

# ACCELERATE RESEARCH REPORT

**Assessment of health facility readiness to provide sexual and reproductive health and gender-based violence services in four *Accelerate* learning counties: Findings from early intervention**



**January, 2023<sup>©</sup>**

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**Recommended Citation:** Njogu, J., Ndung’u L., Momanyi H., & Rothschild C.W (2023). Assessment of health facility readiness to provide sexual and reproductive health and gender-based violence services in four *Accelerate* learning counties: Findings from early intervention.

**Acknowledgement:** Julius Njogu (Principal investigator), designed the study, oversaw field implementation, conducted analysis, and wrote the report; Lydiah Ndung’u and Harmon Momanyi, oversaw field implementation and reviewed the report; Masila Syengo and Dr. Jerry Okal, supported qualitative data analysis; Claire Rothschild, provided technical oversight throughout the design phase, field implementation, analysis, and reporting. We also acknowledge members of field research team comprised of Brenda Mutio, Daniel Saidimu, Dorcas Metoyu, Eric Namiti, Evans Wambua, John Lokal, Linah Mukha, Linet Seyiano, Mohamed Magan, Mohamed Sabdow, Richard Njoro, Shafaa Mohamed, Tabitha Katimu, Titus Okendo and Yussuf Mohamed. Finally, we appreciate County Health Management Teams (CHMTs) in the four learning counties for their study support, and all participating health facility providers for their valuable insights.

**Attribution of support:** The Accelerate project is funded by the Danish Ministry of Foreign Affairs represented by the Embassy of Denmark in Kenya.

# Contents

<b>1.0 Introduction</b> .....	7
1.1 <i>Accelerate</i> Program.....	8
1.2 Research Significance.....	9
1.3 Learning Question.....	9
1.4 Research Objectives.....	9
<b>2.0 Methods</b> .....	9
<b>3.0 Results</b> .....	10
3.1 Sample Description – Health Facility Assessment.....	10
3.2 Availability of short-acting hormonal contraceptives.....	11
3.3 Availability of non-hormonal contraceptives.....	11
3.4 Availability of LARC.....	12
3.5 Availability of a range of contraceptives.....	12
3.6 Availability of contraceptive procedure services.....	13
3.7 Readiness to offer implant services.....	13
3.8 Reasons for not offering implant insertion service.....	14
3.9 Readiness to offer IUD services.....	14
3.10 Reasons for not offering IUD insertion service.....	15
3.11 Access to national FP guidelines and job-aids.....	15
3.12 Health worker exposure to FP training.....	16
3.13 SRH/GBV room and provision of routine GBV services.....	16
3.14 Readiness to offer medical services to survivors of sexual violence.....	17
3.15 Availability of testing services among facilities with a functional laboratory.....	17
3.16 Health worker exposure to GBV training.....	18
3.17 Availability of post-rape care form (MOH 363) among GBV offering facilities.....	18
3.18 Availability of SGBV register (MOH 365) among GBV offering facilities.....	19
3.19 SRH/GBV service integration.....	19
3.20 Access to integrated GBV/SRH guidelines and scorecard.....	21
3.21 Health facility exposure to supportive supervision.....	21
3.22 Sample Description – Facility chart review.....	22
3.23 Characteristics of survivors of sexual violence.....	22
3.24 Characteristics of aggressors of sexual violence.....	23
3.25 Characteristics of sexual violence.....	24
3.26 Reporting and care-seeking patterns following sexual violence.....	24
3.27 Completion of psychosocial assessment task.....	26
3.28 Administration of recommended emergency therapies.....	26

## List of Tables

Table 1: Health facility assessment sample size distribution by level county and by level of care .....	10
Table 2: Reasons for not offering implant insertion service on the day of the assessment (N=28).....	14
Table 3: Reasons for not offering IUD insertion service on the day of the assessment (N=52) .....	15
Table 4: Number of health facility charts extracted by level county and by level of care.....	22
Table 5: Demographic data of survivors of sexual violence among reviewed facility charts, by level of care	22
Table 6: Characteristics of sexual violence among reviewed facility charts, by level of care .....	24
Table 7: Reporting patterns among cases of sexual violence among cases presenting for medical care for the first time, by level of care .....	24
Table 8: Completion of psychosocial assessment among cases of SGBV managed in the last 6 months, by county .....	26
Table 9: Administration of emergency treatments among eligible SGBV cases managed in the last 6 months .....	26
Table 10: Conclusions and recommendations .....	27

## List of Figures

<i>Figure 1: Availability of short-acting methods during the day of the assessment, by county .....</i>	<i>11</i>
<i>Figure 2: Availability of non-hormonal methods during the day of the assessment, by county .....</i>	<i>11</i>
<i>Figure 3: Availability of LARC during the day of the assessment, by county .....</i>	<i>12</i>
<i>Figure 4: Availability of a range of contraceptives during the day of the assessment, by county .....</i>	<i>12</i>
<i>Figure 5: Availability of FP procedure services during the day of the assessment, by county .....</i>	<i>13</i>
<i>Figure 6: Availability of implant procedure service during the day of the assessment, by county .....</i>	<i>13</i>
<i>Figure 7: Availability of IUD procedure service during the day of the assessment, by county .....</i>	<i>14</i>
<i>Figure 8: Access to FP guidelines and job-aids on the day of the assessment, by county .....</i>	<i>15</i>
<i>Figure 9: At least one HF staff attended FP in-service training in the last 12 months, by county .....</i>	<i>16</i>
<i>Figure 10: Availability of a private SRH/GBV room and offering of routine GBV services, by county .....</i>	<i>16</i>
<i>Figure 11: Readiness to offer selected post-violence medical care, by level of care .....</i>	<i>17</i>
<i>Figure 12: Availability of testing services, among facilities with a functional laboratory on the day of the assessment, by level of care .....</i>	<i>17</i>
<i>Figure 13: At least one facility staff attended GBV training in the last 12 months, by county .....</i>	<i>18</i>
<i>Figure 14: Availability of PRC form/MOH 363 on the day of the assessment, among GBV offering facilities</i>	<i>18</i>
<i>Figure 15: Availability of SGBV register/MOH 365 on the day of the assessment, among GBV offering facilities .....</i>	<i>19</i>
<i>Figure 16: Extent of SRH/GBV service integration, among facilities offering GBV care (%) .....</i>	<i>19</i>
<i>Figure 17: Access to integrated GBV/SRH guidelines and scorecard on the day of the assessment, by county .....</i>	<i>21</i>

## List of Abbreviations and Acronyms

ASRH	Adolescent Sexual and Reproductive Health
AYFS	Adolescent and Youth Friendly Service
BCP	Basic Care Package
CBO	Community Based Organization
CHVs	Community Health Volunteers
CIP	Costed Implementation Plan
COC	Combined Oral Contraceptive
COE	Committee of Expert
DMPA IM	Intramuscular Depo Medroxyprogesterone Acetate
ECP	Emergency Contraceptive Pill
FP	Family Planning
GBV	Gender-Based Violence
GVRC	Gender-Based Violence Recovery Centre
HB	Heamoglobin
HF	Health Facility
HFA	Health Facility Assessment
HIV	Human Immunodeficiency Virus
HTPS	Harmful Traditional Practices
HVS	High Vaginal Swab
ICPD	International Conference on Population and Development
IDI	In-Depth Interview
IPV	Intimate Partner Violence
IUD	Intrauterine Device
KDHS	Kenya Demographic Health Survey
KNBS	Kenya National Bureau of Statistics
LARC	Long-Acting Reversible Contraception
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Questioning
MEC	Medical Eligibility Criteria
MCH	Maternal Child Health
MCPR	Modern Contraceptive Prevalence Rate
MII+	Method Information Index Plus
MOH	Ministry of Health
PEP	Post-Exposure Prophylaxis
PI	Principal Investigator

POP	Progestogen-only pill
PRC	Post Rape Care
PS Kenya	Population Services Kenya
PSI	Population Services International
PWDS	Persons With Disabilities
RE-AIM	Reach Effectiveness Adoption Implementation, and Maintenance
SBCC	Social and Behaviour Change Communication
SDP	Service Delivery Point
SGBV	Sexual Gender-Based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TOC	Theory of Change
TWGS	Technical Working Groups
VACS	Violence Against Children Study
VDRL	Venereal Disease Research Laboratory
WRA	Women of Reproductive Age

## 1.0 Introduction

Although Kenya has made great strides to increase uptake of family planning, including surpassing FP2020 target of 58% modern contraceptive use by married women (FP2020, no date), many women still have unmet need for contraception and disaggregated data by region show wide disparity with very low use in some of the regions/counties. Specifically, by 2014, almost a fifth (18%) of currently married women expressed unmet need for family planning services, including 9% in need of spacing and 8% in need of limiting (KNBS, 2014). Some of the counties reported very low use of modern contraception among married women, which was nearly five times less than the national estimate, for instance a prevalence of 2-6% in Mandera and Garissa, 11-13% in Marsabit and West Pokot, was also low in Samburu (20%), Baringo, Kilifi, Kwale and Narok (33-38%), and ranged between 44% in Elgeyo Marakwet and 54% in Nairobi (KNBS, 2014). Furthermore, while the national estimate shows nearly universal awareness of any method of family planning among married WRA (99%), only half of married women (50%) in Mandera were knowledgeable, 76% in West Pokot, and 87% in Garissa (KNBS, 2014).

Documented literature shows, multiple barriers hinder uptake of family planning services such as low awareness of FP methods (e.g., 50% among WRA in Mandera), religious and sociocultural factors including misconception and myths, and lack of spousal support. Furthermore, woman's decision to adopt a method or to continue using a method or even to switch method is influenced by multiple health system factors including continuous availability of contraceptive commodities; availability of a trained provider/equipment; sufficient counselling including all four pieces of information as defined by the method information index plus (MII+); provider bias and other negative behaviours, previous experiences at the service delivery point (SDP) including privacy, confidentiality and respect, out-of-pocket cost, distance to the SDP, among other reasons (PMA 2020a, 2020b; PS Kenya, 2020).

Similarly, multiple community-level factors preclude access to timely, quality, and affordable support and care services among many survivors of GBV including sexual violence. Some of the key impediments include lack of awareness of existing structures in the community and/or lack of functional support and care structures (Mwangi & Jaldesa, 2009; Muuo et al., 2020; Wangamati et al., 2019), fear of retaliation and abandonment given that in seeking for support services may end up revealing the perpetrator (Muuo et al., 2020). Gender based violence, such as rape, is faced with stigmatization which discourage women/girls from seeking services, as women expressed fear that their case and information may not be kept confidential (Muuo et al., 2020), and as such, in some settings, may limit girl's chance of getting married in the future (Mwangi & Jaldesa, 2009). Furthermore, deep-rooted sociocultural norms around the role of women in protecting marriage and family privacy have played a major role in limiting women's ability to utilize health care services. For instance, intimate partner violence (IPV) is widely regarded as a normal occurrence, thus the survivors do not see the need to seek for medical services (Ministry of Labour and Social Protection, 2019).

Additionally, a qualitative survey in Wajir county revealed that most of sexual violence is settled through the traditional methods, which are preferred because of compensation and punishment which range from buying clothes for inappropriate touching to stricter punishment for defilement (about 10 goats and KES 5,000), while rape for divorced women is not taken seriously (Mwangi & Jaldesa, 2009). Typically, the traditional arbitration systems, locally known as "Kangaroo courts", are convened by community traditional elders together with the male heads of household representing survivor and perpetrator (Handicap International, 2015). Given that women are not typically engaged in the traditional arbitration process they also do not receive the "cleansing" compensation. Furthermore, the situation is dire among household headed by a female, as is the case for many women and girls living with disability, as they do not get fair representation thus increasing their vulnerability to repeated abuse (Handicap International, 2015).

