



SGBV STUDY REPORT

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

Primary Outcome

Increased Awareness, Reporting and Effective Action Against Sexual and Gender-Based Violence (SGBV) by 30% for Women Economic Empowerment by 2025 in Tharaka Nithi County- Kenya

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1. Introduction

The most common type of gender inequality globally is sexual and gender-based violence (SGBV) (World Bank, 2013). In this regard 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 Africa Women Report (2018) reports that Gender Violence Against Women (GVAW) is a widespread human rights violation which transcends geographical, race, class, sexuality, ethnicity and religious boundaries among others. 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 had a similar encounter at least once in their life. Available data demonstrates that SGBV is rampant in Kenya at over 35%, (KDHS, 2014; KNBS, 2014). Its prevalence however, differs according to context and source of data. Observably, other than the variations on actual rates, most cases also unreported. In view of this, Orlale (2015) opines that 72% of the survivors are not only unwilling to report SGBV but also do not pursue justice.

SGBV is a major health, social, economic and human rights issue that affects individuals, communities and has dire consequences on national development (NGEC, 2016). In their strategic plan, COVAW (2018) underlines its major driver as the power imbalance between women and men in patriarchal societies. Galtung (1990) posits that violence does not occur in a vacuum, but is linked to socio-cultural and structural factors that impact on men and women's choices and behaviour. Mc Evoy (2012) notes that SGBV is not only widely accepted 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's prevention, but also response to it. The latter for instance requires a multifaceted individual-based approach and a broad range of services including, but not limited to, medical, psychological (counseling), legal, and financial.

There are a number of state and non-state actors, such as GVRC under Ministry of Health (MoH) and Rescue, Recovery and Rehabilitation Programs (RRRPs) by NGOs among other initiatives that carry out awareness and advocacy programmes on various forms of SGBV. The first GVRC was established in the Nairobi Women's Hospital (NWH) in 2001. Based on lessons learnt from NWH GVRC, NGEC (2016) recommended the establishment of GVRCs in all major County hospitals. It also emphasizes the role of non-state actors in RRRPs. Although these efforts focus on response and prevention, their effectiveness is unclear, since SGBV persists and continues to act as a barrier to WEE. Observably, studies have illustrated a connection between economic disempowerment of women and SGBV (Temmerman et al. 2019; Dimovitz, 2015). Although some non-state RRRPs have a WEE component, their programs are survivor- and symptom specific, oblivious SGBV root causes. This study will thus evaluate one state -run GVRC and one non-state RRRP with the aim of generating evidence on their efficacy in transforming survivors of SGBV to economic viability. Considering the relationship between women's economic empowerment and SGBV prevalence, it was important to establish the effectiveness of RRRPs in comprehensively transforming survivors to meaningful economic activities. This pilot study sought to establish the effectiveness of RRRP programmes in achieving recovery and women's economic empowerment.

1.1 Statement of the Problem

Despite numerous approaches to address SGBV in Kenya, its prevalence amongst women and girls remains high (at over 35%). This raises questions on the efficacy and relevance of response and prevention frameworks put that address it. Contextual analysis reveals that state and non-state actors have individually implemented RRRPs that primarily focuses on medical, psychosocial and legal needs of survivors. Notwithstanding that many cases within the family and community go unreported, RRRPs respond to violence after it has occurred. Further, services to survivors are offered by actors who lack coordination, thereby making access even to RRRPs elusive. Observably, 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 comprehensively addressing SGBV and helping survivors recover but also interrogate it as a constraint to women's work.

1.2 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 women's economic empowerment. The specific objectives were to:

1. Establish the economic cost of SGBV on women survivors.
2. Determine the effectiveness of Makueni GBVRC and Life Bloom services International facilitate the recovery of SGBV survivors.
3. Establish the extent to which skills and experiences gained from RRRPs lead to WEE.
4. To examine Relationship between SGBV and socio-economic conditions.

1.3 Study Hypotheses

1. Exposure to SGBV has no economic cost on survivors' empowerment.
2. Uptake of GVRCs/RRR programmes does not facilitate the recovery of SGBV survivors.
3. The types of Skills provided by RRRPs have no effect on WEE.
4. Socio-economic conditions are associated with a higher incidence of sexual and gender-based violence

1.4 Literature Review

1.4.1 SGBV Prevalence

SGBV is the most impacting¹ issue affecting women¹ across the world. Globally, there are more than¹ 736 million or¹ 35% women who have been exposed to SGBV (UN Women, 2021). A few others are casualties due to lack of finance, which keeps them from accessing the required assets, education¹ as well as taking an interest in productive jobs and businesses. SGBV happens in various structures fluctuating with financial and social foundations, and women are expected to speak out openly about it, rather, allow it to happen to them, as well as legitimize SGBV. This position has extremely devastating consequences to women survivors as well as their families. In Kenya, SGBV emanates from social cultural inequalities grounded on gender roles and disparities

among communities, stemming out from power differentials between genders. SGBV's centrality is on patriarchal power allocated to male members of the community and condoned by culture. Hence, women's subordinate status in many communities, combined with an overall powerless position as compared to men, make them more vulnerable to bargain for their rights, hence susceptible to violence. As such, instances of SGBV¹ in Kenya¹ have accelerating, more so¹ during the¹ Coronavirus pandemic.¹

CREAW¹ (2021), reports¹ that SGBV cases¹ in Kenya have risen by¹ 42.0% during¹ the pandemic at 47.0% of women¹ compared to 3.0% men being subjected to SGBV¹ during this¹ period. In addition, ¹the Gender Violence¹ and Recovery¹ Centers (GVRCs)¹ and Rescue, ¹Rehabilitation and¹ Reintegration Programs¹ (RRRPs) have¹ been recording ¹an increase in the number of¹ survivors during¹ the pandemic (NGEC 2016). For¹ instance, the¹ Nairobi Women's Gender and Recovery Centre report (GVRC, 2020), shows that the centre admits 3,000 survivors every year, with the numbers rising during Covid-19 pandemic. In another report, (Nairobi Women's Hospital 2015) GVRC concedes that the numbers admitted at the centre are mostly women at 56% and young girls at 36%. In¹ Tharaka Nithi, ¹the National¹ Crime Centre¹ (2018) registered 23.8% SGBV related offences in¹ the County. Notably, with Covid-19 pandemic restrictions, this number may be on the rise. In another research by the State ¹Department of ¹Gender Affairs ¹in Kenya, (UN¹ Africa Renewal ¹Magazine 2017) results showed that 5 in every 10 women between¹ 15 to 24 year of age¹ accept that men have power over women and may violate them without redress. Further, the research revealed that in the period 2013 – 2017, there were over 47,000 SGBV cases recorded through the government call centres. This is relatively low as compared to reports from NGOs, as wells as the shelters where reports indicate higher numbers as shown elsewhere in this proposal. As such, this is a pointer that SGBV still remains in private rather than public domain hence the need to break the silent of this form of violation.

In a 2016 overview on¹ SGBV, the¹ Institute of¹ Economic Affairs¹ (IEA) and¹ the local Daily Nation shared in a report shared indicated that 40.0% women and 10.0% men had been survivors of SGBV. In¹ addition, over 26.0% of women and 7.0% men had encountered physical and sexual maltreatment in 2016 alone¹(Daily ¹Nation, 2016). However, the report conceded that men are the main violators. However, there is information gap as to the degree of¹ SGBV meted among¹ men in¹ the country. Furthermore, Jewek et al. (2010) too contends that there is hardly study reports as to the extent of men's violation due to many studies basically focusing on women.

1.4.2 Socio Economic Costs of SGBV

Researchers recognize the nexus between SGBV and access to finance to an extent economic empowerment. A World bank report (2018) put a value of economic loss of about 1.2% - 3.7% of developing countries GDP due to SGBV. Globally however, the UN Women report (2016) puts the economic loss of the vice at 2% of global GDP. In yet another study investigating economic costs on violence against women in Bangladesh by Siddique (2011) revealed the country lost 2.7% its GDP to the vice. In ¹Uganda (UNCEA, 2012), women lost about 9% of their incomes due to

constrained working hours, as a result of SGBV, cumulatively totaling to around 11 days of productive work per year. Information from NGEK (2016) in Kenya also stipulates a percentage between 7.8% and 10% loss of GDP due to SGBV. Similarly, the same report (ibid) indicates that cases brought by survivors to police gender desks in the same period costed Kshs 820 in terms of transport expenses, and Kshs 2,320 for other related expenses such as food and other incidentals. Cumulatively, the report indicated a total Kshs 3.10 billion was incurred supporting the SGBV survivors in the country through transport, processing police reports and affidavits, doctors' fees among others (ibid). This is an indication that social and financial expenses of SGBV replicates itself at individual, family, business, government, and society levels (Duvvury¹ et al. 2013; Day, 2005; 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 health conditions, lack of access to services such as reproduction and maternal health care, loss of time and property (Bacchus et al. 2018; WHO 2013; Duvvury and Minh, 2012). SGBV can also have short, medium and long-term effects such as impacts on professional development, continuation of education, mobility and upward progression in formal employment, lead to disability, mortality and morbidity, family stability as well as in terms of loss of quality life (Sabia, Dillis, and DeSimone 2013; Crowne¹ et al. 2011; Reeves¹ and O'Leary-Kelly 2007). However, there is information gap as to the actual loss of incomes of families and survivors as well as loss of productive time for businesses and employers due to SGBV. The data collected from this research will be utilised to enhance advocacy work at government, private and economic sectors to invest more in the SGBV programmes and protect survivors of the vice. Demonstrating these costs through evidence-based data, will help to influence government, private and informal sectors to respond to SGBV by developing gender-responsive policies and establishing effective units to prevent and manage SGBV. When it is clearly demonstrated that SGBV affects the profits and has an economic and social cost, there would be an incentive for businesses to lobby governments to work towards effective strategies and to implement their own prevention and support programmes as pointed out in a report by (NGEK 2016).

1.4.3 SGBV Prevention Programs, Response Measures and Stakeholders Analysis

Governments¹ globally and¹ in Kenya, have come up with policies and strategies to address SGBV through signing global commitments in terms of conventions and treaties, hence recognizing the effects the vice has on women (UN Women (March 2021). The prevention and response of SGBV in many countries has different actors such as private organisations, civil society organisations, media and development partners. However, there has been no clear distinction of the areas these actors focus on; there are indications on specific areas of programmes in their operations. 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, collection of information and data, development, and implementation of policies of SGBV at workspaces, as well as laying out procedures of the referral systems of survivors. The framework has also set out the roles of Civil Society Organisations which include information and data collection, referral systems, policy development, programming on SGBV, resource mobilisation procedures, research for evidence-based advocacy for prevention and response to the vice (Ministry of Devolution and Planning, 2014). Additionally, the Kenya Government's Third¹ Medium Term¹ Plan 2018-2022 (GoK, 2018) has set out as its priority, the prevention and response to SGBV. Further, the national

government has intentions of setting up One-Stop¹ SGBV Recovery¹ Centers in all counties together with several health-related institution. At the county levels, the government plans to enhance research on the vice, as well as setting up SGBV information management systems. Other efforts to address SGBV by the government include; the launch of a program with the UN, that is the GOK/UN Joint Program on Gender Based Violence (JP-GBV), which is has five pillars namely; Prevention, Protection, Prosecution, Programming and Partnerships which are all interlinked and underpinned through a plan of strong coordination, communication, advocacy, innovation, all leveraging on ICT and policy related dialogues at the national government and county government levels. Similarly, other strategies set out to address SGBV include helpline such as, The National GBV helpline 1195, Children's Department's Child line Kenya Helpline 116, GOK/UN UWIANO SMS Platform 10 for reporting any kind of violence, The Kenya Police helpline 999/112. The Kenya National Action Plan (KNAP) based on the United Nations Security Council Resolution (UNSCR) 1325 on Women, Peace and Security is another response mechanism set out by the government to monitor and address violence against women in line with the Resolution. The Civil Societies too have call centres to address SGBV such as Kimbilio SGBV helpline 1193, LVCT's one 2 one 1190 helpline and FIDA 21661 short message services platform. (NGEC, 2016).

The county governments too, have set up centres to address SGBV for example, the launch of GVRC in Makueni, Kilifi, Taita Taveta and Meru counties. 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 no-state actors have developed a multi-stakeholder strategy to capacity build of vulnerable people to combat SGBV, as well as supporting in provision of rehabilitation centres for survivors, counselling, referral and legal services, economic empowerment kitties among others. The development partners too finance SGBV initiatives through providing technical support to key state and non-state actors and communities for participation in awareness raising campaigns and in the Alternative Dispute Resolution systems (ADR) initiatives, reporting mechanisms of incidences of SGBV and encouraging actors to use the existing services to address SGBV (Ministry of Devolution and Planning, 2014). Other sectors include the Media which has been singled out to play the important role of SGBV's awareness creation, policy dissemination and gender responsive interventions (ibid).

Noticeably, there are a number of preventative models adopted by stakeholders to address SGBV in Africa such as SASA! Approach. Specifically, NGOs in Kenya have successfully implemented the prevention approach in Kibra, Nairobi County. The¹ term 'SASA' is a phased approach to addressing SGBV, that is; Start, Awareness, ¹Support and Actions. The first phase 'Start' stage is the phase of contemplation, which includes raising awareness to the community members, who in turn start to understand the interconnectedness of SGBV and HIV & AIDs (or loss on incomes) through open conversations with one another. Through this awareness, the communities identify the power within themselves to address and stop SGBV, and the community identifies power within itself to stop SGBV. The second phase of 'awareness' focuses on how men use power over

women which results to violence against women. The third phase, ‘Support’ involves documenting of experiences from community members, how they have supported survivors of SGBV, especially talking to men who have become champions in addressing the vice, who join others in sensitisation. The last phase is Action, which is the final step in the approach, involving both men and women taking action to prevent SGBV using the power they have developed within themselves. The models take one-year training and it has been growing in its usage among many actors addressing SGBV, and to date has been implemented in several operations in the region (Raising Voices, 2020). Ideally, the SASA approach is different from the proposed Tamar Campaign Model for this study, which is anchored on religious beliefs (ibid, 2020).

Additionally, the United Nations HeForShe Campaign, initiated by the United Nations in 2014, mobilizes men to support women’s empowerment, as well as addressing issues of gender equality (The UN Women, 2020). There are also specific initiatives involving men to challenge social norms that justify SGBV, monitor and raise awareness, rescue survivors and provide linkages to service providers. The initiatives include Men for Gender Equality Now, Men Engage and Peace Initiative Kenya among others. In addition, the Cultural and Religious Leaders Project spearheaded by the Pan African NGO, FEMNET and other partners in Meru, Tharaka Nithi and Homabay mobilizes leaders to monitor SGBV and lead their communities towards eradicating it. However, the initiatives face skepticism about their motivation due to the stereotyped belief that only ‘hen-pecked’ men talk about gender equality. The skepticism even emanates from some women’s organizations that consider men’s involvement as an unwelcome competition for donor funding and transgression into their territory. The male activists are also often forced to house survivors in their own residences due to shortage of institutional shelters and rely on personal resources to carry out the work, which FEMNET reports as counterproductive (FEMNET, Annual Report 2014).

Other key players include the Community Education and Empowerment Centre which raises awareness on the connection between negative masculinities and SGBV in Nairobi, Kiambu and Uasin Gishu. In addition, local NGO, CREAM also engages law and policy makers on development and implementation of regulatory frameworks concerning SGBV. It also applies the SASA Approach! to stimulate community-driven actions such as counselling support, litigation services to SGBV women survivors across Kenya and particularly in Kibra, Nairobi. The NGO also supports formation of survivors’ support groups to prevent and support cases of SGBV. CREAM reports also points out at the policy gaps in addressing and documenting the SGBV survivors as well as linking them with WEE programmes (CREAW, 2021).

Women’s Empowerment Link (WEL) too, works with multi-sectoral working groups in Nairobi, Naivasha and Mombasa, to empower women with skills for economic empowerment, though the gaps exist in the traceability and follow-up of these survivors. The Coalition on Violence Against Women (COVAW) runs a Safe Spaces Project in Kwale to create a critical mass of girls and young women who can challenge the normalized violence and the beliefs underlying it (COVAW

Strategic Plan, 2018 – 2023). However, the challenge remains on how to link the survivors with financial resources for WEE. At the county and community levels, specific actors working to prevent and respond to SGBV in Kenya include: chiefs, ward administrators, vigilante groups, male anti-GBV champions, religious leaders, community elders, *Nyumba Kumi* operatives; the law enforcement agencies (police gender desks, probation office, judiciary), sectoral service providers (health services, shelters and rescue centres, Government's Children's Departments, Children's homes, County Commissioners' offices, offices of County Women Representatives, County Gender Departments, school teachers), and civil society (NGOs, CBOs and FBOs) (NGEC, 2016; National Agriculture and Inclusive Growth Project, Gender Analysis Study, 2020 – unpublished Reports). However, these actors lack in terms of SGBV sensitive approaches in addressing the vice at these levels. There are very few referral systems for WEE, policy, as well gender sensitive training gaps. Similarly, other strategies laid out by the government to address women economic empowerment such as the Women Enterprise Fund (WEF); The Consolidated Social Protection Fund; Affirmative Action Policy; Youth Empowerment Centres and Youth Enterprise Development Fund. These initiatives by the Government link all women to ensure WEE. However, it is not clear how many of SGBV survivors have been able to access these funds for economic empowerment, which this study will endeavour to link SGBV survivors with information on the access. As it can be stated here, the initiatives, though numerous are fragmented and with little evidence that their effectiveness has been evaluated. Oxfam (2019) too acknowledges that the planning on how to reconstruct the response to SGBV in a systematic and effective way is lacking. In addition, how to mitigate, not only the symptoms but its root causes have not been addressed.

A UN Women (2019) report also points 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. NGEC (2016) too, alludes to a gap in SGBV management, especially on the trainings for health staff, social workers, the judiciary, security agencies, and policymakers, there is also a clear hiatus in policy guidelines on service delivery and awareness creation on SGBV. Other gaps include limited coordination of stakeholders, weak data management, poor Monitoring and Evaluation framework, lack of evidence research to inform policy advocacy as well as for program development in SGBV. In addition, deficient rehabilitation and reintegration programmes targeting SGBV survivors and specifically perpetrators, scarcity of evidence base information on what works in terms of SGBV prevention, linkages with different economic sectors, and low levels of male involvement in SGBV prevention and response initiatives are evident (NGEC, 2016). There are also few shelters and safe houses to meet the demand, lack of rehabilitation to cater for the survivors, additionally few registered rehabilitation programmes for the violators and finally, inadequate mechanisms to systematically address preventative measures of SGBV (ibid, 2016). The Constitution has not provided for solutions on how to address socio-cultural context to set women free of violence, nor has it provided for frameworks that could be used to educate citizens to reject violence and the culture that perpetuates it.

