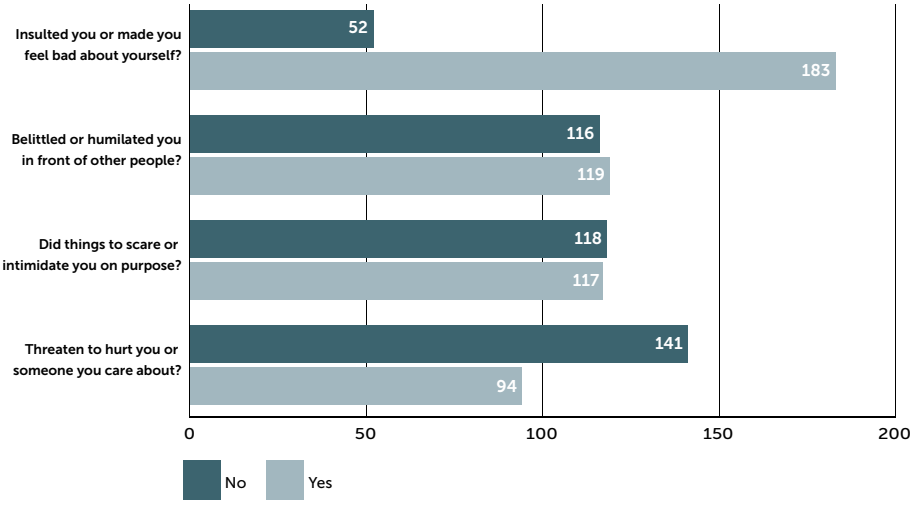


Figure 3: Physical abuse by husband/partner (N)

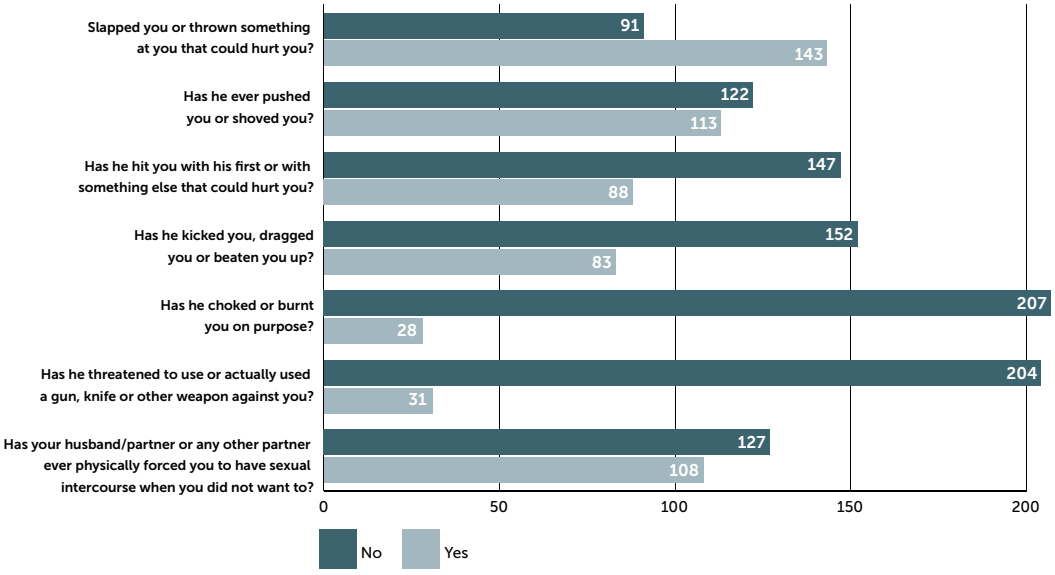


TABLE 2. NUMBER & PERCENTAGE OF PARTICIPANTS REPORTING VIOLENCE FROM PARTNER BY AGE & EDUCATION		
AGE	PSYCHOLOGICAL[A] N (%)	PHYSICAL[B] N (%)
18 – 25 YEARS OLD	14 (18.40)	39 (51.30)
26 – 34 YEARS OLD	18 (13.60)	91 (68.90)
35 – 41 YEARS OLD	11 (19.00)	35 (60.30)
42 – 49 YEARS OLD	4 (16.70)	17 (70.80)
50 – 65 YEARS OLD	2 (22.20)	3 (33.30)
ABOVE 65 YEARS OLD	0 (0)	1 (50.00)
HIGHEST LEVEL OF EDUCATION	PSYCHOLOGICAL[A] N (%)	PHYSICAL [B] N (%)
PRIMARY	20 (14.90)	95 (70.90)
SECONDARY	21 (16.50)	68 (53.50)
HIGHER	5 (20.00)	14 (56.00)
DO NOT KNOW	3 (20.00)	9 (60.00)

[A]REPORTED PSYCHOLOGICAL VIOLENCE ONLY.

