



KENYATTA UNIVERSITY
WOMEN'S ECONOMIC EMPOWERMENT HUB

THEME THREE

Addressing Sexual and Gender Based Violence as a Constraint to Women's Work

Pilot Study on Nairobi Women's Hospital Gender Violence recovery centre

Topic

Impact of programmes and Initiatives addressing Sexual and Gender-Based Violence as a constraint to Women Economic Empowerment

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ABBREVIATIONS

CDTD:	Centre for Domestic Training and Development
COVAW:	Coalition on Violence Against Women (COVAW)
Covid-19:	Coronavirus-19
CSO:	Civil society organization
GDP:	Gross Domestic Product
GVAW:	Gender Violence against Women
GVRC:	Gender Violence Recovery Centres
JP-GBV:	Joint Program on Gender Based Violence
KNBS:	Kenya National Bureau of Statistics
NGEC:	National Gender and Equality Commission
NGO:	Non-governmental Organisation
NWH:	Nairobi Women's Hospital
ODK:	Open data kit
RRRPs:	Rescue, Recovery and Rehabilitation Programmes
SGBV:	Sexual and Gender-Based Violence

1.1 Introduction

1.1.1 Overview

The most common type of gender inequality globally is Sexual and Gender-Based Violence (SGBV) (World Bank, 2013). In concurrence with this, The World Health Organisation, WHO (2013), explains that one out of every three women in romantic relationships is subjected to physical and sexual violence or both by a companion. Further, State of African Women Report (2018) notes that Gender Violence against Women (GVAW) is a widespread human rights violation which transcends geographical, race, class, sexuality, ethnicity and religious, among other boundaries. Additionally, the report notes that in 19 out of the 28 countries for which data was available, 20-45% of women aged 15 to 49 have undergone SGBV at least once in their life. Available data demonstrates that SGBV is rampant in Kenya at over 35% with variations manifesting according to context and source of data (KNBS, 2014). Observably, other than the variations on actual rates, most cases go unreported and about 72% of the survivors are not only unwilling to report SGBV but also to pursue justice after violation (Orlale 2015).

SGBV is a fundamental health, social, economic and human rights issue that affects individuals and communities with dire consequences on national development (NGEC, 2016). In its 2018 strategic plan, the Coalition on Violence Against Women (COVAW) underlines the main driver of SGBV as the power imbalance between women and men in patriarchal societies (COVAW 2018). Galtung (1990) posits that gender-based violence does not occur in a vacuum, but is linked to socio-cultural and structural factors that impact on men's and women's choices and behaviour. Mc Evoy (2012) notes that SGBV is not only widely tolerated by individuals and communities in Kenya but also takes place within the intricate web of families, thereby entrenching it as normal life. This reality compromises not just SGBV prevention, but also responses to it which require a multifaceted individual-based approach and a broad range of services including, but not limited to the medical, psychological (counselling), legal, and financial.

The myriad state and non-state actors addressing SGBV in Kenya include the Gender Violence Recovery Centres (GVRCs) under the Ministry of Health and Rescue, Recovery and Rehabilitation Programs (RRRPs) by non-governmental organisations (NGOs). The first GVRC was established in the Nairobi Women's Hospital (NWH) in 2001. Based on lessons learnt from it, NGEC (2016) recommended the establishment of GVRCs in all major County hospitals.

Although the efforts of GVRCs and RRRPs focus on response and prevention, their effectiveness remains unclear, since SGBV persists and continues to act as a barrier to women's economic empowerment (WEE). Observably, there is a connection between economic disempowerment of women and SGBV (UNECA, 2012; Duvvury et al. 2013; Dimovitz, 2015; World Bank, 2018; Temmerman et al., 2019). While some non-state RRRPs have a WEE component, their programmes are survivor- and symptom specific, oblivious of the root causes of SGBV and broad spiralling effects which impact on women's economic wellbeing.

This pilot study thus evaluates one non-state GVRC and three non-state RRRPs with the aim of generating evidence on their efficacy in transforming the lives of survivors of SGBV economically. The purpose was to inform the design and approach proposed for the fuller study

and to test if the tools and analytical procedures were robust enough to establish the effectiveness of RRRPs in meaningfully transforming survivors' economic status.

1.1.2 Statement of the Problem

Despite numerous approaches to address SGBV in Kenya, its prevalence amongst women and girls remains high putting in question the efficacy and relevance of response and prevention frameworks tackling it. Contextual analysis reveals that state and non-state actors implementing recovery programmes primarily focus on medical, psychosocial and legal needs of survivors that are immediate following violation. Notwithstanding that many cases within the family and community go unreported, RRRPs respond to violence after it has occurred and the interventions often ignore the nexus between violence and WEE. Evidently, SGBV interferes with women's wellbeing, thereby constraining their work, which in turn limits their economic empowerment (NGEC, 2016). Unfortunately, data to link SGBV with survivors' economic output is not available. This pilot study, therefore, sought to not only establish the effectiveness of RRRPs in addressing SGBV and helping survivors recover but also interrogate it as a constraint to women's work with implications on WEE.