1.5 Methodology and Approach

This pilot study adopted a mixed method design combining both qualitative and quantitative approaches firstly to conduct an exploration of the economic cost of SGBV on survivors and then to evaluate effectiveness of existing RRR programmes on facilitating recovery and WEE.

1.5.1 Research Design

a) Exploratory Survey

To support the qualitative analysis, the exploratory approach was used as it is aligned to the phenomenological methodology. William (2006) cited in Gumani and Mudhovozi (2013) defines an exploratory survey as an open, flexible, and inductive approach to research, which addresses questions of all types and attempts to look for new insights into a phenomenon, hence its applicability in SGBV research so as to answer different types of questions. The exploratory survey addressed objective 1 and 2 on the economic cost of SGBV and the effectiveness of RRRPs/GVRCs by allowing collection of qualitative data from women survivors in RRRPs/GVRCs or that have gone through RRRPs/GVRCs

b) Accounting Model

To evaluate the economic impact of SGBV on the selected survivors, an accounting model was utilized taking cognizance of both direct and indirect costs of SGBV. Direct costs covered out-of-pocket expenses incurred in dealing with violence suffered by individual woman as well as the total charges of service provision to survivors by RRRPs such as on health and law enforcement. Indirect costs comprised the value of what is lost as a result of SGBV. This includes income lost from closure of business, jobs lost, increased absenteeism, decreased productivity in the workplace, changes in living standards, quality of life, change in alcohol and drug use. The accounting model multiplies the unit cost of a service by the number of times the service was provided to each beneficiary.

The study adopted the methodology as used by Duvvury (2016) to calculate the cost of SGBV.

Cost incurred to seek health services

The formula in equation 4.1 was used to calculate the actual cost incurred to seek health services

$$TDOPC = \sum_j \sum_i \sum_s C_{is} \dots \dots \dots 4.1$$

Where;

TDOPC- total survivors out of pocket cost, j- type of incidence reported perpetrated by either husband, fiancé, stranger, i-index of the victimized woman, s- service sought, C_{is} - cost paid by the woman for the services.

Lost working days

The study used equation 4.2 to determine the SGBV cost due to lost working days

$$COWDL = \sum_j \sum_i \{FE_i \times FD_i + HE_i \times HD_i\} \times \dots \dots \dots 4.2$$

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

Cost of lost School Days

The study determined the cost of lost school days using equation 4.3

$$COSDL = \sum_i \{C_i \times LD_i\} \times \dots \dots \dots 4.3$$

Where; COSDL- cost of school days lost, C_i - yearly school fees or numbers of days in academic year, LD_i - days lost by the woman's children or girl survivors.

Lost Domestic Work

Equation 4.4 was used to estimate SGBV cost to domestic work days lost

$$CODWDL = \sum_j \sum_i \{RW_i \times AH_i + D_i\} \dots \dots \dots 4.4$$

Where; CODWDL- cost of domestic work days lost, RW_i - minimum hourly wage rate in household service for woman, AH_i - daily hours spent in domestic work by the woman/ survivor, D_i - woman number of days lost for domestic work.

Total costs

Total SGBV costs is a summation of direct and indirect costs as shown in equation 4.5

$$TSGBVC = TDOPC + COWDL + COSDL + CODWDL \dots\dots\dots 4.5$$

Where; TSGBVC is total SGBV costs.

c) Logistic model

A multinomial logistic regression will be used to compute the relative risk of reporting adverse health outcomes due to SGBV. Logistic regression is the most frequent method for modeling connections with a binary outcome variable. Such associations can be estimated and conveyed as relative risks. Relative risk regression is preferred as it allows the direct assessment of relative or prevalence risks.

The logistic function could be written as:

$$\text{Log}\left(\frac{a}{y}\right) = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \dots + \beta_n X_n \dots\dots\dots 4.6$$

Where y includes all the cases (non-cases as well as cases), and X_i is the characteristics (factors that lead to SGBV occurring in a society or a community or among partners which the study can simply categorize as covariate) while β_0 is the constant term that defines the magnitude of SGBV in the absence of factors considered and β_i are the coefficient of the covariates that determine the relationship between the dependent and the independent variables in the study.

1.5.2 Piloting

Piloting for this study was done in Nairobi Women's Hospital GVRG in Nairobi County and Women's Empowerment Link (WEL). Nairobi Women's Hospital GVRG was founded in March 2001. GVRG is the charitable trust of The Nairobi Women's Hospital. GVRG's main purpose is to bring back meaning to the lives and families of survivors of sexual and gender-based violence by providing free medical treatment and psychosocial support. This site was selected as it was the first GVRG in the country upon which other GVRGs in the country have been modelled.

The participants were women survivors who had gone through the center. Sekaran and Bourgie (2009) opines that a 5- 10 per cent of the main sample makes an adequate size of sample for pilot study. Therefore, this study targeted 32 women survivors (around 5% of the actual Sample) for

piloting. The instruments were administered to the survivors upon random selection, which was done after approval and informed consent protocols had been adhered to. To select the participants, a meeting was held with the management of Nairobi Women's Hospital GVRC, to explain the rationale of the research and role they were expected to play. A list was sought from the management of the GVRC. Thereafter, a meeting with the survivors was organized and piloting of the tool done. To participate in the piloting, the woman survivor must have sought help from the GVRC and graduated in 2018 and 2019. The arising data was analyzed with the aim of establishing the soundness of the instruments, reliability and validity.

1.5.3 Study Sites

The research was conducted among survivors who had sought assistance at two distinct locations: Makueni GBVRC in Makueni County and Life Bloom Services International (LBSI) in Naivasha, Nakuru County. Makueni GBVRC, operated by the Makueni County government, is a specialized facility dedicated to addressing and preventing GBV. It offers a range of support services for GBV survivors, including medical care, legal aid, psychosocial support, and other forms of assistance. The primary objective of Makueni GBVRC is to aid survivors in their recovery and empowerment while promoting gender equality within the community. On the other hand, LBSI is a non-profit organization based in Naivasha, Kenya, with a mission to improve the lives of local communities by providing essential services such as education, healthcare, and clean water. LBSI also extends support and resources to individuals and families affected by poverty, HIV/AIDS, and GBV.

1.5.4 Sample Size and Sampling Technique

The desired sample size for women survivors who have gone through the GVRCs was determined after calculating the full study sample. The total desired size was arrived at using Slovin's formula (Isip, 2015) as illustrated below:

$$\text{Sample size} = \frac{\text{Population size}}{1 + (\text{Population size})(\text{Margin of error})^2}$$

With a total target population size of 396 and a 5% margin of error, the sample size will be:

$$\text{Sample size} = \frac{396}{1 + (396)(0.05)^2} = 199 \text{ participants}$$

Total eligible Sample size was 199 women survivors. This included 123 from Makueni GBVRC and 76 from LBSI.

1.5.5 Sampling Procedure:

A complete enumeration survey was employed to include all eligible participants in the study. This approach is ethically sound and reliable for GBV research, aligned with Reliefweb's (2018) recommendations for conducting research on GBV in communities. The distribution of

respondents across the two facilities was 61 percent in Makueni GBVRC and 39 percent in LBSI-Naivasha.

A complete enumeration to include every eligible participant who was willingness, available and consent to participate, a total of 149 women survivors participated in the study. This included 91 from Makueni GBVRC and 58 from LBSI. The total percentage of the participants was 75%.

In implementation, the study reached 149 survivorsⁱ distributed as indicated in Table 1.1. below. The respondents were randomly selected from the master lists provided by the initiatives after screening to ensure that they fulfilled the inclusion and exclusion criteria.

Table 1.1: Distribution of Study Respondents (were they selected randomly?)

Location	Frequency	%
Makueni (GBVRC)	91	61.1
Nakuru (LBSI)	58	38.9
Total	149	100.0

Source: Study Data (March,2022)

Table 1.1. shows that majority (61.1%) of respondents were sampled from Makueni County and the minority (38.9%) form Nakuru County. Attainment of the desired sample was constrained by a number of factors. First, the master lists provided, especially from Makueni GBVRC, included minors and adults who were not actually survivors but had accompanied the latter to the centre. Second, many of the survivors were no longer residing in the counties of the study and were therefore geographically remote. Third, a number of targeted respondents were unreachable physically and on phone. Fourth, some survivors who had originally consented to the interviews reneged and were therefore not interviewed. The factors notwithstanding, this was a qualitative study hence emphasis was lid on the richness of information received and its interpretative value rather than the bulk of responses. Moreover, the initiatives studied are unique hence the research findings are representative.

1.5.6 Inclusion and exclusion Criteria

To participate in the RRRP/GVRC study, the following inclusion criteria was used for Women Survivors who have gone through RRRP/GVRC:

- A woman SGBV survivor 18 years and above
- Must have sought services from RRRP/GVRC
- Must be post one year since leaving the RRRP/GVRC
- Must have sought help from the RRRP/GVRC and graduated during 2018 or 2019
- Willingness and consent to participate

1.5.7 Data Collection Research Instruments/tools

This study utilized an interview schedule and a questionnaire used to collect data from the RRRP survivors. The interview schedule was to gather data from managers of the RRRPs. This study

will utilize both primary and secondary data. Specifically, the qualitative data collection tools included:

- (a) **In-depth Interviews schedules:** In-depth face to face interviews were conducted with the women SGBV survivors to gain a deeper understanding of their experiences in RRRPs. These interviews ensured that participants give answers in their own words. **The in-depth interviews** aimed to record *own* feelings, impressions, and changes experienced by the SGBV survivors according to what they felt comfortable sharing and regarded as important and relevant to their personal growth.
- (b) **KII-** these targeted the leaders in the RRRPs/GVRCs as well as duty bearers in the selected locations.

All interviews, were captured using notebooks and recorders with the informed consent from participants.

The recruitment of respondents will took cognizance of the need to protect survivors of SGBV and closely aligned to the WHO (2016) ethical and safety recommendations for research on domestic violence against women protocol. Identified participants were approached to participate in the study individually. In this process, the purpose of the study and use of the data were explained in detail. Targeted participants were asked to indicate that they fully understood the explanation and where affirmative, they were then asked to grant consent verbally and to sign the informed consent form which ascertained that they were above 18 and had legal capacity to make such consent. Targeted respondents were assured that their names and personal details would be anonymized in the report and identifiers would be immediately removed after analysis. Meetings with targeted respondents to explain the study and get consent were held in private, secure and discreet locations in order not to raise curiosity. Targeted survivors were asked to indicate a place of preference where they could meet the researcher for the initial meetings to ensure that they were exposed to the public and their safety and security not jeopardized. Privacy and discreteness was maintained at all times to avoid stigmatization on the part of the survivors.

1.5.8 Data Analysis

Quantitative data generated in the study was analysed using measures of central tendency, measures of dispersion and percentages. Multivariate logistic regression was used to establish the economic cost of SGBV, impact of skills gained at RRRPs/GVRC on survivor's economic empowerment. Qualitative data was analysed by firstly coding (denotation of theme or variable identified from the data and developing a matrix with units fitting into a specific variable). The data was classified thematically and according to the variables of study which involved identification of the textual material: what is key from among a large amount of information, contextualization of the textual material – identification of the origin of material, the source, the context under which it originated, creating distinct categories of analysis based on the theoretical conceptions- this is guided by emergent ideas and concepts, establishing procedure for analysis – choice of the schematic procedure e.g percentages or frequencies, defining units in the analytical framework and interpretation of the results – reporting meanings and inferences from the analysis.

1.5.9 Ethical protocols

All Researchers including enumerators were required to understand, sign and adhere to Code of Conduct. All personnel were trained to understand and commit to creating and maintaining a safe environment for survivors of SGBV and take measures to prevent, detect and appropriately respond to any instances where there is likelihood abuse or exploitation are suspected due to participation in the research.

a) Confidentiality

WHO (2016) gives guidelines on how to maintain confidentiality and ensure that participants have an opportunity to consider the sensitivity of the research. This should be done through signing an informed consent, and continually using a checklist for ongoing consent. It also recommends researchers use a form to document adverse events or social harms that may affect the participants. The need for confidentiality should be reaffirmed on an ongoing basis and participants should be asked to acknowledge their responsibility to respect the confidentiality of others, especially in FGDs. The researchers continuously seek participants consent to participate in the study and this will be reassessed on a regular basis. Participants were informed of their right to withdraw from the study at any point without any implications on their part. To ensure confidentiality of data collected, recorded verbatim and field notes will be destroyed 3 years after completion of the activity.

Detailed information about possible risks of participation in the study was included in the informed consent form including sensitive types of questions that were therein. This enhanced informed decision making for participation. Further, to ensure anonymity of respondents, codes were used as much as possible to minimize need for personal identifiable information on data collection tools and generated raw data. The research team put in place robust coding system with unique anonymous identifiers to ensure confidentiality of data collected, thereby protecting respondents' privacy.

b) Ethical Review

As a standard procedure, the researchers in this study undertook an ethical review research assessment. Each team member was assessed on their understanding of research ethics to undertake research with survivors of SGBV. Further, the research proposal was subjected to Kenyatta University Ethics Review Committee (KUERC) for evaluation to ascertain that the research approaches adhere to the ethical standards set for such type of studies.

Study sites:
Makueni GBVRC and LBSI

Inclusion and exclusion Criteria:

- A woman SGBV survivor 18 years and above
- Must have sought services from RRRP/GBVRC
- **NB:** Identification of women survivors who meet the above criteria had been a priori made and only those who meet the criteria were in our sample.

Total eligible Sample size (n):
n=199
This included 123 from Makueni GBVRC and 76 from LBSI

- Participants:**
- A complete enumeration to include every eligible participant who was willing, available and consent to participate (n=149)
This included 91 from Makueni GBVRC and 58 from LBSI
 - Percentage of participation was 75%

Figure 1.1: Study flow chart

2.0 STUDY FINDINGS

2.1 DEMOGRAPHIC CHARACTERISTICS

This section presents demographic data on the profile of respondents by age, level of education, marital status, residence, religion and on assistance received from relatives.

2.1.1 Age of Respondents

The study looked at the age of respondents primarily to detect which cohort is most affected by GBV, hence establish the implications of this for their economic empowerment. All study participants were over 18 years of age. Table 2.1 presents the breakdown by cohort.

Table 2.1: Age of Respondents

County	Age Bracket	Frequency	Percentage
LBSI (Nakuru)	18-25 years	5	8.6
	26-35 years	27	46.6
	36-45 years	18	31.0
	46-55 years	5	8.6
	Above 55 years	3	5.2
	Sub-total	58	100.0
Makueni GBVRC	18-25 years	16	17.6
	26-35 years	28	30.8
	36-45 years	26	28.6
	46-55 years	16	17.6
	Above 55 years	5	5.5
	Sub-total	91	100.0

Source: Study Data (March, 2022)

Table 2.1 shows that majority of respondents were in the 26 to 45 age bracket in both study sites, accounting for 79 (66.4 %) of all survivors interviewed. Thus, they fell within the economically productive age group. This finding corresponds with data from the KDHS (2014) which shows that majority (77%) of married women who had ever experienced violence fell in the age brackets 25 to 39. That women in this category face GBV implies an interference with their personal development, empowerment and livelihoods.

2.1.2 Respondent's Religion

Religion predetermines people's beliefs and practices, including attitudes towards and toleration of GBV as well as appropriate solutions to problems faced. Considering how critical religion is in

shaping peoples' perceptions, the study thus sought to document the religious affiliations of survivors. Results are presented in Table 2.2.

Table 2.2: Respondents' Religion

Facility	Religion	Frequency	% age
Makueni GBVRC	Christian - Catholic	26	28.5
	Christian - Evangelical	25	27.5
	Christian – Anglican	40	44.0
	Total	91	100.0
LBSI (Nakuru)	Muslim	9	15.5
	Christian - Catholic	16	27.6
	Christian - Evangelical	10	17.2
	Christian – Anglican	17	29.3
	No affiliation	2	3.4
	No response	4	7.0
	Total	58	100.0

Source: Study Data (March, 2022)

Table 2.2 shows that all respondents in Makueni were Christians. In LBSI (Nakuru), the majority (77.5%) were Christians while 15.5% were Muslims. Additional information from survivors showed that some women opt to remain in violent marital unions due to religious canons on the sanctity and permanence of marriage. Religion is also recognized to perpetuate violence by legitimizing women's subservience (Stiebert, 2019).

2.1.3 Respondents' Education

Formal education facilitates decision-making and equips individuals with knowledge and skills that position them for opportunities in the labour market. Thus it relates to economic empowerment. As such, the study sought to establish respondents' levels of education as an indicator of personal empowerment and potential deterrent to GBV. Table 2.3 captures the findings.

Table 2.3: Respondents' Levels of Education

		Makueni GBVRC		LBSI (Nakuru)	
	Level of Education	Frequency	Percentage	Frequency	Percentage
1	Never attended school	2	2.2	9	15.5
2	Primary	34	37.4	18	31.0
3	Incomplete primary	4	4.4	12	20.4
4	Secondary	30	33.0	9	15.5

5	Incomplete secondary	1	1.1	2	3.4
6	College	9	11.7	5	9.2
7	University	2	2.2	1	1.7
	Total	91	100.0	58	100.0

Source: Study Data (March, 2022)

The results show that majority (82.5%) of respondents had primary and secondary levels of education. Less than a quarter (17.5%) had middle level college and university education. This suggests that exposure to GBV reduces with a rise in women's levels of education. It may be inferred that this is because those with higher education have better knowledge of their rights and freedoms and are therefore ready to terminate abusive relationships. It could also be that education enables them to be self-reliant hence not depend economically on violent partners. Additionally, it is possible that limited ability to afford similar services elsewhere led women with secondary and primary levels of education to predominantly seek services from the programmes. The finding resonates with Marium (2014), which show a positive relationship between a woman's high education level and lower domestic violence, attributed to improved dialogue between spouses, which results in ability to resolve disagreements without resorting to violence.

2.1.4 Marital Status

Marital dynamics are critical in determining exposure to GBV. Being in an unstable marriage may predispose one to violence or one's affiliation after, considering that intimate partners are the majority perpetrators of GBV (Bevilacqua, Williams, Wood, Wamue-Ngare, Thiong'o, Gichangi, & Decker 2022). The study thus documented the marital status of survivors seeking services from the selected institutions before and after the violence. Figures 2.1 and 2.2 show the respective results.

