

**ACCESS TO REPRODUCTIVE HEALTH SERVICES BY FEMALE
SURVIVORS OF SEXUAL GENDER-BASED VIOLENCE IN SELECTED
HOSPITALS IN NAIROBI CITY COUNTY, KENYA.**

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DECLARATION

This thesis is my original work and has not been presented for a ward of a degree in any other University.

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We confirm that the work reported in this thesis was carried out by the candidate under our supervision as the University Supervisors.

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DEDICATION

First I give thanks and Glory to God who has guided me throughout this academic process. Secondly, I dedicate this work to my loving wife Patience Makari, My Son Presley Coredo and my daughter Pearlrита Coredo for their greatest source of inspiration and strength throughout this process. And to all who have greatly contributed to my academic process my brother Julius Coredo and everyone who has contributed to this process I am forever grateful.

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ABBREVIATIONS AND ACRONYMS

CDC	:	Centre for Disease Control
EC	:	Emergency Contraceptive
GBV	:	Gender-Based Violence
GVRC	:	Gender Violence Recovery Centre
HFR	:	Health Facility Report
HIV	:	Human Immunodeficiency Virus
ICPD	:	International Conference on Population and Development
IPV	:	Intimate Partner Violence
KDHS	:	Kenya Demographic Health Survey
NFHS	:	National Family Health Survey
NGMSV	:	National-Guidelines-on-management-of-Sexual-Violence
NPV	:	Non-Partner Violence
PEP	:	Post Exposure Prophylaxis
RH	:	Reproductive Health
RHS	:	Reproductive Health Services
SGBV	:	Sexual Gender-Based Violence
SRH	:	Sexual Reproductive Health
STI	:	Sexual Transmitted Infections
TCCs	:	Thuthuzela Care Centres
UNFPA	:	United Nations Population Fund
UNHCR	:	United Nations High Commissioner for Refugees
UNSDG	:	United Nations Sustainable Development Goal
WHO	:	World Health Organization

DEFINITION OF OPERATIONAL TERMS

- Access to reproductive health services** : This refers to the availability of comprehensive care for survivors of sexual violence, which includes legal services, emergency medication to lower the risk of HIV and other STDs, medical treatment, including the management of physical injuries, and emergency contraception to lower the risk of unintended pregnancies. When survivors have the information to improve access and receive at least three of the services offered, they are given access.
- Comprehensive management** : Refers to access to wholesome management of reproductive healthcare for survivors.
- GBVRC Model** : Is a partnership that offers paralegal services, mental health support, and integrated collaboration with law enforcement, the judiciary, local leaders, and the community at large, in addition to emergency healthcare.
- Gender-based violence** : Is male-female violence that stems from the unequal power dynamics between the sexes and typically involves the female as the victim.
- Intimate partners** : In most countries, the recognized gender role for male intimate partners is one of decision-making and authority over the female partner. Unfortunately, this power and influence is often expressed through discrimination, aggression, and abuse.

Sexual Gender-Based Violence : Sexual and gender-based violence (SGBV) refers to any act that is performed against a person's will and is based on gender norms and uneven power relationships. It encompasses physical, emotional or psychological, and sexual assault, and denial of resources or access to services.

Sexual Violence : Sexual violence is any sexual act or effort to achieve a sexual act by violence or compulsion, acts to traffic a person, or acts intended against a person's sexuality, regardless of the relationship to the victim.

ABSTRACT

Women and girls ages 15-49 years married are estimated to form 30% of the victims of Sexual Gender Based Violence. World Health Organization reports that women who have experienced SGBV are at a higher risk of gynecological morbidities, miscarriages, unsafe abortions, pregnancy complications, HIV, and unwanted pregnancies. This study therefore aimed to determine the access to reproductive health services by female survivors of sexual gender-based violence in Nairobi City County, Kenya. The study used a descriptive cross-sectional design with pretested questionnaires. The study involved female survivors of sexual gender-based violence. The sample size comprised 269 survivors and 10 key informants. A pretest of research tools was carried out at the Mathare sub-county hospital. Data analysis was done by use of thematic content and quantitative data presented by use of percentages and frequency distribution tables. For inferential quantitative analysis, a binary logistic regression was used to determine the availability of reproductive health services, knowledge, attitude, and type of reproductive health services predictors of access to reproductive health services by female survivors of sexual gender-based violence. Odds Ratios were evaluated for significance by considering the 95% Confidence Interval or at a p-value ≤ 0.05 for the statistic generated. The results showed that access to reproductive health services by female survivors of sexual gender-based violence was relatively low at (26%). Majority had moderate knowledge of access to reproductive health services provided to survivors of sexual gender based violence (39%). The study found that 67.3%, of respondents did not have reproductive health services nearby, 54% found services not affordable, and 60.2% said transport services were unavailable. The majority 40.9% had moderate knowledge of post exposure prophylaxis and sexually transmitted infections prevention and treatment, and 46.4% knew about mental health and psychosocial support. A majority (33.5 %) had moderate knowledge of emergency contraception. On post exposure prophylaxis for HIV, a majority (42.8%) of the respondents had low. On sexually transmitted infections prevention and treatment, majority (40.9%) had moderate knowledge. The majority had low knowledge of Mental Health and Psychosocial Support (46.4%). On Access to Legal Aid for Survivors, a majority had moderate knowledge (37.2%). The study recommended that county government to ensure the implementation of the policy on national guidelines on the management of sexual violence to enhance the availability, affordability, and accessibility of reproductive health services to the survivors. There is a need for the involvement of community health volunteers to help in the identification of sexual violence cases and link to the right facilities to enhance quick management to prevent progression to worse conditions such as seroconversion from AIDS to HIV. The county government to ensure health facilities are equipped with both staff and commodities that will ensure comprehensive management of sexual gender based violence survivors.

CHAPTER ONE: INTRODUCTION

1.1 Background of the study

Women and girls ages 15-49 years who have been married are estimated to form 30% of the victims of Sexual Gender Based Violence (SGBV) (Campbell, *et al.* (2021). Violence among partners living together is estimated to have been experienced by 31% of women who had ever been in a relationship (El-Adawy, 2021). The victims of SGBV have poor mental and sexual reproductive health outcomes, World Health Organization (WHO, 2021). Indeed, the WHO reports that women who have experienced SGBV are at a higher risk of gynecological morbidities, miscarriages, unsafe abortions, pregnancy complications, HIV, and unwanted pregnancies (WHO, 2021). Enhancement of health system in championing efforts to put forward an elaborate plan and emphasizes the significance of a multi-sectoral approach leaving no one behind in campaign against violence.

Women globally frequently visit health services for reproductive health needs, such as family planning, antenatal care, and Sexual Transmitted Infections (STI) treatments, presenting an opportunity to identify and manage the adverse effects of SGBV. These visits could also offer psychological support, helping survivors cope with the trauma (WHO, 2016). However, Intimate Partner Violence (IPV) especially in marginalized African countries, exacerbates the issue, with 37% of women reporting experiences of SGBV (Kalra *et al.*, 2017).

Medical management of survivors is considered a key approach in reducing severity of their condition, particularly in addressing physical injuries and providing post-rape care, as well as the prevention of pregnancies which are not planned and sexually transmitted infections National Guideline on Management of Sexual Violence (NGMSV, 2014). It is

estimated that the probability to use contraceptives is considered increased for women who have experienced SGBV but remain at higher risk for genital tract infections (Mitchell, & Bennett, 2020). Furthermore, those who experience violence at a young age are particularly vulnerable to reproductive health complications, such as uterine fibroids, in adulthood if they do not receive appropriate medical care. Despite the growing evidence of the long-term reproductive health consequences of SGBV, many survivors struggle to access the comprehensive services needed for early detection and response. This gap in healthcare services represents a significant challenge to women's reproductive health (Kassim, 2022).

In Kenya, the issue is even more pressing. According to Kenya Demographic Health (KDHS, 2022), 16% of women and girls aged 15–49 years have experienced SGBV. These statistics highlight a critical gap in the healthcare system and the urgent need for better responses to address the reproductive health consequences of SGBV. The problem, therefore, is not just the widespread nature of SGBV, but the inadequate healthcare infrastructure and resources to support survivors. This results in a failure to provide timely and comprehensive care that addresses the physical, psychological, and long-term RH needs of survivors, particularly in regions with high incidences of violence related to gender like Kenya.

1.2 Statement of the Problem

Sexual Gender Based Violence continues to be an important public health issue globally, responsible for the reproductive health problems of female survivors. In a number of global locations, including sub-Saharan Africa, Insufficient availability of suitable reproductive health care remains a significant barrier for women who have been victims of sexual assault. Female survivors of SGBV often face a range of problems related to reproductive

health, including STIs and unwanted pregnancies, pelvic injuries, and chronic illnesses such as post-traumatic stress disorder (PTSD), depression, and anxiety (Decker *et al.*, 2020; WHO, 2021). Despite significant international and regional efforts to enhance survivor's accessibility of Reproductive Health Services remain inconsistent, particularly in resource-constrained settings.

In Kenya, SGBV is a major public health concern, exacerbated by social, economic, and cultural barriers that hinder the survivors' access necessary healthcare services. According to the Kenya Demographic and Health Survey (KDHS, 2022), sexual violence is prevalent in Kenya, with one in every five women reporting having been the victim of sexual assault at some point in their lives Kenya National Bureau of Statistics (KNBS, 2020). While Kenya has made notable strides in addressing sexual violence through the Sexual Offences Act (2006) and the Reproductive Health Policy (2012), barriers to accessing reproductive health services remain widespread. These barriers include stigma, discrimination, lack of awareness about available services, inadequate healthcare infrastructure, and financial constraints (Gichuru *et al.*, 2022; Osero *et al.*, 2023).

In Nairobi City County, as Kenya's capital and largest urban area, reproductive health for survivors of SGBV should theoretically be higher in availability than in rural areas due to better healthcare infrastructure. However, female survivors in Nairobi still face significant challenges in accessing timely and comprehensive reproductive health services. These challenges are compounded by the social stigma surrounding sexual violence, a lack of specialized services in some healthcare settings, and inadequate training of healthcare providers to deliver survivor-centered care (Sileshi *et al.*, 2022). Furthermore, some

survivors face difficulties in seeking care due to fear of judgment, concerns about confidentiality, or lack of transport and financial resources (Rashid *et al*, 2021).

1.3 Justification of the study

Sexual Violence continues to be the most widespread abuse of human rights. Globally, with profound effects on the health and survivors' satisfaction. Female survivors of SGBV are particularly vulnerable to severe RH outcomes such as unwanted pregnancies, sexually transmitted infections (STIs), HIV, pelvic injuries, and long-term psychological trauma, which can have enduring effects on their lives and communities (Decker *et al.*, 2020; WHO, 2021). Despite significant global and national efforts recognizing the need to eliminate all forms of violence against women and girls, including sexual violence, by 2030 (UN, 2015). The Sustainable Development Goal (SDG) 3 and Goal 5, explicitly call for improving access to healthcare for survivors of SGBV, including reproductive health services. Furthermore, according to (WHO, 2021), violence against women, has underscored the need for integrated health services that provide SRH, mental health support, and Post Exposure Prophylaxis (PEP) for survivors of SGBV (WHO, 2021). Despite these efforts, survivors continue to face substantial barriers in accessing the RSH they urgently require. According to (KDHS, 2022) approximately 16% of women have experienced sexual violence in their lifetime, and only 56% of women who have experienced physical or sexual violence seek assistance (KNBS, 2020). This study is justified by the critical need to explore these barriers and identify gaps in service delivery to better support SGBV survivors in Kenya, specifically in Nairobi City County.

1.4 Research Questions

1. What reproductive health services are available for female survivors of sexual and gender-based violence in Nairobi City County, Kenya?
2. What is the level of knowledge of female survivors of sexual and gender-based violence on reproductive health services in Nairobi City County, Kenya?
3. What is the attitude of female survivors of sexual and gender-based violence on access to reproductive health services in Nairobi City County, Kenya?
4. Which reproductive health services are offered to female survivors of sexual gender based violence in Nairobi City County, Kenya?

1.5 Hypothesis

There is no association between availability of reproductive health services, knowledge on reproductive health services, attitude and type of reproductive health services provided and access to reproductive health services for female survivors of sexual gender-based violence in Nairobi City County, Kenya.

1.6. General Objective

The study aimed to establish access to reproductive health services by female survivors of sexual gender based violence in Nairobi City County, Kenya

1.7. Specific objectives

1. To determine the extent of availability of reproductive health services to female survivors of sexual and gender-based violence in Nairobi City County, Kenya
2. To determine the knowledge level of female survivors of sexual and gender-based violence on reproductive health services in Nairobi City County, Kenya.

3. To establish the attitude of female survivors of sexual gender based violence on reproductive health services in Nairobi City County, Kenya
4. To determine reproductive health services offered to female survivors of sexual and gender-based violence in Nairobi City County, Kenya.

1.8 Significance of the study

The study is significant to address critical gaps in the healthcare system regarding the access of female survivors of SGBV to RHS in Nairobi City County, Kenya. Despite numerous efforts aimed at reducing prevalence of SGBV and provide healthcare services for survivors, barriers to care continue to undermine the well-being of women and girls. By investigating these barriers and assessing the access to RHS availability in selected hospitals. The study will help in the improvement of healthcare services for SGBV survivors and the achievement of SDG (3), which focuses on improving the standard of living for all women, regardless of age, and the SDG (5), which addresses gender equality.

1.9 Delimitation and Limitation

1.9.1 Limitation

This study is limited by several factors, primarily the geographic scope, as it focuses solely on selected hospitals in Nairobi City County. As Nairobi is an urban center with varying levels of healthcare infrastructure, the findings may not be generalizable to rural or peri-urban areas in Kenya, where healthcare services for SGBV survivors are less accessible or comprehensive. Additionally, the study relied on self-reported data from female survivors of sexual violence, which could have introduced biases that could compromise the quality and dependability of information supplied, such as recollection bias or social desirability bias. The sample size was also restricted by hospitals in the study, which limited the

diversity of healthcare settings examined and may not be extrapolated in other settings. Furthermore, obtaining access to survivors for interviews or data collection was challenging due to institutional protocols or confidentiality concerns.

1.9.2 Delimitation

This study is delimited to its focus on women survivors of SGBV and the challenges they face in Nairobi City County. Having a specific focus enables a greater investigation of the reproductive health services provided for this cohort in a particular urban context. The research only assessed RH services including EC, HIV, PEP, STI treatment and counseling, and legal aid, purposefully excluding broader health or social support services, such as long-term mental healthcare. Additionally, the study did not examine male survivors of SGBV or those from rural areas, thus narrowing the scope to the experiences of women in Nairobi's healthcare facilities. This focus helped maintain a manageable scope while ensuring an in-depth investigation of the accessibility, quality, and barriers to RHS for female survivors of SGBV.