1.1.3 Objectives of the Study

This pilot study aimed at generating evidence on what works to effectively respond to and prevent SGBV as a constraint to WEE. The specific objectives were to:

1. Establish the economic cost of SGBV on women survivors who had graduated from four selected GVRCs/RRRP before 2020.
2. Determine the effectiveness of services offered by the selected GVRC/RRRPs in facilitating the recovery of SGBV survivors.
3. Establish the extent to which skills and experiences gained from the selected GVRC/RRRPs led to women's economic empowerment.

1.1.4 Review of Extant Evidence

1.1.4.1 Prevalence of Sexual and Gender-Based Violence

SGBV is one of the most severe violation of women's rights across the world. Globally, there are more than 736 million or 35% women who have encountered SGBV (UN Women, 2021). SGBV happens in various structures with financial and social foundations, and is in most cases unspoken and unreported. This has extremely devastating consequences for women survivors as well as their families. In Kenya, SGBV largely emanates from social cultural inequalities grounded on gender roles and disparities among communities, stemming out from power differentials between genders. Women's systemic subordination, combined with an overall powerless position relative to men, makes them less able to bargain for their rights, and hence susceptible to violence. A research by the State Department of Gender Affairs in Kenya, (UN Africa Renewal Magazine 2017) results showed that 5 in every 10 women aged 15 to 24 accepted that men have power over women and may violate them without redress. As such, instances of SGBV in Kenya has been accelerating, more so during the Coronavirus (Covid-19) pandemic which originated in December 2019. CREAM (2021) reports that SGBV cases in Kenya have risen by 42% during the pandemic at 47% of women compared to 3% men being subjected to SGBV. In addition, the GVRCs) and RRRPs have been recording an

increase in the number of survivors during the pandemic. For instance, the NWH GVRC's 2020 annual report shows that the centre realized a remarkable increase in the number of survivors admitted in the wake of Covid-19.

1.1.4.2 Socio-Economic Costs of SGBV

Researchers recognize the nexus between SGBV and access to finance and, inferably, economic empowerment. A World Bank report (2018) puts the value of economic loss due to SGBV at about 1.2% - 3.7% of developing countries Gross Domestic Product (GDP). Globally, the UN Women report (2016) pegs the economic loss due to the vice at 2% of global GDP. In yet another study investigating economic costs of violence against women in Bangladesh by Siddique (2011) revealed that the country lost 2.7% its GDP to the vice. In Uganda, women lost about 9% of their incomes due to constrained working hours, as a result of SGBV, cumulatively totalling to around 11 days of productive work per year (UNECA, 2012). Information from NGEC (2016) assigns a percentage between 7.8% and 10% loss of Kenya's GDP due to SGBV. It also indicates that cases brought by survivors to police gender desks in the same period costed Kshs 820 (about 8 USD) in terms of transport expenses, and Kshs 2,320 (about 230 USD) for other related expenses such as food and other incidentals. Cumulatively, the report indicates that a total of Kshs 3.10 billion was incurred supporting the SGBV survivors in the country through transport, processing police reports and affidavits, doctors' fees, among other expenses. This is an indication that social and financial expenses of SGBV replicate themselves at individual, family, business, government, and societal levels (Day, 2005; Duvvury et al. 2013; Walby and Olive 2014).

The effects of SGBV can be immediate such as missing to report to work, whether paid or unpaid, mental and physical illness, poor access to services such as reproduction and maternal health care, loss of time and property (Duvvury and Minh, 2012; WHO 2013; Bacchus et al. 2018). SGBV can also have medium and long-term effects such as on professional development, continuation of education, mobility and upward progression in formal employment due to disability, mortality, morbidity, family instability as well as loss in quality of life (Reeves and O'Leary-Kelly 2007; Crowne et al. 2011; Sabia, Dillis, and DeSimone 2013).

However, there is an evident gap on the actual loss of incomes to families and survivors as well as loss of productive time for businesses and employers due to SGBV. Demonstrating these costs through evidence-based data will help to influence state and non-state sectors to respond to SGBV through gender-responsive policies and establishment of effective units to prevent and manage the vice. Demonstrating that SGBV affects the business profits and has an economic and social cost, creates incentive for businesses to lobby governments to work towards effective strategies and to implement their own prevention and support programmes as anticipated in a NGEC (2016)

1.1.4.3 SGBV Prevention Programs, Response Measures and Stakeholder Analysis

Governments globally and in Kenya have come up with policies and strategies to address SGBV through ratification of global commitments, conventions and treaties, hence recognizing the effects the vice has on women (UN Women, 2021). The anti-SGBV initiatives in many countries are driven by different actors such as private organizations, civil society organizations (CSOs), media and development partners. However, there appears to be no defined scope or distinction on the programme areas of focus. The National Monitoring and Evaluation

Framework Towards Prevention of and Response to SGBV in Kenya (GOK, 2014) has documented the financing roles of SGBV programs, and need for collection of information and data, development, and implementation of policies of SGBV policies at workspaces, as well as referral procedures and systems for survivors. The framework has also set out the roles of CSOs (Ministry of Devolution and Planning, 2014). Additionally, the Kenya Government's Third Medium Term Plan 2018-2022 (GoK, 2018) priorities the prevention and response to SGBV. Further, the national government has intentions of setting up One-Stop SGBV recovery centres in all counties. The government also plans to enhance research on the vice, as well as set up SGBV information management systems at county level. Other government efforts to address SGBV include the GOK/UN Joint Program on Gender Based Violence (JP-GBV), which has five pillars namely: prevention, protection, prosecution, programming and partnerships, which are synergized and underpinned by a plan of strong coordination, communication, advocacy and innovation, all leveraging on information communication technology and policy related dialogues at national and county levels.

