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Sexualised violence against children: a review of laws and policies in Kenya

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Abstract: *Child sexual abuse (CSA) is a major global health challenge. Extant literature shows that CSA is prevalent in Kenya. As a signatory of the United Nations Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child, the Kenyan government is mandated to ensure that children are protected from sexual abuse through sound laws and policies. This paper reviews existing laws and policies on CSA and highlights their strengths and weaknesses. Our findings indicate that laws on child protection exist and are protective to a large extent, as harsh penalties are outlined for sexual offences. Survivors of CSA are entitled to free legal and medical services. However, there are no reparations offered to survivors in criminal proceedings. Moreover, there is no legislation on age-appropriate comprehensive sexuality education which plays an important role in cultivating positive gender norms and describing what constitutes CSA and reporting procedures. The national standard operating procedures for the management of sexual violence against children lack CSA screening procedures. There is urgent need for review of these laws and policies and development of multisectoral protocols at the national and county level, that outline roles and responsibilities for various service providers, supervisory and accountability measures and referral networks.* DOI: 10.1080/26410397.2019.1586815

Keywords: Sexual Offences Act, Children Act, guidelines, Kenya, sexuality education, post-sexual assault care

Introduction

Child sexual abuse (CSA) is a major global health concern. As such the sustainable development goals (SDGs) have reiterated calls for ending all forms of violence against children (target 16.2) and harmful cultural practices (target 5.3) that affect the development and wellbeing of children.[1] The World Health Organization (WHO) defines CSA as an involvement of a child in sexual activity that he or she does not fully comprehend, is unable to consent to, or is not developmentally prepared for.[2]

Globally, CSA is estimated at 15–20% for girls and 8% for boys.[3,4] A 2010 national survey on Violence Against Children in Kenya reported that 23% of the girls and 12% of the boys aged between 13 and 17 had experienced some form of sexual abuse (unwanted sexual touching, unwanted attempted sex, pressured or physically forced sex).[5] Among respondents aged 18–24 years 32% of women and 18% of men experienced some form of CSA before age 18.[5]

Child sexual abuse in Kenya is perceived to be influenced by developmental issues, economic, social and gender inequities. They include peer pressure, drug and substance abuse, orphanhood, poverty, social media influence, a culture of silence on sexual matters and huge gender disparities.[6,7] Patriarchy is pervasive in Kenya as gender norms assign domestic work to women and provision roles to men, thus generating power differences as men assume dominant roles whereas women

take on submissive ones.[8] Women who do not comply with the gender norms risk physical and sexual violence.[9] Moreover, most young men are socialised to be sexually adventurous and aggressive to prove masculinity.[10] In contrast, chastity, domesticity, and compliance are viewed as desirable attributes for girls and unmarried women.[11] Rape myths are also prevalent; some common beliefs are that rape is not a serious crime, men have no control over their sexual desires, and a man is entitled to sex through marriage.[12] Such attitudes place blame on survivors of sexual abuse and exonerate the perpetrators.

Despite ubiquitous patriarchy, Kenya has strong women's movements and civil societies that continuously push for protection of women and children from sexual violence and for the right to health care, legal aid and justice in several legislative and policy documents. Pressure from the women's movements, democratisation, pressure from the international community and obligations from ratified international instruments have birthed laws that criminalise sexual violence and protect victims of abuse, and policies that outline responses to sexual violence.[13] However, Kenya still decriminalises marital rape and criminalises abortion except for when the mother's life is in danger.

Under the Kenyan law, a child is anyone below 18 years of age. Children comprise half of the survivors seeking post-rape care.[14] However, many cases of CSA go unreported in Kenya. Poor reporting of cases is partly attributed to preference for traditional justice systems to resolve CSA as they offer compensation to victims' families, unlike the criminal justice system which offers no reparation.[15] Kenyan social and cultural norms also tend to blame victims for the abuse as society perceives most perpetrators' actions as justified and hence victims are silenced.[12,16] Although comprehensive post-rape care services can be obtained in some health facilities and one-stop centres, most facilities, especially in rural areas, are ill equipped, and service providers are not well trained to provide care.[16,17] National standard operating procedures for the management of sexual violence against children have been developed but are unavailable in most health facilities.[17]

Kenya is a signatory of the United Nations Convention on the Rights of the Child (CRC)[18] and the African Charter on the Rights and Welfare of the Child (ACRWC)[19] and is obligated to meet stipulations outlined in such international instruments. These instruments integrate social, economic and cultural rights with civil and political rights and are based on the principles of non-discrimination, participation, survival and the best interests of the child.[20] They are also binding for State Parties and therefore suitable standards of good practice. The WHO provides standards of good health care practice based on evidence-based research and consequently, many governments, Kenya included, borrow heavily from it when developing policies. Therefore, we use the "Responding to children and adolescents who have been sexually abused: WHO clinical guidelines" as standards of good practice. We discuss the provisions further under different policies.

Child protection issues in Kenya are coordinated by the National Council for Children Services (NCCS) and the Department of Children Services. The two work together with other line ministries, the community and civil society in responding to child abuse and maltreatment. Several laws and policies exist in Kenya that outline rights of the child with regard to sexual abuse and give directions on management of CSA. Despite the existence of laws and policies to protect minors against sexual violence, research indicates that their operationalisation is difficult.[21] Cited reasons are: inadequate financial and human resources, legal pluralism, cultural beliefs, legal illiteracy, poor knowledge and competence of service providers, and poor monitoring and evaluation frameworks.[21]

Few studies have reviewed legislation and policies on gender-based violence laws in Kenya and sub-Saharan Africa with little focus on CSA.[22,23] The aim of our study is therefore to examine the extant legislation and policies that relate to CSA in Kenya, highlight their strengths and weaknesses and put forth suggestions for better care of CSA survivors.

