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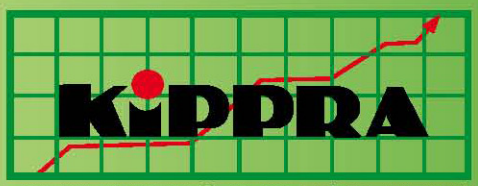

The KENYA INSTITUTE for PUBLIC
POLICY RESEARCH and ANALYSIS

Gender and Health: An Assessment of the Burden of Gender-Based Violence on Health and Implications for Attainment of Universal Healthcare in Kenya

Florence Nyamu
Leah Wanjama

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THE KENYA INSTITUTE FOR PUBLIC POLICY
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Abstract

Gender-based violence (GBV) is defined as a harmful act directed at an individual on the basis of gender. In Kenya, a report by the National Gender Equality Commission indicates that approximately 39 per cent of women and girls aged 15 years and above have experienced physical violence. Further, NGEC estimated productivity losses to be Ksh 25 billion for serious injuries, Ksh 8 billion for minor injuries, which is approximately 1.1 per cent of Gross Domestic Product (GDP). Productivity losses are a burden on GDP, and are likely to slow down attainment of universal healthcare. This paper is a review of literature whose general objective is to investigate costs associated with GBV and its impact on GDP. The specific objectives are to: (a) assess the magnitude of GBV; (b) identify the drivers of GBV; (c) document the burden of GBV on healthcare and productivity; and (d) discuss implications for the attainment of universal healthcare in Kenya. The review is guided by a hypothesis that reduction of cost burden of GBV is a strategy for attainment of universal healthcare. The reviewed articles were identified from books, peer reviewed journals, reports, policy documents and websites of agencies and organizations. The data was analysed using the funnel approach - global, regional and national. Results showed an increase in GBV at the individual, household and community levels. Further, in 2016, NGEC calculated cost of GBV as Ksh 46.5 billion, which translated to 0.6 per cent of Ksh 7.470 trillion GDP for Kenya. The results also indicated other costs incurred by individuals and families that are difficult to quantify and factor into the GDP. The recommendations include intensifying research on: (a) magnitude; (b) types and forms; (c) drivers; and (d) impact of GBV on healthcare and productivity.

Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CSO	Central Statistical Office
DHS	Demographic and Health Survey
FGM	Female Genital Mutilation
GBV	Gender-based Violence
GDP	Gross Domestic Product
GOK	Government of Kenya
HIV	Human Immunodeficiency Virus
IMAGES	International Men and Gender Equality Survey
IPV	Intimate Partner Violence
KDHS	Kenya Demographic and Health Survey
Ksh	Kenya Shilling
KIPPRA	Kenya Institute for Public Policy Research and Analysis
KNBS	Kenya National Bureau of Statistics
MOH	Ministry of Health
MICS	Multiple Indicator Cluster Survey
NCRC	National Crime Research Centre
NGEC	National Gender and Equality Commission
NHIF	National Hospital Insurance Fund
PTSD	Post-Traumatic Stress Disorder
RHS	Reproductive Health Survey
SDG	Sustainable Development Goal
STI	Sexually Transmitted Infection
UN	United Nations
USAID	United States Agency for International Development
WHO	World Health Organization

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1. Introduction

1.1 Background to the Study

Gender-based violence (GBV) is defined as harmful acts directed at an individual on the basis of their gender (WHO, 2014). It is any act that results in physical, sexual or psychological harm or suffering, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private (NGEC, 2016). Intrinsically, all forms of violence are gendered and emanate from power relations between men and women. GBV is a significant contributor to health problems, limiting the productivity of both women and men, creating a heavy burden on the resources intended for health systems, and impacts negatively on well-being of families and communities (Oxfam International, 2001). This situation makes it difficult to eradicate disease, poverty and ignorance as envisaged at independence in 1963. Further, it compromises and slows down the attainment of the Kenya Vision 2030, Sustainable Development Goals (SDGs), the Africa Development Agenda 2063 and, most importantly, the attainment of universal health care, one of the four priority areas in the "Big Four" agenda.

Universal health care is intended to ensure that "all persons in Kenya will be able to use the essential services they need for their health and well-being through a single unified benefit package without the risk of financial catastrophe (Government of Kenya, 2018). The key message is to provide access to safe, effective, quality essential health care services that include essential medicines and vaccines at an affordable price for all. Further, universal health care is directly related to target 3.8 of the Sustainable Development Goals to ensure that all persons have access to quality health services without financial constraints.

Gender-based violence is distinct because the gender of the victim of violence is directly related to the motive for the violence (McIlwaine, 2013). The "social" nature of GBV is often assumed. However, violence can take any form, including sexual, political, institutional and economic, primarily based on power-play. More specifically, occurrences of GBV are not limited to households or communities. There is evidence of workplace gender-based violence, doctor-patient violence, violence in schools and children's homes and violence among commercial sex workers and the transport sector. In all these different situations of violence, the underlying cause relates to the perceptions and perspectives created about men and women, boys and girls in the socialization process in different cultural and religious contexts. This perhaps partly explains why in some instances female employees are perceived as women, and not as officers, and are expected to respond to sexual advances without raising an alarm. This is particularly so when

women are applying for promotion or for jobs. This causes psychological trauma for women in the workplace.

According to the World Bank, there is overwhelming evidence that GBV is a worldwide pandemic that affects approximately 35 per cent of women during their lifetime. It takes several forms, such that 35 per cent of women will have experienced physical and/or sexual intimate partner violence or non-partner sexual violence. On average, seven per cent of women have been sexually assaulted by someone other than a partner. In addition, international statistics show that as many as 38 per cent of murders of women are committed by an intimate partner. Overall, approximately 200 million women have experienced female genital mutilation/cutting (World Bank, 2019).

Data on the prevalence of GBV around the world is usually compiled using the Demographic and Health Surveys (DHS), Reproductive Health Surveys (RHS) and Multiple Indicator Cluster Surveys (MICS) compiled by governments periodically. Global data reveal that the proportion of women who experience GBV during their lifetime ranges from seven per cent in Azerbaijan to 68 per cent in Peru. Overall, the GBV experience over a lifetime is highest in the Caribbean, Africa and Latin America. In more than half of the countries surveyed in Latin America and the Caribbean, the prevalence of GBV is higher than 40 per cent (UN Statistics Division, 2015).

An analysis of DHS data in Asia undertaken by Tuladhar et al. (2013) showed that the prevalence of spousal violence is high, with severe health consequences. In China, for example, 33 per cent of women aged 20-64 reported being hit by their spouse in their current relationship. The consequences as reported by 12 per cent of the women included bleeding, bruises, severe pain, or injuries. Further, severe hitting was a significant risk factor for self-reported adverse general and sexual health outcomes, including sexual dysfunction, sexual dissatisfaction and unwanted sex. Data from a hospital-based study in Pakistan found that 75 per cent of the 373 ever-married women aged 16-49 experienced severe psychological violence. From the study, 30 to 35 per cent had experienced physical and sexual violence at least once in their marital life (Zakar et al., 2010).

In Kenya, cases of GBV are rising at an alarming rate. According to a report by National Crime Research Centre (National Crime Research Centre, 2014), the identified forms of GBV include: grievous bodily harm (battering, amputation of limbs, murder), verbal abuse, sexual violence (marital and non-marital rape, defilement), psychological harm (humiliation, frustration), economic deprivation, human trafficking, harmful traditional practices (forceful and early marriages, forceful circumcision/initiation) and restricted association and movement of

women and girls, men and boys. Data on women and fertility rates is recorded in the DHS of 1998, 2003, 2008 and 2013. However, data on GBV is reported in DHS 2003, 2008 and 2013. As an example, in DHS (2013), rape was reported by 43.7% of female and 38.7% of male respondents, while inflicting bodily harm (expressed as hitting/battering/beating) was reported by 74.1% of female and 68.1% of male respondents. Cases of domestic conflict (which includes bodily harm and verbal abuse) was indicated by 51.5% of female and 58.3% of male respondents. Use of verbal abuse/abusive language was reported by 44.6% of female and 49.1% of male respondents.