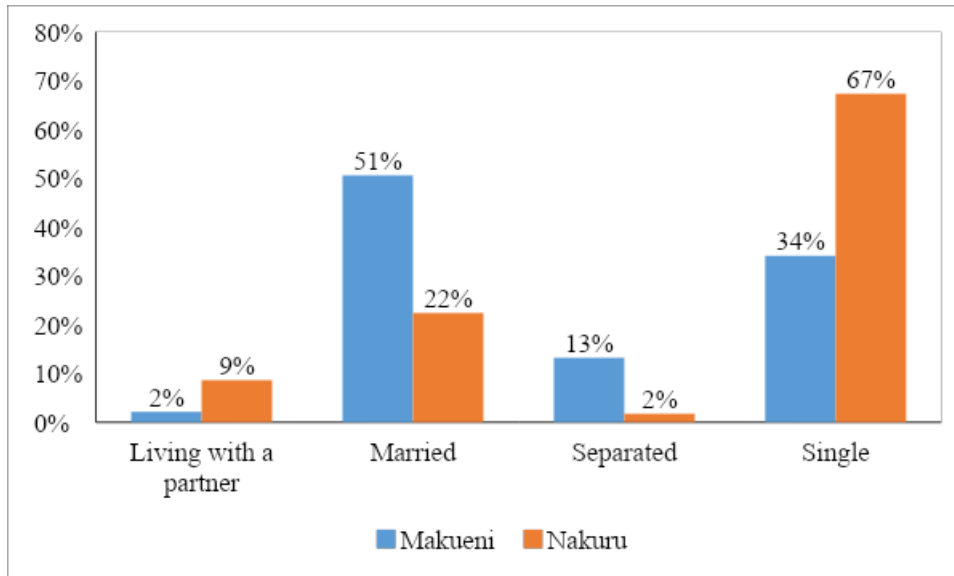


Figure 2.1: Respondents' Marital Status Before Violence. Source: Study Data (March, 2022)

Data in Figure 2.1 shows that majority (51%) of survivors in Makueni GBVRC were married before the onset of violence. On the other hand, most (67%) of those from LBSI (Nakuru) were single. The figure also shows that in Makueni, single women were the next most affected group, at 34%. For LBSI (Nakuru), married women were the second most affected category at 22%. This variation may be associated with contextual factors, particularly the fact that Makueni respondents were largely rural while those in LBSI were partly urban. The pattern from the combined findings shows that married and single women were most predisposed to GBV. This is significant when linked to the fact that intimate partners (boyfriends and husbands) are the main perpetrators of GBV (WHO, 2013; KDHS, 2014). The study further sought to determine the survivors' marital status after the violence. Figure 2.2 shows the distribution.

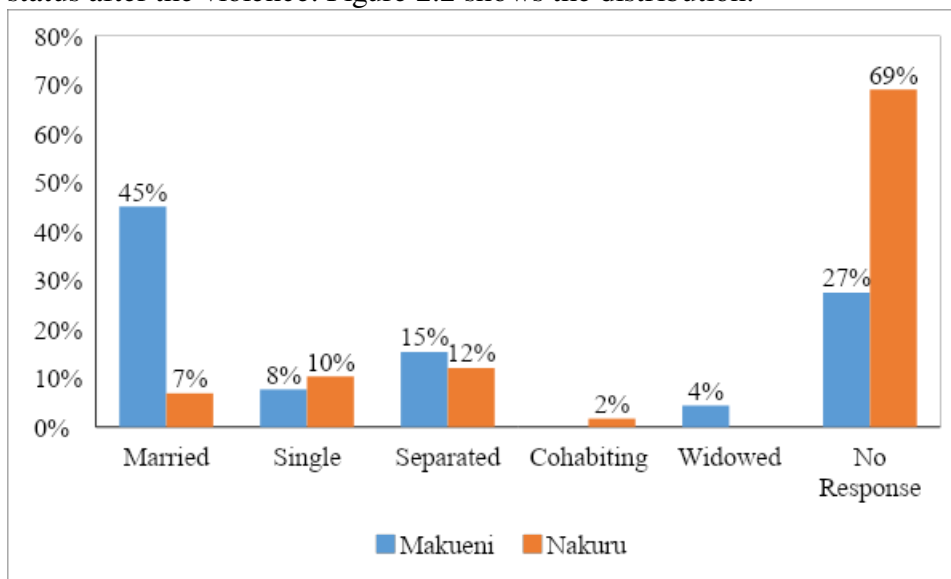


Figure 2.2: Current Marital Status. Source: Study Data (March, 2022)

The data from Makueni shows that slightly fewer women (45%) were married at the time of the study compared to the time before onset of violence (51%). This may be a hint that experience of GBV contributed to 6% separating from their partners.

In LBSI (Nakuru), majority (69%) did not respond to the question, probably an indicator of instability in their marriages. Of those who responded, 15% were separated.

The consistent pattern from both sets of data is that exposure to violence was high among married women, confirming that Intimate Partner Violence (IPV) within marriages is the most common form of GBV against women. This is congruent with Kimuna and Djamba (2008), Akamike, et al (2019) and Shannon, et al (2022).

This study further looked at the age when survivors started living with a partner. This would help in detecting whether the age of a woman determines domestic power dynamics and helps to show the potential longevity of exposure to GBV, if the survivor does not terminate the relationship. Findings on this variable are presented in Table 2.4.

Table 2.4: Age Survivor Started Living with a Partner

Programme	Age	Frequency	Percentage
Makueni GBVRC	Below 18 years	5	5.5
	18-25 years	38	41.8
	26-35 years	11	12.1
	36-45 years	1	1.1
	46-55 years	4	4.4
	No response	31	34.1
	Not Applicable	1	1.1
	Sub-total	91	100.0
LBSI (Nakuru)	Below 18 years	4	6.9
	18-25 years	11	19.0
	26-35 years	3	5.2
	36-45 years	1	1.7
	No response	39	67.2
	Sub-total	58	100.0

Source: Study Data (March, 2022)

Table 2.4. shows that majority (41.8%) of respondents in Makueni started living with a partner when aged 18-25. For LBSI (Nakuru), the majority did not disclose such information. However, 19% indicated that they also started living with a partner at that age. This resonates with Wado et al. (2021) that in Sub-Saharan Africa, a substantial number of women/girls aged 15-25, who are in intimate relationships reported experiencing physical and/or sexual violence. Thus, the onset of GBV seems to come early in marital life. If it persists throughout, then women experience life-long exposure to the vice and its consequences. It is from this context that data was collected on the duration women had stayed in the marriages at the time of the study.

2.1.2 Duration in current marriage

Combined with data on the age at which women entered a union, information on the duration in current marriage helps in establishing the length of time survivors have tolerated violence, from which economic implications can be deduced. Findings are presented in Figure 2.3.

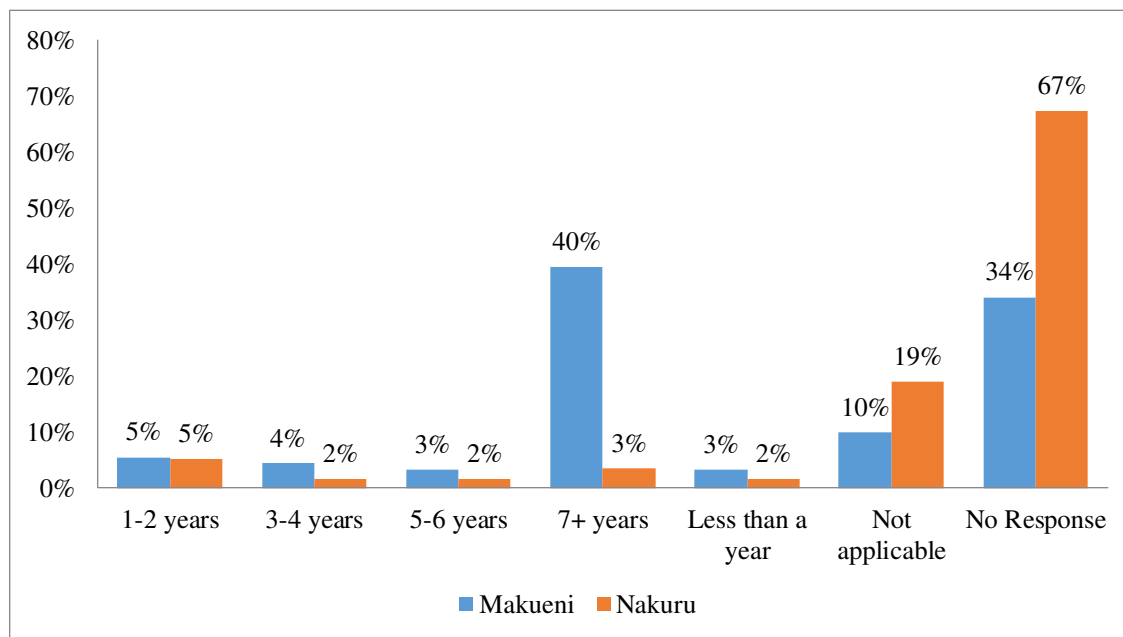


Figure 2.3: Duration in Current Marriage. Source: Study Data (March, 2022)

Only a quarter of the respondents (35 percent) indicated that they had been in relationships that were more than 7 years. Victims noted the difficulty that they often experienced in moving out of abusive intimate relationships is due to stigmatization in the society which may sometimes lead to neglected. One noted that no one else knew that she was experiencing violence and preferred it that way citing it as a ‘private matter’. This may contribute to the longer duration in marriage as well as the lower levels of economic empowerment among the survivors. Another survivor stated that as soon as she started getting money to facilitate her transportation to the GVRC for therapy, she started saving it and started being conscious of her capability for self-sufficiency that led to her separation from her partner after an abusive relationship that spanned 10 years. After SGBV majority (56.4 percent) were forced to change their place of residence and slightly less than a half (43.6 percent) continued to stay with the victims as shown in table 2.4

Table 2.4: Victims Change of place of residence

	Indicator	Frequency	Percent
Makueni GBVRC	Yes	35	38.5
	No	56	61.5
	Sub-total	91	100.0
LBSI (Naivasha)	Yes	49	84.5
	No	9	15.5
	Sub-total	58	100.0

2.1.3 Husband/partner having other partners

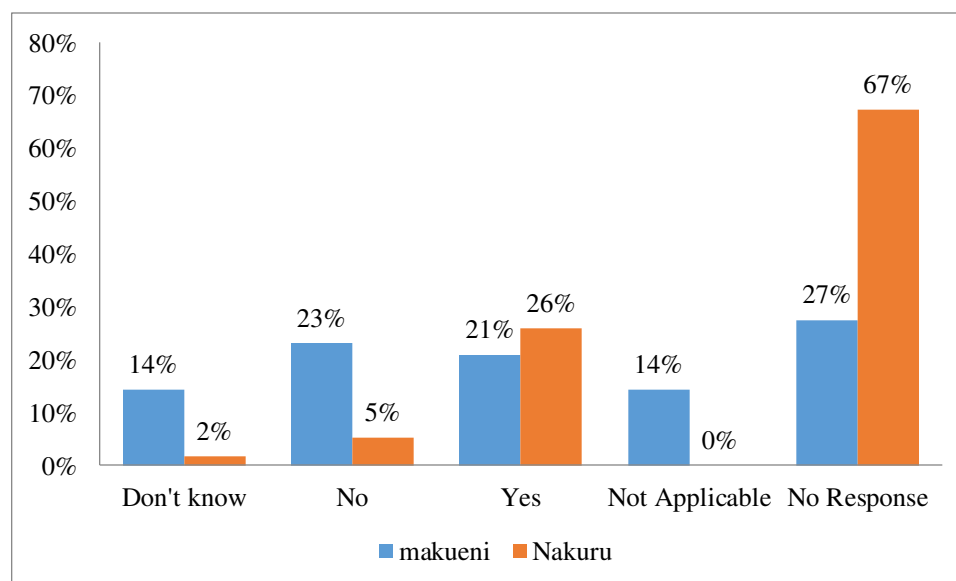


Fig 2.4 Husband/partner having other partners

Findings showed that 48.3% of survivors knew that their husband/partner had other partners while being married to them with 16.8% indicating that they don't know. The survivors who had knowledge of the extra-marital affairs cited the behaviour as exposing them to violence. One noted that his husband had several partners and when she discovered that as the case her partner turned violent. Another indicated that how her partner treated her showed that he had an extra-marital relationship such as dating house girls and other clients.

2.1.4 How extra marital-relationships contributed to the violence experienced

Extramarital relationships have been identified as a significant contributor to violence experienced by survivors based on the accounts of women who sought assistance at Makueni GBVRC in Makueni County and Life Bloom Services International (LBSI) in Naivasha, Nakuru County. The narratives shared by these women highlight the various ways in which extramarital relationships have led to or exacerbated instances of violence.

- **Direct Violence upon Discovery:** Discovering extramarital affairs often leads to immediate physical violence, with partners becoming violent when confronted with their infidelity.
- **Emotional and Psychological Abuse:** Alongside physical violence, emotional and psychological abuses were common, including demeaning comments and threats. This form of violence was sometimes used to isolate the victims, preventing them from talking to others or questioning their affairs.
- **Neglect and Abandonment:** The initiation of extramarital relationships often results in the neglect of family duties, including financial support. This neglect extended to extreme cases in which the partner entirely abandoned their family, including children with special needs.
- **Cultural and Social Dynamics:** In instances, cultural or social pressures compounded the issue, such as advice based on tribal affiliations that led to further mistreatment of the partner and even their children.
- **Financial Implications:** The affairs often had significant financial implications, with perpetrators refusing to pay for basic needs, such as rent and food, further destabilizing the family structure.
- **Threats and Coercion:** Threats of violence, including death threats, were used to coerce and control victims, especially when they attempted to confront or question their partners about extramarital relationships.
- **Impact on Children:** The Violence and neglect also extended to children who suffered from their parents' abandonment and neglect, impacting their physical and emotional well-being.
- **Social Isolation and Stigmatization:** The existence of extramarital relationships often led to social isolation for victims, who were stigmatized and blamed for violence, exacerbating their suffering and hindering their ability to seek help.

These accounts paint a harrowing picture of the intersection between extramarital relationships and gender-based violence, underscoring the need for targeted interventions to support survivors and address the root causes of violence in intimate relationships.

2.1.5 Perpetrator of the Violence

Respondents were asked to identify the perpetrators of the violence they experienced. Figure 2.5 shows the distribution of responses. From Figure above, it is evident that for 36.9% of survivors the perpetrators of violence were husbands, followed by boyfriends at 14.1%. Combined, the two accounted for 41% of the violence which is slightly less a half of the violence. Strangers and others accounted for 11.4% and 12.1% respectively. This implies majority of survivors suffered SGBV in the hands of men they were very close to, and with whom they shared intimate relationships. Thus, intimate partner violence is the most common of violation faced by women survivors of SGBV.

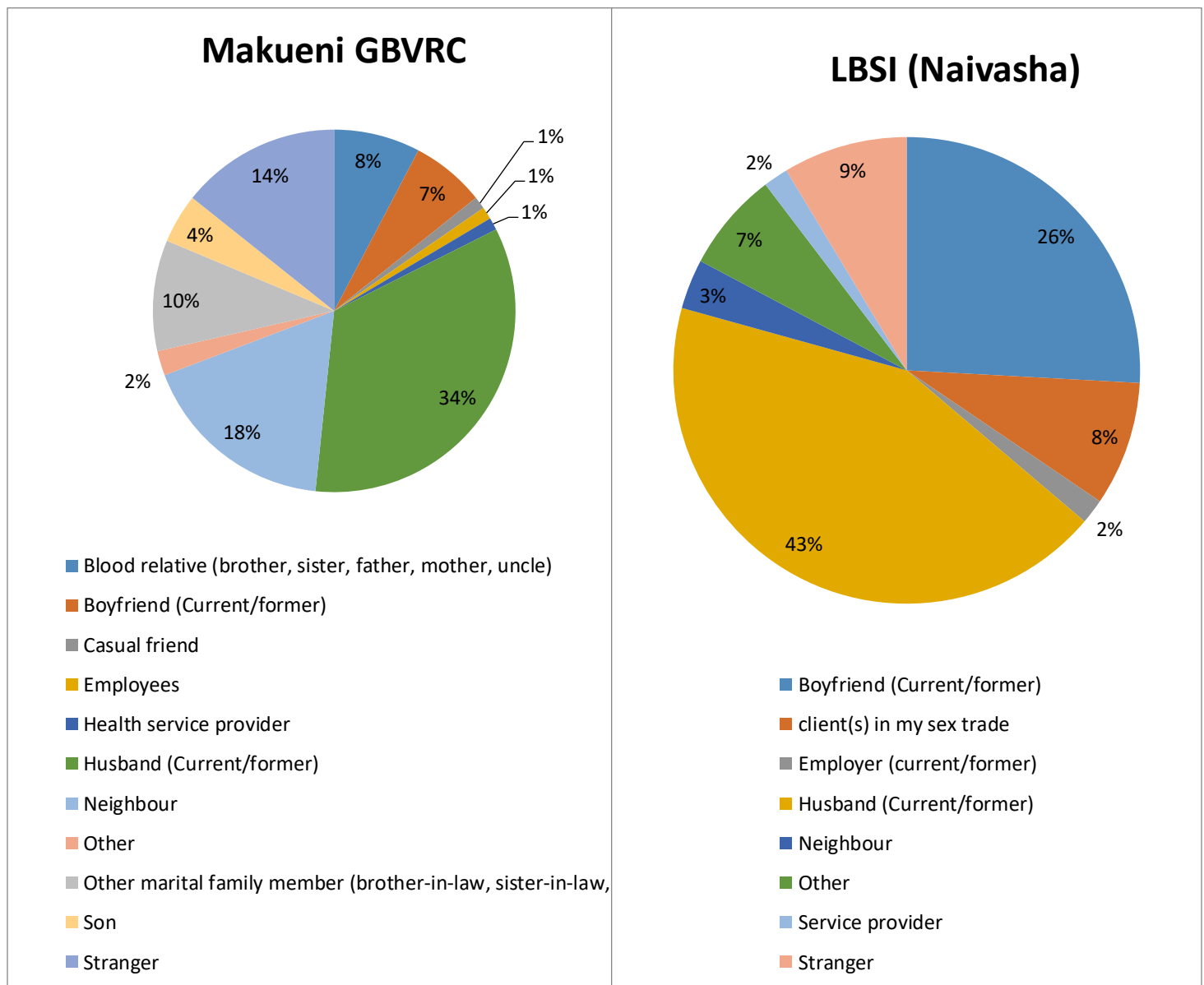


Figure 2.5: Perpetrators of violence

Figure 2.5 detailing the perpetrators of violence as reported by survivors at Makueni GBVRC and Life Bloom Services International (LBSI) in Naivasha, makes the following observations:

At Makueni GBVRC:

- A significant proportion of violence was perpetrated by current or former husbands (34%), indicating that intimate partner violence is a major issue in this area.
- The next largest category was other marital family members (18%), which included in-laws. This suggests a considerable influence of the extended family on personal relationships and possibly in conflict.
- Boyfriends (current or former) were also notable perpetrators, accounting for 14% of the reported cases.
- Other categories, such as casual friends, employees, and neighbors, though less prevalent, still play a role in the landscape of gender-based violence in this region.