Methods

This study reviews existing laws and policies that relate to CSA in Kenya. The review assesses the quality of local laws and policies by comparing their content and enforcement to provisions in the international treaties (the United Nations Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child) and the WHO clinical guidelines on responding to children and adolescents who have experienced sexual abuse. The review draws on extant CSA literature in Kenya (accessed through various search engines including Google Scholar, Oria, Pubmed, Embase

etc), the authors' wide experience on sexual and reproductive health and rights, and findings from extensive field work on CSA in Kenya, to reflect on the laws and policies and their impact on survivors of CSA.

The research was conducted over an eighteen-month period. As part of a wider study, the first author assessed the knowledge, attitudes and practices of 15 health providers with regard to post-rape care, and observed interactions of CSA survivors with health providers and the police.[17] In addition, she followed up two girls as they interacted with the health system and law enforcement officers, held informal conversations with their parents and service providers and reviewed their health records.[24] Findings from these studies revealed that most of the health providers were not conversant with the guidelines on management of sexual violence; the health facility was ill equipped and poorly staffed. We also found that health providers showed little regard for informed assent, confidentiality, and privacy while offering post-rape care (post-sexual assault care). The first author also conducted in-depth interviews with 61 key informants (legal, social work and non-governmental organisation workers) on their role in child protection, policies and guidelines they used, their challenges and suggestions regarding areas of improvement. The policies and laws listed are discussed in detail in this review. Child sexual abuse survivors (10 girls), of whom the majority had reported the cases to the courts, were followed up, their family members were interviewed and observations of their interactions with court officials and court processes were noted. The authors draw on these experiences to highlight pitfalls within the policies and laws.

The local laws and policies reviewed were selected based on suggestions from key informants (children officers, police and judicial officers, teachers, and staff of non-governmental organisations such as Plan Kenya, the Red Cross within Homa Bay County) on relevant CSA policy documents, a review of extant literature, and consultations with colleagues working on child protection issues in Kenya on extant laws and policies. The selected documents included in this paper are those that service providers mentioned using frequently as guidelines when addressing sexual abuse of minors, and those on the NCCS and Kenya law review website.

Selection criteria were: (i) nationally constituted recognised laws (gazetted) and policies that relate to CSA, (ii) provisions within the laws and policies on response and prevention of CSA, and (iii) availability of laws and policies in print or digital media for public consumption. Documents not fulfilling any of these criteria were excluded (e.g. those developed and specific to operations within the non-governmental organisations).

In analysis of the legislation and policies, we used the United States Centre for Disease Control (CDC) brief on evaluation of violence and injury prevention policies as our analytical framework.[25] Our review focused on: (i) objectives/aims of the legislations and policies, (ii) articulation of the policy content, (iii) components of the policy consistent with international instruments (iv) clear statement of the requirements for implementation, (v) feasibility of the requirements, and (vi) indicators for assessment of success of the policy.

Results

This section outlines the contents of the laws and policies with regards to CSA and highlights inherent strengths and limitations. We begin with a presentation of the laws followed by policies at the national and county level.

Laws with stipulations on CSA Kenya

The laws reviewed include: (i) the National Constitution 2010, (ii) the Children Act No. 8 of 2001, (iii) the Sexual Offences Act No. 3 of 2006, (iv) the Victim Protection Act No. 17 of 2014, and (v) the Prohibition of Female Genital Mutilation Act No. 32 of 2011. All these laws lack indicators for the assessment of implementation.

(i) The National Constitution 2010

The Constitution of Kenya stipulates the rights and obligations of Kenyans.[26] According to the Constitution, children are entitled to healthcare, education, shelter and protection from all forms of violence, in line with rights outlined in the CRC and the ACRWC. 26 It grants Kenyans access to justice and is against the detention of children and states that, in the event that they are detained, the period should be short and they should be held separately from adults.[26] With regard to people with disabilities, it states that they should be integrated into society and treated with dignity.[26] Although the Constitution makes these stipulations, the government does not meet them mainly due to financial and human resources constraints; Kenya is a low-middle income economy.

For instance, welfare institutions are poorly funded and as a result, children are constantly subjected to conditions such as poverty that make them susceptible to abuse. The Constitution also states that abortion is only permitted when a trained health professional is of the opinion that there is need for emergency treatment or if the life of the mother is threatened.[26] Adolescents who get pregnant from rape have no access to abortion services as the clause does not include them. This puts them at risk for procuring unsafe abortions, contravening the right of adolescents to healthcare as stipulated in the CRC and the ACRWC. There is need for the government to invest more in welfare services and include a clause in the Constitution making it possible for pregnant adolescents (who conceive from rape) to access abortion services.

(ii) The Children Act No. 8 of 2001

The Act makes provisions for duties and responsibilities of the parent and the child, foster care, adoption, custody, maintenance, guardianship, care and protection of the child, administration of children institutions and responsibilities of child protection officers.

According to the Children Act, a child is any person below the age of 18 years and as such cannot consent to sexual relations.[27,28] The Act outlines the rights of the child and stipulates that in all matters concerning children, the best interests of the child should be upheld as advised in the CRC and ACRWC.[25] Accordingly, children have a right to education, health care, privacy and protection from sexual abuse and harmful traditional practices.[27]

Although children have a right to education, the right to comprehensive sexuality education is violated, contrary to stipulations in CRC and ACRWC. The national adolescent sexual and reproductive health policy (2015) recognises children's right to information on sexual and reproductive health (SRH) and states that it shall support the provision of age-appropriate adolescent SRH information and strengthen age-appropriate comprehensive sexuality education for out-of-school and in-school adolescents.[29] However, the government lacks official legislation to enforce the proposed policies and programs including comprehensive sexuality education.[30] Consequently, sexuality education which helps in shaping minors' attitudes towards sex and their sexual behaviours is poorly implemented.[30] There is need for official legislation on the provision of adolescent SRH, including comprehensive sexuality education, to young adults.

The Children Act stipulates that proceedings involving children should be conducted in a children's court (Section 73).[27] Few counties in Kenya have children's courts and there are no guidelines on making courts child-friendly. While in the field, the first author observed proceedings taking place in adult courts and magistrates' chambers due to a lack of children's courts. In addition, we observed children and alleged perpetrators sitting in the same waiting areas as they waited for the hearings to commence. There is need for guidelines on creating and providing child-friendly facilities and services respectively in order to make the legal process non-threatening for the child.