Other strategies set out to address SGBV include helplines, such as the National GBV Helpline 1195, Children's Department's Childline, Kenya Helpline 116, GOK/UN UWIANO SMS Platform 10, Kenya Police Helpline 999/112, Kimbilio SGBV Helpline 1193, LVCT's one 2 one 1190 Helpline and FIDA's 21661 short message services platform. (NGEC, 2016). The Kenya National Action Plan based on the United Nations Security Council Resolution 1325 on Women, Peace and Security is yet another response mechanism set out by the government to monitor and address violence against women.

County governments of Makueni, Kilifi, Taita Taveta and Meru too have set up centres to address SGBV. However, there is concern that these programmes lay more emphasis on responding to SGBV and not its prevention (GoK, 2018). Observably, there is need for more budgetary allocation to comprehensively address SGBV programmes at national and county levels. Notably, the non-state actors have developed a multi-stakeholder strategy to build the capacity of vulnerable people to combat SGBV, as well as support related services. Development partners also finance SGBV initiatives through technical support to key state and non-state actors and communities for participation in awareness raising campaigns and in the Alternative Dispute Resolution (ADR) initiatives (Ministry of Devolution and Planning, 2014). The mass media is single out as a critical player in creating awareness about SGBV, policy and gender-responsive interventions (ibid). Other efforts include the HeForShe campaign by the United Nations (UN Women, 2020), the Community Education and Empowerment Centre (CREAW), Women's Empowerment Link (WEL), the Coalition on Violence Against Women (COVAW). At community level are specific actors such as chiefs, ward administrators, vigilante groups, male anti-GBV champions, religious leaders, community elders, *Nyumba Kumi* operatives, law enforcement agencies, sectoral service providers and CSOs (NGEC, 2016).

Notably, most of these initiatives lack a strong link and referral systems for WEE. A UN Women (2019) report posits that there is a gap on what works to prevent SGBV in different cultural contexts and how to ensure an intersectional approach, while continuing to support local women's movements to address the vice on a large scale and in a sustainable way. Other gaps include limited coordination of stakeholders, weak data management, poor monitoring and evaluation frameworks and inadequate researched evidence to inform policy advocacy and programme development on SGBV. In addition, evidence points to deficient rehabilitation and reintegration programmes for SGBV survivors and towards holding perpetrators accountable. Consequently, gaps pertaining to what works for effective SGBV prevention, linkages with

different economic sectors, and low levels of male involvement in SGBV prevention and response initiatives are manifest (NGEC, 2016).

2.1 Methodology and Approach

2.1.1 Design

This pilot study was conducted ahead of the main one to test the recruitment procedures for the targeted SGBV survivors, data collection instruments and their reliability and the Open Data Kit (ODK) in collecting and processing the data. It adopted the mixed method design combining both qualitative and quantitative approaches. Aspects of exploratory and evaluation design were combined to allow an open inductive inquiry and to gauge the psychological and socio-economic impacts of the selected programmes addressing SGBV and WEE. In addition, the accounting approach allowed quantification of both direct and indirect costs of SGBV on survivors and programmes in line with the study objectives.

2.1.2 Pilot Study Sites

The study was done at NWH GVRC, Centre for Domestic Training and Development (CDTD), Talia Agler and Women's Empowerment Link (WEL) in Nairobi County. The NWH- GVRC was founded in March 2001 as a charitable trust of The Nairobi Women's Hospital to bring back meaning to the lives and families of survivors of SGBV by providing free medical treatment and psychosocial support. This site was selected because it was the first GVRC in the country upon which others have been modelled. The centre does not provide shelter, legal and economic support but relies on partners to provide these complementary services. CDTD is an NGO that targets and benefits girls and women in domestic labour, migrants, victims of trafficking, refugees'/asylum seekers and survivors of SGBV towards recovery, social reintegration and economic empowerment. Established in 2007, Women's Empowerment Link (WEL) works in empowering women and girls by challenging gender inequalities and marginalisation, SGBV, illiteracy and insensitive laws and policies. The NWH relies on the last three organisations as partners to which it refers survivors that require shelter and economic empowerment services.

2.1.3 Target Population and Sampling

In line with Sekaran and Bourgie (2009) a 5- 10% of the main sample is an adequate sample size for a pilot study. Thus the study targeted 45 women and reached 32 women who had benefited from the four organisations after SGBV. In order to randomly select the pilot respondents, lists of survivors were acquired from the respective programmes and filtered by age and year of exit to capture only those who were aged 18 and above and graduated from the programmes before year 2020. Cluster and systematic random sampling procedures were then utilized to select respondents from each of the lists according to calculated sampling intervals. Substitution of selected respondents was done where those targeted were not available, unwilling to grant interviews; or too emotional to recount their experiences. The GVRC/RRRPs assisted in providing physical and contact addresses of survivors selected for study.

2.1.4 Data Collection Research Instruments/tools

The study utilized a key interview guide in collecting data from managers of the GVRC/RRRPs and a questionnaire to interview SGBV survivors. Both instruments were administered face to face and by telephone when physical access to the respondent was not possible.

