

## 904. Gender and Sexuality Based Violence

### **Do survivors of sexual violence access timely and quality medical care in Kenya? A mixed methods study.**

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#### **Short Abstract (150/150 words)**

**Background:** In many low- and middle-income country settings, detailed data on the quality and pathways of facility-based sexual gender-based violence (SGBV) care is sparse, hindering health systems improvements.

**Methods:** We report results from first round of an ongoing mixed methods study to assess quality of sexual and reproductive health, including SGBV, services in public and private health facilities in four Kenyan counties. Health facility assessments included provider interviews, direct facility observations, and structured chart review.

**Results:** Among 123 facilities, availability of functional laboratory services ranged from half among dispensaries (47%, n=40/86) to 92% among hospitals (n=12/13). Few facilities stocked emergency contraceptive pills (15%). Eighty percent of facilities offered psychosocial support. About 60% of survivors arrived on time to be eligible for emergency therapies.

**Discussion:** Although all levels of the Kenyan health system are expected to offer an essential package of SGBV services, we observed steep gradients in service readiness across levels of the healthcare.

## Extended Abstract

### 1. Significance/background

Globally, an estimated one-in-three women have experienced either physical or sexual violence in their lifetimes (WHO, 2013). Health systems approaches are essential for providing coordinated, timely, comprehensive, and effective medical care and treatment for survivors of gender-based violence (GBV), and for effectively linking survivors with non-clinical resources. Healthcare workers are well-placed to act as first responders in identification of survivors and delivering integrated medical care, and are often also best positioned to connect survivors to a constellation of non-medical services such as psychosocial support and legal aid (Ashford & Feldman-Jacobs, 2010; García-Moreno et al., 2015).

Enabling healthcare providers to be effective in a care coordination role requires the support of health systems, including definition of a basic package of essential GBV services provided by health facilities; pragmatic approaches to GBV screening and active case identification; adequate and ongoing training and supervision supported by clinical protocols; availability of essential clinical supplies, commodities, equipment, and infrastructure; existence of non-clinical resources and straightforward referral pathways; and documentation and routinized monitoring and evaluation for adaptive management, quality improvement, and evidence-based decision making at national and subnational levels (WHO, 2017). Despite the key role of the health system in supporting survivors of GBV, many health providers and facilities in low- and middle-income country (LMIC) settings remain under-resourced to deliver effective GBV care (García-Moreno et al., 2015; Kirk et al., 2017; Sikder et al., 2021). Deeper understanding of care pathways and the current quality and availability of GBV services within LMIC health systems is critical for identifying gaps and developing health systems-focused interventions that integrate global best practice and context-specific capacity.

In Kenya, national clinical guidelines recommend administration of time-sensitive therapies following sexual violence to prevent pregnancy, HIV, and other sexually transmitted infections (STIs), and including psychosocial support, forensic medical examination, and specimen collection. Previous studies suggest many survivors do not readily access post-violence support services, and when they do they present late or may end up receiving inadequate quality health services (Barnett et al., 2016; Shako & Kalsi, 2019; Wangamati et al., 2016). While there is a dearth of published data on the quality of care provided to survivors of sexual violence in Kenya, a recent study in two public referral hospitals revealed major gaps in sexual violence case management, including failures to provide treatments to prevent pregnancy, HIV and other STIs and inadequate clinical examination and documentation of care process, including findings of the requested laboratory tests (Gatuguta et al., 2018).

The five-year “Accelerate” program, led by Population Services Kenya and Gender Violence Recovery Centre with research and monitoring and evaluation support provided by Population Services International, is currently being implemented across 13 underserved counties in Kenya. The Accelerate program aims to improve sexual health and wellbeing, including through the provision of improved sexual and reproductive health and rights (SRHR), through supply- and demand-side interventions. On the supply-side, Accelerate partners with public and private health facilities to strengthen service readiness to deliver high-quality, integrated SRHR and GBV care. On the demand-side, Accelerate is conducting a range of social and behavior change activities aimed to shift individual attitudes and social and community norms related to SRHR and GBV among women, male partners, and community leaders.

