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COVID-19 and gender-based violence (GBV): hard-to-reach women and girls, services, and programmes in Kenya

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ABSTRACT

Pandemics and government-imposed restrictions to control them, such as quarantines and school closures, exacerbate gender-based inequalities and increases exposure of women and girls to gender-based violence (GBV). The impacts of these adverse outcomes are further heightened due to diminished access to comprehensive GBV services, as governments redirect resources towards the emergency and deprioritise services such as GBV. Early reports suggest that the COVID-19 pandemic is no different, with GBV surging as governments imposed restrictive policies. In response, we conducted a rapid study in Kenya and interviewed 37 GBV and sexual and reproductive health (SRH) stakeholders from different sectors and types of organisations to understand how COVID-19 containment polices were impacting harder-to-reach women and girls, as well as availability and access to services and programmes. As the Government of Kenya imposed restrictive policies to contain the spread of COVID-19, comprehensive GBV services were not deemed essential in the beginning. The government turned its attention to GBV only after reports of rising GBV in the early months of the pandemic led to advocacy by GBV stakeholders. Even then, the government's response was *ad hoc*, and lacking sector-specific guidelines to ensure availability of comprehensive GBV services and programmes. Ultimately, this led to confusion and large-scale disruption in the availability of GBV services and programmes on the ground. Kenyan women and girls will pay the price of this negligence, and some may never fully recover from experienced adverse outcomes.

Les pandémies et les restrictions imposées par les gouvernements pour les contrôler, telles que les quarantaines et la fermeture des écoles, exacerbent les inégalités entre les sexes et font que les femmes et les filles sont plus exposées aux violences sexistes. L'impact de ces conséquences néfastes est encore aggravé par la diminution de l'accès à des services complets de lutte contre les violences sexistes, car les gouvernements réorientent les ressources vers l'urgence et accordent une priorité moindre aux services de lutte contre des problèmes comme les violences sexistes. Les premiers rapports suggèrent que la pandémie de COVID-19 n'est pas différente, les violences sexistes accusant une forte hausse chaque fois que les gouvernements imposent des politiques restrictives. Face à cette situation, nous avons mené une étude rapide au Kenya et interrogé 37 parties prenantes dans le domaine des violences sexistes et de la santé sexuelle et reproductive (SSR), issues de différents secteurs et types d'organisations, afin de comprendre l'incidence des politiques de contention du virus de la COVID-19 sur les femmes et les filles plus

KEYWORDS

Kenya; COVID-19; gender; gender-based violence (GBV); GBV prevention and response; hard-to-reach women and girls; government policy

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difficiles à atteindre, ainsi que sur la disponibilité et l'accès aux services et programmes. Lorsque le gouvernement kenyan a imposé des politiques restrictives pour contenir la propagation de la COVID-19, des services complets de lutte contre les violences sexistes n'ont pas été jugés essentiels au départ. Le gouvernement ne s'est intéressé aux violences sexistes qu'après que des rapports faisant état d'une augmentation de ces violences dans les premiers mois de la pandémie ont conduit les parties prenantes à entreprendre des activités de plaidoyer. Même après cela, le gouvernement a lancé des interventions ponctuelles et dénuées de directives sectorielles spécifiques pour garantir la disponibilité de services et de programmes complets de lutte contre les violences sexistes. En fin de compte, cela a entraîné une confusion et une perturbation à grande échelle de la disponibilité des services et des programmes de lutte contre les violences sexistes sur le terrain. Les femmes et les jeunes filles kenyanes paieront le prix de cette négligence, et certaines ne se remettront peut-être jamais complètement des conséquences négatives qu'elles ont subies.

Las pandemias y las restricciones impuestas por los gobiernos para controlarlas, entre ellas, las cuarentenas y el cierre de escuelas, exacerban las desigualdades de género y aumentan la exposición de mujeres y niñas a la VBG. Los efectos adversos se agudizan aún más al disminuir el acceso a los servicios integrales destinados a tratar casos de VBG, pues los gobiernos reorientan los recursos hacia la emergencia, restando prioridad a este tipo de servicios. En este sentido, los primeros informes sugieren que la pandemia de COVID-19 no es la excepción, ya que la VBG aumenta conforme los gobiernos imponen políticas restrictivas. Para confirmarlo, realizamos un estudio rápido en Kenia, en el que entrevistamos a 37 actores involucrados en temas de violencia de género y salud sexual y reproductiva (SSR) de diferentes sectores y tipos de organizaciones. El objetivo del mismo fue comprender cómo las políticas de contención de la COVID-19 estaban afectando a las mujeres y niñas más difíciles de contactar, así como la disponibilidad y el acceso a distintos servicios y programas. Cuando el gobierno keniano impuso políticas restrictivas para contener la propagación de la COVID-19, inicialmente los servicios integrales destinados a atender VBG no se consideraron esenciales. El gobierno sólo prestó atención a la VBG una vez que los informes sobre el aumento de la violencia de género en los primeros meses de la pandemia propiciaron acciones de incidencia por parte de activistas interesados en el tema. Incluso a partir de ese momento, la respuesta del gobierno fue *ad hoc*, pues carecía de directrices sectoriales específicas en el sentido de garantizar la disponibilidad de servicios y programas integrales contra la VBG. En última instancia, esto condujo a la confusión y la interrupción de la disponibilidad de servicios y programas de VBG a gran escala. Las mujeres y las niñas kenianas pagarán el precio de esta negligencia y es posible que algunas nunca se recuperen del todo de las vivencias adversas experimentadas.