1.10 Conceptual Framework

The independent and dependent conceptualized by the researcher through a survey of the literature. For female survivors of SGBV, access to RHS, knowledge, attitude toward health for better reproduction, and types of RHS offered to survivors are all important considerations (Fig: 1.1 Conceptual framework of access to RHS by survivors of SGBV

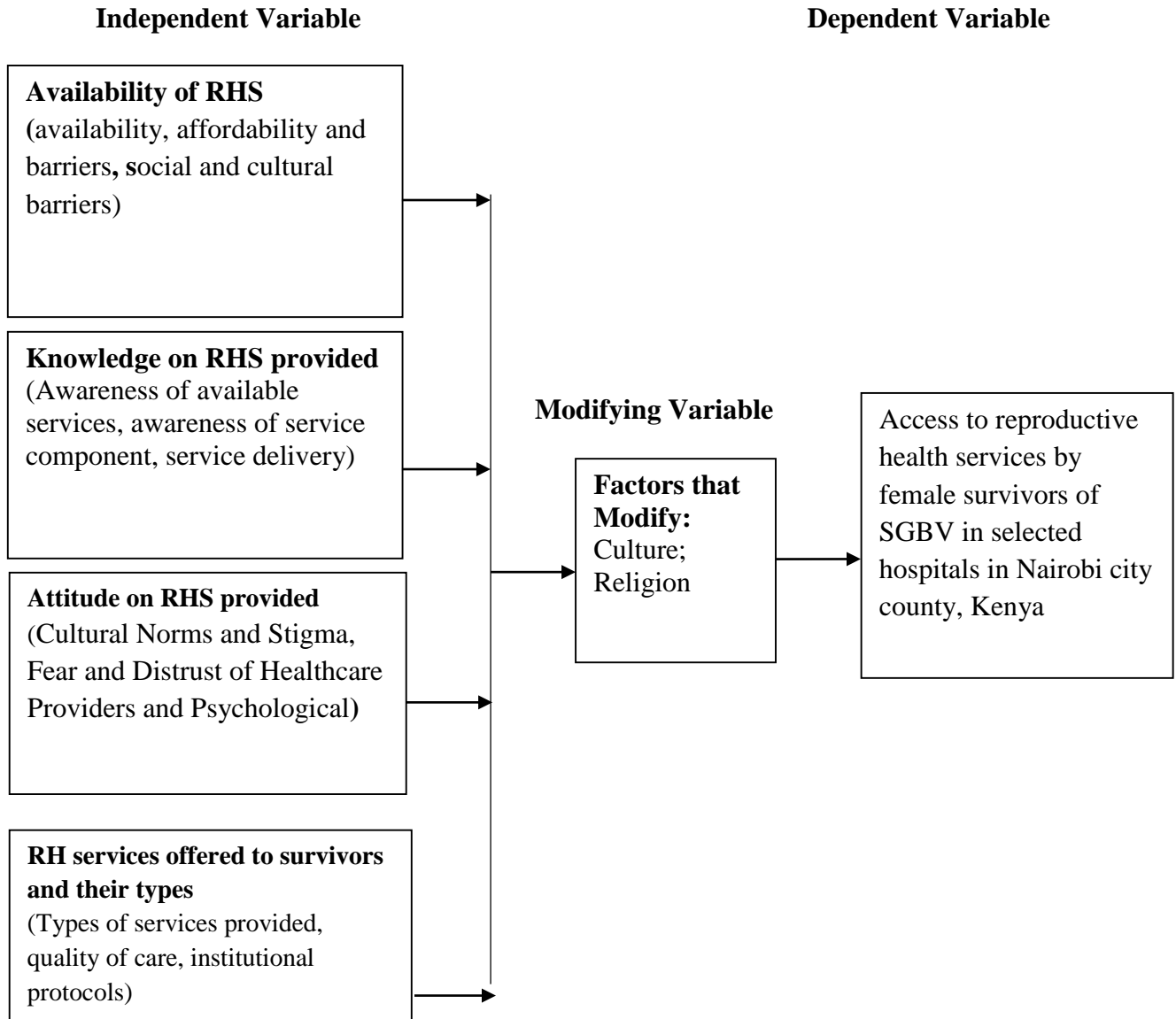


Fig 1.1 Conceptual framework on access to RHS for survivors of SGBV

Source: (Adopted from *Health Belief Model Glanz K et al (2015)*)

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter presents, empirical literature on access to services for RH for survivors of SGBV. This reviewed theoretical and empirical literature provided the gaps on the study area upon which this study is premised.

2.2 Theoretical Review

2.2.1 Health Belief Model

Health Belief Model (HBM) widely used to provide explanation to health behaviors, particularly in the context of accessing medical care. According to this paradigm, people are more inclined to act in ways that promote their health when they feel threatened. (e.g., health risks associated with SGBV), believe that the benefits of taking action outweigh the costs, and feel that they are capable of taking the necessary actions. In the context of female survivors of SGBV in Nairobi, the model helped to explain how perceptions of vulnerability, the severity of consequences, and belief in the effectiveness of treatment influence women's decision to seek reproductive health services.

Moreover, barriers to access, such as lack of finances, fear of judgment, and low confidentiality in healthcare settings, play an important part in limiting survivors' willingness to seek care, even when they are aware of the available services. The HBM suggests that addressing these barriers is essential for improving healthcare access among survivors.

2.2.2 Social Ecological Model

Social Ecological Model (SEM) a comprehensive approach that emphasizes importance of different ways and influence on health outcomes. The model is important in understanding the dynamics surrounding access to RHS for SGBV survivors, as it highlights the issues between personal, social, and environmental factors. At the individual level, factors such as health literacy, awareness of services, and mental health (post-trauma effects) directly affect women's decision to seek reproductive health services. Many SGBV survivors in Nairobi City County did not seek immediate medical care due to psychological trauma, fear of further victimization, or lack of knowledge about available reproductive health options.

At the community level, factors such as social support systems and community norms play a critical role. Stigma and victim-blaming, common in many Kenyan communities, often discourage survivors from accessing care. Gender norms and societal views that minimize the severity of sexual violence further complicate the situation. For example, Karanja *et al.* (2021) found that survivors in some communities in Nairobi faced significant social stigma when seeking reproductive health services, which deterred them from accessing care.

At the institutional or healthcare level, the availability of resources, trained personnel, and health infrastructure determines whether survivors receive comprehensive and timely reproductive health services. Studies, such as Ngugi *et al.* (2020), indicate that healthcare facilities in Nairobi often lack the necessary resources or are not adequately equipped to handle the specific needs of SGBV survivors, leading to underutilization of reproductive health services.

2.2.3 Theory of Planned Behavior

Theory of Planned Behavior (TPB) builds on Health Belief Model but adds an important dimension: the perceived behavioral control over actions. Three elements, according to the TPB, affect behavior: perceptions of behavioral control, subjective norms, and attitudes toward the activity. This model is useful for understanding why some survivors of sexual violence in Nairobi may not access reproductive health services even if they know about their availability. For instance, attitudes toward seeking medical care post-SGBV are shaped by cultural, social, and personal beliefs. If survivors have internalized negative views about themselves due to the assault or fear of judgment from healthcare providers, their attitudes toward seeking help may be negative. Subjective norms, or the beliefs about what others think one should do, may also play a role. The perceived behavioral control factor is particularly relevant in the Nairobi context, where logistical barriers such as distance to healthcare facilities, cost, and availability of specialized services make it harder for women to seek the care they need. Gichuru *et al.* (2021) found that survivors of SGBV in Nairobi often feel powerless due to these structural barriers, resulting in a lack of action, even when they are aware of the services.

2.3 Overview of sexual gender-based violence

Sexual Gender Based Violence include but not limited; to spoken harassment, forced penetration, intimidation, pressure from physical force to intimidation by peers and society (WHO, 2021). Sexual violence on women and girl is a serious problem with a range of many negative outcomes on reproductive health among female survivors and violation of rights of female survivors that finds its root in gender differences and power differences. SGBV can result in many long term health challenges that include physical, emotional,

psychological, or reproductive health impacts, United Nations High Commissioner for Refugees (UNHCR, 2022).

Kalra & García (2017), survivors experience victimization, social stigma, fear, or discrimination that restricts participation in society and support their families. Sexual gender base violence can affect female survivors in a variety of ways, including physical, psychological, sexual, socioeconomic, and destructive cultural practices (UNHCR, 2022).

Socio models that depicts aspects of ecology help in the understanding intricacy of ex violence mated on women problem, (WHO, 2021), this shows that no fair treatment to the survivors. In which case, sexual gender-based violence it may be said to be as a result of many factors such as relationships, community, and society Bhatt, *et al.* (2022). Current studies indicate that SGBV may be averted (Cohen *et al.*, 2016) higher measures for prevention are still no longer in reality recognized. A scientific overview of existing components of information regarding sexual gender based violence has shown that comprehensive packages for response have proven to have a high-quality effect on management of survivors.

Therefore, the outcome of these studies shows that for better management of survivors in the healthcare set up should be the most improved sector in the line of management of survivors (Tiwari, *et al.* 2020). Survivors of rape should acquire a comprehensive package for complete management and a well-coordinated referral pathway for ease of access to other service providers. There is need for improvement of gender recovery centers to meet international standards for better management of survivors of all forms of GBV (Bhatt, *et al.* 2022). Currently, the center for control of diseases has come up with comprehensive package aiming at different groups of survivors and seeks to limit the level of suffering to

the survivors. In as much as progress towards redress to survivors needs has continually been made, there is still need for- research to take care of precise survivor needs at gender recovery centers.

2.3.1 Global perspective of sexual gender based violence

Literature from a study by Horn- *et al.* (2021), alludes that 74% of Liberian girls in the reproductive age range (15–49) living in one of the three suggested refugee settlements in Sierra-Leone reported experiencing SGBV, and 71% reported having experienced not less than one incident of physical violence prior to displacement. Over the course of the displacement period, these percentages decreased from 71% to 66.1%. Men and women from seven camps for internally displaced people in Montserrado County participated in a series of cognizance-organization talks and character interviews as part of the same study. The outcomes demonstrated that women and girls in the IDP were victims of many forms of gender-based abuse. The main one is sexual violence committed by those who are part of the forces that prevent. Two types of violence that occur in the IDP camps are domestic and sexual. A third reported having been sexually exploited, with the women using the phrase, and also you need" to describe the event. Persons with power and influence were the ones who committed the crimes.

The research highlighted some issues that women face when they are sexually assaulted. Reproductive health issues and gynecological issues are included. Using a series of attention institution discussions and in-person interviews with 412 women and women inside the chosen communities and IDP camps, another study conducted with the assistance of WHO workplace in collaboration with MOH/SW confirmed that sexual attack was high (nearly 80%) during the duration of the conflicts.

On women and girls, twenty-one (21) distinct acts of violence had been committed. The results for mental health were feelings of shame, a diminished dislike of sexual activity, and hopelessness. The social and financial outcomes of sexual gender-based violence were mostly characterized by stigmatization, a high divorce rate, unintended pregnancies, and poverty. Physical and/or sexual abuse was reported to survivors during disputes. Several girls made various violent suggestions at different times or throughout the encounter.

According to the author, the victims had unusual problems. Sexually transmitted diseases and their consequences accounted for the majority of the physical fitness impairments seen by the survivors. According to Jewkes, *et al.* (2020), thirty-seven percent of women experienced SGV including physical or psychological abuse. In many cities in India the prevalence is as high as thirty-one percent of women and girls. Sixty-two percent among women in urban slums have reported experiencing SGBV in their home (Mitchell, & Bennett, 2020), 35% of female gender violence has been either physical or involves IPV or non-partner sexual assault, according to a global systematic study on the incidence of violence committed by partners and sexual violence committed by someone other than a spouse (WHO, 2021).

2.3.2 African perspective of sexual gender based violence

The term "sexual gender-based violence" is an act/attempt to obtain a sexual act, unwelcome sexual utterances or advances, or any other case directed against a person's sexuality that involves coercion by anyone, regardless of their courtship of the victim, in any setting, including but not limited to the home and workplace (García-Moreno., *et al.*, 2021). Numerous primary polls indicate that quite excessive degrees of violence from intimate partners and sexual violence form partners who are not intimate, IPV unusual

violence against girls/women. Human being's regardless genders course intimate course sexual gender violence, customarily male perpetrators are more common and women/girls being the survivors. Rashid, *et al.* (2021), about twenty-five percent to forty-five percent of South African women have experienced Intimate Partner Violence.

South Africa has continued to report high rates of rape cases estimated to be between 12% and 28% (Rashid, *et al.* 2021). Non-accomplice sexual violence is rampant; however, case reporting among the survivors is still rated to be low. According to Gomez, *et al.* (2020), one in thirteen girls experienced non-partner rape, and one in twenty-five rape cases were either reported to the police or required medical attention. South Africa reports excessive occurrences of women raped by gangs. There may be limited research into rape focused on ladies who've had intercourse with ladies. Southern African countries has shown that 31.1% of women have gone through pressured intercourse.

In South African, over 1.75 million yearly visit health care facilities for injuries due to sexual gender based violence. A predicted sixteen percent of human immune-deficiency virus have the possibility to be averted when revel in domestic violence from partners can be prevented. Male survivors have a long time accelerated threat of getting HIV, alcohol abuse, despair and suicide are predisposing factors for men. Women and girls having experienced sexual violence such as rape are much more exposed to unwanted pregnancies, sexual transmitted infections. Women and girls have gone through sexual violence are at increased risk of psychological problems with over a third at an increasing rate due to post-traumatic stress disorder (PTSD), which if not properly treated can result in despair, sociality and drug misuse are not unusual, (Machisa, & Jewkes. 2022).

2.3.3 Kenyan perspective of sexual gender based violence

A research conducted by Kenya Demographic Health Survey (KDHS, 2022), indicates that thirty-eight percent of women and girls aged 15-49 mentioned having experienced abuse and fourteen percent underwent sexual assault. Data from the health survey shows that, cases of defilement were high followed by rape and incest and were reported as follows: three thousand five hundred and ninety-six were cases of defilement; nine hundred and thirteen of rape; two hundred and forty-two of incest and one hundred and forty-two were cases of sodomy.

