

The Role of Faith Actors in the Care Continuum for Survivors of Sexual Gender Based Violence in Urban Slum and Pastoral Settings in Kenya

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Abstract

Sexual and gender-based violence (SGBV) is widespread among women and girls in Kenya despite extensive legal, policy, and institutional measures. The role of faith-based actors (FBAs), though crucial in supporting prevention and survivor recovery, has remained underexplored. This study examined the essential role of FBAs in SGBV in Narok and Nairobi counties. Data were collected through case narratives, key informant interviews, and focus group discussions with purposively selected participants, and analysed thematically. The findings show that SGBV manifestations and drivers differ by location. Urban slums reported higher rates of rape, sodomy, and sexual harassment, while pastoral areas reported more cases of FGM and forced marriages. Drivers in the slums included social media, substance abuse, and peer pressure, whereas in pastoralist communities, cultural norms and poverty were more prominent. Faith-based interventions included sensitisation sessions, educational sponsorship, life skills training, and counselling. These strategies addressed the main drivers identified in each setting such as social norms in Narok and social disorder in Nairobi. The study concludes that faith-based actors can utilise their strengths to be effective agents of survivor-centred change. Collaboration with these actors is vital to enhance and expand efforts to eliminate SGBV.

Keywords: Faith-based actors, sexual gender-based violence, care continuum, survivors, Kenya.

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Introduction

Sexual and Gender-Based Violence (SGBV) constitutes a pervasive global health crisis and a profound violation of human rights, rooted in gendered power imbalances and structural inequality (Grugel *et al.* 2022). SGBV presents varying degrees of prevalence and manifestation across geographical settings. It encompasses acts such as rape, sexual assault, physical violence, deprivation of resources or opportunities, and psychological and emotional abuse, inflicting devastating consequences on survivors' health, dignity, and well-being (Bhattacharjee *et al.* 2020; Wairimu, Keraka and Mutabazi 2023; UNHCR 2023). Globally, one in three women experiences physical or sexual violence in their lifetime (WHO, 2013; Bhattacharjee *et al.* 2020). In Kenya, the situation is alarming, with the 2022 Demographic and Health Survey indicating that 34% of women aged 15-49 have experienced physical violence since age 15, while 13% have experienced sexual violence (Decker *et al.* 2015; Campbell 2022). This prevalence exists despite a robust legal and policy framework in Kenya, including the Sexual Offences Act (2006) and the Prohibition of Female Genital Mutilation Act (2011) (KNBS and ICF 2023), illustrating a critical implementation gap and the need to engage complementary, community-embedded actors within the SGBV response ecosystem.

The role of faith-based actors (FBAs), comprising religious leaders, congregations, and faith-inspired organisations, has emerged as an important but complex intervention. On the one hand, religious institutions can be sites where harmful norms are reinforced and where perpetration by trusted leaders creates profound barriers to reporting and justice (Swart 2013; Jakobsen 2016). On the other hand, FBAs command unparalleled trust, extensive social networks, and moral authority, positioning them as potential first responders and powerful agents of change in preventing violence and supporting survivors (Parsitau 2011; Pertek 2020; Pertek *et al.* 2023). This dual potential of risk factors and protective assets forms a critical gap in the literature, which often examines FBAs in isolation rather than comparing their roles across different contexts.

The effectiveness of any SGBV intervention is not universal but highly contextual (Kok *et al.* 2023). However, there is a paucity of studies on how FBAs tailor their interventions across different socio-ecological contexts. Our article addresses this gap by asking: how do FBA's roles and interventions within the SGBV care continuum differ between an urban slum setting characterised by social disorder and a rural pastoral setting governed by powerful social norms? In answering this question, we employ the SGBV care continuum as our primary analytical framework, categorising FBA

activities into the prevention, response, and recovery stages. This framework applied across the two distinct settings enables us to provide a nuanced, evidence-based understanding of how the unique strengths of FBAs can be strategically leveraged to develop context-specific solutions for eradicating SGBV.

Study Sites and Methods

Study sites and sampling

The study was conducted in Kasarani and Illaramatak in Nairobi and Narok counties, Kenya, respectively. Kasarani is an urban informal settlement characterised by poverty, high population density, and limited social services. Here, SGBV is frequently linked to social disorder (Okallo 2017). Reports from local authorities and NGOs indicate a high incidence of rape, sexual assault, and cases of sodomy against young boys (WHO 2013; Okallo 2017; UNHCR 2023; UNFPA 2023). These acts are often driven by substance abuse, peer pressure, and a lack of safe spaces for youth, resulting in high rates of teenage pregnancy and school dropouts.