This level of magnitude of GBV raises concerns about the sanctity of human life among Kenyans as highlighted in the Bill of Rights in the Constitution, and most importantly, the implications for the attainment of universal healthcare, one of the *four priority areas* spearheaded by the Presidency in 2018. Of significant concern is the rising number of cases related to GBV, and the cost on healthcare. Data from National Gender and Equality Commission (NGEC) indicates that the number of GBV cases in the year 2013 received at Nairobi Women's Hospital were 2,689, Kitale District Hospital 821, Coast Provincial General Hospital 597, Naivasha District Hospital 458, and Kenyatta National Hospital 457 (NGEC, 2016a).

Actual expenses related to GBV are difficult to quantify in absolute monetary terms because they include not only actual monetary costs incurred but also non-monetary costs such as loss of life, reduced productivity, psychological trauma and disability. Additional costs of GBV include direct and indirect effects on those depending on the victim for maintenance. These may be young children, who may also become victims of violence out of neglect, impacting their health and nutrition, exposure to abuse, metal torture and schooling and are likely to become social misfits. The costs, both monetary and non-monetary, are borne by individuals, households, communities, businesses, non-government and government institutions.

The costs can be classified as directly tangible, indirectly tangible, directly intangible and indirectly intangible. Directly tangible costs represent actual money spent, expenditure on prevention and service provision including legal, health, social services and counselling. Indirectly tangible costs are measured as a loss of potential and income. Directly intangible costs result from the GBV, but have no monetary value, for example psychological trauma, pain and suffering. Indirectly intangible costs result from the GBV but have no monetary value. This includes negative psychosocial effects on witnesses of violence, especially children. Unless checked and monitored, GBV has the potential to become a heavy burden on Kenya's Gross Domestic Product (GDP) and have a negative impact on the attainment of universal healthcare.

1.2 Research Problem

Gender-based violence (GBV) is recognized as a fundamental violation of human rights and a significant public health concern worldwide. More importantly is the cost of GBV and its effect on Gross Domestic Product (GDP). According to available research reported by UN Women, the cost of violence against women is estimated to be US$ 1.5 trillion, approximately two per cent of the global gross domestic product (UN Women, 2016). In Kenya, NGEC estimates the cost burden of GBV to be Ksh 1.1 billion (NGEC, 2016). This is only an estimate as the real expenses related to GBV are difficult to quantify in absolute monetary terms. This is because they include not only the actual monetary costs incurred, but also non-monetary costs such as loss of life, reduced productivity, psychological trauma and disability.

Kenya is a signatory to the Convention on the Elimination of All Forms of Discrimination (CEDAW), and has local institutions such as the Human Rights Commissions that are expected to address human rights. The Constitution of Kenya 2010 is elaborate in the Bill of Rights that violation of women and men, girls and boys, is a violation of human rights. Despite the legal provisions to stem GBV, the magnitude continues to rise. This means that victims of GBV have reduced productivity, which impacts directly on the level of GDP, which in turn negatively impacts on the attainment of universal healthcare and the Kenya Vision 2030. The focus of this paper is to analyse the effects of the cost burden of GBV on GDP and its implications on attainment of universal health care.

1.3 Study Objectives

The general objective of the study is to investigate the cost associated with GBV and its impact on GDP, which is a critical driver in the attainment of universal health care.

The study objectives are to:

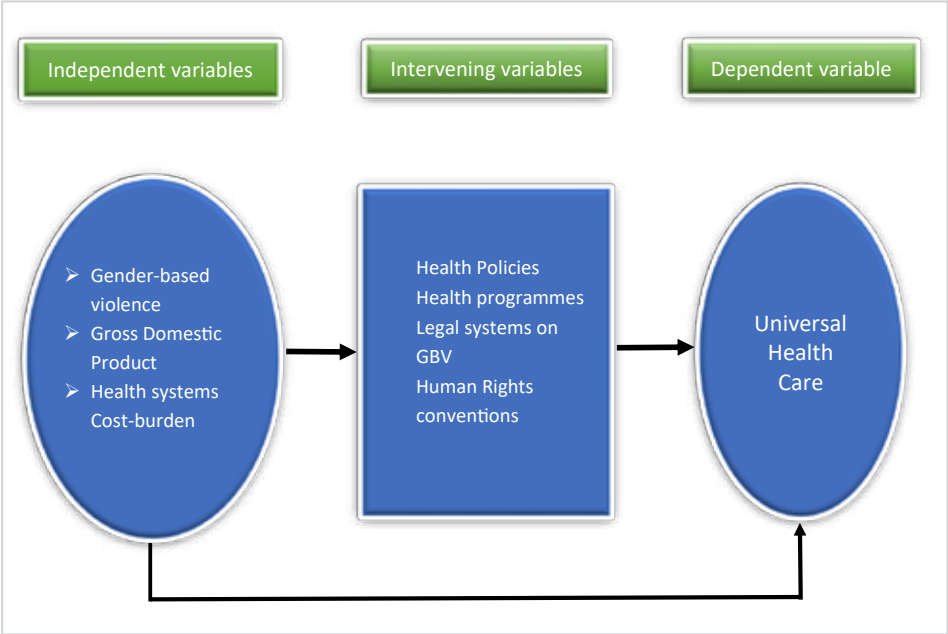
(i) Assess the magnitude of GBV;

(ii) Identify the drivers of GBV;

(iii) Document the burden of GBV on health care and productivity; and

iv) Discuss implications for the attainment of universal healthcare in Kenya.

Figure 1.1: Conceptual framework



Source: Author

The conceptual framework depicts the relationships between GBV, GDP and cost burden on the health system. This in sync with the general objective of this paper, which is to investigate the cost associated with GBV and its impact on GDP, which is a critical driver in the attainment of universal health care.

2. Methodology

This paper is a review of literature compiled by analysing secondary data from different sources. The researchers reviewed both published and unpublished reports and articles on gender-based violence from different parts of the world to give a global and regional perspective of the magnitude and prevalence of GBV, roots of GBV and the burden of GBV. The documents reviewed included Demographic Health Surveys in Kenya and other countries, reports, journal articles, policy documents and websites of agencies and organizations that operate in the gender and health sector. Around the world, the prevalence of GBV has been tracked through the periodic Demographic and Health Surveys (DHS) undertaken by governments with the support of the United States Agency for International Development (USAID). In this study, the authors have reviewed global statistics and data showing the prevalence of GBV in different parts of Africa based on DHS 2013 to 2016. The DHS data analysed is from Egypt, Ethiopia, Kenya, Nigeria, Tanzania, Uganda and Zambia.

The researchers used a mixed research method to collect data and followed a specific procedure of identifying, recording, reading for understanding, making meaning of the information and categorizing the information in line with the study objectives. The researchers integrated and summarized the information into thematic areas and patterns to generate a comprehensive status of the prevalence of GBV, expound on the roots of GBV, and document the burden of GBV on healthcare and productivity. From the data obtained, the researchers teased out the implications on attainment of universal healthcare coverage as envisaged by the Government of Kenya, and made recommendations for further research and policy formulation.