Research further suggests, while at the health facility, survivors of GBV face another set of obstacles that prevent them from receiving quality and timely services. Most health facilities, especially at lower levels such

as dispensaries, typically do not have required capacity to carry out comprehensive GBV management as they lack trained GBV providers e.g., for psycho-social support, lack prerequisite job aids and national guidelines (Wangamati et al., 2017), lack functional laboratory and basic examination equipment such as speculums and rape kits (Gatuguta et al., 2018), face unsteady supply of essential commodities for managing GBV such as ECs, PEP and STI prophylactic antibiotics (Otsola, 2012), and lack required rape register or Post Rape Care (PRC) forms (Mwangi & Jaldesa, 2009).

Moreover, studies have extensively documented issues around non-compliant health workers such as invoking unjustified requirements and other negative practices. For instance, it is not uncommon for providers to demand for police abstract before agreeing to attend to a survivor (PS Kenya, 2021). Another study revealed health workers do not always routinely screen for domestic violence even in situations where there are suggestive clues of violence, (Githui et al., 2018). Another recent study conducted in two referral hospitals (Thika and Naivasha), revealed that physical examination and laboratory findings are not always documented or when documented some of the clinical notes lacked precision given that they are too broad/general or uninformative (Gatuguta et al., 2018). Furthermore, the study reported that, a sizeable portion for sexual violence survivors who presented at these facilities were not managed according to the national recommendations, 30% did not receive HIV PEP, while prophylaxis for STI and EC was administered to 84% and 57% of the survivors, respectively (Gatuguta et al., 2018). Notably, a significant portion of SGBV survivors (estimated 30-50%) did not return for follow-up care given that healthcare facilities lack formal systems to ensure that they returned to complete their treatment (Gatuguta et al., 2018).

### 1.1 Accelerate Program

Population Services Kenya (PS Kenya) led consortium in partnership with Gender Based Violence and Recovery Centre (GVRC), and Population Services International (PSI) is implementing a five-year (2021-2025) Accelerate project funded by Danish government. Accelerate project is designed to contribute toward ICPD25 promises of zero unmet need for contraception, zero preventable maternal deaths and zero gender-based violence and harmful practices. Accelerate seeks to build on the milestones that Kenya has achieved towards the realization of true universal access to quality sexual and reproductive health services, prevention, and management of gender-based violence and reduction in harmful traditional practices. Accelerate is focused on 13 underserved, and hard-to-reach counties of West Pokot, Elgeyo Marakwet, Baringo, Narok, Kajiado, Samburu, Garissa, Mandera, Marsabit, Homabay, Kilifi, Kwale and Nairobi.

Among the Accelerate implementation activities are, strategies targeting adolescent /youth (girls) so that they have an opportunity to plan their lives without the risk of unplanned pregnancies, GBV and HTPs that infringe on their rights and dignity; strategies for reaching out to survivors of GBV (women, girls, and boys) to increase their awareness and remove physical, socio-cultural, and economic barriers to reporting abuse and accessing services; strategies that target across all groups of boys, men, girls, and women to shape their attitudes towards gender equality and to play a bigger role in protecting women and girls' rights; finally deliberate strategies reaching out to marginalized women and girls such as women of low socio-economic status, those living in hard-to-reach areas (including rural), marginalized groups (including LGBTQ+ & PWD) as they are often left behind in many SRHR and GBV programs.

Additionally, multiple health system investments are being implemented to strengthen local capacity for quality and integrated SRHR services, including linkage to auxiliary support services such as access to justice system. Among these are targeted service providers/health workers capacity building strategies including specific SRHR trainings such as adolescent and youth friendly services, service inclusivity to cater needs for marginalized populations like PWDs and LGBTQ+. Furthermore, service providers will receive comprehensive training related to GBV case management as per the MOH guidelines, including survivor clerking, management of specimen, administration of the policy recommended emergency treatments to prevent pregnancy, STI and HIV infections among SGBV survivors, counselling, and psychosocial therapy. Supported facilities will



further receive various SRHR job aids including recommended guidelines for the health workers, case management wall charts, and IEC materials. Finally, at the county level, the program will work closely with the health managers to strengthen SRHR programming, including accountability, stewardship, and ownership of SRHR/MCH and GBV interventions. Specifically, the program will support development of county specific costed implementation plan (CIP) for family planning, adoption of county specific SRHR/ GBV scorecards, support formation and operations of SRHR technical working group (TWGs) / committee of experts (COE), and implementation of joint support supervision.

## 1.2 Research Significance

Despite the key role of the health system in supporting uptake of SRH and GBV services, many health providers and facilities in Kenya remain under-resourced to deliver quality and integrated care. Moreover, dearth of evidence, at national and sub-national levels, limit ability monitor provision of quality and integrated SRH and GBV care services. Deeper understanding of current quality and availability of integrated SRH/GBV services is critical for identifying gaps and developing health systems-focused interventions that integrate global best practice and context-specific capacity.

## 1.3 Learning Question

This study was implemented to explore the following question for guiding *Accelerate* learning agenda and program adaptation.

- How can we remove facility-level constraints which hinder client's uptake of GBV services, including integration of GBV into routine SRH services?

## 1.4 Research Objectives

The objectives of this study were.

- Assess availability and quality of SRHR service provision among sampled health facilities
- Investigate nuanced barriers related to access to timely, quality, and integrated SRHR services including GBV

## 2.0 Methods

The study took place in four *Accelerate* counties including Kwale, Garissa, Narok, and West Pokot. These counties were purposively selected to represent a diversity of settings including region, religion, and cultural practices. We used a mixed method study to measure readiness to provider SRH/GBV care, including the following methodologies.

- A quantitative health facility assessment (HFA), using a census approach among 123 program-supported facilities, was administered to capture facility SRH/GBV service readiness data. The study collected information on the availability of FP commodities and sexual violence-related treatments, laboratory services, clinical guidelines, job aids, equipment, and privacy of consultation/examination room.

- Hospital chart reviews were completed among all 123 surveyed facilities to examine timeliness of care-seeking and quality of care provided to survivors of sexual violence. Charts were selected for extraction if the date of service was within the 6 months preceding the assessment; if more than 30 charts were available within that period, we selected the 30 charts with the most recent service date to reduce oversampling concerns among high caseload facilities. A structured data extraction form was deployed to capture survivors’ socio-demographic data, characteristics of the violence and the perpetrator, and administration of health services including examination, laboratory tests, treatments, and psychosocial support. Structured extraction forms were pre-tested prior to finalization. No individually identifiable data was collected during chart extraction.
- In-depth interviews (IDIs) were conducted with a total of 46 providers selected from 46 of the 123 facilities. Facilities participating in the qualitative component of the study were purposively sampled by facility level and public-private sector. In-depth interviews explored experiences related to medical management of sexual violence, services integration, perceived challenges and missed opportunities. In addition, providers described common processes of care delivery and service integration by describing patient journeys from entry to exit of the health facility.

In this report, we present findings from a first-round data collection, which represents the *Accelerate* program’s early implementation period, conducted between the months of July and September 2022. We provide descriptive summaries of SRH/GBV service readiness and quality of care provision for survivors of gender-based violence who accessed facility-based care.

## 3.0 Results

### 3.1 Sample Description – Health Facility Assessment

Of the 123 assessed health facilities assessed, the majority were dispensaries and clinics (70%), while health centres and hospitals accounted for a fifth (20%) and a tenth (11%) of the sample, respectively (Table 1).

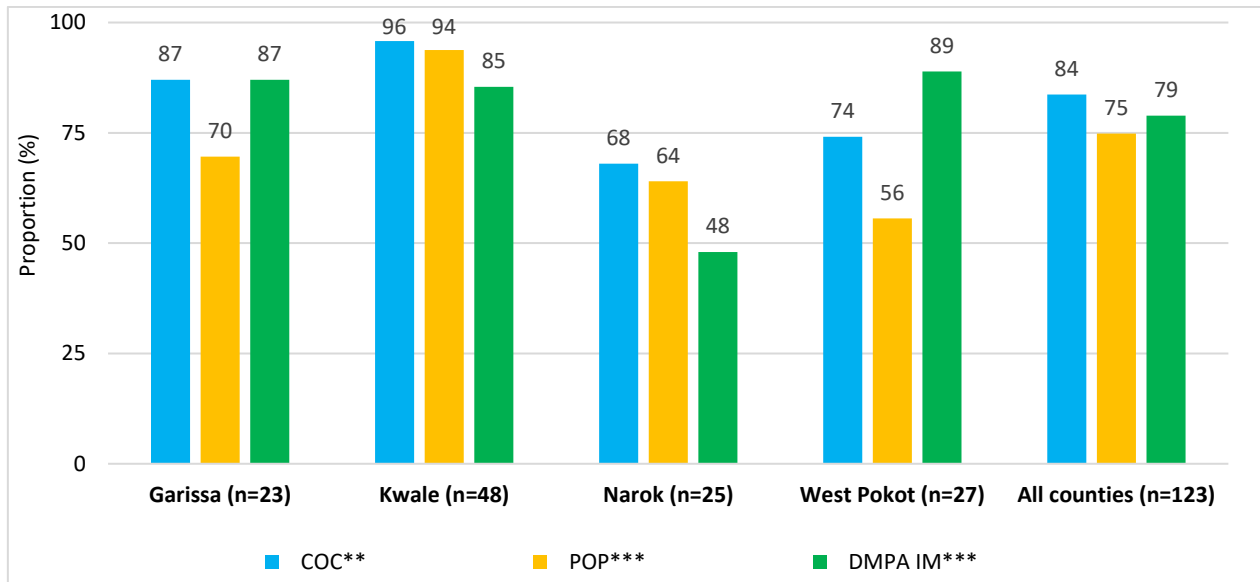
*Table 1: Health facility assessment sample size distribution by level county and by level of care*

Sample description	Garissa N=23		Kwale N=48		Narok N=25		West Pokot N=27		All counties N=123	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Level-of-care										
Dispensary/clinic	11	48	41	85	11	44	23	85	86	70
Health centre	8	35	4	8	10	40	2	7	24	20
Hospital	4	17	3	6	4	16	2	7	13	11

### 3.2 Availability of short-acting hormonal contraceptives

Overall, on the day of the assessment, there was relatively high availability of short-acting hormonal contraceptive methods ranging from 75% (POP), 79% (DMPA IM) to 84% (COC). However, availability differed significantly by county with highest availability among health facilities in Kwale (range: 85-94%) compared to Narok (range: 48-68%).

