Why This Matters

• **Gender-based violence (GBV),** particularly intimate partner violence (IPV) and sexual violence, is a major human rights violation and public health issue that **affects more than 1 in 3 women globally.** It has both short and long-term consequences for women, impacting their physical, sexual, mental, emotional, and reproductive health (1).

• **Prevalence of GBV is high in Kenya,** with 34% of women over age 15 reporting physical violence and 16% reporting sexual violence at least once during their lifetime (2).

• **The COVID-19 pandemic amplified needs for violence-related supports for women, in Kenya and globally.**

• In June 2021, **the Kenyan Government committed to ending all forms of GBV by 2026,** with coordinated action across 5 pillars: financing, accountability and leadership, ratification and implementation of laws and conventions, data utilization, and service delivery (3).

Key Findings: Intimate Partner Violence (IPV)

**Figure 1: Prevalence of past-year physical or sexual IPV among partnered young women, weighted (n=593)**

- **Any Physical IPV 23.6%**
  - 9.9% Physical IPV (Often)
  - 12.0% Physical IPV (A few times)

- **Any Sexual IPV 17.8%**
  - 10.3% Sexual IPV (Often)
  - 7.0% Sexual IPV (A few times)

**Past-year IPV was common among young women (28.1%); 23.6% experienced physical IPV and 17.8% of women experienced sexual IPV at least once.**

**Figure 2: Overlap of physical and sexual IPV among partnered young women, weighted (n=593)**

- 10.3% Physical IPV Only
- 4.4% Sexual IPV Only
- 13.3% Physical and Sexual IPV

*not to scale

My husband started asking me to show him all the money I had. The violence started to get worse when his mother told him that I had another man. **When he came home, I would experience hell,** until the neighbors were sympathizing with me because he would beat me the whole night. One day, he beat me, and I had to stay in the hospital for two days.

– 17-year-old female IDI participant.
Most of the times it happens when I’m walking in my community, and you meet a man and he throws dirty words at you that I don’t feel okay about… I prefer to walk away because if you turn and start arguing with him… The words will now change to sexual verbal abuse.

- 17-year-old female IDI participant

I think [women] are not safe around gangs… These men are probably addicted to drugs… [there] are those [men] who do not value women… We recognize him if he beats his wife… One who makes her not go to look for work… You see, they still keep the old things of a woman having to stay at home and raise the children.

- 18-year-old male IDI participant

Figure 3: Prevalence of past-year sexual violence by a non-partner or sexual harassment among young women, weighted (n=828)

4.5% reported that they were forced to have sex by someone other than their partner. Approximately three-quarters of the women experienced sexual harassment in the past year.

Figure 4: Types and frequency of past-year sexual harassment among young women who reported sexual harassment, weighted

The most common type of sexual harassment was being stared or leered at, followed by unwanted sexual comments, jokes, or gestures.

Figure 5: Women’s perception of safety in home and public space, weighted (n=830)

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Prioritize survivor-centered prevention and response services specifically for IPV given the prevalence.

Expand access to survivor support services, including by training healthcare providers and community health workers to reduce self-blame and facilitate connection to care.

Invest in evidence-based programs to transform patriarchal norms that promote GBV perpetration and stigmatize survivors for seeking help.

Increase involvement of diverse gender equity stakeholders, including legislators, healthcare providers, and community and religious leaders to address GBV prevention and response.

More than one in four women have experienced physical or sexual IPV in the last year.

Sexual harassment is pervasive at 72%.

Performance Monitoring for Action (PMA) Agile is a longitudinal cohort of adolescents and youth ages 15-24 in Nairobi, Kenya initially recruited via respondent-driven sampling from June-August 2019 (n=690 young men, n=664 young women). From 2020-21, fully remote follow-up data collection was conducted with the cohort to track changes in contraceptive dynamics and assess the gendered impact of COVID-19 (survey rounds at 12-month follow-up from August-October 2020, and 18-month follow-up from April-May 2021 [n=586 young men, n=591 young women]), accompanied by qualitative methods, including focus group discussions (FGDs) and in-depth interviews (IDIs) with youth and relevant stakeholders.

From June to August 2023, data collection with the Nairobi youth cohort (now ages 19-28) was conducted (n=551 young men, n=550 young women), and with replenishment sampling for youth ages 15-19 to account for attrition and cohort aging (n=320 young men, n=281 young women (total n=871 young men, total n=831 young women)). Data collection was in-person, computer-assisted as in the initial wave, with a remote option. These data track and compare contraceptive use and behaviors, gender-related norms and attitudes, and gender-based violence (GBV) experiences and sources of support.

Accompanying qualitative methods included in-depth interviews with youth ages 15-29, sampled purposively based on demographics (N=30, male n=15 and female n=15).


PMA Gender, Kenyatta University, and International Center for Reproductive Health Kenya (ICRHK). Results from PMA Agile 2/GBV-Descriptive Analysis, 2023. Baltimore, Maryland, USA & Nairobi, Kenya.


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