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ACCELERATE RESEARCH BRIEF

Advancing Evidence for Sexual and Reproductive Health and Gender-Based Violence Programming in Kenya: Findings from four Accelerate program Counties.

Accelerate Program

Accelerate is an integrated Sexual and Reproductive Health (SRH) and Gender-Based Violence (GBV) program implemented by a Population Services Kenya (PS Kenya)-led consortium with partners Gender Violence and Recovery Centre (GVRC) and Population Services International (PSI) and funding by Danish government. The program is designed to contribute toward ICPD25's targets to eliminate unmet need for contraception, preventable maternal deaths, and gender-based violence (GBV) and harmful traditional practices (HTPs). Accelerate seeks to build on the milestones that Kenya has achieved towards the realization of universal access to quality sexual and reproductive health services, prevention, and management of gender-based violence and reduction in harmful traditional practices. Over a 5-year period (2021-2025), Accelerate will implement activities across 13 underserved and hard-to-reach counties including West Pokot, Elgeyo Marakwet, Baringo, Narok, Kajiado, Samburu, Garissa, Mandera, Marsabit, Homabay, Kilifi, Kwale and Nairobi. Visit PS Kenya's website (https://www.pskenya.org/reproductive-health-2-2/) for more information.

Learning Agenda

The Accelerate consortium implements monitoring, evaluation, and research activities to strengthen the evidence based on evidence-based SRHR and gender-based violence programming and to guide adaptative implementation of Accelerate's interventions. Overarching objectives of the Accelerate learning agenda include evidence-gathering aimed at strengthening health system's response to client centered SRHR needs; catalyzing increased respect for human rights, including reproductive and contraceptive autonomy, among local communities; and improving access to and quality of GBV/HTPs prevention and response models. Mixed method approaches are employed to generate rich data among health facilities, localized duty-bearers, and rights-holders across four purposively selected learning counties including Garissa, Kwale, Narok, and West Pokot.

Health facility assessments comprise three modes of data collection to assess SRH/GBV service readiness and quality. First, a quantitative longitudinal assessment is conducted among all program-supported facilities to measure SRH/GBV services readiness and integration. Secondly, among all censused facilities, chart reviews are conducted, using a structured data extraction form, to examine timeliness of care-seeking and quality of care provided to sexual and gender-based violence (SGBV) survivors. Thirdly, to supplement quantitative evidence,

in-depth interviews (IDIs) are conducted among purposively selected health providers (n=50).
A key strength of the health facility assessments is the inclusion of all program-supported facilities in the research; this census approach allows inference at each level of the health system and within each of the learning lab counties. This research contributes significantly to the growing body of knowledge given that there are no comprehensive evaluations of the quality of SGBV care or facility based SGBV service readiness among underserved Kenyan counties.

In the community, qualitative interviews are conducted to generate localized insights related to contraceptive use, GBV/HTPs prevention and response using key informant interviews (KIIs) with grassroot duty bearers and community leaders (n=34); focus group discussions (FGDs) with program supported CBOs and CHVs (n=4); and cross-sectional FGDs with male members of the community and longitudinal FGDs (open cohort) with female/rights holders (n=37).Three waves of learning agenda studies are planned over the life of Accelerate program, including wave 1, early intervention experiences; wave 2, mid-intervention experiences; and wave 3, late intervention experiences. In this brief, we present key findings from the first wave implemented between July and September 2022; results therefore represent finding from Accelerate's early intervention period.

Findings

Sample – Health Facility Assessment

Most program-support facilities in Accelerate's learning lab counties are dispensaries and clinics (86/123, 70%).

