Assessment Report

COVAW
Coalition *on* Violence Against Women

An Assessment of existing Gender Based Violence response hotlines within Nairobi and Kiambu Counties

December 2020

Acronyms and Abbreviations

CBO	Community based organization
COVAW	Coalition on Violence Against Women- Kenya
FGD	Focus group discussion
GBV	Gender based violence
HAK	Healthcare Assistance Kenya
KII	Key informant interview
PEP	Post-exposure prophylaxis
NGO	Non-governmental organization
SGBV	Sexual and gender based violence
SOP	Standardized operating procedure

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Executive Summary

This report details the findings of an assessment which took place in between December 12 to 21, 2020 in Nairobi and Kiambu counties. The broad purpose of this assessment was to provide assessment on existing gender based violence response hotlines and the extent to which incidents of SGBV reported through the hotlines receive appropriate responses and support. The assessment entailed two components: i) mapping of the existing hotlines, and ii) qualitative assessment comprising focus group discussion, key informant interviews, and case studies, alongside a review of best practices in gender based violence response using hotlines.

Since the assessment rotates around availability of hotline services to meet the need for SGBV services, from the outset, it was important to establish the number of GBV hotlines and responders. The findings indicate that GBV hotlines are coming from different sectors. In total, 12 organizations were identified to be providing hotline support for responding to GBV. These comprise 11 with outreach in Nairobi and 7 in Kiambu.

Looking at the aspect of capacity of the existing gender based violence hotlines, results indicate that in total; approximately 250 to 310 cases are handled per month from calls reported through the hotlines. Analysis by hotline show relatively wide distribution of the number of cases handled. The numbers range from just 10 to 100. In total, between 140 to about 5000 cases have been handled since the first case of COVID 19 in March 2020. Based on the ratio of cases to staff members managing the hotlines, there's so much discrepancy in the caseloads, ranging from 1 to 6.7 cases.

When it comes to training and skills, the findings suggest staff with different levels of proficiency overlap within the sector. Staff in some hotlines did not have any specific training. However, what we see for a large part of the staff is on-the-job training. In one respect, the personnel engaged are that already have qualifications in counseling psychology. The findings indicate extensive portfolio of on-the-job training courses covering a range of thematic areas of gender based violence prevention and response. What stands out is a general lack of specific training on the course of actions when receiving a call in a way that meet the immediate safety needs of sexual and gender based violence survivor.

With regard to case management response, the findings point to challenges arising from a lack of standardized approach for case management over the phone. This is in part driven by the fact that some of the organizations that provide hotline services do not have standard operating procedures pertaining to what actions should take place. In this sense, a senior officer provides guidance or direction to the helpline staff on how to proceed with the case.

From the responses, there is indication of an operational gender based violence coordination system with links to various secondary and tertiary services in a referral system. The services to which

survivors are currently referred for needed sexual and gender based violence support included legal aid, health facilities, children's office department, safe accommodation. Generally, the referral process is facilitated using documents and/or receipts.

It was also of interest to this assessment to look at communities' knowledge of hotline services available for reporting cases of gender based violence. Analysis of the focus groups suggests that the commonly used channels for reporting sexual and gender based violence cases are through the formal legal system, often involving the police and chief, as well as 'traditional justice system'; the latter often used as the first level of redress. There remains a relatively low level of awareness regarding hotlines as a means for sexual and gender based violence reporting.

1 Introduction

1.1 Context

The COVID 19 pandemic has magnified the risks of Gender based violence (GBV) faced by women and girls in Kenya. Cross-county comparable data on GBV prevalence give an apparent indication of increasing women's and girls' vulnerability in Nairobi and Kiambu Counties. Since the outbreak of COVID-19, emerging data and reports have shown that all types of violence against women and girls, particularly domestic violence, have intensified. Data compiled from the (GBV hotline 1195 managed by the Health Assistance Kenya (HAK) showed that in July, Nairobi and Kiambu ranked first and third respectively in terms of the number of GBV cases recorded.

A key priority is to scale up hotlines as a remote means for survivors to access case management and support services for survivors of GBV. Existing hotlines spotlight both good practice and gaps in service delivery of GBV services. In particular, making sure that the hotlines work as they should be critical for the safety of survivors of GBV. In view of this, Coalition on Violence Against Women- Kenya (COVAW) commissioned an assessment of existing GBV hotlines for a Project entitled "Enhanced Access to Justice for Women and Girls with Intellectual Disabilities During COVID-19 Pandemic," a COVID-19 response project in Nairobi and Kiambu Counties. The Project is a recipient of financial support from Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ).

The project seeks to achieve the following:

i. Raise awareness on challenges faced by girls and women as they report cases relating to Sexual and gender based violence (SGBV)
ii. Sensitize households on the rights and protection of women and girls with intellectual disabilities
iii. Conduct an assessment of the pre-existing Gender Based Violence hotlines and to what ex tent organizations are responding to complaints of SGBV and public consumption of the available hotline facilities

1.2 Purpose and Scope of Assessment

In accordance with the terms of reference, the broad purpose of this assessment was to provide assessment on existing GBV response hotlines and the extent to which incidents of SGBV reported through the hotlines receive appropriate responses and support. The focus is primarily on tackling violence against women and girls. The assessment sought to establish the value-addition of hotlines in facilitating reporting and response mechanisms in Nairobi and Kiambu Counties.

The following underlined the specific objectives this assessment sought to establish:

a) The existing hotlines in the two target counties managed by organizations responding to SGBV survivors during the COVID-19 Pandemic;
b) The protocols/standards that exist to guide the management of cases reported through the hotlines;
c) The capacity of existing GBV hotline systems to support GBV survivors;
d) The personnel operating and managing the hotlines (i.e. how are calls answered and by whom);
e) The training and skills of the personnel handling the hotlines to enable them to provide an effective service;
f) The management and supervision structure to ensure quality and appropriate services issued
g) The number of hotlines that are toll free and whether the clients' ability to call in for free determines the uptake of reporting of SGBV cases;
h) Explore the level of awareness on the existence of the SGBV hotlines;
i) Explore the linkages and referral systems in place to ensure the continued support of callers/clients in the GBV continuum of care.
j) Development of at least 3 cases studies related to cases reported through the hotlines; and
k) Compile a set of recommendations to relevant stakeholders, based on findings of the assessment

2 Methodologies

2.1 Approach of Assessment

The approach of assessment consisted of two components: i) mapping of the existing hotlines, and ii) qualitative assessment comprising focus group discussion (FGDs), key informant interviews (KIIs), and case studies. The activities undertaken for this assessment are described below:

2.1.1 Mapping the hotline services

The starting point involved identifying and listings existing hotline platforms for response to SGBV. A large part of this investigation was conducted through desk review, while also drawing on consultations with SGBV service providers for more information about other hotline services available. A list of services will be created and categorized by provider organization and location. After completing and compiling information, verification was done by calling the hotline numbers to test presence.