The search for articles was guided by the search words GBV, roots of GBV, universal health care, drivers of GBV, and cost burden of GBV. For analysis, the search was further narrowed to articles that contained relevant information to the objectives and hypothesis of the study. Table 1 shows the articles that were analyzed for each objective.

Table 1.1: Articles analysed for each objective

Objective	Sources of information
i) Assess the magnitude and prevalence rate of GBV	Heise et al. (2002); García-Moreno et al. (2013); Uganda DHS (2016); Uganda Bureau of Statistics and ICF (2018); Kenya National Bureau of Statistics (2015); KNBS (2015); NGEC (2016b); Ondicho (2018); Government of Kenya (2010); Sexual Offences Act (2006); Protection against Domestic Violence Act (2015)

ii)	Identify the roots of GBV	Bronfenbrenner (1979); Heise et al. (2002); Krug et al., (2002); NCRC (2014); Kameri Mbote and Mbuu (2011); Barker et al. (2013); Abramsky et al. (2011); Ethiopia DHS (2016); Ministry of Health and Population Egypt et al. (2014); Zambia DHS (2013/4); Nigeria DHS (2013); KNBS (2015); Ministry of Health Community Development Gender Elderly and Children et al. (2016); Uganda Bureau of Statistics and ICF (2018); Gupta and Samuels (2017); (KNBS, 2010; 2015); NCRC (2014); Jewkes (2002); WHO/ London School of Hygiene and Tropical Medicine (2010); Russo and Pirlott (2006); Central Bureau of Statistics and Ministry of Health Kenya (2004); Female Genital Mutilation Act of 2011; Flood and Pease (2009)
iii)	Document the burden of GBV on health care and productivity	Ibrahim et al. (2018); García-Moreno et al. (2013); Heise et al. (2002); Krug et al. (2002); Barker et al. (2013); Gupta and Samuels (2017); Krug et al. (2002), Duvvury et al. (2013); NGEC (2016)
iv)	Discuss implications for the attainment of universal healthcare in Kenya	WHO (2013), NGEC (2016a), Ondicho (2018), NGEC (2017), KIPPRA (2018)

Data analysis

The analysis of data was undertaken using steps outlined by Creswell (2014) as follows: i) familiarization with the data; ii) coding; iii) generating themes; iv) reviewing themes; and v) naming themes. The data were thematically coded using an inductive approach. This meant that the themes emerged from the data (Gray, 2014). The themes captured important aspects about the data in relation to the objectives (Gray, 2014). The process of inductive analysis involved the discovery of patterns, themes, and categories (Patton, 2002). The information from the data analysis was collated and synthesized according to the objectives.

3. Results and Discussion

In this section, the results of the literature review are presented and discussed in line with three objectives of the study and presented as: (a) magnitude of GBV; (b) drivers of GBV; and (c) cost burden of GBV on health and productivity. The results of the fourth objective, to make suggestions on ways of reducing cost burden of GBV, are presented in the conclusions and recommendations sections.

3.1 Magnitude of GBV

This section discusses the findings on the magnitude of GBV at the global, regional and national level. Gender-based violence can impact anyone regardless of their geographical location, socio-economic background, race, religion, sexuality, or gender identity. Women and girls are disproportionately affected by GBV, and it has been identified as one of the most prevalent human rights violations in the world (Heise et al., 2002). Men and boys also experience gender-based violence. The World Health Organization (WHO) further categorizes GBV as physical and sexual violence such as rape by an intimate partner, assault and sexual violence by someone other than an intimate partner, female genital mutilation (FGM), honour killings and trafficking of women (García-Moreno et al., 2013).

Gender-based violence has been found to exist in all countries in varying degrees. The data presented in this section captures data globally, countries in Africa whose data was available, and data from Kenya as given in the DHSs from different regions and countries. The data revealed that, on average, 35 per cent of ever-partnered women will experience physical and/or sexual intimate-partner violence or non-partner sexual violence globally during their lifetime.

Table 3.1: Global prevalence of GBV among ever partnered women

Region	% Prevalence of GBV
Africa, Eastern Mediterranean and South East Asia	37
Central and South America	30
Europe and Western Pacific	25
High Income Countries: Australia, Canada, United Kingdom and United States of America	23

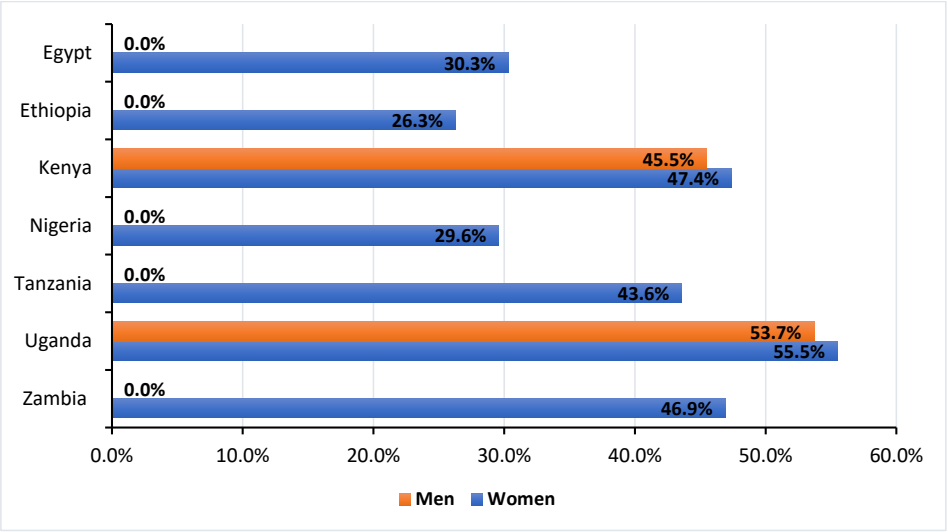
Source: World Health Organization (WHO) on the global prevalence of GBV, García-Moreno et al. (2013)

Table 3.1 reveals that Africa, Eastern Mediterranean and South East Asia have the highest prevalence of GBV among the ever-partnered women, at 37 per cent. The prevalence of GBV in the Americas 30 per cent, while in Europe and the Western

Pacific the prevalence was 25 per cent. Ever partnered women in high income countries such as Australia, Canada, United Kingdom and the United States of America reported the lowest prevalence of GBV at 23 per cent.

A review of the 2013 to 2016 DHS data available from countries in Africa showed that the prevalence of GBV varies in terms of what is reported and the magnitude. Figure 3.1 provides details on the proportion of women and men aged 15-49 who have ever experienced different forms of violence. It was noted that DHS data from some countries such as Egypt, Ethiopia, Nigeria, Tanzania and Zambia did not provide data on physical and sexual violence against men. Limited data was available on spousal violence against men. The magnitude of GBV among women aged 15-49 ranged from 26.3 per cent in Ethiopia to 55.5 per cent in Uganda as shown in Figure 3.1.

Figure 3.1 Proportion of women and men aged 15-49 who have ever experienced different forms of violence



Data source: Demographic and Health Survey (DHS) data from Egypt, Ethiopia, Kenya, Nigeria, Tanzania, Uganda and Zambia between 2013 and 2016

Figure 3.1 shows that for women, GBV is highest in Uganda at 55.5 per cent, followed by Kenya at 47.4 per cent and Ethiopia has the lowest at 26.3 per cent. In Kenya, Tanzania, Uganda and Zambia, the magnitude of GBV for women is greater than 40 per cent, which resonates with the global statistics showing that Africa has an average GBV prevalence of 37 per cent.

