THE SOCIAL AND ECONOMIC IMPACT OF **COVID-19 POLICY RESPONSES ON WOMEN** WORKING IN THE INFORMAL URBAN ECONOMY IN **KENYA**

STUDY REPORT, MAY 2023

2nd Hand Shoes Trader at Gikomba - Nairobi

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Wandera, N., Afifu, C., Suubi, K., Emily, S., Connor, R. and Izugbara, C. (2023). The Social and Economic Impact of the COVID-19 Policy Responses on Women Working in the Urban Informal Sector in Kenya. Nairobi, Kenya. International Center for Research on Women (ICRW), Nairobi.

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ACKNOWLEDGEMENT

This research was done by the International Center for Research on Women, Kenya. We would like to extend our thanks to project members from our wider teams, including Dr. Carol Ajema, Dr. Erick Yegon, and the ACTRA Consulting team. We appreciate the collaboration with REBUILD's Technical Advisory Group (TAG) and REBUILD's Research and Policy Uptake Group (RPUG) during the project period.

The authors would like to extend our gratitude to the participants who provided their time and valuable insight into these processes. We would also like to thank the enumerators who supported our team in collecting this data.

This work was carried out with the aid of a grant from the Bill & Melinda Gates Foundation. We are grateful for the support. The findings and conclusions contained within are those of the authors and do not necessarily reflect the positions or policies of the Bill & Melinda Gates Foundation.

Salonist - Nakuru Town

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TABLE OF CONTENTS

Acknowledgement V
List of Tables VIII
List of Figures IX

Executive Summary 1

1.0. Background 5

2.0. Study Objectives and Research Questions 7

3.0. Methodology 8

4.0. Study Findings 9
- 4.1. Socio-demographic characteristics of the survey respondents ,........ 9
- 4.2. IWWs had pre-existing characteristics that made them particularly vulnerable to impacts of the COVID-19 pandemic. 9
- 4.3. Impact of COVID-19 policies on IWWs' care and domestic burdens 13
- 4.4. Impact of COVID-19 policies on livelihoods of IWWs 17
- 4.5. Access to official COVID-19 resilience measures 21
- 4.6. Impact of COVID-19 policies on GBV and SRH care 26

5.0 Conclusions and Recommendations for Policy and Action 35

Annexes 39

LIST OF TABLES

Table 1: Percent distribution of IWW by household division of labor before the COVID-19 pandemic 10
Table 2: Percentage distribution of IWWs by sources of credit 12
Table 3: Percentage distribution of IWWs by uptake of insurance before and during the COVID-19 pandemic 13
Table 4: Responsibility for household chores and caring for family during COVID-19 16
Table 5: Percentage distribution of IWWs by livelihood challenges experienced due to COVID-19 17
Table 6: IWW employment status before COVID-19 pandemic and after the COVID-19 lockdown (%) 18
Table 7: Percentage distribution of IWWs by reasons for experiencing decline in income....19
Table 8: Percentage distribution of IWWs by livelihood priorities 20
Table 9: Percentage distribution of IWWs by coping strategies in response to COVID-19 25
Table 10: Percentage distribution of IWWs by sources of health care services 27
Table 133: Percentage distribution of IWWs by perpetrators and forms of GBV experienced during COVID-19 32

LIST OF FIGURES

Figure 1: Percentage distribution of IWWs by savings channel 11
Figure 2: Percentage distribution of IWW by changes in the time devoted to household chores during the COVID-19 pandemic 14
Figure 3: Percentage of IWWs reporting time use changes regarding non-household members during COVID-19 14
Figure 4: Percentage of IWW who reported the sources of increased care burden 15
Figure 5: Proportion of IWWs reporting changes in earnings due to increased are burden..........16
Figure 6: Percentage distribution of IWWs reporting changes in the time devoted to paid work during the COVID-19 pandemic 19
Figure 7: Percentage distribution of IWWs by effect on financial well-being due to COVID-19 pandemic 20
Figure 8: Percentage distribution of IWWs by perceived livelihood conditions in the post-COVID-19 period compared to pre-COVID-19 onset 21
Figure 9: Percentage of IWWs aware of and receiving social protection measures 22
Figure 10: Reported use of cash transfer relief 23
Figure 11: Percentage distribution of IWWs by access to a loan in the last 12 months 24
Figure 12: Percentage distribution of IWWs by the possibility of business recovery after COVID-19 24
Figure 13: Reasons for sending away a household member due to COVID-19 pandemic. 26
Figure 14: Percentage distribution of IWW responses on sources of information on SRH and GBV services 27
Figure 15: Percentage distribution of IWWs by challenges to accessing health services during COVID-19..........28
Figure 16: Percentage distribution of IWWs who experienced or knew of someone who experienced GBV during COVID-19 30
Figure 17: Percentage distribution IWWs by experience of GBV during the COVID-19 lockdown 31
Figure 18: Percentage distribution of IWWs by forms of GBV experienced during COVID-19 31

Cereals Trader at Kibuye Market

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EXECUTIVE SUMMARY

Background

At the onset of the COVID-19 pandemic, the Kenyan government, like others in the East African region and around the globe, put measures in place to contain the spread of the virus. The country's COVID-19 policy responses included movement restrictions, curfews, and closure of public places such as schools, shopping centers, places of worship, entertainment venues, and business premises, among others. These policy measures negatively impacted women's livelihoods and economic activities as well as their access to sexual and reproductive health (SRH) and gender-based violence (GBV) services.

Study Objectives and Research Questions

This study explores the impacts of the COVID-19 pandemic and related policy responses on women in the urban informal sector in Nairobi, Kenya. Specifically, the study sought to understand impacts on pre-existing gender inequalities, the economic impact of COVID-19 and coping strategies implemented by informal sector women workers (IWWs), and IWWs' experiences related to SRH and GBV as they related to the pandemic. The study sought to answer the following four research questions:

a) What are the specific gender norms and practices (in the family, community, and businesses) that further exacerbated the vulnerabilities of women in the informal sector during the COVID-19 pandemic?

b) How did COVID-19 policy responses specifically impact the livelihoods activities of IWWs in the service, trading, and food sub-sectors?

c) How did COVID-19 policy responses specifically impact IWWs' exposure to GBV and access to SRH services?

d) What were the coping and resilience strategies/mechanisms for the women in the informal sector amidst the impacts of the pandemic?

Methodology

The study was conducted in seven purposively selected sub-counties of Nairobi: Dagoretti South, Embakasi East, Embakasi West, Kamukunji, Kibera, Starehe. and Westlands, A mixed-methods approach was used involving quantitative and qualitative data collection. Quantitative

data included a survey of 384 women working both in informal food services, including mobile and fixed locations such as restaurants; and in informal trading services, i.e., those engaged in trading various items including short- and long-shelf-life products. Qualitative data included 23 key informant interviews (KIIs), five in-depth interviews (IDIs), and eight focus group discussions (FGDs) with purposively selected respondents. The KIIs included policy makers, civil society organization (CSO) service providers for SRH and GBV, and influential community leaders such as local council leaders and market chairpersons. The IDIs were conducted with the informal women workers (IWW), including those who were pregnant just before and during the pandemic period, women with children under 10 years, women who accessed credit from unregulated financial institutions, and women with disabilities.

Study Findings

a) Socio-demographic characteristics of the survey respondents

IWWs interviewed ranged from 18 to 70 years old, with an average age of 37, and 44% had obtained secondary education. About half were married, and most had children.

b) IWWs had pre-existing characteristics that made them particularly vulnerable to impacts of the COVID-19 pandemic.

The IWWs were the main contributors to all household chores before the pandemic (i.e., cooking, cleaning, guiding and providing care for children), and very few received support from other household members. Access to traditional financial products was rare; about half had mobile finance accounts, a little less than one-third used savings groups, and 21% had no access to savings channels. Women used similar products for access to credit. Most (63%) did not have insurance before the pandemic, and this increased to 71% after the pandemic.

c) COVID-19 policies exacerbated the care and domestic burdens of IWWs.

The closure of education institutions led to a high burden for childcare, forcing IWWs to sacrifice paid working time to increase time spent on care duties. The disproportionately high childcare burden that resulted from the COVID-19 lockdown perpetuated socio-cultural norms that predominantly put home care roles under women.

d) COVID-19 policies negatively affected the livelihoods of IWWs.

Some COVID-19 policy responses hurt IWWs' businesses. Even though some IWWs in the food and trading services were allowed to remain operational, business activity was greatly affected. IWWs reported shifts in type of employment, reduced hours and income, and significantly impacted financial well-being.

e) IWWs lacked access to official COVID-19 resilience measures.
Access to government-provided relief measures was limited among IWWs, even among those who were aware of available schemes. In addition, pre-existing limitations on IWWs' access to insurance and financial products were exacerbated by the pandemic. Many IWWs depleted their savings and working capital to survive during the lockdown, employing coping strategies such as reducing expenditure, buying on credit, depleting savings, and selling property. This reflected how devastating and disruptive COVID-19 and the responses to it were as well as the need for social protection mechanisms to enable low-income groups to recover from social and economic shocks. These coping strategies are unsustainable and potentially exacerbated their vulnerability in the post-lockdown period. Despite these challenges, 34% of IWWs believed that their life and that of their household would bounce back after the pandemic.

f) COVID-19 policies aggravated GBV and SRH care gaps.
During the pandemic, media channels, mainly radio and television, were important sources of information on SRH and gender-based violence (GBV) response services. However, the restrictions in movements and closure of SRH centers limited IWWs' access to and utilization of these services. Community-based sources of care for high quality SRH and GBV services are currently limited, but they are important in emergency situations when access to formal service providers at health facilities or GBV centers becomes difficult.

About 24% of IWWs reported experiencing GBV during the COVID-19 pandemic. Some of the most mentioned GBV cases included physical abuse from law enforcement, emotional abuse from intimate partners, child sexual exploitation, and sexual harassment. The most accessible offices to report cases of GBV were local leaders through word of mouth from the victims. Movement restrictions hampered access to GBV service providers.

Conclusions, Emerging Findings, and Recommendations for Policy and Action

a) Invest in and incentivize accessible childcare facilities: The childcare responsibilities the IWWs face reflect the need for childcare facilities at or near IWWs' workplaces. Affordable and accessible childcare facilities should be integrated in market designs and workplace environments.

b) Support and increase access to formal credit: Few IWWs reported having access to credit during COVID-19, and those who did obtained it largely from informal sources. Government and microfinance institutions in Kenya should provide affordable credit to IWWs to enable them to restart their businesses and at least restore their livelihoods to pre-COVID-19 levels. The government should support all possible platforms for the IWWs to access business credit, including mobile money,

Chamas, savings and credit cooperative organizations, and savings and lending association platforms. Government support could take the form of conducive legal frameworks and policies to increase participation of women in the information sector.

c) Create and implement comprehensive social protection: The government, in collaboration with development partners, should implement a comprehensive social protection program, including universal health insurance coverage to support IWWs and other low-income groups.

d) Increase access to SRH and GBV services: The government should work with CSOs to develop innovative ways of increasing access to SRH and GBV services at the community level. Training community health workers and financially supporting them to provide basic SRH in markets and other workplaces for informal business can increase access and reduce time burden of traveling to appointments. A similar approach should be adopted for GBV service providers at the community level.

