GENDER-BASED VIOLENCE *in* KENYA: THE COST *of* PROVIDING SERVICES

A Projection Based on Selected Service Delivery Points

2016

National Gender and Equality Commission

Head Office
Solution Tech Place, 1st Floor, Longonot Road
Upperhill, next to Crowne Plaza Hotel
PO Box 27512-00506, Nairobi

Kisumu Office
Reinsurance Plaza, 3rd Floor, Wing B
Oginga Odinga Street, Kisumu

Nakuru Office
Tamoh Plaza, 1st Floor, Kijabe Street
PO Box 15263-401, Nakuru

Garissa Office
Opposite Care International offices
Garissa

Contacts
+254 20 272 7778
info@ngeckenya.org
@NGECKenya
www.facebook.com/NGECKenya
www.ngeckenya.org

Content: HECTA Consulting Ltd.
Editing and design: Edward Miller
Printing:

This report was prepared by HECTA Consulting Limited for the National Gender and Equality Commission, with funding from a UNFPA grant.

The report provides an analysis of the total costs of providing comprehensive services to survivors of gender-based violence in Kenya. The study provides an estimation of the resources required to scale up the provision of services related to gender-based violence using the one-stop model and projects the costs of providing such services over a five-year period. Data collection commenced in 2014, and the report was published in 2016.

The National Gender and Equality Commission is a constitutional body established in 2011 to promote gender equality and freedom from discrimination among all Kenyans and in all spheres of life. For more information, visit **www.ngeckenya.org**.

The views expressed in this report do not necessarily reflect the views of the UNFPA.

Financial support provided by:

jpgewe Govt. of Kenya & UN
Joint Programme on Gender Equality & Women's Empowerment

NORWEGIAN EMBASSY

GENDER-BASED VIOLENCE IN KENYA: THE COST OF PROVIDING SERVICES

A Projection Based on Selected Service Delivery Points

CONTENTS

FOREWORD

Gender-based violence (GBV) is one of the most severe forms of gender inequality and discrimination in Kenya. GBV remains one of the most pervasive human rights violations of modern time. It is an issue that affects women disproportionately, as it is directly connected with the unequal distribution of power between women and men; thus, it has a profound effect on families, communities, and societies as a whole.

The consequences of GBV are severe, particularly for women suffering multiple vulnerabilities. These include women from poor and low-resource settings, those with disabilities, women from minority and marginalized groups and communities that have suffered historical injustices, young girls, and older women, just to mention a few. GBV is often condoned by customs and reinforced by institutions.

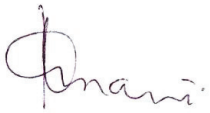
While the world has achieved progress towards gender equality and women's empowerment under the Millennium Development Goals, women and girls continue to suffer discrimination and violence. Gender equality is not only a fundamental human right, but a necessary foundation for a peaceful, prosperous, and sustainable world. Providing women and girls with equal access to education, health care, decent work, and representation in political and economic decision-making processes will fuel sustainable economies and benefit societies and humanity at large.

The elimination of gender-based violence and the protection of survivors are also stated goals in certain Kenyan legislation and in various policy frameworks, as well as in Vision 2030. Kenya is also a signatory to international and regional declarations against GBV. Provision of a comprehensive response to GBV has been a priority objective for UNFPA and the National Gender and Equality Commission (NGEC).

Understanding the costs of providing a minimum package of services to GBV survivors at national and county levels and estimating the resources required to scale up GBV prevention and treatment services in Kenya will contribute to more informed decision making and planning in this sector. It will also support the comprehensive process of implementing policies in this field and will provide data to lobby for additional resources for GBV services from the national and county governments.

This report aims to analyse and estimate the costs of providing GBV services in Kenya from a health systems perspective. The report presents the economic cost of providing a minimum package of GBV services in all county referral hospitals in Kenya and models the cost over a five-year period. The report also presents the financing gap for the provision of services to GBV survivors in Kenya.

This report is expected to guide national and county governments in planning, budgeting for, and investing in prevention and treatment programmes towards the elimination of GBV in Kenya. It is hoped that through this document, Kenya will make even greater strides towards adequate service provision to GBV survivors of all categories, male and female.



Winfred Osimbo Lichuma, EBS
Chairperson
National Gender and Equality Commission

Siddharth Chatterjee
Representative
UNFPA Kenya

ACKNOWLEDGEMENTS

The National Gender and Equality Commission thanks all the people, institutions, and agencies who contributed in various ways towards the completion of this report. We specifically acknowledge the valuable contributions of directors and health providers from the facilities contacted in the course of the study. They made available records and inventories of services and products in their facilities, which we appreciate.

We sincerely appreciate the information provided by the Ministry of Health on this subject, particularly the agreement on the most suitable variable to be used in the costing exercise. We thank the directors of LVCT Health, FIDA-Kenya, the Coalition on Violence against Women, and the Centre for Rights Education and Awareness, who have worked in the GBV sector for many years, for their valuable insights in preparing this report.

We acknowledge the financial and technical resources from UNFPA, without which this study would not have been possible. Special thanks to HECTA Consulting Limited for taking leadership in undertaking this study.

Finally, special thanks to the commissioners and staff of the National Gender and Equality Commission, who worked tirelessly, together with other stakeholders, to ensure the timely completion and dissemination of this report.

Paul Kuria
Ag. Secretary/CEO
National Gender and Equality Commission

EXECUTIVE SUMMARY

Background

Gender-based violence (GBV) is a widespread global epidemic with far-reaching consequences and long-lasting effects on survivors, perpetrators, families, communities, and nations. GBV has been defined as "any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females". It encompasses sexual violence, domestic violence, sex trafficking, harmful practices (such as female genital mutilation/cutting), forced/early marriage, forced prostitution, sexual harassment, and sexual exploitation, to name but a few. Because GBV is rooted deeply in gender inequality, women (young and old) are primarily affected. GBV disproportionately affects low- and middle-income countries, with an estimated more than 90 percent of all violence-related deaths occurring in these settings [1].

While data is very limited on GBV in Africa, estimates suggest that it poses a major health, human rights, and development challenge in the region. In Kenya, the 2008–2009 Kenya Demographic and Health Survey showed that about 45 percent of women aged between 15 and 49 years had experienced either physical or sexual violence. Specifically, the report reveals that 25 percent of women have experienced

ACRONYMS AND ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
FIDA	Federation of Women Lawyers
GBV	gender-based violence
HIV	human immunodeficiency virus
KES	Kenya shilling
NGEC	National Gender and Equality Commission
OSC	one-stop centre
UNFPA	United Nations Population Fund
USD	United States dollar

physical violence, 7 percent have experienced sexual violence, and 14 percent have experienced both physical and sexual violence [2].

With such a high burden of GBV in Kenya, it is imperative that the country prioritizes investment in the provision of care for survivors of GBV. This investment must, however, be guided by evidence on the cost of providing these services.

This report aims to analyse and estimate the costs of providing GBV services from a health systems perspective in Kenya. The study presents the annual economic costs of providing a minimum package of GBV services using the one-stop centre model and the costs of providing these services over a period of five years at the county level. The study also estimates the financial gaps in GBV services.

Objectives of the Report

The objective of the report is to estimate the costs of providing GBV services and the budgetary implications of providing these services using the one-stop centre model proposed by the national government. The report also projects the costs of providing such services for a period of five years from the year of study and estimates the financial resource gap.

Methodology

This was a cross-sectional study, which adopted a health systems perspective on costs. As such, the study considered only those economic costs that are borne by the providers of GBV services. Data was collected through key informant interviews, document reviews, and a facility costing survey.

Key Findings

The mean cost of providing a minimum package of GBV services, as defined in the one-stop model in a first referral public hospital (county referral hospital), is KES 44,717 (USD 502) per survivor, while the median cost is KES 43,769 (USD 492). Of these costs, legal costs consumed the largest share of resources

(75 percent). The total cost of providing GBV services under the one-stop centre model to all 47 counties over a five-year period (2014–2019) is KES 10,798,520,644 (USD 121,331,692.6). Over 90 percent of the resources for GBV services come from development partners.

Summary of Recommendations

A number of recommendations can be drawn from this analysis:

1. Both the national and county governments should set aside adequate domestic resources to support GBV services. While development partners have supported GBV services over a long period, there is a large funding gap (and the heavy reliance on partners has negative implications for sustainability). The GBV unit within the Division of Family Health should draw on the results presented in this report to advocate for resources from the national and county governments.
2. There is a need for the government and stakeholders to clearly articulate the preferred model for the provision of GBV services. Rather than set up one-stop centres where all services (medical, legal, psychosocial, and security) are under one roof, a model that creates a coordinated network of these service providers is preferred. This is thought to be more feasible and sustainable in the Kenyan setting.
3. The government should create a budget line for funding GBV services and commit budgetary resources towards them. There is currently no budget line for GBV services.
4. The government should put in place a robust, routine data collection and information management system for GBV service provision statistics. Our experience was that there was scarcity of data and, where available, it was neither in a standardized format nor good quality. Timely, reliable, and good quality data is a useful ingredient for decision making.

INTRODUCTION

Kenya has made significant strides within its policy and legislative framework relating to GBV through the passing of the Sexual Offences Act (2006), the HIV and AIDS Prevention and Control Act (2006), the Prohibition of Female Genital Mutilation Act (2011), the Employment Act (2007), the Protection Against Domestic Violence Act (2015), and the development of the National Monitoring and Evaluation Framework towards the Prevention of and Response to Sexual and Gender-based Violence in Kenya, among others. The Division of Family Health in the Ministry of Health has also developed relevant policies, namely the National Reproductive Health Policy and a draft Adolescent and Reproductive Health Policy.

The Constitution of Kenya has also brought great gains in human rights protection. A National Framework on Gender-based Violence Prevention and Response in Kenya (2009) has also been developed, which is one step towards the clear coordination of the multisectoral efforts to prevent and respond to GBV. Further, the *National Guidelines on the Management of Sexual Violence in Kenya* (third edition, 2014) and draft multisectoral standard operating procedures on GBV management (2013) are also valuable resources for ensuring that the services provided to survivors of GBV are standardized and of acceptable quality.

Although recent data on GBV is lacking, estimates from the 2008-2009 Kenya Demographic and Health Survey show that about 45 percent of women aged between 15 and 49 years have experienced either physical or sexual violence [3]. Given that GBV is highly stigmatized in Kenya, it is likely that these figures underestimate the prevalence and incidence of the violence. Despite such high levels of GBV, access to GBV-related services remains a challenge for those in need. In order to increase access to care and support, there is a need for Kenya to invest in improving the availability and quality of GBV services offered in the country. Key to the scaling up of these services is estimating the resource requirements and the respective financing gap.

Kenya's GBV response mechanisms are plagued with a number of challenges: lack of institutionalization, inadequate human resource capacity to support GBV services, and chronic underfunding by the government. Most GBV programmes largely depend on donor funding, which at the moment has greatly reduced, making the future of most programmes uncertain. Another challenge is the lack of a centralized and systematic mechanism for collecting GBV data in Kenya, making it difficult to measure the impact of GBV programming for policy decision making, programming, and financing. This need informed

the development of the National Monitoring and Evaluation Framework towards the Prevention of and Response to Sexual and Gender-based Violence in Kenya by the NGEC. Anecdotal observation shows poor implementation of the Sexual Offences Act (2006); this is attributed to poor publicity among law enforcers and the public in general. More specifically, technical know-how on forensic investigation, adequate equipment and laboratories, an appreciation of the special nature of GBV crimes, and an understanding of human rights is largely missing within the police force.

