RESEARCH
REPORT

WOMEN'S EXPERIENCES

ON INTIMATE PARTNER VIOLENCE DURING THE ONGOING COVID 19 PANDEMIC

AN EXPLORATORY QUALITATIVE STUDY CONDUCTED IN FIVE COUNTIES OF KENYA.

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List of Abbreviations

AMREF	African Medical Research and Education Foundation
COVID-19	Corona Virus Disease -2019
CREAW	Centre for Rights Education and Awareness
EIGE	European Institute for Gender Equality
GBV	Gender-based violence
HIV	Human Immunodeficiency Virus)
IDIs	In-depth interviews
IPV	Intimate partner violence
IRC	International Rescue Committee
KDHS	Kenya Demographic and Health Survey
KIIs	Key Informant Interview
KNBS	Kenya National Bureau of Statistics
LSHTM	London School of Hygiene and Tropical Medicine
NACOSTI	The National Commission for Science, Technology, and Innovation
NCAJ	National Council of Administrative Justice
NGO	Non-Governmental Organization
SGBV	Sexual and gender-based violence
SSA	Sub Saharan Africa
UK	United Kingdom
UN	United Nations
UNHCR	United Nation High Commission for Refugees
VAWG	Violence against women and girls
WHO	World Health Organization

Glossary of Terms

Domestic violence refers to "*violence that occurs within the private sphere, generally between individuals who are related through blood or intimacy"*(WHO, 2013).

Gender-based violence (GBV) see Sexual and gender-based violence (SGBV).

Intimate partner violence refers to any "*behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. This definition covers violence by both current and former spouses and partners*" (World Health Organization et al., 2010).

Sexual and gender-based violence (SGBV) refers to "*any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. It encompasses threats of violence and coercion. It can be physical, emotional, psychological, or sexual in nature, and can take the form of a denial of resources or access to services*" (UNHCR, 2021). GBV (or SGBV) is often used interchangeably with violence against women.

Violence refers to "*the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation*" (Krug EG et al., 2002).

Violence against women and girls refers to "*any act of gender-based violence that results in or is likely to result in, physical, sexual or psychological harm or suffering to women and girls, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life*" (United Nations, 1994).

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Executive Summary

Emerging data and reports from those on the frontline have shown that all types of violence against women and girls, particularly domestic violence, have intensified since the start of the COVID-19 pandemic. However, most of the literature in Kenya on COVID-19 and Gender-Based Violence has been anecdotal from commentaries, organizational reports, and news sources. Additionally, the reports have mainly focused on the number of intimate partner violence (IPV) cases with limited information to help understand the risk factors of violence and the support available for the survivors.

The Centre for Rights Education and Awareness (CREAW) conducted this qualitative study between June 2021 to July 2021 in Nairobi, Isiolo, Narok, Mombasa, and Kilifi counties in Kenya. The objective of this study was to understand women's experiences of IPV during the ongoing COVID 19 Pandemic with a view of identifying common drivers and risk factors and interventions that worked well in preventing and responding to IPV. Data were collected through key informant interviews with 28 service providers, including government officials, Non-governmental Organizations staff and lawyers working on GBV, police officers, health providers, community and social workers and In-depth interviews with 26 women who have experienced IPV during the pandemic.

Summary of findings

1. **Increased experience of IPV by women.** Our findings suggest that measures to stop the rapid spreading of the SARS-CoV-2 virus, including recommendations on self-isolation, lockdown, curfew and closing of non-essential business and other working posts, may have unintentionally placed women already experiencing IPV at a higher risk of experiencing it. As a result, women reported increased frequency, severity, and new forms of violence. These findings corroborate the data and reports from those on the front lines, showing that all types of violence against women, particularly domestic violence, have intensified since the pandemic**.**

2. **Forms of IPV during the COVID-19 Pandemic.** The most common form of violence experienced by women in the five counties during the COVID-19 pandemic was physical violence (beating, hitting, and slapping)**.** Other common forms included emotional (e.g., abuse, humiliation threats), sexual (forced or unwanted sexual intercourse), and economic violence (refusing to give money for basic family needs, misuse of limited family resources). In many instances, women experienced more than one form of violence simultaneously.

Summary of findings

3. **Risk factors and drivers of IPV in the home.** Several risk factors have aggravated the IPV occurrence in the homes during the COVID-19 pandemic in the study counties. These included:

   i. **Disruption of jobs and the family economy.** In most instances, loss of income by men, who were the main breadwinner, was a major consequence of the COVID 19 lockdown and led to increased stress, irritability, and eventually violence among couples. Loss of income among women compromised their economic independence and made them more vulnerable to abuse by their partners.

   ii. **Couples spending more time together.** During the lockdown, couples were forced to spend many hours together with limited contact with other people. In the absence of coping mechanisms and security given by an established daily routine, stress escalated in the homes and fueled the perpetration of violence by men.

   iii. **Increased alcohol use.** The measures to limit mobility impacted patterns and places of alcohol consumption. Our findings suggest increased alcohol consumption among men was associated with increased violence episodes in the home.

   iv. **Loss of social support structures.** The self-isolation and social distancing measures took away the protective factors for women who were experiencing IPV, such as moments of relative freedom when the perpetrator or woman went to work or access to support by additional family, friends or service providers in private spaces and exposed them to constant danger by the forced proximity with the perpetrator.

4. **IPV response and prevention interventions during the COVID period.**

   i. **GBV response services disruption.** At the beginning of the COVID 19 pandemic, there was a slow response from the government to enlist GBV services as essential and strengthen response services for survivors. This resulted in several GBV service delivery centres being shut down or converted to COVID-19 centres and service providers, e.g., health care workers and police reassigned from GBV response to other COVID related duties. Also, the few providers that continued to offer GBV services limited the number of women who could attend the facilities to adhere to the Ministry of health social distancing guidelines. This discouraged women from taking up the services. Furthermore, many women did not seek services because they were uncertain about the service availability or feared contracting the coronavirus from the facilities.

   ii. **Strengthening of GBV response interventions.** A few months into the COVID-19 pandemic, the reports of IPV cases started increasing. This prompted groups that offer GBV services to urgently urge the Kenyan government to include GBV services

in the essential service list and augment the investments for GBV services. As a result, GBV service centres re-opened, and women started receiving support services. Also, various GBV partners started providing shelters or safe spaces to accommodate the women who have experienced violence within their homes. The National Government strengthened the national toll-free hotline 1195 to ensure 24-hour availability and collaborated with partners to offer additional hotlines to maximise the availability of virtual counselling and referral services countrywide. In addition, some counties increased the staff who could offer GBV services through training and continued mentorship and developed innovative ways to offer virtual support to women using innovative mobile applications.

iii. **Strengthening of GBV Prevention interventions.** With the rise in IPV cases during the COVID-19 Pandemic, some of the money that had been previously allocated for GBV prevention activities were re-allocated (justifiably) to COVID response services**.** However, the study participants identified some efforts from various partners to prevent IPV from occurring or reoccurring in the various counties. These include IPV awareness creation activities using radio and posters, and trucks etc., women economic empowerment programmes, e.g., issuing of loans and cash transfers to women who had experienced IPV and social support, e.g., food donations and stipends and encouraging neighbours to support each other during the hard times.

Recommendations

The National Government should:

- Allocate additional resources to address violence against women in COVID-19 national response plans and integrate violence prevention and response policies, plans and budgets.
- Include policies to protect survivors in their contingency plans. They should also ensure that IPV prevention, response and risk mitigation activities are included as a specific objective in all current and future funding appeals.
- Ensure that prevention and response services for women who experienced violence as prioritized and included in the list of essential services.
- Prioritize national mental health and psychosocial support system that addresses the risk factors associated with GBV.
- Develop and disseminate policies that create enabling business environment for women to operate their businesses and access government opportunities.
- Expand and provide inclusive social protection and financial support for women who experience IPV to mitigate the loss of income in families during the pandemic.
- Strengthen the GBV monitoring and data systems to collect data on the prevalence and nature of IPV in the context of COVID-19 across the country.