2.1.5 Ethical Protocols

Ethical approval was obtained from Kenyatta University Ethics Review Committee following successful evaluation of the research proposal. Recruitment of respondents took cognizance of the need to protect SGBV survivors from further risk and trauma and were closely aligned to the WHO (2016) ethical and safety protocols for research on domestic violence against women. This ensured strict use of the informed consent process to explain the purpose of study and observance of the principles of voluntarism, confidentiality, anonymity and latitude to withdraw from the study at will. Face to face interviews were conducted in discreet locations chosen by participants and personal security was assured by maintaining privacy at all times. Respondents who encountered emotional breakdown while recounting their experiences with SGBV or who were gauged to have a trauma relapse were referred to the relevant GVRC/RRRP centre for further assistance.

2.1.6 Data Analysis

Quantitative data generated in the study was analysed using measures of central tendency, dispersion and standardization. It is presented in percentages and frequencies. In computing the cost of SGBV, a formula aggregating the direct and indirect costs to survivors and service providers was utilized. Qualitative data was analysed by coding and denotation of theme or variable in reference while developing narratives based on connectivities with the elements under inquiry then generating interpretations.

3.1 Findings of the Pilot Study

The main findings are presented per objective but with a preamble on the respondents' demographic characteristics.

3.1.1 Respondents' Demographic Characteristics

The demographic characteristics of survivors are important in predicting the kind of women likely to be abused as well as factors that pre-dispose them to violence. The findings are presented on age, education, marital status, residence and income.

Majority (81.2%) of the survivors were aged 26 to 45. This shows that they were in their economically most productive age, which implies that the vice interfered with their productivity, suggesting that interventions on SGBV should prioritise this age cohort. More than half of the survivors (62.5%) had attained primary and secondary levels of education. The survivors were, therefore, young and with little professional or skills training, translating into few chances of employment, income generation and ultimately economic empowerment hence dependence on male partners for basic needs, a factor related to their toleration of abusive relationships for long periods. However, some had incomes superior to their partners, which was a direct trigger of violence as the latter tried to exert control.

Studies show that most women marry men who are older and better established economically. This subjects them to a subordinate position that heightens their vulnerability to violence. An overwhelming proportion of survivors (75%) got married or started cohabiting when aged 18-25, an age at which individuals are in college/university or early career life hence are still unstable economically. Getting into a marital relationship at this age implies early assumption of family life, which translates into foregone opportunities in education and career development, as well increased dependence on the husband and likelihood of tolerating abuse for long periods. Correlated with the finding that husbands were the majority perpetrators of SGBV, the age of marriage implies that the vice begins early and persists within the marital cycle.

The study established that majority (40.6%) of respondents had withstood violence for 6-8 years before seeking help. 18.7% had withstood the abuse for more than ten years, implying that it had become a routine part of their lives. This suggests that the impact of the vice on their lives was extensive and perennial. From an economic perspective, such lengthy exposure to violence implies recurrent costs related to time off work, medication, transportation and hiring of domestic help. The pattern evokes questions as to factors that compel women to tolerate abusive relationships for so long. Eradicating such factors would obviously lead to massive reduction in the number of women violated and the related financial costs. Many survivors only got to the GVRRC/RRRP when the violence exceeded their threshold of tolerance.

Half (50%) of respondents indicated that they lived in a single room shared with their family members as this is what they could afford. This confirms their low economic status. The majority (78.1%) lived with their children, who were also exposed to the violence physically and/or emotionally due to trauma. The finding gains extra significance in terms of the cost of SGBV when read in conjunction with data showing that children lost personal items and school days from the violence.

The findings indicate that majority (62.2%) of the women depended on informal sources of livelihood namely petty businesses and casual work. Only 25% were in formal salaried employment, complimented with other revenue streams such as business. The others did not consider their occupations significant enough to be regarded as income-earning. The recurrent message from respondents was that their incomes were low and erratic, translating into high levels of dependency on partners, which may explain why as many as 35% stayed in abusive relationships for more than seven (7) years. NGECC (2015) attributes women's economic vulnerability to concentration in informal work, casual employment and agriculture, which are less stable than formal jobs and yield low incomes, as reflected in the findings.

These findings resonate with Peterman, Roy and Ranganathan (2019) who note that although SGBV cuts across all socioeconomic status, the poor are at higher risk and tend to live in locations with limited social services and weaker legal systems. Thus an overall improvement on economic opportunities and social services would reduce exposure to SGBV. Specifically, interventions that increase and stabilize women's incomes would immensely benefit survivors of SGBV.

Additionally, the study sought to assess whether the survivors controlled their incomes as this is a strong indicator of economic empowerment (Vyas & Jansen, 2018). From the data, 50% of survivors indicated that they controlled their incomes, which they spent on their own and children's welfare. For 18.75%, control was exercised by the partners against their will. Only 3.13% indicated that the partner did so at their will. Those who had no control over their

incomes reported that this made it impossible to invest in ventures of their own choice as these would be sabotaged by the partners. The survivors considered independent decision making on their own income as empowering.