At LBSI (Naivasha):

- Current or former boyfriends are the most reported perpetrators at 43%, indicating a higher incidence of violence in non-marital intimate relationships than in Makueni.
- Husbands (current or former) were also significant perpetrators, accounting for 26% of the cases.
- Clients in sex trade represent 9% of the violence cases, pointing to the occupational hazards faced by those in sex trade.
- Employers and neighbors, along with others, comprise a smaller portion of reported perpetrators.

These data points highlight the complexities of gender-based violence, with intimate partners being the most common perpetrators. It also underscores the need for targeted interventions to address domestic violence in both marital and dating relationships as well as support for women facing violence in other social and occupational situations. The involvement of family members and in-laws also indicates that efforts to combat GBV must consider family dynamics and cultural context.

2.1.6 Level of Education of the Perpetrator

The violence rate depends on the level of education of the perpetrator as indicated in Figure 2.6.

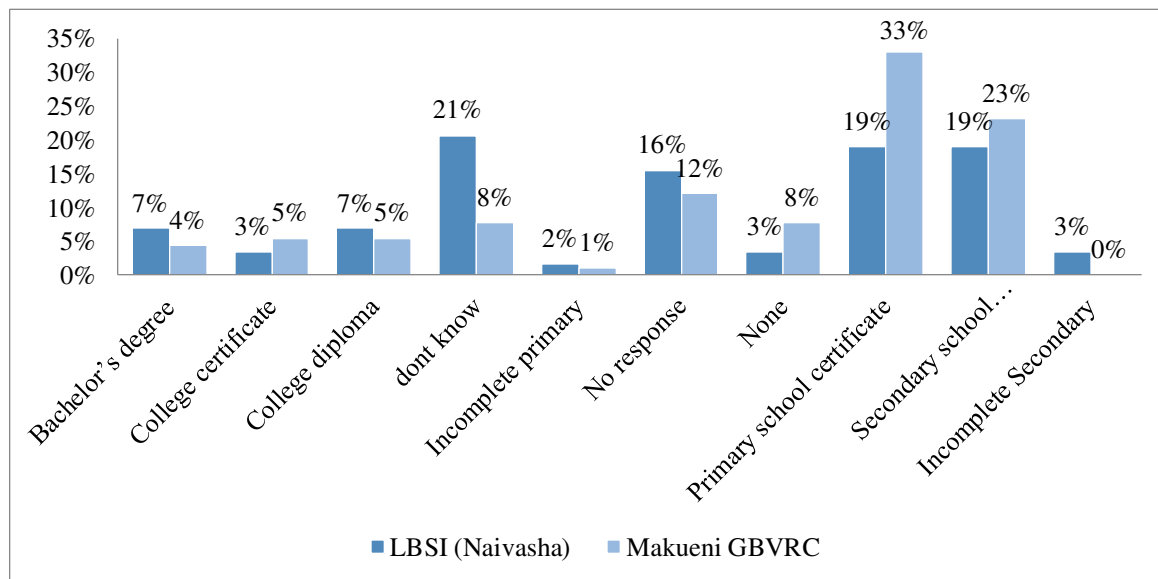


Figure 2.6: Level of Education of the Perpetrator

Figure 206 offers insights into the level of education of the perpetrators of gender-based violence as reported by survivors at Makueni GBVRC in Makueni County and Life Bloom Services International (LBSI) in Naivasha, Nakuru County. The observations are as follows:

At LBSI (Naivasha), the largest group of perpetrators had completed secondary school education (33%), followed by those with no formal education (19%) and those with a college diploma (21%). A smaller percentage attained higher education, with 7% having a bachelor's degree.

At the Makueni GBVRC, the pattern was slightly different. The most common educational background for perpetrators was secondary school, but with a smaller proportion (23%) than in Naivasha. This was followed closely by those with no education (19%) and those with primary school certificates (16%).

In both locations, a significant proportion of perpetrators did not have any formal education, indicating that lower educational levels might be a common trait among the perpetrators in these regions. However, an insignificant number of individuals with a college-level education were also represented.

The category of "Don't know" and "No response" suggests that there may be cases where the survivor is unaware of the perpetrator's educational background or chose not to disclose it, which could point to complexities in the relationship between the survivor and the perpetrator.

It is also notable that a smaller percentage of perpetrators had an incomplete education, whether primary or secondary, which could suggest that interruptions in education may correlate with tendencies toward violence in these cases.

The provided data underscores the diversity in the educational background of perpetrators and may reflect the need for educational and preventive measures that are sensitive to varying educational levels. It also highlighted that while higher education can be a protective factor, it is not a guaranteed safeguard against perpetrating violence.

2.1.7 Age of the perpetrator

Table 2.5 presents data on the age of perpetrators of gender-based violence (GBV) from two different centers: Life Bloom Services International (LBSI) in Naivasha, Nakuru County, and Makueni Gender-Based Violence Recovery Centre (GBVRC) in Makueni County.

Table 2.5: Age of the perpetrator

County	Indicator	Frequency	Percentage
LBSI (Naivasha)	I don't know	12	20.7
	Below 18 years	0	0.0
	18-25 years	4	6.9
	26-35 years	15	25.9
	36-45 years	21	36.2
	46-55 years	5	8.6
	Above 55 years	1	1.7
	Sub-total	58	100.0
Makueni GBVRC	I don't know	13	14.3
	Below 18 years	4	4.4
	18-25 years	9	9.9
	26-35 years	23	25.3
	36-45 years	22	24.2
	46-55 years	10	11.0
	Above 55 years	10	11.0
	Sub-total	91	100.0

The findings were as follows:

At LBSI (Naivasha): A significant proportion of survivors did not know the age of the perpetrator (20.7%). The age group with the highest percentage of perpetrators was 36-45 years (36.2%). The 26-35 years age group also had a substantial representation (25.9%). Very few perpetrators were above 55 years of age (1.7%), and there were no reported cases of perpetrators below 18 years of age.

At Makueni GBVRC: Again, a notable number of survivors were unsure of their perpetrator's age (14.3%). The age groups—26-35 years (25.3%) and 36-45 years (24.2%) had the highest

percentages of perpetrators. Notably, this center had reports of perpetrators below 18 years (4.4%) and above 55 years (11%).

The data from both centers show that the most common age range for perpetrators is within–26–45 year range. There is a slight variation between the two locations in the distribution of perpetrator ages, with a higher uncertainty about perpetrators' ages in Naivasha and a wider age range in Makueni. These age-related statistics are crucial for understanding the demographics of GBV perpetrators and could inform prevention and intervention strategies targeted at the most representative age groups.

2.1.8 Religion of the Perpetrator

Figure 2.7 shows Religion of the Perpetrator from the two study sites.

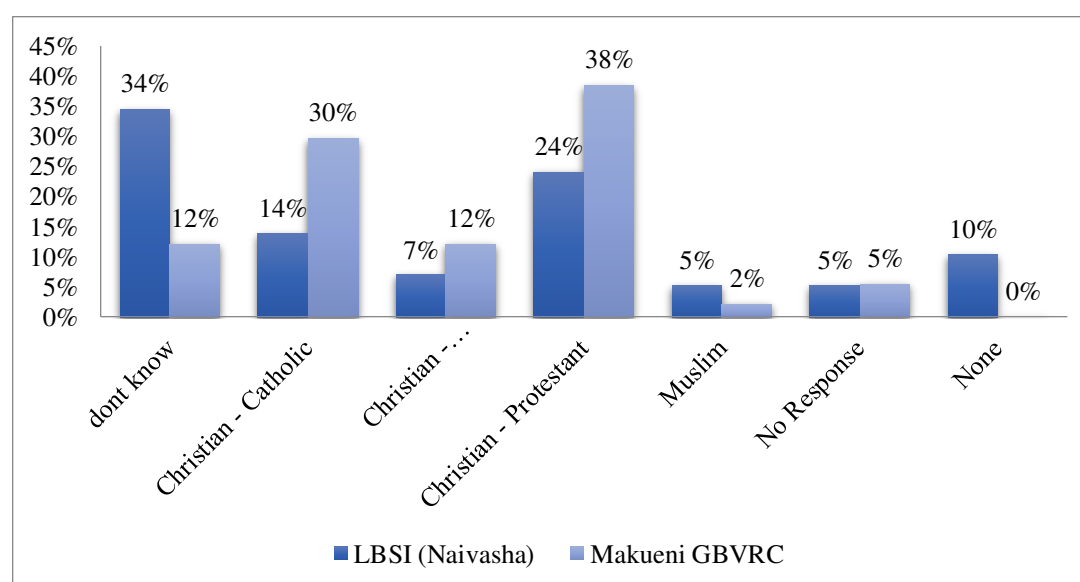


Figure 2.7: Religion of the Perpetrator

Based on the Figure 2.7, we can observe the reported religious affiliations of the perpetrators of gender-based violence as identified by survivors at Makueni GBVRC and Life Bloom Services International (LBSI) in Naivasha:

Makueni GBVRC (Makueni County): The majority of the perpetrators identified were Protestants, accounting for 38%. Catholics were the next largest group (24 %). A significant proportion of the survivors did not know about the religious affiliation of the perpetrator (12%). Only a small percentage were identified as Muslim (5%). There was a notable percentage of cases where there was no response regarding the perpetrator's religion (5%), and no cases were reported of perpetrators with no religious affiliation.

LBSI (Naivasha, Nakuru County): A significant number of survivors did not know about the perpetrator's religious affiliation (34%). Catholic perpetrators accounted for 14% of reported

cases. Protestant perpetrators were identified in 12% of the cases. A smaller percentage of perpetrators were Muslim (2%). There were no reports of perpetrators with no religious affiliation, and a small percentage of the responses did not specify religion (5%).

From the data, we can infer that Protestant and Catholic affiliations were the most reported among the perpetrators in both locations, with a larger proportion of Protestant perpetrators in Makueni County. Additionally, a considerable number of survivors either do not know or do not disclose the religious background of the perpetrator, which could be due to various reasons including the sensitivity of the information or the lack of relevance it has to the survivor's experience. It is important to note that the religious affiliation of a perpetrator does not imply causation or correlation with gender-based violence, but rather reflects the demographics within the surveyed population.

3.0: COST OF SGBV

The first objective of the study was to establish the economic cost of SGBV on women survivors. This section analyzed costs incurred by the survivors of sexual and gender-based violence in the society using different methodologies.

This study adopted a mixed method research design combining qualitative and quantitative approaches to conduct an exploration of the economic cost of GBV on survivors. Specifically, an accounting model was utilized to evaluate the cost of GBV on selected survivors. This model multiplies the unit cost of a service by the number of times the service was provided to each beneficiary (WHO,2013). The total cost of GBV is then simply the sum of all the distinct categories of costs. In addition, a Burden of Disease' design was used to affirm the indirect costs, which spreads over some period of time to a woman survivor. The burden of disease is the impact of a health problem on a given population as a consequence of GBV. It can be measured using a variety of indicators, such as work-time lost due to GBV-related illness, the associated reduction in labor productivity, and the financial cost of dealing with a GBV incidence, such as an expense on legal or counseling services. The burden of disease (BOD) approach, introduced in 1993, has been suggested as a valuable tool for health planning and priority setting, utilizing metrics like disability adjusted life years (DALYs) (Murray & Lopez, 1997; WHO, 2013). A qualitative approach to this methodology was chosen for this study due lack of good data on morbidity, mortality, age of onset, disability severity, and societal preferences for future health and years of healthy life at various ages that is used to calculate DALYs. This is comprehensively quantified with the excess disease burden attributable to exposure to GBV as a risk factor for disease and injury. By so doing, health risks and effects of GBV on survivors was investigated.

3.1 Economic Costs of GBV

Direct costs are actual expenditures incurred by women survivors while indirect costs represent the value of lost labour productivity due to GBV. The total cost is simply the sum of all the distinct categories of costs. These costs are presented both in Kenyan Shillings (Ksh) and their equivalent value in US Dollars (USD). The exchange rate used is Kshs 100 to 1 USD.

3.1.1 Direct Costs

Direct costs refer to actual cash-paid expenses calculated in monetary terms. They include: costs of lost/damaged property, cost for medical care, transport, legal services, counseling, accommodation, and those experienced as a result of children missing school due to the violence. Analyzed separately for Makueni GBVRC and LBSI, respectively, the estimates depended primarily on data collected from the women survivors. The results are shown in Table 4.1.

Table 3.1: Direct GBV Costs

	Makueni GBVRC	LBSI (Naivasha)
Cost items	Estimated cost per survivor (Ksh)	Estimated cost per survivor (Ksh)
Cost of lost/damaged property	17,500 [USD 175]	17,000 [USD 170]
Medical costs	7,344 [USD 73.44]	5,069 [USD 50.69]
Transport costs	3,635 [USD 36.35]	1,389 [USD 13.89]
Legal costs	6,286 [USD 62.86]	2,583 [USD 25.83]
Counseling costs	3,921 [USD 39.21]	3,000 [USD 30]
Accommodation costs	5,000 [USD 50]	5,692 [USD 56.92]
costs as a result of your children missing school due to the violence	33,965 [USD 339.65]	5,400 [USD 54]
Other costs	500 [USD 5]	49,402 [USD 494]
Total	71,865 [USD 718.65]	89,535 [USD 895.35]

Source: Study data (March, 2022)

Table 4.1 provides a detailed breakdown of the estimated costs incurred by the survivors. Survivors at Makueni GBVRC reported an average cost of Ksh 17,500 (USD 175) for lost or damaged property, Ksh 7,344 (USD 73.44) for medical expenses, Ksh 3,635 (USD 36.35) for transportation, Ksh 6,286 (USD 62.86) for legal costs, Ksh 3,921 (USD 39.21) for counseling, Ksh 5,000 (USD 50) for accommodation, and Ksh 33,965 (USD 339.65) for children missing school due to violence. Additionally, there were unspecified "other costs" averaging Ksh 500 (USD 5). In total, the average direct cost for Makueni GBVRC survivors was Ksh 71,865 (USD 718.65). Comparatively, survivors from LBSI (Naivasha) had slightly lower costs for most categories but reported a higher average total cost of Ksh 89,535 (USD 895.35).

3.1.2 Indirect Costs

The study went further to compute the indirect costs, which were measured in terms of productivity losses whose monetary values could be estimated. Variables used were lost working days for survivors and lost school days for children.

(i) Lost working days

From the survey data, the average monthly income for women survivors in Makueni GBVRC was Ksh 5,188 (USD 51.88), translating to a daily income of Ksh 172.93 [USD 1.7293]. 27 working days were lost in GBV cost for the woman survivor due to lost working days. Therefore, the average cost of working days lost per woman survivor in Makueni GBVRC was 4,669 [USD 46.69].

The average monthly income for women survivors in LBSI (Naivasha) was Ksh 8,913 (USD 89.13) translating to a daily income of Ksh 297.1 [USD 2.971]. As a result of the violence, the

woman survivor incurred GBV costs of 29 lost working days. Consequently, the average cost of working days lost per woman survivor in LBSI (Naivasha) was Ksh. 8,616 [USD 86.16].

(ii) Cost of Lost School Days

Survivors with children indicated that the violence they faced trickled down to their children, especially in terms of missing school as the mothers sought alternative accommodation and health care. The text below exemplifies some of the problems experienced by children of survivors.

- *changing schools*
- *Looking for new schools*
- *Acquiring new school uniform as children left all their clothes, books and uniforms behind as they fled,*
- *Purchase of new stationary,*
- *Medical treatment for children injured, psychological counseling fees, legal services, shelter and accommodation provision.*
- *Failing to attend school as a resulted sexual abuse,*
- *Being thrown out of the homes by the abusive fathers.*

The costs as a result of one's children missing school due to violence reveal varying financial demands. For school enrollment, costs are higher in Naivasha (Ksh 10,545 or USD 105.45) compared to Makueni (Ksh 7,333 or USD 73.33), indicating potentially pricier schools or additional enrollment fees. Uniform and stationery expenses also differ, with Naivasha's Ksh 4,899 (USD 48.99) surpassing Makueni's Ksh 3,500 (USD 35), suggesting a local price variation for these items.

Medical treatment costs are quite similar, with Makueni slightly higher at Ksh 6,333 (USD 63.33) versus Naivasha's Ksh 6,000 (USD 60), encompassing potential doctor's fees and medications. In contrast, psychosocial counseling shows a substantial discrepancy, with Makueni at Ksh 9,333 (USD 93.33) and Naivasha at a mere Ksh 500 (USD 5), hinting at differences in service delivery or subsidization.

Shelter costs, covering accommodation like temporary housing, are higher in Naivasha (Ksh 5,333 or USD 53.33) than in Makueni (Ksh 3,533 or USD 35.33), which may reflect the cost of housing or the extent of services provided. 'Other costs'—a category including transportation, legal fees, and food—stand out with Naivasha's considerable Ksh 22,125 (USD 221.25) dwarfing Makueni's Ksh 3,933 (USD 39.33), implying a broader service range or additional survivor needs.

The cumulative cost per survivor totals to Ksh 49,402 (USD 494.02) for Naivasha and Ksh 33,965 (USD 339.65) for Makueni. The stark overall difference suggests Naivasha's higher living costs, pricier services, or a more extensive support network.

Table 3.2 shows the cost of lost school days. The total cost was calculated by multiplying the duration in days the affected child(ren) missed school by the daily school fees cost.

Table 3.2: Cost of lost school days

Makueni GBVRC	School level	Number of children affected	Annual school fees cost (Ksh)	Daily cost (Ksh)	Duration in the days affected child(ren) missed school	Total cost (Ksh)
	Pre-primary	2	14000	78	81	6,300
	Primary	20	14000	78	466	36,244
	Secondary	12	40000	222	400	88,889
	University	1	24000	133	60	8,000
	College	1	24000	133	60	8,000
	Total cost					147,433 [USD 1,474.33]
	Number of women survivors affected					31
	Average cost					4,756 [USD 47.56]
LBSI (Naivasha)	School level	Number of children	Annual cost (Ksh)	Daily cost (Ksh)	Duration in the days affected child(ren) missed school	Total cost (Ksh)
	Pre-primary	10	14,000	78	228	17,733
	Primary	20	14,000	78	389	30,256
	Secondary	2	40,000	222	64	14,222
	University	0	24,000	133	0	-
	College	1	24,000	133	60	8,000
	Total cost					70,211 [USD 702.11]
	Number of women survivors affected					26
	Average cost					2,700 [USD 27]

Source: Study data (March, 2022)

From Table 3.2, the total cost of lost school days in Makueni was Ksh. 147,433[USD 1,474.33]. The number of women survivors whose children missed school was 31. This results in an average cost of lost school days per woman in Makueni at Ksh. 4,756 [USD 47.56].