PWD Hawker- Nairobi CBD

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1.0. BACKGROUND

In Kenya, the informal sector provides 87% of employment opportunities and livelihoods for approximately 15 million people.[1,2] Compared to men, women in the informal sector face a number of challenges including low earning capacity, limited skills, persistent harmful social and gender norms, the burden of childcare, and heightened exposure to gender-based violence (GBV) and conflict. Further, women are less able to access and control resources essential for starting and growing business,[3] driving more women than men into informal business for survival.

In Kenya, as in other countries in the region and across the globe, the COVID-19 pandemic created a climate of high uncertainty, unclear risks, and unprecedented consequences that crippled key economic activities, particularly for informal workers. At the onset of the pandemic, the government introduced several measures to contain the spread of the virus. These measures included a lockdown to restrict movement of persons, a curfew, and a range of standard operating procedures. Amidst these measures, some businesses, including informal sector women workers (IWWs) in markets, were allowed to operate to provide essential services of food and other household necessities. The government also introduced measures to protect businesses and to save millions of jobs in the sector.[4] Some of the measures include the stimulus package and other fiscal and monetary policies to safeguard businesses. Despite the government's stimulus package to support businesses following the pandemic, the initiative had little benefit to women in the informal sector since the conditions to access the stimulus favored the formal businesses. [5]

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1. World Bank (2020). Kenya Economic Update: Turbulent Times for Growth in Kenya; Policy Options during the COVID-19 Pandemic.
2. Afifu C, Ajema C., Suubi K., Wandera N., and Mugyenyi C. (2021). Gendered Impact of COVID-19: A Policy Analysis on the Women Workers in the Urban Informal Economy in Kenya. International Center for Research on Women (ICRW). Nairobi, Kenya
3. Ramani, S. V., Thutupalli, A., Medovarszki, T., Chattopadhyay, S., & Ravichandran, V. (2013). Women entrepreneurs in the informal economy: Is formalization the only solution for business sustainability? MERIT Working Papers 2013-018, United Nations University - Maastricht Economic and Social Research Institute on Innovation and Technology (MERIT).
4. https://kenyanwallstreet.com/informal-sector-is-the-key-to-kenyas-recovery-in-post-covid-19-era-says-fsd-kenya/
5. The Rapid Assessment of Gendered Effects of the COVID-19 Pandemic on Women and Girls in Kenya Report. http://www.psyg.go.ke/?p=3202

Vegetable vendor - Nakuru Town © ICRW

A number of COVID-19 policy responses, including movement restrictions, curfews, and closures of social places, impacted both economic livelihoods and access to services for women in the informal sector. Recent evidence demonstrates that the COVID-19 pandemic exacerbated gender disparities in labor force participation in Kenya, with more women than men losing their jobs.[6] Women additionally were left with greater childcare responsibilities, faced increased GBV, and lacked access to sexual and reproductive health (SRH) and GBV services. [7] This emerging evidence demonstrates a gendered impact of COVID-19, particularly for women in the informal sector.

Despite preliminary evidence, there is still a knowledge gap on the extent of the impact of the pandemic on the women workers in the urban informal sector in Kenya. There are scant empirical studies on how the COVID-19 containment strategies of the Kenyan government affected the lives of Kenyan women working in the informal urban economy.[8] Similarly, it is unclear how the government's social protection interventions have benefited women in the informal sector. Information about IWWs' coping and resilience mechanisms during the COVID-19 pandemic is also limited.

In this study, we examine the specific impacts of COVID-19 policy responses on women in the informal sector in Nairobi. These findings deepen understanding of the effect of policy responses to the pandemic for women in informal economies and the actions required to support them in situations of health and economic shocks and catastrophes.

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6. Evans, D. and Over, M., (2020). "The Economic Impact of COVID-19 in Low- and Middle-Income Countries." Available at https://www.cgdev.org/blog/economic-impact-covid-19-low-and-middle-income-countries

7. ibid.

9. https://www.icrw.org/publications/impact-of-covid-19-on-women-workers-in-the-urban-informal-economy-in-uganda-and-kenya-secondary-review/

2.0. STUDY OBJECTIVES AND RESEARCH QUESTIONS

This study examines the social and economic impact of COVID-19 on women in the informal urban economy in the food and trade services sub-sectors. The specific objectives of the study were:

a) To investigate how COVID-19 policies impacted pre-existing gender inequalities, including GBV/SRH among women workers in informal urban economies.
b) To understand the coping and resilience strategies of IWWs in the context of the pandemic; and
c) To assess IWWs' GBV and SRH experiences, including access to related/appropriate services during the COVID-19 pandemic.

Similarly, the study addressed the following four research questions:

i. What are the specific gender norms and practices (in the family, community, and businesses) that further intensified the vulnerabilities of IWWs during the COVID-19 pandemic?
ii. How did COVID-19 policy responses specifically impact the livelihoods activities of IWWs in the service, trading, and food sub-sectors?
iii. How did COVID-19 policy responses specifically impact IWWs' exposure to GBV and access to SRH services?
iv. What were IWWs' coping and resilience strategies/mechanisms amidst the impacts of the pandemic?

Fruit vendor - Toy Market © ICRW

3.0. METHODOLOGY

We conducted this study in seven sub-counties of Nairobi City County: Dagoretti South, Embakasi East, Embakasi West, Kamukunji, Kibera, Starehe, and Westlands. These sub-counties were purposively selected because they likely have the highest concentration of informal businesses. A mixed methods approach involving both quantitative and qualitative interviews was used. A total of 384 women were surveyed who were working in informal food services, including those that have both mobile and fixed locations such as restaurants; and those working in informal trading services, such as trading various items (including short- and long-shelf-life products) in markets, vendors, hawkers, and women working in temporary stalls. The qualitative portion of the study included 23 key informant interviews (KIIs), five in-depth interviews (IDIs), and eight focus group discussions (FGDs). For more details, see Annex A1.

The KIIs included policy makers, civil society organization (CSO) service providers for SRH and GBV, and influential community leaders such as local council leaders and market chairpersons. Five IDIs were conducted with IWWs: a woman who was pregnant before and during the pandemic; a woman with children under 10 years of age; a woman who accessed credit from an unregulated financial institution; and two women with disabilities.

We used STATA to analyze and detect patterns in quantitative survey data. To establish statistical differences in study outcomes across sectors as well as other demographic characteristics of respondents, namely education, marital status, and age group, we employed two inferential statistical tests: the t-test and a one-way analysis of variance. T-tests were used to determine statistical significance between two groups and relationships, while one-way analysis of variance analyses (ANOVAs) was used to determine differences among three or more groups. In the one-way ANOVA analysis, only two outcomes were examined: involvement of women in household chores and family care and resilience. We performed multiple comparisons with Tukey's method to determine if means are different. We used NVivo software to code, manage, and analyze qualitative data.

4.0. STUDY FINDINGS

This section presents findings on the socio-economic impact of the COVID-19 crisis and whether/to what extent Kenyan government policy actions to mitigate its impacts benefited IWWs. It presents findings on the care and domestic work of the IWWs before and during the lockdown, access to information and services for SRH, exposure to GBV and access to support services, employment and livelihood resources, financial well-being, and financial inclusion.

4.1. Socio-demographic characteristics of the survey respondents

The average age of the IWWs interviewed was 37 years, with a range of 18 to 70 years. Just under half of respondents obtained secondary education (44%) while only 10% obtained tertiary education. About half (52%) were married and 47% were either single or divorced. Forty-two percent had children between 0-5 years of age and 74% had children 6-17 years of age. Descriptive summaries of social demographic characteristics are presented in Annex A2.

4.2. IWWs had pre-existing characteristics that made them particularly vulnerable to impacts of the COVID-19 pandemic.

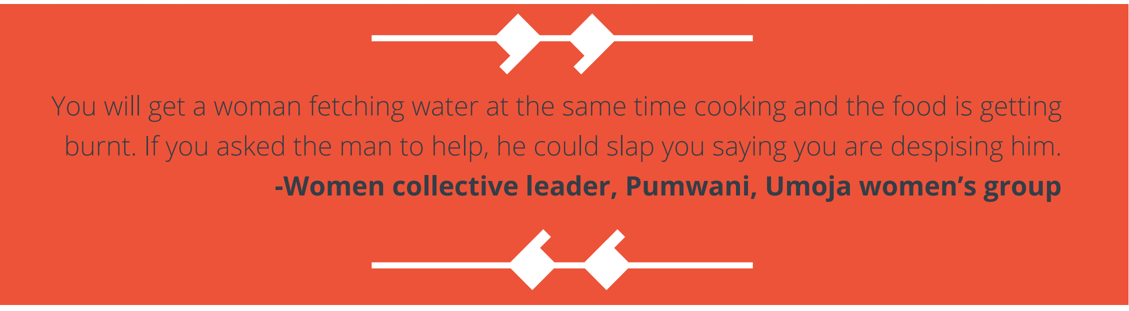
4.2.1. Pre-COVID burden of household labor

Table 1 shows the survey results in response to the question about division of household labor before the COVID-19 pandemic. IWWs reported that they were primarily responsible for all household chores before the pandemic (i.e., cooking, cleaning, guiding and providing care for children), and few received support from spouses and/or children. The limited proportion of IWWs reporting some spousal support to household chores is at least partly attributable to the fact that many of them were single or divorced.

Table 1: Percent distribution of IWW by household division of labor before the COVID-19 pandemic

Task and person responsible	Overall (%)	IWW food service respondents (%)	IWW trading service respondents (%)
Cooking			
IWW	85.8	86.6	85.1
Spouse	0.9	1.4	0.5
Child	8.5	9.0	7.9
Someone Else	4.6	2.7	6.5
Cleaning			
IWW	78.5	75.8	81.4
Spouse	0.9	1.8	0.0
Child	13.7	16.1	11.2
Someone Else	6.4	5.4	7.4
Collecting water/firewood/fuel			
IWW	80.4	78.5	82.3
Spouse	0.5	0.9	0.0
Child	14.2	17.0	11.2
Someone Else	4.3	2.7	6.1
Minding children while performing concurrent chores			
IWW	77.9	77.6	78.1
Spouse	5.3	3.6	7.0
Child	5.9	8.1	3.7
Someone Else	4.6	4.0	5.1
Instructing, teaching, or training children			
IWW	74.0	72.2	75.8
Spouse	8.9	9.0	8.8
Child	4.6	5.4	3.7
Someone Else	5.9	5.8	6.1
Taking care of the elderly/sick/disabilities			
IWW	62.8	60.1	65.6
Spouse	2.1	2.2	1.9
Child	3.0	3.1	2.8
Someone else	6.4	4.9	7.9

The qualitative interviews further revealed a component of gender inequality embedded in social norms whereby women traditionally are expected to shoulder a higher burden of home care.