(iii) Sexual Offences Act No. 3 of 2006

The Sexual Offences Act (SOA), No. 3 of 2006 makes provisions for sexual offences, their definition, prevention and the protection of all persons from unlawful sexual acts. Children in Kenya cannot consent to sex. Defilement (child rape) is defined as an act that causes penetration with a child; penetration is the partial or complete insertion of the genital organs of a person into the genital organs of another person.[28] Sexual assault has been defined as penetration by use of body part or object into any other body part of another person.[28] Penalties for defilement range from 15 years in prison to life imprisonment depending on the age of the child.[28] Attempted defilement or committing of an indecent act (contact between any part of a person with the genital organs, breast or buttocks of another and exposure or display of pornographic material) with a child attracts minimum of 10 years in prison.[26] Child trafficking, prostitution, pornography and sex tourism have sentences ranging from a minimum of five years or more or fines or both.[28] Child offenders face a maximum of three years in borstal institutions or rehabilitation schools or get a commuted sentence with probation. Laws are part of the protection of children and therefore in line with Article 34 of the CRC.

Children who have experienced sexual abuse are entitled to give evidence under a protective cover or through an intermediary, to proceedings taking place outside an open court, and prohibition of publication of personal identifiers.[28] Medical and psychosocial services are borne by the State.[28] Child offenders are entitled to free legal representation. With regard to evidence of crime,

there is no need for corroborating material evidence as long as the court finds the survivor credible.[31] The aforementioned provisions are in line with Article 19 of the CRC.

The SOA relies on the Criminal Procedure Code (CPC) chapter 75 provisions for directions on how to conduct court proceedings[32] and the Evidence Act Chapter 80.[31] The CPC requires that evidence in a trial must be taken in the presence of the accused person or his advocate and the witness must identify him/her as the perpetrator of the crime (code 194).[32] The Evidence Act in section 62 requires that evidence to prove the alleged facts must be adduced orally and must be direct.[31] This makes it inevitable that the vulnerable child will face the perpetrator in court proceedings. Although CSA survivors have the option of giving evidence under a protective box, it was observed by the first author that no observed CSA survivor gave evidence under the protective cover. No measures had been put in place to protect CSA survivors from facing the perpetrators in court as divulged by judicial officers. There is need for measures to be put in place to protect the CSA survivors from interacting with the suspects should they feel uncomfortable.

The law does not permit questions on sexual history of survivors. However, the court may allow the sexual history to be brought up if it is satisfied that such questioning is likely to rebut evidence previously adduced, may explain the presence of semen or the source of pregnancy or disease or any injury to the complainant or is fundamental to the accused's defence.[28] These provisions take away the protection as it is easy for lawyers to use the exemptions and bring up the minor's sexual history in a hearing.

According to the CPC (code 152), refractory witnesses are to be held in remand for 8 days or more to reconsider their statements.[32] Some of the CSA survivors were young girls who consented to sex with older males, refused to testify and were put in remand. In most cases, this was counterproductive as the girls still refused to testify. They were in relationships for economic benefits and were considering marriage or married to these men. The unnecessary detention contravenes Article 37(b) of the CRC as it states it should only be used as a last resort and for the shortest appropriate period of time.[18]

Child sexual abuse is a bailable offence and as such suspects have a right to bail.[32] When suspects are released on bail, there is a high probability of interference in cases by the accused persons as reported by judicial officers. Survivors of CSA are either threatened or their parents are given small tokens to settle the cases out of court.[24] Consequently, survivors of CSA tend to disappear from the locality or refuse to testify in law courts.[24] Bail applications need to be evaluated carefully to ensure that state witnesses (CSA survivors and their families) are not intimidated or persuaded into dropping charges.

Despite the right to medical care and psychosocial support, research indicates that these services are limited in low resource settings, Kenya included.[33] Psychosocial support is poorly administered due to the lack of professionals to offer counselling services.[17,24] There is need for Kenyan government commitment to facilitating psychosocial support for survivors of CSA by either training more service providers or contracting services from the private sector.

Criminalisation extends to consensual sexual activity between minors with the same age or a slight age difference. There are several cases where one of the minors in a consensual relationship was charged for defilement. An example of such a case is Petition No. 6 of 2013 at the High court of Kenya in Eldoret where an adolescent boy was charged with defilement for having sex with a consenting adolescent girl.[34] Consensual sex among age-appropriate minors should be decriminalised.

(iv) The Victim Protection Act, No. 17 of 2014

The Act establishes provisions for protection of and reparation to victims of crime and abuse of power, and provides victims with better information and support services.[35]

It provides for victim participation, privacy preservation in the legal process, legal aid and free medical and psychosocial services as stipulated in the CRC and the ACRWC.[35] Victims are entitled to interpreters during the legal and judicial process, safe places, separate waiting spaces and holding facilities before court appearances and witness protection.[35] Children are entitled to a legal representative.[34] The Act also provides for the establishment of a victim protection fund to support rehabilitative and protective programmes for victims of crime.[35]

Although the Act provides for restorative justice, it is only limited to civil proceedings. Therefore, if the victim seeks reparations, they have to present their case to a civil court. Court proceedings in

Kenya are usually lengthy. The other alternative is the victims' fund which is underfunded as divulged by judicial officers. Although the victims have access to free medical and psychosocial care, they often cannot access these services, which are supposed to be taken care of by the State, because they lack money to cater for transportation expenses. Few shelters exist in the country. Our research findings revealed that girls who had experienced sexual abuse and were deemed to be in need of protection ended up sleeping on cold floors in police cells for a period of a day to a week as children officers sought places to accommodate them. The lack of appropriate measures for physical and psychological recovery of the child contravenes Article 39 of the CRC. There is need for guidelines on creating and providing child-friendly facilities and services respectively which if implemented would make the legal process non-threatening and safe for the child.