2.4 Empirical Literature review

2.4.1 Availability of reproductive health services for women who have experienced gender based violence

Globally, the issue of GBV continues to exert pressure on health and human rights with lasting physical, psychological, and social impacts on women. The integration of RHS for women who have experienced violence is increasingly recognized as essential for effective care. Women who have experienced GBV often face barriers to accessing RHS, including stigma, lack of privacy, and insufficient resources within healthcare systems. According to a 2020 study by Gomez et al., survivors often experience challenges in accessing care due to fear of discrimination or mistreatment by healthcare providers (Gomez *et al.*, 2020). These barriers are particularly pronounced in rural areas and settings with cultural norms that limit women's autonomy and freedom to seek help (Devries *et al.*, 2020).

Studies emphasizes the importance of integrating GBV services into the broader reproductive health framework. The WHO advocates for integration of GBV response into primary care services to ensure comprehensive support for survivors. The "Minimum

Initial Service Package" (MISP) for RH in emergencies, which focuses on SRH services for vulnerable populations, including GBV survivors, remains a key framework. Recent studies have highlighted successful models of integrating GBV services into reproductive health care systems, such as in Colombia and Peru, where national health programs have developed integrated services that provide comprehensive care for survivors of SGBV (WHO, 2021; Hegarty *et al.*, 2021).

International frameworks have increasingly recognized the need for better access to RHS for women who have experienced violence. The SDG 5 on gender equality, emphasize the importance of eliminating violence against women and girls while ensuring access to RHS (United Nations, 2019). The United Nations Population Fund and World Health Organization have jointly developed guidelines and initiatives aimed at strengthening health systems response to GBV, focusing on training healthcare providers, increasing service availability, and improving the quality of care for survivors (UNFPA, 2020).

Studies have shown that cultural norms and stigma continue to affect the availability and utilization of RHS by GBV survivors in Africa. Women in sub-Saharan Africa face multiple barriers to seeking care for GBV, including fears of being blamed for the violence, lack of confidentiality, and a lack of support from health providers (Tiwari *et al.*, 2020). Rural women, in particular, are often unable to access RH due to geographic isolation and inadequately trained healthcare personnel. In addition, the COVID-19 pandemic has exacerbated these challenges, with increased rates of GBV and disruptions to healthcare access in many African countries (UNFPA, 2020).

Several African countries have initiated policies aimed at improving access to RHS for GBV survivors. In South Africa, the Thuthuzela Care Centres continue to provide an integrated response, offering medical, psychological, and legal support in a single location (Jewkes *et al.*, 2020). Similarly, Rwanda and Uganda have integrated GBV care into their reproductive health services, which has led to improved outcomes for survivors (Amnesty International, 2021). The African Union's Maputo Protocol and the East African Community (EAC)'s advocacy for comprehensive GBV services further support the regional push for integrated health services, emphasizing the importance of multi-sectoral responses.

World Health Organization study in 2020 revealed that the pandemic led to increased rates of domestic violence, while simultaneously limiting access to essential health services, including sexual and reproductive health care (WHO, 2020). In many countries, lockdowns and restrictions resulted in reduced access to health facilities, further compounding the challenges faced by GBV survivors. Studies from Kenya revealed that 45% of female's experience physical assault, and 16% have faced sexual violence. GBV contributes to high rates of unwanted pregnancies, HIV, STIs, and mental health problems, placing a significant burden on the reproductive health system (KDHS, 2022). GBV survivors are particularly vulnerable to complications during pregnancy and childbirth, as well as to chronic health problems, including pelvic and genital injuries.

The Kenyan government has implemented policies aimed at providing integrated services for GBV survivors. The National Guidelines for the Management of Sexual Violence (NGMSV, 2014) outline protocols for managing cases of sexual violence, providing care such as HIV PEP, emergency contraception, and trauma counseling. However, access to

these services are not equal, with urban areas having relative access compared to rural and underserved regions. Non-Governmental Organizations such as International Federation of Women Lawyers Kenya (FIDA), Kenya Red Cross, and Amref Health Africa are significant in providing services, including medical treatment, legal support, and psychosocial counseling (FIDA Kenya, 2021).

Studies found that many women in rural areas are unaware of the available services or are afraid to report violence due to fear of retribution or stigma (FIDA Kenya, 2021). Healthcare facilities often lack the necessary resources and trained personnel to manage GBV cases effectively. There is also a widespread lack of coordination between healthcare providers, law enforcement, and social services, making it difficult for survivors to access comprehensive care.

Kenya has passed key laws aimed at addressing GBV and improving the availability of RHS for survivors. The Sexual Offences Act (2006) and the Protection Against Domestic Violence Act (2015) provide important legal frameworks for protecting survivors and improving the response of health systems. However, the implementation of these laws has been inconsistent, especially in rural areas, and gaps remain in ensuring that healthcare providers are properly trained to handle cases of GBV.

2.4.2 Knowledge of female survivors of sexual gender based violence on reproductive health services

Knowledge Gaps exist in Reproductive Health among SGBV Survivors. A significant body of research highlights that many survivors of SGBV have limited knowledge about their reproductive health and rights. In China a lack of awareness about reproductive health services, including emergency contraception and post-exposure prophylaxis (PEP), is

common among women who have experienced sexual violence (Zhang *et al.*, 2020). In regions with high rates of SGBV, such as sub-Saharan Africa and Latin America, women often do not know where to seek help or how to access appropriate RH services (García-Moreno *et al.*, 2021). Psychological outcomes of SGBV well-documented include various disorders such as PTSD, depression, anxiety, and substance abuse. Survivors of both IPV and sexual assault have an increased probability of psychological challenges, with women and girls being disproportionately affected. Studies have emphasized the need for a trauma-informed approach to mental health care for survivors, as traditional mental health services may not adequately address the specific needs of these individuals (Hernández *et al.*, 2021; Krishnan *et al.*, 2023). Despite widespread recognition of the psychological well-being impact of SGBV, many survivors are unaware of the psychological well-being services and Psychosocial Support (PSS) available to them. A major drawback in accessing psychological well-being care is the lack of awareness about both the psychological impact of trauma and available services. Furthermore, stigma surrounding mental health and SGBV can prevent survivors from seeking help.

Attitudes toward RH is another common problem facing SGBV. Research has also documented that SGBV survivors may hold negative attitudes toward reproductive health care due to previous traumatic experiences with health systems, including stigmatization or mistreatment by healthcare providers. A study in Pakistan by Iqbal *et al.* (2021) found that women who had experienced SGB were often reluctant to seek RH care due to fears of being blamed or not believed by healthcare providers. Negative attitudes toward healthcare institutions were compounded by broader societal stigmas around sexual violence, making survivors hesitant to access services. SGBV, including rape, sexual

assault, and IPV, often leads to physical injury, forced unprotected sex, and exposure to harmful sexual practices, all of which increase the risk of STIs. Studies have shown that survivors of sexual violence are more likely to contract STIs, including HIV, due to factors such as lack of access to healthcare, delayed diagnosis, and insufficient knowledge about safe sex practices (Coker *et al.*, 2020).

Reproductive health knowledge as a tool for empowerment efforts to better understanding of SGBV survivors about reproductive well-being have been a key focus of global health programs. According to the World Health Organization (WHO), comprehensive sexual and reproductive health education can empower survivors by informing them about available services, including access to safe abortion, contraception, and STI treatment (WHO, 2020). Studies conducted in Colombia and Peru suggest that when survivors of sexual violence receive targeted education about reproductive health, they demonstrate improved attitudes and a greater willingness to seek care (Alvarez *et al.*, 2022).

Health screenings are a crucial part of the response to SGBV, yet many survivors lack awareness about their availability and importance. Studies indicate that survivors may be unaware of the need for screening for injuries, STIs, and pregnancy, or the specific health care services they can access following violence. Knowledge gaps in this area are often linked to cultural stigmas, a lack of health education, and inadequate outreach by health services to vulnerable populations (Gupta *et al.*, 2020; Fenton *et al.*, 2022). Gupta *et al.* (2020) conducted a study in India and found that many women who had experienced sexual violence did not know about the health services they could access, such as screenings for STIs, HIV, or pregnancy testing. Survivors in rural areas, in particular, had limited

information about the importance of post-violence screenings and how to access these services, with many believing that they were not entitled to health care following SGBV.

Socioeconomic and cultural background are important in shaping knowledge/attitudes of SGBV survivors toward reproductive health. A study in India by Patel *et al.* (2020) found that women from lower socio-economic backgrounds, especially those in rural areas, had poorer knowledge about reproductive health services and faced greater cultural barriers to accessing care. In these settings, women may face additional hurdles such as male-dominated family structures, limited mobility, and financial dependency, all of which contribute to negative attitudes toward seeking RH care (Patel *et al.*, 2020). In Africa, the burden of SGBV on women's reproductive health is substantial, and efforts attempts to enhance awareness and attitudes about reproductive health among survivors are critical. Several studies from sub-Saharan Africa highlight the ongoing challenges related to knowledge gaps and negative attitudes toward RH care among SGBV survivors.

Research has shown that many African women who experience sexual violence lack knowledge of their reproductive and the services available to them. In Kenya, Uganda, and South Africa, studies have shown that SGBV survivors often do not have adequate information about emergency contraception or the availability of HIV post-exposure prophylaxis (PEP) (Olsson *et al.*, 2020; Pande *et al.*, 2021). A study in Kenya by Murphy found that survivors of sexual violence had significant gaps in their knowledge of available RH services, which directly impacted their health outcomes. Research has also shown that one of the most significant barriers for survivors of SGBV is a lack of knowledge about their legal rights and the services available to them. Studies have found that many survivors are unaware of the laws designed to protect them from violence, including laws related to

reporting, obtaining protection orders, and seeking compensation (Monroe *et al.*, 2021; Tareen *et al.*, 2022). Legal literacy is especially low among marginalized communities, such as rural populations, refugees, and women in conflict zones.

2.4.3 Attitude of female survivors of sexual gender based violence on reproductive health services

Accessing reproductive health services is affected by attitudes toward reproductive health care in many African countries are shaped by deeply entrenched cultural and social norms. In Nigeria, Tanzania, and Ethiopia, research indicates that cultural stigmas associated with sexual violence contribute to the reluctance of survivors to access RHS. Study in Tanzania showed that survivors often feared judgment from healthcare workers and were concerned about the social repercussions of seeking help (Msiska *et al.*, 2020). Study in South Africa found that survivors of sexual violence often have negative attitudes toward contraception, with some survivors believing that they should not use birth control after experiencing violence because of feelings of shame or guilt (Sibiya *et al.*, 2021).

The attitudes of healthcare providers toward sexual gender based violence survivors significantly affect their willingness to seek care. When providers lack training in trauma-informed care or hold stigmatizing views about sexual violence, survivors may feel uncomfortable seeking care or may receive inadequate treatment. Training healthcare providers in sensitive, non-judgmental care is essential to improving survivors' experiences and outcomes (Williams *et al.*, 2023).

Several initiatives in Africa have focused on improving survivors' knowledge and attitudes toward reproductive health. In South Africa, the Thuthuzela Care Centres (TCCs) have integrated services that offer medical, legal, and psychosocial support for survivors of

SGBV. Research has shown that survivors who engage with TCCs report better knowledge about reproductive health services, including contraception and STI prevention (Jewkes *et al.*, 2020). Women's Network highlighted that survivors who received comprehensive education on reproductive health after experiencing sexual violence showed more positive attitudes toward accessing RH care. In Kenya, GBV remains a significant area in sexual violence being one of the most prevalent forms. Female survivors often struggle with limited knowledge and negative attitudes toward reproductive health care, which hinders their access to necessary services.

According to (KDHS, 2022), there are significant gaps in knowledge among women, especially survivors of sexual violence, regarding reproductive health services. In particular, many survivors are unaware of EC and HIV, PEP, which are essential for preventing unintended pregnancies and STIs after sexual assault (KDHS, 2022). A study by FIDA Kenya (2020) found that many survivors of sexual violence lacked knowledge about legal and medical options available to them, such as the availability of post-rape care and emergency contraception.

Cultural stigma and societal judgment play an important factor in shaping attitudes toward reproductive health care among Kenyan survivors of SGBV. Survivors in rural and informal settlements often held negative attitudes toward contraception and other due to cultural and religious beliefs. These survivors also feared being ostracized by their communities or blamed for the violence they experienced (Munyua *et al.*, 2021). The study also noted that healthcare providers sometimes exhibited discriminatory behavior, which further discouraged survivors from seeking care.

Recent interventions in Kenya have focused on improving knowledge about reproductive health and changing attitudes among survivors of sexual violence. The Kenya Red Cross and FIDA Kenya have been at the forefront of offering educational programs and legal support for survivors, including workshops on the importance of RH and rights. In Nairobi, community-based programs have been implemented to educate survivors on their sexual and reproductive rights, leading to improved knowledge and more positive attitudes toward seeking RH services (FIDA Kenya, 2020). The Kenyan government has made efforts to improve access to RHS for survivors of SGBV through the NGMSV (2014). However, research by Gichangi *et al.* (2021) suggests that while these guidelines have improved the availability of services in urban areas, there is still a significant gap in access in rural regions, where cultural attitudes toward sexual violence remain a barrier to seeking care.

2.4.4 Types of reproductive health services provided to female survivors of sexual gender based violence

The provision of RHS for female survivors of SGBV has been widely studied and has become a critical part of the global response to gender inequality and sexual violence. Globally, RHS are recognized as important for survivors of SGBV, efforts have been made to integrate services into healthcare systems. Post-Exposure Prophylaxis for HIV is one of the most essential RHS for SGBV survivors it involves the provision of PEP for HIV. WHO has established guidelines for providing PEP to survivors of sexual violence within 72 hours to prevent sero-conversion. A study by Jaffar *et al.* (2020) showed that providing PEP immediately after a sexual assault significantly reduces the risk of HIV, underscoring its critical role in reproductive health care for survivors (Jaffar *et al.*, 2020).

Emergency contraception (EC) is another key service provided to SGBV survivors to prevent unintended pregnancies following sexual assault. The availability of EC has been prioritized globally, with WHO recommending its use within five days of unprotected sex. However, a study in South Africa showed that awareness of EC remains limited among survivors, highlighting the need for greater education and access to this service in post-rape care settings (Boekel *et al.*, 2021). Globally, SGBV survivors are offered comprehensive STI treatment and screening as part of reproductive health services. A systematic review emphasized the importance of prompt STI testing and treatment to mitigate the long-term health impacts of sexual violence. This includes testing for HIV, syphilis, gonorrhea, chlamydia, and other infections, which can have severe reproductive health consequences if left untreated (Machisa *et al.*, 2022).