2.1.2 Qualitative assessment

a) *Key Informant Interviews*

Some identified organizations with hotlines were contacted to provide details of service operations. The interviews were designed to be completed by individuals relevant to GBV service provision, and who are familiar with the protocol and standards. The reference target groups included representatives of NGOs and agencies, local organizations, as well as government officials providing GBV hotline services. The sampling approach for the KIIs was developed based on a service provider file. This entailed first preparing an exhaustive list of all organizations. The organizations were then contacted with a short list of questions and provided an opportunity for them to describe their GBV-related hotline response services. Subsequently, all organizations that provide GBV hotline services will be included in the assessment.

b) Focus Group Discussions

This part of the assessment focused on exploring awareness on the existence of GBV hotlines, while also seeking to explore the local understandings of SGBV and commonly used channels for reporting SGBV. The FGDs were facilitated as semi-structured discussions with small groups of participants to encourage flexible and creative discussions among participants. The dynamics offered by FGDs are intended to encourage the participants to talk to one another, discuss and build upon or challenge each other's opinions, so that the discussions provide an insight into how

a group thinks about an issue, about the range of opinion and ideas, and the inconsistencies and variation that exists in a particular community in terms of beliefs and their experiences and practices.

The key target groups for the FGDs comprised members of Community Based Groups. In order to allow for more diverse profiles of organizations, the approach for selecting participants involved judgmental sampling. This purposive sampling technique was intended to assure that we can obtain a diversity of opinion from different groups. Each FGD was conducted with 6 to 8 discussants so as to allow for more active and in-depth contributions. For this assessment, 10 FGD sessions were conducted in Nairobi and Kiambu Counties.

c) Case studies

The case studies were undertaken to analyze and identify gaps and opportunities in use of hotline as part of SGBV programming. The case studies centre on the KIIs carried out, and sought to highlight best practices on GBV hotline response for SGBV survivors. The case studies were collected by way of narrative interviewing, using retrospective methods combining semi structured and episodic interview modes to document the practical applications of remote service delivery models for management and processes for coordination of care. The method of information-oriented sampling was used for selection of cases. Using this approach, cases were chosen for their significance and relevance, in that they seem to be "typical critical instance case studies."[1]

2.1.3 Challenges and Limitations

Getting to interview certain cadres of officials in the organizations targeted posed a challenge. This limited access to some information and made virtually impossible to obtain reliable figures from the organizations.

Respondent's inability, either because of recall or hesitation to divulge 'deeper' details of the case studies also posed challenges, limiting the extent to which the case studies are able to provide a holistic view of the case management process.

[1] Critical instance case studies allow for investigation of cause and effect for the studied subject

3 A Review of Practices in GBV Hotline Response

Gender based violence is known to be widespread in the Southern African Development Community (SADC) region and presents a major obstacle to attaining gender equality and equity. SADC considers GBV a critical area of concern. The SADC Secretariat facilitates, coordinates and provides oversight in ensuring that State Parties effectively develop and implement clear actions to prevent, combat and effectively reduce GBV (SADC, 2018). When referring to Gender Based Violence SADC recognizes that the discussion is not just about the act of violence, but also about education and prevention, as well as victim assistance (SADC, 2012).[2]

SADC identifies that GBV predominantly remains unreported for many reasons including its occurrence in intimate private spaces where victims may be persuaded to conceal it, or victims may not know where to go even if they wanted to seek redress. Among the reasons commonly documented for GBV under-reporting are: fear of the perpetrator and more victimization, limited knowledge and skills for affective communication and conflict resolution, economic dependence, unequal power relations, self-blame and accepting responsibility for causing conflict and therefore accepting punishment for it, fear of stigmatization, negative and oppressive cultural and traditional practices and norms - all compounding normalization and tolerance of GBV at different levels - family, the community and institutions (Ibid).

SADC recognizes that, in the midst of combating this unprecedented COVID-19 pandemic, it is easy to overlook the abuses that women and girls encounter during this crisis. While it is very important for Governments and stakeholders to focus on measures to contain COVID-19, and Law enforcement establishments to focus on enforcing COVID-19 regulations and measures in the communities, domestic violence should not be neglected (SADC, 2020). In the face of the pandemic restrictions, coupled with a lack of recognition that GBV services are essential services, mainly transitioning to phone, internet, or SMS based services. This includes ultimately making adjustments to deliver slimmed down, GBV case management services - such as facilitating referrals to healthcare and other providers that are permitted to operate, offering emotional support and undertaking enhanced safety planning with survivors (Erskin, 2020).

An examination of the programming around mobile and remote approaches to GBV brings to the fore a number of issues that are worthy of attention in order to take advantage of the opportunities and benefits that may emerge from the use of hotline platforms to implement GBV response services during the COVID 19 pandemic. This review draws from two case studies in Namibia and Zambia to review of best practices in use of toll free helpline numbers for GBV response and prevention.

[2] SADC (2012). Gender Based Violence. https://www.sadc.int/issues/gender/gender-based-violence/

1 Coordination Mechanism for the Implementation of the National Gender Policy

Country	Namibia
Context and challenge being addressed	Gender based violence (GBV) is evidenced by recent statistics that shows an increase in the number of rape and domestic violence cases reported annually. While Namibia has taken great strides in achieving formal protection for women against GBV through laws such as The Combating of Domestic Violence Act 4 of 2003 and The Combating of Rape Act 8 of 2000; effective implementation and consistent enforcement of these laws was limited. It was against this background that Namibia came up with a Coordination Mechanism for the Implementation of the National Gender Policy, which had twelve areas of concern, one of which was focused on Gender Based Violence. The Coordination Mechanism involves overseeing the coordination of the implementation, monitoring and evaluation of the National Gender Policy, the accompanying National Gender Plan of Action and the National Plan of Action on GBV.
Methodological approach	The country experienced an increased number of gender based violence cases, thus a national conference on GBV was held in June 2007, to discuss how best to reduce cases of GBV. The conference came up with various recommendations to be implemented. After the conference a KAP study (2008) was conducted to establish the extent of GBV in Namibia. This led to the development of the Plan of Action on GBV that outlined actions designed to prevent GBV, improve implementation of laws and services aimed at victims of GBV and to provide adequate support services for survivors. It has strategies and action steps that guide stakeholders in their implementation of GBV programmes. The Plan of Action on GBV is coordinated by the GBV & Human Rights Cluster.
Impact	The Coordination Mechanism has brought all players/ stakeholders dealing in the area of GBV under one umbrella of GBV and Human Rights Cluster. This converged effort in the areas of awareness and provision of psycho-social support, which promoted efficiency in human and financial resources. The case management has also improved from reporting to prosecution, in the sense that GBV cases are no longer easily withdrawn before prosecution. Monitoring and reporting by stakeholders has improved, for example from the GBV Protection Units in terms of administrative data. In addition, the coordination mechanism created a clear structure of support from the higher level such as the GAC that provides political support. At the regional level due to the existence of the CM, this prompted the regions to develop region specific plan
Innovation and success factors	Based on the stakeholders' engagement, Namibia introduced a toll free GBV Helpline number – 106 in the year 2015. The number can be dialed by anyone, every day from any phone, and from anywhere in Namibia to seek counseling, information or urgent help. The line receives ±20 calls per day. The toll free GBV services has since been effective and helped a number of victims in