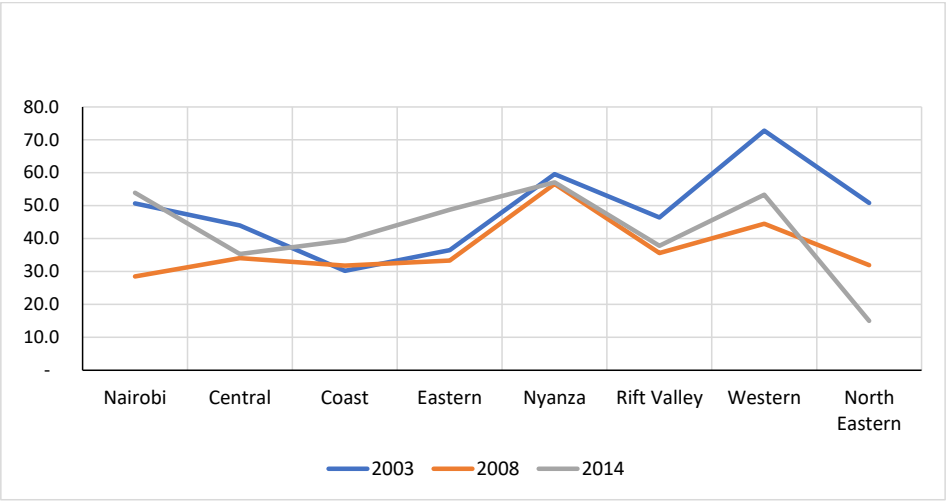
The two countries that reported violence meted out on men are Kenya and Uganda. It is significant that 53.7 per cent of men experience GBV in Uganda while 45.5 per cent of men experience GBV in Kenya. According to 2018 reports by the Uganda

Bureau of Statistics (UBS) and International Coaching Federation (ICF), women's likelihood of having experienced physical violence since age 15 increases with age, from 41 per cent among those aged 15-19 to 60 per cent among those aged 40-49. It was noted that among men, the likelihood of experiencing physical violence does not vary by age. In Uganda, the DHS (2016) observes: "there exist certain customary laws and practices concerning land ownership, marriage, and child custody that conflict with these and other efforts to address GBV" (DHS 2016: 314).

In Kenya, 41 per cent of women aged 15-49 reported that they had experienced either physical or sexual violence. Unlike the situation in Uganda, the percentage of women who have experienced physical or sexual violence increases with age, from 35 per cent among those aged 15-19 to 54 per cent among those aged 40-49. Overall, 45 per cent of men aged between ages 15-49 reported having experienced some form of GBV. The percentage of men who have experienced physical violence in the same age group is 44 per cent (Kenya National Bureau of Statistics, 2015).

A review of the Kenya DHS data for 2003, 2008 and 2014 showed that different indicators related to GBV were measured over the years. One indicator that was common over the ten-year period, 2003 to 2014, is the percentage of women age 15-49 who have ever experienced physical violence in the different regions of the country.

Figure 3.2: Percentage of women aged 15-49 who have ever experienced physical violence



Source: KNBS (Various), KDHS 2003, 2008 and 2014

It is observed that different regions show different trends over the period. In general, there appears to be a consistent downward trend in the prevalence of

GBV for each region. The most significant downward trend is observed in the North Eastern Region from 50.8 per cent in 2003 to 15.0 per cent in 2014. Other regions where the prevalence has reduced are Western Region from 72.8 per cent in 2003 to 53.3 per cent in 2014, and Rift Valley Region from 46.4 per cent in 2003 to 37.8 per cent in 2014. It is worth noting that the prevalence in Nyanza has remained above 50.0 per cent throughout the period.

Another indicator that was assessed from the Kenya DHS (KNBS, 2015) was the prevalence of GBV among different categories of women in Kenya. The statistics are shown in Table 3.2.

Table 3.2: Magnitude of GBV among different categories of women in Kenya

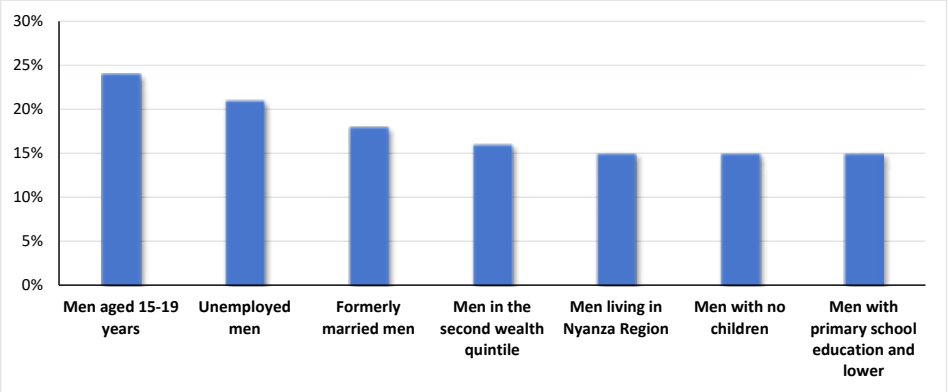
Category of Women	% Magnitude of GBV
Women in Nyanza region	30
Women with no religion	27
Women with three or more children	25-26
Currently or previously married women	24-25
Employed women	22-24
Women aged 25-39	22-23
Women living in rural areas	22
Women with secondary school or higher education	16
Women in the highest wealth quintile	14

Source: KNBS (2014), KDHS 2014

The data in Table 3.2 shows that women in Nyanza region are most at risk of GBV with a magnitude of 30 per cent followed by women with no religion with a magnitude of 27 per cent. Women with three or more children have a magnitude of 25-26 per cent, which is higher than that of women who are currently or previously married, which is 24-25 per cent. It is noteworthy that women with secondary school or higher education have a much lower risk of GBV at 16 per cent and women in the highest wealth quintile have the lowest risk at 14 per cent. This may be explained by the fact that women who have secondary education or higher have developed self-esteem, are more exposed and empowered and are less likely to tolerate GBV from an intimate partner. Economic empowerment appears to safeguard women against GBV, as only 14 per cent of women in the highest wealth quintile have experienced it.

The Kenya Demographic Health Survey, 2014 data also revealed that men are also victims of GBV. Figure 3.3 shows the magnitude of GBV for different categories of men.

Figure 3.3: Magnitude of GBV among different categories of men



Source: KNBS (2014), Kenya Demographic Health Survey (2014)

The data in Figure 3.3 reveals that men aged 15-19, unemployed men, and formerly married men appear to have the highest risk for GBV. This may be explained by the fact that men are socialized to be providers in the home and when unable to provide for their families they use their *macho* power to provoke violence. The feelings of inadequacy work negatively on their ego, making them more prone to perpetrate violence themselves and also to have others perpetrate violence towards them. They consider their domestic partners as not being sympathetic to their situation and making unending demands, leading to fights and arguments. The other categories of men at risk are men in the second wealth quintile, men living in Nyanza, men with no children and men with primary or lower education. It is evident that men with lower education and income levels are more at risk for GBV. This is perhaps because they do not meet societal expectations, which tends to put them into trouble with people in authority, such as parents, peers, police officers and teachers, and not necessarily women.