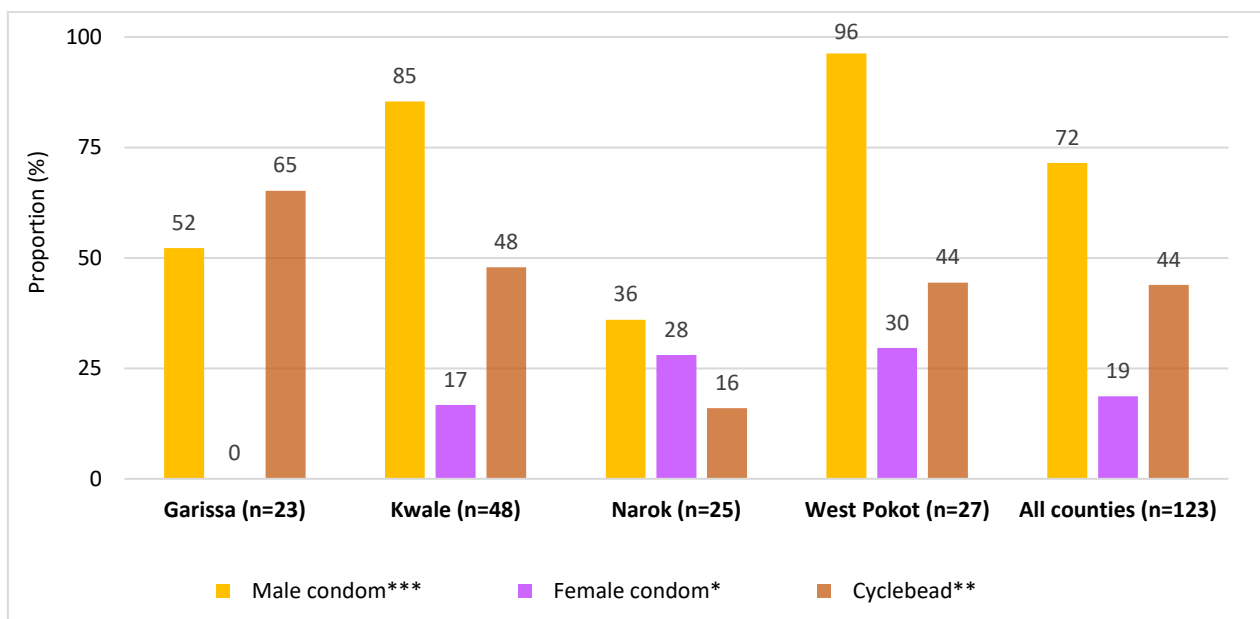
Figure 1: Availability of short-acting methods during the day of the assessment, by county



### 3.3 Availability of non-hormonal contraceptives

Overall, at the time of the assessment, stocking rates of different types of non-hormonal method ranged widely with the majority of facilities stocking male condom (72%) compared to Cycle beads (44%) and female condom (19%). County analysis showed health facility availability of male condom varied significantly from nearly universal, 96%, in West Pokot to just 36% in Narok.

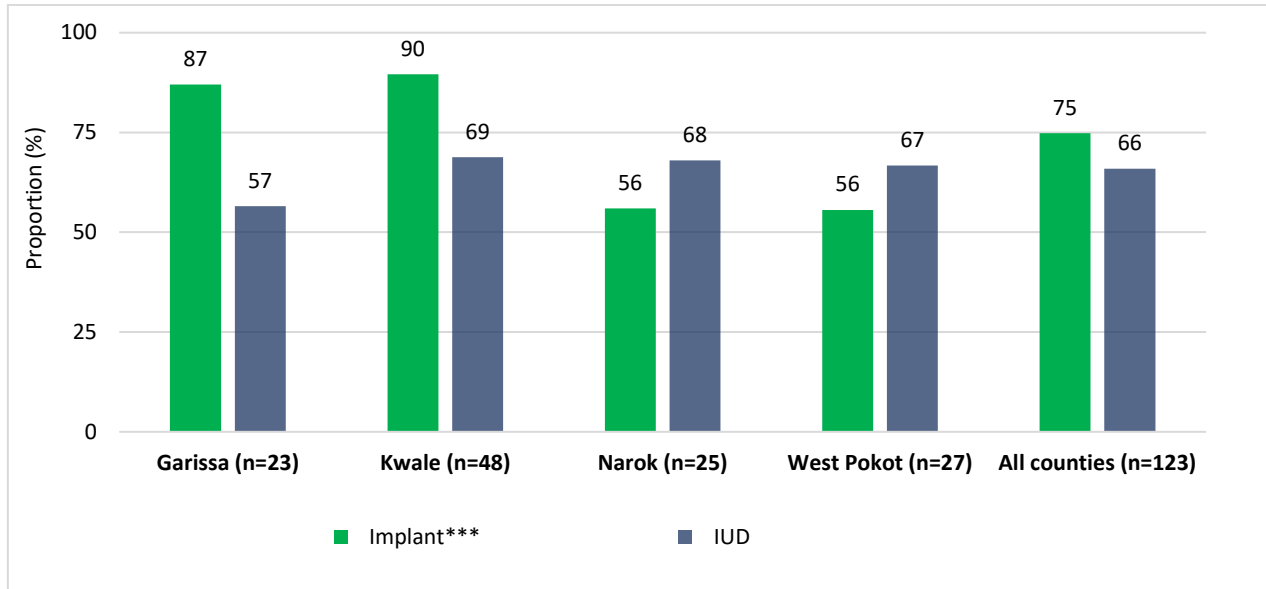
Figure 2: Availability of non-hormonal methods during the day of the assessment, by county



### 3.4 Availability of LARC

Overall, three-fourths and two-thirds of the facilities stocked implant and IUD on the day of the assessment, respectively. Across the counties, availability of implant differed significantly from 56% in Narok and West-Pokot to more than 85% in Garissa and Kwale. However, IUD availability was similar across all the counties (range: 57-69%).

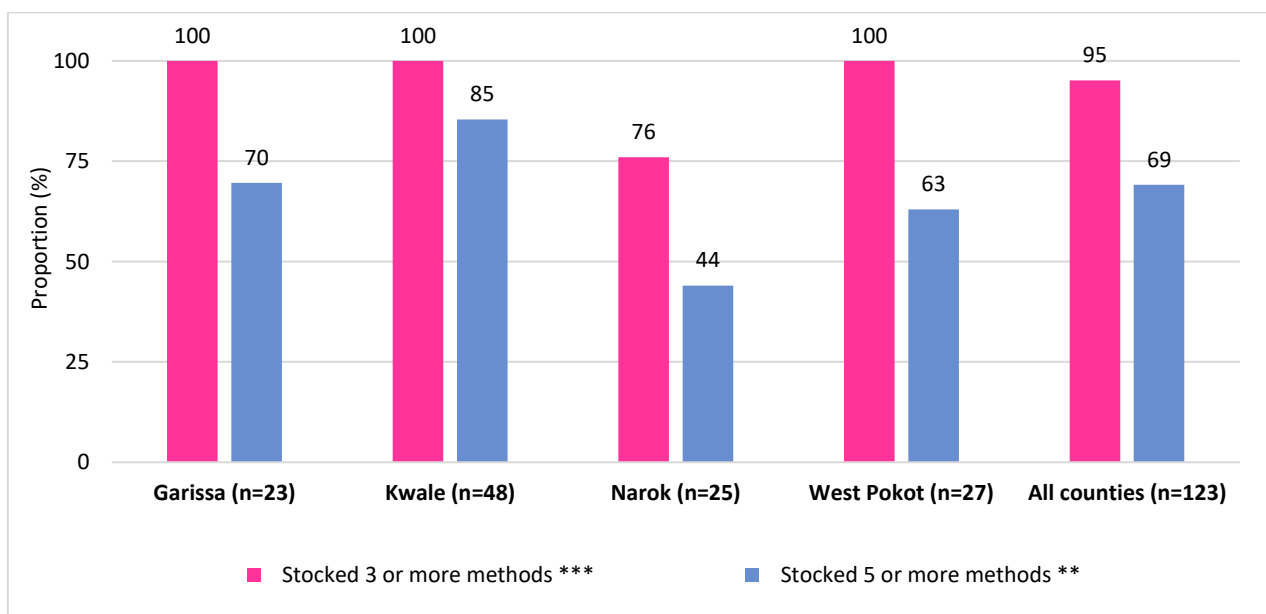
Figure 3: Availability of LARC during the day of the assessment, by county



### 3.5 Availability of a range of contraceptives

Overall, on the day of the assessment, 95% and 69% of facilities were found stocked 3 or more and 5 or more methods of contraception, respectively. County estimates showed higher proportion of facilities in Kwale (85%), and Garissa (70%) stocked 5 or more methods compared with 63% and 44% in West Pokot and Narok, respectively.

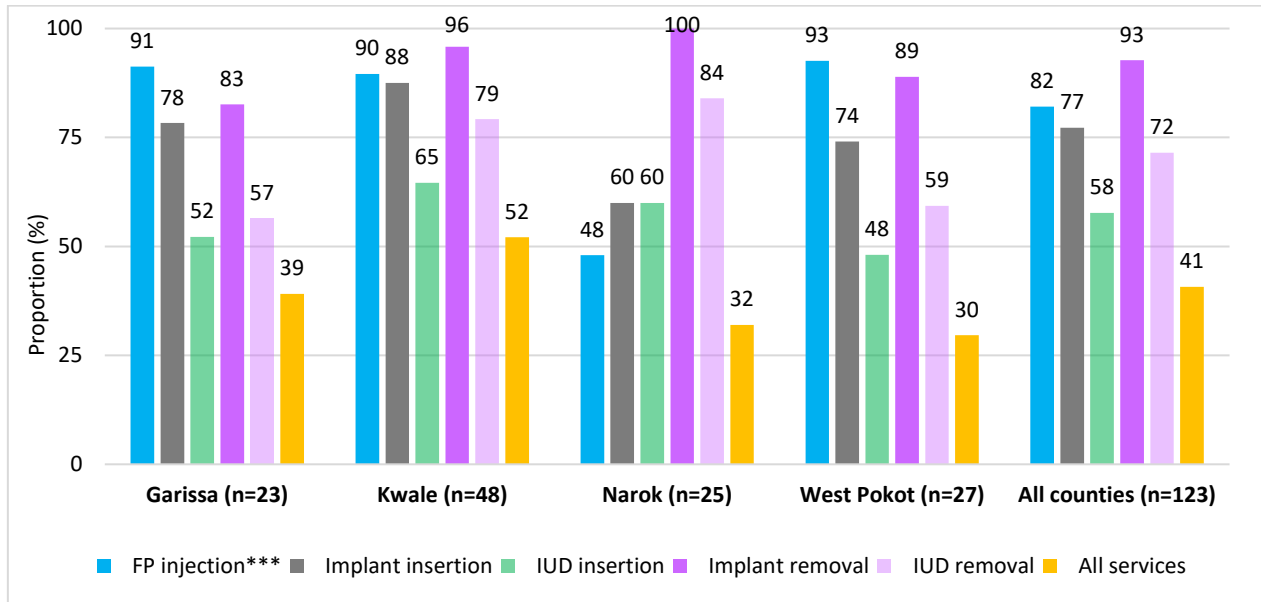
Figure 4: Availability of a range of contraceptives during the day of the assessment, by county



### 3.6 Availability of contraceptive procedure services

Overall, on the day of the assessment, offering of contraceptive procedures was relative higher for implant services (removal, 93%; insertion, 77%), compared with IUD services (removal, 72%; insertion, 58%). Offering of injectable FP service was high, 90% or more, across the counties, with exception of Narok (48%). Notably, offering of all contraception services, were concurrently offered in just 41% of the surveyed facilities (county range: 30-52%).