	opening cases with the courts as the system was designed to enable the calls to be recorded and can be used as evidence in the court of law. It has also rendered assistance to victims who were unable to come out and speak about their abuse because of fear as well as those who could not reach the police station and GBV Investigating Units that offer GBV services. The toll free GBV services are run by an NGO (ChildLine Lifeline) with government support. Another initiative was the launch of the Mass Media Campaign for Zero Tolerance on GBV. The campaign used different platforms such as radio and TV series and also social media to create awareness on GBV. The response, specifically on social media was good based on the feedback received especially from the youth community.

Lessons learnt

- Terms of reference for stakeholders/ implementers required to be clearly stipulated for them to understand their specific roles in terms of implementation
- Due to the inconsistency of members attending meeting permanent members and alternate needed to be appointed
- It was learnt that when there are no memorandum of understanding and clear terms of reference for stakeholders it brings challenges in coordination

2 One-stop model of support for survivors of gender-based violence

Country	Zambia
Context and challenge being addressed	Gender-based violence is a widespread and deeply entrenched problem in Zambia, with one of the highest rates of intimate partner violence in the world. According to the 2007 Zambia Demographic and Health Survey, 47% of women in Zambia have experienced physical violence since age 15—77% by a current/former husband/partner—and one in five have experienced sexual violence in their lives, 64% of which is perpetrated by an intimate partner. Yet less than half (46%) of abused women and girls seek help for various personal, economic, and social concerns, especially fear of stigma. Survivors of GBV face serious and often life-long health problems, such as HIV and other sexually transmitted infections. Survivors may develop subsequent mental health problems, and are stigmatized and often rejected by their partners, families and communities.
Methodological approach	CARE and partners developed a successful one-stop model of Coordinated Response Centers (CRCs) through a pilot GBV project funded by the European Union from 2005 to 2007. For the first time in Zambia, the two initial pilot centers established through this project served as single sites where survivors could access medical, psychological and legal support. This model was then expanded and further developed through 'A Safer Zambia' (ASAZA), a CARE-led project funded by USAID and the European Union (EU) grant for the Expansion of the Coordinated Response to Sexual and Gender Based Violence in Zambia project, which ran from September 2007 to December 2011. The ASAZA project sought to reduce the incidence of GBV in Zambia through a combination of greater knowledge of and changed attitudes towards gender inequalities, as well as access to comprehensive services for GBV survivors to meet their medical, psychological and legal needs. The main focus of the CRCs was counseling and follow-ups by other service providers, especially the police. The CRC counselors continuously followed up with clients and kept track of the process of service delivery for each survivor. These services include trauma prevention, HIV pre- and post-test counseling, and PEP adherence counseling. CRC paralegals, trained by one of CARE's local partners, Women in Law in Southern Africa, also provided counseling to prepare survivors for the justice system. ASAZA set up mechanisms to facilitate information sharing among service providers and to ensure that services are provided in an integrated and coordinated manner. CRC Advisory Councils, consisting of representatives from district government and civil society organizations, were established to oversee the operations of CRCs at the district level to encourage local

	involvement and ownership. CRC Service Provider Networks, composed of both government and local community structures involved in provision of services to GBV survivors, were also established to provide a platform for sharing, learning and a coordinated referral system for survivors.
Impact	A client satisfaction survey was also conducted in 2011 to collect views from GBV survivors regarding the quality of services at various service points (reception, counselors' office, VSU police officer, social worker/paralegal and medical staff) at the CRC. Five CRCs (Chipata, Kabwe, Mazabuka, Mtendere and Livingstone) were selected for the survey after considering the rural-urban mix and provincial distribution. Data was collected from clients that walked into CRCs for a week by research assistants and was entered online using SurveyGizmo. During the week of data collection, the CRCs recoded a total of 197 survivors, indicating that, on average, about 200 people walk into five CRCs in one week. The client satisfaction surveys provided valuable feedback on the quality of services at various service points and on what contributed to client satisfaction. Factors that contribute to client satisfaction included: • Friendly and welcoming environment • Cases treated with privacy and without bias • Positive and respectful interactions with staff • Consistent follow-ups on cases • Handling cases without corruption or bribery • Free services that anyone could access • Linkage to safe houses for certain cases
Innovation and success factors	Towards the end of the project, Life Line Zambia, a 24-hour toll free telephone counseling service, provided telephone counseling services, accessible throughout the country from all mobile and landline telephone networks. 737 survivors received free telephone counseling through this service. ASAZA supported Police Victim Support Unit (VSU) Officers assigned to CRCs to help survivors file a police report at the CRC if they decide to do so. 1,945 cases were taken to court, of which 204 resulted in conviction. The remaining cases were still pending in court at the close of the project. The project also participated in and supported the process of developing the National Guidelines for the Multidisciplinary Management of Survivors of Gender Based Violence in Zambia, and oriented 1,115 professionals at the CRCs on the guidelines. These are the first multi-sectoral GBV guidelines in Africa, and were developed through a comprehensive, multi-stakeholder process that was led by the government.