Discussion

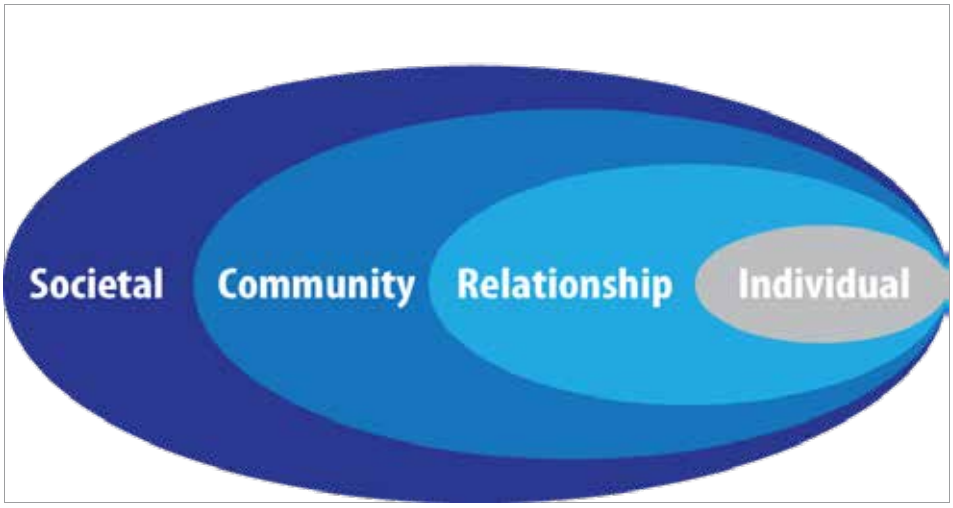
In Kenya, the practice of wife-beating, the most common form of GBV, happens often and is considered a cultural way of life in some communities. Wife-beating is usually not taken seriously and is considered to be a private family matter while female victims accept it as part of life and in line with local culture (KNBS, 2015; NGEC, 2016b; Ondicho, 2018). According to literature, women who are victims of GBV are faced with numerous health complications that burden the public health system in the country. Gender-based violence has also been linked to adverse maternal health outcomes and mental and psychological disorders that are sometimes undiagnosed and even when diagnosed, they are difficult to treat

within the public health care system. Male perpetrators of GBV also suffer from health complications, which is often further compound by alcohol and drug abuse problems and in turn increasing the tendency to perform additional acts of GBV, creating a vicious cycle of domestic violence.

3.2 Drivers of Gender-based Violence

Research on the drivers of GBV indicates that GBV is a complex phenomenon with an interplay of factors. There is a general consensus that the most comprehensive framework explaining the drivers of GBV is the ecological framework initially described by Dr Urie Bronfenbrenner in his book, *The Ecology of Human Development* (Bronfenbrenner, 1979).

Figure 3.4: Ecological model for understanding gender-based violence



Source: A Global Overview of Gender-based Violence (Heise et al., 2002)

This model suggests that gender-based violence is caused by factors at three levels: individual, household/relationship, community/societal. Heise et al., (2002) describe the ecological framework as a series of four concentric circles, the innermost circle being the personal and biological history that each individual brings to the relationship. The second circle is the immediate environment or situation in which GBV takes place, such as the family or intimate relationship. The third circle represents the formal and informal structures in which relationships are grounded, such as social networks, neighbourhoods and workplaces. The fourth and final circle represents the wider socio-economic environment, including cultural norms. The model has also been used to explain the causes of child abuse, youth violence and abuse of the elderly (Krug et al., 2002). They assert that no

single factor can explain the violent behaviour of some individuals towards others.

A more detailed analysis of the three levels (individual, household/relationship, community/societal) outlined in the ecological framework is presented in Table 3.3 with regard to drivers at each level.

Table 3.3: Drivers of gender-based violence

Individual Level	Household/ Relationship Level	Community/Societal Level
Poverty	Quality of marital relationship between spouses	Societal norms that define masculinity and the role of women
Education level	Women's household economic power	Cultural beliefs and practices, such as FGM, dowry and bride price payment
Childhood exposure to violence	Number of partners man/ woman has had	Norms related to acceptable levels of violence
Alcohol and substance abuse	Number of children in the household	Religious practices that condemn or condone violence
Mental health issues		Community responses to GBV
		Mass media and social media

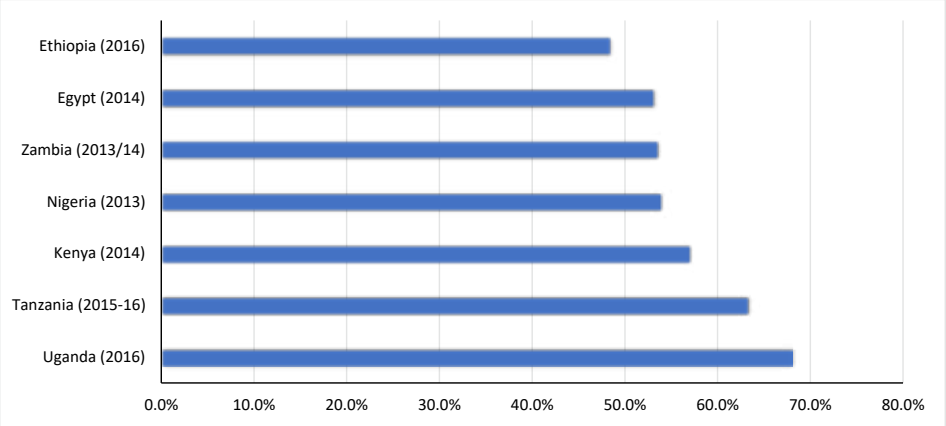
3.2.1 Individual level

At the individual level, different drivers place individuals at a higher risk of GBV. The two drivers discussed in this section are poverty, age and childhood exposure to violence (where the child was a witness of violent behaviour or was abused), alcohol and substance abuse and mental health issues. Although GBV occurs at all levels, literature is inconclusive about the relationship between GBV and poverty. Some researches argue that poverty may be moderated by stress because perpetrators struggling with lack of resources and dealing with stress are more likely to engage in GBV.

In Kenya, a national survey conducted by the National Crime Research Centre considered poverty/stress as the main drivers of GBV (National Crime Research Centre, 2014). Kameri Mbote and Mbuu (2011) agreed with this finding and noted that results from focus group discussions and key informants interviewed showed that when financial resources available to a family are limited, disputes tend to arise between partners, which is often a pre-cursor to GBV.

Another driver of GBV is the history of violence in the family of origin of the perpetrators. Evidence from different parts of the world shows that perpetrators had either experienced, or witnessed violence when growing up. The findings from the seven countries sampled are shown in Figure 3.5.

Figure 3.5: Percentage of ever-married women age 15-49 who have ever experienced emotional, physical, or sexual violence where the woman's father beat her mother



Source: Demographic and Health Surveys (Various Countries)

Data from the Demographic and Health Surveys (DHHs) reports reviewed from seven different countries in Africa reveal that women who experienced domestic violence of any type (i.e. physical, emotional and sexual) reported that they were aware that their fathers were violent towards their mothers. This data was collected from ever-married women aged 15-49. The Ethiopia DHS (2016) showed that 48.5 per cent of women who knew that their mother had been beaten also experienced domestic violence. This is the lowest prevalence among the countries sampled. In Egypt, 53.2 per cent of women reported that their father beat their mother, experienced either physical, emotional or sexual violence (Ministry of Health and Population Egypt et al., 2014). The Zambia DHS (2013/4) and the Nigeria DHS (2013) showed similar prevalence levels at 53.6 per cent and 54.0 per cent, respectively. Data from the Kenya DHS (2014) revealed that the proportion of women who experienced domestic violence and knew that their fathers beat their mothers was slightly higher at 57.1 per cent. The countries with the highest prevalence were Tanzania at 63.4 per cent and Uganda at 68.1 per cent (Ministry of Health Community Development Gender Elderly and Children [Tanzania Mainland] et al., 2016; Uganda Bureau of Statistics and ICF (2018).