Background

Significance

A spike in violence against women and girls is often witnessed during complex emergencies, including large-scale infectious disease outbreaks. Epidemics have been shown to

lead to increased rates of intimate partner violence (IPV), unintended pregnancies, sexual exploitation, and other forms of gender-based violence (GBV) (Onyango *et al.* 2019).

To control disease outbreaks, governments impose several restrictive policies such as quarantines and movement limitations, order school closures, and redirect human and financial resources towards emergency health service provision. These policies can cause both direct and indirect harm to women and girls, particularly if their gendered unintended consequences are not proactively countered. However, this is often forgotten in the frenzy of an emergency. The restrictive policies can indirectly harm women and girls by exacerbating pre-existing gender-based inequalities and power-differences (Al Gasseer *et al.* 2004). For example, women and girls can have increased exposure to violence as stay-at-home orders leave them trapped with their perpetrator for long periods of time. Also, the chances of leaving an abusive relationship diminish as regular formal and informal support systems and networks get disrupted, and travel is restricted. The loss of livelihood and economic strain caused by a pandemic can increase household stress and expose women and girls to heightened aggression as perpetrators are more likely to lash out. More directly, as resources are diverted towards emergency service provision, life-saving critical health and social services are often de-prioritised and/or deemed non-essential and become scarce, heightening the vulnerability of women and girls. Factors such as fear of getting infected in public spaces, disruption of regular transportation or services, imposition of curfew, and fear of being mistreated by the police as they impose government restrictions may further discourage women and girls from accessing critical services.

The 2014–2016 Ebola epidemic in West Africa demonstrated the negative impacts of infectious disease outbreaks on women and girls, particularly the harder-to-reach and overlooked sub-populations. While rigorous studies estimating the increases in GBV prevalence during this period are not available, several small-scale qualitative studies have documented how polices such as quarantines, school closures, and de-prioritisation of GBV and SRH services, along with economic stress, led to increases in exploitation, sexual violence, and unintended pregnancies, particularly among adolescent girls and young women (Onyango *et al.* 2019). A study conducted in the eastern region of Sierra Leone indicated an overall increase in cases of GBV during the epidemic (UNDP 2015). The study group participants perceived a 40–65 per cent increase in teenage pregnancies in their communities and attributed the increases to economic hardships families were facing, leading to engagement in transactional sex to meet necessities. Epidemics can also severely limit access to services for survivors of GBV. During the Ebola epidemic in Sierra Leone, GBV services ceased to function almost entirely; the few GBV response centres that remained open saw a 19 per cent increase in women and girls presenting for services. In Liberia, more than 80 per cent of survivors of GBV were denied health services (IRC 2015).

The COVID-19 pandemic is showing similar trends, with reports of GBV increasing across the globe. In March 2020, when the inevitability of COVID-19's international spread became clear, countries around the world moved to contain its spread by closing borders and implementing movement restrictions and curfews. Early reports suggest that these new restrictions, along with more direct socioeconomic impacts, are having serious consequences for women and girls. A police station in China's Hubei Province recorded a

tripling of domestic violence reports in February 2020 during quarantine (Wanqing 2020). In France, reports of domestic violence increased 30 per cent during lockdown, while countries across the world have seen increasing emergency calls to helplines (UN Women 2020). These increases in GBV are happening when availability of comprehensive GBV services is compromised in several contexts (UN Women 2020). There are reports that essential services for survivors, such as clinical management of rape and mental health and other psychosocial support services, have limited availability in many contexts, as health workers are redeployed to handle COVID-19 cases. In other places, while basic health services are available, referral pathways between different sectors (i.e. health, police, justice, social services) have collapsed or are functioning sub-optimally, making it hard for women and girls to receive the support they need.