Lessons learnt

- With broad-based awareness-raising on GBV, there also must be commensurate broad-based capacity building of local service providers so that survivors can receive quality care within their localities, without having to travel a significant distance to the nearest CRC
- There is a need for additional training, support and mentoring for counsellors, particularly on topics such as child counselling, couples counselling and addressing HIV-related issues. Specialized support tailored to the needs to child survivors is especially important
- Staff should receive ongoing and refresher training, mentoring and support to provide the best possible care to survivors, to inform staff of emerging issues and approaches and to increase staff knowledge and reduce burnout. Specialized training on developmentally appropriate and empathetic support to children should be standardized in training curricula for all service providers
- Clearly marked, stand-alone centers offering services exclusively for GBV survivors are likely to be known as such within communities, and thus risk stigmatizing people who are seen entering these premises. One-stop centers for GBV support services that are located within government buildings or departments with other functions, such as health clinics and hospitals, and integrated into existing services, such as for sexual and reproductive health, are less likely to expose and thus stigmatize those who access services
- Evaluations of ASAZA highlighted the problematic reliance on volunteers to provide core services (counseling and paralegal), given the challenges of retaining volunteer staff and keeping them motivated in the face of high time demand, heavy caseloads and potential secondary traumatization
- An ongoing challenge is that most CRCs do not provide 24-hour care, which can have negative implications for survivors, particularly with regard to accessing timely medical services

4 Results

4.1 Sample Characteristics

4.1.1 Focus Groups Coverage and Sample Characteristics

Six localities in Nairobi and Thika were included in the assessment: Huruma, Kawangware and Kibera (Nairobi), and Juja, Makongeni and Weiteithie (Thika). The FGD respondents for this assessment were members of the community based organizations (CBOs). In total, 14 CBOs were represented. Annex 1 provides information on the CBO and FGDs coverage. In total, the FGDs were conducted with a total of 75 participants. Table 4.1 shows Focus Groups Coverage and Sample Characteristics.

Table 4.1: Focus Groups Coverage and Sample Characteristics

Age	**No.**
18-24	6
25-34	25
35-44	31
45+	13
Education	
No formal Education	2
Some primary	22
Primary complete	21
Some Secondary	7
Secondary Complete	19
College/Tertiary	3
University	1
Marital Status	
Single/Not Married	9
Married	58
Divorced/Separated	2
Widowed	6
Total	**75**

4.1.2 Key Informant Interviews Organizations Characteristics

The respondents for the KIIs represented various sectors. The respondents representing the following categories of organizations were interviewed. Table 4.2 shows the organizational characteristics of the organizations for the KIIs. Description of the key informants is provided in Annex 2.

Table 4.2: Key informant interviews organizations characteristics

Sector	**No.**
Public institution	1
Non state organization	7
Area of focus	
Gender based violence	2
Gender and advocacy	4
Health care	1
Community outreach & empowerment	1
Total	**8**

4.2 Existing Hotlines

To identify existing hotline services, the assessment drew on the LVCT HEALTH GBV and HIV Services Directory. The findings indicate that GBV hotlines are coming from different sectors. In total, 12 organizations were identified to be providing hotline support for responding to GBV. These comprise 11 with outreach in Nairobi and 7 in Kiambu. Note that KIMBILIO is not included in this count because there is currently no funded programme to support the hotline service. Attempts made at testing the functionality of the hotlines indicated that, with exception of KIMBILIO, all the hotlines were usable. All the organizations, with exception of SHOFCO operate either service access or short code numbers. A call however does not result in a charge on the caller. The table 4.3 below highlights the existing hotlines identified and catchment area to which outreach staff are deployed

Table 4.3: Existing hotlines identified and their counties of operation

Organization	**Hotline**	**Catchment area to which outreach staff are deployed**	
		Nairobi	Kiambu
FIDA	0800720501	✓	
Childline	116	✓	✓
COVAW	0800720553	✓	✓
MSF	0800721100	✓	✓
LVCT	1191	✓	✓
LVCT One To One	1190	✓	✓
SHOFCO	0703445737	✓	
Healthcare Assistance Kenya	1195	✓	✓
KIMBILIO	1193	Currently not operational	
CREAW	0800720186	✓	
National Gender Equality Commission	0800720187	✓	✓
MCK – Kibera	0800720529	✓	

4.3 Features and Functionality of the Hotlines

4.3.1 Capacity of existing GBV hotline systems to support GBV survivors

In the current survey, we attempted to assess the capacity of existing GBV hotline systems to support survivors form three dimensions: number of cases handled, staffing levels and services provided to SGBV survivors. The findings around these three dimensions are discussed below.

1) Number and nature of cases handled

To examine capacity of the existing GBV hotlines, it is useful to first consider the average number of cases handled that were reported through the hotlines. Results show relatively wide variation of the average number of cases handled by the hotlines per month. The numbers range from just 10 to 100. One key informant comment intimated to a possibility of higher numbers of cases that go unreported. The table below (table 4.4) shows the distribution of the average numbers of cases per month by hotline.

Table 4.4: Distribution of the numbers of calls made by hotline

Organization/Hotline		Average no. of cases/month
FIDA	0800720501	50 to 100
Childline	116	20-25
COVAW	0800720553	40
SHOFCO	0703445737	80
HAK	1195	40 to 48
CREW	0800720186	20
LVCT	1191	10

The most frequently mentioned cases were incidences of sexual violence, including defilement and rape. Other SGBV cases cited included attempted rape, attempted defilement, sodomy, incest and indecent acts.

2) Staffing levels

A look at the staffing levels indicates varying numbers of staffers, from 5 to 30, most of them permanent personnel, working in shifts throughout the day and night. The assessment found that some hotlines tended also to involve volunteers and interns. Table 4.5 below indicates the number of staffers by organization.

Table 4.5: Number of staff by hotline

Organization/Hotline		No. of staff
FIDA	0800720501	15
Childline	116	30
COVAW	0800720553	1
SHOFCO	0703445737	1
HAK	1195	26
CREW	0800720186	5
LVCT	1191	5

3) Services provided to SGBV survivors

For the third aspect of capacity, we consider the services the organizations providing GBV hotline services are able to provide to SGBV Survivors. Table 4.6 shows the range of services mentioned. These include psychosocial support and referrals, rescue, medical care, legal aid, safe shelter, economic support and mediation. The results show that the major functions across the hotlines are providing psychosocial support and referrals. Capacities remain limited though for the services, other than these two, in any case with just one to three organizations having capability to provide the service.

Table 4.6: Services provided to SGBV survivors

	FIDA	Childline	COVAW	SHOFCO	HAK	CREAW	LVCT
Psychosocial support	✓	✓	✓	✓	✓	✓	✓
Referrals		✓	✓	✓	✓	✓	✓
Rescue		✓		✓		✓	
Medical care				✓			✓
Legal aid	✓	✓	✓			✓	
Safe shelter				✓			
Economic support				✓		✓	
Client & family therapy		✓					
Mediation	✓						

4.3.2 Training and skills of the personnel handling the hotlines

Most of the organizations conduct different levels of in-house training for their staff to help them learn the skills necessary to function effectively in their roles. For some, though, the personnel engaged are those that have completed prior training programmes, notably counselling psychology or law. Table 4.7 below gives an indication of the trainings themes covered under the courses offered. The findings indicate extensive portfolio of on-the-job training courses.