Sample distribution, by level of care and level and county

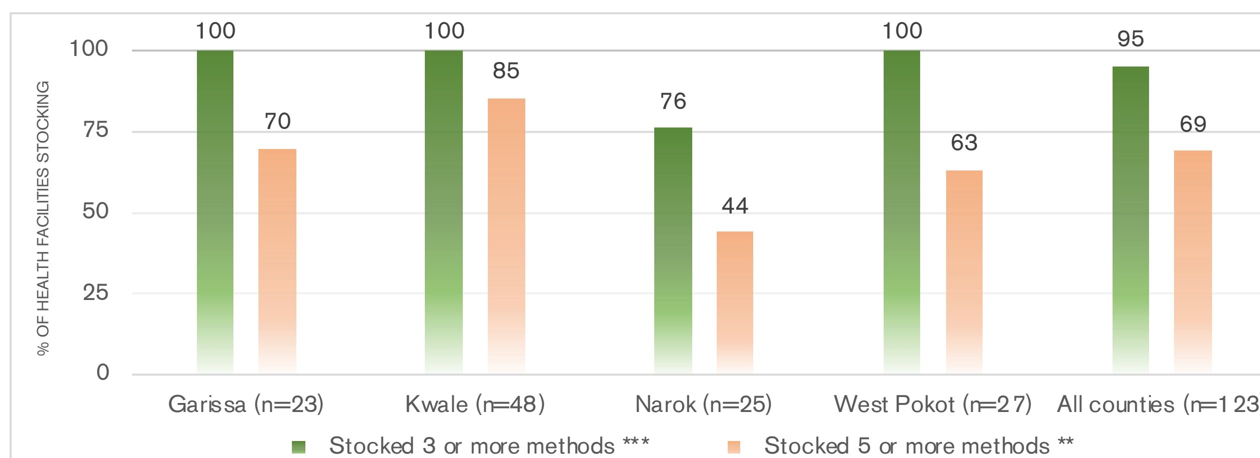
Level-of-care	Garissa		Kwale		Narok		West Pokot		All counties*	
	n	%	n	%	n	%	n	%	n	%
Dispensary/clinic	11	48	41	85	11	44	23	85	86	70
Health center	8	35	4	8	10	40	2	7	24	20
Hospital	4	17	3	6	4	16	2	7	13	11
Total	23	100	48	100	25	100	27	100	123	100

**Denominator includes 99 public health facilities, 16 private-for-profit health facilities, and 8 private-not-for profit health facilities*

Availability of diversity of methods

Access to and choice of contraceptive methods are integral components of rights-based family planning and Kenya's commitment to FP2030. We found that nearly all assessed facilities stocked three or more different types of modern methods (95%). Among the commonly stocked methods were combined oral contraceptive pills (84%), intramuscular depo-medroxyprogesterone acetate (79%), progesterone-only pills (75%), implants (75%), male condoms (72%), and intrauterine devices (66%; data not shown here). However, only two-thirds, or 69%, of facilities were concurrently stocking five or more modern methods. Compared to Kwale (85%) and Garissa (70%), fewer facilities in Narok (44%) had five or more modern methods available on the date of the assessment.

Diversity of available modern methods on the day of the assessment, by County



Readiness to provide contraceptive services

In this section, we examined health facility readiness to offer provider-dependent contraceptive service procedures according to the Kenyan National FP Guidelines for Service Providers. We specifically assessed the facility's availability of FP injection service, insertion and removal service of implants and intrauterine devices (IUD) on the date of the assessment. While there was a high offering of implant removal service (93%), injection (82%), implant insertion (77%), and IUD removal (72%), only 58% of the facilities offered IUD insertion service. Notably, fewer than half of facilities of any type (33-43%) concurrently provided all five contraceptive services on the date of the assessment.

Availability of contraceptive services on the day of the assessment.

Panel A: Availability of contraceptive services, by county					
Availability of services	Garissa (n=23)	Kwale (n=48)	Narok (n=25)	West Pokot (n=27)	All counties (n=123)
	%	%	%	%	%
FP injection	91	90	48	93	82
Implant insertion	78	88	60	74	77
Implant removal	83	96	100	89	93
IUD insertion	52	65	60	48	58
IUD removal	57	79	84	59	72
All services	39	52	32	30	41

Panel B: Availability of contraceptive services, by level of care				
Availability of services	Dispensary/clinic (n=86)	Health centre (n=24)	Hospital (n=13)	All levels (n=123)
	%	%	%	%
FP injection	90	67	62	82
Implant insertion	78	75	77	77
Implant removal	92	96	92	93
IUD insertion	55	54	85	58
IUD removal	70	79	69	72
All services	43	33	39	41

Qualitative insights:

It is so hard to say routinely because they have been out of stock for quite a while. Like, right now, we only have COCs, but initially, we had Depo Provera. We had the implants, the ones for 3 years and 5 years. We used to have the COCs again, even condoms have been out of stock for quite some time, they have just been brought recently. What else, the IUCD are here… (Narok, Nurse 30)

One of the barriers is the inability of the facilities in our community. Now that if someone wants an implant or coil, they have to go to County Hospital or go to Mombasa. So, someone weighs the charges…the fare becomes difficult. (Kwale, FGD - Mature Woman)

The health system lacks a lot of commodities. We are doing the referrals, but there are no commodities. So, they are telling us, if you are doing referrals, can you come up with a procedure. You always bring a lot of clients here for family planning, but there are no products. (Garissa, FGD - CBO)

In this community, seeking family planning services, it seems like, uhm, women do not have a right, it is a secret, so it against their right, it is like their rights are violated when they are denied reproductive health services, either by their spouses, because even in this facility, when a spouse discovers that a woman has gone for family planning, they come and intimidate even the doctors. (West Pokot, Clinician 43)

Providers' exposure to SRHR training

In the last 12 months preceding assessment date, 63% of the facilities reported at least one of the staff had received a training on FP services (ranging from 58% among dispensaries to 77% among hospitals). Over the same period, slightly more than one-half of the facilities (54%) reported at least one of the staff received a training on GBV case-management (ranging from 47% among dispensaries to 69% and 71% among hospitals and health centres, respectively). Notably, just 12% and 28% of facilities reported at least one staff was trained on GBV/ SRH service integration, and courtroom/ forensic skills, respectively.

Proportion of Health Facility where at least one staff received SRHR training in the last 12 months, by County.

Panel A: At least one HF staff received training in the last 12 months, by county					
In-service training*	Garissa (n=23)	Kwale (n=48)	Narok (n=25)	West Pokot (n=27)	All counties (n=123)
	%	%	%	%	%
FP training	83	69	40	56	63
GBV case-management training	70	65	32	41	54
Service integration with SRH	35	33	20	19	28
Courtroom and forensic training	9	21	4	7	12

Panel B: At least one HF staff received training in the last 12 months, by level of care				
In-service training*	Dispensary/clinic (n=86)	Health centre (n=24)	Hospital (n=13)	All levels (n=123)
	%	%	%	%
FP training	58	71	77	63
GBV case-management training	47	71	69	54
Service integration with SRH	7	17	39	12
Courtroom and forensic training	26	25	46	28

**Attended a workshop or on-the-job training.*

Qualitative insights:

"That's a real pressure. Nobody has been trained on GBV in our facility. We are just trying to work with what we were trained from college..." Kwale, Clinician 35.

"There have been trainings so at least most of the health workers are capacity built also at Narok referral hospital there is a GBV desk," Narok, Nurse 30.

"Yes over the last two years there have been several training done over the same there will be improved capacity of health care workers and there is also one done for CHV over the same so there is a lot of changes being done allot of awareness' we also have nowadays that like children's officers initially we don't even know them nowadays we have their numbers we know whom they are we meet during CHVs meeting they form part of us at least there is that going on and there is a big step in this sub-county," Garissa, Nurse 38.

Health facility readiness to offer basic care package to SGBV survivors

The national guidelines on the management of sexual violence recommend the provision of an essential package of care across all levels of the Kenyan healthcare system. Of the facilities providing GBV care, there was uniformly low availability of Hepatitis B vaccination services on the date of the assessment across levels of the healthcare system (18%; range: 14% among health centres to 25% among hospitals). However, there was a steep gradient in the availability of post-exposure prophylaxis for HIV (PEP) services for children, which ranged from just 20% among dispensaries to 83% among hospitals. Similarly, availability of adult PEP and treatment for bacterial STIs was lower among dispensaries and clinics (47% and 65%, respectively) than higher-level health centers and hospitals

(PEP adult, 83-86%, and bacterial STI treatment, 77%-92%). The availability of emergency contraception service and medico-legal examination of survivors was notably lower among dispensaries and health centres (23-31% and 32-32%, respectively, than hospitals (67% and 75%, respectively). Notably, nearly all facilities of any type provided tetanus vaccination (89-100%) and wound care service (88-100%) during the day of the assessment.