(v) Prohibition of female genital mutilation Act No. 32 of 2011

The aim of the Act is to prohibit the practice of female genital mutilation (FGM), to safeguard against violation of a person's mental or physical integrity through the practice of FGM. According to the Act, FGM comprises all procedures involving partial or total removal of the female genitalia or any other injury to the female genital organs, or any harmful procedure to the female genitalia, for non-medical reasons.[36] A person who commits an offence under this Act is liable upon conviction to imprisonment of a term not less than three years or a fine not less than KES 200,000 (USD 2000).[36] In case of death due to sustained injuries from undergoing FGM, the offender gets life imprisonment.[36]

This law incorporates stipulations from the CRC and the ACRWC for protection of children from harmful social and cultural practices. The Act is lauded as one of the most comprehensive laws against FGM in Africa; it provides a clear definition of FGM and criminalises the practice, procurement, aiding and abetting of the crime.[37] The Act also criminalises the failure to report FGM, procuring a person to perform FGM in another country, the possession of cutting tools and verbal abuse or shaming of uncut women.[37] The law was supported by the enactment of the East African Community Prohibition of Female Genital Mutilation Act (EAC Act) in 2016, which promotes cooperation (among Kenya, South Sudan, Tanzania and Uganda) in the prosecution of FGM perpetrators via harmonisation of laws, policies and strategies to end FGM across the region.[37]

Despite the gradual decrease of FGM from 38% in 1998 to 21% in 2014 due to criminalisation of FGM and awareness raising of the consequences of FGM on women and girls, the decrease is only in some ethnic groups.[38] Rates of FGM among Kenyan women of Somali origin still remain high.[38] The EAC Act would be strengthened further by the support of the Somali government. Due to the fact that the Somali government has not criminalised FGM, it is possible that women and girls in the North Eastern region (which has a huge population of ethnic Somalis) cross into Somalia to undergo FGM. The high prevalence of FGM is also attributed to poor implementation and enforcement of laws, a lack of human and financial resources and logistical challenges in accessing remote areas.[39] Research shows that some judicial officers do not adhere to the statutory minimum custodial sentence as provided by the law and sentences are routinely being reduced or overthrown on appeal.[37] There is need for laws to criminalise non-adherence of judicial officers to statutory minimum custodial sentences.

The law is currently being challenged in court. A petition was filed in January 2018 in a Kenyan law court by Dr Tatu Kamau who wanted FGM to be legalised. Her argument is that all females, especially adults, should be allowed to make decisions regarding their bodies without restrictions.[40] This petition is an indication of persistent accepting attitudes towards FGM despite knowledge on the documented negative health consequences.

Policies on child protection in Kenya at the national and county level

They include: (i) the National Children Policy Kenya 2010, (ii) the Framework for the National Child Protection System in Kenya 2011, (iii) the National Plan of Action for Children in Kenya 2015–2022, (iv) the National Plan of Action against Sexual Exploitation of Children in Kenya 2013–2017, (v) the National Standard Operating Procedures for the Management of Sexual Violence against Children (2018), (vi) the National School Health Policy (2009) and the Safety Standards Manual for Schools in Kenya (2008), (vii) the National Special Needs Educational Policy Framework (2009), (viii) the County Government Policy on Sexual and Gender-

based Violence 2017, and (ix) the National Monitoring and Evaluation Framework Towards the Prevention of and Response to Sexual and Gender-based Violence in Kenya. All the policies are intended to meet stipulations of the Children Act which has domesticated the CRC.

(i) The National Children Policy Kenya 2010

The main objective of the policy is the realisation and safeguarding of the rights and welfare of the child.[41] As the policy makers planned to create a 10-year strategic plan following implementation, there are no indicators to gauge implementation of the policy.[41]

The policy advocates for enforcement of legislation against sexual abuse and exploitation, provision of educational programs on life skills education, provision of child-friendly institutions to respond to cases of CSA, establishment of shelters for survivors and support for vulnerable families.[41]It has been eight years since the policy came into effect. However, the policy is rarely used by service providers and participants in our study had no knowledge of the policy. We speculate that the policy has been abandoned by service providers in favour of more recent and robust policies like the National Plan of Action for Children in Kenya 2015–2022, which have indicators for assessment of implementation.

(ii) The Framework for the National Child Protection System in Kenya 2011

The main objective of the framework is to act as a reference for child protection in Kenya, define responsibilities of stakeholders, facilitate coordination in the provision of services, facilitate review and enactment of policies, capacities and resources that would effectively address child rights and concerns.[42]

The framework outlines responsibilities for each actor i.e. line ministries and departments, non-state actors, the private sector, and other stakeholders under the line Ministry in charge of children affairs to collaborate together and address CSA.[42] However, the framework lacks indicators to assess its implementation.

(iii) National Plan of Action for Children in Kenya 2015–2022

The aim of the plan is to coordinate and integrate ongoing sector-specific efforts to avoid replication and ensure optimisation of resources.[43]

The plan is comprehensive as it has plans for an equitable budget to finance activities, establishment of child-friendly spaces in all institutions dealing with children, implementation of parenting, life skills, mentorship, economic empowerment and social programs, strengthening of legal and policy frameworks for child protection, and provision of legal aid to child victims. Other activities include but are not limited to research on child abuse and exploitation and meeting the needs of children with disabilities and special needs.[43] The plan has indicators to measure its success. However, interviews with child officers divulged that many activities were not being implemented, mainly due to lack of financial and human resources.

(iv) The National Plan of Action Against Sexual Exploitation of Children in Kenya 2013–2017

The objective of the plan is to provide a framework for dealing with issues of child sexual exploitation in Kenya.[44]

The document is very comprehensive as it has protection activities planned around areas of prevention, protection, recovery, reintegration, coordination and cooperation, child participation as well as monitoring and evaluation.[44] However, the planned activities do not have budget lines for implementation. In addition, service providers in our study area lacked knowledge of its existence.