There have been recent developments geared at improving health system response to GBV at the national level. First, in June 2022, the Ministry of Health (MOH) launched a series of new policy

documents and reporting tools related to SRHR service delivery(MOH, n.d.). Among the reporting tools include a new national GBV register which was revised to not only capture sexual violence data but to also integrate reporting of all forms of violence including intimate partner violence (IPV), physical violence and harmful traditions such as female genital cutting (FGC). Secondly, following revised policies, a national cascaded in-service GBV training for the health workers was conducted starting with trainer of trainers (TOT) participants drawn across all the counties. Trained participants are expected to further cascade the training in their respective counties.

In this paper, we report findings from a first round of health facility assessments conducted within all Accelerate-supported facilities in four counties. This first round of data collection represents the Accelerate program's early implementation period. We provide descriptive summaries of service readiness and quality of care provision for survivors of gender-based violence accessing facility-based care.

## **2. Main question/hypothesis**

Our aim was to determine timeliness, quality of care, facility readiness and provider knowledge and capacity to deliver an essential package of SGBV health services provided by public and private health facilities. We present descriptive comparisons of service readiness and quality across all levels of the Kenyan healthcare system.

## **3. Methodology**

We used data collected as part of a mixed method study to measure access and quality of SGBV services in four underserved Kenyan counties: Kwale, Garissa, Narok, and West Pokot. These counties were purposively selected from 13 program-supported counties to maximize cultural, socioeconomic, and geographic diversity. The study will collect three rounds of health facility assessments, corresponding with the Accelerate program's early intervention, mid-intervention, and late intervention periods. Between July and September 2022, we conducted the first wave of health facility assessments and report on those data here.

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 sexual violence-related treatments, laboratory services, clinical guidelines, job aids, equipment, and privacy of consultation/examination room.

Hospital chart reviews were completed among all 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.

For the qualitative component, in-depth interviews (IDIs) were conducted with a total of 50 providers selected from 50 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.

All study procedures were reviewed and approved by the AMREF Ethics & Scientific Review Committee (P1168-2022). Verbal informed consent was provided by health facility in-charges prior to conducting the health facility assessment, including chart reviews; providers who participated in IDIs were also consented.

We present descriptive statistics (summaries of counts and proportions) of health facility characteristics, service readiness, and quality of care documented in charts. In future analyses, we will formally assess differences in service delivery by level of facility and by county using statistical methods such as t-tests and chi-squared tests. Analysis of qualitative in-depth interview data will be coded using a deductive-inductive hybrid approach, in which the codebook will be initially developed using a framework developed by the in-depth interview guide supplemented with sub-codes based on emerging themes identified during analysis. In addition, qualitative descriptions of patient flows through the health facility will be used to draft “swim lane” diagrams describing facility-based care delivery, which will be further refined through provider workshops scheduled for early 2023.

#### **4. Results/key findings**

Among 123 facilities included in preliminary analyses, availability of functional laboratory services ranged from almost half of dispensaries/clinics (47%, n=40/86) to 92% of hospitals (n=12/13). Few facilities of any level stocked emergency contraceptive pills (15%, n=18/123). Availability of post-exposure prophylaxis for HIV (PEP) for children on the date of the assessment varied from 22% among dispensaries to 83% among hospitals. Availability of adult PEP and medications for routine treatment of bacterial STIs was lower among dispensaries and clinics (42% and 72%, respectively) than higher-level facilities (82-83% and 96-100%, respectively, among health centres and hospitals). Eighty percent (n=98/123) of facilities offered psychosocial support to SGBV survivors, with relatively high levels of availability (at least 3 of 4 facilities) across levels of the health system.

While 54% of facilities reported at least one staff attending an in-service GBV training in the past year, few (29%) had received GBV-related supervision in the last quarter. Only one-third of facilities provided fully integrated SRH/GBV care, as reported by providers. Thirty-six percent of facilities stocked the post rape care form, which is used as legal evidence, while 30% were currently documenting cases using the national sexual gender-based violence register on the date of the assessment. Sixty-four percent of facilities (n=71/123) reported that they had never used the national SGBV register, while 6% (n=7/123) reported typically using the register but that they were currently experiencing a stockout.

Among 236 hospital chart reviews included in preliminary analyses, more than half (56%) were completed in Kwale county and only 14% and 9% in Garissa and West-Pokot, respectively. Among reviewed charts, most sexual violence survivors were children aged less than 18 years (66%, n=144/218), female (97%, n=229/235), and unmarried/single (84%, n=188/224). Seventy-five percent of perpetrators were reportedly known to the survivors, with most aggressors being either a current/former intimate partner (36%) or a neighbour (36%) with a smaller proportion being friends (6%) or relatives (6%). 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.