Psychosocial Support and Counseling Addressing the psychological impacts of sexual violence is crucial for survivors' recovery and reproductive health. Psychological counseling services, including trauma-focused care and mental health support, are essential components of reproductive health services provided to survivors. WHO and UNFPA have highlighted the importance of integrating mental health care into reproductive health services for survivors, emphasizing trauma-informed care to avoid further harm (UNFPA, 2020). Studies have revealed that access to psychosocial services helps survivors recover more effectively and regain control over their reproductive health decisions. Survivors of SGBV often lack knowledge about their Sexual Reproductive Health Rights (SRHR), and providing education is a crucial service. Global initiatives have focused on offering education about contraception, sexual health, and reproductive rights to empower survivors about their RHS. Programs developed by United Nations and WHO aim to educate

survivors on their rights, available services, and ways to prevent further violence. In Africa, RHC for female survivors of SGBV are critical in mitigating the consequences of sexual violence. African countries face unique challenges due to high rates of GBV, stigma, and inadequate healthcare infrastructure.

South Africa has made significant strides in providing reproductive health services to SGBV survivors. Thuthuzela Care Centres (TCCs) have become a key model for comprehensive post-rape care in the region, offering a range of services, including emergency contraception, STI treatment, HIV PEP, and psychological counseling. Research by Jewkes *et al.* (2020) has shown that these centers have contributed to improved access to reproductive health services for SGBV survivors, including integrated legal and psychosocial support, which leads to better long-term health outcomes for survivors.

In many Sub Saharan Africa (SSA) countries, including Kenya, Uganda, and Tanzania, the provision of STI screening and treatment is a core component of reproductive health services for SGBV survivors. A study by Chirwa *et al.* (2021) in Zambia emphasized the importance of STI screening for survivors of sexual violence, highlighting that early detection and treatment of STIs prevent complications such as pelvic inflammatory disease and infertility. Access to HIV PEP and other post-exposure interventions is prioritized in these regions due to the high rates of HIV transmission linked to sexual violence.

In response to the growing recognition of the psychological toll of sexual violence, many African countries have increasingly integrated psychosocial support into reproductive health services. In Uganda, Kenya, and Rwanda, survivors of SGBV have access to counseling and support groups that are integrated into healthcare systems, especially in

urban and peri-urban areas. These services help survivors cope with the trauma of violence while addressing their reproductive health needs (Khan *et al.*, 2020).

Many African nations have established GBV shelters for survivors to access RHS, including family planning and counseling. These shelters, often run by non-governmental organizations (NGOs), provide essential services like STI treatment and family planning while ensuring that survivors receive legal assistance. Studies have shown that shelters are instrumental in helping survivors access comprehensive reproductive health services in a supportive environment (Khan *et al.*, 2020). Study by FIDA Kenya found that many healthcare facilities in Kenya offer emergency contraception and HIV PEP to survivors of sexual violence, yet access to these services is often inconsistent, particularly in rural and marginalized communities. Awareness campaigns have been implemented, but survivors in remote areas still face challenges in accessing these services within the critical time frame (FIDA Kenya, 2021).

In Kenya, many survivors of sexual violence are provided with STI testing and treatment as part of their post-rape care. The Kenya Red Cross and Amref Health Africa have led efforts to integrate STI services into post-rape care, especially in emergency response settings. These organizations emphasize the importance of treating and preventing STIs to protect women's reproductive health. In Nairobi access to STI testing and treatment improved the health outcomes of SGBV survivors (Kigen *et al.*, 2020).

Psychological support is a critical component of RHS for survivors in Kenya. Many hospitals and health facilities provide trauma counseling strengthening on psychosocial support for survivors. FIDA Kenya has played an essential role in raising awareness of the

psychological impact of sexual violence and advocating for integrated mental health services (FIDA Kenya, 2020). Munyua *et al* (2021), found that survivors who received timely psychological counseling reported better overall health outcomes, including improved reproductive health. Family planning services are also available to survivors of SGB in Kenya, helping them to regain control over their RH. Wambui *et al*, (2020) highlighted that survivors of sexual violence, particularly in urban areas, were more likely to access family planning services, though stigma around contraception still posed a barrier in rural areas.

2.5 Summary of Gaps

While there is literature on the availability of healthcare services in general, limited studies focus specifically on Reproductive health services for survivors of Sexual Gender Based Violence. The existing research failed to highlight the geographic, institutional, and systemic barriers that affect the availability of Reproductive Health Services in Nairobi City County, particularly for women survivors of Sexual Gender Based Violence. There also exists insufficient research on the impact of service availability based on socio-economic status or other demographic factors of survivors.

Many existing studies on Sexual Gender Based Violence survivors tend to focus on psychological or physical health outcomes, but the level of awareness and knowledge about RHS among survivors is underexplored, particularly in urban settings like Nairobi. Most available literature has not captured the awareness of specific services available or how survivors receive this information. The literature does not sufficiently address the attitudes of SGBV survivors toward RHS in Nairobi, or more broadly in Kenya.

Attitudes toward seeking care can be influenced by stigma, fear, or previous negative experiences with healthcare providers, but these specific cultural and contextual attitudes have not been fully explored. There are limited research on the specific types of RHS provided to female survivors of SGBV in Nairobi. While there are general studies on reproductive health services, fewer address how these services are tailored to meet the needs of SGBV survivors, including any gaps in services, underreporting, or challenges in providing comprehensive care.

CHAPTER THREE: MATERIALS AND METHODS

3.1 Research Design

In order to gather data from female survivors of SGBV, the study used analytical cross-sectional research combining qualitative and quantitative components. Data on the accessibility of RHS to female survivors of SGBV, knowledge and attitudes of these survivors regarding RHS, and the types of RHS available to them in Nairobi City County, Kenya were gathered through a mixed method study that combined qualitative and quantitative techniques.

3.2 Study Variables

The study used both dependent and independent variables, with each playing a crucial role in understanding the access to RHS for female survivors of SGBV in Nairobi City County, Kenya.

3.2.1 Dependent Variable

Access to reproductive health services by female survivors' of SGBV in Nairobi City County, Kenya. The measurement of this variable involved assessing. Access that involves a survivor receiving at least three of the five sexual reproductive health services (Family Planning/Pregnancy Care, STI Screening/Treatment, Legal Support, Mental Health Counseling and Post-exposure prophylaxis (PEP)). Access was coded as 1 and No access as 0.

3.2.2 Independent Variable

Study variables: Accessibility of RHS for survivors of SGBV, knowledge and attitudes of SGBV survivors regarding RHS, and types of RHS offered to survivors of SGBV in Nairobi City County, Kenya.

3.3 Location of the Study

Two selected medical facilities located in Nairobi County, Kenya: Nairobi Women's Hospital and Mama Lucy Hospital, were selected. These hospitals were selected due to their strategic roles in providing comprehensive care for survivors of GBV, particularly SGBV. Nairobi Women's Hospital-Prominent facility with a specialized Gender Recovery Center, is one of the leading healthcare providers for survivors of SGBV in the Nairobi region. The hospital has a well-established reputation for offering comprehensive services to women who have experienced SGBV. The Gender Recovery Center at Nairobi among the many services offered by Women's Hospital are emergency contraception and HIV, PEP, STI testing and treatment, psychosocial counseling, and follow-up care. The facility's integrated approach to SGBV care ensures that survivors have access to the necessary reproductive health services, alongside legal and psychological support.

This hospital caters to a broad demographic, including middle-class residents from Nairobi's eastern neighborhoods, such as Dagoretti where the hospital is strategically located. Nairobi Women's Hospital has also gained recognition for handling both community-level cases and referrals from other areas, making it an ideal setting for this study. Mama Lucy Hospital- Government-run medical facility located in Embakasi Constituency, Nairobi County. The hospital plays a crucial role in treating cases of SGBV, particularly from surrounding areas in Nairobi's eastern suburbs. It is known to address GBV at both the community and referral levels. Mama Lucy Hospital provides essential RHS for survivors of SGBV, including emergency contraception, HIV PEP, STI treatment, and psychosocial support.

The hospital serves a diverse population, with a significant number of middle-class families from the region. It is one of the referral hospitals in Nairobi, and many survivors of SGBV are referred to this facility for specialized care. Due to its focus on providing comprehensive care to women who have experienced sexual violence, Mama Lucy Hospital was selected as a suitable location for examining the accessibility of RHS for SGBV survivors in the area.

Both Nairobi Women's Hospital and Mama Lucy Hospital were chosen because of their commitment to providing care for survivors of SGBV, their established roles in both community and referral care, and their ability to cater to a diverse range of patients, including middle-class residents of Nairobi's eastern neighborhoods. Additionally, these hospitals have specialized services designed for managing sexual violence cases, making them ideal settings for examining the accessibility and availability of RHS for female survivors of SGBV. The hospitals' commitment to providing a safe, confidential environment for survivors, along with their integrated service delivery model, enhances the reliability of the data collected from these facilities.

3.4 Study Population

The study intentionally sampled women survivors who either continuing with services or were reporting SGBV cases for the first time and survivors returning for appointments.

3.5 Sample Size Determination

Sample size was obtained by the use of formulae derived from Fisher *et al.* (1998). The method adopts 5% sampling error and a 95% confidence interval.

Therefore: $Z^2pq/d^2 = N$

Where:

N is the ideal sample size for populations bigger than ten thousand.

Z= The associated normal distribution's value at 95% Confidence level= 1.96
 p= Desired population proportion with specific attributes. q=1-p (the percentage of the target population without a specific attribute)
 d=accuracy degree, which is often set at 0.05 level.

Therefore:

Z=1.96 at 95% level of confidence

P=, 0.2 (20% of women have experience sexual gender based violence in Nairobi County)

q= (1-0.2) = 0.8

d=0.05

$N = \frac{1.96^2 \cdot 0.2 \cdot 0.8}{0.05^2} = 245$

Add 10% of n for the non-respondents

10% of 245=24

245 +24=269

n=269

This sample size was present in a ratio of 40: 60 (Nairobi women's hospital and Mama Lucy Kibaki hospital)

The sample size ratio of 60:40 between Nairobi Women's Hospital and Mama Lucy Kibaki Hospital, respectively. This distribution was made based on several key considerations aimed at ensuring representativeness of the study findings. Differences in Size and Patient Load

Nairobi Women's Hospital is a more specialized facility with a dedicated Gender Recovery Center and a broader catchment area, including middle-class residents from various parts

of Nairobi. Due to its higher specialization in gender-based violence care, the hospital tends to handle a higher volume of SGBV-related cases. Therefore, the sample size allocated to this hospital was set at 60% to reflect the substantial role it plays in treating SGBV survivors.

Mama Lucy Kibaki Hospital, while also a government-run facility, serves a different demographic. It is one of the key referral hospitals in the Embakasi Constituency, a densely populated area with diverse socioeconomic backgrounds. Mama Lucy has a larger influx of general healthcare cases, and while it treats a significant number of SGBV survivors, it handles fewer specialized cases compared to Nairobi Women's Hospital. This justifies allocating 40% of the sample size to Mama Lucy Kibaki Hospital.

3.6 Sampling Techniques

Convenience sampling was used to create the sample population because the topic at hand was sensitive. According to the report from the counselling psychologist at Nairobi women's hospital, the facility has a record of over 600 survivors most of who were not willing to consent to speak to an outsider about their ordeal with survivors at Mama Lucy gender desk being approximated to be around 450.

3.7 Inclusion and Exclusion Criteria

3.7.1 Inclusion Criteria

1. Female participants only, as the study focused on female survivors of sexual gender-based violence.
2. Inclusion Age Range: Female survivors aged 18 years and above were included in the study, as they are legally considered adults capable of providing informed consent. Additional Consideration: Female survivors aged below 18 years were

excluded from the study due to legal and ethical considerations related to parental or guardian consent.

3. Only women who have experienced sexual gender-based violence and who were seeking or had sought reproductive health services at Nairobi Women's Hospital or Mama Lucy Kibaki Hospital were eligible for inclusion.
4. Participants who were capable of understanding the study's purpose, procedures, risks, and benefits, and were able to voluntarily agree to participate in the study. Women who were willing to participate in the study and share their experiences regarding access to reproductive health services for SGBV survivors.
5. Healthcare professionals (counselors and clinicians) working in the Nairobi Women's Hospital or Mama Lucy Kibaki Hospital who were involved in providing reproductive health services to SGBV survivors or who had relevant knowledge on the subject.

3.7.2 Exclusion Criteria

1. Since the study focused exclusively on the experiences of survivors, women who had not been victims of SGBV or who were not survivors of SGBV were not included.
2. Female survivors under the age of 18 were excluded from the study due to the need for parental or guardian consent.

3.8 Construction of the Research Instrument

A questionnaire was used in the study. Quantitative and qualitative data was gathered using the questionnaire. Self-reports from the respondents were used in this study since they are a reliable and valuable source of data. The interviewer read the questions. The

researcher also interviewed key informants (health service providers and counseling psychologist) using a key informant schedule to collect information about knowledge and attitudes and types of reproductive health services provided to the female survivors

3.9 Validity and Reliability

3.9.1 Validity

Key variables include access to RHS (dependent variable) and the accessibility, knowledge, attitudes regarding RHS (independent variables) for survivors of SGBV and type of RHS provided.

3.9.2 Reliability

The extent to which the researcher ensured that results produced can be consistently reproduced across different observers under the same conditions was employed according to (Mugenda and Mugenda, 2019). Necessary adjustments were made to the research instrument to address identified errors, misunderstandings and omissions. “Cronbach’s Alpha” was used to estimate the degree of reliability. The coefficient has a range 0 to 1. A range of 0.7 and above is acceptable Tavakol, & Dennick, (2011).

Table 3.1: Reliability Test of Research Instruments

Factor (Scale)	Cronbach's Alpha	Critical Value	Conclusion
Accessibility of RHS	0.745	0.7	Reliable
Knowledge on RHS	0.873	0.7	Reliable
Attitude on RHS	0.722	0.7	Reliable
Type of RHS	0.713	0.7	Reliable

Accessibility, knowledge on RHS, Attitude on RHS and types of RHS provided:

Cronbach's Alpha value was all above 0.7 which is recommended.

3.10 Data Collection Technique

A total 269 participants were recruited through counseling psychologists attached to the two facilities and community health promoters. One-on-one interviews were conducted with survivors through community health promoters. The key informants filled out the key informants guide. All eligible participants who agreed and signed the consent form participated.

3.11 Data Analysis

Descriptive statistics was used to summarize the data and provide an overview of the respondents'. Inferential statistics was employed to test the hypotheses and examine relationships between the dependent and independent variables. Various statistical tests were used to determine the strength and direction of relationships, as well as the significance of the associations.