The perpetrators of GBV from different parts of the world were found to have either experienced violence, or witnessed violence. In the IMAGES study, a statistically significant association was found between childhood violence witnessed or experienced by boys at the hands of parents, older siblings, teachers and relatives and GBV in all the six countries where the survey was administered (Barker et al., 2013). It is thought that witnessing violence during childhood may

teach men that violence can be used as a tool to resolve conflicts, and that it is also an acceptable means of asserting power over others (Heise et al., 2002). Women who reported that their mothers had been victims of GBV were also at greater risk of GBV compared to women whose mothers had not encountered GBV (Abramsky et al., 2011).

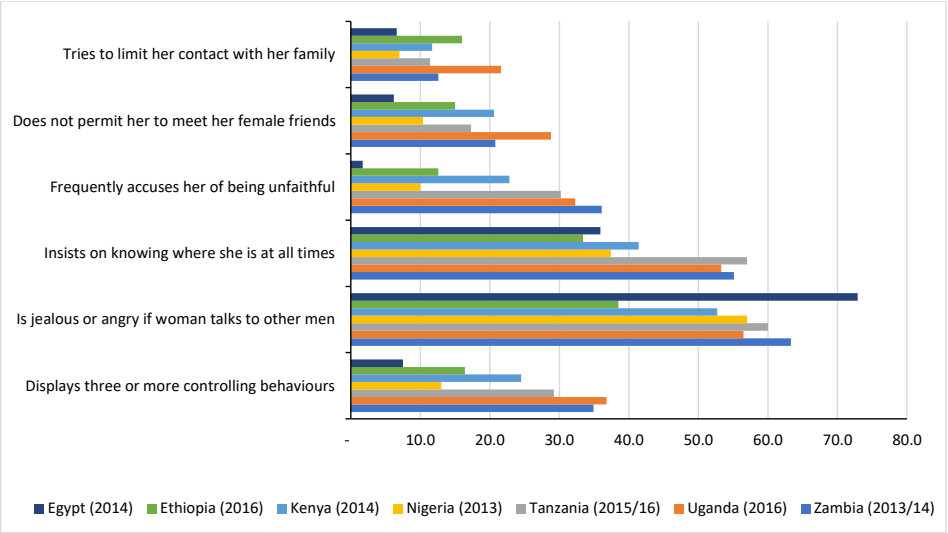
There is an ongoing debate about whether misuse of alcohol actually causes GBV or if alcohol merely increases the likelihood of violence by impairing judgement and reducing inhibitions (Krug et al., 2002). Women who live with male partners who consume large amounts of alcohol or drugs have reported more cases of physical assault than those who do not. Data from a survey conducted in Kenya showed that 65 per cent of women and 69.8 per cent of men ranked alcohol and drug abuse as the most significant causes of GBV (NCRC, 2014). Misuse of alcohol and drugs affects the level of income of users, deprives the affected families of quality time, and isolates the individual from members of their household and community. Most importantly, misuse of alcohol and drugs impacts on the level of productivity of the individuals and slows down the mental capacity to think, learn and innovate.

3.2.2 Household and relationship level

At the household and relationship level, four main drivers of GBV, quality of the marital relationship between spouses, women's household economic power, number of partners a man or woman has had, and the number of children in the household (Gupta and Samuels, 2017). The most prevalent form of GBV appears to be domestic violence. Information on the key predictors of GBV, especially marital control, was obtained from the review of the DHS reports for different countries in Africa, namely Egypt, Ethiopia, Kenya, Nigeria, Tanzania, Uganda and Zambia. A summary of the data on the percentage of women whose current husband/partner (if currently married) or most recent husband/partner (if formerly married) demonstrates a number of controlling behaviours as shown in Figure 3.6.

The controlling behaviour that was reported by most women in the countries surveyed was that their spouse was jealous or angry if they spoke to other men, closely followed by husbands/domestic partners insisting on knowing where the women were at all times. In the seven sampled countries, an average of 23.2 per cent of ever married women aged 15-49 had husbands/domestic partners who demonstrated at least three controlling behaviours. It was noted that the likelihood of spousal violence increased with corresponding increase in controlling behaviour.

Figure 3.6: Percentage of ever-married women aged 15-49 whose husbands/partners have ever demonstrated specific types of controlling behaviours, by background characteristics



Data source: Demographic Health Survey Data for Egypt (2014), Ethiopia (2016), Kenya (2014), Nigeria (2013), Tanzania (2015/16), Uganda (2016) and Zambia (2013/14)

In Kenya, an additional factor that has caused increased levels of GBV is polygyny, the practice where a man has more than one wife. The 2014 Demographic and Health Survey revealed that 11 per cent of married women and six per cent of married men are in polygynous unions (KNBS, 2015). The prevalence of GBV for women over a lifetime was highest among those women categorized as additional wives at 57.1 per cent compared to women who were heads of households at 50.0 per cent, or first wives at 23.5 per cent (NCRC, 2014). Women who earned an income outside the home had a greater risk of GBV than those who did not, especially where their spouses exercised dominance over their earnings against their will. Women who had children from previous relationships were also found to be at an increased risk of experiencing GBV than those who did not. In addition, households with less children also tended to have fewer incidences of GBV.

3.2.3 Community and societal level

The study found that the main drivers perpetuating GBV at the community and societal level arise from norms that define masculinity and femininity. These included social norms, cultural beliefs and practices, religious practices and mass media. According to Jewkes (2002), GBV is a learned behaviour and inter-

generational in nature. Sons who witnessed GBV as children are likely to perpetrate similar acts as adults and daughters of women who were physically assaulted are more likely to tolerate GBV as adults. The manner in which a community responds to GBV is also believed to affect the overall levels of GBV in that community (Krug et al., 2002). However, there is research evidence of societies with low levels of GBV, low tolerance of intimate-partner violence, community sanctions against GBV and also provide shelter and sanctuary to victims of GBV (WHO/London School of Hygiene and Tropical Medicine, 2010). In patriarchal societies, existing social structures serve to perpetuate inequitable gender relationships that tolerate male violence towards women. Women are often perceived as subordinate to men in a way that intelligent women, well-educated, competent and with high self-esteem are considered to be unsuitable for marriage and usually ostracized at home and at the community level (Russo and Pirlott, 2006).

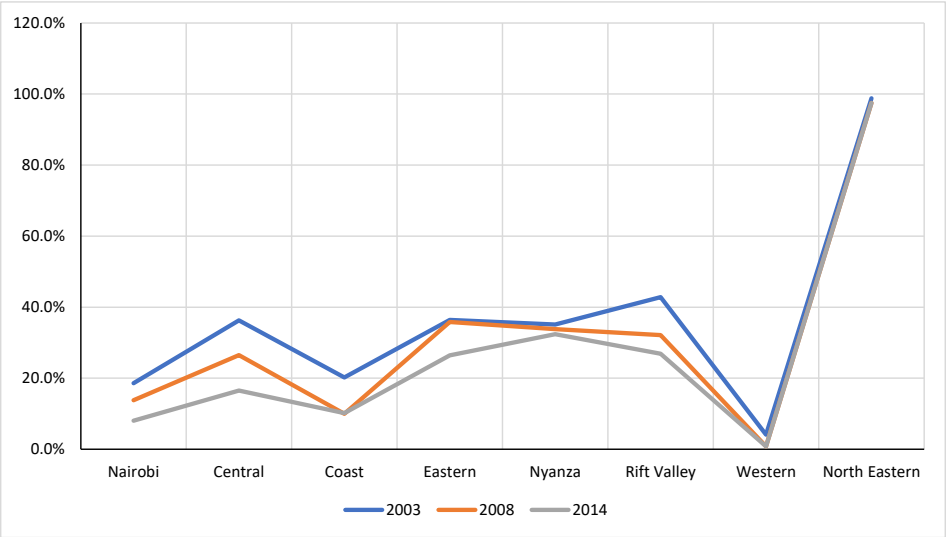
There is evidence that cultural beliefs and practices are a driver of GBV at the community and societal level. A study in Kenya conducted by the National Crime Research Centre to assess community attitudes towards male dominance over women found that 95.7 per cent of male and 94.5 per cent of female respondents believed men are heads and must control their families. In addition, 58.3 per cent of male and 52.4 per cent of female respondents reported that they believed disciplining a woman is a man's traditional right (NCRC, 2014). The pervasiveness of these beliefs is usually used as a justification for wife beating in many communities.