In Kenya too, rates of GBV started going up, as the government began imposing restrictive policies to contain COVID-19. The first recognised case of COVID-19 in Kenya was in Nairobi on 13 March 2020; two days later the government started imposing restrictive policies (WHO 2020). On 15 March, the government ordered schools to close, travel was limited to nationals and permit holders, and large gatherings were banned. On 25 March, a national curfew was imposed and all flights in and out of the country were suspended. Soon thereafter, there were reports on the increasing levels of GBV in the country. LVCT Health, a Kenyan NGO, stated that in the 1.5 months following the COVID-19 lockdown, a total of 793 adolescent and young women presenting to their clinics reported experiencing violence, a stark increase from pre-COVID times (Ngunjiri *et al.* 2020). Physical violence increased from 33 to 43 per cent, while sexual violence doubled from 2.5 to 5 per cent. According to a report by the UN Country Team in Kenya, calls to GBV hotlines increased by 775 per cent in March and April 2020 (UN Country Team 2020). This meant that an additional 3,650 cases of GBV were reported between March and the end of July (UN OCHA 2020). However, at the beginning of the pandemic, as GBV was surging in the country, GBV services were not deemed essential. On the 28 February 2020, the President issued Executive Order No. 2 of 2020 that established the National Emergency Committee on Coronavirus (Government of Kenya 2020). The Committee did not include a representative from the Ministry of Public Services and Gender, which led to exclusion of gender considerations in the COVID-19 response plan. In April 2020, the Ministry of Health (MOH) developed a Community Engagement Health Strategy to respond to COVID-19 but the strategy did not mention GBV (Kenya Ministry of Health 2020b) . The growing concerns over rising rates of GBV coupled with lack of government action to address the issue led to GBV stakeholders and women's groups putting pressure on the government to pay attention to GBV rates and ensure availability of comprehensive GBV services. For example, a group of seven grassroots women's rights NGOs wrote a public letter in April, urging the government to tackle rising GBV and ensure availability of critical GBV services (CREAW 2020). Finally, in May, the MOH released guidelines that deemed health care needed by GBV survivors as essential (Kenya Ministry of Health 2020a). However, the Government of Kenya did not provide clear sector-specific guidelines that cover the full range of comprehensive services and programmes for GBV survivors.

Clearly, the COVID-19 pandemic and policies being imposed to contain its spread are laying bare gender-based structural inequalities and challenging already weak health and social protection systems in many parts of the world. We have already started seeing the devastating consequences of these restrictive policies on women and girls across the globe, particularly as GBV surges across different contexts. However, in this time of increased need, access and availability of critical GBV services is severely compromised due to the same restrictions. In response, we undertook a rapid study in Kenya to understand if and how the government-imposed restrictive policies to contain the COVID-19 pandemic were affecting: (1) women and girls, particularly hard-to-reach populations, and (2) access and availability of comprehensive GBV services. To gather information on the impact of the pandemic on both services and harder-to-reach women and girls, we would have liked to have captured the experiences of women directly. However, we decided to limit our study to GBV service providers, programme managers, and donors, due to the challenges of conducting ethical research in the broader community with COVID-19 restrictions in place. We recognised that ensuring safety, privacy, and confidentiality of our participants would be extremely difficult under the circumstances. This paper synthesises findings from this research and highlights the impact on sub-populations of women and girls most affected by the restrictions. We also track how different components of comprehensive GBV response (i.e. police, judiciary, medical, shelters, and other psychosocial services) and prevention (including access to contraceptive methods) services were impacted by these policies, and how their availability varied as the government adjusted its policies.

Pre-COVID Kenyan GBV context

Pre-COVID GBV prevalence

Prior to the COVID-19 pandemic, GBV was highly prevalent in Kenya. According to the most recent Demographic and Health Survey, conducted in 2014, 40.7 per cent of women in Kenya reported experiencing some form of GBV in their lifetime (Kenya National Bureau of Statistics 2015). While there is evidence of declines in GBV, progress is slow with some forms of GBV persisting. According to Demographic and Health Surveys conducted between 2008 and 2014, incidences of physical violence increased across all age groups from 38.5 per cent in 2008 to 44.8 per cent in 2014, while sexual violence decreased in prevalence from 20.6 to 14.1 per cent. During the same time period, attitudes towards wife beating changed among both men and women, with 52.6 per cent of women and 43.7 per cent of men in 2008 agreeing wife beating is admissible under certain justifications in comparison to 41.8 per cent of women and 36.2 per cent of men in 2014. Major drivers of GBV in Kenya include widespread cultural acceptability and traditional practices, such as child marriage and female genital mutilation (FGM).