Chi-square test was used to examine the association between categorical variables. Specifically to test whether there is an association between independent variables and the

dependent variable. Binary logistic regression was used as a key method for analyzing the relationship between dependent variable (female survivors' access to reproductive health services) and the independent variables (accessibility of reproductive health services, knowledge and attitudes, and types of reproductive health services offered) in Nairobi City County, Kenya.

Qualitative data was gathered from key informant interviews with medical professionals and counselors who work with female survivors of SGBV. The accessibility, knowledge, attitude and RH care for SGBV survivors were thoroughly examined in these interviews. The qualitative information from key informant interviews was examined using thematic analysis. This approach gave a thorough description of the data and made it possible to find, examine, and report on patterns (themes) in the data.

3.12 Logistical and Ethical Considerations

3.12.1 Logistical Considerations

Several logistical factors were considered to ensure the successful implementation of the study. Informed Consent was obtained before participation, ensuring voluntary participation. The interviews and surveys conducted at times and locations that were convenient and safe for the participants. Quiet spaces in the hospitals were designated for data collection to ensure confidentiality.

Data Confidentiality: All collected data were stored securely, with physical records locked. Identifiable information was removed to protect participants' confidentiality. Only authorized personnel had access to the data.

3.12.2 Ethical Considerations

The researcher ensured that the ethical requirements of carrying out the study were adhered to. The researcher sought ethical clearance and approval from Kenyatta University Board of Post Graduate studies, the National Council for Science, Technology and innovations and Local administrative offices (County Approval). For purposes of confidentiality and privacy of respondents, the identities of the respondents involved in the study was duly protected by ensuring that the names of the participants were not indicated in the data collection tools. Data collected from the field was kept in a lockable box to ensure security and confidentiality and only the Principle Investigator had access to the contents thereof.

CHAPTER FOUR: RESULTS

4.1 Introduction

The study sought to determine access to RHS by survivors of SGBV in Nairobi City County, Kenya. The study findings are as presented:

4.2 Response rate

A total of N=269 respondents who were receiving services in the two facilities of Mama Lucy Kibaki hospital or Nairobi Women's hospital and were willing to participate were recruited into the study. A total of (62.1%, n=167) respondents were drawn from Nairobi women's hospital while (37.9%, n=102) respondents were drawn from Mama Lucy

Table 4.1 Response rate of female survivors of sexual gender based violence

Response	Frequency(n=269)	Percentages
Nairobi Women's Hospital	167	62.1
Mama Lucy Hospital	102	37.9
Total	269	100.0

4.3 Socio-demographic characteristics

Table 4.2 sets out details of sample demography: In terms of age, most respondents (21.6%, n=58) were aged 33-37 while respondents aged 18-22 were the least (18.2%, n=49). Secondary level of education was the most attained education (63.2%, n=170). In terms of marital status most respondents were in a relationship (36.4%, n=98), while (35.3%, n=95) were married, (13.4%, n=36) were separated, (9.7%, n=26) divorced, and (5.2%, n=14) were widowed. In terms of occupation majority of the survivors were in self-employment (36.4%, n=98), (32%, n=86) were unemployed, (19.7%, n=53) of the survivors were students while (11.9%, n=32) were civil servants. Most respondents were Christians (85.9%, n=231)

Table 4.2 Socio-demographic characteristics of female survivors of sexual gender based violence

Variable	Category	Frequency (n=269)	Proportions (%)
Age(Years)	18-22	48	18.2%
	23-27	56	20.4%
	28-32	51	19%
	33-37	58	21.6%
	38-42	56	20.8%
Level of education	Primary education	14	5.2%
	Secondary education	170	63.2%
	Tertiary education	85	31.6%
Marital status	In a relationship	98	36.4%
	Married	95	35.3%
	Separated	36	13.4%
	Divorced	26	9.7%
	Widowed	14	5.2%
Occupation	Student	53	19.7%
	Unemployed	86	32%
	Self-employed	98	36.4%
	Civil servant	32	11.9%
Religion	Christianity	231	85.9%
	Islam	38	14.1%

4.4 Level of access to reproductive health services and factors affecting access by female survivors of sexual gender based violence

4.4.1 Level of Access to reproductive health services by female survivors of sexual gender based violence

Access was granted when a survivor received at least three services of the five comprehensive reproductive health services provided to survivors of SGBV (Family Planning/Pregnancy Care, STI Screening/Treatment, Legal support, Mental Health Counseling and Post-Exposure Prophylaxis). Those who received either one or two

services were considered to have no access to RHS. Access was coded as 1= access and 0=No access. Fig 4.1 Illustrates that access to RHS by survivors was approximately low at 26% (n=71). About 74% (n=198) of survivors did not access reproductive health services.

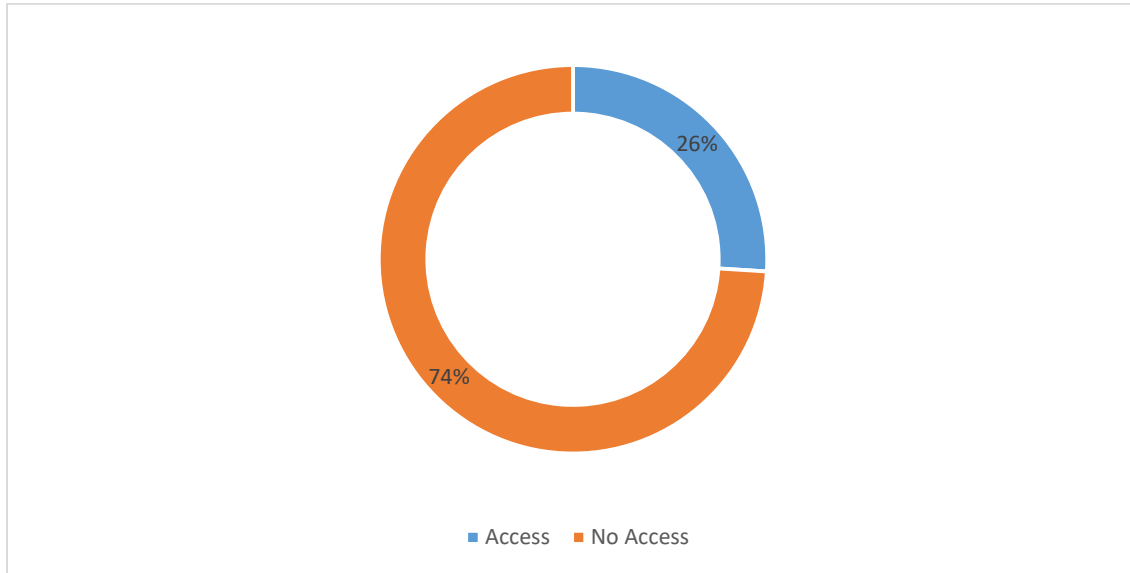


Fig 4.1 Access to reproductive health services by female survivors of sexual gender-based violence

4.5 Factors influencing availability of reproductive health services for female survivors of sexual gender based violence

The study sought to measure various factors influencing availability of RHS for survivors of SGBV. The study findings reveal that (67.3%, n=181), of respondents did not have RHS nearby. Only (32.7%, n=88) of those interviewed came from nearby places and said services were available. The majority of the respondents said affordability was a problem. (54%, n=145) found services not affordable, but (46%, n=124) said services were affordable. Transport to access health facilities hindered access to RHS. Majority of the respondents (60.2%, n=162) said transport services were not available, while (39.8%, n=107) were contented with the transport services available. The convenience of access to

RHS to which the majority of the respondents (53.2%, n=143) said the service provision was not timely and hence hindered access while (46.8%, n=126) said services were timely rendered. A huge majority (70.6%, n=190) said that legal barriers including access to pro bono lawyers were a major challenge to access to RHS. Cultural stigma or taboos also hindered access to reproductive health services by SGBV survivors. The majority (74.9%, n=201) said that their decisions to seek RHS were majorly influenced by their cultural factors. Only (25.1%, n=68) were not influenced by cultural factors. (Table 4.3)

Table 4.3 Factors influencing availability of reproductive health services for female survivors of sexual gender based violence

Accessibility Factor	Frequency(N=269)	Percentages
Availability of services nearby		
Yes	88	32.7
No	181	67.3
Affordability of services		
Yes	124	46
No	145	54
Availability of transport to services		
Yes	107	39.8
No	162	60.2
Services available at convenient times		
Yes	126	46.8
No	143	53.2
Legal barriers to access		
Yes	190	70.6
No	79	29.4
Cultural stigma or taboos in accessing services		
Yes	201	74.9
No	68	25.1

On analyzing responses from key informants, different opinions were fronted to affect accessibility. Transportation *"Many of the survivors live in far-off areas and cannot afford*

the transport to get to the clinics. They end up not seeking help at all." -Key informant, counselor.

Stigma

"Cultural norms are a huge barrier. Some survivors are afraid to be seen at health centers because of the stigma attached to sexual violence." - Key informant, Healthcare Provider.

Cost

"The cost of services, especially for post-exposure prophylaxis (PEP), is too high for most survivors, and they cannot afford it." - Key informant, Clinic Manager.

4.5.1 Availability factors associated with access to reproductive health services among female survivors of sexual gender based violence

Table 4.4 Availability of service nearby for SGBV services for response to SGBV for survivors was a key issue towards access to RHS by survivors of SGB with $\chi^2 = 46.897$, $df=1$ p value=0.00. The findings reveal that affordability of services at the facilities was key to access to RHS by women of sexual gender-based $\chi^2 = 82.490$, $df=1$ p value=0.00. On availability of transport to services for survivors to access RHS the findings revealed that it had association with access to RHS for survivors of SGVB with $\chi^2 = .146.042$, $df=1$ p value=0.00. Services available at convenient times had $\chi^2 = .84.992$, $df=1$ p value=0.00 meaning it had association with access to RHS by survivors of SGBV. The study findings further revealed that Legal barriers had no association with access to RHS for survivors of SGBV $\chi^2 = .40.107$, $df=1$ p value=0.39. And finally the findings revealed cultural stigma had no association with access and therefore had $\chi^2 = 31.994$, $df=1$ and p value=0.91

Table 4.4 Availability of reproductive health services at facility associated with access to reproductive health services among female survivors of sexual gender based violence

Variables	Category	Access to reproductive health services among survivors of SGBV		Statistics		
		0 (No Access) (N=269)	1(Access)	χ^2	df	P value
Availability of service nearby	Yes	88 (63.3%)	51(36.7%)	46.897	1	0.00
	No	110(84.6%)	20(15.4%)			
Affordability of services	Yes	124(89.9%)	14(10.1%)	82.490	1	0.00
	No	74(56.5%)	57(43.5%)			
Availability of transport to services	Yes	36(37.9%)	59(62.1%)	146.042	1	0.00
	No	162(93.1%)	12(6.9%)			
Services available at convenient times	Yes	126(93.3%)	9(6.7%)	84.992	1	0.00
	No	72(53.7%)	62(46.3%)			
Legal barriers to access	Yes	119(64%)	67(36%)	40.107	1	0.39
	No	79(95.2%)	4(4.8%)			
Cultural stigma or taboos in accessing services	Yes	131(72.8%)	49(27.2%)	31.994	1	0.91
	No	67(75.3%)	22(24.7%)			

4.6 Knowledge on sexual reproductive health services and factors affecting access to reproductive health services for female survivors of sexual gender based violence

4.6.1 Knowledge of specific reproductive health services provided to female survivors of sexual gender based violence

Knowledge was measured based on various levels. High knowledge was for participants who correctly identified between 3-5 reproductive health services, contraceptive methods, and sexual health rights. Moderate knowledge was for participants who identified three services and Low knowledge was for participants who showed little or no understanding of reproductive health issues regarding SGBV and mention only one or two of the services offered.

Majority (33.5%, n=130) had moderate knowledge on emergency contraception having mention three of the services in the event of SGBV. On PEP for HIV, majority (42.8%,

n=115) of the respondents had low knowledge since many of them were able to mention one or two services. On STI Prevention and Treatment majority (40.9%, n=110) had moderate knowledge mention three of the services provided. On Mental Health and Psychosocial Support majority had low knowledge (46.4%, n=125) mentioning between one and three services provided. On Safe Abortion Services majority had low to moderate knowledge (37.2%, n=100). On Access to Legal Aid for Survivors, majority had moderate knowledge (37.2%, n=100), On Counseling for Emotional and Psychological Trauma, majority had moderate knowledge (44.6%, n=120). Health Screening for Survivors (e.g., Pregnancy, STI Tests) majority had high knowledge (40.9%, n=110), Gender-Based Violence (GBV) Support Services majority had moderate knowledge (48.3%, n=130) and on Referral Services for Social Support majority had low knowledge (42.8%, n=115).As shown in table 4.5.

Table 4.5: Level of knowledge on reproductive health services provided to female survivors of sexual gender based violence

Health Service for SGBV Survivors	Low Knowledge (Freq/%)	Moderate Knowledge (Freq/%)	High Knowledge (Freq/%)
Emergency Contraception	90 (33.5%)	130 (48.3%)	49 (18.2%)
Post-exposure prophylaxis (PEP) for HIV	115 (42.8%)	95 (35.3%)	59 (21.9)
STI Prevention and Treatment	105 (39.0%)	110 (40.9%)	54 (20.1%)
Mental Health and Psychosocial Support	125 (46.5%)	85 (31.6%)	59 (21.9%)
Safe Abortion Services (Legal and Safe)	100 (37.2%)	100 (37.2%)	69 (25.6%)
Access to Legal Aid for Survivors	95 (35.3%)	100 (37.2%)	74 (27.5%)
Counseling for Emotional and Psychological Trauma	90 (33.5%)	120 (44.6.5%)	59 (21.9%)
Health Screening for Survivors (e.g., Pregnancy, STI Tests)	64(23.8%)	95 (35.3%)	110 (40.9%)
Gender-Based Violence (GBV) Support Services	90(33.5%)	130 (48.3%)	49 (18.2%)
Referral Services for Social Support	115 (42.8%)	95 (35.3%)	59 (21.9%)

4.6.2 Overall knowledge scores on reproductive health services provided to female survivors of sexual gender based violence

Study participants' knowledge score on reproductive health services. Knowledge of reproductive health services was defined based on knowing at least some information on

RHS provided to survivors of SGBV. People who understood least one or two services were rated to have low knowledge (37%, n=100), those who knew at moderate information and had information on three services provided were (39%, n=104) and were the majority. And those who knew a lot of information three to five of services provided were rated to have high knowledge and were the least (24%, n=64). Overall, the knowledge score was averagely 37%. (Table 4.6).