3.1.2 Economic Cost of SGBV on Women Survivors

SGBV has both direct and indirect costs to survivors and their families. The study itemized and computed the costs by time, finances and indirect expenses. The results show that all the SGBV survivors spent time seeking help from the GVRC/RRRP. Slightly more than half (56.3%) spent one month and above while 31.3% took 1-7 days. The vast majority (90.6 %) took time off their daily routines, an opportunity cost of temporarily abandoning their income-generating activities.

The findings are in agreement with previous studies on Bangladesh, Uganda and Kenya by Siddique (2011), UNECA (2012) and NGEK (2016): respectively, which established that women lose more than 9% of their incomes from constrained working hours resulting from SGBV. Such losses cascade to the national Gross Domestic Product (GDP).

Furthermore the results show that for 62.5% of survivors, the violence experienced extended to their children. 56.3% indicated that the children missed school due to the violence with daughters being the majority at 28.1% compared to sons at 12.5% and both at 15.6%. Consolidated, these statistics show that girls are at a clear disadvantage, , obviously due to gender roles in the family.

Some respondents also stated that the children left all their clothes, books and uniforms behind as they hurriedly moved out of the abusive homes with the mothers. Clearly, the mothers would have to incur expenses in replacing the abandoned items when the children resume school. Additionally, such children are traumatized, which requires treatment, at a cost not only to the victims and their families but to the whole nation now and in the future, as established by Save the Children (2007). As Hamby and Ormrod (2011) also noted, exposure of children to domestic violence may lead to lifelong trauma.

The results further show that survivors suffered general emotional disturbance (28.13%), anger (9.38%), persistent fear (3.13%) and misandry (6.25%). Half of them suffered physical consequences in the form of permanent disability (21.88%) and residual pain or discomfort (28.13%). Others experienced loss of interest in sexual relationships. While quantifying the emotional and sexual cost of violence is not straight-forward, there is no doubt that it affects ability to work and economic productivity hence is a financial liability for life.

Regarding direct financial costs, most of the survivors (96.9%) reported that they incurred expenses to replace the items damaged during the incidents of violence. Virtually all of them incurred costs related to transport to hospital, medical bills and counselling services. Others did on legal services and shelter. In addition, abrupt separation meant renting new places of residence and paying bills hitherto catered for by the estranged partners. Some also left the marriage empty-handed, foregoing joint investments with the partner. Whatever the amount incurred by survivors, it is obvious that SGBV contains a direct cost, which constitutes resources diverted from meeting routine needs and investments. Below is a computation of the specific costs.

3.1.2.1 Immediate Costs of Seeking Help

The study used the formula $TFOPC = \sum_j \sum_i \sum_s C_{is}$ to calculate the immediate costs incurred by survivors to seek help in the GVRRC, where:

- TFOPC = total survivors' out of pocket cost.
- j = type of incident reported.
- i = index of the victimized woman.
- s = service sought.
- C_{is} = cost paid by the woman for the services.

Average expenses per cost category were multiplied by the number of respondents (32) to derive the total costs as shown in Table 1.

Table1: Immediate Costs of SGBV

Cost Category	Range (Kshs)	Average costs (Kshs)	No. of respondents	Total Cost (Kshs)
Medical	1,000-5,000	3,000	32	96,000
Transport	1,000-5,000	3,000	32	96,000
Legal	Below 1,000	1,000	32	32,000
Counselling	Below 1,000	1,000	32	32,000
Accommodation	1,000-5,000	3,000	32	96,000
Total				352,000

Note: The report used the exchange rate of Kshs 100 to one US dollar.

3.1.2.2 Cost of Lost Work Days

The study used the formula $COWDL = \sum_j \sum_i \{FE_i FDi + HE_i HD_i\}$ to determine the SGBV cost due to lost working days where:

- COWDL = cost of working days lost.
- FE_i = daily earning per woman.
- FD_i = lost days from work.
- HE_i = partner daily earning, and zero if not married.
- HD = days lost by the partner from work..

The average daily income was 1,500 shillings (USD 14.02). Working days lost per woman and partner were 30 and 10 respectively equating to Kshs 2,000. This sums up to Kshs 1,120,000 shillings (USD 10,467.29). It is important to note that some survivors suffered permanent disabilities or injuries that have translated into chronic illnesses which have consequently impaired their abilities to work.

3.1.2.3 Lost School Days for Children

The study used the formula $COSDL = \sum_i \{CiLD_i\}$ to calculate the SGBV cost due to lost school days for children, where:

- COSDL = cost of school days lost.
- Ci = yearly school fees or numbers of days in academic year.
- LDi = days lost by the children.

Majority of the children lost two weeks of school days. Based on the yearly average secondary school fees of Kshs 65,000, the total amount lost was Kshs 650,000 annually.

3.1.2.4 Lost Domestic Work Value

The study used the formula $CODWDL = \sum_j \sum_i \{RW_i AHi + Di\}$ to compute the SGBV cost due to lost domestic work hours, where:

- CODWDL = cost of domestic work days lost.
- RWi = minimum hourly wage rate in household service for survivor.
- AHi = daily hours spent in domestic work by survivor.
- Di = number of domestic work days lost by survivor.

On average, women lost five domestic work days and 10 hours of domestic work time. The average hourly wage is Kshs 300.

The aggregate of the lost days and work costs appear in Table 2.