[B]REPORTED PHYSICAL VIOLENCE WITH OR WITHOUT PSYCHOLOGICAL.

Exposure to other potentially traumatic events

Virtually all women (96%) had been exposed to at least one other potentially traumatic event, most commonly physical abuse in childhood by a caregiver (62.5%), witnessing or experiencing some other type of violence as an adult (50.8%), and/or sexual violence (26.6%). Previous research has shown childhood abuse to be a risk factor for intimate partner violence in adulthood (Chiang et al., 2018); in this study, women who reported abuse in childhood were approximately two times as likely to report physical violence from their husbands [Chi-square (1, N = 301) = 5.80, p = .02].

Mental Health Symptoms and Functioning

Total scores on the PCL-5 ranged from 0 to 80 with a mean score of 36.00 (*SD* = 20.70). Among Western samples, a score of 31 or higher indicates clinically significant symptoms; 57% of the sample scored within this range. Scores on the HCL ranged from 1 to 4, with an average score of 2.34 (*SD* = 0.76). Among a variety of clinical and community populations, a score of 1.75 or higher indicates clinically significant symptoms; 75% of the sample scored within this range. Economic stress, total number traumatic events reported, and experiencing physical violence from husbands were all significantly correlated with symptoms of PTSD and depression (see Table 3).

On the three items from the WHODAS 2.0 used to assess functionality, 58.2% of women reported moderate to extreme difficulties completing household responsibilities because of health-related problems, 50% reported moderate to extreme difficulties in learning a new task, and 48.2% reported moderate to extreme difficulties engaging in community activities.

Help-seeking

For domestic violence

Of the 235 women who reported some degree of physical or psychological violence from their husbands, 38% had sought help for the abuse outside of the family. Most consulted religious leaders (43.5%), visited a hospital (35.7%), or spoke with a village elder (25.2%).

TABLE 3. CORRELATIONS BETWEEN VARIABLES						
VARIABLE	1	2	3	4	5	6
ECONOMIC STRESS	--	-.13*	.21**	.20**	.37**	.26**
PSYCHOLOGICAL ABUSE ONLY		--	-.56**	.05	.07	.07
PHYSICAL ABUSE			--	.17**	.35**	.27**
NUMBER OF TRAUMATIC EVENTS				--	.37**	.37**
DEPRESSION					--	.77**
PTSD SYMPTOMS						--
*P <.05, **P <.01						

Only one woman had consulted a mental health specialist and only one had tried to get help from the police. Of those who consulted a religious leader, most (88%) reported it was somewhat to very helpful. Visiting the hospital was also rated as very helpful by a majority of those who went (80.5%). Approximately 75% of those who sought help a village elder found it to be somewhat or very helpful. When asked about resources in their communities, approximately 40% reported they were not aware of any type of service available to survivors of domestic or other forms of violence.For mental health concerns

More than half of the sample stated they were not aware of mental health or psychosocial support services available to community members. Approximately 85% of women reported they were likely or very likely to consult a mental health professional for an emotional problem, were there one available. Most also stated they would be likely or very likely to seek help for an emotional problem from a religious leader (80.8%) or community health volunteer (66.8%).

DISCUSSION

Key findings

- This study provides useful insights about the situation of women living in the informal settlements of Nakuru County, including rates of exposure to intimate partner violence and other potentially traumatic events, degree of psychological distress and functioning, and attitudes towards help-seeking. Key findings are listed below.

- Our findings are consistent with prior research showing that violence against women is more pervasive in informal settlements than in the general population in Kenya (Swart, 2012; Winter, 2020). Winter et al. (2020), for example, found 66.2% of women living in an informal settlement in Nairobi had experienced abuse from their husband in the past year, whereas Swart (2012) found 85% of women had a lifetime exposure to interpersonal violence.

- Results suggest that in many cases the violence was severe; 61.5% of women reported the violence from their husbands or partners significantly affected their mental or physical health, and nearly half reported the violence hindered their ability to work.