(v) National School Health Policy (2009) and the Safety Standards Manual for Schools in Kenya (2008)

The main objective of the School Health Policy is to promote gender equality, promotion of children's rights and their protection in schools, and provide a conducive environment for all learners including those with special needs.[45] The Safety Standards Manual aims to create a safe space and caring environment that enhances quality teachings and learning processes.[46]

The National School Health Policy stipulates that risk factors for sexual violence, reporting, response and management of sexual abuse and life skills be part of the school curriculum.[45] With regard to persons with special needs and disability, the policy advocates for a fully accessible and inclusive environment which is secure for all learners.[45] The Safety Standards Manual lists the indicators of school safety which can be used to assess whether schools have met safety requirements.[46] It also provides for establishment of school safety

sub-committees which are responsible for identifying safety needs, mobilising resources, implementation of safety activities, monitoring and evaluation of activities and constantly reviewing issues involving children.[46] The policy also recognises the need for training children with special needs/disabilities and educators on life skills and protection strategies against sexual harassment.[46]

However, the policies do not address rape myth attitudes which increase children' risk of sexual abuse. Although life skills would help in preventing CSA, they are rarely taught in schools. Like most policies, implementation of activities is not feasible, especially for schools in rural communities, due to financial and human resources constraints.

(vi) The National Special Needs Educational Policy Framework (2009)

The mission of the policy is to create a conducive environment for learners with special needs and disabilities in order for them to have equal access to quality and relevant education and training.[47]

One of the areas addressed in the policy is gender mainstreaming in special needs education. The policy document divulges that sometimes learners are left out of sex education, HIV/AIDS and life skills education programmes because people believe that they do not engage in social activities and sex.[47] However, the document does not outline any strategies to try and address this problem.

(vii) National Standard Operating Procedures for the Management of Sexual Violence Against Children (2018)

The aim of the standard operating procedures (SOPs) is to facilitate effective management of CSA.[48]

The SOPs provide instructions to health providers on how to administer comprehensive post-rape care. This entails history taking, physical examination, management of physical injuries, collection and preservation of forensic evidence, screening and treatment of sexually transmitted infections, pregnancy testing for adolescent girls, relevant vaccinations, psychosocial support, medical documentation and follow up care.[48] Instructions are easy to understand, very detailed and in line with most requirements outlined in the WHO guidelines on management of child survivors and adolescents.

In the standard operating procedures, health providers are urged to create rapport by starting the process with neutral questions then moving to specific ones. However, the guidelines fail to direct health providers on different ways in which a child can be allowed to express him/herself when responding to different questions. For instance, as sexuality is tabooed in Kenya,[30] children and adolescents may be unable to talk about their experiences and prefer to write about, draw or illustrate their experiences on a model.

The Evidence Act states that physical evidence is not necessary to prove allegations of sexual violence; weight is placed on the testimony of the child.[31] However, little emphasis is placed on forensic interviews as the guidelines lack interview protocols on obtaining verbal evidence.[17] The SOPs refer to the forensic interview as history with only five questions listed. Improper interviewing of survivors by health providers through poor questioning may elicit false allegations against the accused persons or lead to the court doubting the survivor's credibility.[49] With regard to counselling, counsellors are instructed to provide trauma counselling and psychoeducation. Due to poverty, some adolescents engage in transactional relations and may end up getting married to older men. Research shows that adolescents in early marriages are at a higher risk of intimate partner violence.[50] Counselling alone might not be effective. Therefore, it is imperative for health providers to map out referral centres that can offer such survivors the support needed to break their dependence on their partners.

The guidelines also lack instructions on screening for child sexual abuse; it is prudent for health providers to screen for CSA.[50]

(viii) The National Monitoring and Evaluation Framework Towards the Prevention of and Response to Sexual and Gender-based Violence in Kenya (2014)

Although most of the policies have a monitoring and evaluation framework, it is not exhaustive and integrated. The framework provides an integrated and functional sexual and gender-based violence (SGBV) multisectoral monitoring and evaluation system.[51] The framework has come up with indicators that can be used by different stakeholders in the child protection system to prevent and respond to sexual violence.[51] Although comprehensive, the framework gives children a passive role in monitoring and evaluation of issues affecting them. Children lack an active role in the

process; they are only counted as having been sensitised.

(ix) County Government Policy on Sexual and Gender-based Violence (2017)

The Constitution of Kenya, 2010, provides for a decentralised system of government wherein two of the three arms of government are devolved to the 47 political and administrative counties.[52] The aim of the decentralisation is to devolve power, resources and representation down to the community.[52] This devolution gave birth to the County Government Policy on Sexual and Gender-based Violence 2017.

The policy aims to develop SGBV policies, reduce vulnerabilities for groups at risk of SGBV, increase access to post sexual assault services and establish or strengthen existing safe houses. These aims are accompanied with detailed operational plans. However, its operationalisability remains to be seen. Children officers in our study informed us that the children department is not a devolved function in Kenya. As such most Counties do not have budget allocations to address the needs of children who have experienced sexual abuse. Moreover, County governments are dependent on the National government for funding, which is sporadic. The funds are prioritised for staffing needs with almost none left for child protection activities.

Discussion

This paper reviews existing laws and policies related to CSA in Kenya and their strengths and weaknesses. The laws stipulate harsh penalties for perpetrators of CSA. The extant laws (SOA) and policies (SOPs) stipulate that CSA survivors should have free access to medical care, psychosocial support and legal services. There are also stipulations for the establishment of child-friendly facilities and services (The Children Act). However, implementation of laws and policies is poor due to: (i) lack of financial and human resources, (ii) lack of guidelines on creating and providing child-friendly services, (iii) legal pluralism, (iv) providers' lack of knowledge on existing policies and (v) judicial officers' disregard for minimum statutory custodial sentences. Some laws are based on conservative beliefs (Kenya is a religious country): for example, criminalisation of consensual sexual activity among age-appropriate minors and the absence of abortion services for adolescents who conceive as a result of rape.