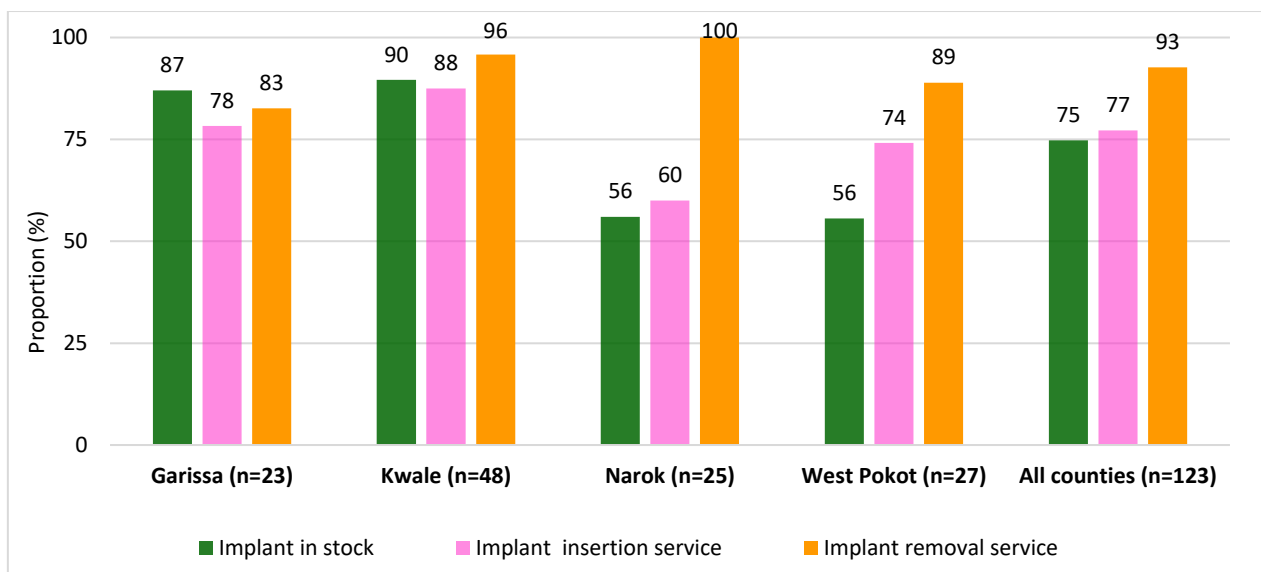
Figure 5: Availability of FP procedure services during the day of the assessment, by county



### 3.7 Readiness to offer implant services

Overall, three-fourths (77%) of facilities were found offering implant insertion service on the day of the assessment, while offering of removal service was nearly universal (93%). Across the counties, readiness to offer implant removal services was high (range: 83-100%), while readiness to offer ranged widely from just 60% of facilities in Narok to 88% in Kwale.

Figure 6: Availability of implant procedure service during the day of the assessment, by county



### 3.8 Reasons for not offering implant insertion service

Of the 28 facilities found not offering implant insertion services, the majority cited a reason of stockout (78%), followed by lack of functional equipment (25%) while only 8% of the facilities mention service provider insertion skill or the services was not routinely offered during the day of the assessment.

Table 2: Reasons for not offering implant insertion service on the day of the assessment (N=28)

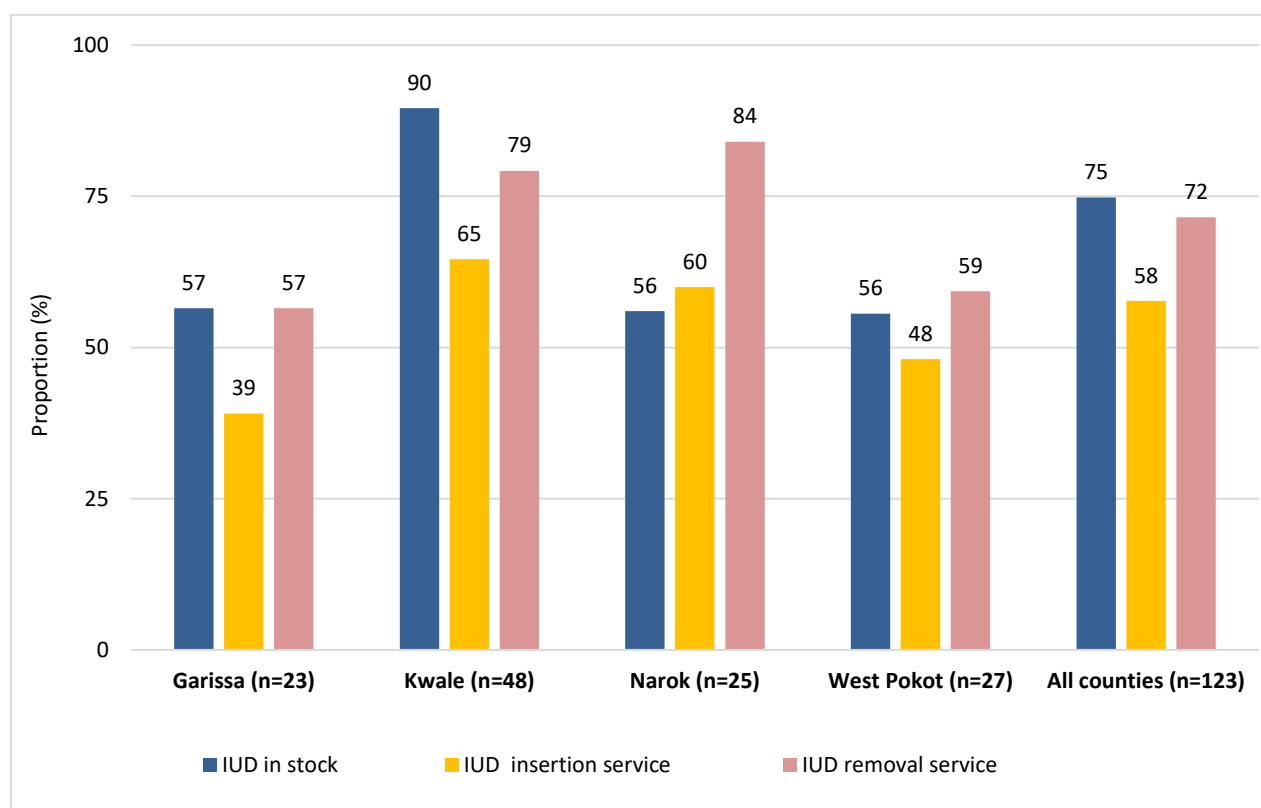
	Why facility was not offering implant insertion service* N=28	
	n	%
Product not available/stockout	22	78
Equipment not available/non-functional today	7	25
Trained provider not available today/lack confidence	1	4
Service not offered today	1	4

\*Percentage exceeds 100% due to mutually exclusive multiple responses

### 3.9 Readiness to offer IUD services

Overall, almost three-fourths (72%) of facilities were found offering IUD removal service on the day of the assessment, while 58% offered insertion service. Across the counties, readiness to offer IUD insertion service ranged from just 39% of facilities in Garissa, 48% in West Pokot to 60-65% in Kwale and Narok.

Figure 7: Availability of IUD procedure service during the day of the assessment, by county



### 3.10 Reasons for not offering IUD insertion service

Of the 52 facilities found not offering IUD insertion services, the majority cited a reason of stockout (56%), followed by lack of functional equipment (40%), lack of skill among service providers (19%) and 6% mentioned the services was not routinely offered during the day of the assessment.

Table 3: Reasons for not offering IUD insertion service on the day of the assessment (N=52)

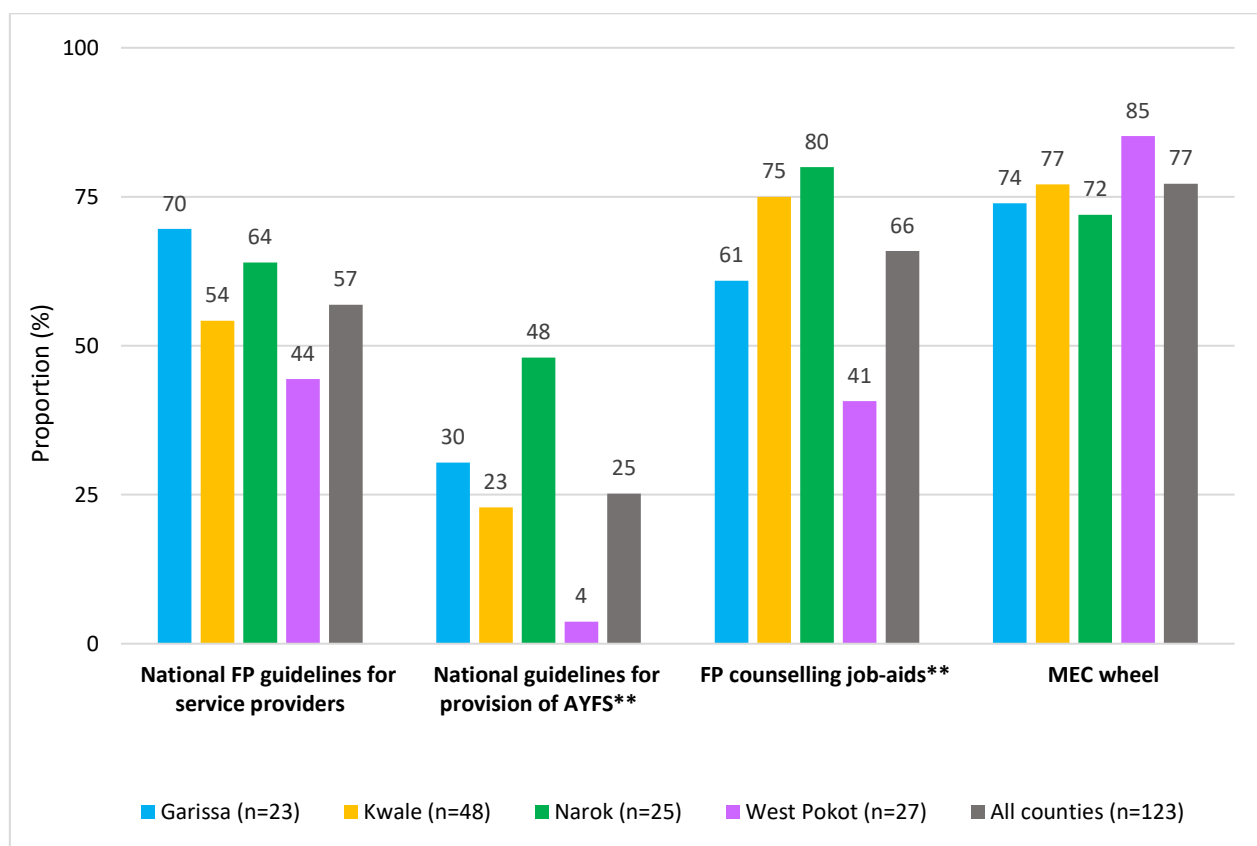
	Why facility was not offering IUD insertion service* N=52	
	n	%
Product not available/stockout	29	56
Equipment not available/non-functional today	21	40
Trained provider not available today/lack confidence	10	19
Service not offered today	3	6

\*Percentage exceeds 100% due to mutually exclusive multiple responses

### 3.11 Access to national FP guidelines and job-aids

Overall, the majority of facilities (77%) had contraceptive MEC wheel (county range 72-85%). Approximately two-thirds of facilities (66%) owned FP counselling job-aids (county range: 41-80%), while there was a lower ownership of national FP guidelines for service providers (57%) and guidelines for provision of AYFS (25%).