Another driver of GBV, which falls under beliefs and practices, is female genital mutilation (FGM). Data from KDHS for the years 2003, 2008 and 2014 from eight regions in Kenya is shown in Figure 3.7.

An analysis of the prevalence of FGM by region showed that the region with the highest rate of FGM was North Eastern. The rate declined slightly from 98.8 per cent in 2003 to 97.5 per cent in 2008 and 2014. This is due to the fact that communities living in that region value the practice and consider it to be culturally significant. Conversely, Western region had the lowest prevalence of FGM, ranging from four per cent in 2003 to just under one per cent in 2014. This is because communities living in that part of Kenya do not consider FGM to be an important cultural practice.

The decline is most likely as a result of the enactment of the Prohibition of Female Genital Mutilation Act of 2011. This is an Act of Parliament that prohibits the practice of female genital mutilation and safeguards against violation of a person's mental or physical integrity through the practice of female genital mutilation and for connected purposes (Act 32 of 2011). However, in spite of this law, some communities continue to practice FGM because community members consider it to be necessary, even desirable, especially since a young woman's prospects of marriage within the community are reduced if she has not undergone FGM.

Figure 3.7: Percentage of women 15-49 circumcised, by region, Kenya



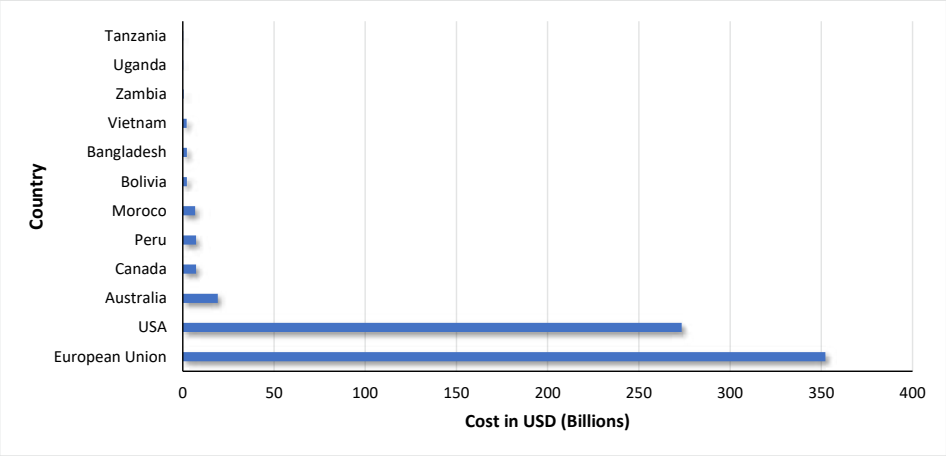
Source: KNBS (Various), KDHS 2003, 2008 and 2014

Religious practices have also been found to be a key driver of GBV because religious leaders and institutions play a strong role in the inculcation of beliefs and values that are intended to create harmony within the society. However, interpretations of masculinity and femininity create perceptions that men are superior to women. This leads to religion being misused to perpetrate violence against women (Flood and Pease, 2009). For example, the Koran has been misinterpreted in some societies and used to show that wife beating is an acceptable practice. The Bible has also been used by religious leaders to discourage women from speaking out against abuse, citing the teachings of Christianity on submissiveness by married women to their husbands. In a study conducted by the National Crime Research Centre, 90.7 per cent of male and 95.0 per cent of female respondents reported that religious teachings were against violence.

3.3 Cost Burden of GBV on Healthcare and Productivity

The cost burden of GBV refers to direct costs such as time, money and effort that are borne with difficulty and become an impediment to sustainable development at individual and societal level. The global economic costs of violence against women have been estimated at about two per cent of the world's GDP, or approximately 1.5 trillion (Ibrahim et al., 2018). Figure 3.8 illustrates the cost of violence against women in selected countries.

Figure 3.8: The cost of violence against women in selected countries



Source: Ibrahim et al. (2018)

The data in Figure 3.8 shows the estimated costs of violence against women for individual countries as US$ 273.4 billion for the United States of America, US$ 7.3 billion for Canada and Peru, and US$ 2.1 billion for Bolivia. In the countries sampled in Africa, the estimated cost burden of violence against women were US$ 6.8 billion for Morocco, US$ 0.5 billion for Zambia and US$ 0.3 billion for Uganda and Tanzania. The consolidated costs for the countries in the European Union was US$ 352.2 billion. In Asia, the two countries whose data was available, the cost is Bangladesh US$ 2.3 billion and Vietnam with a cost of US$ 2.1 billion. The estimated costs for Australia were US$ 19.2 billion. The values for Tanzania Uganda and Zambia are US$ 0.3 billion, US$ 0.3 billion and 0.5 billion, respectively (these cannot be visualised in Figure 3.8 because they are less than USD$ 1 billion (Ibrahim et al., 2018).

In Kenya, a study conducted by the National Gender and Equality Commission (NGEC) gives the economic costs of GBV in Kenya as shown in Table 3.4.

Table 3.4: Individual costs of GBV in Kenya

Cost Category	Estimated Cost/ Individual (Ksh)
Medical costs for GBV victims and perpetrators	16,464
Costs related to the criminal justice system	6,867
Range of loss of productivity	18,623 to 223,476
Loss of productivity from premature mortality caused by GBV	5,840,664

Source: NGEC (2016), Gender-based violence in Kenya: The economic burden on survivors

Table 3.4 reveals that costs incurred to mitigate the outcomes of GBV are prohibitive. For example, loss of productivity from premature mortality caused by GBV amounts to Ksh 5,840.664. The resources spent in these non-productive activities are diverted from family savings and would be better used in supporting the family in more useful ways.

The situation becomes more complicated when these figures are calculated in relation to Kenya's GDP. The 2016 NGEC report on the economic burden on survivors reveals a high impact on the overall GDP of the country as shown in Table 3.5.

Table 3.5: Economic burden of gender-based violence in Kenya

No	Causes	Amount (Ksh billion)	% Contribution
1	Productivity loss due to serious injuries	14.7	32
2	Productivity loss due to mortality	10.5	23
3	Medical related expenses sought by GBV survivors	10.0	21
4	Productivity loss due to minor injuries	8.1	17
5	Cases reported to the police	2.0	4
6	Cost to the community	1.2	3
	Total	**46.5**	**100**

Source: NGEC (2016), Gender-based violence in Kenya: The economic burden on survivors

The data in Table 3.5 shows that productivity loss due to serious injuries (32%) is the highest contributor to the economic burden, followed by productivity loss due to mortality (23%) and medical-related expenses sought by survivors (21%). These three costs contribute to a total of 76% of the total economic burden of GBV. Considering that the Gross Domestic Product (GDP) for Kenya in 2017 was US$ 74.7 billion (approximately Ksh 7.470 trillion), the cost of GBV, therefore, translates to 0.6 per cent of GDP.