Illaramatak offers a contrasting rural, pastoral setting, predominantly inhabited by the Maasai community. Here, SGBV is primarily cultural in nature. The county has one of the highest rates of Female Genital Mutilation (FGM) in Kenya, with a prevalence of 58% (Matanda *et al.* 2018; Uhuru and Wamocha 2020). The practice is a rite of passage, as girls who undergo FGM are considered ready for marriage. This heightens child marriage and teenage pregnancy, severely limiting girls' educational opportunities and perpetuating cycles of disempowerment.

The two counties were purposively selected because Kasarani (Nairobi) is an informal settlement in an urban setting, while Illaramatak (Narok) is a rural and pastoral setting, providing a contrasting context for comparison. Moreover, these settings have been reported to have a high prevalence of SGBV (Pinchoff *et al.* 2021), with Narok having a high FGM prevalence of 58% in 2020 (Uhuru and Wamocha 2020), above the national average rate of 15% (KNBS 2023). Nairobi is an urban and metropolitan area with a diverse population, mostly living in informal settlements.

Participants were also purposively and conveniently selected for focus group discussions (FGDs), case narratives, and key informant interviews (KIIs). These methods aimed to ensure the representation of diverse sub-populations based on religion, age, gender, and geographic location. A total of eight (8) FGDs were evenly distributed between Kasarani and Illaramatak, with 2 FGDs conducted with men-

only groups and 2 with women-only groups. Twelve (12) case narratives from survivors of SGBV (6 from each site) were collected, and twenty-five (25) KIIs were conducted across both sites. Key informants were purposively selected for their expertise and ability to provide diverse perspectives on the topic. Sample sizes for interviews were determined to achieve data saturation where no new themes or information emerged during data collection, highlighting the importance of comprehensive data coverage.

Data collection methods and analysis

Data were collected in the two study sites in February 2023. Secondary data review provided background information for the study. Primary data collection methods included focus group discussions (FGDs), case narratives from survivors of SGBV, and key informant interviews (KIIs). Experienced research assistants with social science backgrounds, trained in qualitative research and research ethics, supported the lead researchers in collecting data. The FGDs gathered normative data on SGBV experiences and practices within faith-based communities across the study areas. While women-only and men-only groups were formed, youth subgroups were not feasible due to time and budget constraints. Each FGD consisted of 10-12 participants and was moderated by a facilitator with a note-taker present. Conducted in church compounds, the FGDs provided a comfortable setting for open dialogue based on guided themes/questions.

The case narratives explored the personal experiences of SGBV survivors and were conducted in private environments that encouraged participants' disclosure. The interviews were facilitated by a researcher and a note-taker, with a counsellor available to support survivors emotionally. The KIIs were conducted alongside FGDs and case narratives to gather comprehensive insights on SGBV. Participants included representatives from various stakeholders, such as WVK staff, local CSOs, NGOs, community leaders, church/faith leaders, police, gender officers, and county officers.

Following fieldwork completion in both counties, the recorded interviews were transcribed verbatim by the research team and translated into English. The researchers and field assistants held a one-day reflection workshop for initial participatory data analysis. The workshop utilised field notes to reflect on the study's key themes, which served as the basis for developing an initial codebook. Thereafter, the thematic content analysis method was used to analyse the data (Guest *et al.* 2006). Using both inductive and deductive approaches, the transcribed data were coded and analysed in NVivo version 12. Through open coding and thorough transcript review, emerging themes and trends were

identified to expand the codebook. Two lead researchers coded each transcript to achieve inter-coder agreement, followed by a thematic relevance assessment (Brown 2019). Triangulation of findings from various data sources, including secondary data, was conducted to provide detailed insights through "thick description". Direct quotes were extracted and incorporated into the findings.

During data collection, the study engaged faith-based actors and community stakeholders to plan and mobilise participants for various data collection methods. The study adhered to research ethics, including obtaining informed consent from participants, ensuring confidentiality, maintaining anonymity, and protecting privacy.

Results

Contextual differences in the SGBV manifestation and drivers

The study revealed two different SGBV ecosystems, each demanding distinct intervention approaches. In Kasarani's urban slum, SGBV was characterised by a high incidence of opportunistic sexual violence linked to social disorder and substance abuse. A CBO representative detailed the relentless caseload, noting that his office handled multiple new cases every week, many involving extreme brutality against young victims.