Table 2: Aggregated Costs of SGBV

Type of Cost	Average (Kshs)	No. of days	No. of respondents	Total
Lost working days - women	1,500	10	32	480,000
Lost working days – partners	2,000	10	32	640,000
Lost school days - children	65,000	10	32	208,000
Lost domestic work - women	3,000 (300 per hour for 10 hours)	5	32	480,000
Total				1,808,000

The total cost of SGBV is summarized in Table 3.

Table 3: Total Cost of SGBV

Indicators	Costs (Kshs)	Cost (USD)
Direct costs	352,000	3,520
Indirect costs	1,808,000	18,080
Total costs	2,160,000	21,600

It must be noted that the above costs do not take into account the expenses paid for by the GVRG/RRRP as well as that used by correctional services (police, courts of law, legal representation, prisons) for apprehended perpetrators.

The findings cohere with NGECC (2016) , which notes that: the cost of medical-related expenses per survivor and family amounted to USD 164; time taken to report to the local administration costed \$31; and loss of productivity as a result of serious harm amounted to \$ 2,235 and the World Bank (2018) and UN Women (2016) on the enormous economic cost of SGBV. This translates into a substantial loss to the GDP and calls for policy intervention.

3.1.3 Effectiveness of the RRRP/GVRC Services in Facilitating Recovery

In order to establish the effectiveness of the GVRC/RRRP services, the study investigated the kinds of violence survivors had experienced. The vast majority (90.6%) had suffered physical followed by psychological/emotional violence (78.1%). Economic, sexual and social abuse were reported by 59.4%, 46.9% and 34.4% of survivors respectively. Majority had experienced multiple types of violence concurrently. The violence manifested in ways that show a clear pattern of gender power relations in which men controlled women's lives. For example, economic violence took the forms of: deprivation of personal assets and effects; destruction/burning of clothing; and forceful diversion of loans secured by wives.

Husbands and boyfriends were identified as the primary perpetrators of SGBV by 84.4% and 9.4% of the survivors respectively. Combined , the two accounted for 93.8% of the violence. This data tallies with statistics from KNBS (2014) which indicates that husbands are the majority perpetrators of SGBV. Equally important is the need to tackle factors that motivate men to commit violence against their partners. These include women's economic dependence on men hence toleration of the vice for their sake and that of their children (Miruka, 2013). As noted by Cameron and Tedds (2021), economic vulnerability and dependence increases risk of SGBV and limit an individual's ability to exit and recover from violent situations. That intimate partner violence is the leading manifestation of SGBV suggests that the household is central for both prevention of and response to the vice.

Before the SGBV incident that led to seeking help from the GVRC/RRRP, majority (84.4%) of survivors had been in marital relationships while 15.6% had not. At the time of the study, 34.4% were separated while only 16.8% were still in the marriages. The divorced and widowed were 3% and 6% respectively. Descriptive responses indicated that the survivors had developed high levels of aversion towards marriage and romance as a result of the violence and preferred to stay alone charting their destiny independently. This indicates that the GVRC/RRRP experience empowered them on self-preservation. On the obverse, the SGBV contributed to family breakups.

The study also established that survivors received information regarding the help available at the GVRC/RRRP from a broad range of sources, meaning that those who disclose their plight are likely to access help. The findings cohere with NGECC (2015) about the duty bearers, their roles and the need for raising awareness on SGBV.

In terms of accessing services, majority (96.9%) of the survivors sought psychological counselling followed by medical help (75%) and legal assistance (46.9%). Only 25% needed shelters. In this regard, 78.1% of survivors reported receiving medical treatment with 21.9% indicating psychological support. Those that needed shelter and other forms of help were referred to service providers such as Talia Agler and Women's Empowerment Link. The services accessed upon referrals included business training (12.5%), legal information and referral (6.3%), psychological support (71.9) and rescue/ shelter/ housing (3.1%).

These findings show a close tally in the services sought and those offered with psychological and medical assistance being the priority in both cases. This study, therefore, notes that these are the forms of assistance central in the continuum of services SGBV survivors needed in the journey to recovery. This notwithstanding, legal services, business training, start-up capital and shelter/safe houses are adjunct services needed.

While all survivors were generally satisfied with the immediate services offered by the GVRC/RRRPs, a number of gaps were identified. First, the period stayed within the programmes (about one year) was not adequate for full recovery for some survivors. Second, some were in a dilemma on where to go from the shelter as they feared being re-victimised on returning to their abusive homes. Third, very few sought judicial intervention to hold the perpetrators to account. Fourth, lack of an economic empowerment in the NWH GVRC means that some would have benefited it from it did not unless referred to the partners.

One of the aims of the GVRC/RRRPs is to help women SGBV survivors regain their worth in society, which is adversely eroded by violence. In order to assess the effect the GVRC/RRRP had on the economic standing of survivors, a broad framework including cognitive, behavioural, internal and external factors was adopted in relation to the recovery journey. Respondents were thus asked to indicate their level of agreement or disagreement with a set of statements capturing the various dimensions of life after the GVRC/RRRP, measured on a five point Likert scale.