Recommendations

- Increase investments (at both National and County levels) for research on COVID and violence.

The County Governments should:

- Include policies to protect women who have experienced intimate partner violence in their contingency plans.
- Identify the interventions that worked well to prevent and respond to IPV during the COVID pandemic and allocate investments to expand and sustain them.
- Strengthen response services for women who experience violence during COVID-19 by:
    - **i.** Designating shelters as essential services and increasing resources to ensure that women have a safe space to go to when exposed to violence at home. There is an urgent need for government-owned and led shelters to ensure the sustainability of this vital intervention.
    - ii. Designating safe spaces for women to report abuse without alerting perpetrators, e.g., in grocery stores or pharmacies.
    - iii. Strengthening Hotlines and innovative service delivery models, e.g., mobile apps like the Komesha Dhuluma app used by Nairobi County during the pandemic.
    - iv. Allocating special courts for GBV cases to urgently deal with the perpetrators and enable survivors to access justice.
- Work closely with women's organizations and survivors of IPV to develop recovery plans and longer-term solutions to address the increase of violence against women and girls during COVID-19.

GBV partners should:

- Build strong advocacy and awareness about increased violence against women during COVID-19.
- Ensure that IPV survivors can access essential response services— such as case management, temporary shelter, urgent medical care and psychosocial support, and other forms of support address that meet their critical needs.
- Provide training for staff regarding how to handle disclosures of IPV and make appropriate and safe referrals.
- Identify new and/ or changed IPV-related risks within the context of their COVID-19 response and incorporate IPV risk mitigation strategies throughout program implementation. It is also important to include interventions that promote the factors that protect women from violence.
- Proactively challenge gender stereotypes and harmful masculinities, heightened under COVID-19 circumstances (e.g., increased household care work for women, financial insecurity/unemployment), with targeted messages for men to encourage healthy coping strategies in stressful situations.
- Ensure that economic support through cash and voucher assistance or adapted social protection programs have targeted women's assistance.

- Capacity building and mentorship for businesswomen, including entrepreneurial skills and helping them to access county and national affirmative action funds.
- Collect data on the needs and capacity of services to respond to the increased demand from women and girls in the context of COVID-19.

Donor should:

- Allocate, as part of the financial support provided to respond to the COVID-19 pandemic, direct funding to women's organizations working to address GBV and advance gender equality to ensure the responsiveness of programming to the needs and priorities of women.
- Align funding priorities to local context and national/county agendas.

Researchers should:

- Develop innovative approaches for research within the context of COVID-19 to better understand the dimensions of IPV, including the scale, nature of IPV, and how women are affected in the various settings.

All actors should:

- Ensure that women are provided with meaningful opportunities to participate in leadership and decision-making around program/policy design and implementation to ensure that GBV prevention, response, and coordination approaches can be carried out in a way that is context-specific, sustainable, and adapted to the gendered dimensions of the COVID-19 pandemic.

Introduction

BACKGROUND

Addressing domestic violence is a global public health priority considering both the prevalence of domestic violence and the associated physical morbidity, psychological morbidity, and mortality (WHO, 2013). Domestic violence often referred to as intimate partner violence (IPV), is a form of interpersonal violence defined as "any behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviours (WHO, 2012).

IPV disproportionately affects women, with nearly one in three women experiencing physical or sexual violence during their lifetime; in Sub-Saharan Africa (SSA), the prevalence is estimated at 37 per cent (Bacchus et al., 2018; Devries et al., 2013; World Health Organization, 2013). Similarly, in Kenya, women aged between 15-49 years are more likely to experience IPV than their male counterparts. For example, according to the Kenya Demographic Health Survey, 25% of women and 7% of men reported recent (past 12 months) exposure to physical and/or sexual IPV (Kenya National Bureau of Statistics and ICF International, 2015).

On March 11, 2020, the World Health Organization declared the novel coronavirus (SARS-CoV-2), or COVID-19, a global pandemic. It began efforts to stop the spread of the disease through hand hygiene, personal protective equipment, and limited contact with others through physical distancing (World Health Organization, 2020). On March 27, 2020, the United Nations issued a warning statement that domestic violence may rise due to the restrictive measures implemented to control the COVID-19 pandemic and called on governments to increase efforts to address the rising risks of violence (United Nations, n.d.). Increased concerns about domestic violence have since been expressed in many countries (Thomas, 2020). The reasons cited include social isolation, exposure to economic and psychological stressors, increased negative coping mechanisms (such as alcohol misuse), and an inability to access usual support mechanisms or escape abusive households, owing to quarantine measures or travel restrictions.

Kenya confirmed its first COVID-19 case on March 13, 2020. In response to the gradually increasing numbers of confirmed cases, the Government of Kenya took proactive action and ordered the closure of Kenya's international airports, introduced a nightly curfew, closed schools, and recommended that those who can work from home do so to observe principles of physical distancing (Wangamati & Sundby, 2020). These measures aim to reduce citizens' and residents' mobility, slow transmission of the virus and prevent an overwhelming burden on the healthcare system. However, while these interventions slowed the COVID-19 spread to some degree, they brought many associated social and health issues and negatively affected families.

The stay-at-home directive aimed at preventing and containing the COVID-19 spread were applied without cognisance of existing risks to vulnerable groups who face restricted movement exposing them to violence, inequalities, and stifling voices of survivors of violence and abuse (Women Rights Organizations, 2020). The inability and reduced access to income-earning opportunities, loss of jobs, and livelihoods exacerbated gender-based violence. In addition, the limited access to service providers such as health facilities, police stations, and access to courts due to physical distancing and curfew measures hampered redress to affected violence survivors (Women Rights Organizations, 2020).

> Women's experiences on intimate partner violence during the ongoing COVID 19 Pandemic

COVID-19 and Violence

Worldwide, the virus and measures to contain it have created a range of primary and secondary effects on individuals and communities (Wenham et al., 2020). There has been an increase in home-based violence against women and girls reported through media and civil society (Fraser, 2020). The UN Women noted that calls to helplines and other domestic violence reports or VAWG increased by 25-33% in various countries such as France, Cyprus, Singapore, and Argentina. Simultaneously, increased domestic violence and demand for emergency shelter have also been reported in Canada, Germany, Spain, the United Kingdom, and the United States (UN Women, 2020). Similarly, UKAID documented increased cases of domestic violence in China and Italy at the beginning of the outbreak; they warned that while the problem has been bad enough in the developed countries affected earliest by the pandemic, we are yet to discover how this will affect developing countries that were affected later. Potential impacts are likely to be exacerbated in contexts with weak health systems and existing high levels of VAWG and gender inequality (UN Women, 2020).

In Kenya, emerging data and reports from those on the frontline have shown that all types of violence against women and girls, particularly domestic violence, have intensified since the start of the pandemic. A recent study established that the number of GBV cases recorded between January and June 2020 increased by 92.2% compared with those between January and December 2019(National Crime Research Centre, 2020).

The number of sexual offences cases during the first quarter of 2020 increased by 35.8%, and the risk factors for violence were more pronounced for women and other vulnerable populations (NCAJ, 2020). Additionally, the national GBV Hotline 1195 also reported an increase of 25% in cases reported. A total of 810 cases were reported in September 2020 compared to 646 cases in August(NCAJ, 2020). The Kenya National Bureau of Statistics study showed that 23.6% of Kenyans have witnessed or heard domestic violence cases in their communities since the COVID-19 containment measure. A study undertaken by the Ministry of Health and Population Council on COVID-19 Knowledge, Attitudes, practices, and needs showed that 39% of women and 32% of men experienced tensions in their homes. Media reports have also suggested an increased risk of violence, abuse, and neglect, particularly affecting women (Austrian et al., 2020).