Availability of the basic package of GBV services on the day of the assessment, among HFs.

Panel A: Facility self-reported availability of GBV services on the day of assessment, by county					
Availability of services	Garissa (n=17)	Kwale (n=44)	Narok (n=24)	West Pokot (n=20)	All counties* (n=105)
	%	%	%	%	%
Survivor medico-legal examination	53	43	13	35	36
Wound care	100	93	88	100	94
Tetanus vaccination	94	89	96	100	93
Treatment for bacterial STIs	77	63	79	70	71
PEP for adult	65	66	58	40	59
PEP for children	35	34	50	30	37
Emergency contraception	24	30	38	25	30
Hepatitis B vaccination	24	14	8	35	18

Panel B: Facility self-reported availability of GBV services on the day of assessment, by level of care				
Availability of services	Dispensary/clinic (n=71)	Health centre (n=22)	Hospital (n=12)	All levels* (n=105)
	%	%	%	%
Survivor medico-legal examination	31	32	75	36
Wound care	92	100	100	94
Tetanus vaccination	92	100	92	93
Treatment for bacterial STIs	65	77	92	71
PEP for adult	47	86	83	59
PEP for children	20	68	83	37
Emergency contraception	23	32	67	30
Hepatitis B vaccination	18	14	25	18

**Denominator includes HFs which self-reported that they routinely provided GBV healthcare services*

SRH/GBV service integration

Qualitative analysis showed that most health providers embraced provision of integrated SRH and GBV services. However, a dominant theme was that service integration effort, particularly among the lower-level facilities, was derailed due to lack of relevant supplies including treatments, equipment, and GBV reporting tools; lack of infrastructure including laboratories and space to provide services; inadequate staffing and providers' skills gap related to GBV case-management.

Qualitative insights:

"Lack of commodities, for example, urine strips, sometimes VRDL [Venereal disease research laboratory] isn't available, most staff aren't trained, lack of reporting tools like PRC forms..." West Pokot, Nurse 39.

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

"The major problem here is that the space is too small and when we have a case of GBV to deal with, for example as we deal with both GBV, and other conditions and our rooms are only two. We have only one consultation

rooms and on top of that the same consultation room also work as a counselling room. So, when we have a case of GBV, and we deal with medical part, and we want to do the psychological part that is counselling. So, we have to vacate one of the rooms and one of us have to go out and wait for counsellor to complete the work so sometimes ends up pilling patients outside waiting for other services to be offered to them," Garissa, Clinician - Public Hospital.

Availability of sexual violence reporting tools

In June 2022, the Ministry of Health launched a series of new policy documents and reporting tools related to SRHR service delivery. Among these, included a new national GBV register revised to integrate reporting of all forms of violence including sexual, intimate partner violence (IPV), physical violence, and harmful traditions such as female genital cutting (FGC). In our facility assessment conducted between July and September 2022, 105/123, facilities self-reported offering GBV care services. Of these 105 facilities, the availability of PRC form and SGBV register, on the date of the assessment, was lowest among dispensaries/clinics (29%) compared to higher-level health centres (55%) and hospitals (83% and 75%, respectively). Notably, more than one-half of the GBV service providing facilities reported that never stocked SGBV reporting tools (PRC form, 57%; MOH SGBV register, 61%). Widespread facility lack of SGBV reporting tools, imply missed opportunities to document crucial medico-legal assessment evidence necessary to pursue justice.

Availability of sexual violence reporting tools on the day of the assessment, among HFs.

Panel A: Availability of reporting tools on the day of assessment, by county					
Availability of reporting tool	Garissa (n=17)	Kwale (n=44)	Narok (n=24)	West Pokot (n=20)	All counties* (n=105)
	%	%	%	%	%
PRC form/MOH 363					
Yes	29	48	42	26	39
No, stocked out	18	0	4	0	4
Never stocked	53	52	54	74	57
SGBV register/MOH 365					
Yes	29	30	54	20	33
No, stocked out	18	5	4	0	6
Never stocked	53	66	42	80	61