The total cost of lost school days in LBSI was Ksh. 70,211 [USD 702.11]. Using the sample of 26, the average cost of lost school days was Ksh. 2,700 [USD 27] per woman survivor.

(iii) Lost Domestic Work

The study established that on average, 27 domestic work days were lost by women in Makueni, with 10 hours spent on domestic work per day and an average hourly wage⁸ is Ksh. 30 [USD 0.3]. This gives an average of Ksh. 8,100 [USD 81] per month lost in terms of domestic work per woman survivor in Makueni.

From the Naivasha sample, an average of 29 domestic work days was lost. Assuming 10 hours are spent on domestic work per day and the average hourly wage¹⁷ for domestic work is Kshs. 30 [USD 0.3]. This gives an average of Ksh. 8,700 [USD 87] lost in terms of domestic work per woman survivor in Naivasha.

(iv) Total indirect costs

The total indirect costs of GBV were analyzed and the results presented separately for the two study sites. The results for Makueni GBVRC show that the average total indirect costs per woman were Ksh. 17,525 [USD 175.25]. This comprised of: average cost of lost working days per woman at Ksh. 4,669 [USD 46.69], average cost of lost school days per child at Ksh. 4,756 [USD 47.56] and average cost of lost domestic work at Ksh. 8,100 [USD 81].

The results for LBSI show that the average total indirect cost per woman was Ksh. 20,016 [USD 200.16]. This was higher than that of Makueni GBVRC. The findings show that in LBSI, lost working days by the woman survivor was Ksh. 8,616 [USD 86.16]. The value of lost domestic work was Ksh. 8,700 [USD 87] while lost school days for children amounted to Ksh. 2,700 [USD 27].

3.1.3 Total Cost

Lastly, the study computed the total GBV cost in the two regions. The results show that the average direct cost per woman survivor was higher than the indirect costs in both regions at Ksh. 161,400 [USD 1,614]. The total GBV cost realized by the survivors was Ksh. 109,551 [USD 1,095.51] in LBSI and Ksh. 89,390 [USD 893.9] in Makueni. These data imply that GBV has heavy economic costs often borne by survivors. Although such costs are incurred by individual survivors, they also have an impact on the national economy since a lot of funds are used to address issues that could be avoided, if GBV was absent. These huge amounts of money could be channeled to other development activities that would improve the standards of living and welfare of citizens.

3.2 Non-monetary costs: Health Risks of GBV

Having looked at the cost of SGBV on survivors, the study went further to investigate long term effects after its occurrence. The study delved into non-monetary costs associated with the health

risks of gender-based violence (GBV) to highlight the concealed expenses beyond the direct and indirect financial burdens. These non-monetary costs shed light on the broader and often overlooked impacts of GBV on survivors and society.

Besides incurring huge economic costs as shown above, the GBV often leave survivors with scars, some which never heal. Nevertheless, these often predispose one to numerous stress-related diseases; which otherwise could be avoided, if one was not exposed to incidences of violence. As such, the study sought to estimate the health risks of GBV among women in Makueni and Naivasha using the burden of disease qualitative explanation.

Table 3.3 is a comparative analysis of the consequences of GBV for respondents in Makueni GBVRC and LBSI.

Table 3.3: Comparative analysis of GBV consequences for the two study sites

<i>Facility</i>	<i>Condition</i>	<i>Frequency</i>	<i>%</i>
<i>Makueni GBVRC</i>	<i>Anger</i>	<i>5</i>	<i>5.5</i>
	<i>Anxiety</i>	<i>1</i>	<i>1.1</i>
	<i>Constant fear</i>	<i>2</i>	<i>2.2</i>
	<i>Depression</i>	<i>13</i>	<i>14.3</i>
	<i>Emotional disturbance</i>	<i>35</i>	<i>38.5</i>
	<i>Feelings of hopelessness</i>	<i>1</i>	<i>1.1</i>
	<i>Permanent disability</i>	<i>2</i>	<i>2.2</i>
	<i>Physical injury</i>	<i>27</i>	<i>29.7</i>
	<i>Sexual dysfunction</i>	<i>3</i>	<i>3.3</i>
	<i>Suicide</i>	<i>1</i>	<i>1.1</i>
	<i>Total</i>	<i>91</i>	<i>100</i>
<i>LBSI (Nakuru)</i>	<i>Anger</i>	<i>1</i>	<i>1.7</i>
	<i>Constant fear</i>	<i>1</i>	<i>1.7</i>
	<i>Emotional disturbance</i>	<i>7</i>	<i>12.1</i>
	<i>Loss of self-esteem</i>	<i>1</i>	<i>1.7</i>
	<i>Others</i>	<i>1</i>	<i>1.7</i>
	<i>Physical injury</i>	<i>37</i>	<i>63.8</i>
	<i>Recurrent pain or discomfort</i>	<i>6</i>	<i>10.3</i>
	<i>Sexual dysfunction</i>	<i>1</i>	<i>1.7</i>
	<i>Sexual transmitted infections</i>	<i>3</i>	<i>5.2</i>
	<i>Total</i>	<i>58</i>	<i>100</i>

Source: Study data (March, 2022)

The analysis above shows that approximately 38.5 % of survivors in Makueni were emotionally disturbed compared to 12.1 % in LBSI. Up to 63.8 % in LBSI experienced physical injuries with the corresponding figure in Makueni being 29.7%. Constant fear was more prominent in Makueni than LBSI. This could be related to the fact that the survivors in Makueni were largely staying with their partners while most of those in LBSI may not have been.

The results in Table 3.4 show the distribution of GBV consequences by age across the two study sites.

Table 3.4: Percentage Distribution of GBV consequences by age

Makueni GBVRC					
Health Outcomes	Age Group (Years)				
		26-35	36-45	46-55	Above 55
Suicide			4		
Constant fear			4	6	
Physical injuries	25	39	31	19	20
Depression	18	18	8	25	
Anxiety		4			
Emotional disturbance	38	32	35	50	60
Sexual dysfunctions			13		
Permanent disability	6				20
Anger	13	7	4		
Total	100	100	100	100	100
LBSI-Naivasha					
	Age Group (Years)				
	18-25	26-35	36-45	46-55	Above 55
Recurrent pain/discomfort	20	11	10		
Constant fear			6		
Physical injuries	40	70	55	60	100
Emotional disturbance	20	7	17	40	
Sexually transmitted infections			6		
Sexual dysfunctions	20	8			
Anger			6		
Loss of self-esteem		4			
Total	100	100	100	100	100

Source: Study data (March, 2022)

In Makueni, the results show that physical injuries and emotional disturbance were prevalent in virtually all age groups. For LBSI, recurrent pain/discomfort featured strongly. Overall, the results show that GBV has varied health implications on survivors, ranging from physical to the sexual, psychological and economic. These consequences have an adverse effect on women's economic productivity and quality of life. To eliminate them, it is imperative to prevent GBV.

The verbatim below are from the women of survivors.

- *“I was constantly under stress and under fear of violence and violence itself. Especially after my hand was broken and I was unable to work for 3 months”*
- *“Uterus removed as it was damaged so this is a loss more than monetary”*
- *“I got emotionally disturbed and could not trust men”*
- *“I could not get out of the house due to shame from the neighbours”*
- *“Chronic forgetfulness, I can plan to work on something then I forget.”*

3.3 Discussion

The total direct and indirect costs of GBV constitute a profound economic detriment, diverting resources that could otherwise be invested in productive economic activities. Costs related to healthcare, transportation, legal representation, and counseling not only deplete individual resources but also affect entire families, contributing to increased poverty. The profound financial implications of gender-based violence (GBV) on survivors are unambiguous. The direct costs for a woman survivor (combining both regions) averaged higher than the indirect costs at Ksh. 161,400 [USD 1,614]. There is a significant economic burden of GBV, affecting not just individual survivors, but also reflecting implications on the broader national economy. Despite primary education being free in Kenya, there are still associated costs that parents bear, impacting their financial capability. There is a clear difference in economic impact between Makueni GBVRC and LBSI, especially in terms of lost working days and lost school days, which needs strategic interventions tailored for each area. The findings corroborate with other studies that there is a huge economic loss due to GBV (Duvvury et al., 2012; NGEC, 2016; Breuer, 2021; Siddique, 2011; Day et al., 2005; Walby & Olive, 2014).

GBV against women has huge economic costs that affect survivors, as well as their children leave alone the entire society. The findings corroborate other studies, which noted that children exposed to GBV are negatively affected as they end up having low self-esteem, a factor that compromises their rights (Save the Children, 2021; Finkelhoret al., 2011). It can have severe and long-lasting impacts on human health. These findings are supported by other similar studies (Sanjel, 2013; Mukanangana et al., 2014; Kosterina et al., 2021). Besides high costs to society in terms of time loss and resources, increased use of health services and facilities divert already scarce resources thereby exacerbating an already existing disease burden. This is a drawback to the health sector, which has an impact on the economy. If GBV was adequately addressed through meaningful prevention measures, costs incurred addressing it would be saved, and health facilities would be free to counter the disease burden.

Beyond direct expenses, GBV has opportunity costs, reflecting what women survivors could achieve if they didn't face the consequences of violence. This includes advancements in careers, community contributions, and overall economic progress. Children affected by GBV may also miss out on their full potential due to disrupted education and psychological trauma. Although there is some evidence on general national losses attributed to GBV, there remains a gap as to the

indirect actual loss of incomes to families, survivors and employers, as well as productive time for businesses. Further, unlike NGEI (2016), which was a country study, the current study's focus was on survivors who had sought services at Makueni GBVRC and Life Bloom Services International (LBSI) in Naivasha, Nakuru County. Demonstrating these costs through evidence-based data makes a case for the public, private and informal sectors that manage GBV to shift focus to investing in prevention programmes, at the same time strengthening government policy and synchronizing response actions. The evidence may be utilized to enhance advocacy work at family, community, government, private and economic sectors to increase investments in GBV prevention programmes and protect survivors from the vice. While the study focused on specific locations, Makueni GBVRC and LBSI in Nakuru, its findings suggest that GBV's economic impact could be representative of a larger regional or national challenge. When scaled to a national level, the economic consequences of GBV become staggering, hindering Kenya's economic growth and development.

Given GBV's significant economic impact, there is a compelling case for increased investment in GBV prevention programs. Allocating resources to prevention measures, such as public awareness campaigns, legal reforms, and support networks, can lead to long-term cost savings. : Economic empowerment of women is also a preventive measure that can yield direct and indirect benefits. Ensuring women have economic independence and access to resources can help them break free from abusive situations and drive societal shifts in gender roles and norms, ultimately reducing the prevalence of GBV.

A study by CARE reveals that survivors bear the biggest cost reflected in social, emotional and economic realms but also that states and not-for-profit entities bear significant costs in provision of services while the private sector incurs losses in terms of working hours. However, this study explored economic costs of GBV in Kenya from the perspective of a woman survivor who sought help from two identified programmes (Makueni GBVRC and LBSI). In-depth face to face interviews were conducted with the women GBV survivors to gain a deeper understanding of their experiences in the RRRPs. These interviews ensured that participants gave answers in their own words. The interviews aimed to record own feelings, impressions, and changes experienced by the GBV survivors.

The study, however, had some limitations:

- The study was constrained by a limited sample size, due to the nature of the problem. However, we made an effort to interview each and every participant who sought GBV help from the two study sites. Costs of GBV are far reaching and distinct.
- The study does not account for the costs associated with victims who did not survive. Such losses encompass not just the loss of these individuals' contributions to the economy but also the opportunity costs related to the resources spent on treatment that ultimately proved unsuccessful. The research focused on survivors, thereby excluding mortality-related data and concentrating on women who were alive during the study period.
- The costs documented may not reflect the full extent of GBV's economic impact, as the data were collected solely from those who sought help from the specified centers. Those with serious injuries or disability might have sought help from better equipped facilities

such as from the City. However, the findings might point towards the invisible nature of many GBV injuries, which might include psychological and emotional.

Despite the limitations, this study makes a substantial contribution by exploring the long-term effects of sexual and gender-based violence (SGBV) beyond immediate costs. It uncovers hidden non-monetary costs associated with the health risks of gender-based violence (GBV), providing a comprehensive understanding of its broader societal impacts. Additionally, the study highlights that apart from substantial economic costs, GBV leaves enduring scars on survivors, increasing their susceptibility to stress-related diseases.

3.4 Conclusion

The study has shown that gender-based violence (GBV) has a significant impact on the health of survivors, including physical, sexual, psychological and economic consequences. These consequences not only affect the survivors' economic productivity and quality of life, but also have an adverse effect on their children and society as a whole. It is therefore crucial to prevent GBV in order to eliminate these negative effects. The study also highlights the high economic costs of GBV on survivors, their children and society, including lost productivity and increased use of health services. Addressing GBV through prevention measures would not only save these costs, but also free up resources in the health sector to address other disease burdens.

In conclusion, GBV is not merely a social issue; it carries substantial economic implications affecting individuals, communities, and nations. Understanding the comprehensive economic costs of GBV highlights the urgency for preventive measures and interventions. Addressing GBV promotes social justice and serves as a prudent economic strategy for nations striving for sustainable development.

4.0 HELP FROM RRRPs/GVRCs

4.1: Effectiveness of Makueni GBVRC and Life Bloom Services International in Facilitating GBV Survivors Recovery

The second objective of the study was to determine the effectiveness of Makueni GBVRC and Life Bloom Services International in facilitating the recovery of GBV survivors based on the services received. This section presents findings on the triggers of the GBV experienced, the kind of help survivors sought in response, what they received and how this contributed to their recovery. It also presents some indicators of recovery.

4.1 Type of Violence Experienced

The study sought to establish the kinds of gender violence they experienced. The responses are captured in Table 4.1 below (Multiple responses apply).

Table 4.1: Type of Violence Experienced

Facility	Nature of Violence	Frequency	Percentage of Total sample
Makueni GBVRC	Sexual	17	18.7
	Physical	31	34.1
	Social	0	0.0
	Economic	3	3.3
	Psychological/emotional	37	40.7
	Cultural	1	1.1
	Other	2	2.2
	Total	91	100%
LBSI (Naivasha)	Sexual	37	63.8
	Physical	14	24.1
	Social	3	5.2
	Economic	1	1.7
	Psychological/emotional	1	1.7
	Cultural	0	0.0
	Other	2	3.4
	Total	58	100%

Source: Study data (March, 2022)

Table shows that 54 out of 149 (36.2%) of the respondents had suffered sexual violence. This was followed by physical violence (30.2%). Other conspicuous forms were psychological/emotional (25.5%), economic (2.7%) and others like being denied food (2.7%) violence. Further, multiple

responses applied, therefore, majority of the survivors had experienced multiple types of violence with physical, psychological and economic kinds being the most common. Very few had experienced cultural violence. This shows that physical, psychological, economic and sexual violence were the most common forms of violence experienced with the first two being the most dominant.

The violence manifested in different ways across the survivors. Physical violence consisted of: battery leading to serious injury and recurrent pains even after treatment; being thrown or locked out of the matrimonial home; knife attacks; plucking of hair; kicking and stepping on the body and stomach; and assault by a proxy (housemaid incited by the husband). In some cases, the violence extended to the children who, as a result became traumatised and would hide whenever the father returned home. In one case, a respondent reported her son being battered by the father when he tried to protect her from battery.

For sexual violence, respondents reported: forced intercourse; defilement of child by a stranger; rape by a stranger; sodomy; rejection of her pregnancy; and denial of conjugal rights by separating bedrooms. Economic violence took the forms of: deprivation of all personal assets and effects (clothes, car, home, income etc); destruction/burning of clothing; loss of capital from a loan when husband prevented wife from constructing a poultry house claiming it would make his compound filthy and smelly; forcing the wife to take a loan then surrender all the monies to him and refusal to pay son's college fees.

Psychological violence resulted from verbal insults of wife and children; threats to life; intimidation; desertion of wife after husband learnt that she was HIV-positive, recurrent sexual affairs with house-maids, including impregnation; and trauma on children from seeing their mother being battered and undressed.

4.2 Number of times Abused

The number of times the victim is abused is important as the studies aims at understating impact of SGBV on economic, social life as well as participation in other welfare activities. Table 4.2 below shows the distribution.

Table 4.2 Duration of Abuse

Facility	Number of times a month	Frequency	Percent
Makueni GBVRC	2-5	30	33.0
	5-10	18	19.8
	11-15	7	7.7
	16-20	3	3.3
	Over 20	5	5.5
	Lost count	6	6.6
	Once	8	8.8
	No response	14	15.4
	Total	91	100.0
LBSI (Naivasha)	2-5	12	20.7
	5-10	9	15.5
	11-15	1	1.7
	16-20	1	1.7
	Over 20	6	10.3
	Lost count	23	39.7
	Once	6	10.3
	No response	0	0.0
	Total	58	100.0

Source: Study data (March, 2022)

Majority of respondents over 50 percent (71.8%) had experienced abuse more than 5 times a month while on 28.2% experience SGBV less than 5 times a month which is still very high figure to be reported. The pattern indicates that most survivors tolerate abuse for at least 3 times before seeking help. From the data, it is clear that only 9.4% of survivors had experienced the abuse for ones in a month. The data also shows that 7.4% of the survivors had withstood the abuse for more than 20 times a month, implying that it had become a routine part of their lives. The study therefore, notes that a vast majority of survivors (more than 70%), do not put up with the violence for lengthy periods. This suggests that the impact of the vice on the lives of women is extensive often spanning several years.

4.3 Day of the week that violence mostly occurred

Table 4.3 shows the day of the week that violence mostly occurred.

Table: 4.3: Day of the week that violence mostly occurred

Facility	Time SGBV occur	Frequency	percent
Makueni GBVRC	Mondays	5	5.5
	Tuesdays	2	2.2
	Wednesdays	6	6.6
	Thursdays	4	4.4
	Fridays	12	13.2
	Saturdays	27	29.7
	Sundays	9	9.9
	All days	26	28.6
	Total	91	100
LBSI (Naivasha)	Mondays	2	3.4
	Tuesdays	1	1.7
	Wednesdays	1	1.7
	Thursdays	0	0.0
	Fridays	10	17.2
	Saturdays	14	24.1
	Sundays	4	6.9
	All days	26	44.8
	Total	58	100

Source: Study data (March, 2022)

The collected data from female survivors at Makueni GBVRC and Life Bloom Services International (LBSI) provide insight into the days when gender-based violence (SGBV) most frequently occurred.