Regarding reporting patterns, reviewed charts showed that most of the violence (93%) was already reported to the police before survivors presented 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 a third (31%) presenting on the same day and 28% 1-2 days post-violence.

Further analysis of chart review data is ongoing; if accepted, we will present data of quality of care based on national SGBV treatment guidelines and completeness of documentation among reviewed charts. We will also present qualitative findings from in-depth interviews with providers, including “swim lane” diagrams documenting processes and pathways of care delivery and integration of SRH/GBV services within study facilities.

## **5. Conclusion/Knowledge contribution**

Although all levels of the Kenyan health system, from dispensaries to referral hospitals, are expected to offer an essential package of SGBV services, we observed steep gradients in SGBV service readiness across levels of the Kenyan healthcare system in four diverse settings. In particular, fewer than half of dispensaries and clinics were able to provide essential services such as routine PEP for HIV (for either adults or children) or routine treatment of bacterial STIs. Dispensaries and clinics are often the first point of care-seeking, particularly for rural communities; inability to deliver essential services at these first-line facilities require survivors to seek higher-level facilities for appropriate care – a barrier with substantial time and monetary costs borne solely by survivors. A key implication of these findings is the need to strengthen the health systems’ ability to provide a basic emergency package of SGBV care within the lowest-level facilities, and to increase effective and timely referral systems for specialized care.

We also observed uniformly low readiness to provide services related to pregnancy prevention across all levels of the health system, with availability of emergency contraceptive pills (ECPs) ranging from just 14% of dispensaries/clinics to 31% of hospitals. These findings align with service delivery point assessments conducted through the Performance Monitoring for Action platform, which have found relatively high prevalence of stockout and low offering of ECPs in Kenyan health facilities, particularly in the public sector (Muhoza et al., 2021). Low facility-based availability of emergency contraceptive pills in Kenya (Ooms et al., 2020) is supplemented by authorized provision of over-the-counter ECPs by non-facility dispensers, such as pharmacists. While pharmacies and chemists play a critical role in ECP delivery, particularly for young and unmarried women or male partners who may be stigmatized seeking facility-based contraceptive services (Coroon et al., 2016), low facility-based availability of ECP may prevent survivors of sexual violence from obtaining timely and comprehensive care and treatment at facilities as part of integrated care; requiring survivors to seek additional care – such as ECPs – outside of health facilities presents yet another burden on survivors.

The study also highlighted low use of post rape care forms and national facility-based documentation tools. This finding has several implications: at the individual level, lack of use of post rape care forms – which are legally required for documentation of sexual violence and used as evidence in the legal system – means that survivors seeking care at facilities that do not stock or use these forms may lack critical evidence needed to seek legal recourse. In addition, poor routine documentation practices prevent monitoring of SGBV caseloads and care quality at a systems level, thereby limiting evidence-based decision making in programming and resource allocation. Previous evidence suggests most health

providers are reluctant note takers in matters related to sexual violence as they feel not ready to deliver legal evidence during court proceedings (Kilonzo et al., 2009). This practice gap further emphasises the importance of ensuring front-line responders, including those serving in smaller health facilities, are adequately supported to manage survivors of sexual and gender-based violence, including through exposure to relevant medico-legal training and continuous supportive supervision. Health facility assessments also identified potential strengths in current facility-based healthcare provision, including that most facilities of all levels could provide at least some level of psychosocial support or resources to survivors. Encouragingly, a vast majority of health facilities have necessary capacity to manage bacterial STIs and infrastructure for managing survivors in privacy while maintaining confidentiality during clinical consultation and examination.

While analysis of chart reviews is ongoing, available data revealed very few cases of sexual violence were managed at the lower levels of health care, with the notable exception of Kwale county. Almost all survivors had reported the crime to the police by the time they sought health services, fewer than 60% of them presented at the health facility on time (i.e., within 72-hour) to be eligible for administration of emergency and prophylactic therapies. These findings taken together may indicate most survivors and their families prioritize crime reporting over healthcare and that post-violence care is not typically sought from facilities closest to their homes, which may contribute to late presentation.

This study has several limitations. First, high amount missing data in specific sections of the reviewed chart reviews raises concern of selection bias. Secondly, while all program supported facilities were included in the sample, there were low numbers of private health facilities which prevented completion of meaningful sub-population analysis by public and private sector. Lastly, these study findings may not be generalizable beyond the study settings given that participating health facilities have received “some” early direct support from the program.