Table 4.7: Training theme covered under the courses offered

Organization	Training themes covered
FIDA	Law –legal issues
	Counselling
	Gender training
Childline	How to receive a call and talk to clients
	Child protection
	Counselling
	Trauma and stress
	Child abuse
	Loss and bereavement
	Child health
LVCT	Child sexual abuse
	Refusal and negotiation skills
	How victims behave
	Creating self-awareness on girls
	Gender training
	Evidence based evaluation
SHOCFO	Handing cases – SGBV interviewing
	Dos and don'ts of case management
	Law – legal issues
	Customer service
	Attending and talking to survivors
CREAW	How to receive a call and talk to clients
	Counselling
	Identifying level of injuries and services to offer

A cursory glance at the above table indicates that hotline personnel have profound training and hands-on information a range of thematic areas of GBV prevention and response, including life skills necessary for children to protect themselves. The other element that the training seems to give attention is in relation to legal and judicial remedies to survivors.

The assessment identifies wide variations in the structure and length of training. These range from short courses that take just one day to delivery to long term training courses, composed of several phases lasting up to 12 months. For organization such as SHOFCO and Childline, some training is provided on an ongoing basis to support and provide both refresher training and opportunities for up-skilling.

4.3.3 Protocols/standards for the management of SGBV cases

Responses to the question as to whether the facilities have protocols or guidelines for the management of SGBV survivors indicated compatibility – at least at the conceptual level. In understanding the level to which case management practices are compatible with the norms and guidelines on management of SGBV cases at practical level, a look at the understanding and actual practices across key services that address all the needs of a survivor is useful. We consider the following four main services which make up a holistic GBV response:

1) Safety and security options

Responses showed that approaches to ensuring safety and security of the survivors focus primarily on addressing confidentiality of the call and contact details.

> "We pride in confidentiality. We assure the survivor that what we discuss is discreet and is kept confidential." [Key informant, SHOFCO]

> "Telling the community members that the calls are handled confidentially; the information regarding the actual individual who called – their identities are not disclosed to anybody except the supervisor." [Key informant, COVAW]

An assessment of the survivors' safety over the phone was mentioned as key to ensuring personal safety and security of the survivors. Immediate safety and security options when an imminent risk to safety is identified or disclosed by a survivor include identifying temporary safe shelter and use of law enforcement response to neutralize the threat.

> "Providing safe space as they proceed with the case…Making the case proceed as much as possible as it is supposed to with the police and in court."
> [Key informant, CREAW]

"We make sure that steps are taken to identify potential risks during the call, and where necessary undertaken safety measures. This can include alerting the law enforcement to move quickly to contain the threat" [Key informant, Childline]

2) Mental health and psychosocial support

When it comes to mental and psychological support, the call answering procedures for most hotlines provide for emotional and psychosocial support to the survivor on the phone, as well as referral for appropriate care. This is observed in the comments below:

"We have tele counselors - for those that cannot be attended to one-on-one we link them with a counsellor within the organization to make sure she is back to normal. If the survivor is able to visit the office, we make an arrangement with counselor and book an appointment." [Key informant, CREAW]

"It is a matter of listening to them and helping them find a solution to their issue. For those cases that need psychosocial support, COVAW works with the counsellors to facilitate counselling support" [Key informant, COVAW]

"Provide basic psychosocial support to gender based violence cases… we also refer to health centre where they can gain support and do a follow-up."
[Key informant, LVCT]

3) Health/Clinical care

For clinical management of rape cases, some organizations guidelines for components of medical care, while others do not. The guidelines implemented include observation of the 'dos' and 'don'ts' to avoid interfering with evidence, as well as provision of post-exposure prophylaxis (PEP).

"If we rescue we ensure we first have the survivor receive medical care. We also have trained the community on dos and don'ts ensuring that when we get to the crime scene, we have evidence and the evidence is well kept." [Key informant, CREAW]

"…we have PEP services - we provide, we have HTS services; then from there if it is something severer, we refer to the hospital; we have a hospital here."
[Key informant, LVCT]

The choice of referral process, unaccompanied or accompanied depends on the client's situation and needs, but generally involves contacting the service on behalf of the survivor, passing on client's information to the service.

For older children, we make an appointment with the health facility on the survivor's behalf, and ask the survivor to visit the facility. We also make contact with the facility for follow-up, and if the appointment was not kept we contact the survivor to establish the reason" [Key informant, COVAW]

4) Legal/Justice assistance

For legal assistance, all organizations essentially follow the SOP for police response on the investigation of SGBV cases. There are differences with the aspects of accompaniment of survivors during meetings with police or legal proceeding. Some organizations provide case officers for accompaniment process, while other leave it to the discretion of the survivor.

> "Yes, we have a team of case officers that accompany survivors to medical services, police and even in court. They do what we call 'WATCH BRIEF'."
> [Key informant, CREAW]

> "It's on a need by need basis, because when the victim knows what to do, or when the evidence has been put in place in a proper manner, there is always no needs - there is no big deal because most of the time it is the survivor who needs to be protected, most of the time the issues are easy to handle." [Key informant, FEMNET]

What also emerges is the aspect of legal referral, more specifically to pro bono lawyers who provide legal assistance to the survivors, starting from police procedures right to the court.

> "We work with pro bono lawyers who will support survivors who are intent on accessing justice. Pro bono lawyers will accompany survivors or caregivers in court – every court session. They will support the process beginning at the police station; the pro bono lawyers will follow-up the case to ensure the culprit is arrested"
> [Key informant, COVAW]

4.3.4 Management and Supervision

In the current assessment, we also attempted to evaluate the quality of the management and supervision. The staff works under managers, who are responsible for directly supervising and guiding the staff on the operating procedures, or in some cases work with team leaders who oversee their teams and task progression.

> "We have a manager, and under the manager team leaders who oversee a team of five to six staff. The functions of the manager include workforce management that entail recruitment, discipline and quality control" [Key informant, Childline]

This lead person is responsible for supervising the case, including overseeing quality aspects, which may include undertaking further investigation to determine whether the case reported is S/GBV.

> "Like for example, if a girl has been raped in the community, I will have to report to my boss before taking any action; may be my boss will make calls to establish incident of rape in Kibera. If this is the case, then our counterparts on the ground also have to be made aware that there is a girl who needs help."
> [Key informant, LVCT]

"There is the lead person who is in charge, and they work as a team when receiving these calls. It is not like it is one-person thing." [Key informant, CREAW]

4.3.5 Linkages and Referral Systems

To effectively deal with SGBV cases, hotline services approach the provision of case management in a collaborative manner. From the responses, there is indication of an operational referral system with links to various secondary and tertiary services. The services to which survivors are currently referred for needed SGBV support include legal aid, health facilities, children's office department, safe accommodation. The referrals are almost entirely initiated and facilitated by the respective hotline case officers who take the responsibility for making appointments.