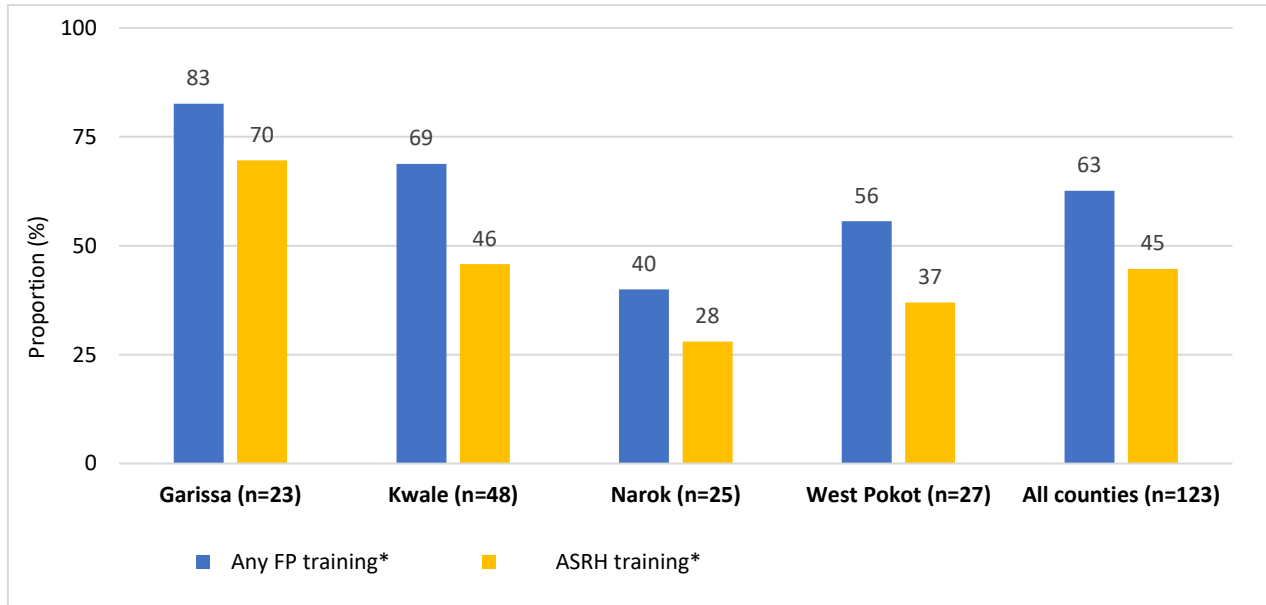
Figure 8: Access to FP guidelines and job-aids on the day of the assessment, by county



### 3.12 Health worker exposure to FP training

Overall, 63% of the facilities reported at least one of their staff had received any FP in-service training including OJT in the last 12 months preceding survey date (county range: 40-83%). Over the same period, fewer than one half of the facilities (45%) reported at least one of the staff was trained on ASRH (county range: 28-70%)

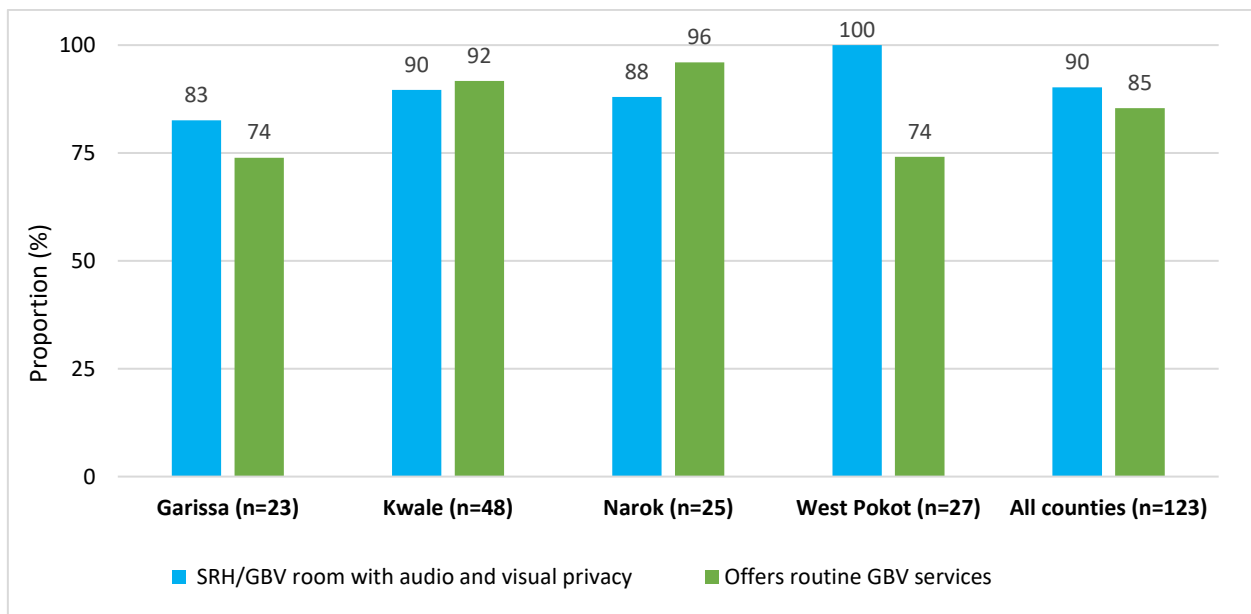
Figure 9: At least one HF staff attended FP in-service training in the last 12 months, by county



### 3.13 SRH/GBV room and provision of routine GBV services

Overall, the majority of facilities (90%) had a private room for managing SRH/GBV clients while maintaining audio and visual privacy. Similarly, most of the facilities (85%) reported offering routine GBV care and support services (county range: 74-96%).

Figure 10: Availability of a private SRH/GBV room and offering of routine GBV services, by county

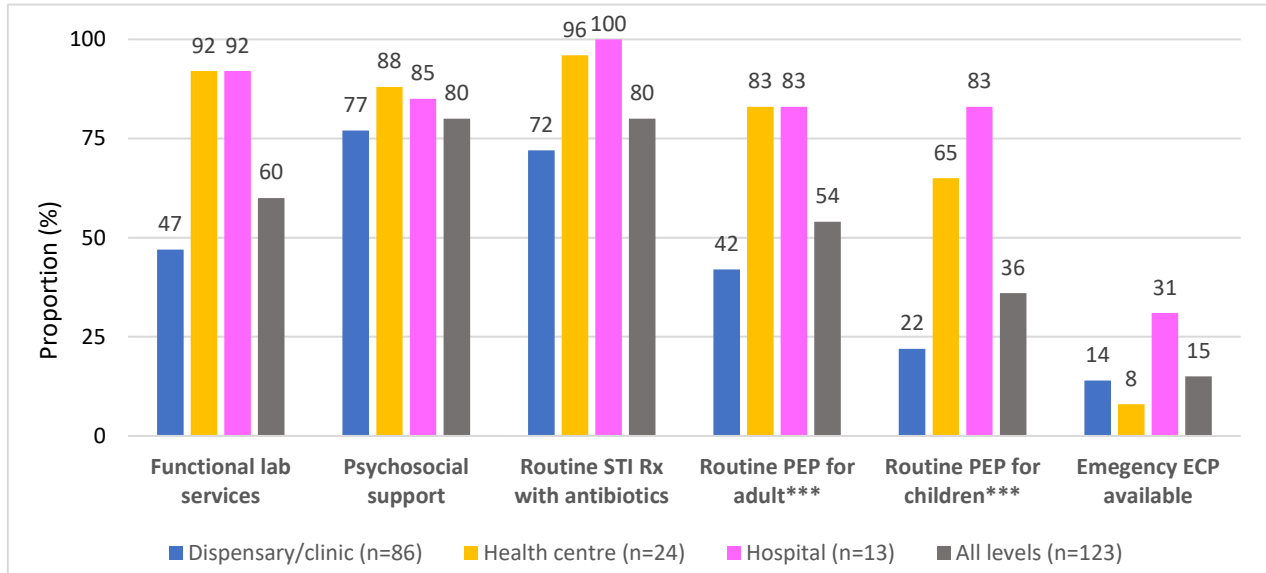




### 3.14 Readiness to offer medical services to survivors of sexual violence

Overall, a large majority of facilities reported offering post-violence psychosocial support (93%) and treatment for bacterial STIs (84%). Approximately two-thirds or 69% of the facilities were offering laboratory services, while offering of routine PEP treatment for HIV prevention was substantially lower (adult, 59% and children, 40%). Notably, ECP for pregnancy prevention was available in just 15% of the facilities at the time of data collection.

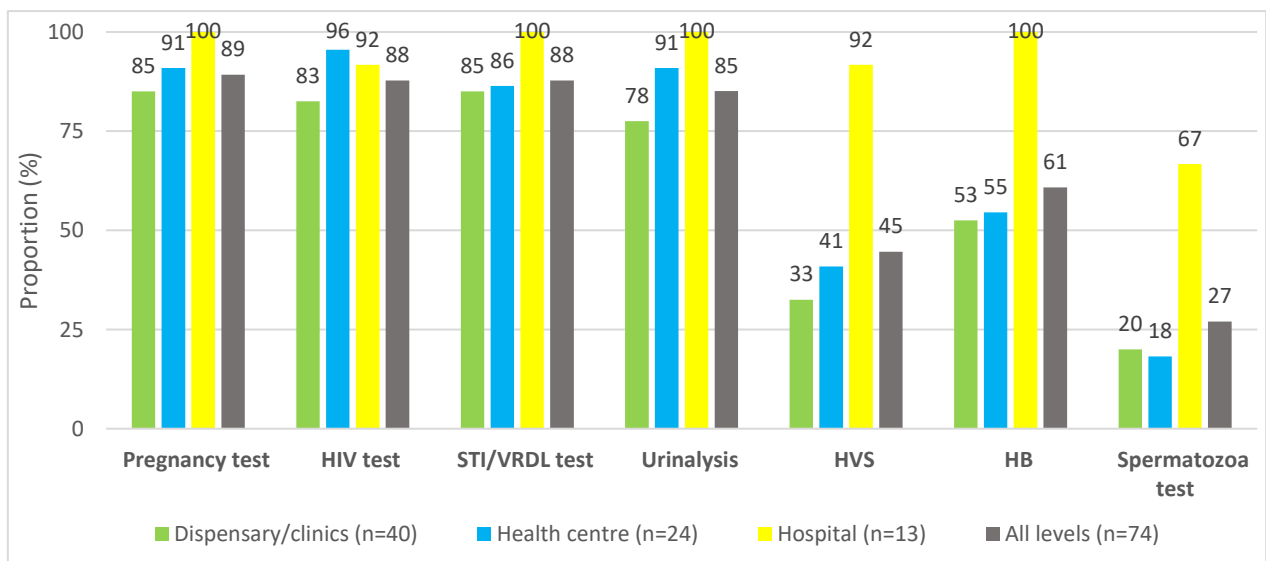
Figure 11: Readiness to offer selected post-violence medical care, by level of care



### 3.15 Availability of testing services among facilities with a functional laboratory

Across all levels of care, there was high offering of testing services for pregnancy, HIV, STI, and urinalysis on the day of the assessment (78%-100%). However, among the dispensaries and health centres there was lower offering of spermatozoa test (18-20%), high vaginal swab (HVS) test (33-41%) and hemoglobin (HB) test (53-55%) compared to hospitals (67-100%).