For the laws to be implemented, practical guidelines on how to operationalise the laws need to be provided. For instance, the Children Act stipulates that the children courts should be child-friendly but there are no guidelines on how to do this. Similarly, the National Standard Procedures for the Management of Sexual Violence Against Children, provide inadequate guidelines for conducting forensic interviews. Research indicates a poor operationalisation of the Sexual Offences Act.[15,53] Lack of guidelines and their unavailability, mainly in rural areas, could partly explain why service providers have difficulties operationalising the law.

The lack of operationalisation of laws and policies is also influenced by other factors: for instance, economic inequities such as inadequate financial and human resources.[21] Poor training of service providers and lack of awareness of the stipulations of existing policies is also a contributing factor.[21] The Kenyan government needs to allocate more resources towards protection of children from sexual abuse.

There is need for multi-sectoral teams to develop joint protocols that make it easier to operationalise the laws in each county. All stakeholders in Kenya – the children department, the health sector, the police, judiciary, prosecution, the education department, and non-governmental organisations – need to develop practical elaborative protocols on management of CSA. These protocols should outline the roles of each department, the responsible persons and accountability measures, work processes and referral mechanisms. When each stakeholder is aware of their responsibility, the role of other stakeholders and work processes, referrals are easier to make. Moreover, regular meetings among stakeholders could provide room for sharing challenges and coming up with joint solutions. Working teams such as the sexual assault response teams (SARTs) in the United States have a coordinated model that has been documented to increase communication between service providers, reduce delays in hospitals and improved forensic evidence collection.[54] Such models could be used to develop multi-sectoral protocols and cooperation at both National and County levels.

It is notable that the government wants to protect children from sexual abuse. However, it should take into consideration the fact that it is not uncommon for adolescents to actively engage in

sexual relationships with peers. To delay sexual debut, more should be done to ensure children have access to comprehensive sexuality education[55] rather than putting them in confinement for consensual sexual relations with peers. Confinement disrupts their learning activity, contravening the stipulations of the CRC and the ACRWC.

Finally, adolescents in consensual sexual relationships with adults would benefit more from life coaching, alternative livelihoods and financial assistance than detention. Most minors engage in transactional sex because of social inequities such as poverty.[7] Therefore, the government needs a policy on financially supporting and counselling minors in transactional sexual relationships.

Strengths and limitations of the study

The study has made a comprehensive analysis of laws and policies in Kenya, highlighting areas for policy makers to improve in order to address CSA but is not without limitations. The views described are from service providers in one region of Kenya and might not be representative, as different counties have different strategies. However, we found from our literature review that service providers from other regions in Kenya faced similar problems. To avoid repetition, we did not discuss the penal code as laws in the penal code were reiterated in specific laws. Our aim was to review all policies that relate to sexual violence but it is possible that we missed out a few that were not listed by service providers or not accessed on the NCCS website.

Conclusion

Many laws and policies exist in Kenya on CSA. However, their operationalisation is limited due to multiple factors that can be attributed to social and economic inequalities. To achieve sustainable development goals, Kenya needs to direct more resources towards child protection.

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References

1. United Nations. Sustainable development goals. United Nations. (2018). Available from: https://www.un.org/sustainabledevelopment/sustainable-development-goals/
2. World Health Organization. Report of the consultation on child abuse prevention WHO, Geneva, 29–31 March 1999. 1999 [cited 2017 Mar 22]. Available from: http://apps.who.int/iris/handle/10665/65900
3. Stoltenborgh M, van Ijzendoorn MH, Euser EM, et al. A global perspective on child sexual abuse: meta-analysis of prevalence around the world. Child Maltreat. 2011;16(2):79–101.
4. Pedera N, Guilera G, Forns M, et al. The prevalence of child sexual abuse in community and student samples: a meta analysis. Clinc Rev Psychol. 2009;123(1):328–338.
5. Mwangi MW, Kellogg TA, Brookmeyer K, et al. Perpetrators and context of child sexual abuse in Kenya. Child Abuse Negl. 2015;44:46–55.
6. Plummer CA, Njuguna C. Cultural protective and risk factors: professional perspectives about child sexual abuse in Kenya. Child Abuse Negl. 2009;33:524–532.
7. Wangamati CK, Sundby J, Prince RJ. Communities' perceptions of factors contributing to child sexual abuse vulnerability in Kenya: a qualitative study. Cult Health Sex. 2018; 20(12):1394–1408. DOI:10.1080/13691058.2018.1438666.
8. Mugoya GCT, Witte TH, Ernest KC. Sociocultural and victimization factors that impact attitudes toward intimate partner violence among Kenyan women. J Interpers Violence. 2015;30(16):2851–2871.
9. Maseno L, Kilonzo S. Engendering development: demystifying patriarchy and its effects on women in Kenya. Inter J Sociol Anthr. 2011;3(2):45–55.
10. Njue C, Voeten HACM, Remes P. Disco funerals: a risk situation for HIV infection among youth in Kisumu, Kenya. AIDS. 2009;23:505–509.
11. Heslop J, Parkes J, Januario F, et al. Sexuality, sexual norms and schooling: choice-coercion dilemmas. In: Parkes J, editor. Gender violence in poverty contexts: the educational challenge. London: Routledge; 2015. p. 135–150.
12. Tavrow P, Withers M, Obbuyi A, et al. Rape myth attitudes in rural Kenya: toward the development of a culturally