> 39% of women and 32% of men experienced tensions in their homes during the ongoing COVID 19 Pandemic

Pathways interlinking IPV and the COVID-19 Pandemic

There are several potential direct and indirect mechanisms purported to be influencing the increase of IPV perpetration during the Coronavirus outbreak. Peterman et al. offered nine main possible mechanisms (Figure 1) through which increases (decreases) of IPV may occur during the COVID-19 pandemic (Peterman et al., 2020). The pathways can be both direct & indirect and are likely to interact, reinforcing existing vulnerabilities.

- First, the pandemic has increased rates of unemployment to unprecedented levels pushing many households into poverty. Also, financial hardship may result in a reduced likelihood of the victim leaving the abuser. Financial abuse could be one of the many strategies for the perpetrators to prevent their victims from escaping (Eriksson & Ulmestig, 2021).
- Second, social isolation measures related to the pandemic leave many victims without social contacts and housebound with the perpetrator and potentially prevents the victim from seeking help from others (Van Gelder et al., 2020).
- Third, pandemics can break down social infrastructure; this may lead to increased family separation, intra-familial violence, and exposure of women and their children to unsafe conditions, including exposure to sexual violence and harassment as they seek to obtain basic goods, including food, firewood, and water.
- Fourth, higher mortality during the pandemic drives extended family networks to care for orphans who have lost their parents to the disease, creating new household strains. Changing family structures, combined with school closures and financial duress, can result in higher exploitation rates, transactional sex among adolescent girls, and fertility rates.
- Fifth, the services that might normally be available to IPV survivors may not be there or function at a reduced capacity. Health care providers and emergency personnel are often the first contact for IPV survivors and play a major role in screening for IPV, identifying it, and encouraging disclosure (Bradley et al., 2020). Also, police are often the first responders to IPV; therefore, restriction of movement and police engagement in new roles as enforcers of the new regulations and/or lockdowns in response to the pandemic, e.g., IPV survivors and bystanders (e.g., neighbours) may be less likely to contact the police during an incidence of physical violence. Many survivors may go unnoticed without the help of authorities and health care providers.
- Sixth, the COVID-19 pandemic has already documented how perpetrators use virus-specific misinformation and scare tactics and control behaviours to withhold safety items, e.g., face masks, hand sanitiser, soap, medications, and access to health services.
- Seventh, women already face complex decisions and a wide range of barriers preventing their ability to escape abusive partners safely. In pandemic times, when mobility is constrained, social distancing measures are imposed, economic vulnerability increases and legal and social services are scaled back, challenges in temporarily escaping abusive partners are exacerbated. The abusers may use this as an excuse for further controlling and isolating the victims.
- Eighth, there have been documented cases of aid workers responsible for assisting vulnerable populations in crises committing acts of violence against women and children (Day, 2001). Unequal power dynamics open possibilities for those meant to help—including, as seen in the Ebola response, health workers, taxi drivers, and even burial teams—to pressure populations into exploitative relationships in exchange for transport, food, cash, and vaccines.

Finally, Women make up nearly 70% of the global health workforce and are regularly subjected to abuse and harassment from colleagues and patients (WHO, 2019). Risks may be heightened in pandemic settings, harming women themselves and crippling broader health systems' effectiveness.

Figure 1 Pathways linking COVID-19 Pandemic and IPV

At the point of this study, most of the literature in Kenya on COVID-19 and violence has been released through commentaries, organizational reports, and news sources. However, the data that has been collected systematically have mainly focused on the prevalence or quantitative measure of cases of IPV. As a result, there is a dearth of qualitative data from women survivors to understand their experiences of IPV during the COVID-19 pandemic. In this background, the Centre for Rights Education and Awareness (CREAW) conducted this qualitative study to understand women's experiences of intimate partner violence during the ongoing COVID 19 pandemic in five counties in Kenya.

RESEARCH OBJECTIVES AND QUESTIONS

Women's experiences on intimate partner violence during the ongoing COVID 19 Pandemic

General objective

To understand women's experiences of IPV during the ongoing COVID 19 period in Nairobi, Isiolo, Narok, Mombasa, and Kilifi Counties in Kenya.

Specific objectives

1. To establish the nature of IPV during the ongoing COVID-19 pandemic.
2. To identify common drivers and risk factors for violence against women within households during the ongoing COVID-19 Pandemic.
3. To identify interventions that worked well in preventing and responding to IPV during the ongoing COVID-19 pandemic.

Research questions

1. What are the common forms of IPV experienced by women since the onset of the COVID-19 containment period?
2. What factors contributed to IPV in households during the COVID-19 containment period?
3. What interventions have worked well in preventing and responding to IPV during the ongoing COVID-19 pandemic?

Methodology

This section presents the study's methodological approach, elaborating the design, site and populations, sampling procedures and sample size, data collection procedures, and ethical considerations.

Design

This study was an exploratory study that employed qualitative methods. The study was implemented from June 2021 to July 2021.

Study sites

The study was conducted in Nairobi, Isiolo, Narok, Mombasa, and Kilifi counties in Kenya. The counties were selected purposively because CREAW has ongoing GBV programme work with them and their situation in regions with a high incidence of domestic violence (Table 1).

Table 1 Prevalence of IPV by region

Regions in Kenya	Nairobi	Rift Valley (including Isiolo, Narok)	Coast (Including Mombasa& Kilifi)
Domestic Violence prevalence (Physical sexual or emotional)	59.6	41.4	35.2

*Cited from Kenya National Bureau of Statistics (KNBS) et al., 2015.

Population

The study population comprised women who have experienced IPV during the COVID-19 pandemic and key informants, including government officials, non-governmental organizations staff and lawyers working on GBV, police officers, health providers, community and social workers. Below is a summary of the inclusion and exclusion criteria applied during the selection of study participants.

Inclusion criteria

Key informants

- Participants aged 18 years and above.
- Participants who work in the study areas, i.e., Nairobi, Isiolo, Narok, Mombasa, and Kilifi counties.
- Participants working in the GBV programme.
- Participants who understand and communicate well in English and/or Kiswahili.
- Participants who provided consent to participate in the study.

Women

- Participants who reside in the study areas, i.e., Nairobi, Isiolo, Narok, Mombasa, and Kilifi counties.
- Participants aged 18 years and above.
- Participants who had experienced IPV in the previous 12 months.
- Participants who provided consent to participate in the study.
- Participants who communicate well in English and/or Kiswahili.

Exclusion criteria

Key informants
- Participants who declined or failed to provide consent to participate in the study.

Women
- Participants who declined or failed to provide consent to participate in the study.

Sampling Methods

Sampling strategy

We used purposive sampling to select the study participants. The key informants were recruited from a predetermined list of actors from sectors working to prevent or respond to GBV in the counties. The specific individuals were chosen because they were knowledgeable of GBV programming. Women were selected from a cohort of CREAW beneficiaries, focusing on those who reported experiencing IPV during the Covid-19 pandemic.

Sample size

We identified and invited 31 key informants and 33 women to participate in the study. Unfortunately, three key informants failed to respond to the interview invite or were unavailable to participate. Therefore, 28 respondents participated in the key informant interviews(KIIS). All 33 women accepted the invitation to participate in the study. However, seven interviews were discontinued and excluded from the analysis because the women had not experienced IPV during the COVID period. Therefore, as shown in Table 2, we analysed 28 KIIs and 26 IDIs.

Sample size per data collection activity						
Persons	Nairobi	Isiolo	Narok	Mombasa	Kilifi	Total
Key informant interviews						
Government officials	1	1	1	1	1	5
NGO workers	1	1	1	0	1	4
Police officers	1	1	1	0	1	4
Health providers	1	1	1	1	1	5
Paralegals or lawyers	1	1	1	1	1	5
Community health workers	1	1	1	1	1	5
Total KIIs	6	6	6	4	6	28
In-depth interviews						
Women	3	5	5	7	6	26
Total	9	11	11	11	12	54

Data Collection

We collected primary data through KIIs and IDIs using semi-structured interview guides. Additionally, secondary data was retrieved through a desk review. Due to the COVID-19 containment measures, the KIIs and IDIs were conducted remotely using telephone calls. Also, a few of the KII respondents opted for zoom interviews. The interviews were lasted an average of one hour and were conducted in English or Kiswahili per the participants' preference. We sought permission from the study participants to enrol them into the study and to record the interviews.