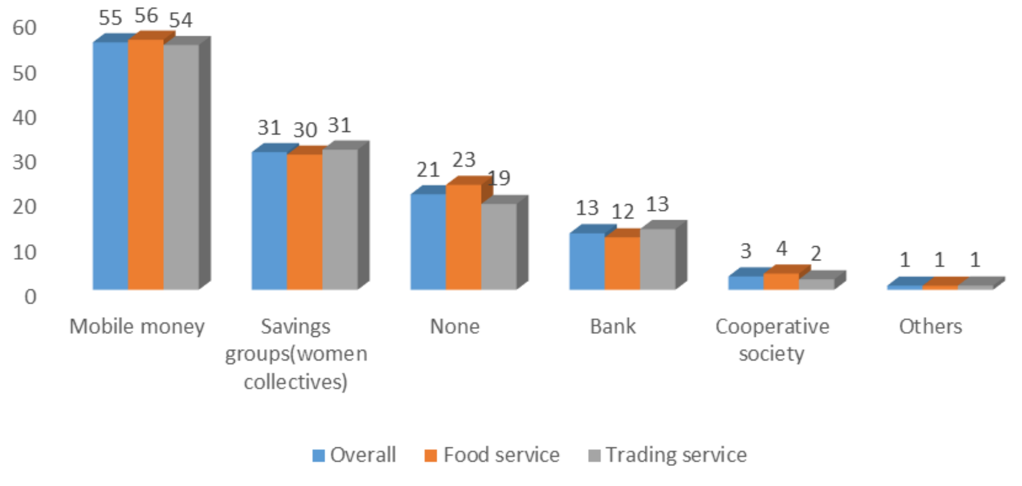


Testimonials like these demonstrate the entrenched and long-standing stereotypes about household chores being mainly the responsibility of women. This finding is consistent with empirical literature showing that traditional household roles of women have remained the same even when women engage in more productive market employment activities. [9]

4.2.2. Financial inclusion of IWWs

To understand the extent and form of IWWs' financial inclusion, the survey collected information about where they keep their money and how they access credit. Figure 1 shows that most women (55%) keep their money in mobile money accounts, followed by women's collectives (31%). The findings demonstrate the importance of women's collectives in advancing women's financial inclusion. Few women are accessing formal financial institutions, with only 13% of respondents reporting that they keep their money in banks. Moreover, 21% of participants do not save money at all.

Figure 1: Percentage distribution of IWWs by savings channel



[9] Greenstein, T. N. (2000). Economic dependence, gender, and the division of labor in the home: A replication and extension. Journal of Marriage and Family, 62(2), 322-335.

Table 2 shows that just as savings groups are a safer place for IWWs to keep their money, they are also the most common source of credit for IWWs (38%), followed by digital lenders (35%). These observations demonstrate the relevance and importance of savings groups in boosting women's informal businesses. Credit from microfinance institutions was also significant, with 14% of the participants reporting having received credit from these. However, more than twice as many IWWs in the food service sector reported receiving credit from microfinance institutions than those in the trade service sector and the difference is statistically significant ($p<0.038$).

According to Table 2, 12% of IWWs in the trade services sector borrow money from lenders commonly referred to as "shylock" (loan sharks) compared to 2% in the food sector ($p<0.006$). In rural areas as well as urban informal settings, shylock loans are widely available, and their terms are heavily influenced by lenders' conditions. Borrowers usually have to provide a guarantor or security to obtain these loans, which are considered to be Kenya's most expensive forms of credit. Because of high interest rates and the requirement for collateral, shylock financing is unfavorable in the context of a business enterprise.[10,11]

Table 2: Percentage distribution of IWWs by sources of credit

	Overall (%)		Food service		Trading service		p-value
Options	**(%)**	**Std Dev**	**(%)**	**Std Dev**	**(%)**	**Std Dev**	
Bank	9	0.28	8	0.27	9	0.29	0.686
Microfinance	14	0.34	19	0.39	8	0.2 8	0.038*
Employer	1	0.10	2	0.14	0	0.00	0.172
Savings group	38	0.49	37	0.49	39	0.49	0.808
Relative	7	0.25	8	0.27	5	0.22	0.469
Pawn shop	1	0.10	2	0.14	0	0.00	0.172
Shylock	7	0.25	2	0.14	12	0.32	0.006**
Digital lender	35	0.48	30	0.46	39	0.49	0.209
Local shop owner	2	0.12	2	0.14	1	0.10	0.605
Money lenders	1	0.07	1	0.10	0	0.00	0.336

*p<.05; **p<.001

[10] Njoki, K. B., & Muturi, W. M. (2019). Effect of Informal Financing Structure on Financial Performance of Women Owned Enterprises in Kenya: A Case Study of Gikomba Market. The International Journal of Business & Management, 7(11). https://doi.org/10.24940/theijbm/2019/v7/i11/BM1911-018.

[11] Kihimbo B. W. (2012) Financing of Small and Medium Enterprises (SMES) in Kenya: A Study of Selected SMEs in Kakamega Municipality International Journal of Current Research Vol. 4, Issue, 04, pp.303-309.

4.2.3. IWWs' access to and uptake of health insurance

Health/life insurance uptake among IWWs is generally low, with over 63% of IWWs surveyed reporting that they did not have any insurance prior to COVID-19 (see Table 3). This proportion increased during the pandemic to 71%, suggesting that COVID-19 and related policy measures affected their access to insurance, including due to reduced earnings. Among the few IWWs who reported having some insurance, government-provided health insurance was the most common prior to the pandemic at 34%, but this fell to 28% during the pandemic. Low insurance uptake by the IWWs could be associated with the inability to pay insurance premiums, exacerbated by the pandemic, and reflects their increased exposure to risks and vulnerabilities without formal social safety nets.

Table 3: Percentage distribution of IWWs by uptake of insurance before and during the COVID-19 pandemic

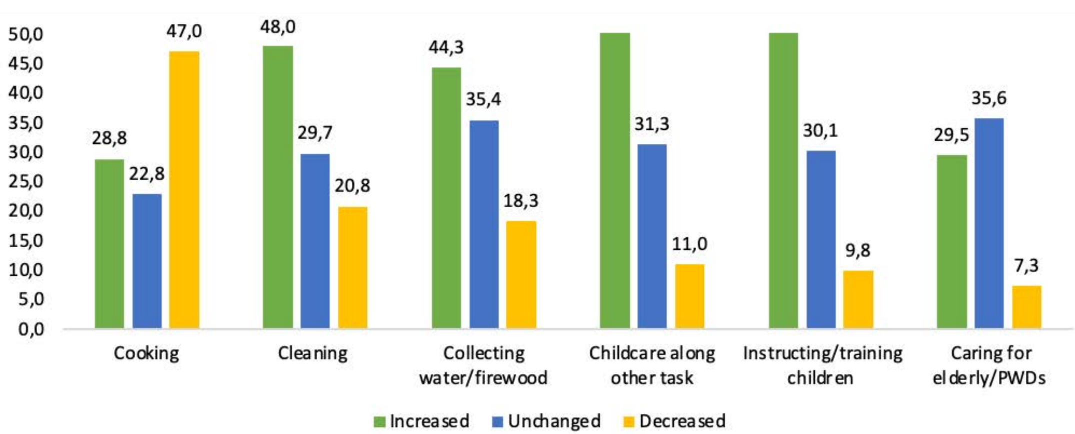
Type of insurance	Insurance uptake before pandemic (%)	Insurance uptake during pandemic (%)
Health insurance (private)	2.8	1.4
Health insurance (government)	34.3	27.8
Life insurance	1.4	0.7
Accident/disability insurance	0	0.2
Did not have any insurance	63.2	71.0

4.3. Impact of COVID-19 policies on IWWs' care and domestic burdens

4.3.1. Increased care burden

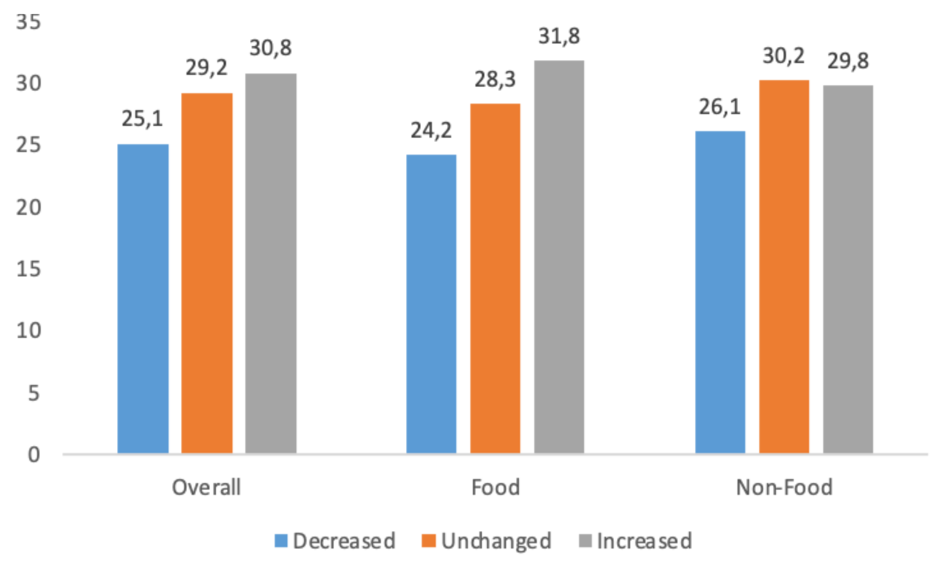
Due to the lockdown, IWWs took on more responsibilities for home care. Forty-eight percent of the IWWs reported that they experienced an increased burden of care because of COVID-19 policy responses. Figure 2 shows the impact of the pandemic on IWWs' time burden around domestic activities. IWWs reported having increased their time devoted to domestic work across all activities except cooking, with most reporting a decrease, and caring for the elderly, with most reporting this to be unchanged. The reduction in IWWs' time allocated to cooking could be either due to older children (especially girls) being home during the pandemic and helping out with domestic responsibilities, or a reduction in the number of meals per day (as reported by some IWWs), or both.

Figure 2: Percentage distribution of IWW by changes in the time devoted to household chores during the COVID-19 pandemic



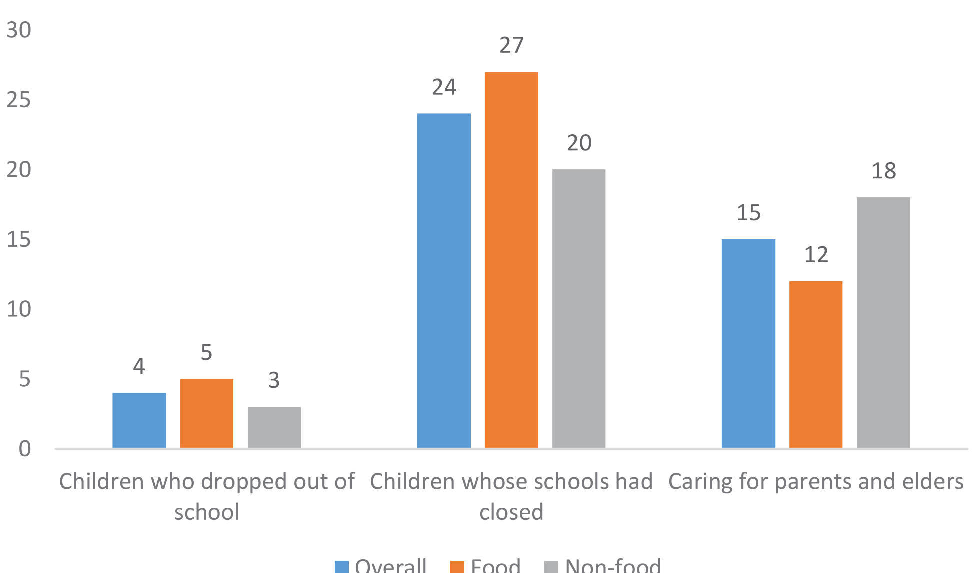
During the pandemic, the amount of time IWWs dedicated to caring for non-household members also increased, as shown in Figure 3. About 31% of the IWWs reported spending more time caring for people outside their households compared to before the pandemic. There were no significant differences in the time allocation between food and non-food sectors.