Over 90% of survivors affirmed that the GVRC/RRRP helped them regain their intrinsic worth. Such help also inspired them to campaign against the vice within their communities, which literally shows that the survivors gained a voice. Furthermore, 59% agreed that the help inspired them to join a women's group. This is indicative that survivors were able to re-connect with others, which is an important step towards recovery and socio-economic empowerment considering that such groups facilitate women's access to finance for social and economic needs (Wanaswa, 2015; Ngumbau, 2017).

3.1.4 Extent to which Skills and Experiences Gained from the GVR/RRRP led to Women's Economic Empowerment

The study sought information on survivors' levels of income and whether it improved after going through the GVRC/RRRP. Majority (68.8%) reported monthly incomes ranging from Kenya Shillings 1000 (~10 USD) to 10,000 (~100 USD). The findings show that 25% of the respondents earned a monthly income of Kshs 1000 [10 USD] and below. In addition, 25% indicated that they earned between Kshs 1000 and 5000 [10-50 USD] per month. Only 6.3 % earned more than Kshs 20,000 [200 USD] a month, which consisted of income from salary and business. Some of the respondents indicated that their incomes improved after the GVRC/RRRP because they could do different jobs without fear and utilize their talents fully.

Probing on how survivors were able to gauge that their incomes had improved revealed that a majority regarded the mere fact of earning their own income and spending it independently as good enough improvement. This reinforces the reports by about 85% of survivors that employment, starting a business and investing on their own were critical for meeting immediate needs. Key among the economic freedoms they talked about was the ability to pay rent and school fees for their children, buy food, and restart their businesses.

As to whether participation in the GVRC/RRRP had any economic impact on the respondents, findings show that 78.1% were affirmative, 15.6% negative and 6.3% did not know. This is an interesting finding considering that the NWH GVRC did not have an economic empowerment component but referred survivors to other service providers to WEL which provided business training and capital for some. For others, the GVRC/RRRP created space to re-think their lives, consult and decide on how to move forward. Thus the positive impact was not only a result of direct economic training and finance but encouragement on the need to be self-reliant, which propelled survivors to initiate own income-generating activities.

It is thus clear that the knowledge and skills from the programmes contributed to the survivors' journey towards economic empowerment even only in a small way

Consolidated with the finding that the GVRC/RRRP contributed to increased income for 26% of survivors, these findings demonstrate a positive effect on their economic empowerment regardless of the actual increment in income and notwithstanding the fact that the NWH GVRC did not have an economic empowerment component. On the flipside, 74% did not realise an increase in income after going through the GVRC/RRRPs. This implies that recovery is multi-dimensional and compounded by several factors that could be outside the realm of the study. Interpreted further, this suggests that programmes that are primarily focused on economic empowerment are likely to be transformative.

3.1.5 Conclusion

It is evident that SGBV affects women in the economically most productive ages. This obviously interferes with economic productivity and diverts the resources in their custody from investment to treatment and recovery. It is further noted that the cost of SGBV is perennial considering that the vice begins early and persists within the marital cycle. The toleration of the vice for long periods raises concerns about factors that tie women to the abusive relations until their lives are threatened. These factors should be identified and eradicated if SGBV and its related costs are to be eliminated.

The findings demonstrate that SGBV has huge direct and indirect costs to survivors and their children. These constitute losses to the individual and overall economy. Thus it is imperative to have strong national and community level initiatives against the vice. Of significance is the finding that intimate partners are the primary perpetrators of SGBV. This suggests need to target the household, and specifically men, in order to tackle the vice from its very root.

It is encouraging to note that information about available help to survivors is available from a wide range of sources. Such actors should be taken advantage of to amplify the messages on sources of help and looped into a network of anti-SGBV agents.

That psychological and medical assistance are primary for survivors means that they should form the core of GVRC/RRRP services. Nevertheless, this should not be done at the expense of other types of services (legal, shelter, economic empowerment) that enable holistically recovery.

Significant to note is that although referral of survivors to service providers offering business training and start-up capital proved essential in enabling self-reliance and re-building of self-

worth. In general, the findings show that the GVRC/RRRP had a positive effect on the survivors.

4.1 Challenges Experienced

The research team experienced various challenges, summarized under facility, survivor and researcher.

4.1.1 Facility-based Challenges

The study established that there are many non-state actors (RRRPs) providing services to SGBV survivors. Getting information from them was, however, difficult for a number of reasons. Some of the staff expected financial compensation for linking the researchers with survivors. Others demanded official memoranda of understanding with Kenyatta University and an indication of how they were to benefit financially from the study. When the research team was categorical that there was no financial benefit attached, cash attached to such, some RRRPs declined to participate or even share any contacts of the survivors.

The research team also noted that the records kept by the GVRC/RRRPs are not updated and that once a survivor graduated from the programme, the facilities hardly followed up. Thus they had little or no information on changes that may have occurred in the lives of survivors including but not limited to the new places of residence and contact details. Additionally, the GVRC/RRRPs have clear programme niches and none offers all the services needed but survivors hence they work in partnership. This meant diversifying the sample base for data collection.

4.1.2 Survivor-related Challenges

The research team experienced difficulties in contacting survivors as most of the contact phone numbers shared by the service providers were either out of use or went unanswered. Where survivors had given numbers of proxies as their contacts, the latter were very uncooperative. In some cases, survivors picked their phones but were unwilling to participate in the study. Others still live in fear or with the perpetrators hence were only willing to talk to the researchers in the company of someone they trust or in an open public place.