To ensure that all Kenyans in need of GBV services can access them in a timely manner and to accelerate the process of dealing with survivors, the Kenyan government is committed to scaling up GBV services to all counties. The country is considering setting up gender violence and recovery centres under the one-stop centre (OSC) model, which is regarded as the ideal model for providing these services. The OSCs provide integrated, multidisciplinary services in a single physical location (usually a medical facility). Such an approach has become popular in other countries in the region, including South Africa, Malawi, Zambia, and Uganda. The OSC, it is argued, poses less risk of exposure and stigma to those seeking services than stand-alone sites. In Malawi and Zambia, for example, OSCs have significantly accelerated the handling of GBV cases, including the arrest and prosecution of suspected perpetrators.

The Constitution of Kenya (2010), Chapter 2, Article 6(1), and the County Government Act (2012), Part 2(5), devolved health service provision to 47 counties, with the exception of national hospitals. Under the new system of governance, counties receive a block allocation of tax revenue from the national government, and they have the autonomy to decide on the share allocated to the health sector, including for GBV services. To align this plan with the current devolved system of government, scale-up of these services is envisaged to ensure the presence of GBV centres and services in every county in Kenya. With this in mind, the NGEC commissioned a costing study to determine the budgetary implications of providing for and scaling up GBV services, to comprehensively and effectively respond to and manage GBV at the county level for five years. The costing exercise focused on the resources required to support a package of services consistent with the one-stop centre model, which includes medical, psychosocial, legal, and security services, for a period of five years from the year of the study.

BACKGROUND

Gender-based violence is a widespread global epidemic with far-reaching and long-lasting impacts on survivors, perpetrators, families, communities, and nations. GBV has been defined as "any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females" [4]. It includes acts that inflict physical, mental, or sexual harm or suffering, threats of such acts, coercion, and deprivation of liberty. GBV encompasses a wide variety of abuses that include sexual threats, exploitation, humiliation, assaults, molestation, domestic violence, incest, rape, forced prostitution, torture, insertion of objects into genital openings, sodomy, and attempted rape, among others. It is a pressing problem, not only because it violates human rights, but also because it poses a challenge to public health and economic and social development. Some of the consequences of GBV include transmission of HIV, sexually transmitted infections, and hepatitis B and C, as well as unintended and unwanted pregnancies, psychological trauma, physical injuries, and even death.

While data on GBV in Africa is very limited, estimates suggest that it is a major health, human rights, and development issue in the region. In Kenya, the 2008–2009 Kenya Demographic and Health Survey indicated that 45 percent of women aged between 15 and 49 years have experienced either physical or sexual violence [2]. It specifically points out that 25, 7, and 14 percent have experienced physical violence, sexual violence, and both physical and sexual violence respectively [2]. The report also indicates that 3 percent of women had perpetrated physical violence against their husbands or partners. Further, it reports that the prevalence of female genital mutilation in Kenya was 27.1 percent in 2009 [2]. Considering that GBV is very stigmatized in Kenya, which may lead to under-reporting, it is likely that the prevalence of violence is higher. A UNAIDS analysis in 2006 collected key facts and figures on GBV (Box 1).

Levels of violence before the age of 18 indicate that during childhood, 32 percent of females in Kenya and 18 percent of males experience sexual violence [2]. Physical violence was experienced by 66 percent of females and 73 percent of males, while 26 and 32 percent of females and males respectively experienced any violence as a child [2]. About 13 percent of females and 9 percent of males experienced all three types of violence during childhood [2].

The costs of GBV to both the survivors and the health system are significantly high. As Kerr and McLean point out, GBV is very costly to the women who experience violence directly, to

Violence against Women and Girls in Kenya – Facts and Figures

- 49% of Kenyan women reported experiencing violence in their lifetime; one in four had experienced violence in the previous 12 months
- 83% of women and girls reported one or more episodes of physical abuse in childhood; 46% reported one or more episodes of sexual abuse in childhood
- Over 60% of these women and children did not report the event to anyone
- Only 12% who had been physically or sexually abused reported to someone in authority, such as a village elder or the police
- 25% of 12- to 24-year-old females lost their virginity by force
- Nairobi Women's Hospital receives an average of 18 cases of rape and incest each day
- There is only one shelter for victims of domestic violence in Kenya
- A majority of the victims of violence are girls: 60% of women who have experienced violence reported the age of first abuse between 6 and 12 years; 24% reported the age between 13 and 19 years

*Source: UNAIDS: *Violence against Women and Girls in the Era of HIV/AIDS: A Situation and Response Analysis in Kenya*, June 2006, p. 6

women generally whose lives are constrained by the fear of violence, and to governments whose expenditures are increased by responding to the consequences of the violence. Individual men, even those who are nonviolent, also lose as a result of the barriers that are created by violence towards women [5]. A study conducted in the United States of America before 2003 reported that the annual cost of GBV was USD 5.8 billion, of which USD 4.1 billion was incurred for direct medical and mental care services, while USD 0.9 billion was attributed to productivity losses among the victims [6].

These costs are borne by the individual survivors, by the state and wider society, and by employers. A study done in the United Kingdom in 2004 estimated the total cost of domestic violence for the state, employers, and survivors to be around GBP 23 billion a year [7]. The study allocated the cost burden at GBP 2.9 billion a year for the state, around GBP 19 billion a year for survivors, and GBP 1.3 billion a year for employers [7]. Most studies on the costs of GBV have been carried out in developed countries, and very little has been done in developing countries. This is despite the fact that GBV has been shown to affect

developing countries more than developed countries, with over 90 percent of all violence-related deaths estimated to occur in the former. The economic consequences of violence are also likely to be more severe in low- and middle-income countries. In Kenya, for example, there is no data on the costs of GBV to the survivors, or any information on the cost of GBV services to the health system. This report fills this evidence gap by estimating the costs of providing GBV services in Kenya from a health systems perspective.

The costs of domestic violence are therefore significant, both in terms of the economic costs borne by the state and society and the costs borne by individual survivors, relatives, and businesses. A better understanding of the full cost implications of interventions addressing GBV provides a basis for action within a financial policy framework. This also increases the number of ways in which a policy intervention can be articulated, measured, and evaluated, and it is especially useful in addressing spending priorities [7]. Moreover, estimating the cost of GBV helps to demonstrate the scale of its impact on society and may enable policymakers and the general public to understand the extent of the problem and the potential benefits that could result from the reduction and elimination of GBV. This is crucial in the shift towards evidence-based policymaking and the development of transparent and comparable measures of the costs and benefits that flow from policy action [5, 6].

METHODOLOGY

Study Design

A cross-sectional study design was employed for this exercise. The study employed mixed (qualitative and quantitative) methods of data collection, namely 1) key informant interviews, 2) document reviews, and 3) facility costing surveys. The use of various methods was essential for answering the study questions; weaknesses associated with a particular methodological approach are corrected by others to ensure valid and comprehensive data analysis and interpretation.

Costing Perspective and Approach

A health systems perspective was adopted for this study. This perspective considered the costs borne by the health system to provide a defined basket of GBV services, based on the model of the one-stop centre (Table 1), to citizens in the country and excluded costs incurred by patients and society to access these services.

An ingredients approach was used to estimate the total costs of providing a defined basket of GBV services based on the OSC model. The ingredients approach involved 1) identifying all the inputs utilized in the provision of GBV services under the one-stop model, 2) identifying their unit costs and quantities, and 3) computing total costs [8]. Economic costs were estimated. These refer to the opportunity costs of allocating resources to the provision of GBV services – for example, the opportunity cost of the time clinicians, counsellors, and legal personnel spent on GBV training workshops. It also includes estimating the market prices for subsidized costs such as free antiretrovirals. Both direct and indirect costs were estimated.

Conceptual Framework

The costing exercise was informed by the position paper to guide the establishment of one-stop units for the support of survivors of sexual violence, developed by the Task Force on the Implementation of the Sexual Offences Act, with the support of UNFPA and others [9]. This framework recommends multidimensional interventions that need to be supported by government resources for addressing GBV in Kenya. The OSC model for Kenya provides integrated, multidisciplinary services to survivors, including medical, psychosocial, legal, and security services.

Figure 1: Conceptual Framework for Costing GBV Services under the One-Stop Centre Model

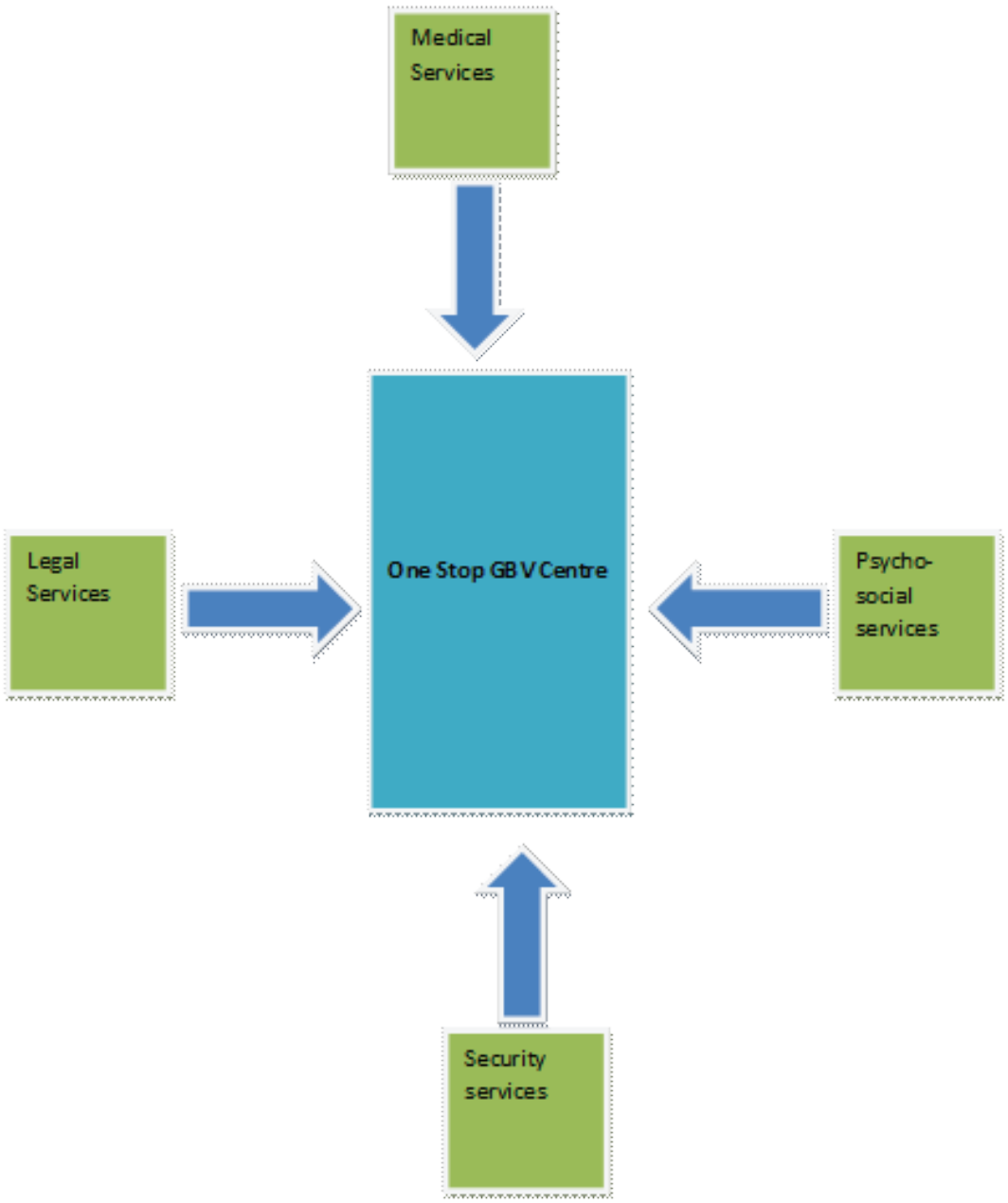


Table 1: Key Components of a Multisectoral Response Provided at a One-Stop Centre