- Lifetime exposure to other potentially traumatic events, including abuse from a caregiver during childhood, sexual violence, and witnessing violence, was also high. Women who reported abuse from a caregiver were twice as likely to report physical violence from their husbands or partners.

- More than half of the sample reported elevated symptoms of PTSD and depression, as well as impaired functioning. Economic stress, number of traumatic events, as well as physical and psychosocial violence from one´s husband or partner were all significantly correlated with symptoms of depression and PTSD.

- Regarding help-seeking, among women who reported some form of violence from their partner (N = 235), 43.5% had consulted a religious leader for help with the violence, 35.7% visited a hospital and 25.2%, consulted a village elder. Only one woman sought help from the police and only one from a mental health professional.

Approximately 40% of participants reported they were not aware of any type of service available to survivors of GBV. More than half of the women were not aware of MHPSS services in their communities. However, a vast majority (85.5%) reported they would seek help from a mental health provider for an emotional problem if one was available. Most also stated they would be likely or very likely to seek help from a religious leader (80.8%) or community health volunteer (66.8%).

There are several potential explanations for the high rates of violence and distress among the sample. Poverty, living in an urban setting (Memiah et al., 2018), and

exposure to childhood abuse (Chiang et al., 2018) have been found to be risk factors for GBV (WHO, 2010). Although not assessed in this study, previous research has shown attitudes towards domestic violence are related to prevalence (Garcia-Moreno 2013). According to data from the Kenya National Bureau of Statistics (2015) 41% of women and 36.2% of men agree that men are justified in beating their wives under certain circumstances.

Given the high rates of exposure to violence and other adversity, it is not surprising that women reported elevated symptoms of PTSD and depression. However, it is also important to consider that interviews were only conducted during the daytime, as such, the sample of women home during these hours may have been those with higher levels of distress, whose functionality was impaired.

Limitations

Results must be considered in light of the study limitations. As noted above, collecting data during the daytime only could have resulted in a sample that is not representative of the population. Data could also be biased due to the nature of self-reporting. It is possible some women did not feel comfortable disclosing information about personal experiences. Although symptom measures were previously validated with the population, because both PTSD and depression are Western psychiatric concepts, the measures may not fully capture the experiences of the population. We did not collect data from men; thus, we do not know the extent to which men may have been exposed to different types of violence, or their rationale for engaging physical or psychological violence towards women.

Conclusion and Recommendations

The purpose of this study was to generate knowledge on the prevalence and impact of domestic violence and other types of trauma on women residing in urban informal settlements in Nakuru County, Kenya. Results show the pressing need for both GBV prevention and MHPSS services for survivors in these communities. Not only were rates of domestic violence higher than in the general population, more than half of the women suffered from clinically significant levels of PTSD and depression. Distress and impaired functionality likely inhibit women's ability to engage in income generating activities, perpetuating the cycle of poverty. Maternal mental health problems can also impact on the psychosocial adjustment and well-being of children. Witnessing domestic violence in the home is a consistent predictor of both perpetration and future victimization (Tol et al., 2019); without intervention the violence may continue throughout generations. Specific recommendations are listed below.

- **Develop an intervention to prevent domestic and other forms of violence.** Results of the study clearly demonstrate the need for a preventive intervention in these communities. A variety of programs for women and men in low- and middle-income countries have shown promising results (Ellsberg et al., 2015). It would be beneficial to coordinate with community organizations in Kenya already engaged in GBV prevention efforts to gain knowledge on implementation of programs in the local context.

- **Conduct an awareness campaign to increase the knowledge on mental health and MHPSS.** Most women did not know where they could go to for help with a variety of psychosocial problems; a public awareness campaign about new and existing services is warranted. Efforts should involve religious leaders and village elders in addition to stakeholders in the health system, given that many women consult these individuals when they experience difficulties.

- **Strengthen access to MHPSS for survivors of GBV through a community-based psychosocial intervention**. Given the size of the population in the communities and the limited number of mental health professionals, training Community Health Volunteers (CHV) to provide a low intensity, evidence-based intervention will allow more individuals to gain access to MHPSS. Most women in this study reported willingness to consult a CHV, suggesting they are trusted in the communities. It is also important to strengthen the referral pathways so the most severely distressed are identified and referred for specialized mental health treatment.

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