Figure 3: Percentage of IWWs reporting time use changes regarding non-household members during COVID-19



In particular, the closure of schools during the lockdown increased childcare burden in households with school-going children. For example, 24% of the IWWs reported increased burden of care arising from children who were in schools before COVID-19 lockdown (see Figure 4). There were also reported increases in domestic work arising from caring for parents and elders during the pandemic. A slightly higher percentage of IWWs in the food sector reported having more children who either dropped out or stayed home due to closure of schools than those in the non-food sector. However, a higher proportion of IWWs in the non-food sector reported caring for parents and elders during the lockdown.

Figure 4: Percentage of IWW who reported the sources of increased care burden



4.3.2. Support from others for domestic chores

There were changes in the involvement of household chores during the COVID-19 lockdown (Table 4), with spouses, sons, daughters, and other family members becoming more involved. This is perhaps because the children were at home due to closure of schools and other members were not working due to movement restrictions and closure of businesses/ loss of jobs.

Table 4: Responsibility for household chores and caring for family during COVID-19

Variable	%
My partner participates more with household chores and caring for family	15%
My daughter(s) participates more with household chores and caring for family	32%
My son(s) participates more with household chores and caring for family	25%
Other family/household members participate more with household chores and caring for family	17%
We hired a domestic worker	3%
Domestic worker/helper works longer hours for us	1%
Domestic worker no longer works for us	4%
I am on my own; nobody helps with household chores and caring for family	29%

4.3.3. Impact of care burden on ability to earn income

The increased burden of care that resulted from COVID-19 and related policies had a direct impact on IWWs' ability to earn income. Overall, 67% of the IWWs interviewed reported reduced earnings due to the need to care for others during the pandemic (see Figure 5). The proportion of IWWs who experienced income losses was slightly higher in the trading services (68%) compared to the food sub-sector (66%).
Figure 5: Proportion of IWWs reporting changes in earnings due to increased care burden

Figure 5: Proportion of IWWs reporting changes in earnings due to increased care burden

4.4. Impact of COVID-19 policies on livelihoods of IWWs

Several livelihood dimensions were explored to understand how the COVID-19 lockdown affected the livelihoods of the participants, including employment status, income changes, and perceived welfare during the pandemic. The survey probed livelihood challenges faced by the IWWs during the lockdowns. Table 5 shows that the most reported challenges were reduced opportunities to earn a living (78%), reduced ability to pay bills (74%), and increased utility costs (69%). Participants also reported difficulties accessing financial services, with 53% reporting a reduction in credit availability.

Table 5: Percentage distribution of IWWs by livelihood challenges experienced due to COVID-19

Challenges due to COVID-19 policy measures	Overall	Food service	Trading service	p-value
Reduced opportunities to earn a living	78%	75%	81%	0.158
Reduced spending power	54%	57%	51%	0.224
Reduced access to credit	53%	54%	53%	0.869
Reduced ability to pay bills	74%	73%	75%	0.671
Disruptions to supply chains for necessities	49%	52%	46%	0.179
Increased costs of utilities	69%	70%	66%	0.440
Increased cost of business due to adapting to COVID SOP measures	46%	48%	43%	0.322
Increased stress/worse mental health among your household	46%	48%	43%	0.322

4.4.1. Impact on employment

Before the COVID-19 lockdown, most IWWs worked alone in their businesses, with 13.2% employing a worker and 10.7% working for someone else. After the lockdown was lifted, the proportion of IWWs working for or employing another person decreased while those managing their own businesses without any employees increased (see Table 6). This implies that some IWWs who were formerly employees had started running their own businesses, and some who employed others before the pandemic no longer did so. However, this study did not explicitly investigate this issue to that level of detail. Thus, while this finding demonstrates a switch between being an employee and a business owner for some IWWs following the lifting of the lockdown, it does not provide insights into changes in their livelihoods.

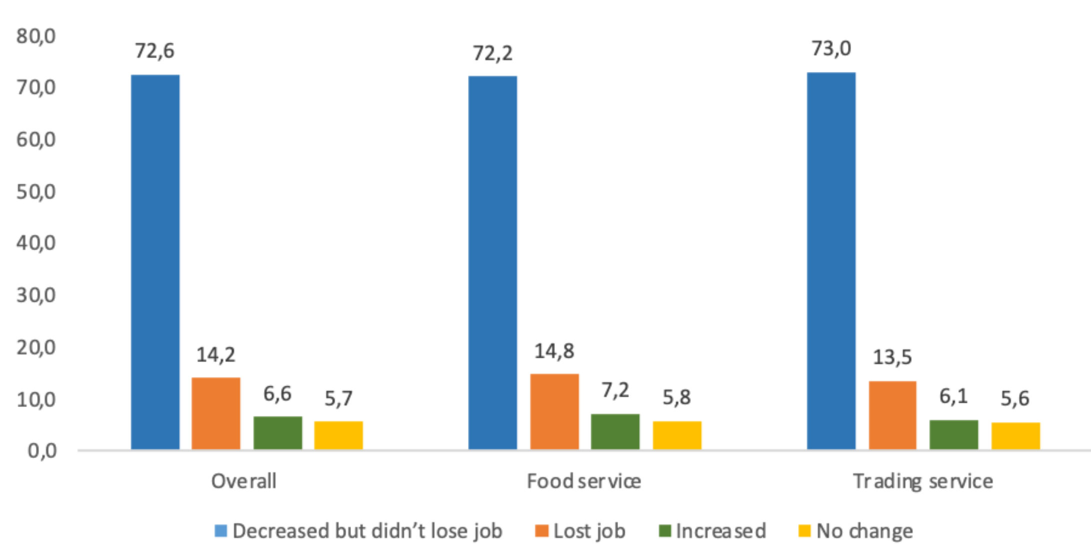
Table 6: IWW employment status before COVID-19 pandemic and after the COVID-19 lockdown (%)

IWW	Type of employment	IWWs' employment status before COVID-19 (%)	IWWs' employment status after the COVID-19 lockdown (%)
Overall	Employee	10.7	5.0
	Owned business and I employ others	13.2	5.7
	Business owner without employees	69.4	87.0
Food service	Employee	13.9	4.9
	Owned business and I employ others	15.7	9.9
	Business owner without employees	65.0	81.6
Trading service	Employee	7.4	5.1
	Owned business and I employ others	10.7	1.4
	Business owner without employees	74.0	92.6

4.4.2. Impact on work hours and income

The study also assessed changes in the time IWWs devoted to paid work during the COVID-19 lockdown (Figure 6). The majority of IWWs (73%) reported a decrease in the hours they devoted to paid work during the pandemic, while a few reported an increase and others lost their jobs entirely. There is not significant difference between IWWs in the food and non-food sub-sectors.

Figure 6: Percentage distribution of IWWs reporting changes in the time devoted to paid work during the COVID-19 pandemic



The main drivers of IWWs' decline in earnings during the COVID-19 lockdown was temporary closure of the workplace (31%) and supply chain issues (30%). Additionally, 15% of IWWs reported loss of jobs and 9% reported permanent closure of businesses due to the lockdowns. IWWs involved in the trading sector experienced supply chain deficiencies more than those in the food sector.

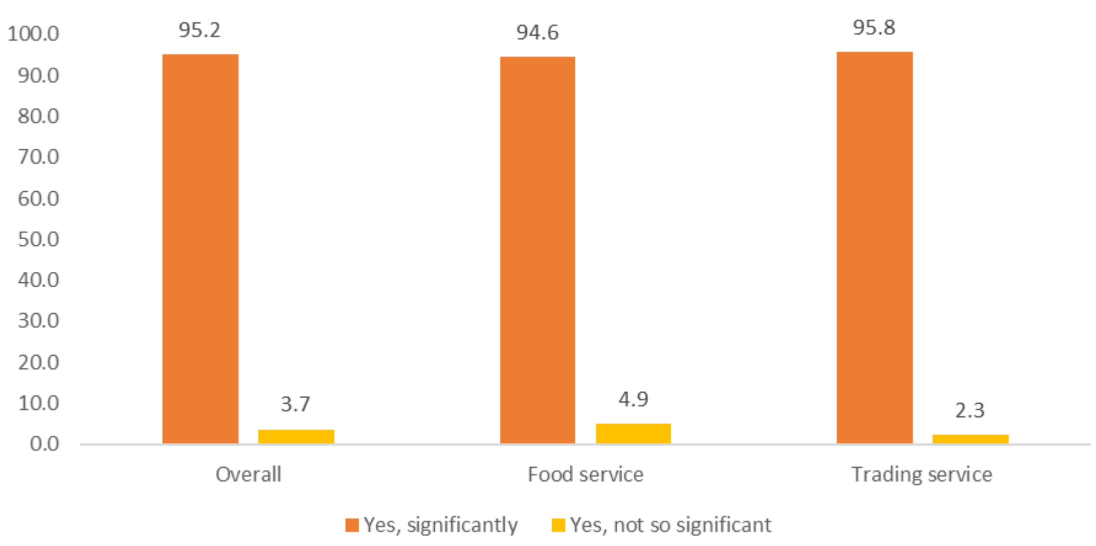
Table 7: Percentage distribution of IWWs by reasons for experiencing decline in income

Reasons	Overall (%)	Food service (%)	Trading service (%)
Place of work was temporarily closed	30.7	34.6	26.5
Supply chain issues	29.5	21.6	37.8
Could not go out to earn a living (lost job)	15.1	18.3	11.7
Business or market was closed (permanently)	8.9	9.6	8.2
Ill health	0.3	0.5	0

4.4.3. Impact on financial well-being

Overall, the IWWs experienced economic hardships due to reduced economic activity, which could have adversely affected their financial well-being. Figure 7 shows that 95% of IWWs in both the informal food and trading sub-sectors reported that the pandemic significantly impacted their financial well-being (freedom to make financial decisions and choices).

Figure 7: Percentage distribution of IWWs by effect on financial well-being due to COVID-19 pandemic



With regards to livelihood priorities, the majority of IWWs (87%) said food is their top priority for safeguarding their livelihoods, followed by education for their children (71%) and health care (67%): see Table 8.

Table 8: Percentage distribution of IWWs by livelihood priorities

Livelihood Priorities	Overall (%)		Food service		Trading service		p-value
	(%)	Std Dev	(%)	Std Dev	(%)	Std Dev	
Health care	67%	0.47	68%	0.47	66%	0.48	0.685
Food	87%	0.34	86%	0.35	88%	0.33	0.499
Shelter	55%	0.50	55%	0.50	55%	0.50	0.921
Finances for my business	61%	0.49	58%	0.50	64%	0.48	0.187
Rent	62%	0.49	59%	0.49	64%	0.48	0.256
Education for my children	71%	0.45	69%	0.46	74%	0.44	0.271
Getting an income/ working	39%	0.49	38%	0.49	39%	0.49	0.885
Safety and security	31%	0.47	32%	0.47	31%	0.46	0.668
Local shop owner	2	0.12	2	0.14	1	0.10	0.605
Money lenders	1	0.07	1	0.10	0	0.00	0.336

4.4.4. Outlook for the future

Figure 8 shows the IWWs perceptions regarding their livelihoods after the pandemic. About the same proportions of IWWs anticipated no difference compared to before the pandemic (33.6%) as those who were optimistic (34.7%), while 15% perceived their future would be worse than before the lockdown.