Sector	Key Components of Response Provided at a One-Stop Centre
Medical	Comprehensive medical examination and treatment
	Laboratory tests
	Pregnancy test and emergency contraception
	HIV diagnostic testing and counselling
	High Vaginal Swab
	Urinalysis
	Provision of post-exposure prophylaxis for sexually transmitted infections
	Evaluation and treatment of injuries, forensic examination, and documentation
	Trauma counselling
	Community awareness raising
Legal and security	Statement taking and documentation; legal counsel
	Collection of forensic evidence and maintaining the chain of evidence
	Ensuring the safety of the survivor
	Training and capacity building of health care providers, police, prosecutors, magistrates, community-based organizations, and survivors
Psychological support	Provision of safe housing and relocation services, if required
	Long-term psychosocial counselling and rehabilitation
	Community awareness raising and stigma reduction
	Referral for services, e.g. legal aid services, safe housing

This study identifies, quantifies, and costs the services essential for providing a comprehensive package of services under the OSC model. Figure 1 provides a diagrammatic illustration of this conceptual framework, while Table 1 presents the basic services at the core of the OSC model.

This costing exercise therefore aimed at estimating the costs of providing the above-mentioned OSC package of services, and modelled the scale-up of these services to all 47 counties in Kenya. A modelling of the expansion and costs over a five-year period was also conducted, along with a financial gap analysis.

Identification, Classification, and Definition of Costs

Costs were classified by inputs into two major categories, capital and recurrent. Capital costs are those that are incurred once and used for a period extending over one year, while recurrent costs are those that are incurred regularly and used up within a year [10]. Examples of capital costs in GBV service provision include the costs of setting up private consultation rooms, training personnel, and printing and distributing GBV guidelines. Examples of recurrent costs include the costs of medical supplies and personnel. In keeping with the ingredients approach, all inputs into the GBV programme were identified and quantified.

Specifically, capital and recurrent costs were identified for the following:

- A defined basket of services, based on the model of the one-stop units for GBV
- The recruitment and capacity building of additional medical personnel to undertake medical examinations of survivors, additional policymaking (and relevant trainings), and private interview rooms with the necessary office infrastructure to support them

Calculation of Costs

Total Costs of Gender-based Violence Programme

Total costs of the GBV programme were computed as outlined below:

- Recurrent (RCx, Yi) = Input quantities (RCx, Yi) x price (RCx, Yi)
- Capital (CCx, Yi) = [Quantities (CCx, Yi) x price (CCx, Yi)]/AF (CCx, Yi)
- Total cost = sum of all recurrent costs + sum of all capital costs

Where:
RCx = for recurrent cost category x
CCx = for capital cost category x
Yi = for year i
AF = Annualization factor, which is a function of the capital assets' useful life year and the discount rate

Total Costs of Scaling Up Gender-based Violence Services to Counties

To estimate recurrent costs of scaling up GBV services to all counties in Kenya, the median cost per GBV case was scaled to the estimated annual GBV centre service utilization levels per county. These levels were determined by factoring in regional (provincial) GBV prevalence and estimated service level utilization rates derived from the facility surveys.

GBV prevalence rates were obtained from the 2008–2009 Kenya Demographic and Health Survey and were only disaggregated to province level rather than counties (Table 2). These scaled-up recurrent costs were then added to capital costs (infrastructure and training). Costs were reclassified into fixed costs and variable costs. Scaled-up costs were estimated using the following model:

$Csu = CC + aRC$

Where:
Csu = Costs of scale-up
CC = Capital costs
a = Number of GBV service centres at scale
RC = Recurrent costs

Table 2: Gender-based Violence Prevalence Rates by Province

Province	Prevalence of Gender-based Violence*
Nairobi	15.4%
Central	19.5%
Coast	18.1%
Eastern	19.1%
Nyanza	35.8%
Rift Valley	24.4%
Western	28.2%
North Eastern	22.9%

*Source – extracted and adapted from Table 16.1 of the 2009 Kenya Demographic and Health Survey

Five-year Costs of Gender-based Violence Services in Kenya

To estimate the cost of scaling up GBV services over a five-year period in all counties in Kenya at Level 4 health facilities (district/county hospitals), the annual costs of GBV service provision were scaled with a projection on changes in the prevalence of GBV cases and help-seeking rates. In line with common practice, these changes were assumed to reflect population growth rate in Kenya [11]. The percentage of women aged 15 to 49 who have ever experienced physical violence and sought help to stop the violence are reported in Table 3.

Presentation, Annualization, and Transfer of Costs over Time

Costs have been presented in both local currency, Kenya shilling (KES), and US dollar (USD) for purposes of cross-country comparisons and adjusted for inflation using a five-year (2009–2013) historical average inflation rate [12].

Economic capital costs were annualized to derive the equivalent annual economic costs of these items [12]. A discount rate of 3 percent and the respective useful lives of the capital resources were utilized to determine the annualization factors for capital resources [13].

Sampling

Sampling of Key Informants

A combination of purposive (based on knowledge of the topic of interest) and snowball sampling was used to select 25–30 key informants at national, county, and facility levels.

These key informants were then asked to suggest other key informants who possess knowledge on the planning and programming of GBV services in Kenya. The list of stakeholders that were interviewed is outlined in Appendix 6.

Sampling of Study Sites

A purposive sample of facilities was selected for the costing exercise. A purposive sampling technique was deemed appropriate to capture variations in the range of services provided (urban and rural), the level of care of the facility housing the OSC (national referral, provincial, district hospital, etc.), and the ownership of the OSC. Efforts were made to have representation of different regions of the country, although this largely depended on the location of the OSC. A total of five OSCs were included in the cross-sectional survey. Table 4 outlines the facilities included in the study.

Table 3: The Percentage of Women aged 15 to 49 Who Have Ever Experienced Physical Violence and Sought Help to Stop the Violence

Province	Prevalence of Gender-based Violence*
Nairobi	29.1%
Central	36.4%
Coast	32.7%
Eastern	34.0%
Nyanza	41.4%
Rift Valley	40.3%
Western	35.2%
North Eastern	29.8%

*Source – extracted and adapted from Table 16.14 of the 2009 Kenya Demographic and Health Survey

Table 4: One-Stop Centres Selected for the Costing Study

Facility Name	County	Ownership	Level
Kenyatta National Hospital	Nairobi	Public	National referral
Nairobi Women's Hospital	Nairobi	Private	Referral hospital
Coast Provincial General Hospital	Mombasa	Public	County referral hospital
Naivasha District Hospital	Nakuru	Public	County hospital
Kitale District Hospital	Trans-Nzoia	Public	County hospital

Sampling of Case Records in Facility

In each facility (except Nairobi Women's Hospital, where access to patient records was not possible), a random sample of case records was selected for purposes of abstraction of resource utilization data. In total, 20 percent of the case records over a 12-month period (May 2013–May 2014) in each facility was selected, giving a total sample of 521.

Data Collection

Key Informant Interviews

Key informant interviews were conducted at national and county facility levels to obtain an understanding of the planned scale-up of GBV services, the targeted package of services, the model that is to be adopted for the scale-up, the phasing of the scale-up, and the factors that will impact the costs of scaling up. These interviews were conducted with a sample of stakeholders involved in the provision of GBV services in Kenya. These stakeholders were identified through a combination of document reviews, consultations with the client, and snow-balling techniques (identified stakeholders point to others).

Those identified as possible interviewees were invited to take part in the study. Adequate information on the objectives of the study was provided to the interviewees, opportunity to ask questions was provided, and written informed consent sought from participants. An in-depth interview guide was used to conduct interviews. Interviews were conducted at the convenience of the interviewee and in a place that provided confidentiality and allowed the interviewee to feel comfortable.

This was particularly important to ensure that the interviewees were able to discuss the various issues openly and in a comfortable manner. Consent was requested for the use of a digital recorder to allow the whole interview to be captured (and later transcribed), while the interviewer and an assistant took notes. In cases where interviewees declined to be recorded, detailed notes were taken.

Document Reviews

Policy documents and reports that contain information useful for the costing of the scaling up of GBV services in Kenya were reviewed. The list of documents reviewed is provided in Appendix 5.

Gender-based Violence Centre Costing Surveys

A survey of facilities in Kenya that offer GBV services in a model that approximates the OSC model was conducted to cost the services they offer. The objective was to analyse the centre-level costs of providing GBV services using the OSC. At the facility level, similar to the national level, data was collected through document reviews, key informant interviews, and direct observation. A data collection tool that combined abstraction, observation, and interviewing methods was used to collect data.

Given that the current GBV centres do not offer all services (medical, legal, security, and psychosocial) under one roof, the costing tool was specifically designed to collect costing information from organizations offering each of these services. For example, when costing the provision of GBV-related services at the Kenyatta National Hospital, costing data was collected from the Kenyatta National Hospital GBV centre, the organization

offering legal support to clients, the police station offering security services, and the organization offering psychosocial support if it was not offered by the hospital. Documents reviewed at this level included staff registers, inventory, client registers, centre utilization reports, and clinic records for the management of GBV patients. Key informants provided information not obtained by observation or in documents.

Data Analysis

Analysis of Quantitative Data

Quantitative data was entered into Microsoft Excel spreadsheets and analysis was done using Stata analysis software. Exploratory data analysis was conducted to detect any errors and examine patterns and relationships in the data. Descriptive measures were obtained for numerical data and frequency tables for categorical data developed. For costs of GBV services, both mean and median were computed, given that cost data are often skewed.

Analysis of Qualitative Data

The study used the thematic framework approach in analysing the qualitative data. Recordings of qualitative data were transcribed along the main thematic areas of essential GBV services, cost drivers, and the process of scaling up GBV centres. The investigators independently read transcripts and listened to the voice recordings to identify key themes. A discussion of the findings followed, and consensus was arrived at on the main themes emerging from the recordings. In cases where themes were contradictory, agreement was arrived at by getting respondent clarification. The analysis of qualitative data was enhanced using NVivo 9 analysis software.