In conclusion, this study identifies several important gaps for improvement of SGBV case-management. Given the observed steep gradients in SGBV service readiness across levels of the healthcare, we advocate for increased investment in capacity building interventions which deliberately target lower-level facilities including dispensaries and clinics.

## 6. Preliminary Tables

**Table 1: Health facility readiness to provide SGBV services in four Kenyan counties, by level of care**

Sample characteristic	Level of care							
	Dispensary/ Clinic (N=86)		Health centre (N=24)		Hospital (N=13)		All facilities (N=123)	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
County								
Garissa	11	12.8	8	33.3	4	30.8	23	18.7
Kwale	41	47.7	4	16.7	3	23.1	48	39
Narok	11	12.8	10	41.7	4	30.8	25	20.3
West Pokot	23	26.7	2	8.3	2	15.4	27	22
Client consultation rooms offers								
Auditory privacy only	1	1.2	0	0	0	0	1	0.8
Visual privacy only	7	8.1	1	4.2	0	0	8	6.5
Auditory and visual privacy	76	88.4	22	91.7	13	100	111	90.2
No privacy	2	2.3	1	4.2	0	0	3	2.4
Availability of routine care services on the day of the survey*								
Functional laboratory services	40	46.5	22	91.7	12	92.3	74	60.2
Emergency contraceptive pills	12	14.0	2	8.3	4	30.8	18	14.6
Routine PEP for children	18	21.7	15	65.2	10	83.3	43	36.4
Routine PEP for adult	35	42.2	19	82.6	10	83.3	64	54.2
Routine STI treatment with antibiotics	60	72.3	22	95.7	12	100	94	79.7
Psychosocial support	66	76.7	21	87.5	11	84.6	98	79.7
Exposure to in-service training, and support supervision								
At least one staff attended an in-service GBV training in the last 12 months	40	46.5	17	70.8	9	69.2	66	53.7
HF received a supervisory visit in the last 3 months preceding the day of the survey	61	70.9	12	50	9	69.2	82	66.7
Supervision included a component of GBV	25	29.1	5	20.8	6	46.2	36	29.3
Availability of SGBV reporting tools**								
Post rape care (PRC) form (MOH 363)								
Yes, available	20	24.4	12	52.2	10	83.3	42	35.9
No, out of stock	1	1.2	3	13	0	0	4	3.4
Never stocked	61	74.4	8	34.8	2	16.7	71	60.7
SGBV register (MOH 365)								
Yes, available	14	16.9	12	52.2	9	75	35	29.7
No, out of stock	2	2.4	4	17.4	1	8.3	7	5.9
Never stocked	67	80.7	7	30.4	2	16.7	76	64.4
GBV services integration with routine SRH services***								
No integration	10	12	5	21.7	2	16.7	17	14.4
A little integration	22	26.5	5	21.7	1	8.3	28	23.7
Moderate integration	25	30.1	8	34.8	4	33.3	37	31.4
Full integration	25	30.1	5	21.7	5	41.7	35	29.7
Don't know	1	1.2	0	0	0	0	1	0.8

PEP is post-exposure prophylaxis for HIV with antiretrovirals

STI is sexually transmitted infections

\*\* Denominator excludes 5 observations with missing data for routine adult PEP, children PEP and STI treatment.

\*\*Denominator excludes 6 and 5 observations with missing data for PRC form and SGBV register, respectively.

\*\*\*Denominator excludes 5 observations with missing data

**Table 2: Characteristics of survivors and aggressors of sexual violence, description of violence, and reporting patterns among reviewed charts in four Kenyan counties, by level of care**

Characteristic	Level of care							
	Dispensary/ Clinic (N=88)		Health centre (N=37)		Hospital (N=111)		All facilities (N=236)	
	n	%	n	%	n	%	n	%
<b>County</b>								
Garissa	0	0.0	2	5.4	32	28.8	34	14.4
Kwale	76	86.4	25	67.6	30	27	131	55.5
Narok	11	12.5	8	21.6	30	27	49	20.8
West Pokot	1	1.1	2	5.4	19	17.1	22	9.3
<b>Survivor's demographics</b>								
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	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	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	3		0		9		12	
<b>Aggressor information</b>								
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	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	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	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	45		25		21		91	
<b>Characteristics of the violence</b>								
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	1		0		6		7	
Condom use if penetration violence 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	49		25		23		97	
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	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	14		11		28		53	