At Makueni GBVRC: Saturdays had the highest frequency of SGBV incidents (29.7%). This was followed by instances in which survivors indicated that violence occurred on all days (28.6%). Fridays also had a relatively high frequency (13.2%), with lower percentages on other weekdays.

At LBSI in Naivasha: The most frequent day reported for SGBV was Saturdays (24.1%), although not as frequently as in Makueni. A significant proportion of survivors reported that SGBV occurred on all days (44.8%), which was the highest percentage among all LBSI categories. Fridays had a higher frequency (17.2%).

The data suggest that weekends, particularly Saturdays, are when most SGBV incidents are reported, possibly due to more interactions between the perpetrator and the survivor during non-working days. The high percentage of violence reported as occurring 'All days' at LBSI indicates a pervasive nature of violence that does not confine itself to a specific day for some survivors.

These insights could be crucial for targeted interventions and support services, which may need to be more readily available during these high-risk times.

4.4 Time of the day was the violence mostly perpetrated

Figure 4.1 outlines the times of day when gender-based violence (GBV) was most frequently reported by survivors at the Makueni GBVRC in Makueni County and Life Bloom Services International (LBSI) in Naivasha, Nakuru County.

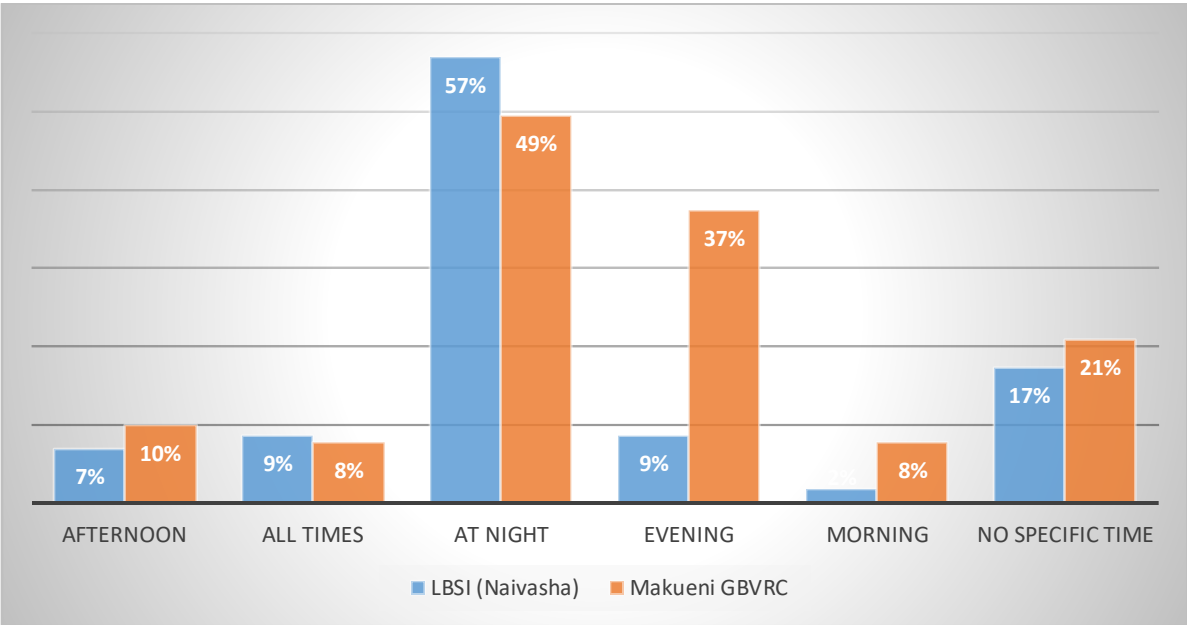


Figure 4.1: At what time of the day was the violence mostly perpetrated
Source: Study data (March, 2022)

At LBSI in Naivasha: Most violence was reported to occur at night (57%). A smaller percentage of survivors reported violence occurring in the afternoon (7%) and morning (2%), whereas 9% indicated that violence occurred at all times. Some survivors (8%) did not specify the specific time for violence.

At Makueni GBVRC: The most frequently reported time for violence was in the evening (49%). This was followed by the morning (37%) and afternoon (9%). A lower percentage of survivors (2%) experienced violence at all times, and 8% did not specify a particular time.

From the data, it is apparent that GBV at both locations occurred more frequently during the later parts of the day, with the evening and night being particularly high-risk periods. It is also notable that a significant number of survivors in Makueni reported morning violence, which is substantially higher than that of LBSI. Understanding the times when GBV is most likely to occur can aid in planning prevention efforts and resource allocation for support services.

4.5 Reasons for Seeking Help

Survivors were asked to explain why they eventually decided to seek help. The responses revolved around: fear for own life due to the severity, frequency and consequences of the violence; inability to withstand the battery and humiliation any longer; guardianship of defiled daughter; injury that required medical attention; advice by a third party, including parents, sisters and employers; and assurance that there were free services for survivors. Three reasons that mainly featured in the responses were fear for life, the frequency of the violence and the injuries.

From the data, it is evident that the women who sought help from Makueni GBVRC in Makueni County and Life Bloom Services International (LBSI) in Naivasha, Nakuru County, experienced a tipping point in their tolerance of gender-based violence that led them to seek assistance. The reasons for seeking help are deeply personal and varied, but include a critical threshold of physical abuse, fear of their lives or the lives of their children, financial abuse, emotional and verbal abuse, sexual violence, and the dire need for a safer environment for their families.

The accounts range from severe physical assaults, fear of further violence and rape, emotional trauma of witnessing abuse in front of children, to significant financial hardship. Several survivors reported that they were compelled to seek help after realizing that the threat to their lives was imminent, particularly when their children were at risk. Others made difficult decisions when they felt neglected or abandoned, especially after significant life events, such as pregnancy or the loss of a child. Some reported that a lack of economic support and the need to provide for themselves and their children pushed them to seek help. In cases of sexual abuse, the immediacy of the incident often leads to seeking immediate assistance.

The decision to seek help was often delayed because of fear, lack of resources, or the presence of children in the household. It is also apparent that for many, abuse was cyclical and multifaceted, impacting them both physically and psychologically. Survivors' stories underscore the complexities of gender-based violence and the critical need for accessible, supportive services that can provide refuge and aid to those in danger.

4.6 Cause of violence

Figure 4.2 reveals varied underlying causes of violence.

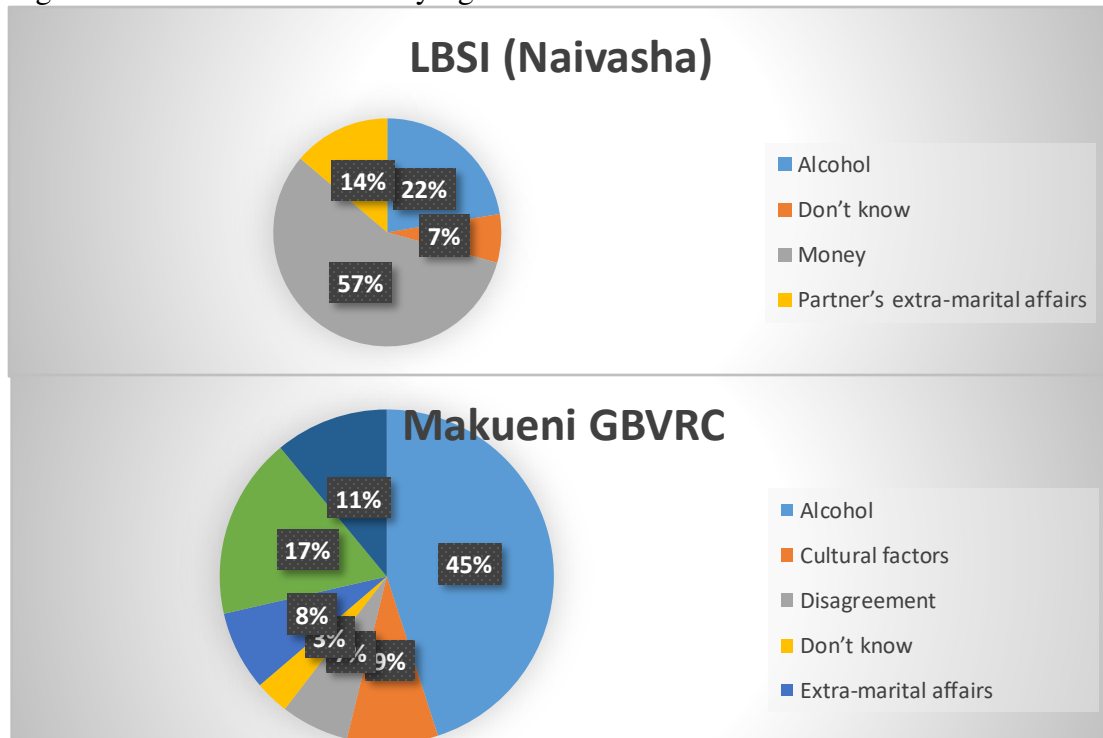


Figure 4.2: Cause of Violence
Source: Study data (March, 2022)

In Naivasha's LBSI, 57% of survivors attributed violence to their partners' extramarital affairs. This significant percentage highlighted the impact of infidelity on domestic stability. Alcohol consumption was the second most cited cause (22 %), suggesting the role of substance abuse in exacerbating violent behavior. A smaller proportion (14 %) could not determine the cause and 7% attributed violence to financial disputes.

In contrast, Makueni GBVRC reported that 45% of the survivors identified alcohol as the primary catalyst for violence, underscoring the pervasive issue of alcohol abuse in domestic conflicts. Partners' extra-marital affairs, although significant, constitute a smaller percentage (17%) than Naivasha's. Additionally, other factors such as disagreements (11%), cultural factors (9%), and monetary issues (8%) played a role, demonstrating that GBV has multi-faceted triggers that can be specific to the regional or community context.

These data underscore the complexity of GBV and the need for targeted interventions that address not only the relational aspects, but also substance abuse and socio-economic stresses.

4.7 Violence causing separation

In assessing the consequences of gender-based violence, one critical aspect explored was whether violence led to separation from partners. The data from the Makueni GBVRC and Life Bloom Services International (LBSI) in Naivasha, Nakuru County, present a concerning picture. Table 4.4 shows whether the violence experienced caused separation from partner.

Table 4.4: Violence causing separation

County	Indicator	Frequency	Percentage
Makueni GBVRC	Yes	31	34.1
	No	35	38.5
	Not Applicable	25	27.5
	total	91	100
LBSI (Naivasha)	Yes	38	65.5
	No	4	6.9
	Not Applicable	16	27.6
	Total	58	100.0

Source: Study data (March, 2022)

At the Makueni GBVRC, 34.1% of the survivors reported that the violence they experienced caused separation from their partners. However, a slightly higher percentage (38.5%) remained with partners. For 27.5% of the respondents, this question was not applicable, which may suggest various circumstances such as not being in a partnership at the time of violence or other factors.

In contrast, the situation at LBSI in Naivasha indicates a more significant impact of violence on relationships, with 65.5% of the women reporting separation from their partners due to the violence endured. Only a small fraction (6.9 %) stayed with their partners despite violence, while 27.6% indicated that the question of separation was not applicable to their situation.

This stark difference between the two locations may indicate varying sociocultural responses to violence or differences in support systems that empower survivors to leave abusive relationships.

The significant disparity in the rates of separation following gender-based violence between survivors from Makueni GBVRC and Life Bloom Services International (LBSI) in Naivasha could be attributable to a mix of sociocultural factors, urbanization, and occupation.

Culture can deeply influence the responses to violence. Traditional beliefs may either stigmatize divorce, compelling women to stay in abusive relationships, or conversely promote support networks that encourage leaving such environments. In Makueni County, cultural factors could contribute to a lower rate of separation.

Naivasha's urban setting may offer more anonymity and support services, enabling survivors to make independent choices, such as separation from abusive partners, more freely. Urban areas

typically provide greater access to resources, including legal and social services, that can facilitate decisions.

Regarding occupation, it is notable that participants from LBSI in Naivasha were sex workers. This group might have already faced stigmatization, which could influence their decisions and ability to separate. The nature of their work may afford them a level of financial independence or, conversely, further marginalization, affecting their responses to violence and the ability to leave partners.

In summary, the confluence of culture, urbanization, and type of work appears to play a role in the divergence seen between the two groups' responses to violence.

4.8 Reporting perpetrator to third party

In the context of gender-based violence (GBV), reporting to a third party can be a critical step for survivors seeking justice and support. Table 4.4 shows whether the perpetrator of the violence was reported to third party.

Table 4.4: Reporting perpetrator to third party.

County	Indicator	Frequency	Percentage
Makueni GBVRC	Yes	85	93.4
	No	6	6.6
	total	91	100.0
LBSI (Naivasha)	Yes	43	74.1
	No	15	25.9
	Total	58	100.0

Source: Study data (March, 2022)

Table 4.4 highlights the propensity for reporting perpetrators among survivors of the Makueni GBVRC and LBSI in Naivasha.

At Makueni GBVRC, a high percentage (93.4%) of survivors reported that the perpetrator was a third party, with only a small fraction (6.6%) not doing so. Conversely, at LBSI in Naivasha, fewer survivors reported the perpetrator (74.1%) and a quarter (25.9%) did not report.

This contrast may reflect different levels of trust in authorities, societal support, and awareness of the services provided to GBV survivors. The higher reporting rate in Makueni might suggest a more robust support system or community encouragement for survivors to come forward. In Naivasha, the lower rate could point to barriers, such as stigma or fear of repercussions, which may discourage survivors from reporting.

Understanding these patterns is crucial for improving GBV interventions and support services, ensuring that survivors feel safe and supported when reporting incidents of violence.

4.9 Sought help from

Figure 4.3 shows where the help was sort from.

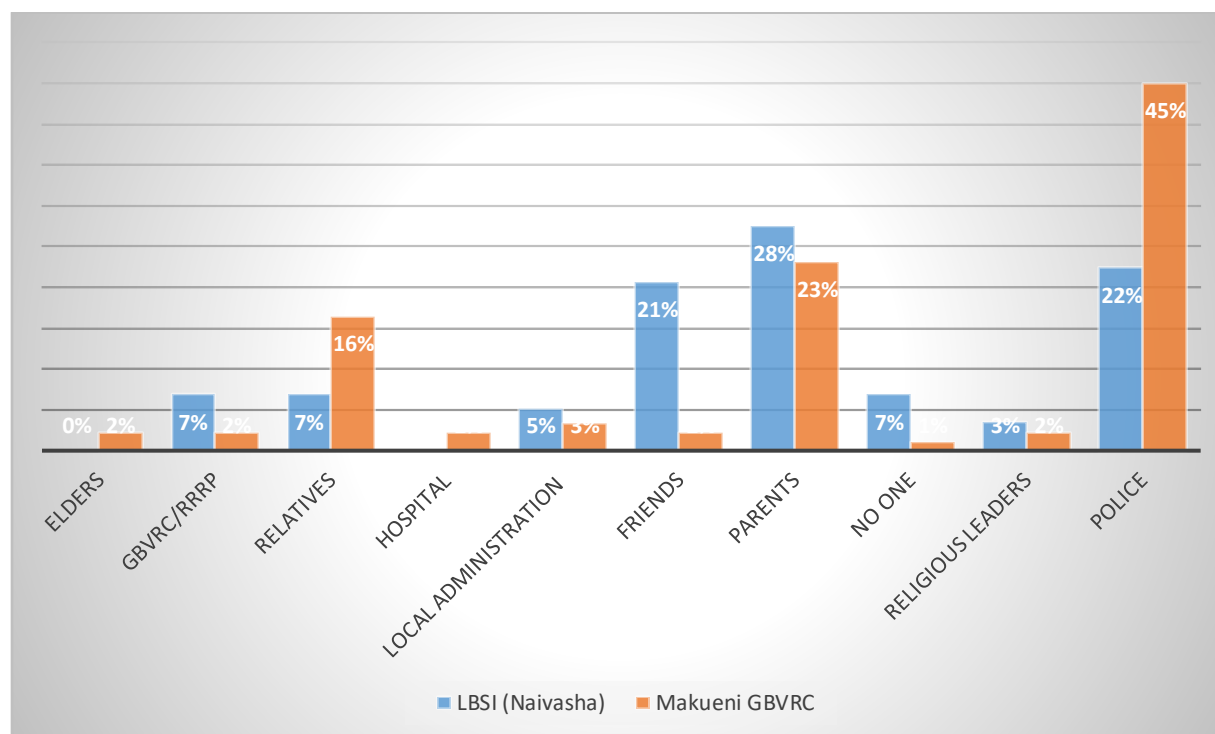


Figure 4.3: where the help was sort from

Source: Study Data (March, 2022)

Figure 4.3, which compares the sources from which survivors of gender-based violence sought help in Makueni GBVRC and Life Bloom Services International (LBSI) in Naivasha, reveals distinct patterns of seeking assistance. In Makueni GBVRC, a significant proportion of survivors turned to the police (45%), indicating a reliance on formal support structures. The data also showed that 28% sought help from friends and 23% sought help from parents, suggesting the importance of personal networks in the process.

Conversely, in LBSI Naivasha, while the police remained a common source of help (22%), there was a noticeable difference, with a higher percentage of survivors not seeking help from any source (7%). This could suggest various factors at play, such as fear of stigma, a lack of trust in authorities, or a sense of helplessness. Additionally, 16% of survivors in Naivasha turned to relatives, which is more than double the percentage of those in Makueni who did the same, perhaps indicating stronger family support systems or cultural differences in their response to violence.

The variance in these figures may reflect sociocultural factors, economic conditions, or the level of urbanization in Naivasha compared to Makueni. Such data are essential for understanding the

complex dynamics at play in gender-based violence reporting and can inform targeted interventions to support survivors effectively.

4.10 Type of Help survivors seek from the RRRPs

Efficient service to survivors is critical in responding to GBV. In order to determine the relationship between what service survivors sought and what they received, respondents were asked to indicate the specific help they sought from the programmes and the actual assistance received. The findings are presented in tables 4.5 and 4.6.

Table 4.5: Help Sought and Received – Makueni GBVRC

SN	Help Sought	Percentage Seeking	Percentage Receiving
1	Rescue/shelter	9	3
2	Family/child support	3	Nil
3	Legal assistance	25	27
4	Medical treatment	37	31
5	Psychological counselling	16	37
6	Police action	7	0
7	Others	5	2
	Total	100	100

Source: Study Data (March, 2022)

Table 4.5 shows that the most common forms of assistance sought at Makueni GVRC were medical (37%), legal (25%) and psychosocial counselling (16%). The two next popular motivations for seeking help were to get rescue/shelter (9%) and police action (7%). It is notable that economic empowerment was not one of the reasons for seeking help. The main forms of actual assistance received were psychological counselling (37%), medical treatment (31%) and legal information (27%). The pattern depicts a correspondence between the help sought and received, with psychological counselling standing out as a service provided to significantly more people than those who sought it.