RESULTS

Quantitative Findings

Characteristics of Selected Gender-based Violence Centres

The number of GBV survivors that sought care at the selected GBV centres is outlined in Table 5. While all the centres provided medical, psychosocial, and security services, only Kenyatta National Hospital (see case study in Appendix 7), Nairobi Women's Hospital (see case study in Appendix 8), and Coast Provincial General Hospital offered legal services to GBV clients. In all the facilities, only medical and psychosocial services were offered by staff stationed within the facility. Legal services were offered in coordination with other organizations, mostly non-governmental organizations offering legal support services to GBV survivors for free.

For example, Nairobi Women's Hospital collaborates with various non-governmental organizations to offer legal services to GBV survivors: the Federation of Women Lawyers (FIDA-Kenya), the Centre for Rights Education and Awareness, the Child Rights Advisory, Documentation and Legal Centre, International Justice Mission, and the Coalition on Violence against Women. When there is a case that requires legal intervention, Nairobi Women's Hospital coordinates with these organizations, who assign their legal officers to provide legal services to the clients. Kenyatta National Hospital also partners with International Justice Mission, the Centre for Rights Education and Awareness, and the Coalition on Violence against Women to provide legal services to victims of GBV. When there is a case in need of legal services, a social worker at Kenyatta National Hospital informs one of the partner organizations and a legal officer is assigned to the case. In both hospitals, the legal officer comes to the facility to offer the services to the survivors.

At Coast Provincial General Hospital, there is a pro-bono lawyer assigned to the GBV recovery centre by the International Centre for Reproductive Health Kenya. They also partner with FIDA to provide legal services, and in both cases the lawyer comes to the GBV centre. In Naivasha and Kitale District Hospitals, there are no working relationships with any organizations to offer legal services. The clinical officers attending to the victims provide advice and guidance to the victims on how to go about the legal process, but ultimately the victims are left to look for legal assistance on their own. In all the facilities, psychosocial services are offered within the facility. At Kenyatta National Hospital and Nairobi Women's Hospital, psychosocial services are offered by a psychiatrist, a counselling psychologist, and a trauma counsellor.

At Coast Provincial General Hospital, these services are offered by a psychosocial counsellor and a nurse counsellor. In the Kitale and Naivasha hospitals, psychosocial services are offered by a psychiatric nurse and a nursing officer.

Characteristics of Sampled Gender-based Violence Health Facility Clients

The average age of GBV survivors that presented for care at the selected GBV centres was 17 (Table 6). Sixty-seven percent were above 18 years. Consistent with findings in other settings, most of the victims were women (92.5 percent), while most of the assaults were sexual (98 percent). The seemingly low prevalence of other forms of GBV (physical, emotional, economic) is likely to be due to poor data and misclassification.

Recurrent Costs of Provision of Gender-based Violence Services Using the One-Stop Centre Model

MEDICAL CARE COSTS

Medical care costs that were considered included the costs of the following services:

1. Medicine costs
2. Medical investigation costs
3. Clinical staff costs
4. Clinical overhead costs

Table 5: Characteristics of Selected Hospitals

		Are these services offered to gender-based violence survivors?			
	Annual number of GBV cases (2013)	*Medical care*	*Psychosocial support*	*Legal services*	*Security services*
Kenyatta National Hospital	457	Service offered	Service offered	Service offered	Service offered
Nairobi Women's Hospital	2,689	Service offered	Service offered	Service offered	Service offered
Coast Provincial General Hospital	597	Service offered	Service offered	Service offered	Service offered
Naivasha District Hospital	458	Service offered	Service offered	Service not offered	Service offered
Kitale District Hospital	821	Service offered	Service offered	Service not offered	Service offered

Table 6: Characteristics of the Study Sample

	Mean (95% Confidence Interval)
Age	*17 (15–19)*
Age Category	**Percent (95% CI)**
Over 18 years	67% (58%–75%)
Below 18 years	33% (25%–43%)
Gender	**Percent (95% CI)**
Male	7.50% (3%–14%)
Female	92.50% (86%–97%)
Marital Status	**Percentage (95% CI)**
Single	22% (15%–30%)
Married	13% (7%–20%)
Separated	1% (0%–5%)
Widowed	1% (0%–5%)
Cohabiting	1% (0%–5%)
Polygamous	63% (54%–72%)
Type of Assault	**Percentage (95% CI)**
Sexual	98% (94%–100%)
Physical	6% (2%–11%)
Emotional	3% (1%–7%)
Economic	1% (0%–5%)
Gender of Perpetrator	**Percentage**
Male	98% (93%–100%)
Female	2% (0%–6%)

Data for resource utilization of each of these cost components was abstracted from sampled clinical records of GBV cases in the sampled hospitals. Unit costs for medicine were obtained from the 2014 Kenya drug index, while unit costs for laboratory investigations were obtained from a sample of five laboratories in Nairobi. Information on staff time was obtained from interviews with GBV centre managers to obtain the average time spent on each GBV case, while unit costs for their time were obtained from staff salary information. Table 7 outlines the mean and median costs of medical care for GBV cases.

PSYCHOSOCIAL CARE COSTS

To obtain costs for psychosocial care, the average time spent per GBV case, the number of

Table 7: Estimated Mean and Median Cost of Provision of Medical Care to Gender-based Violence Care Services in the Sampled Hospitals

Cost Category	*Mean (95% Confidence Interval) KES*	*Mean (95% CI) USD*	*Median (Interquartile Range) KES*	*Median (IQR) USD*
Medicine costs	810 (539–1,081)	9 (6–12)	245 (0–706)	3 (0–8)
Investigations	2,653 (2,403–2903)	30 (27–33)	2,700 (1,950–3,350)	30 (22–38)
Clinical staff costs*	609	7	609	7
Clinical overheads	411 (367–455)	5 (4–5)	459 (153–459)	5 (2–5)
Total Medical Care	**4,482**	**50**	**4,013**	**45**

*On average, a clinician spent 30 minutes on each GBV case

Table 8: Estimated Mean and Median Cost of Provision of Psychosocial Care to Gender-based Violence Care Services in the Sampled Hospitals

Average time spent per counselling session for GBV cases				45 minutes
Average number of counselling sessions per GBV case				5 sessions
Range of monthly salaries for counselling psychologists				KES 60–80,000
	Mean (95% Confidence Interval)		*Median (Interquartile Range)*	
	KES	USD	KES	USD
Cost of psychosocial support	**4,353 (3,983–4,723)**	**49 (45–53)**	**4,818 (2,218–4,818)**	**54 (25–54)**

counselling sessions given to a GBV case, and the employment costs of counsellors providing counselling services for GBV cases were obtained. These are outlined in Table 8.

LEGAL CARE COSTS

To obtain legal costs, information about 1) the range of legal services offered; 2) the unit costs of each of these services; 3) the amount of time offering legal services per GBV case; and 4) the monthly salaries of legal personnel was obtained from interviews with organizations offering legal services to GBV cases. Even though these organizations offered these services for free to GBV clients, the costs were nonetheless obtained, since the intention was to obtain the opportunity costs of offering these services. Table 9 outlines the costing data obtained for legal services.

Table 9: Estimated Mean and Median Cost of Provision of Legal Services to Gender-based Violence Care Services

Cost Input	Estimated Costs
Transport; filing case	KES 160 (USD 1.9)
Stationery and printing costs	KES 3,000 (USD 35.2)
Communication with client	KES 100 (USD 1.2)
Transport; court mentions	KES 1,600 (USD 19)
Transport; court hearings	KES 1,600 (USD 19)
Transport; filing submissions	KES 310 (USD 3.6)
Transport; attending court judgement/ruling	KES 160 (USD 1.9)
Total non-staff costs per GBV case	KES 7,090 (USD 83)
Range of time spent per GBV case	72–96 hours
Legal cost per GBV case	*KES 31,090 (USD 349)*

Table 10: Estimated Mean and Median Cost of Provision of Security Services to Gender-based Violence Services

Cost Component	Cost Estimate
Transport	KES 150 (USD 1.8)
Stationery	KES 100 (USD 1.2)
Range of time spent per GBV case	24 hours–48 hours
Security cost per GBV case	KES 1,760 (USD 20)

Table 11: Mean and Median Cost of Provision of Gender-based Violence Services in the Sampled Hospitals

Cost Category	Mean (95% Confidence Interval) KES	Mean (95% CI) USD	Median (Interquartile Range) KES	Median (IQR) USD
Medical care	4,482	50	4,013	45
Psychosocial care	4,353 (3,983–4,723)	49 (45–53)	4,818 (2,218–4,818)	54 (25–54)
Legal services	31,090	349	31,090	349
Security services	1,760	20	1,760	20
Total GBV services	*44,717 (43,539–45,895)*	*502 (489–516)*	*43,769 (43,769–50,238)*	*492 (492–564)*

SECURITY COSTS

To obtain security costs, information about 1) the range of security services offered; 2) the unit costs of each of these services; 3) the amount of time offering security services per GBV case; and 4) the monthly salaries of security personnel was obtained from interviews with police officers in charge of gender desks in the towns where the facilities were sampled for the studies. Table 10 outlines the costing data obtained for security services.

Total Costs of Gender-based Violence Services

As outlined in Table 11, the mean estimated recurrent costs of provision of GBV services to a client using the OSC model is KES 44,717 (USD 502), while the median is KES 43,769 (USD 492). These include the costs of provision of medical care, psychosocial care, and legal and security services.

Of these costs, legal services are the main cost drivers, constituting 75 percent of total costs, while medical, psychosocial, and security services constituted 11 percent, 10 percent, and 10 percent respectively (Figure 2).

Of the medical costs, medical investigations (specifically laboratory and radiology investigations) constituted 59 percent, followed by medicine costs at 18 percent, while staffing and overhead costs contributed 14 percent and 9 percent respectively.