\*Denominator includes survivors presenting in the current health facility when seeking care for the first time

## References

- Ashford, L., & Feldman-Jacobs, C. (2010). *The Crucial Role of Health Services in Responding to Gender-Based Violence*. <http://www.prb.org/Articles/2010/genderbasedviolencehs.aspx>
- Barnett, J. P., Maticka-Tyndale, E., & Kenya, T. (2016). Stigma as Social Control: Gender-Based Violence Stigma, Life Chances, and Moral Order in Kenya. *Social Problems*, 63(3), 447–462. <https://doi.org/10.1093/socpro/spw012>
- García-Moreno, C., Hegarty, K., D'Oliveira, A. F. L., Koziol-McLain, J., Colombini, M., & Feder, G. (2015). The health-systems response to violence against women. *The Lancet*, 385(9977), 1567–1579. [https://doi.org/10.1016/S0140-6736\(14\)61837-7](https://doi.org/10.1016/S0140-6736(14)61837-7)
- Gatuguta, A., Merrill, K. G., Colombini, M., Soremekun, S., Seeley, J., Mwanzo, I., & Devries, K. (2018). Missed treatment opportunities and barriers to comprehensive treatment for sexual violence survivors in Kenya: a mixed methods study. *BMC Public Health*
- Kilonzo, N., Theobald, S. J., Nyamato, E., Ajema, C., Muchela, H., Kibaru, J., Rogena, E., & Taegtmeier, M. (2009). Delivering post-rape care services: Kenya's experience in developing integrated services. *Bulletin of the World Health Organization*, 87(7), 555–559. <https://doi.org/10.2471/BLT.08.052340>
- Kirk, L., Terry, S., Lokuge, K., & Watterson, J. L. (2017). Effectiveness of secondary and tertiary prevention for violence against women in low and low-middle income countries: A systematic review. *BMC Public Health*, 17(1), 1–21. <https://doi.org/10.1186/s12889-017-4502-6>
- MOH. (n.d.). *Ministry of health launches 14 documents meant to improve maternal and new-born health services*. Retrieved 3 October 2022, from <https://www.health.go.ke/ministry-of-health-launches-14-documents-meant-to-improve-maternal-and-new-born-health-services/>
- Muhoza, P., Koffi, A. K., Anglewicz, P., Gichangi, P., Guiella, G., Olaolorun, F., Omoluabi, E., Sodani, P. R., Thiongo, M., Akilimali, P., Tsui, A., & Radloff, S. (2021). *Modern contraceptive availability and stockouts : a multi-country analysis of trends in supply and consumption*. January, 273–287. <https://doi.org/10.1093/heapol/czaa197>
- Ooms, G. I., Kibira, D., Reed, T., van den Ham, H. A., Mantel-Teeuwisse, A. K., & Buckland-Merrett, G. (2020). Access to sexual and reproductive health commodities in East and Southern Africa: A cross-country comparison of availability, affordability and stock-outs in Kenya, Tanzania, Uganda and Zambia. *BMC Public Health*, 20(1), 1–14. <https://doi.org/10.1186/s12889-020-09155-w>
- Shako, K., & Kalsi, M. (2019). Forensic observations and recommendations on sexual and gender based violence in Kenya. *Forensic Science International: Synergy*, 1, 185–203. <https://doi.org/10.1016/j.fsisyn.2019.06.001>
- Sikder, S. S., Ghoshal, R., Bhate-Deosthali, P., Jaishwal, C., & Roy, N. (2021). Mapping the health systems response to violence against women: key learnings from five LMIC settings (2015–2020). *BMC Women's Health*, 21(1), 1–13. <https://doi.org/10.1186/s12905-021-01499-8>
- Wangamati, C. K., Thorsen, V. C., Gele, A. A., & Sundby, J. (2016). Postrape care services to minors in Kenya: Are the services healing or hurting survivors? *International Journal of Women's Health*, 8, 249–259. <https://doi.org/10.2147/IJWH.S108316>

WHO. (2013). *Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-partner Sexual Violence*.

WHO. (2017). Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for health managers. In *World Health Organization*. World Health Organization. <https://apps.who.int/iris/handle/10665/259489>