Desk review

The desk review included CREAW GBV program reports, national and country-specific reports, and relevant study reports. The aim was to gather information on the nature of IPV during the COVID-19 pandemic in Kenya and within the five study counties.

Interviewer training and supervision

Before data collection, three research assistants underwent a one-day virtual training for remote data collection. In addition, two counsellors per county dedicated to the study also participated in the training. The training included topic on the study procedures and ethics of human subject's research-informed consent and safeguarding, introduction to intimate partner violence, psychological first aid, the study survivor response plan, referral protocols and procedures, data collection process, data quality control procedures, applications, and tools, phone and virtual interview protocols and workflows and remote interview best practices and role-playing.

Key informant interviews

We held 28 KIIs with relevant stakeholders, i.e., government officials, NGOs working with GBV survivors, police officers, health providers, Paralegals or lawyers and community health volunteers (Table 2). The interviews focused on understanding the respondents' perceptions of the common types of male-to-female IPV in their specific counties, the risk and protective factors for IPV against women, and interventions that worked well to prevent and respond to IPV during the ongoing COVID-19 Pandemic with the county. Table 3 gives a summary of the KII areas of focus.

In-depth interviews

We completed 26 IDIs with women who had experienced IPV in the previous 12 months. We interviewed the women on their experiences of IPV during the COVID-19 period. We also explored their perceptions of the IPV risk and protective factors and the support offered to them from formal or informal sectors. Table 3 gives a summary of the IDI areas of focus.

Table 3 Areas of focus for KII and IDI

Research question	Area of focus	
	KII	IDI
What are the common forms of IPV experienced by women since the onset of the COVID containment period?	Types of IPV cases reported handled during the COVID-19 Pandemic	Experiences of IPV during the COVID-19 Pandemic
What factors contributed to IPV in households during the COVID containment period?	Understanding of risk factors and triggers for IPV during the COVID-19 Pandemic	Vulnerability to IPV and triggers of conflict and violence during the COVID-19 Pandemic
What were the protective factors for IPV during the COVID-19 containment period?	Understanding of protective factors for IPV during the COVID-19 Pandemic	Protective measures and safety strategies by women
What interventions have worked well in preventing IPV during the ongoing COVID-19 Pandemic?	Experiences and effectiveness of prevention interventions, including adaptions to existing programmes, during the COVID-19 Pandemic	Experiences of and perceptions on interventions aimed at preventing IPV during the COVID-19 Pandemic
What interventions have worked well in responding to IPV during the ongoing COVID-19 Pandemic?	Experiences and effectiveness of IPV services, including adaptions to existing response mechanisms, during the COVID-19 Pandemic	Experiences of help-seeking and access to IPV services during the COVID-19 Pandemic

Data transcription, translation, and analysis

After data collection, the audio recordings from the KIIs were transcribed verbatim in MS Word and translated (for those conducted in Swahili). All transcripts were checked for accuracy by a qualified researcher. A qualitative research expert then applied an inductive and deductive thematic analysis using NVivo 10 analysis software. This entailed familiarizing herself with the transcribed material and field notes to derive meaning, generating initial codes, searching for themes, reviewing themes, and defining and naming themes (Braun & Clarke, 2006).

We sought to minimize bias by triangulating the interview results among other data sources and comparing interview transcripts between interview respondents and the desk review findings.

Ethical considerations

This study was conducted according to the considerations and research solutions recommended to the WHO by the International Research Network on Violence Against Women. Ethics approval was received from the AMREF Scientific Review
Committee, approval number ESRC P973/2021 and research license obtained from the National Commission for Science, Technology, and Innovation (NACOSTI), License No: NACOSTI/P/21/10943.

All respondents were requested to provide oral informed consent before participating in the study. Only respondents who provided consent were interviewed. The interviewers were trained to initiate the interviews when the respondent was safe and secure and ensured privacy and confidentiality.

Safety precautions were put in place to ensure that the women were not exposed to any harm.
These included conducting the IDIs in CREAW safe spaces, using study dedicated phones at the safe space to reach the respondents, providing the participant with a safe word at the beginning of the interview to use to alert the researchers in case they sensed any danger during the interview, and having a counsellor readily available to support the women at any time point during the study. In addition, the study included a survivor response plan. All the interviewers and counsellors were trained on the response plan protocol before data collection. This equipped the team to offer first psychological first aid to the women and make referrals to the relevant support services as needed. All the women were offered an opportunity to attend free counselling services immediately after the interview and three months post the study.

The research team removed personal identifiers from the dataset to safeguard participants' confidentiality. Additionally, only the study investigators had access to the data.

Study Limitations

This study was conducted in 5 out of the 47 counties in Kenya. Therefore, whilst it is particularly important to investigate the experiences from all counties and the various contexts, our research results cannot be generalized to the whole country.

We investigated the experiences of IPV survivors during the ongoing COVID-19 pandemic. Unfortunately, most of the women were still experiencing IPV and were emotional. This may have affected their ability to identify any protective factors for IPV.

Results

This section presents the triangulated findings from the desk review, in-depth and key informant interviews. The study findings corroborate those reported from other studies conducted in the country that reported an increase in IPV following the government-imposed restrictions to control the COVID-19 pandemic. In most cases, the women had experienced IPV before the institution of the COVID-19 containment measures. However, we limit the themes in this report to those related to experiencing IPV in the context of the COVID-19 pandemic. Thus, the three themes extracted from the data were i) nature of IPV experienced by women during the ongoing COVID-19 pandemic, ii) factors increasing partner violence during the ongoing COVID-19 pandemic, and iii) IPV interventions during the COVID-19 pandemic.

Nature of IPV experienced by women during the ongoing COVID-19 Pandemic.

Increased prevalence of IPV

The Kenya National Bureau of Statistics reports showed that approximately 23.6 per cent of Kenyans have witnessed or heard domestic violence cases in their communities since the COVID-19 containment measures (Kenya National Bureau of Statistics and ICF International, 2015). In addition, the national GBV Hotline 1195 received 810 cases in September (2020 compared to 646 cases in August 2020, an increase of 25 per cent (NCAJ, 2020). These findings were validated by the interviews with the women, which revealed that the COVID-19 containment measures might have unintentionally placed women already experiencing IPV at risk of experiencing it. For example, all the IDI respondents reported that they were already experiencing violence before the COVID-19 containment measures in March 2020. After that, however, the situation was aggravated, with most reporting more severe, frequent, and new forms of violence.

> *"Before corona came, he used to beat me up until I reached a point where I escaped, but I couldn't stay for long because I had left my kids. So, I decided to go back. When corona came last year, things got worse. He would chase me away with a panga [Machete] and even beat me up".*
>
> ***(58-year- old, unemployed woman Isiolo)***

> *"He would beat me, struggle me on the neck telling me that he will kill me, and I decide to leave because he used to say he will kill me. He would pick a knife and a panga and when neighbours see that they would scream until the police come and tell him to stop beating me and leave me alone……. He was beating me daily last year. Even people were saying that's not normal, there must be something, but before, he never used to beat me like that. So last year was worse".*
>
> ***(47-year-old unemployed woman, Mombasa)***

> *"We stayed together until 2019 when we started disagreeing. He had a lot of stress because he had taken some loans, and then COVID-19 came. He had a business of farming and selling cattle. So, he used to go sell at the market, and he used to do wheat farming, but it is like he did not succeed this year……. I don't know if it is because of those stresses, but he started making noise at home, beating me every day, so we started fighting there.*
>
> ***(29-year-old, casual labour, Narok)***

Forms of IPV

The most common form of violence experienced by women in the five counties during the COVID-19 pandemic was physical violence, including beating, hitting, and slapping. Other common forms included emotional, e.g., abuse, humiliation threats, sexual, e.g., forced or unwanted sexual intercourse, and economic violence, e.g., refusing to give money for basic family needs, misuse of limited family resources. In many instances, women experienced more than one form of violence simultaneously. Table 4 show the similarity in the forms experienced across all the study counties.