Figure 2: Share of Cost for Provision of Gender-based Violence Services

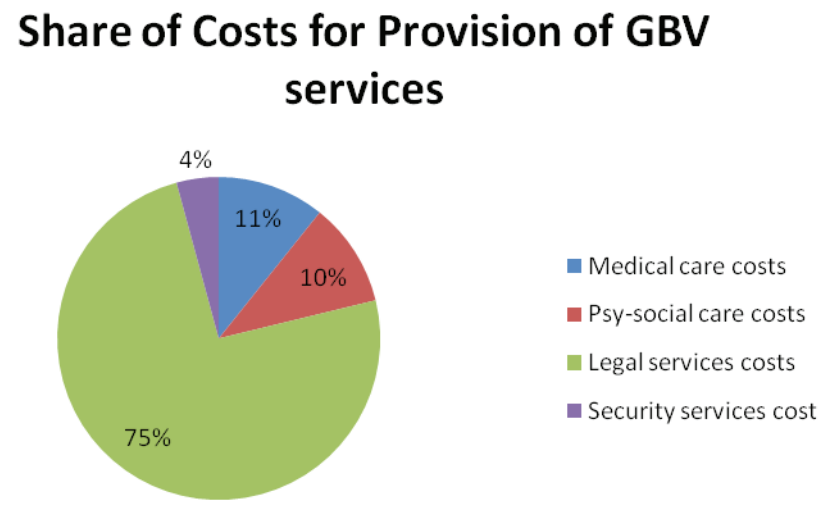
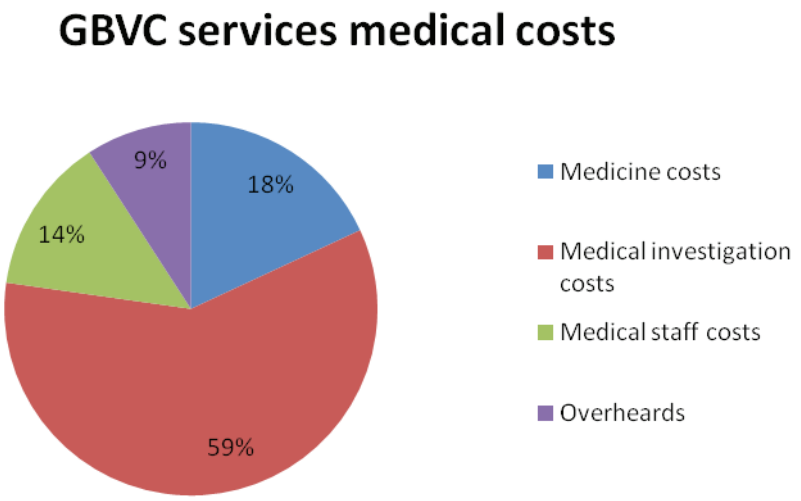


Figure 3: Share of Cost of Provision of Medical Care to Gender-based Violence Survivors



Human Resource Capacity-building Costs

To compute the costs of training human resources to provide services to GBV clients, the following assumptions have been made:

- Every county will need to train four medical doctors, four nurses, four counsellors, four police officers, and four lawyers annually. This makes a total of 20 training participants per year drawn from staff providing the range of GBV services under the one-stop model (medical, psychosocial, security, and legal). In total, therefore, 940 staff will be trained annually across the 47 counties.
- The training structure and curriculum will be delivered using the same model as similar capacity-building trainings in the health sector, such as the HIV/AIDS and malaria case management trainings. Typically these trainings entail a three-day residential training, in which the costs accrued include participant transport, accommodation, subsistence, conference facility costs, and facilitator costs.
- The unit cost of training was estimated to be KES 15,000. These costs have been assumed to be similar to those of comparable trainings in the health sector highlighted above. To achieve this unit cost, the trainings will need to have 40 participants. Therefore, the trainings should ideally be conducted by combining two counties at a time. Table 12 outlines the estimated costs of the training.

Table 12: Human Resource Training Costs

Details	Unit	Days	Amount	Total KES	Total USD
Participant costs					
Per diem	40	3	1,000	120,000	1,348
Conference	45	3	1,300	175,500	1,972
Transport refund	40	2	500	40,000	449
SUBTOTAL				**335,500**	**3,770**
Remuneration costs					
Trainers' facilitation	4	3	10,000	120,000	1,348
Administration officer	1	3	8,000	24,000	270
Lead trainer	1	1	30,000	30,000	337
SUBTOTAL				**174,000**	**1,955**
Administrative costs					
Stationery costs	1	1	25,000	25,000	281
Mobilization costs	1	1	30,000	30,000	337
Transport costs/fuel	1	3	12,000	36,000	404
SUBTOTAL				**91,000**	**1,022**
TOTAL				**600,500**	**6,747**
Training cost per participant				15,000	169
Number of targeted participants	940				
Total cost of training across the 47 counties per annum				**14,100,000**	**158,427**

Infrastructure Costs

To compute infrastructure costs, it was assumed:

- That each county will incur a one-off additional infrastructure cost to partition existing rooms in hospitals to create separate rooms for consultation and counselling related to GBV cases.
- That the size of these separate rooms will be 20 square metres in total. The partitioning costs are estimated at a cost of KES 20,000 per square metre (a total of KES 400,000) based on current market rates for fabricated partitioning.
- That each of these rooms will be equipped with basic furniture (a desk and three seats at a

Table 13: Infrastructure Costs

Cost Item	Unit Cost	Quantity	Total Cost (KES)	Total Cost (USD)
Partitioning	400,000	47	18,800,000	211,236
Furniture and fittings	50,000	47	2,350,000	26,404
Computer and printer	50,000	47	2,350,000	26,404
Total			*23,500,000*	*264,045*

Table 14: Fixed Costs of Provision of Gender-based Violence Care Services in Kenya

Cost Item	Unit Cost	Quantity	Total Cost (KES)	Total Cost (USD)
Infrastructure costs	500,000	47	23,500,000	264,044
Training costs	15,000	940	14,100,000	158,427
Total fixed costs	*515,000*		*37,600,000*	*422,471*

cost of KES 50,000; a computer and a printer at a cost of 50,000). These estimates are obtained from current market prices for these items. Table 13 outlines the infrastructure costs per county.

Capital Costs of Provision of Gender-based Violence Services Using the One-Stop Model

Based on the computations of human resource training and infrastructure costs outlined in Table 12 and Table 13, the fixed costs for provision of GBV services in the 47 counties were KES 37,600,000 (USD 422,471). Of these, training costs were KES 14,100,000 (USD 158,427) and infrastructure costs were KES 23,500,000 (USD 264,044). See Table 14.

Estimated Five-year Total Costs of Provision of Gender-based Violence Services Using the One-Stop Model

The estimated costs for the provision of GBV services in the 47 counties over a five-year period are KES 10,798,520,644 (USD 121,331,692.6).

Table 15: Estimated Costs of Provision of Gender-based Violence Services Using the One-Stop Model over a Five-year Period

	Year 1	Year 2	Year 3	Year 4	Year 5	Five-year Costs	
Cost category	Cost in KES	Cost in KES	Cost in KES	Cost in KES	Cost in KES	Cost in KES	Cost in USD
Medical care	235,083,307	235,138,719	235,199,306	235,265,636	235,338,342	1,176,025,310	13,213,768
Psychosocial care	213,712,098	213,762,472	213,817,551	213,877,851	213,943,948	1,069,113,918	12,012,516
Security services	854,84,839	85,504,989	85,527,020	85,551,140	85,577,579	427,645,567	4,805,006
Legal services	160,2840,733	1,603,218,537	1,603,631,629	1,604,083,881	1,604,579,607	8,018,354,387	90,093,870
Training	14,100,000	15,326,700	16,660,123	18,109,554	19,685,084	83,881,461	942,488
Infrastructure	23,500,000					23,500,000	
Total	*2,174,720,977*	*2,152,951,416*	*2,154,835,629*	*2,156,888,061*	*2,159,124,561*	*10,798,520,644*	*121,331,692.6*

Of these, KES 1,176,025,310 (USD 13,213,768) is for medical care, KES 1,069,113,918 (USD 12,012,516) is for psychosocial care, KES 427,645,567 (USD 4,805,006) is for security services, KES 8,018,354,387 (USD 90,093,870) is for legal services, KES 83,881,461 (USD 942,488) is for training, and KES 23,500,000 (USD 264,045) is for infrastructure. See Table 15.

Assessing the Financing Gap

The overall aim of the financing gap analysis is to compare available resources with those that are needed to adequately provide for GBV services in Kenya, and in so doing form the basis for resource advocacy at the national and county level. To do this comprehensively, complete data on what is currently being spent on GBV in Kenya is needed.

Data for this section was sought from key stakeholders including the NGEC, the Division of Family Health, the Ministry of Health , LVCT Health, UNFPA, GIZ (German Corporation for International Cooperation), KfW (the German development bank), DANIDA, Nairobi Women's Hospital, the Ministry of Public Service, Youth and Gender Affairs, Pathfinder International, Kenya Red Cross Society, and the Kenya Police. Despite these efforts, there was very limited data on the total resources spent on GBV in the country. Hence this section has largely drawn on the available data, but this was adjusted for missing data to arrive at a reasonable estimate of the total funds available for GBV services. Further work is needed in this area.

Interviews with different stakeholders revealed that GBV is often not budgeted for as a stand-alone

item in the Ministry of Health and the Ministry of Labour, Social Security and Services. Expenditure related to GBV is classified together with general expenditure. A review of the budget from the Ministry of Health and the Ministry of East African Community, Labour, and Social Protection showed that spending on GBV is often lumped together into categories such as gender mainstreaming, gender and social services, gender education, gender sensitization, etc. These resources are also not tracked in any form, and thus no documents are available on how these resources are used.

In addition, some of the funds are budgeted for other activities. For example, HIV-related projects include costs for GBV, and so does gender equality. Some development partners for health, contacted through the Division of Family Health, provided information on their resource allocation to GBV, and indicated that the Kenyan government co-finances in kind through staff and drugs, although they were not able to state the share of government spending. Consequently, we drew on the mean costs estimated through the facility survey to estimate the percentage share of government funds allocated to GBV.

Table 16 shows the sources and amounts of GBV funding. The total tracked resources for the financial year 2013/2014 amounted to KES 726,520,625. This presents a funding gap of KES 1,433,183,561 (or 66 percent of required funds). However, not all funding was tracked due to challenges previously reported. Assuming that these captured 80 percent of the resources available, the total financing gap reduces to KES 1,251,553,419 (or 58 percent of required funds).

We recommend that the relevant ministries and departments develop a spending line item for GBV and that there is a resource-tracking mechanism to know what resources are being spent in various areas. This will not only be useful for documentation and accounting purposes, but can also highlight the importance of allocating resources to GBV and act as a resource for advocacy.

Qualitative Findings

Challenges in Offering Gender-based Violence Services

Interviews with various stakeholders revealed that the GBV centres faced a number of challenges. One of the challenges was the reliability and sustainability of funding mechanisms for GBV services. It was indicated that a significant proportion of GBV services are funded by donors. This was thought not to be sustainable, and respondents felt that there is a need to put in place reliable and sustainable funding mechanisms for GBV services in the country. The government should prioritize the provision of much-needed GBV services and increase their funding.

Human resource capacity also significantly challenges the provision of GBV services. It was reported that often medical staff in public GBV centres have to multitask, while lawyers offer pro

Table 16: Estimated Funds for Gender-based Violence Services in the 2013/2014 Financial Year

Source	Amount (KES)	Amount (USD)
GIZ and KfW	336,000,000*	(3,952,941)
NGEC	32,503,334**	(382,392)
Government of Kenya	13,776,000‡	(162,070)
UNFPA	254,241,234	(2,991,073)
Nairobi Women's Hospital	60,000,000	(705,882)
DANIDA	30,000,000‡‡	(352,941)
Total tracked resources	726,520,625	(8,547,301)
Sensitivity analysis		
Total resources, assuming that 20% of resources were not tracked	*908,150,710*	*(10,684,126)*

*Total cost for GBV project for one financial year.
**Includes costs for decentralization of GBV, legal, continuous working groups, capacity building, etc.
‡Assumes that the Kenyan government contributes 4.1 percent of GIZ and KfW funds through staff and treatment costs. Percentage estimated using the cost data presented previously.
‡‡DANIDA has allocated KES 150 million to GBV for a five-year period.