The effectiveness of GBV referral pathways and sectoral services to which SGBV survivors can be referred rests on existing partnerships and networks. One key informant described the referral system as having already a network of contacts. This is illustrated in the comment below:

"We have networks that are actors, and it's usually very easy to just refer them from one organization to the other based on their areas of specialization. When we talk about health we usually refer them to gender violence recovery centre; when we talk of legal, we always talk to FIDA among other organizations"
[Key informant, FEMNET]

The current interactions and communication that exist between referring and referred-to providers does seem to play an important role in ensuring prompt access quality and timely for the SGBV survivors as well as smooth follow up of cases to ensure care plans are following.

"We have a network of contacts that we work with. For referral, we often call or let them know we are sending these persons to them and give them these kinds of support or we write a letter and give a person to take them to the service provider to be supported." [Key informant, CREAW]

One response identified two some in the current coordination system in terms of preventing and responding to SGBV.

Response 1: "Less positive attitudes of some personnel among the coordination partners at times compromise essential support within the referral system" [Key informant, Childline]

Response 2: "There are critical issues around GBV case management database. The registers do not provide for unified collection of referral data, which makes it challenging to comprehensively manage survivors' needs within the referral system" [Key informant, Childline]

4.4 Awareness on the Existence of the GBV hotlines

FGD with community based organizations (CBOs) served as a means to assess the communities' knowledge of hotline services available for reporting cases of GBV. Given this objective, reporting of the findings in this section focus on four main areas: 1) perceptions of what women and children do after they experience violence, 2) commonly used channels for reporting SGBV, 3) knowledge of the system in place for reporting SGBV, and 4) strengths and weaknesses of existing hotlines for reporting SGBV

4.4.1 What women and children do when they experience violence

Our FGD findings suggest that it remains a challenge for women and children to seek redress for GBV. While some seek redress, it was apparent that many other choose not to take any action. Various comments indicated that incidents of SGBV continue to be under reported; the respondents placed the numbers of reported incidents at roughly one-third to about half.

> "Out of the incidences that occur, I think only 30 percent of cases get reported" [FGD, Makongeni, Thika]
>
> "It's fifty-fifty – only about 50 percent of the cases are reported" [FGD, Juja, Thika]

The decision to report a case of GBV takes into account victim-perpetrator relationship, and the age of the victim. One comment to that effect was that survivors are more likely to report a case of harassment instigated by non-family member.

> "They look for help but mostly for harassment but not necessary domestic violence." [FGD, Juja, Thika)

The FGDs indicate less likelihood in women being able to report incidents of violence experienced in a domestic setting. Married women in particular were reported to be often reluctant to report these violations. The reasons cited vary: these include, among others: fear of the consequences, lack of knowledge where to report, a fear that not action will be taken, and stigma associated with exposing the incident. These are reflected in the quotes below.

> "No, especially when it involves married woman and man because of fear of consequences" [FGD, Huruma, Nairobi]
>
> Response 1: "Some fear because of further consequences from the partner" [FGD, Mkongeni, Thika]
>
> Response 2: "Some are advised by the extended family not to report to avoid embarrassing their partner" [FGD, Mkongeni, Thika]

Response 1: "The child or woman don't report because they feel the accused may bribe the chief" [FGD, Huruma, Nairobi]

Response 2: "They don't act because of lack of awareness on what to do" [FGD, Huruma, Nairobi]

4.4.2 Commonly used channels for reporting/resolving SGBV

Analysis of the FGD responses indicate that the commonly used channels for reporting and resolving SGBV cases are by way of family or community arbitration. Particularly, if the perpetrator is a family or household member, there tend to be a sense that the case is 'family issue'. Varied quotes from the FGDs demonstrate this viewpoint.

"We sit as community members and try to see the weight of the matter before reporting to relevant authorities" [FGD Kibera, Nairobi]

"Mostly they don't; instead they seek to solve the matter domestically" [FGD Kibera, Nairobi]

"They report to village elder who try to intervene to find a way out" [FGD Huruma, Nairobi]

"They report to the older woman who handle the matter in a way that everything follows the laid down protocol" [FGD Huruma, Nairobi]

The other option available to survivors is through the law enforcement system; in this case the offices of village elder and chief seeming to play key roles in cases.

"They report to the relevant authorities such as the chief, village elder" [FGD Huruma, Nairobi]

"The follow the protocol of reporting to the chief, village elder or nyumba kumi initiative" [FGD Huruma, Nairobi]

"They report to the chief to report the matter" [FGD Kawangware, Nairobi]

Alternatively, some women may seek counseling and support from their social network, often a trusted friend to disclose their experience.

"Yes, women go to their friends to try to seek help or advice" [FGD Kibera, Nairobi]

On the other hand, fear of disclosure was noted as likely to lead to a woman to taking own action.

> "Some women fear breach of confidentiality and so decide to take action by themselves" [FGD Kibera, Nairobi]

From the discussions, it was also evident that CBO are increasingly playing important roles in SGBV response and prevention efforts. Varies quotes from the FGDs point this.

> "We follow the protocol; we start with investigating the case, then we follow up with the police, then bring the victim to the hospital. For those afraid we take them to rescue centres" [FGD Weitethie, Thika]

> "When you get a case, you first try to affirm that it's true; if it is indeed true you report to police as you try to s take them to hospital. If the victim agrees you go ahead, first secure the safety of the victim and then to take them to hospital. Also, if the victim agrees you move ahead

> "When they report to us, we take them to the doctors for examination, then we go to the police for P3 forms, then we come back to the hospital with the filled P3 form and then we take it to the chief. If the family accepts, we arrest the perpetrator" [FGD Juja, Thika]

> "We just report to the police, the police investigate, the case, they take it to court and justice is served" [FGD Juja, Thika]

4.4.3 Community knowledge of the system in place for reporting SGBV

A question was directed to the FGD participants to assess their knowledge of the system in place for reporting SGBV. From the FGDs, only two mentions regarding 'hotlines' did seem to emerge, suggesting that use of hotlines remain at the lower rank of "top of mind" when it comes to SGBV reporting. One observation is a general comment that does not make specific mention of any hotline.

> "Use the hotline number to report." [FGD, Huruma, Nairobi]

The other observation is specific mention, albeit pointing to limited recall of existing hotlines, in this case **1196**

> "Use 1196 to call child abuse office number." [FGD, Kibera, Nairobi]

4.4.4 Community perceptions on strengths and weaknesses of hotlines

Responses from the questions asked regarding strengths and weakness of hotlines showed a mix of perspectives. On the strengths, one of the notable responses, and which are of particular relevance to SGBV report emerging was on the basis of confidentiality and anonymity in the way the cases are managed.