> *"During the pandemic, the problems we experience are finances because you find he scrutinizes my finances, and when I ask about his, it becomes a problem. When you ask him to do something that needs cash, it ends up being an argument. You find that we can't sit and discuss and reason out an issue like other couples".*
>
> ***(30-year-old, employed woman, Mombasa)***

> *"He married and brought the girl home. He chased me from the house and took me to another house there which was for drivers. I stayed there and persevered, but we were not getting along well. We do not understand each other completely. He comes takes the children to the second wife, forcing me to be alone. I saw we were not getting on well until my father came and took me out. I went stayed at home a little. He had beaten me, and I had some wounds, but I later healed."*
>
> ***(29-year-old, casual labourer, Narok)***

> *"It did [violence increased], he even sold my piece of land which I had and spent all the money. I even have a case on land matters. When he was selling, he wrote his wife died, and he doesn't have children and yet I'm alive, and I have kids".*
>
> ***(58-year-old woman, unemployed, Isiolo)***

Table 4 Forms of IPV experienced by women during the COVID pandemic in the five counties.

Nairobi	Narok	Isiolo	Mombasa	Kilifi
Physical Violence Emotional Violence Economic Violence Sexual Violence	Physical Violence Emotional Violence Economic Violence Sexual Violence	Physical Violence Emotional Violence Economic Violence Sexual Violence	Physical Violence Emotional Violence Economic Violence Sexual Violence	Physical Violence Emotional Violence Economic Violence Sexual Violence

* Retrieved from the Desk review, IDIs and KIIs.

Factors increasing partner violence.

The respondents identified various factors that increased partner violence. The common factors mentioned were financial stress due to loss of employment and income, misuse of limited family resources, couples spending more time together, increased alcohol use and loss of social support structures.

Financial stress due to loss of employment and income

After the government announced the restrictive policies to contain the COVID-19 pandemic, many families lost income due to job loss or pay cuts. The respondents stated that their husband lost their jobs or source of income during the pandemic. As a result, the men who were the main breadwinners in most households could not provide basic needs for their families. This increased stress and irritability and eventually led to violence.

> *"Culturally, men don't want to accept the situation of maybe not being able to provide for their families and would in a way escape embarrassment from their partners and end physically abusing their partner to silence them in a way".*
> *(Reproductive Health Clinician, Kilifi)*

> *"He had a business of farming and selling cattle. So, he used to sell at the market, and he used to do wheat farming, but it is like he did not succeed this year……. So, I do not know if it is because of those stresses, but he started making noise at home, beating me every day, so we started fighting there".*
> *(29-year-old woman, casual labourer, Narok)*

Women also lost their source of income during the COVID 19 period. They believed that lacking regular income led them to depend on their partners, who were often unwilling to support them, increasing the tension and violence in the homes.

> *"It has been more because of that straining I had in the house because I wasn't working. I usually say it coronad my marriage because I would have been able to buy things. After you have no job and then you are left, he also didn't want to take responsibility, so it was during this Covid time, and then there was violence, and we had nothing, so it hasn't been easy".*
> *(38-year-old, self-employed woman, Nairobi)*

> *"It started before corona, and when corona came, and I lost my business, it got worse".*
> *(32-year-old woman, unemployed, Mombasa)*

Misuse of limited resources

Despite the loss or decline in the family income during the pandemic, several participants mentioned their male partners used the limited family resources to support their social activities at the expense of basic family needs. In some cases, men resorted to selling some of the assets in the home to support some of their social habits, such as alcohol and substance abuse. This heightened the tension within the home and led to violence.

> *"So, if the money comes, it does not go to good use. Maybe the man has sold some sheep or chicken or even potatoes; he takes the money and drinks with it. When he is asked, it becomes a problem, and you know in the Maasai community, the man is the king".*
> *(Police officer, Narok)*

> *Corona had just started, and that time people didn't have money. So, slowly he decided to sell the land so that he could get money. So, I knew we were going to clash with him because I would not have accepted".*
> *(28-year-old woman, unemployed, Isiolo)*

> *"He came the other day and stole from me; he took the TV and gas, and people saw him. He was denying it, but there was a child in the plot who saw him. He also threatened me by telling me leaving him will not be so easy".*
> *(37-year-old, self-employed woman, Nairobi)*

Couples spending more time together.

As a result of the COVID-19 containment measures put in place by the government, movement was restricted, and as such, couples were forced to spend more time together at home. This seemed challenging for many, particularly where violence pre-existed in the home. In addition, women were trapped in houses with the perpetrators and could not seek external help or escape when threatened or exposed to violence.

> *"Couples been locked in the house for long hours caused a lot of tensions. Most people live in small spaces shared by large families and were not used to been contained in the space day in day out. This increased argument and tension and increased the time of exposure to partners that were already perpetrators of violence.".*
> *(Senior government official, Mombasa)*

> *"Before (COVID-19), it was at least because he would go to work. He is a driver, so he doesn't stay in the house, but when corona came, and he started staying in the house, then it (physical violence) got worse".*
> *(28-year-old woman, unemployed, Isiolo)*

Additionally, some participants indicated that when the men stayed in the house, they started noticing "faults" that would have not usually been picked up as they were exhausted from working and came home late in the evenings. This created conflict at home.

> *"So, you see the man is there every day; he sometimes sees some mistakes being done because the spaces that were there for a man to do his stuff and a woman to do hers, now that the man is in the house, you find that those spaces are not there and the little money that the woman was getting you will find it being diverted to the man".*
> *(Police officer, Narok)*

There was a general belief among many of the participants that men have authority over women in the homes and that women needed to "obey" or abide by the man's rules. This caused a lot of tension when the men had to spend more time at home.

> *"After covid came and these cases (IPV) increased, men came back home, and you know when a man is not in the house the woman is the king, she is the one controlling. And you know, in the Maasai community, the man is the king. So when he talks, the woman becomes a big child".*
> *(Police officer, Narok)*

Increased alcohol use

The COVID-19 Pandemic and its associated government measures to limit mobility impacted patterns and places of alcohol consumption. Many study participants observed an increased alcohol consumption among men and related this to the loss of jobs that left them idle and as a means to cope with stress. In addition, they associated the increased drinking with increased violence episodes in the home.

> *"This man will be at home even during the day, and you find he is now drunk. Unlike when he would be in his business the whole day, if he would drink maybe, it would be over the weekend. So, I think such closeness, which is supposed to be cordial, ended up being violent.*
> *(Prosecutor, Kilifi)*

> *"Yes, it has increased [violence]. That time he lost his job, so he became violent, he started using illicit brews. He would have issues all the time".*
> *(37-year-old, self-employed woman, Nairobi)*

> *"By virtue of the containment measures, you find, for example; here, you find the community misusing alcohol and substances. Now that happens within the living space when one happens to be intoxicated, and they tend to manifest violence to their partners".*
> *(Medical social worker, Isiolo)*

Loss of social support structures

The restriction of movement in the COVID-19 pandemic period cut off women from their social networks. The respondents noted that social isolation meant less contact with family and friends who usually provided support and protection from violence.

> *"Before people would go out and share and seek those kinds of services and social support. Now you are at home; you are cut off from your peers, particularly young people; you do not have access to any information, you do not have access to your social network, so you are just alone. That, again, is causing a lot of trauma to most of these victims.*
> ***(Reproductive Health Nurse, Narok)***

> *"Women also the lack the escape route they had, e.g., they would previously say they were going to the market or visit relatives".*
> *(Senior government official, Mombasa)*

Closure of support services

At the beginning of the Pandemic, the stay-at-home orders that the government instituted led to the disruption of most services across the country. A key concern raised by the respondents was the government's slow response in including GBV in the list of essential services. This led to the shutdown of several of the GBV support centres or conversion to COVID-19 centres. Therefore, women who were experiencing violence had nowhere to seek support or refuge.