> "If lawyers don't offer their services pro bono, the survivors will not afford legal services. For example, time spent by a lawyer per case is anything between one and two years. A case manager is paid 20,000 Kenyan shillings per month, a court clerk is paid 50,000 shillings per month, and advocates are paid at least 150,000 to 300,000 shillings per month. You can see most survivors cannot afford this." – *Respondent from an organization offering legal services*

bono services or are funded by donors. In addition to the challenge of insufficient numbers, the lack of funding for training of GBV providers and the lack of GBV modules or course content in in-service and pre-service curricula were also reported as challenges.

GBV centres also reported facing an unreliable supply of essential materials and medicine. While donors and Kenya Medical Supplies Authority provide basic medications and HIV test kits free of charge to survivors, their supply is erratic and characterized by frequent stockouts.

Lastly, there is limited coordination of all players in GBV service provision. Respondents felt that there is a need for the Ministry of Health to consider a national coordinating body akin to the National AIDS Control Programme for HIV/AIDS. This will avoid unnecessary competition among players and will foster a goal-oriented approach to the utilization of funds.

"Everyone does their thing. Sometimes they do the same thing, leading to duplication and a waste of funds; if we had a body like the National AIDS Control Programme coordinating all players, we would do so much with the same limited resources." – *Respondent from an organization supporting GBV services*

Feasibility of the One-Stop Centre Model

When asked about the suitability and feasibility of the one-stop centre model in Kenya, most respondents felt that the idea of having all these services (medical, psychosocial, security, and legal services) under one roof is not feasible. Rather, an integrated, coordinated service approach was thought by many to be a more feasible approach. For example, police officers, gynaecologists, and lawyers can be a phone call away.

"Survivors don't come streaming; surely if they did, what kind of people do we have in this country? For this reason, it is only sensible to call in a lawyer or gynaecologist when a survivor comes. This means we will have officers on call. Also remember that, for example, a gynaecologist or a lawyer could be doing something more useful than wait for a whole day in the GBV centre for a survivor to come. This would be the worst use of their time." – *Respondent from a GBV centre*

Respondents also felt that there is a need to define the one-stop shop within the Kenyan context.

The current one-stop model leans more towards response than prevention. The roles of all players and the mechanism of coordination need to be spelled out.

"All this can be done virtually; it doesn't need to be physical." – *Respondent from an organization supporting GBV services*

Respondents also felt that the scale-up should start with pilot sites. The pilot sites should be drawn from those that have some GBV services already going on. Scale-up from pilot sites should be implemented by drawing on lessons learned. The scale-up should be phased and embedded within existing facilities. There were mixed opinions on the level of facilities that should provide GBV services as part of the scale-up. Some respondents were of the opinion that these services should be restricted to county facilities, while others said that all facilities should provide GBV services, with some clear guidance on what services can be offered at each level.

DISCUSSION

Evidence suggests that GBV is a major health, human rights, and development issue in sub-Saharan Africa, as it is globally. In Kenya, 39 percent of women aged 15 to 49 have ever experienced physical violence since the age of 15, and one in five (21 percent) reported sexual violence, which is referred to as ever being forced to have sexual intercourse or perform any other sexual act against one's will (Kenya Demographic and Health Survey 2008–2009). There is therefore need for a meaningful response from governments and civil society.

To increase timely access to care and support, many countries in the region have invested in improving the quality and quantity of services offered in public institutions. As mentioned in the introduction, an increasingly popular strategy for doing this has been through the establishment of OSCs, which provide integrated, multidisciplinary services (medical, legal, security, and psychosocial services) in a single physical location – generally, a medical facility.

Kenya is considering the OSC model to provide GBV services to the population, and to inform this decision it is important to determine the costs of the provision and scale-up of these services during the planning period. The costing exercise presented in this report has the intention of addressing this information gap.

In estimating the costs of providing GBV services in all 47 counties in Kenya over a five-year period, the major cost driver, according to this analysis, is the provision of legal services (75 percent). This is largely because the provision of legal services to clients utilizes significant time and because staffing costs for legal personnel are high.

A key sustainability factor in the scale-up of GBV services is a mechanism for reducing the costs of legal services. One of the determinants of legal costs was the cadre of staff used. For example, using paralegals instead of lawyers to provide services that do not legally require a lawyer has the potential to reduce legal costs by more than 50 percent.

Another issue that requires critical consideration is the specific OSC model that will be adopted for the Kenyan setting. While the model requires that medical, psychosocial, legal, and security services are provided under one roof, the feeling of most stakeholders is that this is perhaps not feasible.

It is recommended that the country considers scaling up using a model that requires coordination of

service providers rather than physical co-existence. Such a model would require setting up networks of service providers for each of the four core OSC services and working out mechanisms for providing services in a coordinated fashion. The current GBV centres typically use this model, as they find it more feasible and sustainable.

As the government considers scaling up GBV services, it is imperative that the issue of the sustainability of the funding mechanism be considered. Currently, a significant portion of the funding of GBV services in the country is provided by development partners (donors). Experience both locally and in other settings has shown that this is not a sustainable funding mechanism. The national and county governments should prioritize the provision of these services and make the required funding commitments.

RECOMMENDATIONS

A number of recommendations can be drawn from this analysis:

1. Both the national and county government should set aside adequate domestic resources to support GBV services. While development partners have supported GBV services over a long period of time, there is a large funding gap and heavy reliance on partners has implications for sustainability. The GBV unit within the Division of Family Health should draw on the results presented in this report to advocate for resources from the national and county governments.

2. There is a need for the government and stakeholders to clearly articulate the preferred model for the provision of GBV-related services. Rather than setting up one-stop centres where all services (medical, legal, psychosocial, and security) are under one roof, a model that creates a coordinated network of these service providers is preferred. This is thought to be more feasible and sustainable in the Kenyan setting.

3. The government should create a budget line for funding GBV services and commit budgetary resources towards it. There is currently no budget line for GBV services.

4. The government should put in place a robust routine data collection and information management system for GBV service provision statistics. Our experience was that there was scarcity of data, and where available it was neither in a standardized format nor good quality. Timely, reliable, and good quality data is a useful ingredient for decision making.

STUDY LIMITATIONS

This study has a number of limitations. First, the purposive selection of facilities could potentially introduce selection bias and compromise the validity of the findings. Second, the sample size of five facilities is arguably too small and compromises the generalizability of the study findings. However, given that the data from the sampled facilities was not used as an end in itself but rather as an input into a national-level model, generalizability concerns are limited. Third, the health facilities sampled do not maintain standardized and updated records of GBV statistics.

Where available, the data was not disaggregated to types of GBV cases. It was therefore not possible to estimate costs of different categories of GBV cases. Fourth, even though the original objective of the study was to estimate costs of provision of GBV services according to the one-stop model, none of the facilities sampled fully complied with this model. Rather, the sampled facilities approximated the one-stop model.

ENDNOTES

1. Waters, H., A. Hyder, Y. Rajkotia, S. Basu, J. Rehwinkel, and A. Butchart, *The Economic Dimensions of Interpersonal Violence*, Department of Injuries and Violence Prevention, World Health Organization, Geneva, 2004.
2. Kenya National Bureau of Statistics and ICF Macro, *Kenya Demographic and Health Survey 2008-2009*, KNBS and ICF Macro, Calverton, Maryland, 2010.
3. Ministry of Health, Kenya Demographic and Health Survey, Nairobi, Kenya, 2009.
4. Inter-agency Working Group on Reproductive Health in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, Geneva, 2010.
5. Kerr, R. and J. McLean, *Paying for Violence: Some of the Costs of Violence Against Women in BC*, Ministry of Women's Equality, British Colombia, 1996.
6. National Center for Injury Prevention and Control, *Costs of Intimate Partner Violence Against Women in the United States*, Atlanta, Georgia, 2003.
7. Walby, S., *The Cost of Domestic Violence*, Lancaster University, Lancaster, UK, 2004.
8. Claxton, K., "Exploring Uncertainty in Cost-effectiveness Analysis," *PharmacoEconomics*, Vol. 26, No. 9, pp. 781–98, 2008.
9. Task Force on the Implementation of the Sexual Offences Act, *Position Paper to Guide the Establishment of One-Stop Units for Support of Survivors/Victims of Sexual Violence*, Nairobi, Kenya, 2010.
10. Drummond, M. F., J. M. Sculpher, W. G. Torrance, J. B. O'Brien, and L. G. Stoddart, *Methods for the Economic Evaluation of Health Care Programmes*, third edition, Oxford University Press, Oxford, 2005.
11. The National Council to Reduce Violence against Women and their Children, *The Cost of Violence against Women and their Children*, Commonwealth of Australia, 2009.
12. Walker, D., and L. Kumaranayake, "Allowing for Differential Timing in Cost Analyses: Discounting and Annualization," *Health Policy and Planning*, Vol. 17, No. 1, pp. 112–118, 2002.
13. WHO, "Choosing Interventions that are Cost Effective," WHO-CHOICE, 2010, available: http://www.who.int/choice/costs/unit_regions/en/index.html.

APPENDIX 1: TERMS OF REFERENCE

OBJECTIVES

The National Gender and Equality Commission (NGEC), with support from the United Nations Gender Equality and Women's Empowerment Joint Programme (UN JP GEWE), commissioned HECTA Consultants (K) Ltd to conduct a costing study to determine the budgetary implications of providing/scaling up existing GBV services to respond to and manage GBV for a period of five years from the year of the study. The costing exercise was to be advised by the National Framework on the Prevention of and Response to Gender-based Violence. This framework recommends multidimensional interventions to address GBV in Kenya that need to be supported by government resources. The costing exercise was also to be advised by a model based on the one-stop units for GBV (developed by the Task Force on the Implementation of the Sexual Offences Act with support from the United Nations Population Fund (UNFPA) and the United Nations Office on Drugs and Crime (UNODC) towards GBV prevention and response management in Kenya).

SCOPE OF WORK

The following specific tasks were to be undertaken in order to achieve the objectives of the assignment:

- To project the budgetary requirements based on a minimum and comprehensive basket of services, including medical, psychosocial, legal, and security services, based on the model of one-stop units for GBV developed by the Task Force on the Implementation of the Sexual Offences Act.
- To assess the costs of recruitment and capacity building of additional medical personnel to undertake medical examinations for survivors and additional police, as well as the cost of private interview rooms with the necessary office infrastructure to support them.
- To identify the gaps in government spending and the budgetary implications of scaling up these GBV services in the country for a period of five years from the year of study.
- To identify variables that may impact on the costing between counties and how costing in such cases should be approached.

APPENDIX 2: ETHICS APPROVAL

amref health africa

Amref Health Africa in Kenya

REF: AMREF-ESRC P115/2014 **17th June 2014**

Dr. Edwine Barasa
HECTA Consulting Limited
Mobile: +254 722 129757
Email: Edwine.halton@gmail.com

Dear Dr. Barasa,

RESEARCH PROTOCOL: AN ASSESSMENT OF COSTS OF PROVISION OF SEXUAL AND GENDER BASED VIOLENCE SERVICES IN KENYA (P115/2014)

Thank you for submitting your protocol to Amref Health Africa Ethics and Scientific Review Committee.

This is to inform you that the ESRC has reviewed and approved your above protocol. The approval period is from 18th June 2014 to 18th June 2015.