GBV legal context

Kenya is a state party to all international human rights conventions, as well as relevant regional protocols including the Convention on the Elimination of All Forms of

Discrimination Against Women (CEDAW), Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and Convention on the Rights of the Child (CRC), amongst others. The 2010 Constitution of Kenya prohibits discrimination based on race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language, or birth (Government of Kenya 2010). Kenya has a plural legal system where several different legal and normative systems operate alongside each other. The interaction of legal systems is complex and often engenders conflict and competition. Customary, religious, and statutory laws operate within the same social context and cover similar ground, particularly in the areas of personal law, which include marriage, divorce, inheritance, custody and guardianship of children, and land tenure.

Under the Sexual Offences Act, extramarital rape is punishable by ten years to life in prison (Kiarie 2007). Only penetration by a genital organ is covered under the crime of rape; other penetration constitutes sexual assault. The Sexual Offences Act contains an explicit exception for marital rape, which is not recognised as a criminal offence in Kenya (Kiarie 2007). The Protection Against Domestic Violence Act recognises sexual violence within marriage but provides only civil, not criminal, sanctions (Government of Kenya 2015). The Protection Against Domestic Violence Act recognises domestic violence in multiple forms (physical, economic, emotional, verbal, and psychological). It also prohibits many traditional practices including child marriage, FGM, forced wife inheritance, virgin testing, and widow cleansing (Government of Kenya 2015). All same-sex sexual relations are illegal in Kenya according the Penal Code §165 and the Sexual Offences Act of 2006.

The Penal Code provisions are not wide-reaching enough to include all cases of violence against women (Kameri-Mbote 2000). The Government of Kenya does not easily prosecute domestic violence and sexual harassment cases, and Penal Code gaps leave them difficult to prove (Kameri-Mbote 2000). Also, punishment as addressed in the Penal Code for rape, defilement, incest, and assault are lacking. Victims must pursue justice through the civil justice system, often leading them to not pursue their case (Kameri-Mbote 2000).

GBV prevention and response approach

The Kenyan approach for GBV prevention and response has several weaknesses. While the Government of Kenya recognises the importance of a co-ordinated multi-sectoral GBV response across health, police, judicial, and social services, as laid out in several policy documents, co-ordination between sectors remains challenging, creating many inefficiencies (Kenya Ministry of Devolution and Planning 2014; Kenya Ministry of Health 2014a, 2014b; Kenya National Gender and Equality Commission 2014). GBV response services for survivors are limited and more prevalent in urban centres. Most comprehensive health and counselling services for GBV are available in hospital-based One Stop Centers (OSCs) in urban centres such as Nairobi; survivors from neighbouring counties are often referred to these services (Fernandes *et al.* 2020). In the rural areas, accessing services is a challenge, particularly due to long distances, as well as issues related to finding transportation and associated costs (Fernandes *et al.* 2020). While referral to

shelters is included in the National Guidelines on Management of Sexual Violence (Kenya Ministry of Health 2014a) as part of the Minimum Post Rape Care Package, there is a shortage of shelters in the country, particularly in rural areas.

The police are the primary gatekeepers to justice in incidences of GBV. When women who have faced GBV want to report their experiences or seek justice against their perpetrators, police stations serve as the first response. However, the police are often corrupt, dismissing GBV cases in exchange for bribery (Arnoff *et al.* 2013). In rural areas, where police stations and OSCs are unavailable, community chiefs serve as the first line of response to GBV cases. Chiefs, who are usually male, are susceptible to bribery and neglect in the same manner as the police. The judicial system lacks resources and capacity to deal with GBV cases adequately. Formal judicial services are one of the least accessed services because of factors such as lengthy court procedures, high costs, and GBV laws not being enforced, particularly for cases of IPV (Fernandes *et al.* 2020). Estimates suggest that, on average, GBV cases take about three years to reach a conclusion (Fernandes *et al.* 2020). Access is further hindered by location of courts in centralised, populous cities that are expensive and time-consuming to navigate. Some survivors fear utilising formal judicial mechanisms because of perceived or real danger of retaliation from the parties accused of wrongdoing.

The Government of Kenya does not prioritise GBV prevention work that aims to raise awareness and tackle underlying drivers of GBV. This work is primarily supported by international NGOs (INGOs), and it remains heavily under-funded. INGOs often see GBV prevention as an add-on to larger SRH programmes (Orindi *et al.* 2020). Local NGOs focused on prevention do not receive sufficient funding to achieve lasting change.