> "Hotlines have an advantage in the sense that the person reporting the case remains anonymous" [FGD Juja, Thika]
>
> "Hotlines bring more justice and ensures confidentiality" [FGD Huruma, Nairobi]
>
> "The receivers are trained and a person can be helped or even counseled 'telephonically'" [FGD Huruma, Nairobi]

The other comments worthy of note, and which in this case have particular bearing on SGBV report were on the basis that they offer free access to support.

> "They are toll free, you are not charged" [FGD Juja, Thika]
>
> "They are free of charge and this makes it easier to call urgently" [FGD Kawangware, Nairobi]

A look at the weaknesses points to a number of challenges associated with the related issues of awareness and accessibility. This view is reflected in the following comments:

> "Lack of awareness of the number to most victims" [FGD Kibera, Nairobi]
> "Not located in areas where we can easily access the numbers" [FGD Kibera, Nairobi]
>
> "Most of them are based in Nairobi, so the call goes to Nairobi and then redirected here" [FGD Jua, Thika]
>
> "Only few people know about them" [FGD Juja, Thika]
>
> "They are not known to members of the public" [FGD Juja, Thika]

4.5 Case Studies

After gathering information on what is known of the nature of response to SGBV in each context, the information will then be succinctly summarized, identifying the main gaps, barriers around hotline access and use, and emerging good practice in SGBV prevention and response, as identified by the key informants and focus group participants.

Note that names indicated in the case studies are fictitious and do not represent actual of the persons illustrated in the case studies.

Case Study 1: Neighbour's concern ensures SGBV survivor receives appropriate support to deal with domestic violence

Location: Kayole, Nairobi
Date: September, 2020

Anne[3] had been married for 5 years and lived in Kayole with her husband and children. She had been subjected to physical violence during the years of marriage. In September 2020, a concerned neighbour who felt that the lady was in danger of getting harmed called the CREW hotline number 0800 720 186 to report the case. CREAW case officers made contact with Anne to establish her experience and side of the story.

The outcome of the caseworker's safety assessment was that she was not safe at her home where her husband continually assaulted her, and though felt that safe accommodation was the first priority for Anne and the children. A referral was made for Anne to be assessed for medical care and treatment of injuries before taking her to the shelter. The case workers requested the neighbour to accompany her to the hospital, to which he readily agreed to do so. The injuries were determined not to be so severe, she was treated and she was well.

They placed her and her children out of her home to a safe shelter for about a month as she looked for a place to stay. She was accompanied by the CREAW case officers to the shelter. She has since found a place to stay and she is safe at the moment. Since she has been reluctant to persecute the case, the case is yet to proceed to the police or court.

CREAW was able to provide her with money to support her and help her start up her own business out of its cash transfer through the safety net programme that it operates in partnership with other organizations like the MasterCard and the European Union. The case officers have followed on her progress, and through counseling sessions with CREAW counselors, she has been able to access routine counselling. She was able find her own time and call the hotline on her own because the hotline is free and therefore there were no challenges. It was not easy, but in any case, she was desperate and she needed some support, it was not so hard.

CREAW case officers are still making following ups now that she is out of the shelter and starting her life. Out of the follow ups the case officers established that she moved from where she was to a new location because she felt she was not safe where she was, and is at the moment is adapting slowly to where she relocated to. The case is closed up but it's still under follow up and monitoring.

[3] Not her real name

Case Study 2: Mothers' responses to the sexual abuse of a child

Location: Kiandutu, Thika
Date: April 2020

Joan[4] is a16 year old girl with autism. She lived in Kiandutu slums in Thika, with her mother and step-father. From April 2020, Joan was assaulted sexually by her step-father; it is not clear for how long this went on. When her mother came to know this, she wanted to report to the police, and when her husband got to know about this, there was a fight and he beat her to an extent of inflicting serious injuries on her, which made her to become fearful.

In July she heard about SASA Centre and she talked to one of the agents who gave her the hotline number 1190 (operated by LVCT One to One). Case officers rescued the girl and took her to Kiambu centre for children with Autism, a rescue centre, while her mother was referred to Langata rescue Centre for women in Karen. Prior to relocation to the rescue centre, Joan was examined at Kiandutu Health Center, although by the time the case was reported the victim had no any wounds or injuries. During the evaluation, it was determined that she was sexually active, although valid determination to be made regarding whether or not sexual abuse had occurred. Clinical management procedures included HIV screening among other tests. Additionally, both were offered the psychosocial support at the rescue centre both the mother and the victim that entailed 3 counselling session per week.

Since the child was not in the legal age of consent, there was coordination with the Sub-County Children's Department regarding where to take the girl. Joan and her mother are still in shelter. Joan will be at the shelter until she is about 18 years. At the rescue centre Joan's mother was placed on vocational training to give skills for self-sustenance. As of now she has completed her counselling appointments. Their case is closed for now. Joan's mother is unwilling to pursue legal recourse. Until after 4 months at the facility, then it will be possible to know if she has decided to pursue the case legally and also see how she can put the skills she has learned to practice.

[4] Not her real name

Case Study 3: Role of community in SGBV response and protection

Location: Kibera, Nairobi
Date: August, 2020

CREAW has been having protection-related community outreach activity aim to attend to the needs of GBV survivors during the COVID 19 pandemic who have had no means of survival or meals. In that process they had some people that called to report experiences of GBV. One lady called and said that she has been having issues with the husband, she was being buttered and she felt that she was not safe from wherever she was.

Agnes[5] has been living in Kibera with her partner for a period of about six year. Over time problems developed in their relationship and her boyfriend became increasingly aggressive and was battering her. Through our community forums she had about CREW hotline number 0800 720 186 and called to reported the case.

Initially, assistance was primarily through counseling and after sometime she was able to visit the offices which are in Kibera, easily locating the site since she lived in the locality, and was able to make subsequent visits for psychosocial support for victims, scheduling time for her appointments so there were no challenges for her. During the office visit, the case officers inquired whether she felt safe, and if she knew a relative that could provide her safe accommodation. Having answered affirmatively, the case officers certified the place safe and facilitated her relocation.

So far she has undergone four counseling sessions. Assessment made on her determined that she had no injuries or any medical emergency so there was no need of going to the hospital. The case has not yet proceeded to court because the office closed before the legal process could be initiated. They anticipate that in January if she accepts to institute police and legal processes they will provide the necessary support as needed. CREAW has still continued the financial support by linking her with the organization doing the cash transfer. The follow ups are ongoing. She is still living with the relative until when she decides the next step, but in case of emergency case officials remain on standby to provide assistance.

[5] Not her real name

her own, because the hotline is free and therefore there were no challenges. It was not easy, but in any case, she was desperate and she needed some support, it was not so hard.

CREAW case officers are still making following ups now that she is out of the shelter and starting her life. Out of the follow ups the case officers established that she moved from where she was to a new location because she felt she was not safe where she was, and is at the moment is adapting slowly to where she relocated to. The case is closed up but it's still under follow up and monitoring.