In my area, rape cases are very common. In my office, in a week, you can expect between 2 and 5 rape cases since most are referrals from the chief's office and the police station. So, it is very rampant, and recently, there was a case of a girl who was raped by three boys. (Male KII, CBO, Kasarani).

Violence was not restricted to women and girls. Male faith leaders described a troubling prevalence of sodomy among street-connected children, highlighting a specific vulnerability within the urban setting. One leader stated:

In our area, those things happen...mostly sodomy. Boys are abused. They are raped by their peers. Where I am staying... that is the centre for street boys...we call them to improve their lives. I have given my house to them as a hostel. I experienced challenges in the past. A young boy would come because he had been attacked by older boys. So, it is here in this area of ours. (Male FGD, Faith Leader, Kasarani).

A consistent finding across data sources was the betrayal of trust by those closest to the victims. Perpetrators were rarely strangers; instead, they were fathers, uncles, and even faith leaders themselves, individuals vested with the duty of care and protection.

On several occasions, incest plays a very major role, since for most people, the perpetrators are very close to them. In this area, we have cases involving faith-based leaders, uncles, and dads with very close family members as the main perpetrators. These are people you never expect to be in those situations. (KII Female, CBO, Kasarani).

In Kasarani, SGBV occurs within a broader social environment where individuals learn violent behaviour through peer influence. This encompasses exposure to various media platforms and the internet, as well as social observation and learning. Women faith leaders put this into context:

The environment in which we raise our children is also to blame. When you rent a house in a slum with open bhang or alcohol trade...or where there are drunkards, children will see people becoming violent and committing acts of SGBV. So don't expect a mango tree to produce oranges because children see and hear. Children copy the behaviours in that environment. (Women FGD, Faith leaders, Kasarani).

In these social environments, children can be exposed to sexual behaviours through observation of their parents' conduct at home and exposure to certain content on the internet. The behaviours they witness, including inappropriate touching and open sexual activity, can influence their perceptions and actions as they mature. Sodomy among boys is also attributed to drug use and peer influence.

When our boys use bhang, they get confused and indulge in sexual abuse with their fellow boys. Peer pressure also comes in. When you see your peer has done it, you will also want to do it so that you are seen to belong to the group. (Men FGD, Faith leaders, Kasarani).

Although substance use can be learned from the social environment, it also stands alone as a driver of SGBV.

In Illaramatak, the experiences of survivors and the explanations of community leaders pointed to a deeply institutionalised system of SGBV, where violence was not a random act but a scheduled community-awareness event. A survivor's narrative revealed how FGM was a parental decision, executed during school holidays with the full awareness and implicit acceptance of the wider community.

FGM was done on me because they claimed that it was the culture of the Maasai community. At that time, no one was aware of the dangers of FGM. Years later, they have realised that FGM is a harmful practice. I, however, continued my studies until I completed secondary school. I experienced pain during the cut, but eventually healed after a month, and a lot of bleeding was also experienced. (Case Narrative 1 Illaramatak)

The practice was often carried out with deliberate secrecy, as another survivor recounted:

I was taken to my relatives, then I was cut at night, and the next day nobody suspected, only the family members knew. (Case Narrative 2 Illaramatak).

This pattern shows that FGM was a calculated family strategy often concealed from authorities but sanctioned within the kinship network. The practice was intensified by cultural beliefs that directly linked a girl's physical alteration to her social and economic value. Faith leaders explained that FGM was rationalised within the community as a method to control female sexuality and was a non-negotiable prerequisite for marriage.

The most affected people are our girls; the older women and men believe that once a child is taken through FGM, her libido level reduces since they believe that their private parts should only be used for

reproduction and not for pleasure. These cultural beliefs, where one is not allowed to be married if they are not circumcised, bring the value attached to FGM. (Women FGD, Faith leaders, Ilaramatak)

This cultural framework was often compounded by economic pressure, where families living in poverty see the marriage of a circumcised daughter as a critical financial strategy.

Sometimes poverty also plays a big role in this, for instance, in the case of early forced marriage. (Male FGD, Faith leaders, Ilaramatak).

Male faith leaders in Ilaramatak reported that parents who use drugs are likely to commit violence in their families. Recalling a case, an FGD discussant reported that the drug-using father "would attempt to harass her sexually [the daughter] in her mother's absence."

Faith-based actors' response to SGBV

FBAAs deployed various strategies across prevention, response and recovery stages, leveraging their unique community-positioned strengths. At the response stage, FBAs provided immediate psychosocial support and served as a critical first point of contact, guiding survivors through the reporting system.