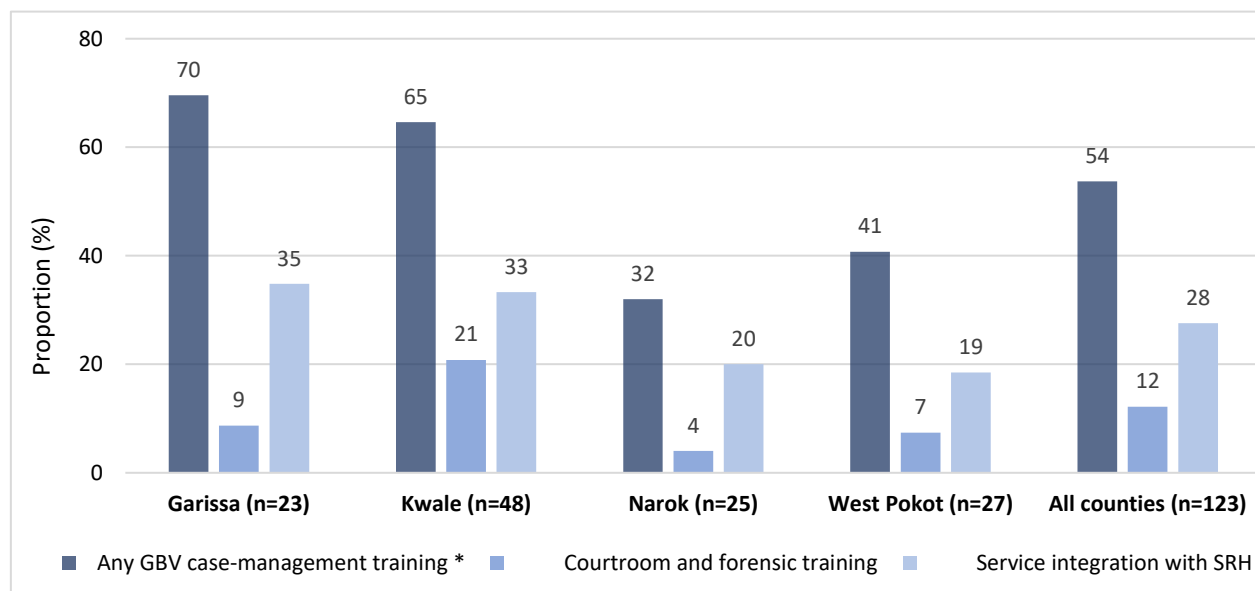
Figure 12: Availability of testing services, among facilities with a functional laboratory on the day of the assessment, by level of care



### 3.16 Health worker exposure to GBV training

Overall, in the last 12 months preceding survey date, one-half (54%) of the facilities had at least one of their staff attend any GBV in-service training including didactic workshops and on-the-job-training (OJT) (county range: 32-70%). Over the same period, facilities reported modest coverage of specific GBV training that included a component service integration (28%, county range: 19-35%) or courtroom/forensic skills (12%, county range: 4-21%).

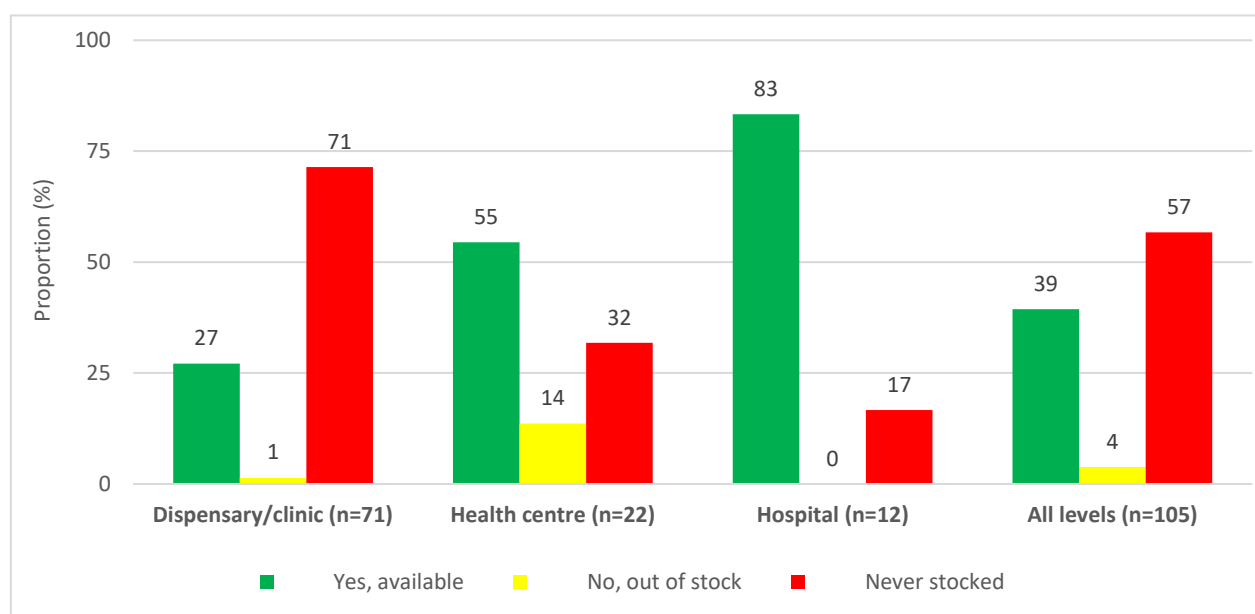
Figure 13: At least one facility staff attended GBV training in the last 12 months, by county



### 3.17 Availability of post-rape care form (MOH 363) among GBV offering facilities

Overall, just 39% of GBV offering facilities were found stocking PRC form during the day of the assessment with more than one-half (54%) of the facilities reporting never stocked them. While availability of PRC was high among hospitals (83%), fewer than one-third (27%) of dispensaries stocked these medico-legal forms.

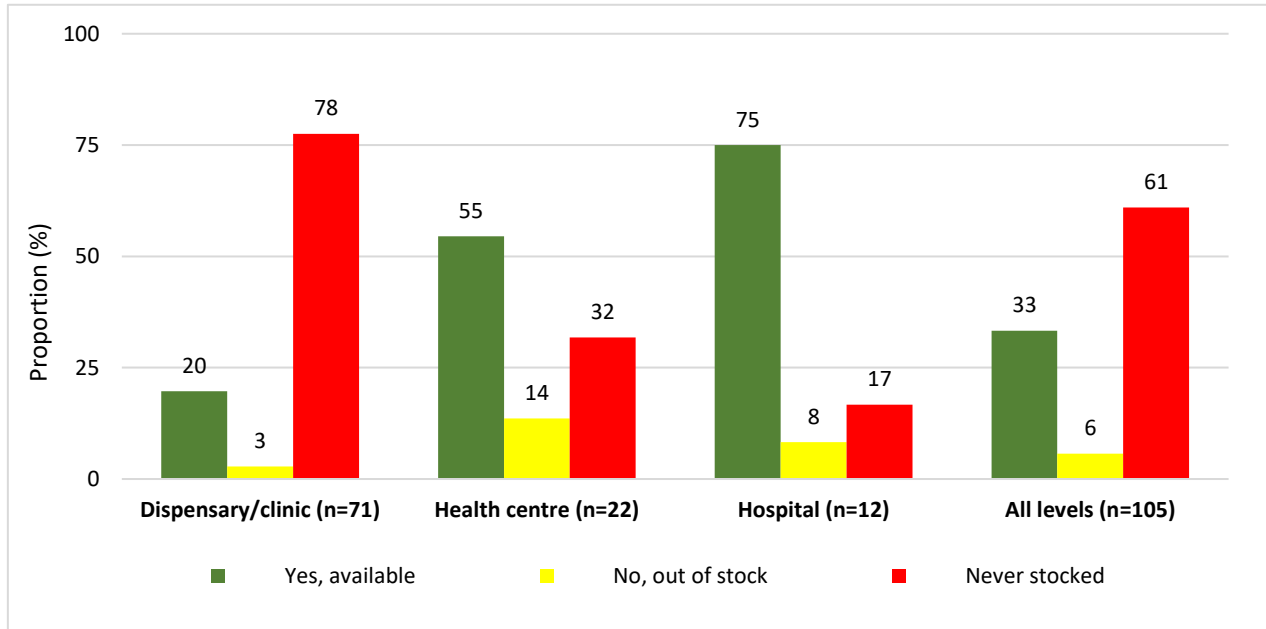
Figure 14: Availability of PRC form/MOH 363 on the day of the assessment, among GBV offering facilities



### 3.18 Availability of SGBV register (MOH 365) among GBV offering facilities

Overall, during the day of the assessment, only a third or 33% of GBV facilities had MOH approved sexual violence register, while 61% of the facilities reported that never stocked them. Of concern, 8 in 10 of dispensaries/clinics offering GBV services had never stocked MOH approved violence register (78%).

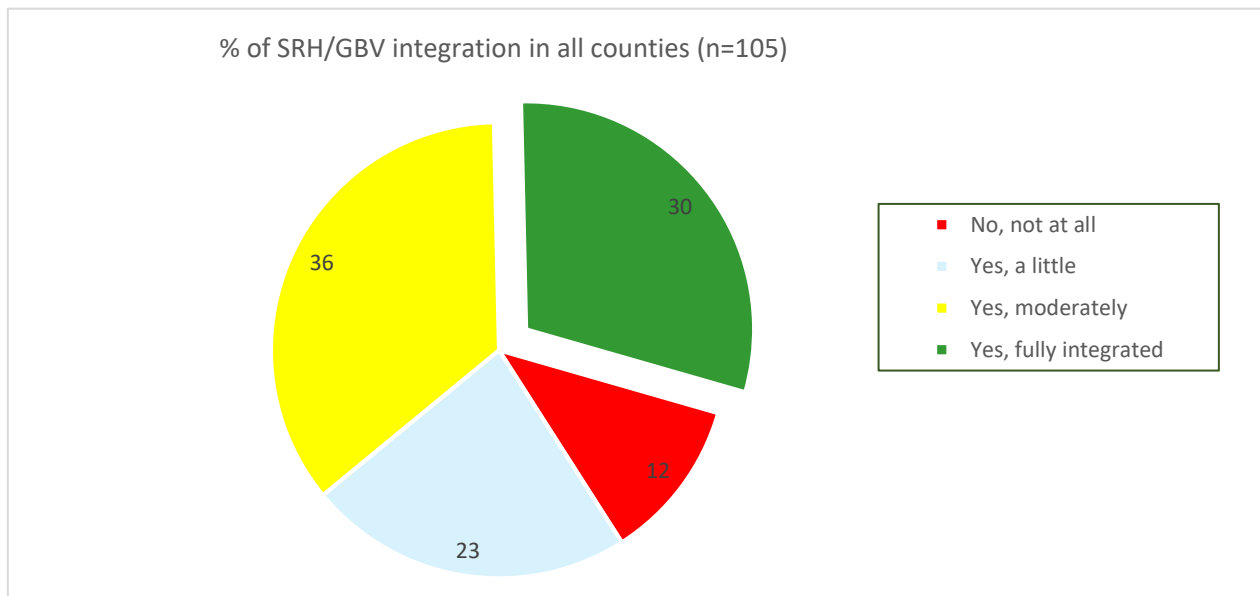
Figure 15: Availability of SGBV register/MOH 365 on the day of the assessment, among GBV offering facilities



### 3.19 SRH/GBV service integration

Overall, among GBV offering facilities, 30% reported services are fully integrated with SRH while 36% offered moderately integrated services. Approximately one-third of the facilities reported GBV services were either little integrated (23%) or not at all integrated (12%).

Figure 16: Extent of SRH/GBV service integration, among facilities offering GBV care (%)



Findings from qualitative interviews with health providers showed majority of providers embraced GBV/SRH service integration. However, across all the counties, majority of the facilities were not offering integrated services due to ongoing challenges including lack of supplies, equipment and reporting tools, lack of/inadequate infrastructure and space, inadequate staffing, and provider skills to handle GBV cases.