Study methods

Our study explored how government's COVID-19 containment policies impacted women and girls, particularly those harder to reach. We also tracked the extent to which these containment strategies, and the prioritisation of GBV services within them, evolved and impacted availability and access to comprehensive GBV services and prevention programmes, including community-based awareness and preventive services, and access to contraceptive services. We conducted remote, in-depth interviews, with 37 GBV and SRH programme managers, service providers, and donors working in different GBV sectors and types of organisations. Respondents were selected purposively based on their reputation and experience working in different GBV/SRH sectors such as judiciary, police, shelters, health, and prevention services. Respondents belonged to a range of institutions and worked in INGOs, local NGOs, community-based organisations (CBOs), government departments, and bi-lateral and multi-lateral funding agencies. Semi-structured interview guides were used to conduct the interviews. Interviews were audio-recorded with the permission of the respondent. Detailed notes were taken during the interview, which were updated with the audio-recordings. Emerging themes were identified both deductively and inductively, and were based on our understanding of the literature as well as what was emerging from the data.

Study results

The results are organised under two overarching themes: (1) impact on hard-to-reach women and girls; and (2) impact on availability and access to GBV services and programmes, including stakeholder's assessment of government's response in ensuring availability.

Unanimously, the respondents felt that COVID-19 containment measures had exacerbated GBV by heightening gender-based vulnerabilities, reducing access to GBV prevention and response services, and stretching an already weak GBV prevention and response system. This was coupled with a government that was grossly ill-prepared to handle GBV in an emergency. We now elaborate on key themes.

Impact on hard-to-reach women and girls

A large proportion of the respondents felt that the government's restrictive policies to contain the COVID-19 pandemic and the related socioeconomic impacts led to increased exposure of women and girls to different forms of GBV. Many saw adolescent girls and sex workers as the hardest hit.

Adolescent girls

Respondents identified adolescent girls as a particularly vulnerable group and noted that reports of increases in teenage pregnancies and transactional sex were coming in from different regions of the country. Respondents also noted that harmful practices, particularly FGM, were on the rise.

The abrupt closure of schools and community-based SRH and other programmes that support marginalised girls, as well as the economic insecurity fuelled by the pandemic, were seen as major factors for increased exposure of teenage girls to the risk of pregnancy. Respondents observed that schools and community-based SRH programmes provided girls a safe space away from their perpetrators and offered opportunities for guidance and counselling on how to avoid risky situations and behaviours. Schools and community-based SRH programmes also provided girls with access to essential services, such as menstrual hygiene products, contraceptive methods, and other SRH services.

> There is an increase in teen pregnancy. Each safe space has not less than three girls that are pregnant and it is because they missed services. (NGO provider)

> One thing I have realised, especially with the pandemic … school plays a big role in educating our children … somebody had written and said, 'all along we didn't know that teachers are contraceptive (*sic*).' Just by being there, having that class every day, they usually have these counselling sessions with the girls … look at what 3 months, 4 months, 5 months not being in school has done to our girls. (Government official)

> Schools helped us to co-ordinate supplies [sanitary towels] to girls; when the girls are out of school, distribution is difficult. (NGO provider)

The lack of services along with the economic hardships that families were facing because of the pandemic and the preventive measures has also led to reports of girls engaging in

transactional sex to obtain basic necessities, such as food and sanitary towels. Respondents were aware of cases where financially distressed caregivers encouraged girls to go out looking for money for food and other necessities:

> There is no work, but periods [menstruation] will still come. A girl got friendly with a Bodaboda [motor bike driver] to get pads and she got pregnant. (NGO provider)

In communities where FGM is still practised, respondents attributed its surge to the closure of boarding schools, which are often run by anti-FGM organisations as a strategy to protect girls from practices such as FGM and child marriage. The girls stay in the schools throughout their primary and secondary education and do not return home, even during school holidays. There were also reports that in certain communities, aided by their local leaders, individuals took advantage of the chaos caused by the pandemic to secretly conduct FGM on hundreds of girls. Other respondents noted that the government did not prioritise child protection services as essential, which meant that child protection officers, who play a critical role in helping children and their families access comprehensive post-violence services, were not available to offer support during the early phases of the pandemic:

> At first, government was in denial, but we kept on pushing and said girls are being circumcised. In May, we had 300 cases of FGM. Government was very slow and in denial and them [community] tried to hide evidence so they are not apprehended. Right now, the response is working … government is responding to cases reported. (NGO provider)

Sex workers

Sex workers were identified as another group hard hit by the restrictions imposed to contain the pandemic. Sex workers reported a loss of livelihood and inability to buy necessities as bars closed and curfew restricted movement during the night. Some have resorted to working during the day, which has come with its own challenges. For example, it has made it harder for those living with HIV to access their antiretroviral medications from clinics that operate during the day. This has also led to a loss of clients enrolled in HIV care and treatment. The closure of bars, which provided some degree of protection, has meant that sex workers must access their clients in other spaces, which has exposed them to exploitation by both their clients and the police. Their ability to negotiate is also diminished due to lack of other options to earn a livelihood:

> Girls [sex workers] are like, 'I don't really need the service, I need to look for the money because the time I have for sex work is very limited.' (NGO provider)

Impact on availability and access to GBV services and programmes

The initial phases of the pandemic were characterised by large-scale disruption of services and programmes across the different GBV sectors – essential medical and psychosocial services, police and judicial services, shelters and other social services, and community-based prevention work. Respondents attributed this to lack of preparedness to

provide essential GBV services during emergencies, weak pre-COVID GBV prevention and response systems, as well as lack of prioritisation and integration of GBV services into the government's early COVID-19 response.