They [faith leaders] also try counselling for a few individuals and also do referrals. (KII Male, CBO, Kasarani).

Counselling was another key service offered by trained faith leaders.

I counsel people on the main causes of Gender Based Violence and how to deal with the issue whenever it occurs. I mainly do this to women, teenagers and children. So, wherever there are workshops or a pastor sets time to talk to people, I use the time to counsel people (Female KII, Faith Leader, Kasarani).

In Ilaramatak, response to FGM and forced marriage included the creation of physical safe havens. These rescue centres provided a vital escape for girls whose immediate families were the source

of danger. The process, as described by a faith leader, involved not only rescue but also a deliberate effort to reintegrate and elevate the survivor's status in the community.

After being rescued, the girls are taken to school away from their families, and afterwards, we bring them back to their families and communities, who are always ready to embrace them. So their running away from violence bore many fruits (Men FGD, Faith Leaders, Illaramatak).

For long-term recovery, FBAs invested in strategies to promote economic and educational empowerment, breaking cycles of dependency and vulnerability. In Kasarani, economic empowerment through group-based initiatives was key. A survivor shared how this transformed her capacity to cope and rebuild in the following manner:

World Vision” has brought us into groups, and through these groups, we can get quick support in case of anything. They visit us every month to check how we are faring, whether we are doing table banking, and where we have fallen short. They advise us to take a loan from the group and restock our business (Case Narrative 6 Female Kasarani).

In Illaramatak, education sponsorship was a dominant strategy reported by eight actors to provide girls with an alternative to early marriage.

Faith-based actors' prevention of SGBV

FBAs engaged in primary prevention activities to shift community knowledge and attitudes. The most common intervention was public sensitisation, which involved delivering messages directly to the community. A male faith leader described this proactive, community-wide approach, stating as follows:

At times, we go out and even try to do road shows; we try to empower the community at large on how to identify those abuses, how to deal with them, how to monitor, how to document and how to report and to liaise with relevant institutions that help them in terms of seeking redress and such things (Men FGD, Faith Leaders, Kasarani).

In Illaramatak, prevention directly involved confronting the cultural norms that drive FGM and early marriage. Faith leaders named and worked against these norms.

What causes this is our culture, like the Maasais, whereby a girl gets cut and even forced into marriage because we still practice and follow our traditions (Women FGD, Faith Leaders, Ilaramatak).

FBA's also implemented targeted, practical skills training to reduce vulnerability. Life skills training emerged as a key strategy, and in one notable example in Kasarani, this extended to teaching self-defence to older women, a group uniquely vulnerable to rape.

There used to be this trend where old women were raped. The ages of 60, 80, and 100 years. As a community, we decided to teach them Karate. We are the only group in Korogocho that empowers older women in terms of Karate [self-defence]. Yes, self-defence. They use that to protect themselves (Men FGD, Faith Leaders, Kasarani).

Comparative analysis of FBA strategies

The study reveals a clear pattern of strategic differentiation between the two sites. The interventions deployed by FBAs were not uniform but were instead closely aligned with the specific SGBV threats prevalent in each environment. In Narok, where the study showed cultural norms around FGM and early marriage drove SGBV, the FBA interventions were predominantly long-term and focused on providing alternatives to these cultural pathways. The most common strategies were education sponsorship and the operation of rescue centres, which directly addressed the need to remove girls from familial pressure and invest in their prospects beyond marriage.

Conversely, in Kasarani, where the data showed a high prevalence of opportunistic sexual violence and substance abuse, often perpetrated by individuals known to the victims, the FBA interventions were more immediate and targeted towards mitigating environmental risks. Here, the focus was on life skills training to build resilience against peer pressure, self-defence classes for vulnerable groups, and economic empowerment to reduce the financial desperation that fuels transactional sex. The consistent theme was creating buffers against the volatile urban slum environment.

Table 1: Contextual adaptation of FBA interventions in the SGBV care continuum

Intervention Spectrum	Narok (Rural Pastoral) - Core Challenge: FGM/Child Marriage	Kasarani (Urban Slum) - Core Challenge: Sexual Violence/Substance Abuse
Primary Prevention	Public Sensitisation directly countering cultural myths around FGM.	Public sensitisation on rights, reporting, and available services. Life skills training to resist peer pressure.
Immediate Response	Rescue Centres provide a safe haven for families. Counselling for FGM/early marriage survivors.	Counselling for rape/defilement survivors. Referrals to health (e.g., MSF) and police.
Recovery & Reintegration	Education Sponsorship as a primary strategy for empowerment and delaying marriage. Vocational Training in rescue centres.	Economic Empowerment (e.g., table banking) for financial independence. Sporting Activities for positive engagement and safe spaces.