Figure 8: Percentage distribution of IWWs by perceived livelihood conditions in the post-COVID-19 period compared to pre-COVID-19 onset

	Overall	Food service	Trading service
Better	34.7	33.6	35.8
Neither better nor worse	33.6	30.9	36.3
Worse	15.8	17.0	14.4
Significantly worse	8.2	7.6	8.8
Significantly better	5.0	7.2	2.8

4.5. Access to official COVID-19 resilience measures

Formal and informal social protection programs are critical to addressing unprecedented emergencies and building resilience of all workers against any risks that might cause them to fall back into poverty. Due to the nature of their businesses, IWWs and their families are prone to shocks that are exacerbated by a lack of operational capital and access to credit. The outbreak of the pandemic and related government containment strategies severely affected the IWWs, forcing them to adopt a number of coping strategies to make it through the crisis, which will be described in this section.

4.5.1. Access to government relief mechanisms

Only 45 out of 389 (12%) IWWs surveyed received unconditional cash transfers for their households. The IWWs noted that many people did not benefit from cash transfers due to poor data capture and record keeping, which obstructed the identification of needy and deserving beneficiaries. They also reported corruption and poor consultation as affecting the cash transfer program, resulting in an unfair registration process that excluded deserving

cases. Key informant interviews corroborated this finding, with one informant—a social protection policy officer—pointing to the lack of a database presenting a barrier to fair distribution of cash transfers. This was a contentious issue during the FGDs, with women expressing frustration over the poor management and oversight of the program:

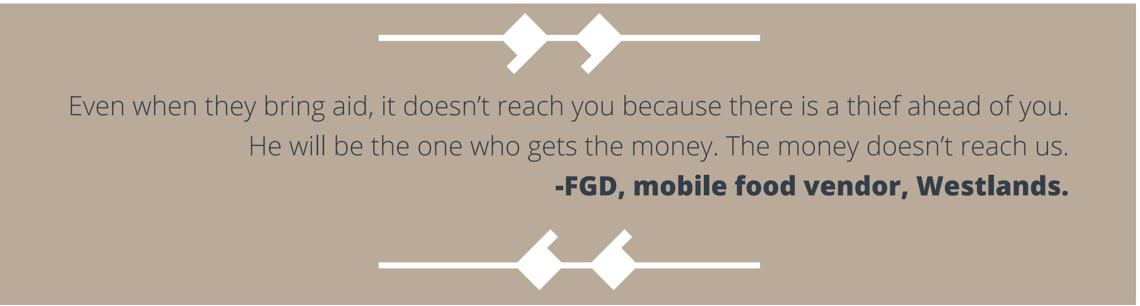
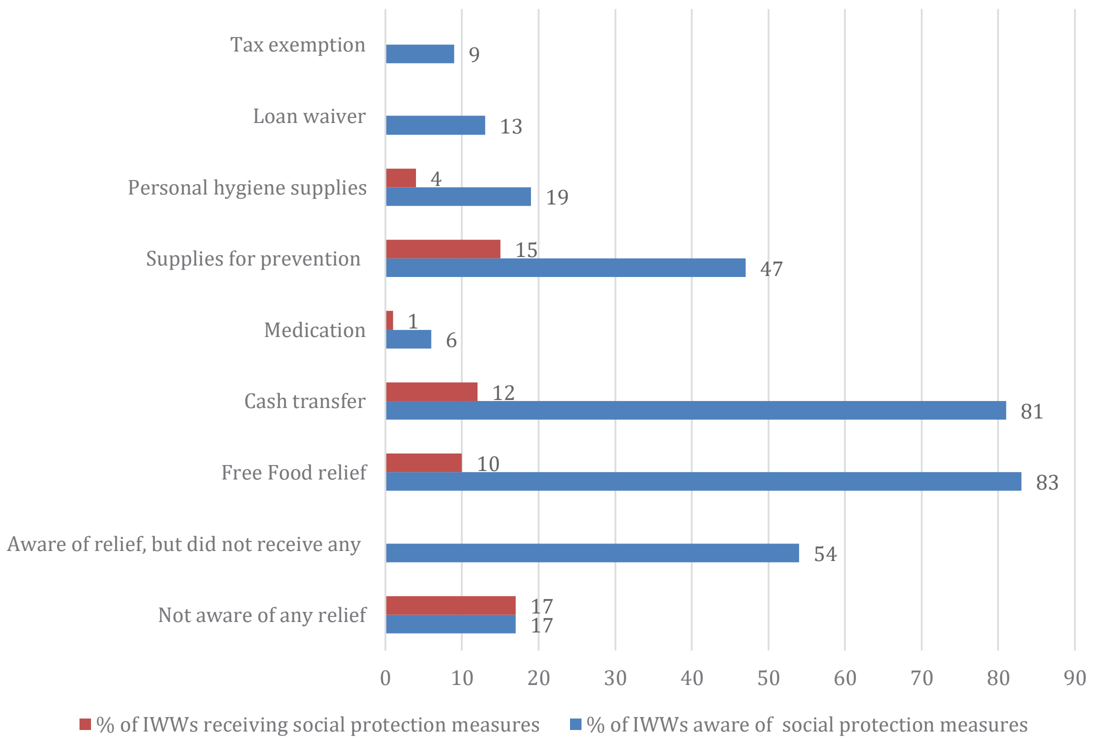


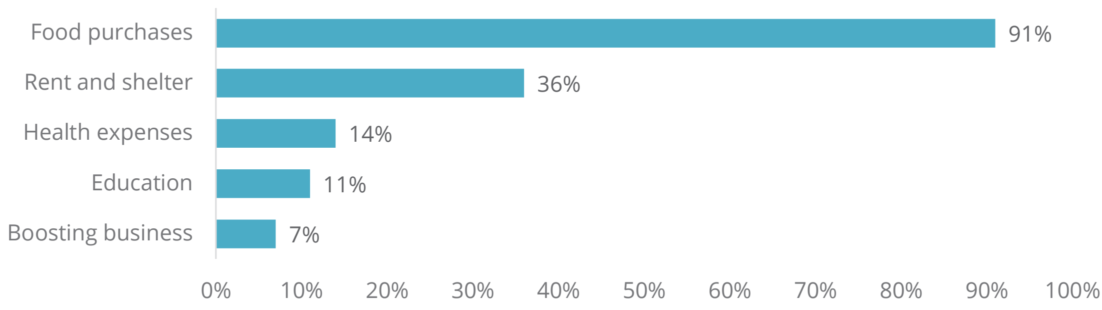
Figure 9: Percentage of IWWs aware of and receiving social protection measures



The results further show that significantly more IWWs in the trading services sector (56%) were aware of supplies for prevention COVID-19 compared to IWWs in the food services sector (40%). However, only 15% reported receiving supplies, with no difference between sectors.

Among IWWs who received the cash transfer, most used this money to meet basic needs, particularly food (91%), rent and shelter (34%), and health (16%), followed by education (11%) and reinvestment in business (7%) (Figure 10). The most preferable means to receive government cash transfer support reported by IWWs was mobile money (87%).

Figure 10: Reported use of cash transfer relief



Some IWWs confirmed receiving support from non-government bodies and individuals, including for basic needs, health, and personal protection equipment, among others. Some non-state actors mentioned included St. John's Ambulance, Inua Dada, Shining Hope for Communities (SHOFCO), Center for Rights Education and Awareness (CREAW), and Carolina for Kibera (CFK).

We got assistance from an organization called St. Johns Community Center. There was a donor who was giving out food after every two weeks and that went for a long time. **- FGD with women's collectives**

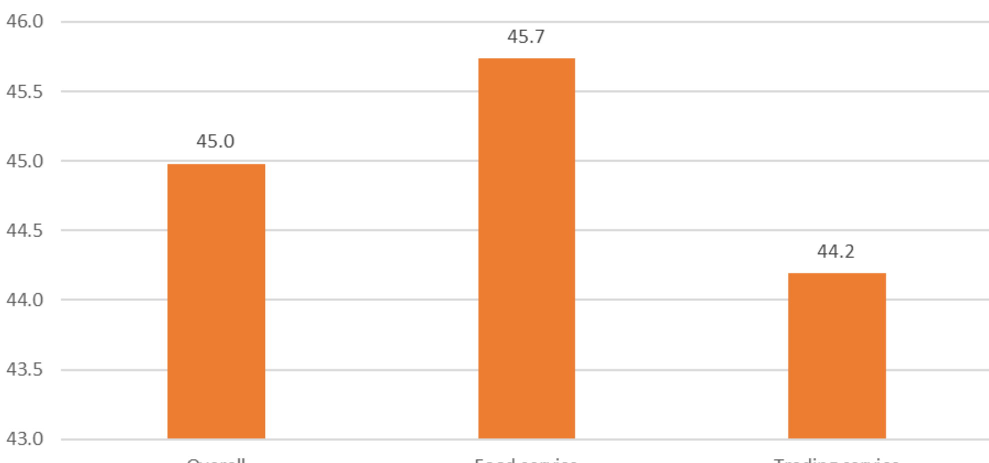
We had NGOs like also SHOFCO that were really supporting women and girls and families giving them food baskets. **-KII, GBV service provider**

Even if I did not get it, there was another one called "Inua dada." Women from 30 years and above were given a stipend. They used to receive 5,000 for 4 to 5 months. **-Female FGD, Embakasi East – Vibandas and Jua Kali.**

4.5.2. Access to loans

Figure 11 shows that 45% of IWWs had borrowed money from both formal and informal lenders within the 12 months prior to the survey. Women in food and trading services had relatively similar access to credit.

Figure 11: Percentage distribution of IWWs by access to a loan in the last 12 months



4.5.3. Coping strategies

The study explored IWWs' coping strategies and perceptions regarding post-pandemic business recovery. In response to a question about whether their lives (and their households' lives) would bounce back after COVID-19, only 24% of the IWWs interviewed believed they would (Figure 12). This indicates how socially, and economically devastating and disruptive COVID-19 was to the lives of many informal workers, eventually undermining their adaptive capacity and resilience. Figure 12 further shows that there is little difference in perception of recovery between the two sectors that this study analyzed.

Figure 12: Percentage distribution of IWWs by the possibility of business recovery after COVID-19

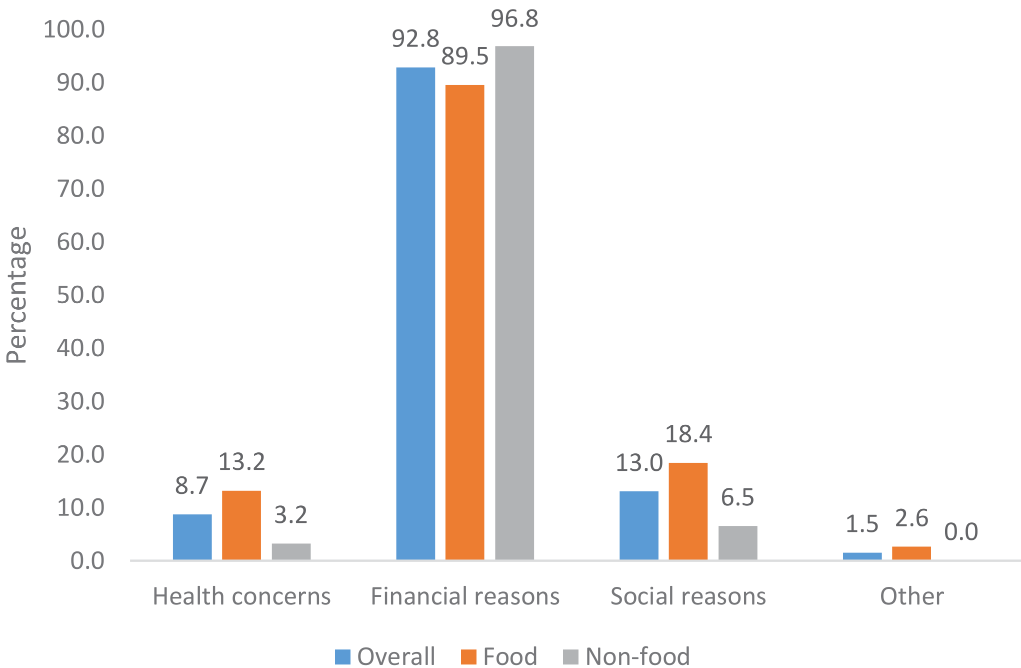
IWWs adopted several coping strategies to manage the livelihood challenges caused by COVID-19 lockdowns. Although the Kenyan government provided short-term food rations to vulnerable households during the lockdown, this was insufficient to sustain them. Consequently, IWWs improvised their own coping and resilience strategies. As shown in Table 9, most participants (90%) responded to the situation by reducing their expenditures on non-food items, such as health care and clothing. Buying food on credit (85%) and reducing meal frequency (72%), spending savings (54%), selling household property (51%), and moving (43%) were other reported coping strategies. These coping mechanisms are household-based and have potential to heighten household vulnerability to external shocks. Rapid depletion of savings and increased emergency debts and crisis borrowing can adversely affect informal business operations.