> We don't know how to handle GBV in emergencies. All agencies should be trained on what to do if there are floods, pandemics and they know that GBV will increase, so we start with prevention. (Government official)

We now outline the impact of containment policies on different sectors and areas of service provision.

Access to justice services

Police. The initial phases of the pandemic were characterised by low reporting of GBV to the police, which led to a public outcry on the disconnect between what was perceived to be rising GBV cases in the communities, and paradoxically low reporting to the police. Respondents noted that the low reporting in the initial phases of the pandemic could be explained by several factors. In the first few weeks of the pandemic, the police focused on enforcing the government's COVID-19 containment directives and did not prioritise GBV cases. There were reports that survivors were turned away from police stations or asked to come back after two to three days. In addition, the national GBV hotline had to limit its operating hours to allow staff to abide by the curfew guidelines, which further restricted the ability of survivors to report to the police. Other factors that prohibited getting police support included proximity to the perpetrator, shortage of masks and transportation, fear of being mistreated by the police as reports of police abuse in imposing curfew gained media attention, as well as fear of contracting COVID-19 in public spaces:

> The major problem is that we have police involved in curfew issues. Most Gender Units are understaffed to respond to GBV … At night victims fear going to the police station due to curfew hours and people are not supposed to be outside yet you can report your case at any time. (Government official)

Subsequently, after increased public outcry and media attention on the issue, the police took several measures to prioritise GBV cases and ensure they were reported in a timely manner. In June 2020, the National Police Service set up a toll-free hotline for survivors to report GBV. The hotline is operated by trained police officers who link survivors to the nearest police stations, and connect them to the national GBV hotline so that they can access critical health, psychosocial, and other services. The police also utilised social media platforms to increase awareness and promote the use of their hotline. In August, with support from bi-lateral donors, the police launched the first Policare (Police Care) in Milimani, Nairobi. Policare is a one-stop model police station, where survivors can access critical multi-sectoral services within 48 hours of reporting:

> National Police Service is working on Policare concept, a one-stop centre for GBV survivors to access police services, legal aid, and shelter and counselling. All actors are on board. The Policare model replaces the police gender desk that has not worked well due to transfer of trained police officers. (Government official)

Courts. The courts were closed throughout the country in the early phase of the pandemic as restrictions were imposed. When they reopened, respondents noted they held fewer sessions, postponed pending cases, and gave lenient bail to GBV perpetrators to avoid overcrowding the remand prisons. There were instances where courts had to close as staff contracted COVID-19. Also, the courts only handled defilement (or sex with a minor) and rape cases, which were considered essential services, and all other GBV cases were handled at the police station level. Moreover, courts were defined as public places, deemed unsafe for children, prolonging the duration of cases involving violence against children. Respondents feared that the slower operation of the courts was likely to lead to witness tampering and repeat offences by perpetrators. From July 2020 onwards, to reduce some of the backlog, courts made provisions for electronic filing of cases and set up virtual court hearings to comply with social distancing guidelines. While respondents lauded these innovations, some felt that many women lack digital literacy skills and do not have access to internet services, so will not be able to avail themselves of these services:

> Women are not tech savvy. They can't use Zoom to address court and some don't know how to operate Zoom or Teams or a computer, especially for women in remote areas. (NGO provider)

Health and social services

Emergency clinical and post-rape care. While emergency clinical and post-rape care services were deemed essential in May 2020 by the MOH, services continued to be disrupted as the government converted health facilities into quarantine centres, and redeployed health-care workers to COVID-19 quarantine and isolation centres. Respondents noted that survivors kept away from health facilities due to fear of contracting COVID-19; or of being forced to test for COVID-19, even if they had no symptoms and had come in for another ailment, and then be made to go to a quarantine centre if they tested positive. The economic strain of the pandemic, along with increasing costs of public transportation due to social distancing measures, also made it harder for some survivors to access services, especially those living far away from the nearest facilities. Respondents noted that these factors ultimately led to survivors who made their way to the health centres receiving delayed services:

> We are seeing pregnancies [among survivors of sexual violence] that could have been avoided … Services did not stop but lots of delayed response starting with the police; people were asked to come back after two to three days. (NGO provider)

> Very many people are afraid to come to the [hospital] because people are afraid of screening. They think if you come if you have a stomach problem you are going to be screened and perhaps you may be taken to isolation. (NGO provider)