The responses tally very well with the mandate of the Centre, explained by one key informant as “to provide free medical treatment and psycho-social support to survivors of GBV in the county and beyond”. This included temporary shelter and collaboration with the police for reporting cases and apprehension of perpetrators.

The help sought and received in LBSI (Nakuru) are presented in Table 4.6. It should be noted that the kind of help sought does not necessarily reflect the menu of services offered by LBSI but the needs of the GBV survivors that have been identified by the service providers. Likewise, the help received is not necessarily from LBSI directly as the service provider but include referrals to partners.

Table 4.6: Help Sought and Received – LBSI (Nakuru)

SN	Help Sought	Percentage Seeking	Percentage Receiving
1	Employment	Nil	4
2	Skills for income generation	11	25
3	Start-up loans	Nil	10
4	Family/child support	18	4
5	Legal assistance	24	9
6	Medical treatment	9	11
7	Psychological counselling	7	34
8	Police action	20	Nil
9	Others	11	3
	Total	100	100

Source: Study Data (March, 2022).

According to Table 4.6, the main reasons for seeking help from LBSI were: legal assistance (24%); police action (20%); and family/child support (18%). Skills for income generation only featured as the fourth reason, at 11%, which is rather curious given that LBSI (Nakuru) runs a vocational training programme for GBV survivors. This finding could mean that either LBSI (Nakuru) has not widely popularized its vocational training programme or it is just known as a general sanctuary for survivors who then hope to get referrals to other service providers. In terms of actual help rendered, LBSI (Nakuru) provided mainly psychological counselling (34%) and business training (25%) for survivors, followed by medical treatment (11%) and start-up loans (10%). It is notable that the LBSI services related to economic employment covered 39% of respondents (employment, start-up loans, skills training), again reflecting the economic empowerment component. The two leading forms of assistance rendered fall under two of LBSI's programmes which cover counselling, financial literacy, entrepreneurship and vocational skills.

Overall, the findings confirm the primacy of psychological counselling in the menu of services provided in both study sites. Additionally, they show that where a programme has an economic empowerment component, it benefits even those that have not directly sought it as evident in the cases of survivors who received employment and start-up loans.

4.11 Help sought Received

Figure 4.4 shows an analysis of help sought and received by survivors of Gender-Based Violence.

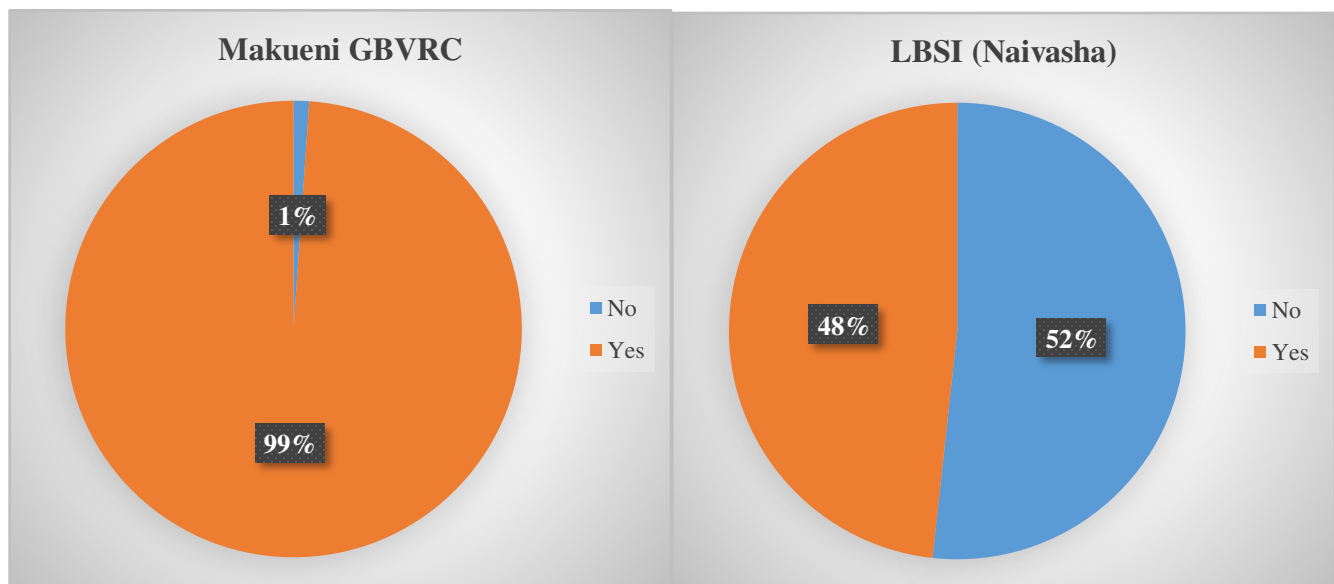


Figure 4.4: Help sought Received
Source: Study data (March, 2022)

The research indicated a significant difference in the receipt of help between the two facilities studied. At the Makueni GBVRC, 99% of the survivors reported receiving the help they sought. This high percentage suggests a strong support system and efficient service provision enabling survivors to receive assistance.

In contrast, the Life Bloom Services International (LBSI) in Naivasha showed a near-even split, with 52% of survivors indicating that they did not receive the help they sought, and 48% confirming that they did. This suggests that nearly half of the survivors seeking help at LBSI faced challenges in obtaining support. This could indicate resource limitations, potential gaps in service provision, or other barriers that prevent survivors from accessing help.

These disparities underscore the importance of evaluating and addressing the different factors that affect the effectiveness of support services for survivors of gender-based violence. Ensuring that all survivors receive the help they seek is crucial for their safety, well-being, and overall success of intervention programs.

4.12 Duration of the service

The victims or survivors who sort for help from the GBVRCs did actually received the services they sort and was given to them for a number of days and or month so as to ensure the victims are secured, stable financially and also resume studies accordingly. The results are presented in Figure 4.5

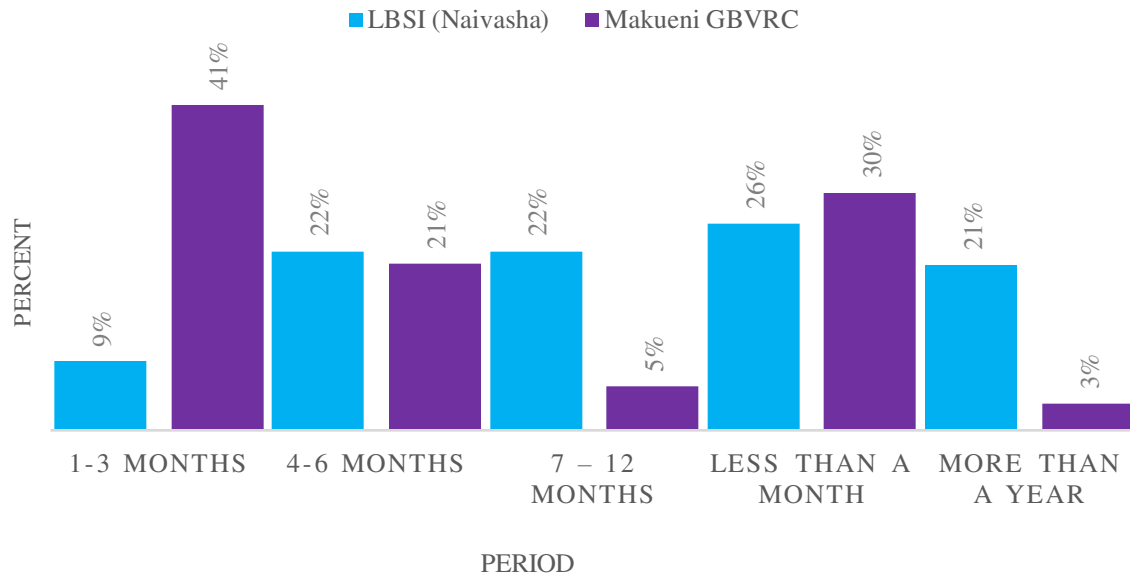


Figure 4.5: Duration offered for the services sort

Source: Study data (March, 2022)

The data present a clear contrast in the duration of services provided to gender-based violence (GBV) survivors between the Makueni GBVRC and Life Bloom Services International (LBSI) in Naivasha. In Makueni, the majority of survivors (41%) received services for a period ranging from 1 to 3 months. Meanwhile, for LBSI in Naivasha, the most common duration was over a year, with 30% of survivors receiving long-term assistance.

The relatively shorter service duration at Makueni GBVRC could be influenced by various factors, including resource availability, program design, or the nature of the support services provided, which may be focused on immediate, short-term assistance. On the other hand, the longer engagement observed in Naivasha's LBSI might suggest a model geared towards comprehensive, long-term recovery, which could include extensive rehabilitation programs and ongoing support.

Such a discrepancy might also reflect the different needs or conditions of survivors accessing these two centers, which could be shaped by regional socioeconomic factors, the nature of violence experienced, or differences in the operational mandate of the two institutions.

4.2 Conclusions

The second objective of the study was to determine the effectiveness of Makueni GBVRC and LBSI in facilitating the recovery of GBV survivors. Psychological and medical assistance emerged as the priority needs, inferably because of their direct implications on physical and mental recovery, which are primary before economic empowerment. That most survivors were satisfied with the change realized as a result of assistance received indicates the programme's contribution to recovery.

Findings from both sites suggest that programmes habitually focus on their narrow specializations hence have a limited menu of services to which they subject survivors even when the needs of the latter differ. This is evident in LBSI where more survivors were assisted with employment, start-up loans and skills for income generation than those seeking the same. In Makueni, the trend was apparent in the number of survivors being offered psychological counselling against those seeking it.

5.1: COPING AND RECOVERY AFTER RRRP/GVRC

5.2 Skills and Experiences Gained from Rescue Centres in Enhancing Women's Economic Empowerment

The third objective of the study was to establish the extent to which skills and experiences gained from Makueni GBVRC and Life Bloom Services International led to women's economic empowerment. This was examined by looking at their economic status in terms of sources of, levels of and control over income. Findings on the three variables are presented below.

5.2.1 Sources of Income

Information on the respondents' main sources of income is shown in Figure 5.1.

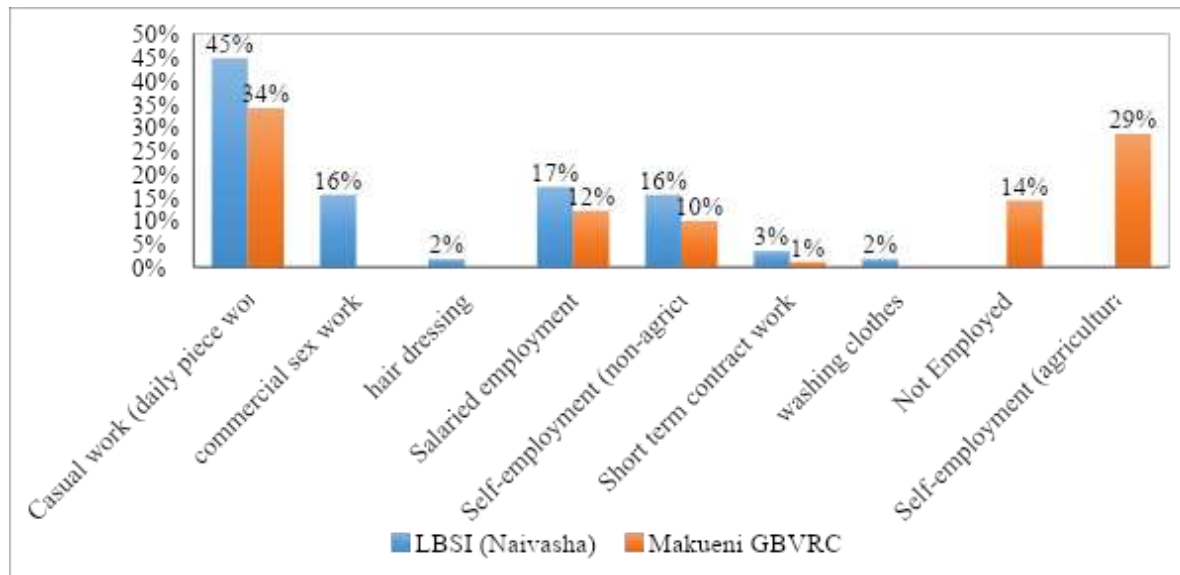


Figure 5.1: Sources of Income.

Source: Study Data (March, 2022)

The findings indicate that casual work was the main source of income for majority of respondents, 45% in LBSI (Nakuru) and 34% in Makueni. Considering the temporal nature of such work, this means that majority of respondents did not have consistent and predictable income, which is an indicator of their economic vulnerability. In addition, some survivors lamented that they earned so little it was a mockery labelling it as income. A number in LBSI (Nakuru) specified that lack of reliable income pushed them into commercial sex work, a predicament caused by the fact that they were single parents hence sole providers for their children.

These findings indicate that the survivors had low levels of economic power. As captured in Peterman, Roy and Ranganathan (2019), such socio-economic groups face a high risk of exposure to GBV and tend to live in locations with fewer support services and weaker legal systems.

Logically then, they are prime candidates for economic empowerment programmes, alongside other social services.

5.2.2 Levels of Income

Concomitant to the sources of income, the study investigated the survivors' total earnings before and after going through the RRRPs. Table 5.1 presents the findings.

Table 5.1 Income Before and After Programmes

		Before		After		% Difference
County	Indicator	Frequency	Percentage	Frequency	Percentage	
LBSI (Nakuru)	Nil	10	17.2	1	1.7	-15.5
	Kshs. 10,000 and below	36	62.1	35	60.3	-1.8
	Kshs. 10,001-20,000	10	17.2	18	31.0	13.8
	Over Kshs. 20,001	2	3.4	4	6.8	3.4
	Sub-total	58	100.0	58	100.0	
Makueni GBVRC	Nil	16	17.6	15	16.5	-1.1
	Kshs. 10,000 and below	62	68.1	60	65.9	-2.2
	Kshs. 10,001-20,000	9	9.9	11	12.1	2.2
	Above Kshs. 20,001	4	4.4	5	13.2	8.8
	Sub-total	91	100.0	91	100.0	

Source: Study Data (March, 2022)

The data above shows that 17.2% of respondents in LBSI (Nakuru) and 17.6% in Makueni did not have tangible income before the programme, perhaps indicating that they were housewives or unpaid family workers. After the programme, only 1.7% reported remaining in the same position

in LBSI (Nakuru), showing a remarkable change in their status. In Makueni, the improvement was more modest, from 17.6% to 15.5%. These findings also indicate that before going through the programmes, majority respondents from LBSI (Nakuru) (62.1%) and Makueni (68.1%) earned Kshs. 10,000 and below per month. This reflects the finding that their main source of income was casual work, which does not attract high incomes in the country. After the programme, there were fewer in this band, showing that they had progressed to slightly higher incomes.

Incomes of Kshs10,000 – 20,000 were earned by 17.2 % of survivors in LBSI (Nakuru) and 9.9% in Makueni before the programmes. Only 3.4% respondents at LBSI (Nakuru) and 4.4% in Makueni earned over Kshs. 20,000. The majority of the respondents were therefor, economically vulnerable and could benefit from economic empowerment programmes.

For those earning Kshs10,001 – 20,000, the proportions increased by 13.8% in LBSI (Nakuru) and 2,2% in Makueni after the programmes. Those earning above Kshs. 20,001 increased by 4.4.% in LBSI (Nakuru) and 8.8% in Makueni. The general pattern is that survivors' incomes improved after going through the programmes.

To ascertain that the programmes contributed to the changes in the incomes, respondents were asked to state whether the variations resulted from the initiatives studied. The findings are shown in Figure 5.2.

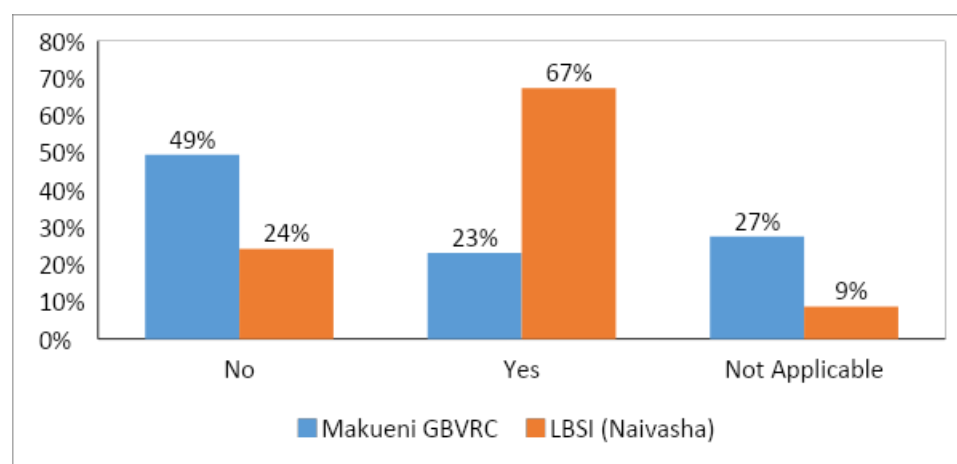


Figure 5.2: Attribution of Income Changes to Programmes.

Source: Study Data (March, 2022)

The results reflected in Figure 5.2 indicate that majority (67%) of respondents in LBSI (Nakuru) attributed the changes in their incomes to the programme. Only 23% did so in Makueni.

Upon further probing, the LBSI (Nakuru) beneficiaries explained that the programme enabled them to: negotiate increased salaries; access credit for business; learn and apply entrepreneurial skills; and diversify sources of income. Some indicated that they were advised to be self-sufficient while others were motivated by programme alumni on how to progress after counselling. The study observes that the confluence of counseling and economic empowerment is potent in enhancing survivors' recovery.

The effect of the programmes on economic empowerment are captured in stories of beneficiaries.

Sabina (not her real name) a survivor at LBSI) explained;

*“... I began to train as a **caterer** and to plan events at LBSI. This became my source of income. I also developed my skills through the **finance and business literacy classes**. The programme inspired me to become a peer counsellor and **programme manager**. I went up from zero income to a level where I bought plots of land which I have developed and rented out, giving me income”.* Another survivor Esther (not her real name) noted;

*Life Bloom took me through **counseling and training on beauty therapy, catering, paralegal work and computers**. One of the partner organizations which supported the computer training gave me a job that paid me 5,000 shillings. We were then **organized into women’s catering groups**. From this, we would earn between 1,500 and 2,000 shillings per event. **We learnt to save and invest**.*

The above excerpts indicate that at LSBI in Naivasha, survivors benefited from skills’ training in the economic empowerment component. However, the programme at Makueni GBVRC did not have such a component. Notwithstanding, beneficiaries of the facility underlined that the counseling received helped them to begin thinking about what they would do to earn an income.