Table 4.6: Distribution of overall knowledge score for female survivors of sexual gender based violence

Knowledge Level	Frequency	Percentage (%)
High Knowledge	65	24%
Moderate Knowledge	104	39%
Low Knowledge	100	37%
Total	269	100%

Analysis from Key Informant Interviews revealed that knowledge gaps, barriers to access, and the long-term impact of SGBV on reproductive health are central concerns for female survivors in Nairobi City County. Respondents indicated the need for targeted awareness to increase knowledge about reproductive health, contraception, and the risks of sexually transmitted infections among survivors of gender-based violence. There was also emphasis on policies and programs aimed at reducing financial and social barriers to reproductive health care, including subsidized services and anti-stigma campaigns, which are crucial.

4.6.3 Knowledge factors associated with access to reproductive health services among female survivors of sexual gender based violence

Table 4.7 Knowledge on emergency contraception was a key issue for women survivors to access reproductive health services $\chi^2 = 103.138$ $df=2$ and p value = 0.00 indicating significant association with access to reproductive health. Knowledge on PEP for HIV was found to have a significant association with access to RHS with services $\chi^2 = 135.216$ $df=2$ and p value = 0.00. On assessing association between Knowledge on STI prevention and treatment and access, the study findings revealed that there was association with $\chi^2 = 146.042$ $df=2$ and p value = 0.00. Knowledge on Mental health and psychosocial Support had association with $\chi^2 = 103.138$ $df=2$ and p value = 0.00. Knowledge on legal services for survivors had an association with access to RHS with $\chi^2 = 170.275$ $df=2$ and p value = 0.00. The study findings revealed that knowledge of counseling for emotional and psychological trauma had $\chi^2 = 125.315$ $df=2$ and p -value = 0.00 and therefore had an association with access to RHS. Knowledge on health screening for survivors (e.g., Pregnancy, STI Tests) was also found to have an association with access to reproductive health among survivors with $\chi^2 = 146.042$ $df=2$ and p value = 0.00. Finally, on gender-based violence (GBV) Support Services had $\chi^2 = 107.852$ $df=2$ and p value = 0.00 also revealing an association with access to RHS.

Table 4.7 Level of knowledge factors associated with access to reproductive health services among female survivors of sexual gender based violence

Variables	Category	Access to reproductive health services among survivors of sexual gender based violence		Statistics		
		0 (No access) (n=198)	1(Access) (n=71)	χ^2	df	p-value
Knowledge on emergency contraception	Low	45(59.2%)	31(40.8%)	103.138	2	0.00
	Moderate	94(89.5%)	11(10.5%)			
	High	59(67%)	29(33%)			
Knowledge on Post-exposure prophylaxis (PEP) for HIV	Low	41(66.1%)	21(33.9%)	135.216	2	0.00
	Moderate	82(68.9%)	37(31.1%)			
	High	75(85.2%)	13(14.8%)			
Knowledge on STI Prevention and Treatment	Low	129(83.8%)	25(16.2%)	146.042	2	0.00
	Moderate	33(66%)	17(34%)			
	High	36(55.4%)	29(44.6%)			
Knowledge on Mental Health and Psychosocial Support	Low	64(68.8%)	29(31.2%)	125.315	2	0.00
	Moderate	42(57.5%)	31(42.5%)			
	High	92(89.2%)	11(10.8%)			
Knowledge on legal services for survivors	Low	150(80.7%)	36(19.3%)	170.275	2	0.00
	Moderate	26(52%)	24(48%)			
	High	22(66.7%)	11(33.3%)			
Knowledge on counseling for Emotional and Psychological Trauma	Low	110(81.5%)	25(18.5%)	125.315	2	0.00
	Moderate	42(59.2%)	29(40.8%)			
	High	46(73%)	17(27%)			
Knowledge on Health Screening for Survivors (e.g., Pregnancy, STI Tests)	Low	81(75%)	27(25%)	146.042	2	0.00
	Moderate	81(73.6%)	29(26.4%)			
	High	36(70.6%)	15(29.4%)			
Knowledge on Gender-Based Violence (GBV) Support Services	Low	107(74.3%)	37(25.7%)	107.852	2	0.00
	Moderate	56(60.2%)	37(39.8%)			
	High	35(48.6%)	37(48.6%)			

4.7 Attitude of female survivors towards sexual reproductive health services

4.7.1 Types of sexual gender based violence experienced by female survivors of sexual gender based violence in Kenya

The study assessed various SGBV experienced by the survivors to determine their attitude on RHS. Rape was the most experienced SGBV (36.8%, n=99), sexual assault (22.3%, n=60), Domestic and Intimate Partner Sexual Violence (18.6%, n=50), Sexual Exploitation and Trafficking (16.7%, n=45), Female Genital Mutilation (FGM) (3.7%, n=10) and (1.9%, n=5). As shown in table 4.8.

Table 4.8: Types of sexual gender based violence experienced by female survivors of sexual gender based violence in Kenya

Type of Sexual GBV	Frequency (N=269)	Percentage (%)
Rape	99	36.8%
Sexual Assault	60	22.3%
Domestic and Intimate Partner Sexual Violence	50	18.6%
Sexual Exploitation and Trafficking	45	16.7%
Female Genital Mutilation (FGM)	10	3.7%
Sexual Harassment	5	1.9%
Total	269	100%

4.7.2 Attitude on reproductive health services provided to female survivors of sexual gender based violence

Table 4.9 shows that rape survivors were the largest group (36.8%, n=99) and show a mean attitude score of 3.2, indicating that rape survivors tend to be neutral to slightly positive about access to reproductive health services. About 55% agree or strongly agree that they have access to RHS. Survivors of Sexual Assault showed a similar trend, with a slightly

more positive mean score (3.5) and 53% agreeing or strongly agreeing with access to reproductive health services. Domestic & Intimate Partner Violence survivors had the highest percentage of survivors who felt they had access to reproductive health services (64%). Sexual Exploitation & Trafficking survivors report the most positive mean score (3.6), with 68% agreeing or strongly agreeing with access to reproductive health services. FGM survivors show the lowest percentage of agreement with access to services (40%), possibly indicating higher barriers to reproductive health services in this group.

Table 4.9: Attitude on reproductive health services provided to female survivors of sexual gender based violence

Type of Sexual GBV	Frequency (N=269)	Percentage (%)	Mean Attitude Score	Access to RH Services (Agree/Strongly Agree)
Rape	99	36.80%	3.2	55%
Sexual Assault	60	22.30%	3.5	53%
Domestic & Intimate Partner Violence	50	18.60%	3.3	64%
Sexual Exploitation & Trafficking	45	16.70%	3.6	68%
Female Genital Mutilation (FGM)	10	3.70%	3.1	40%
Sexual Harassment	5	1.90%	3.2	60%
Total	269	100%	3.3	57%

Analysis from the Key Informant Interviews revealed that trust and confidentiality influenced attitude as some survivors expressed a lack of trust in healthcare providers, fearing that their experiences will not be kept confidential or that they will be judged.

Further cultural beliefs and norms around sexuality, reproductive health, and sexual violence influenced the feeling of survivors when seeking care. Survivors reported varying levels of satisfaction with the services they receive, citing issues like inadequate support, insufficient information about reproductive health, or unprofessional conduct from health workers. Barriers like lack of transportation, financial constraints, or geographical distance limited survivors' access to reproductive health services. Some survivors felt empowered by services that was provided to them with the necessary support, counseling, and reproductive health care, while others felt isolated or unsupported.

4.8 Reproductive health services provided to female survivors of sexual gender based violence

Table 4.10 shows that the highest access rate was observed for STI screening and treatment, with (83.8%, n=140) of survivors at Nairobi women's seeking this service. This suggests a strong emphasis on the prevention and treatment of STIs following sexual violence. Family Planning/Pregnancy Care had (65.8%, n=110) of survivors at Nairobi women's Hospital accessed Family Planning/Pregnancy Care services, Mama Lucy Hospital (68.6%, n=70), though both hospitals offered these services widely. Access to legal support was somewhat limited, with (41.9%, n=70) of survivors at Nairobi Women's and (49%, n=50) at Mama Lucy Hospital seeking legal assistance and being able to access it. This suggests that legal support services might be less accessible or less prioritized compared to other health services. Access to mental health services including psychosocial support at Nairobi women's hospital with (53.9%, n=90) of respondents and (58.8%, n=60) Mama Lucy. Post Exposure Prophylaxis (PEP) was relatively high at both hospitals at Nairobi Women's Hospital (56.9%, n=95) and (63.7%, n=65) for Mama Lucy hospital.

Table 4.10: Reproductive health services provided to female survivors of sexual gender based violence

Reproductive Service	Health	Nairobi Women's	Mama Lucy	Overall Frequency/percentage (N=269)
Family Planning/Pregnancy Care		110 (65.8%)	70 (68.6%)	180 (66.9%)
STI Screening/Treatment		140 (83.8%)	70 (68.6%)	210 (78.1%)
Legal Support		70 (41.9%)	50 (49%)	120 (44.6%)
Mental Health Counseling		90 (53.9%)	60 (58.8%)	150 (55.8%)
Post-exposure prophylaxis (PEP)		95 (56.9%)	65 (63.7%)	160 (59.5%)

4.8.1 Type of reproductive health services associated with access to reproductive health services among female survivors of sexual gender based violence

The results in Table 4.11 indicate that family planning/pregnancy care was important for access to RHS had $\chi^2 = 146.042$, $df=2$ and p value= 0.00 therefore an association with access to RHS by women sexual gender-based violence.

STI Screening/Treatment for RH care was found to have an association with access to RHS with $\chi^2 = 92.939$ $df=2$ and p -value = 0.00. Findings reveal that there was no association between the Legal Support and access to RHS by survivors of SGBV $\chi^2 = 269.007$, $df=2$ p value = 0.39. The results further reveal that there was an association between mental health counseling and access to RHS with $\chi^2 = 188.679$, $df=2$ p value =

0.00. Post-exposure prophylaxis (PEP) was also associated with access to RHS for SGBV survivors with $\chi^2 = 173.828$ $df=2$ and p value = 0.00.

Table 4.11 Type of reproductive health services provided associated with access to reproductive health services among female survivors of sexual gender based violence

	Category	Access to reproductive health services among survivors of SGBV		Statistics		
		0(No access) (n=198)	1(Access) (n=71)	χ^2	df	p-value
Family Planning/Pregnancy Care	Mama Lucy Nairobi Women's	76(61.3%) 122(84.1%)	48(38.7%) 23(15.9%)	146.042	1	0.00
STI Screening/Treatment	Mama Lucy Nairobi Women's	88(59.1%) 110(91.7%)	61(40.9%) 10(8.3%)	92.939	1	0.00
Legal Support	Mama Lucy Nairobi Women's	97(74.6%) 101(72.7%)	33(25.4%) 38(27.3%)	269.007	1	0.39
Mental Health Counseling	Mama Lucy Nairobi Women's	70(72.2%) 128(74.4%)	27(27.8%) 44(25.6%)	188.679	1	0.00
Post-exposure prophylaxis (PEP)	Mama Lucy Nairobi Women's	93(80.2%) 105(68.6%)	23(19.8%) 48(31.4%)	173.828	1	0.00

4.9 Logistical binary regression for dependent and independent variables

The study examined the association of socio-demographic, accessibility, knowledge, attitude and types of SGBV services and the odds of accessing reproductive health services by survivors of SGBV. The adjusted odds ratios (OR) were calculated for each variable, along with their 95% confidence intervals (CI) and p-values. As shown in table 4.13 age, education, marital status, and religion were statistically significant.

Education: The adjusted OR for education was 0.27 (95% CI 0.09-0.58, $p=0.00$), indicating education was 0.27 times more likely to influence survivors' access to RHS. The

results suggest that education is a significant factor in determining whether to seek for reproductive health services after experiencing sexual gender-based violence. Age: adjusted OR for age was 0.15 (95% CI 0.07-0.29, $p=0.00$). Marital status: adjusted OR for marital status was 0.37 (95% CI 0.29-0.63, $p=0.00$). Occupation: adjusted OR for occupation was 0.36 (95% CI 0.18-0.75 $p=0.01$) and religion: adjusted OR for religion was 0.53 (95% CI 0.19-1.52, $p=0.23$) was not statistically significant.

Awareness on reproductive health services provided: The adjusted OR was 26.10 (95% CI 2.47-18.212, $p=0.01$), indicating awareness on reproductive health was 26 times more likely to influence survivors' access to RHS. The results suggest that awareness on RHS provided is a significant factor in determining whether to seek for RHS after experiencing sexual gender-based violence.

Availability of reproductive health services nearby: The adjusted OR was 6.58 (95% CI 2.28-18.99, $p=0.00$), indicating availability of RHS was 6 times more likely to influence survivors' access to RHS. The results suggest that availability of RHS is a significant in determining access to RHS by survivors of SGBV.

Knowledge on RHS provided: The adjusted OR was 14.70 (95% CI 1.46-78.28, $p=0.00$), Knowledge on reproductive health was 14 times more likely to influence access to RHS by survivors and was therefore significant in determining access to RHS by survivors. **Service affordability:** The adjusted OR was 10.07 (95% CI 3.12-32.59, $p=0.00$). The results suggest that affordability of RHS is significant in determining access to RHS by survivors of SGBV.

Transport to access health facilities: The adjusted OR was 0.08 (95% CI 0.03-0.22, $p=0.00$), transport availability was significant in determining access to reproductive health

services by survivors of SGBV. Timeliness of service provision: The adjusted OR was 4.24 (95% CI 1.57-11.55, $p=0.00$), the result suggest that timeliness of service provision was significant in access to RHS by survivors. Legal barriers: The adjusted OR was 0.61 (95% CI 0.19-1.90, $p=0.39$), the result suggest that legal barriers were not significant in determining access to RHS for survivors of SGBV. Cultural stigma: The adjusted OR was 1.06 (95% CI 0.41-2.75, $p=0.91$), this therefore means that cultural stigma was not significant in determining access to RHS by survivors. Attitude on RHS provided the adjusted OR was 0.55 (95% CI 0.37-0.81, $p=0.00$), this therefore means that attitude was significant in determining access to RHS by survivors and on type of sexual gender based violence experienced; The adjusted OR was 0.45 (95% CI 0.33-0.60, $p=0.00$), this therefore means that type of sexual gender based violence experienced was significant in determining access to RHS by survivors.