Counselling services. To comply with the government's COVID-19 guidelines, organisations providing psychosocial services to survivors closed operations in the initial phases of the pandemic. Even the national GBV hotline limited its hours of operations

to allow staff to conform to the government's curfew restrictions and get back to their homes safely. As reports of GBV surging in the country became prominent, stakeholders lobbied to keep open the national hotline. As a result, additional resources were provided by foreign donors to hire counsellors, advertise services provided by the hotline, and strengthen referrals for survivors. Other service providers resumed operations and set up toll-free hotlines, phone calls, and other virtual platforms to offer counselling services to survivors. While using technology and virtual platforms has helped cover an essential service gap, many recognised that using technology has limited impact and cannot reach the most marginalised women and girls who often lack digital literacy or do not have access to technology. Recognising this limitation, some organisations have tried to train and utilise community health volunteers to support women and girls in their communities. However, they fear this comes at a price in terms of quality of services and could lead to mistrust of the services themselves in the future:

> Majority of survivors are more comfortable with one-on-one counselling. We serve Mukuru community [an informal settlement]. Some do not have access to phones. Survivors may not have airtime and some may be using other people's phones. (NGO Provider)

> We did basic Community Health Volunteer [CHV] training on basic psychological first aid for survivors before they refer cases to health facilities. The challenge is that clients will not believe that a CHV can give professional counselling. (Government official)

Shelters. According to several respondents, the early days of the pandemic saw an increased demand for shelter services, which are very scarce in the country to begin with and could not handle this surge. Before the pandemic, the country had only one state-run shelter; most of the shelter services are provided by NGOs, using informal strategies such as finding shelter in individual homes. The surge in GBV cases, delays in obtaining protection orders, restricted movement, and lenient bond terms for perpetrators led to increased demand for shelters. Government-imposed restrictions led to several shelters closing in the initial phases of the pandemic. The few that remained open were hesitant to take new residents due to lack of food and other supplies, or demanded a COVID-19 medical certificate, which could take up to 14 days to obtain:

> Most of the shelters are privately owned and when COVID hit, they sent survivors back home because they could not afford to keep them and the ones [shelters] open are not admitting people. Most are supported by individuals. (NGO provider)

> At the beginning, shelter worked well or there were few victims. Now they are full and lack support in equipment and food to feed victims … (Government official)

The government has since tried to address some of the gaps in availability of shelters. The State Department for Gender worked with other stakeholders to map out existing and new shelters and to share information with GBV actors. At the county level, one of the counties (Makueni County) established a fully resourced shelter.

Prevention services

Community-based prevention and awareness-raising activities. Due to lack of prioritisation and restrictions imposed by the government, all community-based prevention and awareness-raising activities came to a halt in the first few weeks of the pandemic.

As COVID-19 containment measures eased from May onwards, the MOH came out with guidelines on how to resume prevention work and conduct activities in communities. The organisations are now utilising phone calls, virtual platforms, social media, and radio platforms to reach clients and communities with prevention messages and referrals to services. Organisations have also resumed in-person contact with communities, as the MOH allows activities with 15 beneficiaries per session:

> Prevention awareness has stopped completely. We had to ask what are the best methods to use? … we are now serving 15 people. (Government official)

Respondents noted that adherence to COVID-19 guidelines has increased operational costs due to the need for personal protective equipment (PPE), hand sanitiser, and larger meeting rooms, and their organisations are concerned about their ability to recover all their operational costs.

Contraceptive services. Although the government deemed family planning services as essential in May, many respondents reported large-scale disruption in availability of contraceptives, which they fear will increase unintended pregnancies. Several respondents noted that the government was discouraging use of long-acting contraceptive methods such as IUDs and implants because of the need to go into a health facility and physical contact required with a health-care worker to place them, a situation they felt will reverse gains made in promoting the use of long-acting contraception methods:

> I actually [think] the worst thing that was done was to give a direction first that SRH services were not essential, and then actually they discouraged what we call 'intrusive procedures'. And so some methods like implants, intrauterine devices (IUDs) were discouraged, which reduced the choice of the woman when it comes to the methods available. (NGO provider)

Access was also limited due to closure of community-based programmes and other outreach activities that are important sources of contraception for women living in rural and remote areas. Stakeholders also reported challenges such as stockouts of condoms and other contraceptive methods:

> Contraceptives were a challenge even before COVID; even now we don't have and looking for other ways. (NGO provider)

> Priority has been shifted to actually attend and address COVID … Even if you go to a health facility, you are told, 'ah, you've just come for family planning, you go, it's not an emergency, you have to go back. That's not an emergency, you can't be given services right now.' (NGO provider)