Panel B: Availability of reporting tools on the day of assessment, by level of care				
Availability of reporting tool	Dispensary/clinic (n=71)	Health centre (n=22)	Hospital (n=12)	All levels* (n=105)
	%	%	%	%
PRC form/MOH 363				
Yes	27	55	83	39
No, stocked out	1	14	0	4
Never stocked	71	32	17	57
SGBV register/MOH 365				
Yes	20	55	75	33
No, stocked out	3	14	8	6
Never stocked	78	32	17	61

**Denominator includes HFs which self-reported offering GBV healthcare services*

Assessment of quality of SGBV care through structured chart review

Facility chart reviews were completed among all program supported facilities to examine timeliness of care-seeking and quality of care provided to survivors of sexual violence. Charts were selected for extraction if the date of service was within the 6 months preceding the assessment; if more than 30 charts were available within that period, we selected the 30 charts with the most recent service date to reduce oversampling concerns among high caseload facilities. A total of 285 SGBV charts were extracted across the study counties. Of these, 62% of the charts were extracted from hospitals, while 27% and 11% were from obtained from health centres and dispensaries/clinics, respectively. Across the counties, nearly all extracted SGBV cases were accounted by hospitals (85-100%) with notable exception of Kwale (49%).

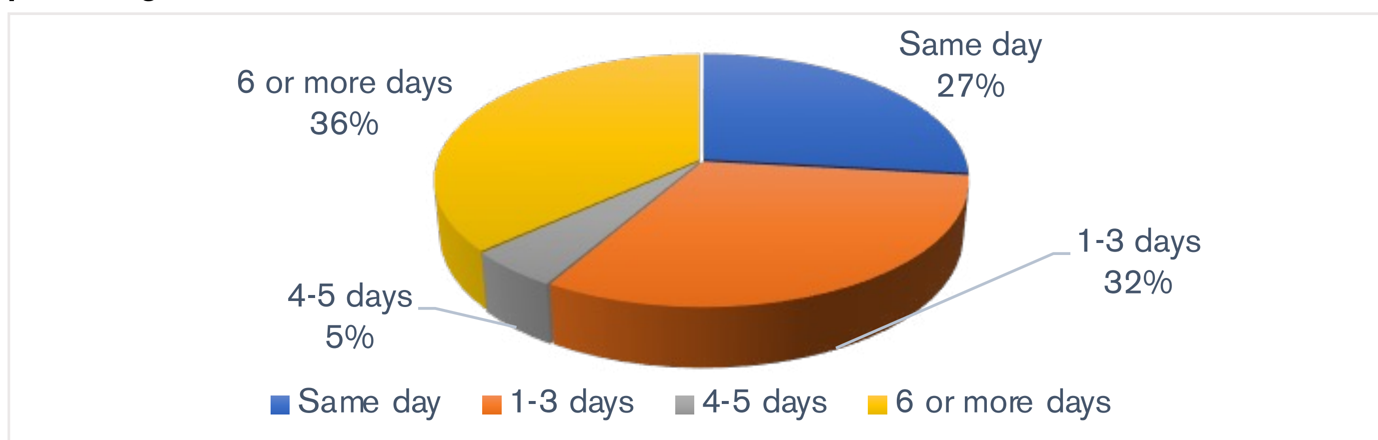
Sample size of extracted SGBV charts, by level of care and county.

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

SGBV reporting and care-seeking behavior

When documented by the provider, approximately 6 in 10 (59%) SGBV survivors seeking medical care for the first time did so within the recommended window period of three days after sexual violence at the current health facility. However, a substantial proportion of survivors were late presenters, rendering them ineligible for time-sensitive emergency care, including 5% and 36% who sought facility care for the very first time in 4-5 days and 6 or more days after the violence, respectively.

Duration after which healthcare was first sought following sexual violence, among survivors presenting at the current HF (n=259*).



Denominator excludes 26 observations in which there were missing values for any of these variables: date of violence, arrival date at the current HF, and if care was sought at another HF.

Qualitative findings revealed that most cases of GBV were reportedly settled at community level with engagement of family members, village elders, chiefs, and Kangaroo courts. A key theme that emerged across all counties, was that medical interventions were typically sought when violence and inflicted injuries were perceived to be serious and life-threatening, or when sexual violence resulted to a pregnancy particularly among young girls. Our findings also showed that community health volunteers (CHVs), particularly in Kwale county, played a critical role in GBV response referral and reporting including survivor identification and accompanying them to a health facility for care and support.