> *"Support services were also closed or transformed to COVID response centres, so women had nowhere to seek support".*
> *(Senior government official, Mombasa)*

> *"When covid came, and everybody was thrown off guard, it took some time before the Ministry also began to re-organize itself so that people can access the health facilities. At some point, people were being asked to mainly visit their local dispensaries, and unfortunately, some of these health centres do not provide the needed care for such victims. They would require higher-level support from higher health facilities at the district level; by then, these services were not being faced."*
> *(Nurse, Narok)*

Additionally, some IPV providers scaled down their services to adhere to the social distancing guidelines. This limited the number of women who could offer services daily and discouraged some from taking up the services.

> *"When people come to our offices, we make sure they do not come many of them, we plan them…. We make sure they are not many, we give them appointments to make sure we don't get Covid".*
> *(Community health volunteer, Mombasa)*

IPV interventions during the COVID-19 Pandemic

IPV Response services

As the reports of IPV started increasing, groups that offer IPV response and prevention services successfully urged the Kenyan government to include GBV services in the essential service list. This aided the opening of the GBV service centres, and women started receiving support services.

> *"We were also writing our recommendations to the president as COVID-19 information is being given; we had a task force for the government. So that the task force would raise issues and made sure that even IPV services were regarded as essential services. And we achieved that of course, and so the survivors can be supported".*
> *(Senior government official, Nairobi)*

Health services

Several of the women expressed their satisfaction with the support that they received from the service centres.

> *"Medical health, yes I was satisfied. They always attended to me well. They made sure that I am treated; they made sure I got the proper medication, and even as we speak now where I go and get my medicine, they know my problem, and they do it well".*
> *(29-year-old, small scale business owner, Nairobi)*

> *"The hospital was able to help me because I got healed completely where I had been beaten because they gave me something to apply and medicine to swallow".*
> *(27-year-old, small scale business owner, Isiolo)*

> *"I reported three times. Around Nyali, there is an office for Gender-based violence for women. They referred me to Tononoka where they really helped me".*
> *(25-year-old small scale business owner, Mombasa)*

> *"Of course, most of the services were affected because remember when the covid crisis came in a lot of people were told not to visit health facilities. I think there was a lot of discrimination around health facilities. The fact that when you go to a health facility, there is a possibility that you will be infected by COVID, so most of these people were not able to come for those essential services."*
> *(Reproductive Health Nurse, Narok)*

The respondents also identified the countrywide curfew as a barrier to accessing services and reporting. In addition, the police, who are usually the first point of contact for IPV reporting, were unavailable to support the women as they were engaged in new roles such as enforcing lockdown and curfew directives

> *"Of course, yes, when a person is abused after the curfew, they can't come to report for us to get the evidence in case it is rape, assault because they fear they will get arrested. When curfew starts, most of our personnel are not concerned with such issues; rather, they are concerned by enforcing the curfew."*
> *(Policeman, Kilifi)*

Shelters / safe spaces

Most key informants highlighted that the lack of shelters or alternative safe spaces to refer to the women experiencing violence in the communities was a major problem.

> *"One of the challenges we face is finding an alternative space for the survivor at that particular moment when they come to the hospital …. After we have treated and given them counselling, but you find they have to go back to the same environment, and she will be exposed to another assault because the issues have not been resolved.*
> *(Reproductive Health Clinician, Kilifi)*

> *"Actually, you would find no shelter would accept these victims of intimate partner violence. So, you could be placed in a difficult place between a rock and a hard ground on where to place this particular victim of intimate partner violence that you may be faced with."*
> *(Police officer, Isiolo)*

> *"You know in Mombasa we don't have a centre, so what normally happens, maybe like you take her to her relatives, or a social worker has taken her in or the church or the mosque, religious leaders".*
> *(Community Health Volunteer, Mombasa)*

The few available shelters received a higher number of women who had experienced violence coming in during the COVID pandemic than before and were overwhelmed. Also, they had to limit the number of women they could take in to adhere to the COVID-19 control measures.

> *"Cases of Intimate Partner Violence has increased from 50% to 90 %. We have received a lot of cases during this COVID Pandemic, i.e., women who have been abused physically like through fights, Economic abuse, Emotional abuse like insults".*
> *(Shelter coordinator, Mombasa/Kilifi)*

In response to advocacy efforts by various GBV partners across the counties for the government and funders to provide shelters or safe spaces to accommodate the women who have experienced violence within their homes, the respondent noted some effort from the government. For example, some county governments strengthened their policy documents to highlight the need for more investment in shelters and developed operational guidelines. Others collaborated with NGOs and private partners to convert government offices and schools into temporary shelters.

> *"Then we have also established guidelines for the establishment of those safe and protective spaces".*
> *(Senior Government official, Nairobi)*

> *"Yeah, there are shelters. Last year we managed to convert some of our offices to that kind of shelters, and we are working in collaboration with non-state actors to develop it and probably put some budget to make them habitable. But we have already identified some as a county".*
> *(Senior Government official, Narok)*

> *"All of them are privately owned. It's now that we are putting one up for the county that is government-owned. It's now that we're in the process of putting one up, but previously we have worked with like Shinning Oak for communities, it's called Shofco, we have another one called Woman hope".*
> *(Senior Government official, Nairobi)*

The respondents lauded the efforts made by the NGOs to bridge the gap of inadequate government-owned shelters by advocating for and supporting more shelters during the COVID period that supported women and their children to access safety and other appropriate services.

> *"I can mention of I know like Makaueni already put one in place [a shelter], I also know Mombasa they are also doing the same, I know they have identified the site, they identified the site. In Meru the centre is complete. Only that it has not been equipped. We have been pushing for the same. Most of the CSO, you realize we are in the national technical group and also in the counties that we are working in advocating for better health services, Shelters and safe spaces in police stations".*
> *(NGO worker, Nairobi)*

> *"We also had a case where a father was abusing the children, and when the mother intervened, she was beaten and sent out of the house. We are currently offering shelter for her and the children. CREAW has supported us in ensuring that the women recover. When they arrive at the shelter, we give them soap, toothbrushes, toothpaste, sanitiser, pants, and lotion. When they are discharged to a safe space, they are given some small funds to start life at home for those who are not able".*
> *(Shelter coordinator, Mombasa/Kilifi)*

Several partners used social media platforms to create awareness to ensure that women knew of the shelter services.

> *"We collaborate with other institutions and organizations through social media and word of mouth, i.e., the GBV centres, the police, FIDA, CREAW etc. We also have a hotline where the survivors can call for rescue".*
> *(NGO staff, Nairobi)*

Toll-free Hotlines and virtual services

The respondents commended the national government for strengthening the 1195 GBV toll-free hotline to ensure that it was accessible 24-hours. They also noted an increase in the number of additional hotlines supported by partners to support violence survivors across the country.

> *"Of course, some of those additional interventions were to revamp the 1195 to make sure that we more staff be able to respond to the many calls that were coming. So, we had to make sure that 1195 is working 24 hours and it has enough staff to be able to handle the numbers".*
> *(Senior government official, Nairobi)*

> *"What the Ministry of Health initially did in addition to 1195 was the other hotline given by the police, we also had our lines, whereby they were initially set out because of COVID related issues."*
> *(Medical social worker, Isiolo)*

> *A toll line was also provided by individual health facilities so that in case there is any challenge, they are able to reach out to the nurse, the clinician who is in charge of that facility, they would still care for them, or they would be visited at the household levels."*
> *(Reproductive Health Nurse, Narok)*

The hotlines were manned by trained service providers who counselled the survivors and referred them to appropriate services.

> *"I was given their number by another Swahili lady who used to stay in Tononoka, and she told me to call them, and when I called they told me to go to their office in Tononoka, and I explained to them what I was going through, and they directed me to an advocate who drafted a letter to give to my husband….So, when you go there, the GBV team intervenes, and you are helped."*
> ***(47-year-old, unemployed woman, Mombasa)***

In addition, some counties also developed innovative ways to continue offering support to women virtually through innovative mobile applications and Zoom apps.