Stakeholders' assessment of government's response

Respondents understood the unprecedented nature of the COVID-19 pandemic, and felt that everyone, including the government, was caught off guard. At the same time, they recognised that many women and girls will pay the price of the government's failure to incorporate consideration of gender-based inequalities into the initial COVID-19 response. Respondents noted that the government could have prevented the surge in GBV by not closing schools abruptly, declaring comprehensive GBV services essential earlier and providing sector-specific guidelines, and ensuring that a safety net was available for vulnerable groups early in the pandemic. They noted that GBV stakeholders had been working with the State Department for Gender as early as March to promote the integration of gender and GBV in the government's COVID-19 response, and to find solutions for some of the challenges women and girls were facing, but they were not taken seriously in the early phases of the pandemic. Others compared Kenya's response to that of other African countries, and felt Kenya has fallen short in its response. Many noted that the pre-COVID GBV prevention and response model was weak and unprepared to handle a crisis as big as the pandemic. They noted that the Kenyan government has not fully embraced GBV as an important issue in the same way it had done for HIV, which can partly explain the weak response. Respondents called for greater ownership and engagement of the government in responding to as well as preventing GBV in the future:

> Compared to South Africa, we are not there. There is a lot that needs to be done. The national government needs to own it up. This is not a partners' problem. It is our own problem. Government needs to accept GBV the way they accepted HIV. We need to create awareness from the school, to church and everywhere. (Government official)

The respondents also highlighted that to date the government's strategy to contain GBV has mostly been reactive and weak. The government turned its attention towards GBV only after cases escalated, followed by public outcry and advocacy. For example, it was as late as May when guidelines were released by the MOH declaring emergency GBV health services as essential, and many on the ground were unaware of these directives. The police and judicial services were disrupted in the beginning, and resumed services for survivors only after increasing concerns among civil society groups on the lack of reporting of GBV cases at a time when they were escalating. Similarly, in response to social media accounts and concerns raised by GBV stakeholders on rising numbers of teenage pregnancies in all counties, on 6 July the President directed the National Crime Research Centre (NCRC) to launch an investigation on teen pregnancy/defilement. The President also directed Chiefs to register all pregnant girls so they can access free prenatal care and reveal the identities of the perpetrators. Following the presidential directives, the Ministry of Education issued a circular directing all principals and head teachers to work with the local administration to obtain details about pregnant teens. A government-led committee was constituted to generate credible data to inform strategies to address the issue. Finally, as late as 10 September, a Cabinet memo was approved to create an Interagency Programme to prevent and respond to GBV in the context of COVID-19. Under this memo, the cabinet approved the establishment of toll-free

hotlines and online and mobile applications to enable anonymous reporting of GBV and Child Rights abuses.

Overall, while respondents appreciated that the government was finally taking steps to address the serious GBV situation in the country, many were sceptical that these directives would accomplish anything tangible because of lack of resources attached to them:

> GBV has been a shadow pandemic. The President has said it has to be dealt with but no significant change in resource allocation. We are engaging the Council of Governors [COG] to adapt the Makueni county leadership that has come up with county shelter to do the same. (Donor)

> The President announced GBV is one of the priorities … looking at the patriarchal system we have, they commit to doing it but it does not translate to allocation of resources, personnel, offices; commodities needed to accomplish the goals. (NGO provider)

Conclusion

Like in the case of previous pandemics, the Government of Kenya's COVID-19 containment measures heightened the exposure of women and girls, particularly those harder to reach, to different forms of GBV. While GBV was surging in the country in the initial months of the pandemic, the government's omission to prioritise GBV services and programmes as part of the COVID-19 response greatly impacted the availability of essential services needed by survivors, such as health care, shelters, and access to justice, as well as preventive services. The government started prioritising GBV only after public outcry unfolded as GBV cases surged in April, losing critical time to counteract the surge at the beginning of the pandemic. Finally, in May the government came out with guidelines for essential health services and included health services for GBV survivors among those, and yet sector-specific guidelines to ensure availability of comprehensive GBV services were missing.

In summary, the government's approach towards handling GBV was reactive rather than proactive, and problems were addressed as they surfaced in the different sectors. Ultimately, this *ad hoc* approach has caused a great deal of hardship to Kenyan women and girls, some of whom may never fully recover from these adverse events. This could have been avoided with proper planning and the availability of strong and comprehensive GBV services and social protection systems.

The international community recognises the need for continuation of comprehensive GBV services during crises and have promulgated country guidelines to ensure the availability of a minimum package of essential services (UNFPA 2019). Availability of comprehensive GBV services, along with strong social protection systems can go a long way to avoid unintended consequences of pandemics. Countries should commit to providing these services during emergencies to prevent harm to women, girls, and children.

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