The approval is subject to compliance with the following requirements:

a) Only approved documents (informed consents, study instruments, advertising materials etc) will be used.

b) All changes (amendments, deviations, violations etc) are submitted for review and approval by AMREF ESRC before implementation.

c) Death and life threatening problems and severe adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the ESRC immediately.

d) Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to AMREF ESRC immediately.

e) Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period (attach a comprehensive progress report to support the renewal).

f) Clearance for export of biological specimens must be obtained from AMREF ESRC for each batch of shipment.

g) Submission of an executive summary report within 90 days upon completion of the study. This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/or plagiarism.

In case of any clarification or query, please do not hesitate to contact the ESRC Secretariat (esrc.kenya@amref.org).

Yours sincerely,

Prof. Mohamed Karama
ESRC Chair, Amref Health Africa in Kenya
CC. Dr. Meshack Ndirangu, Deputy Country Director and ESRC Vice Chair, Amref Health Africa in Kenya
Dr. David Ojakaa, Programme Manager Research Advocacy and Business Development, Amref Health Africa in Kenya

APPENDIX 3: MODEL ASSUMPTIONS

Assumption	Value	Source
Kenya population growth	2.7%	World Bank
Five-year average inflation rate	8.6%	Central Bank of Kenya
Regional Prevalence of GBV		
Nairobi province	15.4%	Extracted and adapted from Table 16.1 of the Kenya Demographic and Health Survey 2009, which reports the percentage of women aged 15 to 49 who had experienced physical violence in the 12 months preceding the survey.
Central province	19.5%	
Coast province	18.1%	
Eastern province	19.1%	
Nyanza province	35.8%	
Rift Valley province	24.4%	
Western province	28.2%	
North Eastern province	22.9%	

APPENDIX 4: FIVE-YEAR MEDIAN COSTS PER COUNTY

County	Service Provision (KES)	Infrastructure (KES)	Personnel Training (KES)	Total Cost (KES)	Total Cost (USD)
Baringo	118,662,429.55	500,000.00	1,784,711.94	120,947,141.49	1,358,956.65
Bomet	543,667,999.73	500,000.00	1,784,711.94	545,952,711.67	6,134,300.13
Bungoma	402,603,136.15	500,000.00	1,784,711.94	404,887,848.09	4,549,301.66
Busia	120,483,432.00	500,000.00	1,784,711.94	122,768,143.94	1,379,417.35
Elgeyo-Marakwet	79,027,976.42	500,000.00	1,784,711.94	81,312,688.36	913,625.71
Embu	86,308,411.20	500,000.00	1,784,711.94	88,593,123.14	995,428.35
Garissa	124,898,439.37	500,000.00	1,784,711.94	127,183,151.32	1,429,024.17
Homa Bay	302,036,134.65	500,000.00	1,784,711.94	304,320,846.59	3,419,335.35
Isiolo	25,287,280.78	500,000.00	1,784,711.94	27,571,992.72	309,797.67
Kajiado	146,803,162.53	500,000.00	1,784,711.94	149,087,874.47	1,675,144.66
Kakamega	409,967,788.53	500,000.00	1,784,711.94	412,252,500.47	4,632,050.57
Kericho	161,973,839.34	500,000.00	1,784,711.94	164,258,551.29	1,845,601.70
Kiambu	277,089,611.05	500,000.00	1,784,711.94	279,374,322.99	3,139,037.34
Kilifi	175,828,599.58	500,000.00	1,784,711.94	178,113,311.52	2,001,273.16
Kirinyaga	90,137,312.85	500,000.00	1,784,711.94	92,422,024.79	1,038,449.72
Kisii	2,554,782,187.77	500,000.00	1,784,711.94	2,557,066,899.72	28,731,088.76
Kisumu	303,639,085.94	500,000.00	1,784,711.94	305,923,797.88	3,437,346.04
Kitui	169,320,559.77	500,000.00	1,784,711.94	171,605,271.71	1,928,149.12
Kwale	102,976,348.00	500,000.00	1,784,711.94	105,261,059.95	1,182,708.54
Laikipia	85,271,006.71	500,000.00	1,784,711.94	87,555,718.65	983,772.12
Lamu	20,293,192.93	500,000.00	1,784,711.94	22,577,904.87	253,684.32
Machakos	183,678,487.93	500,000.00	1,784,711.94	185,963,199.87	2,089,474.16
Makueni	185,784,317.39	500,000.00	1,784,711.94	188,069,029.34	2,113,135.16

Mandera	205,622,770.81	500,000.00	1,784,711.94	207,907,482.75	2,336,039.13
Marsabit	58,367,057.75	500,000.00	1,784,711.94	60,651,769.69	681,480.56
Meru	226,767,654.42	500,000.00	1,784,711.94	229,052,366.36	2,573,622.09
Migori	322,338,617.32	500,000.00	1,784,711.94	324,623,329.27	3,647,453.14
Mombasa	148,835,633.36	500,000.00	1,784,711.94	151,120,345.30	1,697,981.41
Murang'a	160,895,890.34	500,000.00	1,784,711.94	163,180,602.29	1,833,489.91
Nairobi	423,074,047.02	500,000.00	1,784,711.94	425,358,758.96	4,779,311.90
Nakuru	342,454,635.68	500,000.00	1,784,711.94	344,739,347.62	3,873,475.82
Nandi	160,826,218.77	500,000.00	1,784,711.94	163,110,930.71	1,832,707.09
Narok	181,748,241.06	500,000.00	1,784,711.94	184,032,953.00	2,067,785.99
Nyamira	187,481,683.46	500,000.00	1,784,711.94	189,766,395.40	2,132,206.69
Nyandarua	101,781,248.24	500,000.00	1,784,711.94	104,065,960.18	1,169,280.45
Nyeri	118,388,373.96	500,000.00	1,784,711.94	120,673,085.90	1,355,877.37
Samburu	44,892,355.15	500,000.00	1,784,711.94	47,177,067.10	530,079.41
Siaya	263,963,299.59	500,000.00	1,784,711.94	266,248,011.53	2,991,550.69
Taita-Taveta	45,101,615.85	500,000.00	1,784,711.94	47,386,327.80	532,430.65
Tana River	38,037,955.95	500,000.00	1,784,711.94	40,322,667.89	453,063.68
Tharaka-Nithi	62,360,789.81	500,000.00	1,784,711.94	64,645,501.75	726,353.95
Trans-Nzoia	174,878,536.88	500,000.00	1,784,711.94	177,163,248.82	1,990,598.30
Turkana	182,704,911.92	500,000.00	1,784,711.94	184,989,623.86	2,078,535.10
Uasin Gishu	190,987,942.98	500,000.00	1,784,711.94	193,272,654.92	2,171,602.86
Vihiga	136,910,847.76	500,000.00	1,784,711.94	139,195,559.70	1,563,995.05
Wajir	132,692,514.14	500,000.00	1,784,711.94	134,977,226.08	1,516,598.05
West Pokot	109,505,600.65	500,000.00	1,784,711.94	111,790,312.59	1,256,070.93
TOTAL COSTS	**10,691,139,183.04**	**23,500,000.00**	**83,881,461.25**	**10,798,520,644.28**	**121,331,692.63**

APPENDIX 5: LIST OF DOCUMENTS REVIEWED

1. National Monitoring and Evaluation Framework towards the Prevention of and Response to Sexual and Gender-based Violence in Kenya (2014)
2. The National Framework on Gender-based Violence Prevention and Response (2009)
3. The National Plan of Action to aid the Implementation of the National Framework Towards the Prevention of and Response to Gender-based Violence in Kenya (2010)
4. *A Baseline Survey on Gender-based Violence in Kenya* (2010)
5. Ministry of Health guidelines for the delivery of gender-based violence services
6. Draft multi-sectoral standard operating procedures for gender-based violence services (2013)
7. *National Guidelines on Management of Sexual Violence in Kenya* (second edition)
8. *Position Paper to Guide the Establishment of One-Stop Units for Support Of Survivors/Victims of Sexual Violence*, developed by the Task Force on the Implementation of the Sexual Offences Act, with the support from UNFPA and others (2010)
9. Reports providing information on the prevalence and trends of GBV (for example, the Kenya Demographic and Health Surveys and reports by organizations working on GBV)
10. *Kenya Violence against Children Study* (2010)
11. *Realizing Sexual and Reproductive Health Rights in Kenya* (2012), by the Kenya National Human Rights Commission

APPENDIX 6: LIST OF INTERVIEWED STAKEHOLDERS

- National Gender and Equality Commission
- United Nations Population Fund
- Centre for Rights Education and Awareness
- German Corporation for International Cooperation/GIZ (Project Manager, SGBV Networks project funded by the Government of Germany)
- Kenya Legal and Ethical Issues Network on HIV and AIDS
- UN Women
- Ministry of Health – Division of Reproductive Health
- Kenya Police – Division of Gender, Children, and Community Policing
- Office of the Director of Public Prosecutions
- Kenya Medical Supplies Agency
- Judiciary
- Government Chemist
- Kenya National Commission on Human Rights
- LVCT Health
- Federation of Women Lawyers – Kenya
- Child Rights Advisory, Documentation, and Legal Centre (CRADLE)
- Coalition on Violence against Women
- Women's Rights and Awareness Programme
- Task Force on the Implementation of the Sexual Offences Act
- Five managers of GBV centres, one from each of the five sampled facilities
- Five clinicians, one from each of the five sampled facilities
- Five nurses, one from each of the five sampled facilities
- Five counsellors, one from each of the five sampled facilities
- Five organizations offering legal support, one from each of the five sampled facilities
- Five collaborating police stations' gender desks, one from each of the five sampled facilities

APPENDIX 7: CASE STUDY 1 – KENYATTA NATIONAL HOSPITAL GENDER-BASED VIOLENCE UNIT

The centre, based in Kenyatta National Hospital's mental health department, currently receives GBV cases and referrals from all over Kenya. In the year 2013, the centre offered medical support for a total of 443 patient encounters, as shown in Table 1.

Table 1: Distribution of Patient Encounters during 2013 and 2012

Type of GBV	Total 2013	Total 2012
Sexual assault	419 (94.6%)	411 (88.2%)
Physical assault	17 (3.8%)	55 (11.8%)
Emotional and psychological violence	-	-
Harmful traditional practices	-	-
(Undocumented)	7 (1.6%)	-
Total	*443 (100%)*	*466 (100%)*

An analysis of 30 client files collected between January and July 2014 shows the following distribution.

Table 2: Distribution of Sampled Clients by Age and Gender

Age	Male	Female	Total
Adult (>15 years)	2 (7%)	14 (47%)	16 (53%)
Child	-	14 (47%)	14 (47%)
Total	*2 (7%)*	*28 (93%)*	*30 (100%)*

From a sub-sample of the adults (there were 16 clients older than 15 years) above, the distribution of clients by marital status is shown in Table 3.

Table 3: Distribution of Adult Clients by Marital Status

Marital Status	Male	Female	Total
Married/Cohabiting	1 (6%)	7 (44%)	8 (50%)
Single	-	6 (38%)	6 (38%)
Widowed/Separated	1 (6%)	1 (6%)	2 (13%)
Total	*2 (13%)*	*14 (88%)*	*16 (100%)*

The clinic has staff employed on a permanent basis, including five psychiatrists, three clinical psychologists, six nurse counsellors, and three support staff. There are also five psychologists employed on a contract basis from the PACT partner programme.