> *"We also launched recently an app called Komesha Dhuluma. That one in English is stop violence if I may translate it directly. For the ones who have a smartphone and even those who do not have a smartphone, there's a USSD code that they can use to access the services. So, the services that's out there is that you input your… not necessarily your name, but perhaps the kind of violation that is going on and you're linked to 1195 or 116 for children cases. Yeah. It's very easy to use".*
> ***(Senior government official, Nairobi)***

> *"We've put in place in post-COVID, like constituting, small groups and reaching them through these kinds of meetings, like zoom, the virtual meetings and that kind of thing, which are very expensive, you know."*
> ***(Senior government official, Narok)***

Legal aid and Justice

With the onset of the COVID-19 pandemic in Kenya, diverse interventions were instituted at the judiciary headquarters and court level. While some interventions aimed to mitigate the spread of the coronavirus through courts, others aimed to enhance continuity in access to justice during the pandemic period. Further, the interventions differed across jurisdictions and evolved from time to time as the pandemic persisted. The study respondents appreciated the efforts made by the sector, particularly for adapting their service delivery approaches to online platforms to ensure continuity in service delivery to survivors of GBV.

> *"We now have an online court that enables the cases to be heard faster. This is an automated service that can be accessed anywhere, even through the phone. For those with no such gadgets, CREAW has enabled the survivors to come to their office and access court from their office. I have several clients whom I have never met face-to-face, but through the virtual platform, I have been able to help them file cases, sign online through email, pleading for them, and conducting and presenting their cases in court".*
>
> ***(Lawyer, Nairobi)***

> *"Nowadays, the perpetrators are being heard at the police station. Therefore, the police do not have to wait to present the perpetrators at the physical court. This has ensured that the bond is not given by the police but by the magistrate".*
>
> ***(Lawyer, Nairobi)***

> *"These interventions have been effective to the extent that when these women come to report like for example if they want to take legal action, with the help of organizations like let's say CREAW we have been able to get these cases to go to court and then the partners are summoned, and legal actions are taken on them so that we can be able to prevent them from doing more harm and continuing traumatizing and hurting these partners of theirs".*
>
> ***(Nurse, Nairobi)***

Increased staffing

Additionally, with the increase in the number of IPV survivors reporting at the service centres, there was a need for additional community health volunteers and GBV service providers to provide referral and linkage, health, and counselling services as needed. Respondent working with the county governments confirmed that there were deliberate efforts to increase the number of staff who could offer GBV services through training and continued mentorship.

> *"Ministry trained community health volunteers so that they are able to detect, refer and support those people who are going through that kind of trauma and particularly our focus was gender-based violence general".*
>
> ***(Reproductive Health Nurse, Narok)***

IPV prevention services

The rise in IPV cases during the COVID-19 Pandemic has justifiably led to a lot of focus on the response services. Some respondents note that some of the money that had been previously allocated for GBV prevention activities were re-allocated to COVID response services.

> *"So basically, it (COVID-19 pandemic) affected our prevention measures greatly. Then you see even allocation of resources. We did not have resources to be able to offer even services to the survivors because all the resources went to the prevention of COVID even up to now, we have not received any allocation for IPV issues from the government."*
> ***(Senior Government official, Nairobi)***

However, the respondents noted substantial efforts from various partners to prevent IPV from occurring or reoccurring in all the study counties. The interventions mentioned include IPV awareness creation activities, women economic empowerment programmes and social support.

Sensitization through awareness creation

Several respondents reported working closely with the county government to implement IPV awareness creation activities using mass media, e.g., radio and posters, and trucks and boda boda riders' campaigns. These helped to highlight the seriousness of GBV, disseminate the GBV laws, and inform the women about the existence of GBV services in their communities.

> *"We have done sensitization of the law to let people know it is against the law to beat your wife or anyone you are intimate with. In the scenario people don't listen, the law takes its place".* ***(Policeman, Kilifi)***

> *"Awareness creation and sensitisation at community through media, talk shows on radio, truck campaigns, bodaboda riders - to disseminate the message that IPV is wrong and help community members understand the negative impacts of IPV and know where to access the services".*
> ***(Senior government official, Mombasa)***

Despite these efforts to create awareness around IPV services, several IDI respondents were unaware of any services provided by the government to survivors and therefore did not access any services. On the other hand, a number reported that NGOs, family, and friends supported them.

> *I have not seen such. When one is abused, you have to go to the police or the chief because no one will come and check up on you.*
> ***(58-year-old, small scale business owner, Isiolo)***

> *I don't know because I don't see it anywhere.* ***(36-year-old, small scale business owner, Kilifi)***

> *Not from the government but my friend who gave me a place to stay.*
> ***(32-year-old, unemployed woman, Mombasa)***

> *I can't talk about the government because I haven't engaged them on GBV. But, I would say NGOs are trying because there are so many organizations dealing with those issues.*
> ***(37-year-old, self-employed woman, Nairobi)***

Economic empowerment

To ease the economic hardships aggravated during the COVID-19, some county governments and NGOs started to offer economic support to IPV survivors. The support included loans and cash transfers.

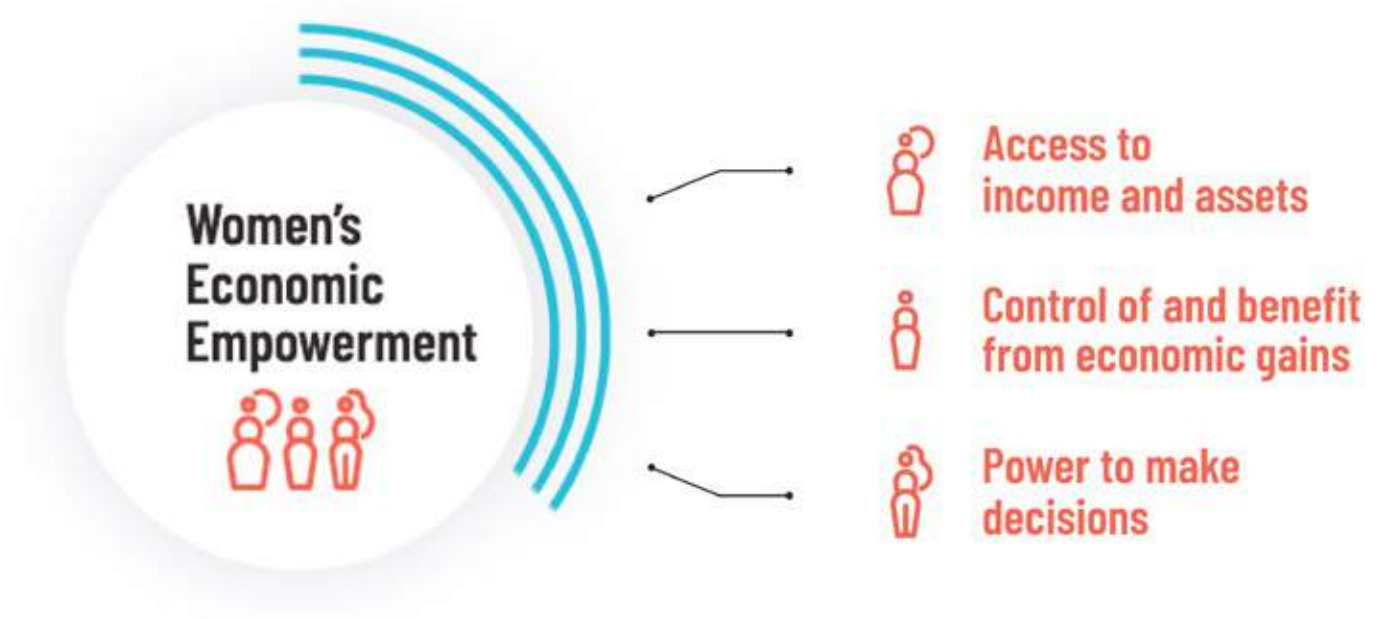
> *"Women are given loans to start businesses after the counselling. Also, you can't just counsel someone. You have to help further, you help them start a business, and you follow up on how it is going.*
> ***(Community Health Volunteer, Kilifi)***

> *"The one that is there is the one from CREAW, the money they gave us really helped me a lot. It made me grow my business, and I took all my children to school and bought them what they needed, so they feel like the other children who have a father and a mother".*
> ***(58-year-old woman, small scale business owner, Isiolo)***

> *What I can say is CREAW, through Mastercard, have brought funding for women to start businesses so that they can depend on themselves because there are many women who come to me and tell me that the project has really helped".*
> ***(Community Health Volunteer, Kilifi)***

Some counties offered female-run businesses waivers for their business permits and encouraging neighbours to support each other during the hard times.