relevant attitude scale and "blame index". J Interpers Violence. 2013;28(10):2156–2178.
13. Domingo P, McCullough A, Simbiri F, et al. Women and power: shaping the development of Kenya's 2010 Constitution. Overseas Development Institute; 2016. Available from: https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/10292.pdf
14. Ranney ML, Rennert-May E, Spitzer R, et al. A novel ED-based sexual assault centre in western Kenya: description of patients and analysis of treatment patterns. J Emerg Med. 2010;28:927–931.
15. Kilonzo N, Ndung'u N, Nthamburi N, et al. Sexual violence legislation in sub-Saharan Africa: the need for strengthened medico-legal linkages. Reprod Health Matters. 2009;17(34):10–19.
16. Ajema C, Mukoma W, Kilonzo N, et al. Challenges experienced by service providers in the delivery of medico-legal services to survivors of sexual violence in Kenya. J Forensic Leg Med. 2011;18(4):162–166.
17. Wangamati CK, Gele AA, Sundby J. Post rape care provision to minors in Kenya: An assessment of health providers' knowledge, attitudes and practices. J Interpers Violence. 2017:1–27. DOI:10.1177/0886260517696863.
18. United Nations Human Rights Office of the High Commissioner. Convention on the Rights of the Child. (2018). Available from: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx
19. African Commission on Human & People's Rights. The African Charter on the Rights and Welfare of the Child. African Union; 2018. Available from: http://www.achpr.org/instruments/child/
20. Imoh AT. Realizing children's rights in Africa: an introduction. In: Imoh AT, Ansell T, editors. Children's lives in an era of children's rights. New York (NY): Routledge; 2014. p. 1.
21. NCCS. Summary of the outcome of mapping and assessing Kenya's child protection system: strengths, weaknesses and recommendations. National Council for Children Services.2010. Available from: https://resourcecentre.savethechildren.net/sites/default/files/documents/5122.pdf
22. Committee on African Affairs of the New York Bar. Gender-based violence laws in sub-Saharan Africa. Committee on African Affairs of the New York City Bar; 2007. Available from: https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/GBV_Laws_in_Sub_Saharan_Africa.pdf
23. Kenya Law. Situational analysis and the legal framework on sexual and gender-based violence in Kenya: challenges and opportunities. Kenya Law. Available from: http://kenyalaw.org/kl/index.php?id=4512
24. Wangamati CK, Combs Thorsen V, Gele AA, et al. Postrape care services to minors in Kenya: are the services healing or hurting survivors? Int J Womens Health. 2016;8:249–259.
25. CDC. Step by step – evaluating violence and injury prevention policies. Center for Disease Control; 2018. Available from: https://www.cdc.gov/injury/pdfs/policy/Brief%203-a.pdf
26. Kenya Law. Constitution of Kenya, 2010 Laws of Kenya. Government of Kenya; 2010. Available from: http://www.kenyalaw.org/lex/actview.xql?actid=Const2010
27. Kenya Law. Children Act, No. 8 of 2001 Laws of Kenya. Government of Kenya; 2001. Available from: http://kenyalaw.org/Downloads/GreyBook/12.%20The%20Children's%20Act%20Act.pdf
28. Kenya Law. The Sexual Offences Act, No. 3 of 2006, Laws of Kenya. Government of Kenya; 2006 Available from: http://kenyalaw.org/lex/rest//db/kenyalex/Kenya/Legislation/English/Acts%20and%20Regulations/S/Sexual%20Offences%20Act%20Cap.%2062A%20-%20No.%203%20of%202006/docs/SexualOffencesAct3of2006.pdf
29. Ministry of Health. National adolescent sexual and reproductive health policy. Ministry of Health, Kenya; 2015. Available from: https://www.afidep.org/?wpfb_dl=131
30. Sidze EM, Stillman M, Keogh S, et al. From paper to practice: sexuality education policies and their implementation in Kenya. New York (NY): Guttmacher Institute & APHRC; 2017.
31. Kenya Law. Evidence Act chapter 80, Laws of Kenya. Government of Kenya. Available from: http://kenyalaw.org/lex/rest//db/kenyalex/Kenya/Legislation/English/Acts%20and%20Regulations/E/Evidence%20Act%20Cap.%2080%20%20No.%2046%20of%201963/docs/EvidenceAct46of1963.pdf
32. Kenya Law. Criminal code procedure, chapter 75, Laws of Kenya. Government of Kenya. (2010). Available from: https://www.ilo.org/dyn/natlex/docs/ELECTRONIC/85001/94924/F209599740/KEN85001.pdf
33. Population Council. Sexual and gender-based violence in Africa: Literature review. Population Council; 2008. Available from: library.health.go.ug/download/file/fid/666
34. Kenya Law. Petition 6 of 2013, Laws of Kenya. Government of Kenya; 2013. Available from: http://kenyalaw.org/caselaw/cases/view/100510/
35. Kenya Law. The Victim Protection Act, No. 17 of 2014, Laws of Kenya. Government of Kenya; 2014.Available from: http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/VictimProtectionAct17of2014.pdf.
36. Kenya Law. Prohibition of female genital mutilation Act No. 32 of 2011, Laws of Kenya. Government of Kenya; 2011. Available from: http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/ProhibitionofFemaleGenitalMutilationAct_No32of2011.pdf
37. Thomson Reuters Foundation. Kenya: The law and FGM-28 too many. Thomson Reuters Foundation; 2018. Available from: https://www.28toomany.org/static/media/uploads/Law%20Reports/kenya_law_report_v1_(may_2018).pdf