*“Lack of commodities, for example, urine strips, sometimes VRDL isn't available, most staff aren't trained, lack of reporting tools like PRC forms. There are also a few challenges associated with referral of clients because they have to use their own means because there is no ambulance. Cost is also a challenge” (West Pokot, Nurse 39)*

*“One is the knowledge gap, we need training. Number two we need the tools for the PEP, initially we used to stock here for PMCT mothers and emergencies, but of late we have not had such provisions, so all the cases we have to refer. If we get support from the MOH and supplies, then it would not be hard to integrate the services.” (West Pokot, Clinician 43)*

*“The biggest challenge I can say is enough trained staff. When we talk of GBV, it would be better if all the staff are trained well. I can also say, the services will move faster.” (Narok, Nurse 45)*

*“Integration efforts of course. First of all, is continuous trainings to staff, more health care workers should be sensitized and trained on GBV and how to tackle a victim and another thing is the tools should be available ..... Yeah, more staffs should be deployed to the facilities so that we can have ample time with them [clients] and at the sometime not hindering other services..... So those three things.” (Kwale Clinician 32)*

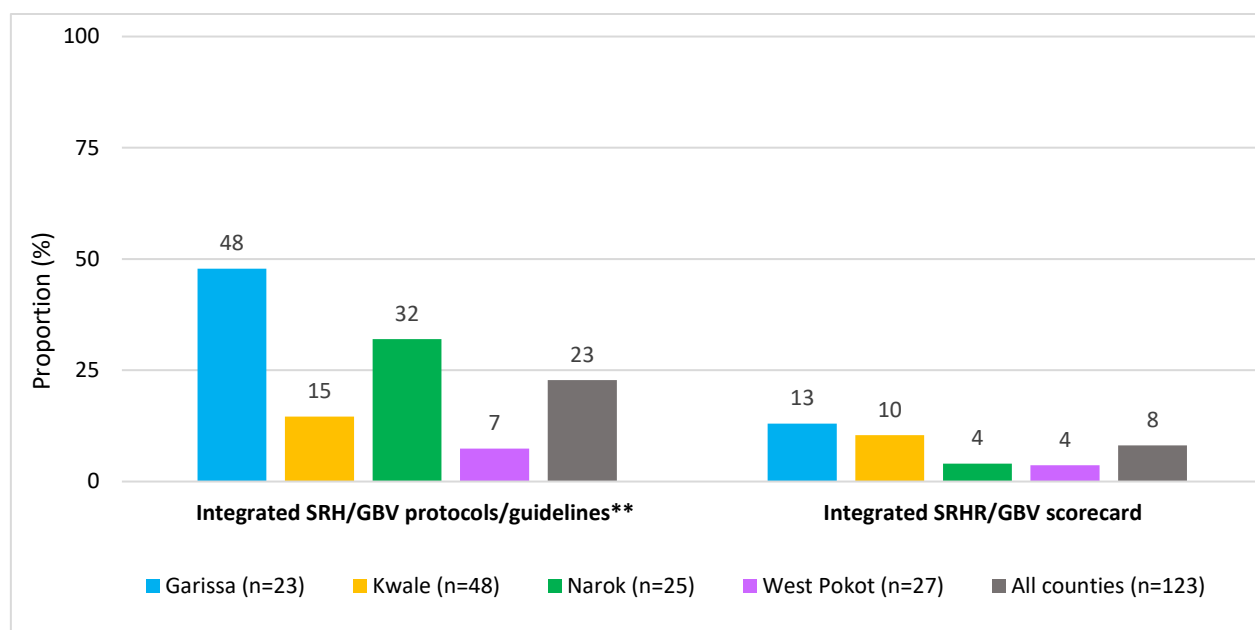
*“Staffing, yeah, we have limited staffs only two. We don't have the resources and those two staff are the ones with the skills to do all that, so we are not adequately trained most of us eenh. ....specifically, on GBV we don't have training. Like today if I'm told to do screening, I will do it what I learned in school but not current update...” (Garissa Nurse 45)*

*“Challenge is knowledge gaps, there is no training recently, actually we are waiting....” (Garissa Clinician 35)*

### 3.20 Access to integrated GBV/SRH guidelines and scorecard

Overall, at the time of the assessment, only 23% and 8% of the surveyed facilities possessed a copy of integrated GBV/SRH service guidelines and scorecard, respectively.

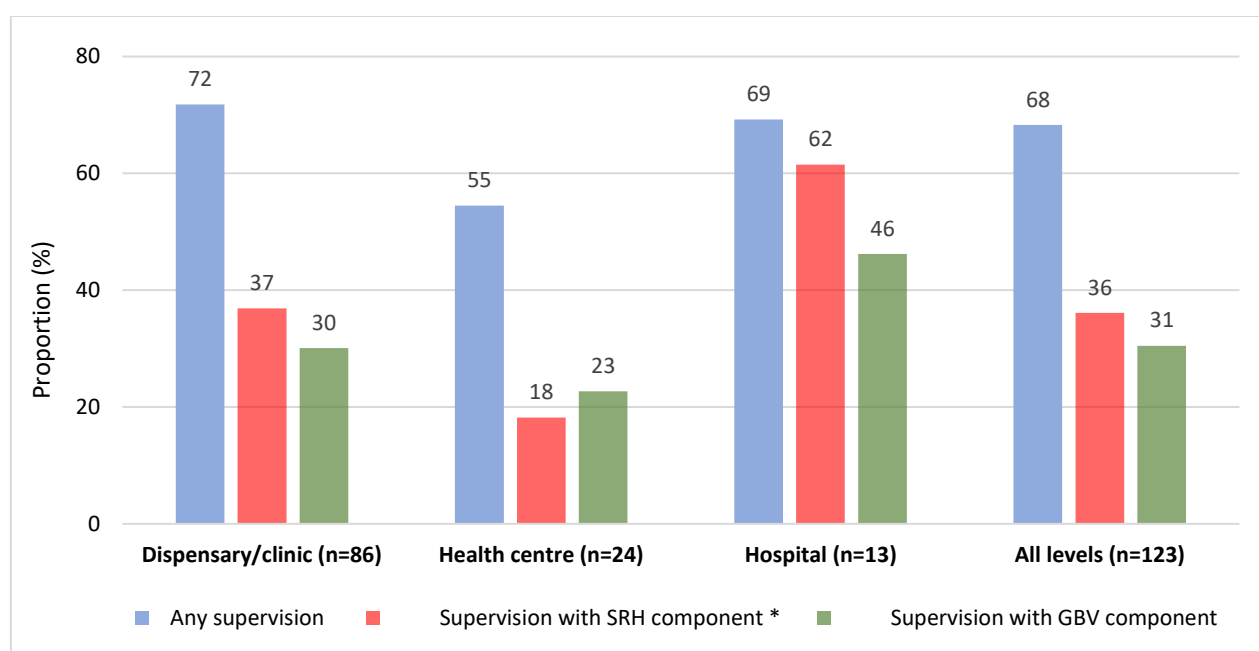
Figure 17: Access to integrated GBV/SRH guidelines and scorecard on the day of the assessment, by county



### 3.21 Health facility exposure to supportive supervision

Overall, two-thirds (68%) of the facilities had received supportive supervision of any kind in the past 3 months preceding the survey date. However, over the same period, just a third of facilities received a supervisory visit with a component of GBV (31%) and SRH (36%).

Figure 18: Health facility exposure to supportive supervision in the last quarter, by level of care



### 3.22 Sample Description – Facility chart review

Among all surveyed facilities, a total of 285 facility charts were reviewed for SGBV data extraction. Of these, 62% of the cases were extracted from hospitals while 27% and 11% were obtained from health centres and dispensaries/clinics, respectively. Across the counties, almost all reviewed cases were from hospital records (85-100%) with exception of Kwale county (49%) (Table 4).

Table 4: Number of health facility charts extracted by level county and by level of care

Level-of-care	Garissa N=33		Kwale N=175		Narok N=55		West Pokot N=22		All Counties N=285	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Dispensary/clinic	0	0	32	18	0	0	0	0	32	11
Health centre	0	0	58	33	17	31	1	5	76	27
Hospital	33	100	85	49	38	69	21	96	177	62

### 3.23 Characteristics of survivors of sexual violence

Of the 236 hospital chart reviews, most survivors of sexual violence were children aged less than 18 years (66%), females (97%), and unmarried individuals (84%).

Table 5: Demographic data of survivors of sexual violence among reviewed facility charts, by level of care

Survivor's demographics *	Level of care							
	Dispensary/ Clinic (N=88)		Health centre (N=37)		Hospital (N=111)		All facilities (N=236)	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Age in years								
<18	61	70.1	14	37.8	69	73.4	144	66.1
18 and above	26	29.9	23	62.2	25	26.6	74	33.9
Missing data	1		0		17		18	
Sex								
Female	84	96.6	37	100	108	97.3	229	97.4
Male	3	3.4	0	0.0	3	2.7	6	2.6
Missing data	1		0		0		1	
Marital status								
Single	71	83.5	27	73	90	88.2	188	83.9
Married	8	9.4	8	21.6	11	10.8	27	12.1
Divorced/Widowed/Separated	6	7.1	2	5.4	1	1.0	9	4.0
Missing data	3		0		9		12	

\*Percentages are calculated based on a denominator which excluded missing values

### 3.24 Characteristics of aggressors of sexual violence

When aggressor information was documented by the facility, 75% of aggressors were reportedly known to the survivors, with most known aggressors being either a current/former intimate partner (36%) or a neighbour (36%) with a smaller proportion being friends (6%) or relatives (6%).

Table 6: Characteristics of aggressors of SGBV among reviewed facility charts, by level of care

Aggressor information *	Level of care							
	Dispensary/ Clinic (N=88)		Health centre (N=37)		Hospital (N=111)		All facilities (N=236)	
	n	%	n	%	n	%	n	%
Known or unknown to survivor								
Known	45	69.2	21	56.8	74	87.1	140	74.9
Unknown	20	30.8	16	43.2	11	12.9	47	25.1
Missing data	23		0		26		49	
If known, relationship to survivor (N=140)								
Partner (current or former)	15	33.3	10	52.6	15	32.6	40	36.4
Neighbour	23	51.1	7	36.8	10	21.7	40	36.4
Friend	2	4.4	1	5.3	3	6.5	6	5.5
Relative	4	8.9	1	5.3	1	2.2	6	5.5
Other associations*	0	0	0	0	5	10.9	5	4.5
No association	1	2.2	0	0	12	26.1	13	11.8
Missing data	0		2		28		30	
Age in years								
<18	12	30.8	0	0	9	12.9	21	17.6
18 and above	18	46.2	10	100	50	71.4	78	65.5
Unknown	9	23.1	0	0	11	15.7	20	16.8
Missing data	49		27		41		117	
Number of aggressors								
1	30	69.8	10	83.3	84	93.3	124	85.5
2	3	7	1	8.3	5	5.6	9	6.2
3 or more	2	4.7	1	8.3	1	1.1	4	2.8
Missing data	45		25		21		91	

\*Percentages are calculated based on a denominator which excluded missing values

### 3.25 Characteristics of sexual violence

When nature of the violence was documented by the facility, a high proportion of violence involved penetrative sexual activity (vaginal, 68% and unspecified penetration, 24%). Of penetrative violence, condoms were reportedly used in just 12% of occurrences.