Qualitative insights:

"Medical [care] has improved because it starts in the community with the CHVs who collect the community information and take them to the health facilities. They also take patients from the community to the hospitals. For example, if someone has been raped, then the CHV is the first contact taking that person to the relevant place, not referring but accompanying them. So that one has helped a lot, even then community knows that in case this thing happens, they will go to the CHV..." Kwale, CBO – KII participant.

"Mostly because of fear of society or the norms of the society they don't come to get services, they don't show up..." Garissa, Nurse 27.

"The man's family will meet, talk to the woman, pay a fine to the man's family and carry out some rituals because it is an abomination in this community," West Pokot, FGD - Mature Woman."So there again it is there [Rape cases], but you know the community again is somehow reluctant on taking actions because they feel like it's a family member, he is one of us so let us just bring the elders to come and do what and talk. At Maslaha, they talk there as elders and then they give something then things go flat (laughing) yeah," Garissa, IDI -Teacher.

Administration of psychosocial assessment and emergency therapies

When care was documented by the facility, there was a high initiation rate for time-sensitive emergency therapies among eligible SGBV survivors including PEP for HIV prevention, emergency contraception (EC) for prevention of pregnancy, and treatment for sexually transmitted illnesses (STIs) with antibiotics (71-79%). However, approximately a fifth or more of eligible survivors (as per the treatment protocol) were missed opportunities for treatment as they left the facility without these life-saving therapies and the majority of survivors (61%) did not receive the recommended psychosocial assessment. Moreover, among the eligible cases, there was a widespread provider failure related to care documentation including psychosocial assessment (151/285), ECP administration (25/81), PEP administration (26/102) and STI treatment with antibiotics (30/105).

Medical care given among eligible GBV cases managed in the last 6 months

Care given	Selected medical care given among eligible SGV cases*			
	Psychosocial assessment N=285	ECP N=81	PEP N=102	STI antibiotics N=105
	n (%)	n (%)	n (%)	n (%)
Yes	52 (39)	42 (75)	54 (71)	59 (79)
No	82 (61)	14 (25)	22 (29)	16 (21)
Missing data	151	25	26	30

**Percentages are calculated based on a subset of survivors who were eligible for each care. We excluded observations with missing values when calculating estimates for respective care given.*

Qualitative findings showed that while higher level facilities (hospitals) had the capacity to provide comprehensive care to survivors of SGBV, factors including negative provider attitudes, provider's lack of confidence to give expert evidence in the court, and low motivation due to lack of logistical support to attend court proceedings hindered SGBV service provision and documentation. Among lower-level facilities, care provision was obstructed by lack of essential medical equipment and continuous supply of essential medicines and laboratory reagents. Furthermore, providers in these facilities widely reported they lacked adequate clinical expertise for GBV case management including post-trauma counselling. Some of the providers lacked clear information on where GBV survivors should be referred for further management. These findings highlight the need to strengthen provision of recommended BCP at across all levels of healthcare system and streamlining upward referral of survivors for advanced care and support.

"There are dispensaries and hospitals in the villages. When they get a case that they cannot handle, they refer to the main referral hospital and the treatment that they receive at the facility health is satisfactory.

Qualitative insights:

So, the linkage has really improved," Narok, CBO - FGD participant.

"Lack of commodities, pharmacy the drugs, the investigations aspect even items to used take sample might not be available sometimes..." Garissa, Clinician 33.

"You know in terms of medical, you know most of the hospitals do not have medicines. So even, the person who has been raped will not access the medicine as expected. You will be taken to the hospital, then the doctor will give some painkillers, then she will walk home," KII Teacher, Garissa.

"Maybe about the referral system, when you refer a patient, it should be clear where you refer the patient, because sometimes you are not sure where you are referring the patient," Narok, Nurse 30.