Table 4.12 Binary logistical regression analysis for dependent and independent variables

Variables	Adjusted OR	95% C.I. for EXP(B)		p-value
		Lower	Upper	
Education	0.27	0.09	0.58	0.00
Age	0.15	0.07	0.29	0.00
Marital status	0.37	0.29	0.63	0.00
Occupation	0.36	0.18	0.75	0.01
Religion	0.53	0.19	1.52	0.23
Awareness on reproductive health services provided	26.1	2.47	18.21	0.01
Availability of reproductive health services nearby	6.58	2.28	18.99	0.00
Knowledge of reproductive health services provided	14.7	1.46	78.28	0.00
Service affordability	10.07	3.12	32.59	0.00
Transport to access health facilities	0.08	0.03	0.22	0.00
Timeliness of service provision	4.24	1.57	11.55	0.00
Legal barriers	0.61	0.19	1.9	0.39
Cultural stigma	1.06	0.41	2.75	0.91
Attitude on RHS provided	0.55	0.37	0.81	0.00
Type of sexual gender based violence service provided	0.45	0.33	0.60	0.00

Key: OR – Odds Ratio, CI-Confidence Interval

CHAPTER FIVE: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This section presents discussion, conclusions and recommendations of the study based on the study objectives.

5.2 Discussions

The section discusses study results in relation to other past studies as well as interpretation of the study results in the context of the study. The discussion is based on study objectives as follows: availability of RHS, knowledge on RHS, attitude of survivors on RHS and types of RHS provided to the survivors of sexual gender based violence.

5.2.1 Availability factors associated with access to reproductive health services among female survivors of sexual gender based

The Odds Ratio for availability of service nearby was a significant factor for access. The findings are consistent with the findings of previous studies which have reported that service availability is a key component that drives accessibility. For instance, (WHO, 2021; Hegarty *et al.*, 2021). Studies are important in integrating GBV services into the broader reproductive health framework. The WHO advocates for the integration of GBV response into primary care services to ensure comprehensive support for survivors. Service affordability was 10.07 times likely to increase survivors' access to RHS. The results suggest that the affordability of RHS is significant in determining access to RHS by survivors of SGBV. These findings are supported by the study's findings (Gomez *et al.*, 2020). The study found that women who have experienced GBV often face barriers to accessing RHS, including stigma, lack of privacy, and insufficient resources within healthcare systems. Cultural stigma was not a significant factor on access to RHS. These findings are inconsistent with previous study by Gomez *et al.*, 2020). The study found that

women who have experienced GBV often face barriers to accessing RHS, including cultural stigma, lack of privacy, and insufficient resources within healthcare systems

5.2.2 Knowledge factors associated with access to reproductive health services among female survivors of sexual gender based violence

This study further provided valuable insights into on knowledge and access to RHS by survivors of SGBV. Knowledge on reproductive health was 14 times more likely to influence access to RHS by survivors and was therefore significant in determining access to RHS by survivors. Majority of the respondents had between low and moderate knowledge on various parameters used to measure knowledge. We found that knowledge on emergency contraception and PEP was significant factor for women survivors to access RH. This in essence created queues to action which in the theory of the health belief model provided the survivors with a reason to seek for services in the event of experiencing sexual gender based violence. Study by (García-Moreno *et al.*, 2021)) affirm this finding. Knowledge and access to EC among women survivors of SGBV.

Knowledge on STI prevention and treatment and access. There was significant association and therefore knowledge of STI prevention and treatment influenced access to reproductive health services. These findings are supported by the findings of the study by (Coker *et al.*, 2020; Ghimire & Nybachi, 2022) which showed that survivors of sexual violence were more likely to contract STIs, including HIV, due to factors such as lack of access to healthcare, delayed diagnosis, and insufficient knowledge about safe sex practices. Knowledge of mental health and psychosocial support was also found to be significant in influencing access to RHS by survivors of SGBV. These findings are consistent with the findings of the study by (Zhang *et al.*, 2022) which concluded that the major barrier to

accessing mental health care is the lack of awareness about both the psychological impact of trauma and available services. Furthermore, stigma surrounding mental health and SGBV can prevent survivors from seeking help.

Knowledge on legal services for survivors had an association with access to reproductive health. Knowing the available legal procedures increased the level of access. This finding was significant and is supported by the findings of previous research. Studies have found that many survivors are unaware of the laws designed to protect them from violence, including laws related to reporting, obtaining protection orders, and seeking compensation (García-Moreno *et al.*, 2021). Legal literacy is especially low among marginalized communities, such as rural populations, refugees, and women in conflict zones. The study findings revealed that knowledge of counseling for emotional and psychological trauma had an association with access to RHS. Knowledge on health screening for survivors was also found to have an association with access to RHS among survivors. These findings are supported by the findings of the study by Gupta *et al.* (2020) in India and found that many women who had experienced sexual violence did not know about the health services they could access, such as screenings for STIs, HIV, or pregnancy testing. Survivors in rural areas, in particular, had limited information about the importance of post-violence screenings and how to access these services, with many believing that they were not entitled to health care following SGBV.

5.2.3 Attitude factors associated with access to reproductive health among female survivors of sexual gender based

This study investigated the association between the attitude of survivors and access to RHS. We found that attitude majorly depended on the type of SGBV experienced by survivors.

Attitude was found to be significant in determining access to RHS by survivors. Rape survivors tended to be neutral to slightly positive about access to RHS. This was due to elaborate procedures put in place by the facilities to promote access to RHS. Domestic & Intimate Partner Violence survivors had the highest percentage of survivors who felt they had access to reproductive health services. Sexual Exploitation & Trafficking survivors report the most positive and agreeing or strongly agreeing with access to reproductive health services. FGM survivors show the lowest percentage of agreement with access to services possibly indicating higher barriers to reproductive health services in this group. Findings are supported by the studies on the attitudes of healthcare providers toward SGBV survivors which significantly affect their willingness to seek care. When providers lack training in trauma-informed care or hold stigmatizing views about sexual violence, survivors may feel uncomfortable seeking care or may receive inadequate treatment. Training healthcare providers in sensitive, non-judgmental care is essential to improving survivors' experiences and outcomes (Williams *et al.*, 2023).

5.2.4 Type of sexual gender based violence services provided associated with access to reproductive health services among female survivors of sexual gender based violence

The study found that type of sexual gender based violence service provided was significant in determining access to RHS for survivors of SGBV. The study findings revealed that family planning/pregnancy care was important for access to services for RH for survivors. STI Screening/Treatment for Reproductive Health Care was also found to have an association with access to RHS. Previous studies have also shown that Sexually Transmitted Infections (STI) Treatment and Screening Survivors of sexual violence are at increased risk of contracting sexually transmitted infections (STIs). Globally, SGBV

survivors are offered comprehensive STI treatment and screening as part of RHS. A systematic review emphasized the importance of prompt STI testing and treatment to mitigate the long-term health impacts of sexual violence. The results further reveal that there was an association between mental health counseling and access to RH. The results further reveal that there was an association between mental health counseling and access to RHS and PEP was also associated with access to RHS for SGBV survivors. This finding was supported by previous study which revealed that PEP for HIV is one of the most essential RHS for SGBV survivors it involves the provision of PEP for HIV. The World Health Organization (WHO) has established guidelines for providing PEP to survivors of sexual violence within 72 hours of exposure to reduce the risk of HIV transmission. A study by Jaffar *et al.* (2020) showed that providing PEP immediately after a sexual assault significantly reduces the risk of HIV, underscoring its critical role in RH care for survivors (Jaffar *et al.*, 2020). However, the study findings reveal that there was no association between Legal Support and access to RHS by survivors of SGBV

5.3 Conclusion

Reproductive health services were available for female survivors of sexual gender based violence in Nairobi City County, Kenya, the study found that availability of reproductive health services was only at 36.7% and therefore access is limited in certain areas. Factors such as geographic location, socio-economic status, and cultural barriers contributed to uneven access to these services. Rural and marginalized urban areas face significant challenges in accessing reproductive health services, despite the presence of service providers. In particular, health facilities often under-resourced, and service providers were

not adequately trained to handle the unique needs of sexual gender based violence survivors, especially in terms of privacy and sensitivity

The study revealed that female survivors had low level of awareness on reproductive health services provided to survivors of sexual gender based violence. Many survivors were unaware of the full range of services they are entitled to or how to access them. Information gaps existed, particularly in low-income and informal settlement areas, where survivors often relied on informal channels for information. This knowledge gap significantly hinders survivors' ability to seek timely and appropriate care.

The study identified low attitudes toward reproductive health services among female survivors of sexual gender based violence. Survivors expressed mistrust of health service providers due to previous negative experiences, perceived stigma, and concerns about confidentiality. However, there was also a notable willingness to seek care if they felt supported by empathetic and trained professionals. Survivors often preferred services that were sensitive to their trauma and offered a holistic approach to healing, including mental health support.

Reproductive health services offered to female survivors of sexual gender based violence was more predominant in Nairobi women's compared to Mama Lucy Kibaki hospital. While Mama Lucy Kibaki hospital provided a range of services, including emergency contraception, post-exposure prophylaxis (PEP) for HIV, and mental health support, survivors reported that these services were not consistently available or were of low quality. Inadequate staff training, poor resource allocation, and lack of privacy in service delivery hinder the effectiveness of reproductive health services for survivors of sexual gender based violence.

5.4 Recommendations

5.4.1 Recommendations from the study

1. There is need for involvement of community health volunteers to help in the identification of sexual violence cases and link them health facilities to enhance quick management to prevent progression to worse conditions such as sero-conversion from AIDS to HIV.
2. The need for continuous health education provided at household levels or community will enhance knowledge and increase access.

5.4.2 Recommendations for policy

1. The county government to ensure implementation of the policy on national guideline on management of sexual violence to enhance availability, affordability and accessibility of reproductive health services to the survivors.
2. Integrate sexual gender based violence services into reproductive health services: Strengthen the integration of SGBV services into routine reproductive health services, ensuring that women who seek care for reproductive health also receive support for SGBV-related needs, such as counseling, legal assistance, and safety planning.
3. Improve Accountability for service providers: implement policies that hold health providers accountable for providing respectful, confidential, and non-discriminatory care. Ensure they have proper training on handling cases of SGBV with sensitivity.

5.4.3 Recommendations for further study

1. A study could be carried out to evaluate the implications of increased access levels of sexual reproductive health among women.
2. A study could be carried out to evaluate knowledge levels of all women and not survivors on health problems of sexual gender based violence

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APPENDICES

Appendix I: Consent Form

My name is **Pascal Onyango Oredo** /I am a Master's degree in Public Health (Epidemiology and Disease Control) student from Kenyatta University). I am conducting a study titled "**Access to reproductive health services for female survivors of sexual gender based violence in Nairobi city county, Kenya**". The information will be used to improve access to reproductive health and improve service delivery to women of reproductive health services among survivors of sexual gender based violence.

Procedures to be followed

Participation in this study will require that I ask you some questions regarding your past experience as a survivor of sexual gender based violence in order to screen you for **Access to reproductive health services**.

Voluntarism

You have the right to refuse participation in this study. You will get the same services and care whether you agree to join the study or not and your decision will not change the care you will receive. Please remember the participation in this study is voluntarily. You may ask questions related to the study at any time.

You may refuse to respond to any questions and you may stop an interview at any time.

You may also stop being in the study at any time without any consequences to the services you receive here or any other organization now or in the future.

Discomforts and Risks

Some of the questions you will be asked are on intimate subject and may be embarrassing or make you uncomfortable. If this happens, you may refuse to answer these questions if you so choose. You may also stop the interview at any time.

Benefits

If you participate in this study you will help us to learn how to provide effective reproductive health services to women survivors of sexual gender based violence: You will also benefit from being referred to other service providers should there arise need for better service provision. **Reward**

If you agree to participate in this study, lunch will be provided and transport expenses will be reimbursed at 200/- per visit.

Confidentiality

The interviews and examinations will be conducted in a private setting within the clinic. Your name will not be recorded on the questionnaire. The questionnaires will be kept in a locked cabinet for safe keeping at Kenyatta University. Everything will be kept private and only shared with the study team.

Contact Information

If you have questions about the study call 0720840372 Principle Investigator.

However, if you have questions about your rights as a study participant: You may contact Kenyatta University Ethical Review Committee Secretariat on chairman.kuerc@ku.ac.ke,

Participant's statement

The above information regarding my participation in the study is clear to me. The study has been explained to me and I have been given a chance to ask questions and my questions have been answered to my satisfaction. My participation in this study is entirely voluntary. I understand that my records will be kept private and that I can leave the study at any time. I understand that I will still get the same care and medical treatment whether I decide to leave the study or not and my decision will not change the care that I will receive from the clinic today or that I will get from any other clinic at any other time.

Name of Participant:

Signature or Thumbprint, Date Name of Representative/Witness (where necessary)

Relationship to Subject

Investigators statement

I, the undersigned, have explained to the volunteer in a language s/he understands, the procedures to be followed in the study and the risks and benefits involved

Name of Interviewer

Signature

Date

Appendix II: Survey Questionnaire for Female Survivors of SGBV
PARTICIPANTS' INSTRUCTIONS

Do not write your name;

(1) Tick only one correct response and multiple responses where choices are provided and fill in the spaces given.

Section A: Socio-Demographic Data

1. What is your age?

- a. 18-22 { }
- b. 23-27 { }
- c. 28-33 { }
- d. 34-37 { }
- e. 38-42 { }

2. Level of education?

- a. Primary education { }
- b. Secondary education { }
- c. Tertiary education { }
- d. Others (Specify)

3. Marital status?

- a. Single { }
- b. In a relationship { }
- c. Married { }
- d. Widowed { }
- e. Separated { }
- f. Divorced { }

4. What is your occupation?

- a. Student { }
- b. Unemployed { }
- c. Civil servant { }
- d. Self-employed { }
- e. Others (specify).....

5. Which religion do you practice?

- a. Christianity { }
- b. Islam { }
- Others (specify).....