Discussion

This study reveals how faith-based actors strategically adapt their approaches across the SGBV care continuum based on fundamentally different drivers of violence in two Kenyan contexts. Our findings make three key contributions to understanding community-led interventions. We demonstrate that the care continuum operates not as a standardised protocol but as a menu for strategic selection, in which FBAs emphasise different components based on their diagnoses of local violence patterns. This approach aligns with established practice, which holds that effective violence prevention requires integrated strategies across multiple levels of the social ecology (Michau *et al.* 2015). In Illaramatak's pastoral setting, this meant prioritising normative contestation and protective measures against culturally-sanctioned practices, while in Kasarani's urban environment, the focus shifted to crisis response and resilience-building against opportunistic violence. The findings are consistent with other studies that place culture as a key driver of practices such as FGM in Kenya (Kabiru, Mumah and Abuya, 2018; Perrin *et al.* 2019; Sheikh, Cheptum and Mageto 2023;).

The preventive approaches observed reflect this strategic adaptation. In Illaramatak, FBAs engaged in deliberate normative contestation, directly challenging the cultural foundations of FGM. This

aligns with social norms theory (Perrin *et al.* 2019), which emphasises that sustainable change requires altering collective expectations rather than relying solely on individual attitudes (Cislaghi and Heise 2019), and demonstrates FBAs' unique position as internal critics who can leverage religious authority to counter harmful traditions. Conversely, in Kasarani, prevention emphasised practical harm reduction in an environment characterised by social disorganisation, where strategies like self-defence training represented adaptive responses to community-level risk factors rather than attempts at broader normative transformation (Decker *et al.* 2015; Powers *et al.* 2020).

Our study identifies how contextual adaptation manifests systematically across intervention phases. The response mechanisms revealed contrasting models of protection: Narok's rescue centres provided essential extra-familial sanctuary, where families were the primary threat, directly countering anthropological analyses that identify kinship systems as enforcement mechanisms for harmful practices (Shell-Duncan, 2018). Meanwhile, Kasarani's model emphasised brokerage, with FBAs serving as cultural translators who facilitate access to police and healthcare services, addressing critical gaps in SGBV response for marginalised urban communities. Similarly, recovery strategies reflected divergent temporal orientations and theories of empowerment. Narok's emphasis on education sponsorship represents a long-term investment seeking to create alternative life pathways that diminish the economic rationale for early marriage, engaging with the economic anthropology of bride wealth and intergenerational contracts (Corno and Voena 2023). Kasarani's focus on immediate economic empowerment through group initiatives addresses pressing vulnerabilities created by poverty, providing practical alternatives to survival sex and economic dependence, an approach supported by evidence that economic empowerment programmes can enhance women's agency and reduce vulnerability to violence (Ferrari 2016).

Additionally, the study complicates the dual-role narrative of FBAs (Swart 2013; Jakobsen 2016) by revealing the paradox of embeddedness. This reflects the concept of 'continuums of violence' where the same social structures that enable protection can also facilitate harm (Yadav and Horn 2021). While we documented instances of pastoral authority being exploited, the predominant pattern showed how deep community ties enable effective intervention through what anthropologists term "insider privilege": the ability to challenge sensitive issues with cultural competence that external actors lack (Fiddian-Qasmiyeh 2020). However, this very embeddedness creates accountability challenges, as the same social

bonds that facilitate access also complicate reporting mechanisms, necessitating robust safeguarding protocols that respect FBA's community role while ensuring survivor protection.

Conclusion

The prevalence of SGBV is a complex social and cultural phenomenon. Comprehensive programming must address contextual cultural, gender, and social landscape and incorporate a multi-faceted yet transformative framework that considers social, legal, and psychological dimensions. Tapping into the agency and potential of all actors is paramount. The remarkable capacity and commitment demonstrated by faith-based actors and civil society organizations elaborate on their essential role as practical partners in SGBV interventions. Leveraging their established trust within communities, extensive networks, and resources, these agents serve as facilitators of change, supporting survivor-centred approaches. Sustained collaboration and investment in the capacities of faith-based actors and civil society organizations are essential to strengthen efforts aimed at eradicating SGBV.

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