While respondents reporting improvements in income attributed this to the programmes, those who did not observed that the support received was meant to address their immediate material needs and was not business capital. Additionally, they blamed economic stagnation on shortage of opportunities in the labour market, expenses incurred in relation to the abuse, and perpetual prohibition by partners from working.

The survival and financial stability of any individual is determined not only by levels of income, but also control over the same. This study, therefore, sought to establish who controlled the income earned by the GBV survivors before and after the programmes. Such information would indicate gender power imbalances between them and their intimate partners.

5.2.3 Control Over Income

According to Vyas and Jansen (2018), inequalities between men and women are products of broader structural systems. One of the main indicators of such inequalities is the control over resources. The study was therefore interested in checking the income control patterns among study respondents before and after getting assistance in order to establish whether it changed for the better. Findings are shown in figures 5.3 and 5.4.

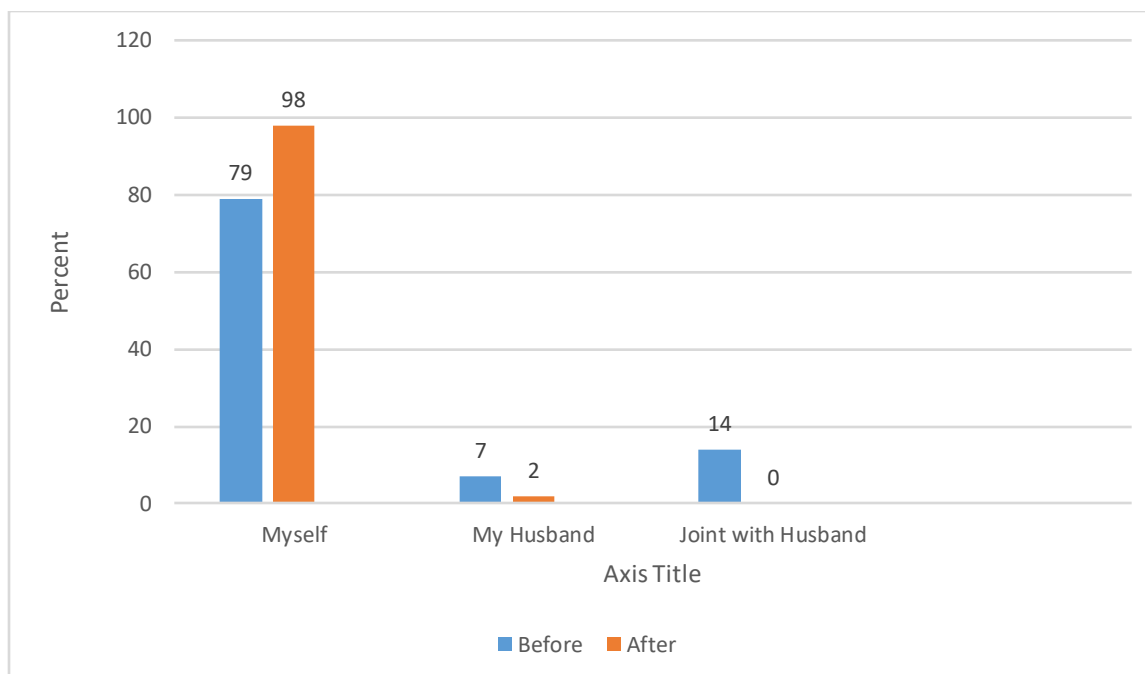


Figure 5.3: Control of Income Before and After Programme – LBSI (Nakuru)

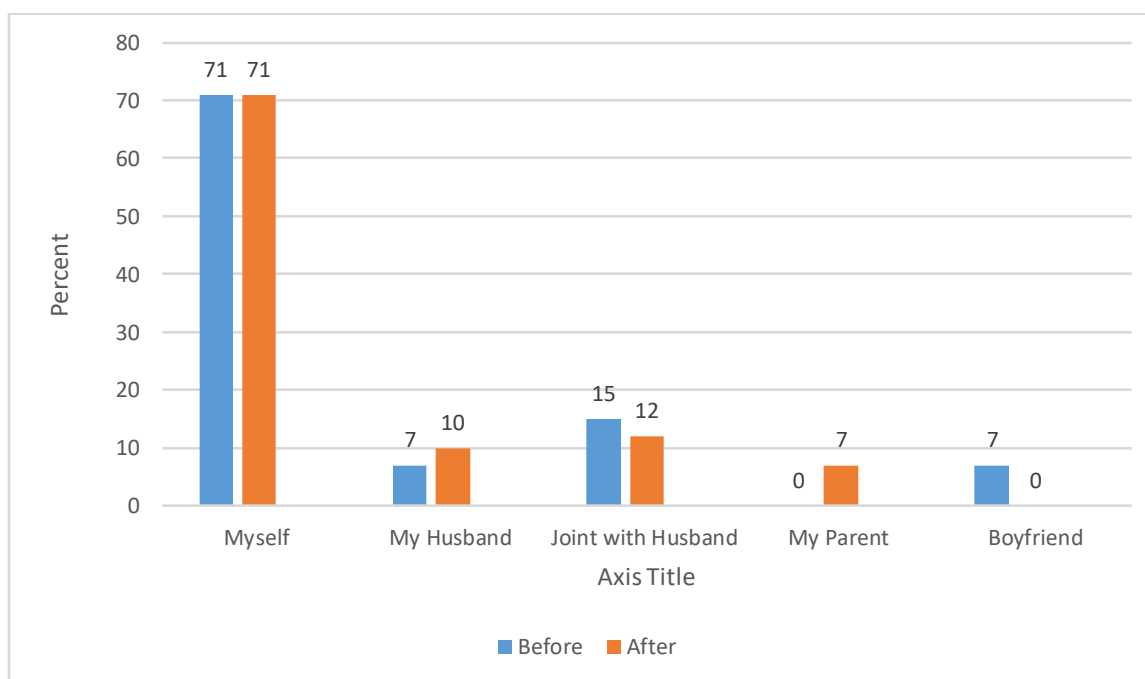


Figure 5.4: Control of Income Before and After Programme – Makueni GBVRC

Figures 5.3 and 5.4 show that in both study sites, majority of respondents controlled their incomes before participating in the programmes. That only 7% from LBSI (Nakuru) and a similar percentage from Makueni indicated that their income was controlled by husbands shows that the women largely had freedom on the use of their earnings.

After the programmes, however, the proportion of respondents who controlled their incomes increased from 79% to 98% at LBSI (Nakuru) but remained 71% in Makueni. This depicts a remarkable increase in LBSI (Nakuru), suggesting a strong association between income control and their experiences at the programme. At LBSI (Nakuru), the percentage in joint control with husbands reduced to zero while in Makueni, it decreased to 12% from 15%. The results suggest that the programmes enhanced survivors' control over their incomes. This is excellent but can you suggest mechanisms/channels through this empowerment happened)

LBSI seems to have had a greater impact in doing this than Makueni considering the 19% change from 79% to 98% among those in sole control over their incomes. This could be attributed to the fact that they benefitted from the vocational and financial skills training offered at LBSI. Besides, majority were noted to be single (unmarried, divorced or separated), information that shows increased autonomy due to increase in levels of income; or a mere fact that control is decreased due to the absence of a spouse. Since Makueni did not have an economic empowerment component, data does not show much difference, indicating that most probably, women remained in their economic status quo.

5.0 Conclusions

The third study objective was to establish the extent to which skills and experiences gained from Makueni GBVRC and LBSI led to women's economic empowerment.

That majority of respondents were casual workers implies that they were economically vulnerable hence candidates for economic empowerment. It is evident that the programmes offered by the RRRP/GBVRC had a positive effect on survivors whether through direct economic components or implicitly through attitude change and counselling. Adoption of initiatives such as table banking and savings groups demonstrates the potential of economic empowerment as a recovery strategy. The programmes gave survivors a chance to reflect on their lives hence consider alternatives to remaining in abusive relationships.

Survivors' incomes improved after going through the programmes, especially in LBSI, which had an economic empowerment component, indicating a causal relationship between the two variables. The same correspondence was evident in the increase in number of survivors who controlled their incomes after the programmes. In this case, the trend is attributable to the fact that majority were single (unmarried, divorced or separated) and had benefited from the vocational and financial skills training, which were not available in Makueni.

Emergence of money as a leading trigger of violence indicates that empowering women economically could have a significant impact in lowering GBV by giving them financial autonomy. However, that studies show that control over finances also predisposes women to GBV means that economic independence is a double-edged sword, which should be promoted with a caveat that it is not a panacea.

6.0 Relationship between SGBV and socio-economic conditions

In the fourth objective, the study sought to investigate the factors affecting GBV. This study used the identified variables related to community setting from literature review and also captured by the available data. Utilizing already identified factors, this study investigated the determinants of IPV with a case study of Makueni and Naivasha as a community. The aim was to identify the key determinants of GBV and to measure the effect of each determinant on GBV. An ordinal Logistic regression was used for analysis.

Logistic regression gives each predictor a coefficient which measures its independent contribution to variation in the dependent variable. The regression coefficients show how closely each independent variable and the outcome are related. Each coefficient represents the amount of change in the response variable that would be expected if the predictor variable changed by one unit. The purpose of logistic regression is to use the optimal model to correctly predict the outcome category for individual cases. To do this, a model is built that includes all predictor factors that can be used to predict the response variable. The probability of success vs the probability of failure is calculated using logistic regression. The analyses' findings are presented as an odds ratio. The odds value, which can range from zero to infinity, indicates how much more likely an observation is to belong to the group than to belong to the other group. The odds ratio (OR) calculates the change in the probability of being a member of the target group when the predictor is increased by one unit Mbugua, (2014).

An ordinal logistic regression was done to assess whether identified variables caused an increase in GBV. The dependent variable was the number of times, on average, that the survivor was violated in a month before she took action. If the number of times was more than five, then this was taken to show an increase in GBV.

The hypotheses tested were:

H_0 : The various identified variables do not cause an increase in GBV.

H_1 : The various identified variables cause an increase in GBV.

The independent variables in the model were: survivor's age, level of education and religion; and perpetrator's age, highest level of education, religion and other partners.

A number of tests were conducted to ascertain the stability and reliability of the model. The tests conducted were model fitting information, goodness of fit, Pseudo R-Square as well as parameter estimates.

6.1 Model Fitting Information

The results from the model fitting information test are presented in Table 6.1.

Table 6.1: Model Fit

Model	-2 log likelihood	Chi-Square	df	P-value
Intercept Only	235.286			
Final	203.320	31.966	18	0.022

Source: Study data (March, 2022)

The results show that the p-value is 0.022 which is less than 0.05 at 5 % level of significance. This means that the study's factors are more likely to predict SGBV among community members.

6.2 Goodness of Fit

The study carried out the test of goodness of fit of the model using Chi square test. The Chi square test is a statistical hypothesis test that determines how closely observed and expected data match. It assists in identifying whether a sample follows a normal distribution, whether categorical variables are connected, and whether random samples are from the same distribution. The results are presented in Table 6.2.

Table 6.2: Goodness of Fit

	Chi square	df	P-value
Pearson	352.490	402	0.964
Deviance	203.320	402	1.000

The results reveal that the Pearson Chi-Square p-value is more than 0.05, with a 5% statistical significance level and a moderate Chi-Square value, indicating that the model best fits the data and is suitable for the study's analysis.

6.3 Ordinal Logit Regression Results

The study adopted ordinal logit regression model to estimate the coefficients of the factors determining GBV in the society as well as the probability of the survivor being violated. The variables were subjected to logistic regression using statistical software SPSS and the results of the estimation are presented in the Table 6.3.

Table 6.3: Ordinal Regression Results

Dependent variable: Number of times violated	B	S.E.	Wald	df	Sig.	Exp (B)	95% C.I for EXP(B)	
							Lower	Upper
Less than 5 times	-23.767	2.021	138.286	1	0.000	0.000	-27.729	-19.806
5-10 times	-22.484	2.018	124.095	1	0.000	0.000	-26.44	-18.528
6-15 times	-21.969	2.019	118.404	1	0.000	0.000	-25.926	-18.012
16-20 times	-21.61	2.02	114.478	1	0.000	0.000	-25.569	-17.651
Over 20 times	-21.227	2.021	110.318	1	0.000	0.000	-25.188	-17.266
Lost count	-18.437	2.112	76.207	1	0.000	0.000	-22.576	-14.297
Age of the Survivor	0.353	0.339	1.087	1	0.297	1.424	-0.311	1.018
Survivor level of education	0.217	0.128	2.885	1	0.089	1.242	-0.033	0.467
Perpetrator highest education	0.046	0.11	0.179	1	0.672	1.048	-0.169	0.262
Perpetrator age	-0.199	0.233	0.732	1	0.392	0.819	-0.656	0.257
Religion-Catholic	-24.885	1.698	214.69	1	0.000	0.000	-28.214	-21.556
Protestants	-25.041	1.718	212.357	1	0.000	0.000	-28.409	-21.673
Pentecostal	-25.115	1.771	201.117	1	0.000	0.000	-28.586	-21.644
Muslim	-1.324	19484.06	0.000	1	1	0.266	38189.4	38186.74
Perpetrator having other partners	1.377	0.97	2.016	1	0.156	3.962	-0.524	3.277
Perpetrator having no other partners	2.19	0.971	5.081	1	0.024	8.932	0.286	4.094
Perpetrator religion-Catholic	-0.174	0.858	0.041	1	0.84	0.841	-1.856	1.509
Protestant	0.223	0.834	0.072	1	0.789	1.25	-1.411	1.857
Pentecostal	-1.551	1.091	2.022	1	0.155	0.212	-3.688	0.587
Muslim	-21.649	19484.06	0.000	1	0.999	0.000	-38209.7	38166.41

Source: Study data (March, 2022)

The results show that out of the 14 variables identified, only three significantly explain whether GBV is meted on the survivor or not. These are; survivor's level of education, Survivor's Religion and Perpetrator having no other partners. The confidence level intervals for all the variables show that the odds ratios are statistically significant at 5 % level of significance.

The coefficients of survivor denomination was negative (Catholic was -24.885; Protestants was -25.041; Pentecostal was -25.115 and Muslim was -1.324) and statistically significant at 5 percent level with the odd ratio less than 1. This implies that the more religious the survivor is, the lower the GBV occurrence. This may be due to the fact the survivor would be as much abiding to religion as possible to avoid rubbing the perpetrator / husband in the wrong way.

Similar results were obtained by other denominations. This means that religion reduces occurrences of GBV in the society because the value of the odd ratios in all the cases were less than 1 in absolute terms.

The coefficient of the perpetrator having no other partners was positive (1.377) and statistically significant at 5 % level of significance with an odd ratio of 8.932. This implies that if the perpetrator has no other partners, then the survivor is most likely to be violated. The absolute value of the odd ratio is also more than 1. This implies that chances of the survivor being violated are higher in a monogamous than polygamous family. However, the coefficient of the perpetrator's other partners and religion were found not to be statistically significant at 5 % significance level implying that the factors do not contribute to GBV in the society.

The study shows that various socio-demographic characteristics are significant determinants of GBV. Women's economic empowerment can thus be one way of reducing GBV in the country

6.4 Conclusion

The results of the ordinal logistic regression analysis indicate that out of the 14 variables examined, only three variables significantly explain whether gender-based violence (GBV) is perpetrated on women survivors or not. These significant factors are the survivor's level of education, the survivor's religion, and whether the perpetrator has no other partners.

Survivor's Level of Education: The coefficient of the survivor's level of education was statistically significant and negatively related to GBV. This suggests that as the survivor's level of education increases, the occurrence of GBV decreases. It implies that education may act as a protective factor, providing women with resources and knowledge to better cope with or avoid abusive situations.

Survivor's Religion: The coefficient of survivor denomination (Catholic, Protestant, Pentecostal, and Muslim) was statistically significant and negatively related to GBV. This indicates that the more religious the survivor is, the lower the occurrence of GBV. It is possible that adherence to religious teachings and values may deter the perpetrator from engaging in abusive behavior.

Perpetrator Having No Other Partners: The coefficient of the perpetrator having no other partners was statistically significant and positively related to GBV. This implies that if the perpetrator is

monogamous (has no other partners), the survivor is more likely to experience violence. The odds ratio suggests that the likelihood of GBV is higher in monogamous families compared to polygamous families.

7.0 Streamlined Recommendations for Addressing Gender-Based Violence

To enhance women's autonomy and address gender-based violence (GBV), it is imperative that the government initiate financial programs that promote economic independence from abusive partners. This should include empowerment strategies and diverse livelihood options. Specifically, the Women's Enterprise Fund policy should encompass an affirmative clause granting GBV survivors financial and business support. Additionally, offering skill development opportunities and low-interest options is essential. Social protection measures such as cash transfer programs and community support systems for GBV survivors must be established.

The integration of a GBV survivor component into existing affirmative funds is crucial, with transparent guidelines detailing fund accessibility. Survivors must be informed of these resources and processes for their utilization. Economic empowerment programmes for GBV survivors are vital, particularly when traditional livelihoods are disrupted. Implementing these as part of the recovery process fosters job acquisition and business management skills.

Furthermore, the government must enforce robust policies and procedures for the creation and functioning of Recovery and Rehabilitation Protection Programs (RRPPs). These RRPPs should incorporate halfway shelters, enabling women to contemplate and embark on their paths to economic empowerment in a supportive environment facilitated by the government, non-governmental organizations, and community collaborations.

Addressing GBV holistically involves several strategies.

- **Education:** Empower women through educational enhancement to assert their rights and pursue economic self-sufficiency.
- **Religious Collaboration:** Work with religious entities to foster a supportive atmosphere that counters GBV.
- **Polygamy Dynamics:** Assess the impact of familial structures on GBV to inform policy.
- **Prevention Programs:** Deploy comprehensive GBV prevention programs that engage various stakeholders to mitigate violence.
- **Legal and Social Frameworks:** Reinforce legal avenues for justice and extend social support to GBV survivors.
- **Economic participation:** Facilitating women's financial and entrepreneurial endeavors to decrease reliance on abusers.

Addressing GBV is multifaceted and requires evidence-based targeted interventions that address the identified risk factors and root causes. By implementing such interventions, society can move towards a more secure and just environment for all women.

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