MEDICAL AND COUNSELLING

Medical and counselling support offered in the clinic is based on the *National Guidelines on Management of Sexual Violence in Kenya* (2013) and is summarized as follows:

A. Consenting (obtaining informed consent)

Obtaining consent involves filling in a one-page consent form that goes into the patient's file. It involves counselling (which takes approximately five minutes), normally conducted by a certified counsellor or a nurse in a private room at the clinic. This is not to be confused with therapeutic counselling, which is integral to medical case management, takes much longer, and continues throughout the management process of the clients, as demonstrated below. Once consent is obtained, a detailed incident form is filled, containing data on the self-reported case incident and perpetrator details.

B. History taking and physical examination

This is performed by two persons: a clinician and a trained support person (nurse) present for observation. It is expected to take about 30 minutes, because it involves a thorough head-to-toe examination.

Each examination consumes one post-rape kit per patient. The kit should contain the following items:

- Powder-free gloves
- Sterile (surgical) gloves – for sterile procedures
- Stick swabs (6)
- Masking tape and brown envelope for samples
- Tape measure
- Needles and syringes, Vacutainers for blood sample collection
- Urine bottle / cup
- Speculum
- Pregnancy testing kit
- Zip-lock bag
- Green towels (2) for wiping

Documentation of observations is done on the medical sheet, the post-rape care register booklet (where needed), and the psychological assessment form, which captures the psychological assessment and care plan.

Generally, the physical examination is similar, with regards to costing considerations, for children and adults. It is also essentially similar across gender (with regard to skill and time-based costing considerations). For children who refuse examination (due to trauma, etc.), this may be skipped or deferred till later, implying repeat examination costs, but this is not the norm.

Clinical and laboratory investigations are conducted based on the type of GBV. For sexual assault, urinalysis (urine microscopy), pregnancy test, sperm detection test (from urine and from High Vaginal Swab, anal and oral swabs), HIV test, haemoglobin levels, liver function tests, and screening for sexually transmitted infections such as gonorrhoea, VRDL/syphilis, and hepatitis B are indicated.

For physical assault, the haemoglobin levels and liver function tests may be the only lab investigations routinely performed, unless other presenting history indicates the need for further investigations. Radiological investigations are available where needed and typically include ultrasound, X-ray, and CT scans (primarily head and chest scans).

C. Initial management

Acute medical management of the survivor is dependent on their present status, and mainly involves administration of analgesia, wound care (including stitching under local anaesthesia when necessary), and vaccination (tetanus toxoid, with a booster dose a month later), and where sexual assault has been attempted, prophylaxis is issued – pregnancy for women using a dose of P2, STI prophylaxis using antibiotics, and HIV for all using a month's dose of triple therapy as per post-exposure prophylaxis guidelines.

There may be subtle differences in the kind of medication given, such as antibiotics for pregnant women or for children. However, this may not have a large impact on the overall medical management cost per typical patient.

High vaginal tears, which occur principally in young females through sexual assault, may require surgical/gynaecological repairs that may impact significantly on the cost of medical management.

D. Psychosocial care

At the clinic, clients are offered a number of counselling and psychosocial care services, including psychotherapy (offered by the psychiatrist, and which takes about 45 minutes to 1 hour), support groups, and trauma counselling (offered by the counsellor, and which takes about 45 minutes to 1 hour) where necessary.

For children, a child counsellor is available and so is play therapy and support group therapy.

E. Follow-up

Follow-up care is offered ideally every fortnight for the next six weeks and may include wound care and counselling. A final clinic visit 12 weeks post-incident is also recommended to review laboratory indicators before discharge from the clinic.

LEGAL SERVICES

Kenyatta National Hospital partners with International Justice Mission, the Centre for Rights Education and Awareness, and the Coalition on Violence against Women to provide legal services to victims of GBV. When there is a case in need of legal services, a social worker at the hospital informs one of the partner organizations and a legal officer is assigned to the case.

SECURITY SERVICES

Kenyatta National Hospital provides its clients with linkages to security services through collaboration with the gender desks of police stations within its vicinity.

APPENDIX 8: CASE STUDY 2 – NAIROBI WOMEN'S HOSPITAL GENDER VIOLENCE RECOVERY CENTRE

The centre, based in Nairobi, was set up in 2001 and currently receives the largest number of GBV cases in Kenya. In the financial year April 2014 to March 2015, the centre offered medical support to a total of 3,247 survivors, as shown in Table 1.

Table 1: Age and Gender Distribution of Survivors Supported During Financial Year 2014–2015

Age	Male	Female	Total
Children (<15 years)	304 (9.4%)	940 (28.9%)	1,244 (38.3%)
Adults	139 (4.3%)	1,864 (57.4%)	2,003 (61.7%)
Total	*443 (13.6%)*	*2,804 (86.4%)*	*3,247 (100%)*

This number has increased by 17.6 percent from the 2,762 reported in the previous financial year (2013–2014), mainly due to an increase in adult female cases (which increased by 25.9 percent from 1,481).

From a sample of 135 survivors selected at random from survivors seen between January and July 2014, the distribution of survivors by type of GBV is as shown in Table 2 below.

Table 2: Distribution of Survivors by Type of Gender-based Violence Case

Type of GBV	Male	Female	Total
Forced marriage	-	1 (0.7%)	1 (0.7%)
Physical assault	7 (5.2%)	27 (20.0%)	34 (25.2%)
Rape	-	46 (34.1%)	46 (34.1%)
Sexual assault	10 (7.4%)	39 (28.9%)	49 (36.3%)
(Undocumented)	1 (0.7%)	4 (3.0%)	5 (3.7%)
Total	*18 (13.3%)*	*117 (86.7%)*	*135 (100%)*

From a sub-sample of the adults (there were 74 survivors older than 15 years) above, the distribution of survivors by marital status is shown in Table 3.

Table 3: Distribution of Adult Survivors by Marital Status

Marital Status	Male	Female	Total
Married/Cohabiting	2 (2.7%)	23 (31.1%)	25 (33.8%)
Single	4 (5.4%)	38 (51.4%)	42 (56.8%)
Widowed	-	1 (1.4%)	1 (1.4%)
(Data missing)	7 (1.4%)	5(6.8%)	6 (8.1%)
Total	*7 (9.5%)*	*67 (90.5%)*	*74 (100.0%)*

MEDICAL AND COUNSELLING CARE

Medical and counselling support offered in Nairobi Women's Hospital's Gender Violence Recovery Centre is based on the National Guidelines on Management of Sexual Violence in Kenya (2013) and is summarized as follows:

A. Consenting (obtaining informed consent)

Obtaining consent involves filling in a one-page consent form that goes into the patient's file. It involves counselling (which takes approximately five minutes), normally conducted by a certified counsellor or a nurse in a private room at the clinic. This is not to be confused with therapeutic counselling, which is

integral to medical case management, takes much longer, and continues throughout the management process of the clients, as demonstrated below. Once consent is obtained, a detailed incident form is filled, containing data on the self-reported case incident and perpetrator details.

B. History taking and physical examination

This is performed by two persons: a clinician and a trained support person (nurse) present for observation. It is expected to take about 30 minutes, because it involves a thorough head-to-toe examination.

Each examination consumes one post-rape kit per patient. The kit should contain the following items:

- Powder-free gloves
- Sterile (surgical) gloves – for sterile procedures
- Stick swabs (6)
- Masking tape and brown envelope for samples
- Tape measure
- Needles and syringes, Vacutainers for blood sample collection
- Urine bottle / cup
- Speculum
- Pregnancy testing kit
- Zip-lock bag
- Green towels (2) for wiping

Documentation of observations is done on the medical sheet, the post-rape care register booklet (where needed), and the psychological assessment form, which captures the psychological assessment and care plan.

Generally, the physical examination is similar, with regards to costing considerations, for children and adults. It is also essentially similar across gender (with regard to skill and time-based costing considerations). For children who refuse examination (due to trauma, etc.), this may be skipped or deferred till later, implying repeat examination costs, but this is not the norm.

Clinical and laboratory investigations are conducted based on the type of GBV. For sexual assault, urinalysis (urine microscopy), pregnancy test, sperm detection test (from urine and from High Vaginal Swab, anal and oral swabs), HIV test, haemoglobin levels, liver function tests, and screening for sexually transmitted infections such as gonorrhoea, VRDL/syphilis, and hepatitis B are indicated.

For physical assault, the haemoglobin levels and liver function tests may be the only lab investigations routinely performed, unless other presenting history indicates the need for further investigations. Radiological investigations are available where needed and typically include ultrasound, X-ray, and CT scans (primarily head and chest scans).

C. Initial management

Acute medical management of the survivor is dependent on their present status, and mainly involves administration of analgesia, wound care (including stitching under local anaesthesia when necessary), and vaccination (tetanus toxoid, with a booster dose a month later), and where sexual assault has been attempted, prophylaxis is issued – pregnancy for women using a dose of P2, STI prophylaxis using antibiotics, and HIV for all using a month's dose of triple therapy as per post-exposure prophylaxis guidelines.

There may be subtle differences in the kind of medication given, such as antibiotics for pregnant women or for children. However, this may not have a large impact on the overall medical management cost per typical patient.

High vaginal tears, which occur principally in young females through sexual assault, may require surgical/gynaecological repairs that may impact significantly on the cost of medical management.

D. Psychosocial care

At the clinic, clients are offered a number of counselling and psychosocial care services, including psychotherapy (offered by the psychiatrist, and which takes about 45 minutes to 1 hour), support groups, and trauma counselling (offered by the counsellor, and which takes about 45 minutes to 1 hour) where necessary.

For children, a child counsellor is available and so is play therapy and support group therapy.

E. Follow-up

Follow-up care is offered ideally every fortnight for the next six weeks and may include wound care and counselling. A final clinic visit 12 weeks post-incident is also recommended to review laboratory indicators before discharge from the clinic.

LEGAL SERVICES

In addition to medical care, Nairobi Women's Hospital's Gender Violence Recovery Centre provides linkages to legal support. The hospital collaborates with various non-governmental organizations to offer legal services to GBV survivors. These organizations include FIDA, the Centre for Rights Education and Awareness, the Child Rights Advisory, Documentation and Legal Centre, International Justice Mission, and

the Coalition on Violence against Women. When there is a case that requires legal intervention, Nairobi Women's Hospital coordinates with these organizations, who assign their legal officers to the clients. In the 2014–2015 financial year, 236 cases were supported through the provision of expert testimonies in a court of law. This reflects an increase from 228 cases in the 2013-–2014 financial year. Table 4 shows a distribution of the cases that were supported, by offence type.

Table 4: Distribution of Legal Cases Supported, by Offence

Offence	Number (percentage)
Defilement	159 (67.4%)
Attempted defilement	23 (9.7%)
Rape	18 (7.6%)
Attempted rape	17 (7.2%)
Gang rape	8 (3.4%)
Sexual assault	9 (3.8%)
Rape of person with disability	2 (0.8%)
Total	*236 (100%)*

SECURITY SERVICES

The Nairobi Women's Hospital provides its clients with linkages to security services through collaboration with the gender desks of police stations within its vicinity.