Table 9: Percentage distribution of IWWs by coping strategies in response to COVID-19

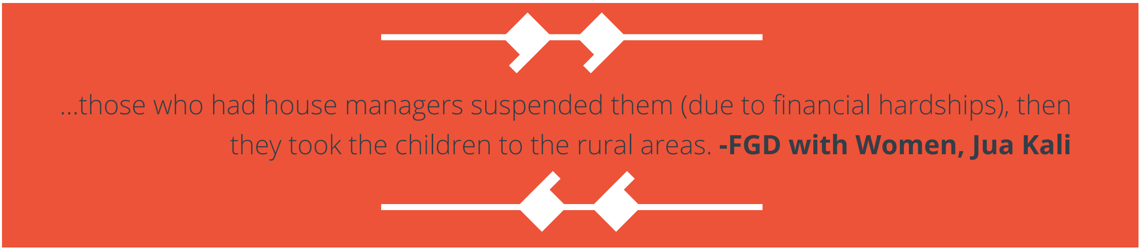
Coping strategies to livelihood challenges	Overall	Food service	Trading service	p-value
Selling household property	51%	50%	53%	0.561
Spending savings	54%	52%	57%	0.024
Buying food on credit through borrowed money	85%	85%	85%	0.976
Reducing expenditure on non-food items (health, education, clothing)	90%	88%	92%	0.254
Change place of residence to reduce expenses	43%	43%	44%	0.888
Children dropped out of school	13%	15%	12%	0.329
Children under 18 work to support family	13%	14%	11%	0.250
Reduced the number of meals per day	72%	72%	71%	0.578

As another coping mechanism, some IWWs sent family members away from the household, with about 16% of the IWWs reporting this. About 35% of the IWWs reported sending away the children, 20% an elderly relative, and 49% other family members. The reasons cited ranged from health concerns to financial and social reasons, with financial being the most common: see Figure 13.

Figure 13: Reasons for sending away a household member due to COVID-19 pandemic



The interviews corroborated the quantitative findings on financial concerns, being the key factors for sending away household members particularly the children and household helpers.



...those who had house managers suspended them (due to financial hardships), then they took the children to the rural areas. **-FGD with Women, Jua Kali**

4.6. Impact of COVID-19 policies on GBV and SRH care

4.6.1. Access to information and services

IWWs were asked about the sources of information on SRH and GBV during the pandemic. Most mentioned television (74%), followed by radio (68%), as their sources of information for SRH and GBV services (Figure 14). This could be partly attributed to the fact that the government intentionally used televisions and radios to reach people during COVID-19 lockdown since many people were at home. Local leaders were also essential sources of information about these health services.

Figure 14: Percentage distribution of IWW responses on sources of information on SRH and GBV services

Of those indicating they needed care related to SRH or GBV, most IWWs obtained care through home remedies (60%), followed by procuring medication from pharmacies (41%). Praying for healing was the third most common answer, with around one-fifth of respondents using this method.

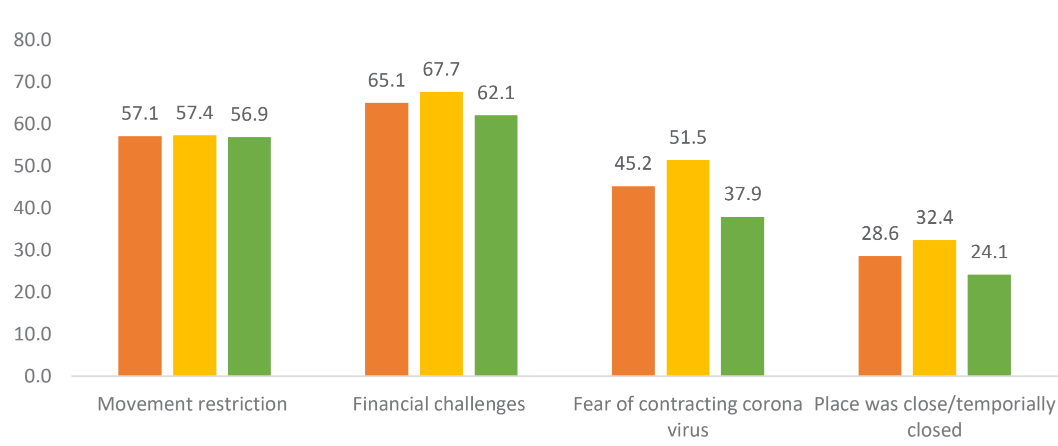
Table 10: Percentage distribution of IWWs by sources of health care services

Source of care	Overall	Food service	Trading service	p-value
No need to seek health care	19%	22%	17%	0.255
Visiting herbalists	4%	6%	1%	0.008**
Procuring medication from pharmacies	41%	42%	40%	0.721
Praying for healing	19%	23%	17%	0.167
Using midwives	1%	0%	1%	0.299
Phone call to personal/family doctor for consultation and prescription	3%	4%	2%	0.215
Home remedies	60%	58%	61%	0.575

$^{**}p<.01$

Around 65% of IWWs indicated financial difficulties as a major challenge to accessing health services for SRH and GBV (see Figure 15). Over half (57%) of the surveyed IWWs reported that public transport bans and curfews impacted access to SRH and GBV services.

Figure 15: Percentage distribution of IWWs by challenges to accessing health services during COVID-19



Accessing SRH services at health facilities during the COVID-19 lockdown was difficult due to movement restrictions, the high cost of transport, and some service points being temporarily closed. The SRH services that this study examined included contraception and family planning, and antenatal, delivery, and postnatal care. They also included management of abortion complications, prevention and treatment of sexually transmitted infections, and GBV-related care such as clinical management of rape survivors and intimate partner violence. COVID-19 policy measures to restrict movement, the fear of contracting the virus, IWWs' reduced income, and the temporary closures of some health care facilities made accessing care during the lockdown very challenging for IWW and other women more generally.

Infographic 1 below summarizes some of the responses from study participants on the impact of COVID-19 policy responses on their access to SRH services.

THE IMPACT OF COVID-19 POLICY RESPONSES ON ACCESS TO SRH SERVICES

IWWs faced challenges related to accessing health services during the **COVID-19 LOCKDOWN** put in place by the government to curb the spread of the pandemic.

It was hard for us to go to the hospital for delivery. We had curfew, women were in labor and could not go to the hospital. The curfew was from 7 pm to 6 am in the morning... the first challenge was getting to the hospital because we had curfew. ***-IDI, IWW with children younger than 10***

PREGNANT WOMEN from 6 months and above were not allowed to go to hospitals due to fear of them contracting the virus

...I stopped at 6 months, I could not go for clinic; wherever I went they would send me back. They would say it's risky to go during COVID season and it was risky, that is what they would tell us. ***-IDI, IWW with children younger than 10***

COST OF SRH WAS HIGH during COVID-19 compared to the pre-pandemic period.

...So, the cost was high...but because you need to give birth we had to pay, everything was expensive generally because COVID-19 policy measures affected everything. ***-FGD, women with children younger than 10***

A SHORTAGE OF SOME SRH PRODUCTS affected uptake.

...they reached out to the few they could but there was a shortage of the services they would offer. There were no condoms or others. ***–Informant with CSO offering GBV and child rescue services***

Infographic 2 below summarizes the alternative options used for SRH care during COVID-19.

USE OF COMMUNITY HEALTH VOLUNTEERS (CHVS)/ VILLAGE HEALTH TEAMS

There were those who opted to go to the chemist to buy medicine, especially those who could afford...Unless the CHVs in the community visited a household and found a patient who is on home care and cannot visit the hospital. ***-Clinical Officer, GBV & SRH service provider-Shauri Moyo]***

USE OF HERBAL MEDICINE

...with the family planning methods, we have [to see a provider every] three months or the three years and so on, but with the herbal, you only take once. ***-GBV and SRH service provider, Medheal Hospital***

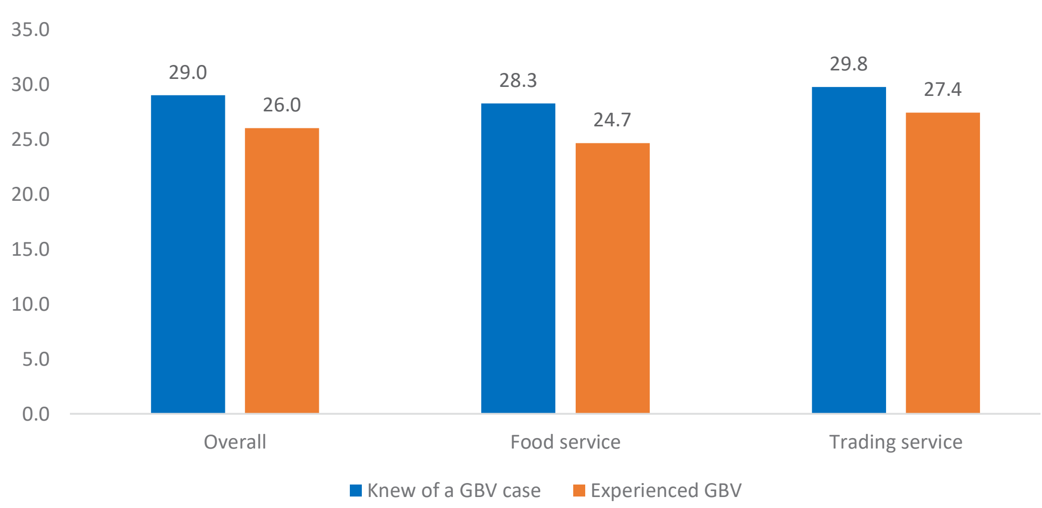
HEALTH CARE PROVIDERS

...the women resorted to getting just medication from the chemist, the nearest chemist, then going to the hospital. ***-GBV service provider, SHOFO***

4.6.2. GBV experience during the pandemic

Exposure to GBV increased during the COVID-19 lockdown, with 29% of participants knowing someone who had experienced GBV at home or at work, and a similar proportion (26%) reporting experiencing GBV themselves (Figure 16). Among participants in the trading sector, 29.8% were aware of at least one GBV case, compared with 28.3% in the food sector. Similar results were observed among survivors of GBV (27.4% and 24.7%, respectively).