38. Shell-Duncan B, Gathara D, Moore Z. Female genital mutilation/cutting in Kenya: Is change taking place? Descriptive statistics from four waves of demographic and health surveys. New York (NY): Population Council; 2017.
39. UNFPA & UNICEF. Joint evaluation UNFPA-UNICEF joint programme on female genital mutilation/cutting: accelerating change 2008–2012. New York (NY): UNFPA & UNICEF; 2013.
40. Muthini S. Legalise female genital mutilation, says doctor in court. Daily Nation; 2018. Available from: https://www.nation.co.ke/news/Legalise-female-circumcision–says-doctor-in-court/1056-4267584-11ajval/index.html
41. NCCS. The National Children Policy Kenya. (2010). National Council for Children Services; 2010. Available from: http://www.childrenscouncil.go.ke/images/documents/Policy_Documents/National-Children-Policy.pdf
42. NCCS. The framework for the national child protection system for Kenya. National Council for Children Services. 2011. Available from: https://resourcecentre.savethechildren.net/sites/default/files/documents/5429.pdf
43. NCCS. National Plan of Action for Children in Kenya 2015–2022. National Council for Children Services. 2015. Available from: http://www.childrenscouncil.go.ke/images/documents/Policy_Documents/National-Plan-of-Action-for-Children-in-Kenya-2015.pdf
44. NCCS. The National Plan of Action Against Sexual Exploitation of Children in Kenya. National Council for Children Services. (2013). Available from: https://ssa.riselearningnetwork.org/wp-content/uploads/sites/5/2015/11/Copy-of-NPA-against-SEC-Kenya.pdf
45. Ministry of Public Health & Sanitation and Ministry of Education. The National school health policy. Ministry of Public Health & Sanitation and Ministry of Education. (2009). Available from: https://www.prb.org/wp-content/uploads/2018/05/National-School-Health-Policy-2009.-without-cover..-Kenya.pdf
46. Ministry of Education. Safety standards manual for schools in Kenya. Ministry of Education. (2008). Available from: http://cwsglobal.org/wp-content/uploads/2017/01/CWS-SSZ-Schools-Manual_Kenya.pdf
47. Ministry of Education. The National special needs educational policy framework. Ministry of Education. (2009). Available from: http://www.unesco.org/education/edurights/media/docs/446808882707702aafc616d3a2cec918bfc186fc.pdf
48. Ministry of Health. National standards operating procedures for the management of sexual violence against children. Ministry of Health. (2018). Available from: https://www.lvcthealth.org/wp-content/uploads/2018/06/SOPVAC-Book-.pdf
49. Wood JM, Garven S. How sexual abuse interviews go astray: implications for prosecutors, police & child protection services. Child Maltreat. 2000;5:109–118.
50. WHO. 2017. Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. WHO; 2017. Available from: http://apps.who.int/iris/bitstream/handle/10665/259270/9789241550147-eng.pdf;jsessionid=06252E7B36AB2DF70370A8C2B853F649?sequence=1
51. National Gender and Equality Commission. The national monitoring and evaluation framework towards the prevention of and response to sexual and gender-based violence in Kenya. National Gender and Equality Commission. (2014). Available from: http://www.ngeckenya.org/Downloads/National-ME-Framework-towards-the-Prevention-Response-to-SGBV-in-Kenya.pdf
52. Kenya Law. Laws on devolution, Laws of Kenya. Government of Kenya. (2018). Available from: http://kenyalaw.org/kl/index.php?id=3979
53. KNCHR. Kenya 2014 human rights report. Nairobi: Kenya National Human Rights Commission 2014.
54. Sexual Assault Response Teams. National Sexual Violence Resource Center. (2018). Available from: https://www.nsvrc.org/sarts
55. UNESCO. Comprehensive sexuality education: a global review 2015. UNESCO; 2015. Available from: http://unesdoc.unesco.org/images/0023/002357/235707e.pdf

Résumé

Les abus sexuels sur les enfants sont une menace majeure pour la santé dans le monde. Les publications existantes montrent que les abus sexuels d'enfants sont prévalents au Kenya. En qualité de signataire de la Convention relative aux droits de l'enfants et de la Charte africaine des droits et du bien-être de l'enfant, le Gouvernement kenyan est chargé de veiller à ce que des lois et politiques solides protègent les enfants des abus sexuels. Cet article examine les lois et politiques existantes sur les abus sexuels chez l'enfant et met en lumière leurs forces

Resumen

El abuso sexual infantil (ASI) es un grave problema de salud mundial. La literatura disponible muestra que el ASI es prevalente en Kenia. Como signatario de la Convención de las Naciones Unidas sobre los Derechos del Niño y la Carta Africana sobre los Derechos y el Bienestar del Niño, el gobierno keniano tiene el mandato de velar por que los niños sean protegidos de abuso sexual por medio de leyes y políticas sólidas. Este artículo revisa las leyes y políticas vigentes sobre el abuso sexual infantil y destaca sus fortalezas

et leurs faiblesses. Nos conclusions indiquent que des lois existent sur la protection de l'enfant. Dans une large mesure, elles sont protectrices, puisque les délits sexuels sont passibles de peines sévères. Les enfants victimes d'abus sexuels ont droit à des services médicaux et juridiques gratuits. Néanmoins, aucune réparation n'est proposée aux victimes dans les procédures pénales. De plus, le pays ne dispose pas d'une législation sur l'éducation sexuelle complète, adaptée à l'âge, qui joue un rôle important pour cultiver des normes de genre positives et informe sur ce qui constitue l'abus sexuel et sur les procédures de signalement. Les procédures d'opération normalisées nationales pour la prise en charge des violences sexuelles sur les enfants manquent de mécanismes de dépistage de ces actes. Il est urgent d'examiner ces lois et politiques et d'élaborer des protocoles multisectoriels au niveau national et des comtés, afin de dégager les rôles et responsabilités de différents prestataires de services puis mettre en place des mesures de supervision et de redevabilité ainsi que des réseaux d'aiguillage.

y debilidades. Nuestros hallazgos indican que existen leyes sobre la protección de niños. En gran medida, éstas son protectoras, ya que establecen severas sanciones por delitos sexuales. Los sobrevivientes del ASI tienen derecho a recibir servicios médicos y jurídicos gratuitos; sin embargo, en los procesos penales no se les ofrecen reparaciones. Más aún, no existe legislación sobre la educación sexual integral adecuada para este grupo de edad, la cual desempeña un papel importante en cultivar normas de género positivas, que defina lo que constituye ASI y los procedimientos de denuncia. Los procedimientos operativos nacionales para el manejo de violencia sexual contra niños carecen de procedimientos para detectar ASI. Existe la necesidad urgente de revisar estas leyes y políticas y elaborar protocolos multisectoriales, a nivel nacional y en cada condado, que definan las funciones y responsabilidades de diversos prestadores de servicios, así como medidas de supervisión y rendición de cuentas y redes de referencia.