Conclusion

The findings of this assessment show that hotlines are playing an important role in tackling SGBV and represent a significant achievement in the effort to strengthen the continuum of prevention and assistance to SGBV survivors. One key area this assessment attempted to assess was in regard to training and development. The training contents shows some limitation in respect to consistency of and provision of GBV training, including content. From the findings, a conclusion that can be easily drawn is the need to focus training efforts towards delivering a common set of performance expectations to personnel.

Another intention of this assessment was also to look at the practice of case management. The results, while generally point to promising practice, the results also suggest some level of inconsistency in the ways case management is understood and/or implemented. These differences in understanding and implementation of process tasks, and the influence these differences have on how survivors are assisted, particularly around services relating to safety and security, mental & psychosocial support, clinical services and legal/justice assistance is extremely important.

With regard to linkages and referrals to services, the assessment findings indicate relatively good collaboration and network between the hotlines and various referral services. Notable gaps were however cited regarding the less positive attitudes of some personnel among the coordination partners, which is seen to compromise essential support within the referral system, and lack of unified collection of referral data, which makes it challenging to comprehensively manage survivors' needs within the referral system.

Nonetheless, it is important to acknowledge that as yet, that hotline reporting does not yet offer SGBV response and prevention solutions for a large part of the community; in large part due to lack of awareness of hotlines, but also to a small extent due to reluctance to report GBV-related incidents. Looking at the reporting patterns of SGBV cases, it is evident that there is still a preference for survivors to seek redress through family and community arbitration. Intimate partner violence in particular is considered a private matter within families. These preferences are driven both by personal biases and community perceptions around stigma and shame of SGBV. Moreover, in many settings, many people remain unaware of the hotlines services, and how they work.

Recommendations

The findings of the assessment lead to the following broad recommendations. The recommendations are offered under three categories to support policy, service provider and community solutions.

Recommendations

The findings of the assessment lead to the following broad recommendations. The recommendations are offered under three categories to support policy, service provider and community solutions.

Policy solutions

i. *SGBV should be framed as a priority health issue*: People provided GBV services, including hotline personnel should be classified under the category of essential services to facilitate access to essential services for survivors
ii. *Law enforcement*: Through collaborative efforts, strengthen law enforcement responses and enforcement of laws and policies towards to SGBV
iii. *Social protection*: Similarly, through collaborative efforts, strengthen protection mechanisms for vulnerable for women and children through access to livelihood support to reduce GBV cases, while also enhancing reporting of cases

Service provider solutions

i. *Using community structures to create hotlines awareness*: Work with community structures to raise awareness to maximize the effectiveness of hotlines. One case study showed that community dialogue or forums are an important setting for GBV response and prevention efforts, particularly in terms of providing information and reaching GBV survivors who feel that there is no help. But based on the observation that hotlines do not seem to be "top of mind" even among CBOs when it comes to knowledge of what systems are in place for reporting SGBV, it is crucial to first target CBOs for awareness building activities. This knowledge and information can then be expected to cascade to members of the community. This approach is particularly to target groups outside Nairobi, where as established from the results awareness remain lower
ii. *Improving staff training and development*: Training and skill gap is evident, and is certainly the most important concern. A recommendation for consideration is to develop standardized training modules to enable common approach for staff training and development, as well as for common understanding and application of SOPs
iii. *Guidelines for hotline SOPs*: Results demonstrate that the case management are relatively effective. It is nonetheless necessary that the process tasks are guided by commonly structured procedures. This therefore underlines the need to develop common guidelines specific to mobile and remote services around the features relating to safety and security, mental & psychosocial support, clinical services and legal/justice assistance that the hotlines can adapt according to their setting and requirements, while allowing for minimum standards of practice
iv. *Referral database*: Build a unified collection of referral data to ensure a coordinated approach and comprehensive management survivors' needs within the referral system

Service provider solutions

i. *Strengthening community-level support for SGBV survivors*: From these findings, what appears to be the weak link in GBV response and protection is the issue of referral back to community. In order to help reintegration and continuity of care and support for survivors in the community, linkages with local community support system should be

developed and strengthened. This can also be used to monitor the survivors and whether the desired outcomes are being achieved

ii. *Strengthen social standing and agency of community-based protection networks*: FGD responses indicate some actions undertaken by CBOs that show they are already championing SGBV response and protection. A recommendation for consideration to develop a framework to establish and build the capacity of community-based protection networks with specific focal points. This can help create safe spaces where women and girls can access information on issues relating to GBV as well as how to seek help from a hotline

iii. *Motivate citizen action*: Foster a prevention-focused environment where citizens are motivated to take action to reduce SGBV in their communities

References

CARE (2013). One-stop model of support for survivors of gender-based violence: lessons from care Zambia

Erskine, D (2020). Not just hotlines and mobile phones: GBV Service provision during COVID-19, *UNICEF*.
https://www.unicef.org/media/68086/file/GBV%20Service%20Provision%20During%20COVID-19.pdf

SADC (2018). Regional Strategy and Framework of Action for Addressing Gender Based Violence; 2018 - 2030

SADC (2012). Gender Based Violence.
https://www.sadc.int/issues/gender/gender-based-violence/

SADC (2020). Statement by the SADC Executive Secretary, Dr Stergomena Lawrence Tax on Covid-19 and Gender Based Violence and Domestic Violence, 22 Apr, 2020
https://www.sadc.int/news-events/news/statement-sadc-executive-secretary-he-dr-stergomena-lawrence-tax-covid-19-and-gender-based-violence-and-domestic-violence/

Annex 1: FGDs Coverage

Name of Group	Location	Participants
Madoya Tumaini Youth Group	Nairobi - Huruma	7
Huruma Mathare Wome for peace	Nairobi - Huruma	8
Bidii Masachi Women Group	Nairobi - Kawangware	7
Vision	Nairobi - Kawangware	8
Kichinjio Community Unit	Nairobi - Kibera	1
CPV	Nairobi - Kibera	2
Tatua Souls	Nairobi - Kibera	2
Living Bread Organization	Nairobi - Kibera	2
CHV	Nairobi - Kibera	2
Kibera Langata GBV Network	Nairobi - Kibera	2
Juja Youth Association	Thika - Juja	14
Start Awareness Support Action	Thika - Makongeni	15
Change Champions	Thika - Weitethie	3
Activists	Thika - Weitethie	2

Annex 2: Description of Key Informants

Organization	Title
FIDA	Client Service Officer
COVAW	Programme Associate
SHOFCO	Gender Programme Coordinator
HAK	Head of GBV Helpline
FEMNET	Regional Advocacy Officer
CREAW	Care Officer
Childline	Executive Director
LVCT	Facilitator

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