Table 6: Characteristics of sexual violence among reviewed facility charts, by level of care

Characteristics of the violence*	Level of care							
	Dispensary/ Clinic (N=88)		Health centre (N=37)		Hospital (N=111)		All facilities (N=236)	
	n	%	n	%	n	%	n	%
Type of violence								
Vaginal	36	41.4	33	89.2	86	81.9	155	67.7
Anal	0	0	1	2.7	2	1.9	3	1.3
Combined (vagina, anal or oral)	2	2.3	2	5.4	1	1	5	2.2
Unspecified penetration	44	50.6	0	0	10	9.5	54	23.6
Non-penetrative	5	5.7	1	2.7	6	5.7	12	5.2
Missing data	1		0		6		7	
If penetration violence, condom use was reported (N=217)								
Yes	2	6.1	1	9.1	11	14.5	14	11.7
No	30	90.9	9	81.8	59	77.6	98	81.7
Unknown	1	3	1	9.1	6	7.9	8	6.7
Missing data	49		25		23		97	

\*Percentages are calculated based on a denominator which excluded missing values

### 3.26 Reporting and care-seeking patterns following sexual violence

Of the documented data by the facility, most of the violence (93%) was already reported to the police before survivors presented at the current facility for healthcare services. Slightly over half of the survivors presented themselves for the first time for healthcare within the recommended 72-hour window period following sexual violence, with 31% and 28% presenting on the same day and 1-2 days post-violence, respectively.

Table 7: Reporting patterns among cases of sexual violence among cases presenting for medical care for the first time, by level of care

Reporting pattern	Level of care							
	Dispensary/ Clinic (N=88)		Health centre (N=37)		Hospital (N=111)		All facilities (N=236)	
	n	%	n	%	n	%	n	%
Violence reported to police before presenting at the current facility								
Yes	30	88.2	8	80.0	89	95.7	127	92.7
No	4	11.8	2	20.0	4	4.3	10	7.3
Missing data	54		27		18		99	
Duration between violence and care seeking								
Sought healthcare (n=216) *								
Same day	39	56.5	6	23.1	5	7.4	50	30.7
1-3 days	13	18.8	11	42.3	21	30.9	45	27.6
4-5 days	1	1.4	0	0	4	5.9	5	3.1
6 or more days	16	23.2	9	34.6	38	55.9	63	38.7
Missing data	14		11		28		53	

\*Percentages are calculated based on a denominator which excluded missing values



Findings from qualitative interviews with health providers revealed that a range of actions are taken by female survivors of gender-based violence. Most cases of violence are reportedly settled within the local context with the involvement of family member, village elders and other community systems including Kangaroo courts. Although, many cases of sexual violence are reported to chiefs and police stations fewer cases seek medical care at the health facilities. Providers reported that medical interventions are typically sought when violence is perceived to be serious, life-threatening, when is too late especially when it has resulted to pregnancy among young girls. Provider reported that some of the reasons that prevent prompt care-seeking include social norms which normalize violence, stigma and shame, preference to seek care at a larger facility or those located far, and lack of awareness regarding existing support resource centres.

*“Most of them run to the parents or wazee wa mtaa, (village elders) or the chief. Some who are enlightened come to the hospital or go to the police but in most cases, they go to the village chairman. Those who may be the young ones because they don’t want to say it, they just cool it down until you realize there is a pregnancy that’s when the parent can take action... When they go to the village chairman, they force the child to say who the pregnancy is. If they say they call that person, they do it underwater. It is just like that. That’s why you see a lot of teenage pregnancy here in Msambweni. There is what we call Kangaroo courts, they solve underground, they don’t bring to the hospital or the police.” (Kwale, Clinician 39)*

*“Sexual assault is there, but people don’t know when to seek for care, and, ah, whether it is their right, they stay in denial, with their problems, then there is the issue of ah, early pregnancies, early marriages” (West Pokot, Clinician 43)*

*“A few who are enlightened, are the ones who will start by seeking medical care. But the majority would want to seek justice first. Because, if you see, eeh, see, uh, the data that is collected from the facility, it is fewer compared with those who go to report to the gender-based violence desk at the police stations, or the cases that are reported to the chiefs.” (West Pokot, Clinician 43)*

*“In our community that is settled by our elders, religious leaders they settled or finished at the community level” (Garissa, Nurse 24)*

*“Mostly because of fear of society or the norms of the society they don’t come to get services, they don’t show up” (Garissa, Nurse 27)*

*“Clients are not coming for the services, so they go to the main hospital for those services” (Garissa, Nurse 45)*

*“No turnover, clients are not there but in case there are there we offered them we haven’t turn any clients who come for those services” (Garissa, Nurse 45)*

*“They report to the facility, I mean they report to law enforcement officer and police those things and in case they are really injured they seek for health services mostly done in the facility eenh” (Garissa, Nurse 45)*

*“R: Mostly they [SGBV survivors] go to the police station first, then the police send them here. Here we assess, we do medical examination, we give medication, we write a P3 form then it’s taken back. They get treatment and then the P3 forms are filled and then they go continue with the police.” (Narok Nurse 30)*

### 3.27 Completion of psychosocial assessment task

Of the cases with documented care, only 39% of the cases of sexual violence received psychosocial assessment. Of concern, there was a high frequency of providers failing to document whether psychosocial assessment was completed or not (151/285).

*Table 8: Completion of psychosocial assessment among cases of SGBV managed in the last 6 months, by county*

Psychosocial assessment*	County									
	Garissa N=33		Kwale N=175		Narok N=55		West Pokot N=22		All Counties N=285	
	n	%	n	%	n	%	n	%	n	%
Yes	2	6	37	60	13	35	0	0	52	39
No	31	94	25	40	24	65	2	100	82	61
Missing data	0		113		18		20		151	

\*Percentages are calculated based on a denominator which excluded missing values

### 3.28 Administration of recommended emergency therapies

Among the cases with documented care, approximately seven in ten survivors who sought health services for the first time and were eligible for emergency care received post-exposure prophylaxis (PEP) (71%), emergency contraception pill (ECP) (75%), and antibiotics to manage/prevent sexually transmitted infections (STIs) (79%).

*Table 9: Administration of emergency treatments among eligible SGBV cases managed in the last 6 months*

Administered treatment	Administered therapy among eligible cases*		
	ECP N=81	PEP N=102	Antibiotics against STIs N=105
	n (%)	n (%)	n (%)
Yes	42 (75)	54 (71)	59 (79)
No	14 (25)	22 (29)	16 (21)
Missing data	25	26	30

\*Percentages are calculated based on a denominator which excluded missing values

Qualitative findings showed that provision of recommended basic care package among survivors of sexual violence was impeded by lack of equipment, essential medical supplies, and provider skill. Insufficient readiness at the health facility often compelled providers to refer client elsewhere for essential laboratory diagnostic tests or to purchase prescribed therapies when faced with stockout. Providers also commonly reported they lacked capacity to offer post-trauma psychosocial counselling and support services. Furthermore, some of the providers expressed lack of clarity regarding existing referral systems raising a concern of effectiveness of linkage to care and support services.

*“For now, we don’t have the lab services here. If it is lab, here we just do like a physical examination let’s say, cos we don’t have lab services for the client, maybe PT [pregnancy test] .... only, because the sperm... is done in Narok [elsewhere].” (Narok, Nurse 30)*

*“We provide treatment. We offer emergency pills, combined estrogens progesterone oral contraceptive pills (COCs), although the patients usually go and buy, we prescribe. We have laboratory services, like urinalysis, testing for sexually transmitted infections, vaginal swabs, post-exposure prophylaxis, especially for rape cases, and we also refer for psychological services.” (Narok, Nurse 45)*

*“Maybe about the referral system, when you refer a patient, it should be clear where you refer the patient, because sometimes you are not sure where you are referring the patient to.” (Narok, Nurse 30)*

*“When a survivor of a rape case comes in. We attend to them, we attend them as an outpatient, and since we don’t have most of the medicines here, we mostly request the survivor to buy after prescription given by the doctor. You can see we have no room for special cases here and we don't send them away, we actually attend them with the ones we have as they get what's needed.” (Narok Nurse 28)*

*“Lack of commodities, pharmacy the drugs, the investigations aspect even items to used take sample might not available sometimes .....” (Garissa, Clinician 33)*

## 4.0 Conclusions and recommendations

The presented data from Round 1 of learning agenda studies indicated several important gaps in the efforts to increase health facility and provider readiness to offer quality and integrated SRH/GBV services. In table 10, we provide of a summary of recommendations to help address the identified gaps.

*Table 10: Conclusions and recommendations*

Conclusions	Recommendations
<ul style="list-style-type: none"> <li>❖ Overall, 95% and 69% of facilities stocked 3 or more methods and 5 or more methods, respectively.</li> <li>❖ Only 1 in 4 facilities (41%) could offer all procedure services concurrently (IUD, implant and injectable) at the time of assessment. Among all services, IUD service reported the lowest readiness (48%, insertion, and 59%, removal), due to product stock-out, lack of equipment and provider skill.</li> <li>❖ Moderate proportion of service providers recently attended any FP training. Sixty-three percent and 45% of the facilities had at least one staff receive any FP and ASRH training in the last 12 months, respectively.</li> </ul>	<ul style="list-style-type: none"> <li>• Accelerate should strategically support program counties to ensure FP commodity security by strengthening commodity monitoring, forecast, ordering, and supply systems.</li> <li>• Deliberate efforts should be made to increase coverage of FP related training and specifically capacity build health workers with skills related to offering of LARC and youth-friendly contraceptive services. Importantly, these initiatives should be complemented with on-going support to ensure skill proficiency and retention, and values clarification, particularly, among health workers serving in smaller or remote health facilities.</li> </ul>
<ul style="list-style-type: none"> <li>❖ Majority of facilities have a dedicated GBV/SRH room for client privacy (85%), reported offering of routine GBV services and treatment for bacterial STIs (80%-100%).</li> <li>❖ We observed sub-optimal readiness to offer emergency PEP therapy for different age groups (40-59%), and very low availability of ECP (15%). In addition, there was low offering capacity for essential laboratory services to a GBV survivor among health centres and dispensaries. Among the reviewed cases, 1 in 5 survivors who were eligible for emergency care</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthen capacity to offer an essential basic care package (BCP) as stipulated by the national guidelines across all levels of care. Among the most urgently needed support, particularly from level 3 and below, include expanding capacity to offer quality psychosocial support, PEP and ECP therapies, laboratory testing services, and care documentation and reporting.</li> </ul>

left the facility without PEP therapy, STI treatment and ECP.

- ❖ Approximately, 1 in 3 GBV offering facilities stocked MOH approved SGBV reporting tools, including PRC form (39%) and SGBV register (33%).

- ❖ Only, a third or 30% of facilities reported fully integrated GBV/SRH services.

- ❖ There was a moderate proportion of service providers who recently attended a GBV training - including 54% of facilities who had at least one of the staff receive any GBV training, service integration (28%) and courtroom/forensic skill training (12%) the last 12 months.

- ❖ Slightly over half of the survivors presented themselves for the first time for healthcare within the recommended 72-hour window period following sexual violence, with a third (31%) presenting on the same day and 28% 1-2 days post-violence.

- Provide on-going support across all levels of care to facilitate GBV/SRH services integration. Among the support required will include extending coverage of GBV related trainings and regular supportive supervision to capacity build more health workers to effectively manage GBV cases, including all process related to clinical examination, documentation, specimen management and other forensic skills, and psychosocial support.

- Investments to increase laboratory capacity to offer essential diagnostic services as well as PEP services to SGBV survivors are needed particularly among dispensary and clinics.

- Novel SBCC strategies should be explored to mainstream GBV reporting and care-seeking practices by the communities. Such strategies should deliberately harness collaboration among all grassroots stakeholders and community gatekeepers including police, chiefs, teachers, cultural leaders, religious leaders, and local health workers to create awareness about existing local resources, to streamline referral and linkage processes to care, and advocate for timely access to medical treatment for GBV survivors. Empowering communities through local structures such as CBOs and CHVs among other stakeholders such as women leaders with basic GBV management and para-legal skills may be potential solution.

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