Figure 16: Percentage distribution of IWWs who experienced or knew of someone who experienced GBV during COVID-19

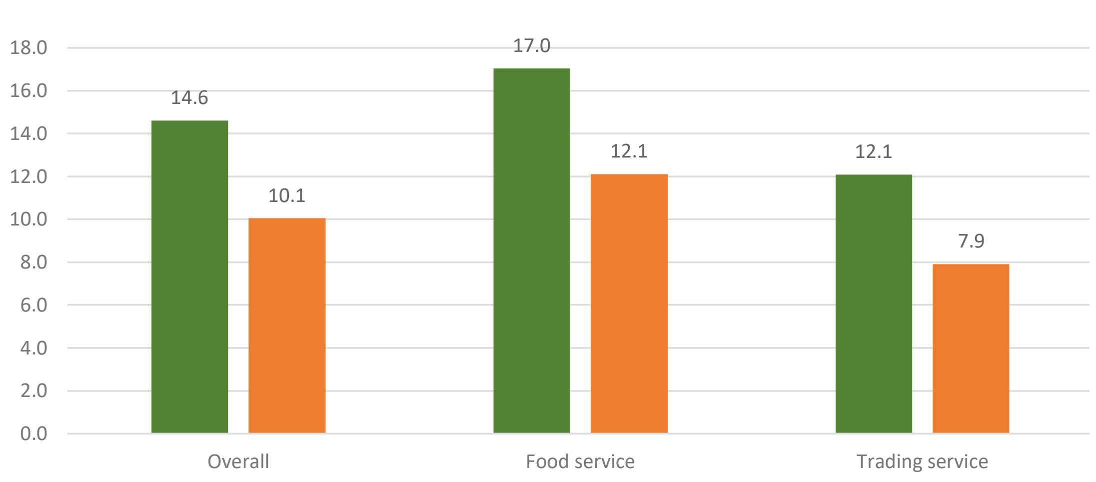


Respondents explained that some GBV cases were related to the economic hardships experienced by men during the COVID-19 pandemic.

> Their husbands were coming home with no money yet there are costs to pay. This could lead to misunderstandings between spouses … leading to domestic violence. That was the main cause of GBV. **-KII, GBV service provider and hotline coordinator**

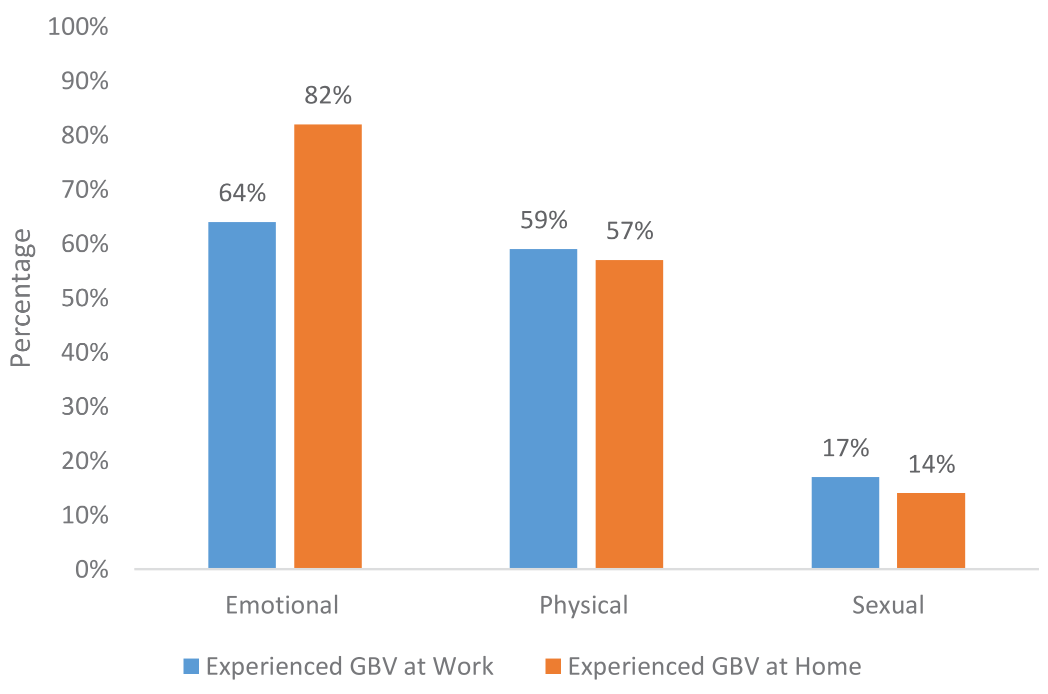
IWWs experienced GBV both at home and at work, as shown in Figure 17. More IWWs reported being subjected to GBV at work (15%) than at home (10%).

Figure 17: Percentage distribution IWWs by experience of GBV during the COVID-19 lockdown



The main forms of GBV experienced were emotional and physical, and to lesser extent, sexual harassment (see Figure 18). The extent of exposure was similar at work and at home.

Figure 18: Percentage distribution of IWWs by forms of GBV experienced during COVID-19



Sexual violence was the least reported form of GBV at both work and home, though this could be due to underreporting of such cases as a result of social stigma around discussing sexual violence.

Table 13 presents the different forms of GBV reported by IWWs. The results show that security personnel (police and council askaris) were the major perpetrators. This was manifested in the form of physical beatings/slapping that happened during enforcement of travel restrictions and the curfew. Statistically significant differences by sector are observed for child marriage and emotional abuse from spouses/ partners.

Table 133: Percentage distribution of IWWs by perpetrators and forms of GBV experienced during COVID-19

Forms of GBV	Overall	Food service	Trading service	p-value
Physical beatings/slap by spouses/ partners	51%	50%	53%	0.561
	26%	32%	20%	0.147
Physical beatings/slap by council askaris/police	68%	62%	73%	0.175
Rape	6%	8%	3%	0.246
Emotional abuse by spouses/partners	32%	42%	22%	0.018
Sexual exploitation in exchange for a service	7%	7%	7%	1.000
Sexual harassment	17%	15%	18%	0.628
Child marriage	3%	7%	0%	0.042

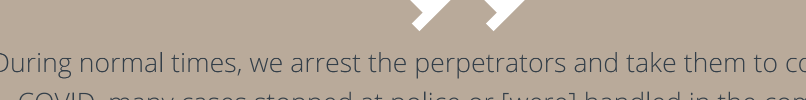
4.6.3. GBV grievance mechanisms during the pandemic

Access to GBV care services during the pandemic was limited due to movement restrictions, higher transport costs, and financial hardships. However, some women accessed GBV services through structures established within their localities.

But for women, they could report to nyumba kumi heads [local leaders] or CHVs [community health volunteers] and the cases were handled at that level.

-Village elder, Eastleigh

The qualitative findings revealed that the pandemic cut off the most common source of support for GBV survivors. During COVID-19, due to lockdown restrictions, survivors' access to police support for GBV cases reduced significantly.



During normal times, we arrest the perpetrators and take them to court... but due to COVID, many cases stopped at police or [were] handled in the community...people could not move easily. **-GBV desk officer, Shauri Moyo Police Station**

However, those who found their way to health facilities received care. The services included assessment to confirm the nature and extent of the violence experienced and provide necessary medical treatment and counseling.

There are those who come and get treated; and after that, we write a medical report because most of them when they come here, they already have an OB, meaning they have reported the matter to the police.
-Clinical Officer, GBV and SRH service provider, Shauri Moyo

Hawker in Kangemi - Nairobi

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5.0 CONCLUSIONS AND RECOMMENDATIONS FOR POLICY AND ACTION

Numerous exploratory and descriptive studies have been conducted since the onset of COVID-19 and associated policy measures to understand the depth and breadth of the pandemic's impact on well-being. Many of these studies have focused on how governments' containment strategies affected the well-being of different categories of people, both at household and enterprise levels, and how countries can build more resilience during and beyond the COVID-19 pandemic.[12,13,14,15] Some of these studies examine the macro-economic and social impacts of the COVID-19 pandemic in Kenya and elsewhere, while others examine health outcomes. This study focuses specifically on IWWs in Kenya's urban areas. To develop effective policies for addressing the negative effects of the pandemic on specific groups, focused studies are needed that identify specific impacts of the pandemic.

This section outlines the key conclusions and policy recommendations that can be drawn from the findings of this study.

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Emerging findings	Recommendations for policy action
Over half of the IWWs in Kenya are in their productive age with a median of 36.5 years (range 18-70), and most had completed secondary education and above. Nearly half are single, divorced, separated, or widowed and are the head of their households, with nearly half having children under five years old. Many IWWs were primarily responsible for childcare and domestic labor even before the pandemic. The closure of education institutions led to a high burden for childcare, implying IWWs had to divide their time between business and domestic activities. The particularly high childcare burden during the COVID-19 lockdown further entrenched socio-cultural norms and reduced IWWs' access to paid employment.	1. National and county governments should collaborate with the private sector to establish accessible, affordable, and quality childcare common-user facilities in markets and other informal workplaces to provide safe places for infants and children under four years old. This will enable IWWs to devote more time to their businesses while being assured of the safety of their children. 2. The State Department for Social Protection should determine and categorize social vulnerabilities of the IWW to guide establishment of responsive support and protection mechanisms to ensure they have access to sustainable options for coping and resilience.
The lockdown policy to contain the spread of COVID-19 reduced potential earnings for IWWs. Even though some IWWs in the food and trading services were allowed to remain operational during the lockdown, business activity was greatly curtailed. At the same time, financial inclusion and social protection are limited for IWWs, and they were not able to take advantage of the protection schemes that they government enacted in the wake of the pandemic. Many IWWs resorted to reducing expenditures, depleting savings, and selling property for survival. These coping strategies are unsustainable and potentially exacerbated their vulnerability in the post-lockdown period. As a result, few IWWs believed that their lives and those of their household would bounce back after the pandemic, reflecting the extent of the socially and economically devastating COVID-19 responses.	1. Redesign the social protection mechanisms, especially social health insurance (contributory) responsive to the level of income of IWWs. Review and adjust the social protection policy to recognize IWW as a category of beneficiaries of the social assistance programs. 2. Relevant government ministries departments and agencies should revisit the devolved funds mechanisms such as Uwezo Fund, Constituency Development Fund, Hustler Fund, National Government Affirmative Action Fund, and any other funds to ensure their relevance to the informal sector ecosystem. Provision of responsive credit to IWWs will be an enabler to restarting businesses and restoring livelihoods. The savings groups and trade associations for the IWWs, with group guarantee mechanisms for the women to access business loans, are viable channels for such credit which they cannot easily access through formal commercial banks.

3. The State Department for Cooperatives, small and medium enterprise (SME) lending institutions, and the private sector (FinTechs) should develop innovative platforms and gateways for the IWWs to access business credit. Government support could take the form of conducive legal frameworks and policies to increase women's opportunities for financial inclusion. This could include transforming the IWWs collectives into community development financial institutions to access to financial services and credit.

4. Support IWWs to diversify their livelihoods to strengthen their resilience in case of hardship or a crisis and improve their quality of life. In addition to diversification, government and non-state actors should support IWWs to strengthen their enterprises through measures to help formalize their businesses, creating market linkages, and facilitating access to formal credit services.