4. Discussion on the Implications of the Cost Burden of GBV on the Attainment of Universal Healthcare in Kenya

The World Health Organization (WHO) defines universal healthcare as the provision of preventative, curative and rehabilitative health services equitably to all people and communities. These services should be of sufficient quality to be effective, while also ensuring that those using the services do not suffer financial hardship (WHO, 2013). Universal healthcare is one of the strategies that governments are using to achieve the Sustainable Development Goal No. 3 (SDG 3), which aims at ensuring healthy lives and promoting well-being for all people at all ages by 2030. In line with these international health goals, the Government of Kenya has adopted universal healthcare as one of the "Big Four" agenda to be achieved by 2022.

The findings from this study have established that victims of GBV incur heavy costs that negatively impact on gross domestic product. According to the National Gender Equality Commission, physical injuries arising from domestic violence are often handled by family members to avoid costs to the health system (NGEC, 2016a). Although GBV is not a new phenomenon in Kenya, the Government has only recently recognized it as a public health issue. Findings from this study show that the Ministry of Health in Kenya is in formulating a policy framework to deal with GBV in partnership with government agencies, county governments, non-governmental organizations and other stakeholders in the public health arena (Ondicho, 2018). Some of the public health policies that have been implemented to reduce the prevalence of GBV in Kenya include the National Guidelines on the Management of Sexual Violence, and the National Plan for the Elimination of Female Genital Mutilation. Efforts have also been made to improve the training of healthcare workers so that they are better prepared to handle cases of gender-based violence.

The National Gender and Equality Commission has prepared a policy framework on sexual and gender-based violence for use by county governments in developing county legislation to counter GBV (NGEC, 2017). The study found that the Government of Kenya is scaling up the National Health Insurance Fund (NHIF) to increase insurance coverage to 100 per cent, especially for the poor and vulnerable (KIPPRA, 2018). Currently, more than 181,000 households are covered by the Health Insurance Subsidy Programme and enjoy full access to healthcare benefits. The Government has also instituted the *Linda Mama* programme, which provides free maternal health services to pregnant women.

The outcomes of GBV are broad-based and affect not only the individual but the community at large. Numerous studies have found that people who experience GBV are more likely to experience serious health problems than those who have not (García-Moreno et al., 2013; Heise et al., 2002). The literature indicates that there are direct and indirect pathways in which GBV affects and impacts on victims. For example, physical injury is often viewed as a direct pathway to adverse health outcomes such as disability and even death. Psychological trauma affects the mental health of individuals and may also manifest as physical ailments that lead to disability or death (Krug et al., 2002).

Findings from the IMAGES survey show that male perpetrators of GBV also suffer from a variety of physical and mental health ailments (Barker et al., 2013). Research has also shown that GBV often takes the form of sexual violence, which in turn leads to reproductive health problems that can also cause mental health issues and related adverse health outcomes (Gupta and Samuels, 2017). Victims of GBV are also at increased risk of contracting sexually transmitted infections (STIs) and even HIV/AIDS.

These and several other health problems strain health systems that are often already burdened by caring for patients, with other serious ailments such as malaria, tuberculosis and Cancer. GBV also limits the productivity of victims, both men and women, and therefore affects the well-being of communities. In addition, a majority of healthcare professionals are ill-equipped to handle GBV victims because they are not adequately trained. The adverse health outcomes produced by GBV cause a serious economic burden on societies through loss of productivity and increased use of social services such as hospitals and health centres (Krug et al., 2002).

Researchers have concluded that estimating the direct costs of GBV is much simpler than estimating the indirect costs. Duvvury et al. (2013) define direct costs related to GBV as direct expenses incurred on services following incidences of GBV, and costs incurred for preventing and responding to GBV. Indirect costs are those that arise from psychological and physical trauma, and other intangible effects of GBV.

The reduced quality of life of survivors of GBV and their family may also be considered as indirect costs. Most studies quantify GBV costs by measuring several aspects such as the cost burden on the criminal justice system, the costs related to the provision of health care and treatment, resources spent on providing social services for victims such as shelters and child care services, and forgone income due to lost wages following GBV incidences.

Most studies quantify GBV costs by measuring several aspects such as the cost burden on the criminal justice system, the costs related to the provision of healthcare and treatment, and resources spent on providing shelter, social and childcare services. The literature revealed that the burden of GBV is extensive and affects every country around the world. However, most in-depth studies on the cost burden of GBV have focused on violence against women. Reducing GBV should, therefore, be considered a priority to advance the global economy.

In Kenya, healthcare is now a devolved function, meaning that county governments are responsible for managing health services and providing adequate health infrastructure and qualified health professionals. These and other efforts to raise awareness on GBV at both national and county levels, and the recognition that GBV is a serious public health problem in Kenya will slowly ensure that the country makes some progress in the achievement of universal healthcare coverage as envisaged.

5. Conclusion and Recommendations

5.1 Conclusion

The general objective of the study was to investigate the cost associated with GBV and its impact on GDP, which is a critical driver in the attainment of universal healthcare in Kenya.

The data on the magnitude of GBV in Kenya revealed that the levels are high and are on an upward trend. The drivers of GBV fall into three broad levels: individual, household/relationship, and community/societal. These drivers form a complicated web such that it is difficult to draw direct causal relationships for any one of them to a particular type of GBV. In addition, the cost of GBV as calculated by the National Gender Equality Commission in 2016 was Ksh 46.5 billion, which translates to 0.6 per cent of Ksh 7.470 trillion GDP for Kenya in 2017. An important point to note is that there are other costs incurred by individuals and families that are difficult to quantify and factor into GDP.

In addition, GBV has been associated with poor mental health outcomes for both men and women, even though women experience a wider range of mental health issues than men (Stith et al., 2012). These mental health issues further stretch struggling health systems and impede productivity through grievous bodily harm, suicides and homicides to intimate partners. The consequences of GBV tend to be very severe as they affect the social well-being of families and communities. They touch on social issues leading to stigmatization of men and women, fear and psychological torture especially of children living in households where there is GBV, low self-esteem and social isolation. All these forces combine to create a situation where there is low economic productivity and social exclusion. It is the view of the researchers that unless and until GBV is considered a national disaster and strategies put in place to mitigate its effects, it will be more difficult to achieve the Kenya Vison 2030 and the "Big Four" agenda, particularly universal healthcare.

The rising magnitude of GBV in Kenya has precipitated special circumstances that warrant immediate action beyond what is provided for in the existing registration to prevent and contain the threat of GBV to the healthcare system, economy and, most importantly the effects on individuals and society. This situation will slow down the achievement of the Kenya Vision 2030, the Sustainable Development Goals, and the universal healthcare under the "Big Four" agenda.

5.2 Recommendations

Based on the findings of this study, the authors make the following recommendations:

i) Government, universities and other research institutions to intensify research and documentation of the magnitude of GBV, and different types and forms of GBV in Kenya to inform academia and to provide robust evidence for formulation of relevant government interventions.

ii) Government, universities and other research institutions to intensify research on drivers of GBV and reasons for continued rise in GBV trajectory.

iii) Additional research is needed to establish the estimated costs of GBV on healthcare and productivity.

iv) The Government needs to expand the provisions of universal healthcare to grassroots to sensitize and train champions to use universal healthcare as an opportunity to stem GBV.

5.3 Limitations and Areas of Further Research

This was a literature review study of documents, including Demographic Health Surveys from Kenya and other countries, international agencies and journal articles. One of the limitations of the study is that comprehensive and current data on the prevalence, magnitude and types of GBV in Kenya is not readily available. The most authoritative sources of GBV data in Kenya were the DHS of 2003, 2008 and 2014.

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