Section B: Availability of Reproductive Health Services to Survivors of Sexual Gender Based Violence

6. Are reproductive health services available nearby?

- a. Yes { }
- b. No { }

7. Are reproductive health services affordable in the facility where you sought it from?

- a. Yes { }
- b. No { }

8. Availability of transport to services

- a. Yes { }
- b. No { }

9. Services available at convenient times

- a. Yes { }
- b. No { }

10. Have you ever experienced any Legal barriers to accessing reproductive health

a. Yes { }

b. No { }

11. Does cultural stigma or taboos affect your ability in accessing reproductive health services

a. Yes { }

b. No { }

Section C: Knowledge of Female Survivors of Sexual Gender Based Violence on Reproductive Health

12. Knowledge on Contraceptive Accessibility & Use

13. Knowledge on Post-exposure prophylaxis (PEP) for HIV

No.	Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	Post-Exposure Prophylaxis (PEP) is a preventive treatment to reduce the risk of HIV infection after potential exposure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	PEP must be started within 72 hours of potential exposure to HIV to be effective.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3	PEP is a combination of antiretroviral drugs that must be taken for 28 days to be effective.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	PEP is only recommended for people who have had unprotected sexual intercourse with someone who is HIV-positive or whose HIV status is unknown.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	PEP is an emergency measure and should not be relied on as a regular method of HIV prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Knowledge on STI Prevention and Treatment

No.	Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	Sexually transmitted infections (STIs) can be transmitted through sexual contact.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Consistent and correct use of condoms is one	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	of the most effective ways to prevent STIs.					
3	Some STIs, such as HIV, can be transmitted through sharing needles or other drug paraphernalia.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Vaccines are available to prevent certain STIs, such as the human papillomavirus (HPV) and hepatitis B.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	It is possible to be infected with more than one STI at the same time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Knowledge on mental health and psychosocial support

No.	Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	Mental health is just as important as physical health in overall well-being.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Psychosocial support is essential for people going through stress, trauma, or difficult life events.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3	Mental health services are available and accessible to most people in my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	There is adequate mental health support for individuals affected by sexual and reproductive health issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Stigma around mental health often prevents people from seeking help for mental health issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. Knowledge on legal support

No.	Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	Survivors of gender-based violence (GBV) have legal rights that can help protect them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	There are legal services available to support survivors of sexual assault or violence in my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Legal aid services are important for helping survivors of violence to navigate the legal system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	I am aware of the specific laws in my country or community that protect survivors of violence or abuse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5	Legal services are free of charge for survivors of sexual violence or gender-based violence in my area.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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17. Knowledge on counseling for Emotional and Psychological Trauma

No.	Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	Counseling is an essential part of the recovery process for survivors of emotional and psychological trauma.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	I believe survivors of sexual violence and abuse should be offered psychological counseling immediately after the event.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Survivors of trauma should receive long-term counseling to help them manage the psychological impact of violence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Emotional and psychological counseling should be a part of comprehensive post-rape care for survivors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Counseling for survivors should address both the emotional and psychological aspects of trauma, not just the physical impact.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

18. Knowledge on Health Screening for Survivors (e.g., Pregnancy, STI Tests)

No.	Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	Survivors of sexual and gender-based violence (SGBV) should receive comprehensive health screenings for pregnancy, STIs, and other reproductive health concerns.	[]	[]	[]	[]	[]
2	Pregnancy testing is an essential part of the health screening for survivors of sexual violence.	[]	[]	[]	[]	[]
3	STI testing should be a routine part of the health screening for survivors of sexual violence.	[]	[]	[]	[]	[]
4	Health professionals should offer survivors of SGBV regular screenings for both pregnancy and sexually transmitted infections (STIs).	[]	[]	[]	[]	[]
5	It is important to provide survivors of sexual violence with health screenings even if they are not immediately concerned about pregnancy or STIs.	[]	[]	[]	[]	[]

Section D: Types of Reproductive Health Services Provided to Survivors of Sexual Gender-Based Violence

19. Indicate the services provided from the facility you visited

No.	Statement	1	2	3	4	5
1	Family Planning/Pregnancy Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	STI Screening/Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Legal Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Mental Health Counseling.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Post-exposure prophylaxis (PEP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix III: Key Informant Interview Guide

Section 1: General Information

1. Can you please tell me your role or position?
2. How long have you been working in this field/organization?

Section 2: Availability of RHS to Female Survivors of SGBV

1. What reproductive health services are available for female survivors of SGBV in Nairobi City County?
2. Are these services accessible to all survivors? Are there any barriers to accessing these services?
3. How do survivors typically find out about the availability of RHS?
4. In your opinion, is the availability of RHS sufficient to meet the needs of survivors in Nairobi? Why or why not?

Section 3: Knowledge of RHS among Survivors of SGBV

1. From your experience, how knowledgeable do you think female survivors of SGBV are about available RHS?
2. What methods do survivors typically use to gather information about RHS (e.g., healthcare providers, community programs, online resources)?
3. Do you think there is a gap in the knowledge of SGBV survivors regarding the types of RHS available to them?
4. In your opinion, what factors contribute to the knowledge (or lack of knowledge) about RHS among survivors of SGBV?

Section 4: Attitudes towards RHS among Survivors of SGBV

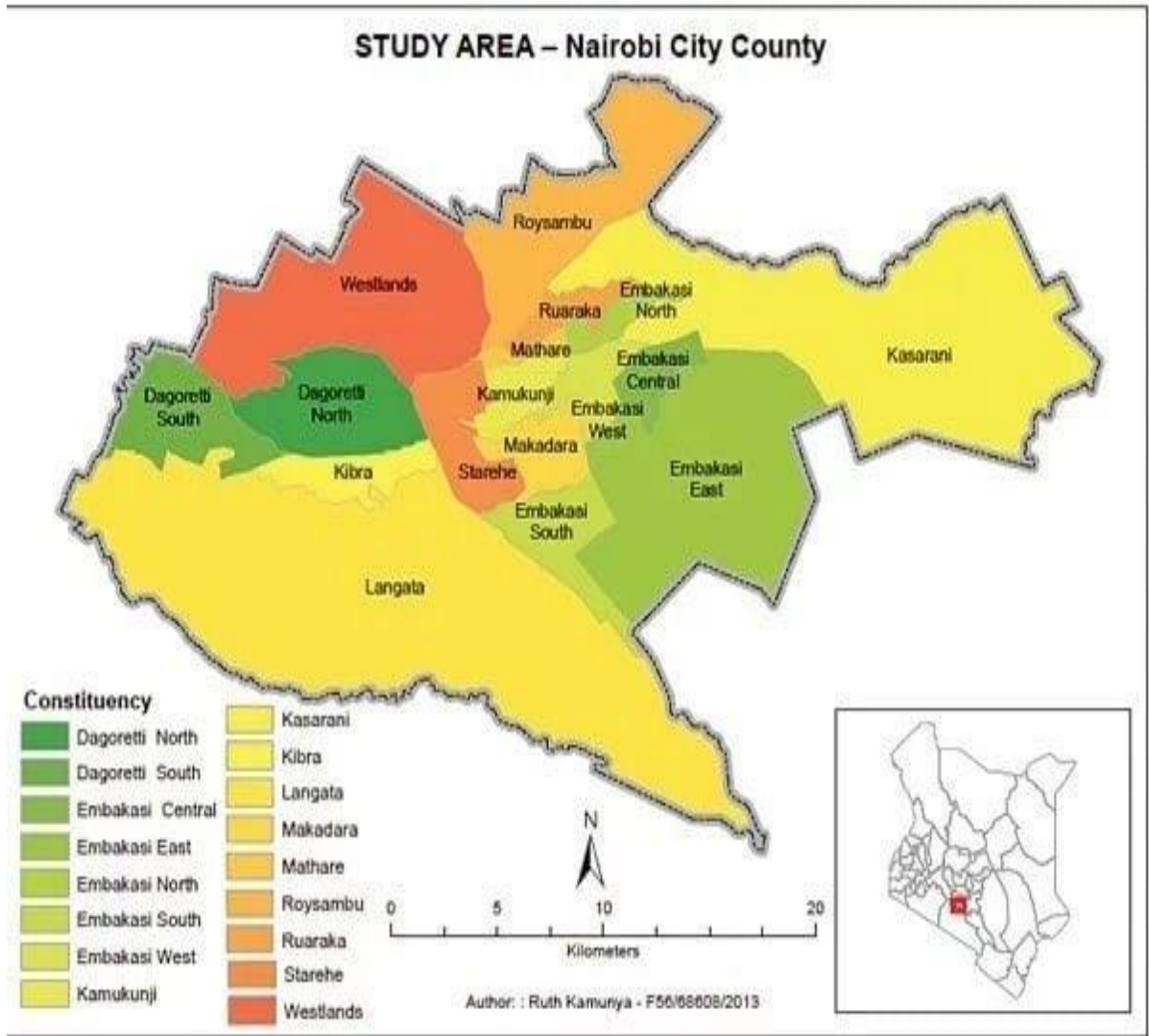
1. What are the common attitudes of female survivors of SGBV towards seeking RHS?
2. Do survivors face any stigma or discrimination when seeking RHS? If so, how does this affect their willingness to seek care?
3. From your experience, do survivors feel that their health needs are taken seriously by healthcare providers when they seek RHS?

Section 5: Types of RHS Offered to Female Survivors of SGBV

1. How comprehensive are these services? Do they address both immediate and long-term reproductive health needs?
2. Are there any gaps or limitations in the types of RHS currently offered to survivors of SGBV?
3. How are these services integrated with other support services, such as psychological counseling or legal assistance, for survivors?

Appendix IV: MAP of Nairobi County

MAP OF NAIROBI COUNTY



Source: Google Map

Appendix V: Nairobi City County Research Authorization**NAIROBI CITY COUNTY**

Telephone 020 344194

Web: www.nairobi.go.ke



City Hall,
P. O. Box 30075-00100,
Nairobi,
KENYA.

COUNTY HEALTH SERVICES**REF: NCCG/DHS/REC/270****DATE: 13th January 2023**

MR. PASCAL ONYANGO COREDO
KENYATTA UNIVERSITY
NAIROBI.

Dear Mr. Pascal,

RE: RESEARCH AUTHORIZATION

This is to inform you that the Nairobi City County – County Health Services Research Ethics Committee (REC) reviewed the documents on the study titled "ACCESS TO REPRODUCTIVE HEALTH SERVICES BY FEMALE SURVIVORS OF SEXUAL GENDER BASED VIOLENCE IN NAIROBI CITY COUNTY, KENYA."

I am pleased to inform you that you have been authorized to carry out the study in Nairobi County. The researcher will be required to adhere to the ethical code of conduct for health research in accordance to the Science Technology and Innovation Act, 2013 and the approval procedure and protocol for research for Nairobi.

On completion of the study, you will submit one hard copy and one copy in PDF of the research findings to the REC. In addition, you will disseminate recommendations of the research at a virtual meeting organized by the REC. By copy of this letter, all the Sub County Medical Officers of Health are to accord you the necessary assistance to carry out this research study.

Yours sincerely,

DR. ANDREW TORO
CHAIR - RESEARCH ETHICS COMMITTEE

Cc: Chief Officers - Public Health and Health Facilities
All Sub County Medical Officers of Health

Appendix VI: Kenyatta University Graduate School Approval for Research Proposal



**KENYATTA UNIVERSITY
GRADUATE SCHOOL**

E-mail: dean-graduate@ku.ac.ke

P.O. Box 43844, 00100
NAIROBI, KENYA
Tel. 020-8704150

Website: www.ku.ac.ke

Internal Memo

FROM: Dean, Graduate School

DATE: 8th February, 2022

TO: Mr. Pascal Onyango Oredo
C/o Department of Community
Health & Epidemiology

REF: Q57/CTY/PT/38840/2016

SUBJECT: APPROVAL OF RESEARCH PROPOSAL

=====

We acknowledge receipt of your Research Proposal after fulfilling recommendations raised by the Graduate School Board of 19th January, 2022.

You may now proceed with your Data collection, subject to clearance with the Director General, National Commission for Science, Technology & Innovation and Ethics Review Committee, Kenyatta University.

As you embark on your data collection, please note that you will be required to submit to Graduate School completed Supervision Tracking and Progress Report Forms per semester. The forms are available at the University's Website under Graduate School webpage downloads.

Thank you.

JOHN M. ODONGI
FOR: DEAN, GRADUATE SCHOOL



CC. Chairman, Department of Community Health & Epidemiology

Supervisors:

1. Dr. Harun Kimani
C/o Department of Community Health & Epidemiology
Kenyatta University
2. Dr. Judy Mugo
C/o Population, Reproductive Health & Community
Resource Management Department
Kenyatta University

Appendix VII: Kenyatta University Ethics Review Committee Approval



KENYATTA UNIVERSITY ETHICS REVIEW COMMITTEE

Fax: 8711242/8711575
Email: kuerc.chairman@ku.ac.ke

P. O. Box 43844,
Nairobi, 00100
Tel: 8710901/12

Website: www.ku.ac.ke

Our Ref: **KU/ERC/ COND. APPROVAL/VOL.1**

Date: 20th /04/ 2022

Pascal Oredo
P.O Box 43844, 00100
Nairobi.

Dear Mr. Oredo,

APPLICATION NUMBER: PKU/2488/I1615- Access to reproductive Health Services by Female Survivors of Sexual Gender Based violence in Nairobi City County

1. IDENTIFICATION OF PROTOCOL

The application before the committee is with a research topic “Access to reproductive Health Services by Female Survivors of Sexual Gender Based violence in Nairobi City County”. Received on March and discussed on April, 2022.

2. APPLICANT

Pascal Oredo

3. SITE

Nairobi City County

4. DECISION

The committee has considered the research protocol in accordance with the Kenyatta University Research Policy (section 7.2.1.3) and the Kenyatta University Ethics Review Committee Guidelines and **APPROVED** that the research may proceed **ON CONDITION** that you **incorporate its advice as below**

5. ADVICE/CONDITIONS

- Use cross-sectional analytical study design
- How will care and protection of research participants will be ensured
- State Community considerations incorporated with COVID 19 protocols

The above specific conditions must be fulfilled in writing before an approval can be granted.

The manner of fulfilling these conditions should be outlined and submitted to Kenyatta University Ethical Review Committee.

Write a detailed report to the Chair and show the pages the corrections are in the proposal

When replying, kindly quote the application number above.

If you accept the decision reached and advice and conditions given please sign in the space provided below and return to KU-ERC a copy of the letter.

Signature: *[Handwritten Signature]* 20 APR 2022

Prof. Judith Kimiywe
CHAIRPERSON - ETHICS REVIEW COMMITTEE

Iaccept the advice given and will fulfill the conditions therein.

Signature..... Dated this day of..... 2022.

cc: DVC-Research Innovation and Outreach

**Appendix VIII: National Commission for Science, Technology and Innovation
Approval**



REPUBLIC OF KENYA



NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION



Ref No: **144737**

Date of Issue: **01/July/2022**

RESEARCH LICENS

This is to Certify that Mr. Pascal Onyango Oredo of Kenyatta University, has been licensed to conduct research in Nairobi on the topic: ACCESS TO REPRODUCTIVE HEALTH SERVICES BY

FEMALE SURVIVORS OF SEXUAL GENDER BASED VIOLENCE IN NAIROBI

CITY COUNTY, KENYA for the period ending: 01/July/2023.

License No: **NACOSTI/P/22/18316**

Walter Muriuki



144737 Applicant Identification Number