There were some survivors who gave consent when contacted on phone but changed their mind once the researcher got to the meeting point. This translated into waste of time and money. In addition, some survivors suffered emotional breakdowns while recounting their experience of SGBV. Consequently, the researchers had to stop the interview for a while. This meant that filling the questionnaire took longer than was anticipated. In fact, the researchers noted that some sampled survivors had not gone through the entire treatment prescribed by the NWH GVRC hence did not fulfil the inclusion criteria and were rejected. Some survivors were only available for interviews in their business premises. This created pauses as they attended to their customers hence increased the duration of interviews.

4.1.3 Researcher-related Challenges

The researchers approached the fieldwork with lots of assumptions that were proved wrong in the field. One was that the GVRC/RRRPs would readily share survivor contacts once the purpose of the study was explained. This was not forthcoming as they created pre-conditions for doing so, including official memoranda and payment. Another was that all the SGBV

survivors treated by the NWH GVRC lived within Nairobi City or its environs. The reality was that they were dispersed in neighbouring counties, which had implications on time to physically reach them. The third was that survivors who had completed their programs had healed. It was noted that although the questions did not seem to require much detail on their SGBV experience, recollecting it created an emotional burden resulting in the researchers having to slow down for them to regain composure as well as repeat the ethical protocol and seek permission afresh to continue with the questions while re-assuring them. The questionnaire was also problematic in some instances where questions did not elicit meaningful responses and/or generated answers already captured from earlier items. For example, the question on the financial value of losses incurred limited the responses to options which did not cover survivors who had lost massive investments. This means that the actual cost of SGBV is not adequately reflected in the computation. In response, the team had to make instant adjustments while in the field.

Furthermore, instances arose where the team felt inadequate and unprepared. First, some of the survivors expressed interest in continuing to engage in programs and projects aimed at responding to and addressing SGBV. However, the research team had no meaningful response to them. Second, some researchers were themselves emotionally overwhelmed from listening to the stories. The overall effect is that it was not possible to do many interviews hence most teams ended up with a maximum of three per day.

5.1 Proposed Changes Based on Experiences from Pilot Study

The research team proposes the following changes on the research instruments and approach.

1. Re-order the items in the questionnaire questions to eliminate confusing or redundant ones and include prompts to skip those that do not apply for some survivors.
2. Broaden the options on the monetary values on losses incurred to cover survivors who lost millions of shillings so as to get a more accurate computation. The current options are limited to a over Kshs 20,000.
3. Include a section on the cost of SGBV in the key informant schedule. This ought to include not just what the GVRC pays for medical and counselling services for each survivor but also their institutional costs in order to capture a more accurate cost of SGBV.
4. Stratify the key informants for different types of information. The study noted that some mid-level staff (counsellors, case managers and social workers) with a lot of information hence need to have a separate tool to capture their views.
5. In terms of approach, conduct a visit to the RRRPs/ GVRCs in advance to introduce the study, establish rapport enable them prepare survivors before the actual research. This would improve the efficiency of the study and level expectations as well as clarify how they can use the findings in their own programming.
6. Include counsellors to work with the teams and/or have a clear referral system to deal with the emotional dimensions to ensure strict compliance with the do no harm principle.
7. Translate the questionnaire into Kiswahili to ease communication with survivors. In addition, take linguistic diversity into consideration when composing the research sub-teams to capitalise on ability to use vernacular where necessary and appropriate.

6.1 Lessons Learnt

The research team derived a number of lessons from the pilot study. First, the cost of SGBV differs by type experienced, individual affected and facility where help was received. To

capture the actual cost of SGBV, it is therefore important to have several layers of questions that capture direct and indirect costs met by survivors and all facility related costs including the institutional ones. In the pilot study, there were limitation on the scope of costs captured, which results in a skewed estimate.

It was noted that long-term shelters are structured to meet the needs of young women and girls that have experienced SGBV. There is a gap on how shelters ought to operate. The NWH GVRC does not have a shelter yet it is best placed to have one for short-term purposes e.g 24-48hours. Additionally, there should be a half house where needs assessments and referrals would be anchored. Long term shelters would then be tailored for business training; education and rehabilitation especially for those who are incapacitated as a result of the SGBV. From a policy perspective, there is need for standardised procedures on starting and operating such shelters.

Legal help was recognized as very weak in the continuum of services offered. This was attributed to encumbrances in seeking justice in relation to time, distances to courts, attitude of police officers and corruption in the system. Unless these are dealt with, survivors will remain without closure and with a feeling of injustice.

Finally, the facilities providing services to survivors require official memoranda of understanding with Kenyatta University. Such should be built into the main study, on top of report building visits in advance.

7.1 Way Forward

The team proposes the following activities as preparations for the main study get underway.

1. Completion of writing the full pilot study report.
2. A dissemination webinar on the findings of the pilot study.
3. Drafting of a policy brief emanating from the findings of the pilot study.
4. Revision of the data collection instruments.
5. Drafting of standard memoranda of understanding for anticipated facilities in the main study.
6. Advance rapport-building visits to the RRRP/GBVRC to be involved in the main study and mapping of survivors.
7. Draft policy brief
8. Pilot Report writing
9. Preparation for a webinar

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