> *Waiver of 30% was offered to women doing new business. They were also offered reprieve for a single business permit to women. We provided revolving funds for women and special interest groups who could not support themselves. This time the county made special consideration for IPV survivors as a priority and were now considered to access the fund as individuals (previously only given to groups) and loans with A small interest of 7% with one year Grace period."*
> ***(Senior government official, Mombasa)***



Social support

Additionally, the county government and GBV partners offered women experiencing IPV social support, e.g., food donations, dignity packs and stipends. Some IDI respondents also acknowledged that they received support from their family and neighbours.

> *"We actually made sure that those families were given food and the government stimulus packages that were coming through the county commissioner's offices. We actually liaise together to make sure that the most vulnerable families received those stipends, even if they were too little.".*
>
> ***(Senior government official, Nairobi)***

> *"There are days the kids don't get anything, so I go borrow from the neighbour. My mother also gave me a cow which I now milk and boil for the children some milk……. she gave me the cow to come and milk".*
>
> ***(31-year-old, small scale business owner, Narok)***

> *"We offered cash transfers and in-kind support, including dignity packs with soap sanitisers, under ware, Menstrual hygiene commodities, food etc."*
>
> ***(Senior government official, Mombasa)***

RECOMMENDATIONS

As a key priority, it is crucial for policymakers at the national and county level, funders and GBV implementing organizations to prioritize GBV prevention, response, and risk mitigation approaches as essential parts of COVID-19 related programming. Without adequate funding and political will, it will not be possible for GBV interventions to be carried out effectively. These sections summarize the key issues the stakeholders should consider strengthening the services offered to women experiencing IPV during the COVID pandemic and beyond.

THE NATIONAL GOVERNMENT SHOULD:

- **Allocate additional resources to address violence against women in COVID-19 national response plans** and integrate violence prevention and response policies, plans and budgets.
- **Include policies to protect survivors in their contingency plans.** They should also ensure that IPV prevention, response and risk mitigation activities are included as a specific objective in all current and future funding appeals.
- **Ensure that prevention and response services for women who experienced violence as prioritized and included in the list of essential services.** This will ensure that whenever movement restrictions are put in place to prevent the spread of COVID-19, exceptions to these policies should be issued for survivors of violence or those at risk of experiencing violence so that they can seek safety and vital access forms of support.
- **Prioritize national mental health and psychosocial support system that addresses the risk factors associated with Gender-Based Violence.**
- **Develop and disseminate policies that create enabling business environment for women to operate their businesses and access government opportunities.**
- **Expand and provide inclusive social protection and financial support for women who experience IPV to mitigate the effects of the loss of income in families during the Pandemic**
- **Strengthen the GBV monitoring and data systems to collect data on the prevalence and nature of IPV in the context of COVID-19 across the country.**
- **Increase investments (at both National and County levels) for research on COVID and Violence.** This will give appropriate information to inform quality and responsive programmes.

THE COUNTY GOVERNMENTS SHOULD:

- **Include policies to protect women who have experienced intimate partner violence in their contingency plans.** They should also ensure that IPV prevention, response and risk mitigation activities are included as a specific objective in all current and future funding appeals.

- **Identify the interventions that worked well to prevent and respond to IPV during the COVID pandemic and allocate investments to expand and sustain them.** This is critical because although the COVID-19 restriction measures are easing, the social and economic impact of the pandemic will linger on for a while. Therefore, risk factors of IPV are likely to continue.

- **Strengthen response services for women who experience violence during COVID-19 by:**
  1. Designating shelters as essential services and increasing resources to ensure that women have a safe space to go to when exposed to violence at home. There is an urgent need for government-owned and led shelters to ensure the sustainability of this vital intervention.
  2. Designating safe spaces for women to report abuse without alerting perpetrators, e.g., in grocery stores or pharmacies.
  3. Strengthening Hotlines and innovative service delivery models, e.g., mobile apps like the Komesha Dhuluma app used by Nairobi County during the pandemic.
  4. Allocating special courts for Gender-based Violence cases to urgently deal with the perpetrators and enable survivors to access justice.

- Work closely with women's organizations and survivors of IPV to develop recovery plans and longer-term solutions to address the increase of violence against women and girls during COVID-19.

GBV PARTNERS SHOULD:

- **Build strong advocacy and awareness about increased violence against women during COVID-19.**

- **Ensure that IPV survivors can access essential response services— such as case management, temporary shelter, urgent medical care and psychosocial support, and other forms of support address that meet their critical needs.** Considering the heightened risk of household violence within the context of COVID-19, service providers should also carefully determine ways to reach survivors who may be restricted from accessing forms of support. They should ensure that information on existing services and mechanisms for seeking help within the context of the COVID-19 pandemic are widely disseminated throughout appropriate networks and mechanisms.

- **Provide training for staff regarding how to handle disclosures of IPV and make appropriate and safe referrals.**

- **Identify new and/ or changed IPV-related risks within the context of their COVID-19 response and incorporate IPV risk mitigation strategies throughout program implementation. It is also important to include interventions that promote the factors that protect women from violence.** For example, in this study, men's alcohol use was identified as a common cause of IPV in the homes.

- Therefore, an IPV prevention strategy that addresses alcohol is critical and should be situated within a broader prevention strategy. In addition, to help alleviate the finance-related stress, another common cause of

violence, there is also a need to expand activities to improve women's control and use of resources. Also, considering the gendered dimensions of the COVID-19 pandemic, GBV service providers must engage in GBV prevention approaches to address the root causes of violence and discrimination.

- Proactively challenge gender stereotypes and harmful masculinities, heightened under COVID-19 circumstances (e.g., increased household care work for women, financial insecurity/unemployment), with targeted messages for men to encourage healthy ways of coping with stressful situations
- Ensure that economic support through cash and voucher assistance or adapted social protection programs have targeted women's assistance.
- Capacity building and mentorship for businesswomen, including entrepreneurial skills and helping them to access county and national affirmative action funds.
- Collect data on the needs and capacity of services to respond to the increased demand from women and girls in the context of COVID-19.

DONOR SHOULD:

- **Allocate, as part of the financial support provided to respond to the COVID-19 pandemic, direct funding to women's organizations working to address GBV and advance gender equality to ensure the responsiveness of programming to the needs and priorities of women**
- **Align funding priorities to local context and national/county agendas.**

RESEARCHERS SHOULD:

- **Develop innovative approaches for research within the context of COVID-19 to better understand the dimensions of IPV, including the scale, nature of IPV, as well as how women are affected the various settings**

ALL ACTORS SHOULD:

- **Ensure that women are provided with meaningful opportunities to participate in leadership and decision-making around program/policy design and implementation to ensure that GBV prevention, response, and coordination approaches can be carried out in a way that is context-specific, sustainable, and adapted to the gendered dimensions of the COVID-19 pandemic.**

CONCLUSION

This study highlighted the experiences of IPV by women during the COVID-19 pandemic in five counties in Kenya.

Even though the COVID containment measures have begun to ease, the social and economic impact of the pandemic will linger on for a while.

Therefore, the risk factors of IPV are likely to continue. Understanding the dynamics of violence and risk factors associated with IPV can facilitate the discussion and understanding of how emergencies, like the Covid-19 pandemic, can impact and further aggravate those factors triggering occurrences of IPV.

This report has proposed actionable recommendations to mitigate IPV in emergency settings, including highlighting some of the interventions that worked well that can be sustained beyond the pandemic.

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