5. The ministry of cooperatives, small and medium enterprises to develop models for individual asset building approaches critical to strengthening the IWWs' collectives and businesses. Increased income and wealth lead to better health outcomes. Improved access to financial resources will lead to long-term transformative socio-economic outcomes such improved access to education, employment and well-being that will consequently aid in asset and wealth building. Individual asset-building approaches could include improving portfolio for businesses, improving market access, and saving u financial assets. Interventions to this end could include efforts to improve financial literacy and financial inclusion and promotion of individual savings and re-capitalizing the IWWs collectives.

<table>
<tr>
<td>During the pandemic, media—mainly radio and television—was an important source of information on SRH and, to a lesser extent, GBV support services. The movement restrictions which limited access to these, and other social services amplified the vulnerabilities women in the informal sector faced pre-COVID. The stay-home policy response to COVID-19 and the economic hardships due to closure of businesses and loss of jobs and incomes led to higher incidences of GBV, which in turn intensified the vulnerability of women as a result of the COVID-19 policy responses. At the same time, access to services was limited by the same stay-home policies. Community-based sources of good quality care for SRH and GBV are currently limited, but important in such emergency situations when access to formal service providers at health facilities or GBV centers becomes difficult.</td>
<td>1. The Ministry of Health and county governments should work with CSOs to develop innovative ways to increase IWWs' access to support, such as training community health workers to provide basic SRH and GBV services in markets and other informal workplaces.

2. The Ministry of Health should classify SRH and GBV services as essential and remove any restriction or regulations that prevent pharmacies from providing SRH and GBV services; and should introduce telemedicine programs, apply task sharing of SRH services as guided by World Health Organization (WHO) standards, and strengthen the reproductive health commodities supply chain. Another way to improve IWWs' access to SRH and GBV services is by mapping needs and using mobile outreach teams to supply service delivery sites or go door-to-door.

3. The ministry of health employ multi-stakeholder approaches to prioritize plans for safe provision of SRH & GBV in the context of a pandemic. Consider comprehensive and age-appropriate sexual education to reduce instances of teenage pregnancy and increase knowledge on sexual reproductive rights.</td>
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ANNEXES

A1: Study Participants for Qualitative Study

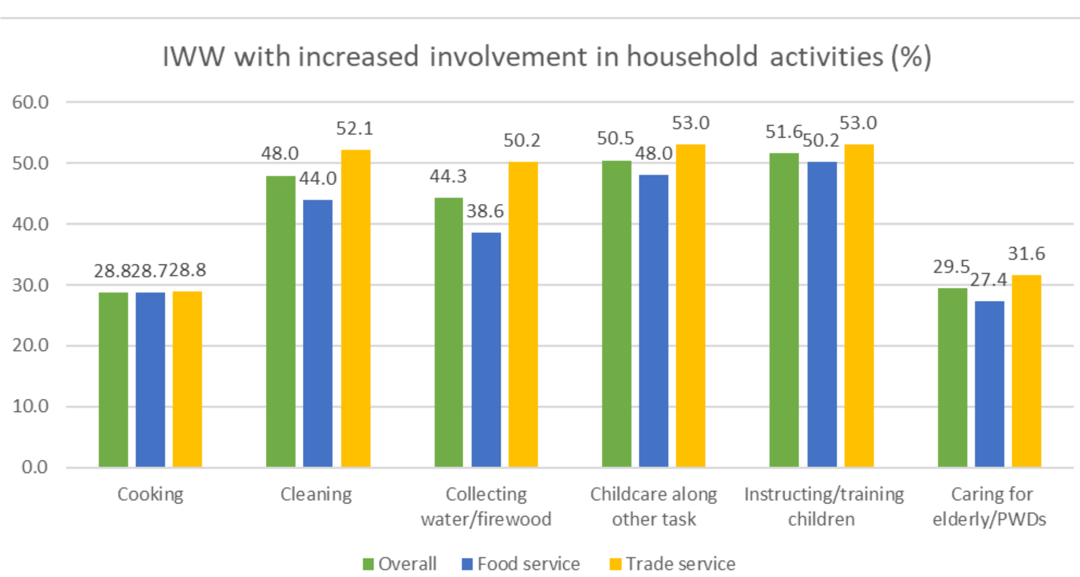
S/N	Category of KIIs Participants	Age	Target Gender of Participant
1.	**Key informants (men and women):** a) Rapid response team/COVID-19 Taskforce. b) National-level policy makers (social protection, GBV, SRH), c) Subject matter experts (social protection, GBV, SRH) d) Informal business owners (targeting those with a higher proportion of female workforce) e) CSOs (those engaged in social protection, GBV, and SRH initiatives) f) Researchers (who have undertaken surveys on the informal sector and women's economic empowerment) g) Women collectives h) Influential community leaders	18 years and above	Males and Females
2.	**Service providers to participate in KIIs:** a) GBV focal persons in health facilities and probation officers at the police stations. b) Community health volunteer/Village Health Teams, to capture frequently requested/ accessed SRH services. c) GBV hotline providers to capture information on cases of GBV reported during the pandemic. d) Coordinators of rescue centers or GBV shelters. e) SRH service providers in health facilities. f) Women's saving group leaders. g) Unregulated financial service providers (e.g., shylocks, FinTech). h) Essential service providers.	18 years and above	20%

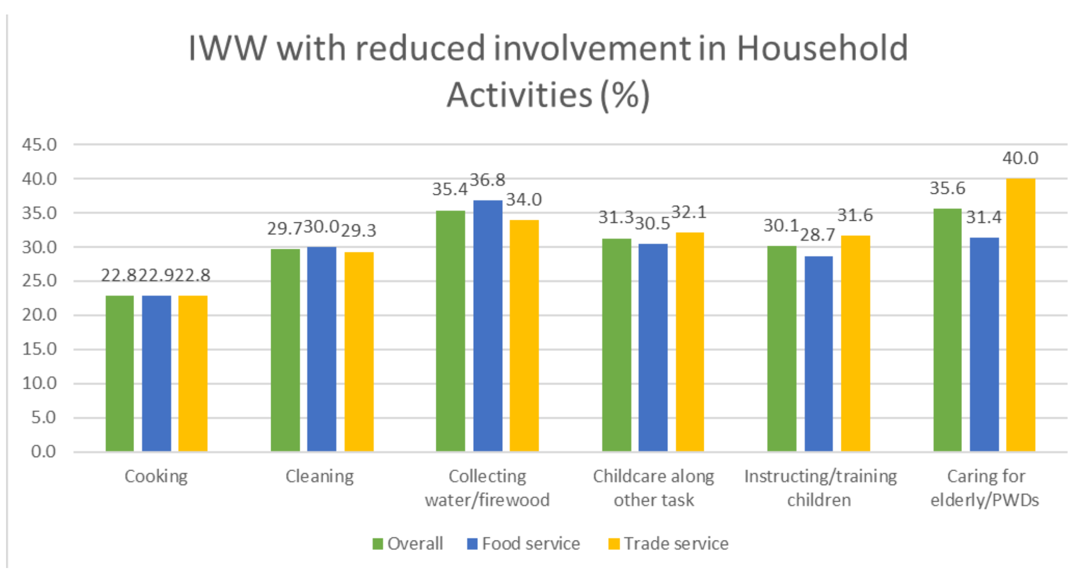
3.	Women in informal sector to participate in the IDIs: a) Women and young girls who were pregnant pre- and during COVID to establish their access to SRH/maternal, newborn, child, and adolescent health services. b) Women who accessed credit from unregulated financial institutions. c) Women with children aged below 10 years who were working in the selected service sub-sectors at the onset of COVID. d) Women working in the informal trading and food service sub-sectors who accessed social protection, mainly cash transfers. e) Young women and girls with diverse vulnerabilities e.g., living with disabilities/HIV engaged as street vendors, prostitutes where applicable.	18–70 years	Female
4.	Informal workers (men and women) to participate in the FGDs. a) Men-only groups b) Women-only groups These workers will be those who offer food-related services in informal food joints and those engaged in trade (markets, stalls, or as mobile vendors)	18–70 years	Male and Female

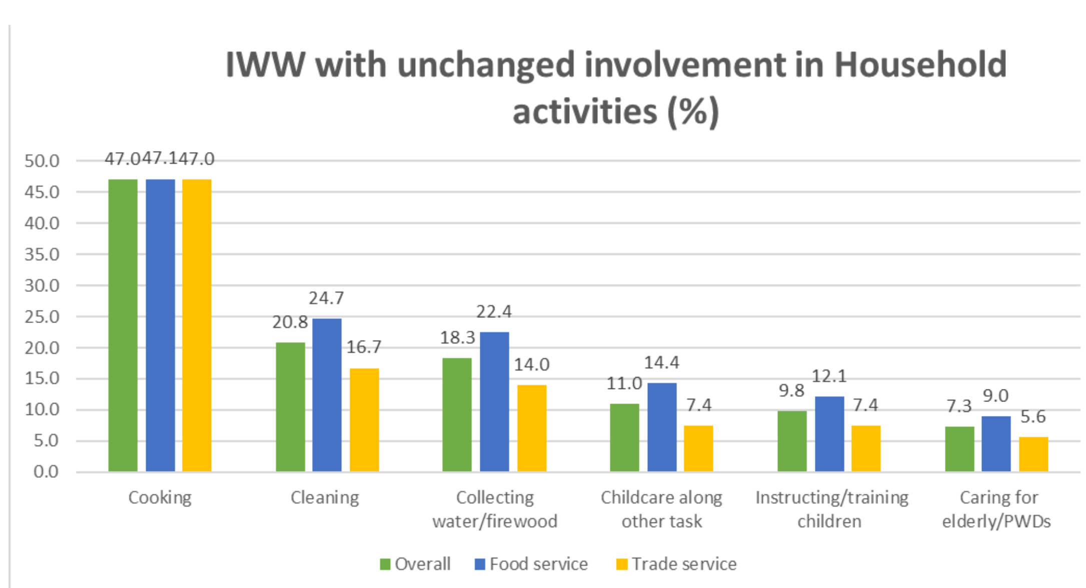
Annex A2: Socio-demographic Characteristics of the IWW

Characteristics (n=438)	Mean	Std Dev	Min	Max
Age of woman	37	10.2	18	70
Marital status				
Single	0.33	0.47	0	1
Married	0.52	0.50	0	1
Divorced	0.14	0.35	0	1
Occupation category				
Food service	0.51	0.50	0	1
Trading service	0.49	0.50	0	1
Education attainment				
No formal education	0.07	0.25	0	1
Primary	0.39	0.49	0	1
Secondary	0.44	0.50	0	1
Tertiary	0.10	0.30	0	1
Disability				
Some form of disability	0.02	0.15	0	1
Head of household	0.55	0.50	0	1
Household composition				
Living alone	0.06	0.23	0	1
Livng_children_0_5yrs	0.42	0.49	0	1
Living_children_6_17yrs	0.74	0.44	0	1
Living_adults_18_64yrs	0.69	0.46	0	1
Living_elderly_65yrs	0.01	0.12	0	1
No_child_5yrs_below	1.47	1.05	1	12
No_child_6_17yrs	2.08	1.42	1	13
No_adults_18_64yrs	2.50	4.49	1	42

Annex A3: Changes in IWWs' time allocation to household activities during the pandemic






IWW with unchanged involvement in Household activities (%)
50.0
45.0
40.0
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
47.0
47.1
47.0
20.8
24.7
16.7
18.3
22.4
14.0
11.0
14.4
7.4
9.8
12.1
7.4
7.3
9.0
5.6
Cooking
Cleaning
Collecting water/firewood
Childcare along other task
Instructing/training children
Caring for elderly/PWDs
Overall
Food service
Trade service

Woman retailer Toy Market - Nairobi

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