Gender-based violence needs time..... people do fear going to courts and all other things..... lack of financial support from maybe let's say Ministry of Health..... because when you handle that case, you are sure of going to court and no one will provide you with transport, lunch and other things..... Yeah. You have to go back to your pocket. For other people, maybe you have seen the patient here at West Pokot but the case is at Kitale or another county..... When you are travelling you have to look for someone who will at least take care of your duties back there..... those are some of the challenges," West Pokot, Clinical officer - Public Hospital.

Summary

Research conducted during Accelerate's early implementation period reveals broad facility-based availability of most contraception products and services – with the notable exception of IUD insertion service. However, sub-optimal contraceptive autonomy among females and unsupportive male partners undermined uptake of modern methods of contraception.

While all levels of the Kenyan health system - from dispensaries to referral hospitals - are expected to offer an essential package of SGBV services, the study identified major variations in the ability to provide specific care components included in the essential package of SGBV services across levels of the Kenyan health system. While there was high facility readiness for wound care, tetanus vaccination and management of STIs with antibiotics (71-94%), we observed sub-optimal facility readiness to provide post-exposure prophylaxis for HIV (PEP) services among adults (59%) and children (37%), and just 30% and 18% of the facilities offered emergency contraception and Hepatitis B vaccination services, respectively. Inability to deliver essential services, particularly among first-line facilities, require survivors to seek higher-level facilities for appropriate care – a barrier with substantial time and monetary costs borne solely by survivors. A key implication of these findings is the need to increase equity in health services access by strengthening the health systems' capacity to provide the basic package of SGBV care including at the lowest-level facilities.

Analysis of extracted facility charts revealed that the majority of SGBV cases were managed at higher level facilities. There was a high initiation rate for emergency therapies among eligible SGBV survivors including PEP, emergency contraception to prevent pregnancy, and treatment for STIs with antibiotics (71-79%). However, approximately a fifth or more of eligible survivors (as per the treatment protocol) were missed treatment opportunities as they left the facility without life-saving therapies. Moreover, majority of SGBV survivors (61%) did not receive recommended psychosocial assessment, suggesting a lack of capacity among health service providers. It is worth noting that poor documentation was common, which could have precluded precise measurement of the quality of service provided given high amounts of missing data observed within the facility records.

The study highlighted low use and availability of facility based GBV documentation and reporting tools. This finding has several implications: at the individual level, lack of use of post rape care forms – which are legally required for documentation of sexual violence and used as evidence in the legal system – means that survivors seeking care at facilities that do not stock or use these forms may lack critical evidence needed when seeking legal recourse. In addition, poor routine documentation practices prevent monitoring of SGBV caseloads and care

quality at a systems level, thereby limiting evidence-based decision-making relevant for programming and resource allocation. This practice gap underscores the importance of ensuring front-line responders, including those serving in lower-level health facilities, are adequately supported to manage survivors of sexual and gender-based violence, including dissemination of reporting tools, exposure to relevant medico-legal training, and continuous supportive supervision.

This study further highlighted multidimensional community-level challenges that undermine GBV reporting and care-seeking. We observed that many cases of GBV, particularly violence of a sexual nature, were negotiated and settled informally, typically by family members, elders, and kangaroo courts; these are the first line of recourse, which may delay health seeking. Moreover, reported stigmatization and normalization of violence may have reduced survivors' autonomy in decision-making related to care-seeking behaviours. These findings demonstrate an urgent need to strengthen grassroot GBV response and prevention systems, including establishment of effective referral systems and stronger rights-based community-health system linkages. Harnessing the ubiquitous power of CHV networks by integrating GBV into their current scope may be a beneficial strategy for not only awareness raising and community mobilization but also facilitating timely linkage of survivors to health services, monitoring of survivors' health and wellbeing outcomes, and adherence to initiated care, including medication and psychosocial support through follow-up home visits. However, CHV capacity building which includes human rights-based approach (HRBA) and empathy training, should be an appropriate first step to prepare and build confidence in the new role.

Accelerate acknowledges study participants for their time and valuable insights, the study team, the Ministry of Health through Division of Reproductive Health (DRH), National AIDS and STIs Control Programme (NASCOP) and County Health Management Teams (CHMTs) in the four learning counties for their unwavering support, and the funder, Danish Ministry of Foreign Affairs represented by the Royal Danish Embassy in Kenya.

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Disclaimer

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Recommended Citation:

Population Services Kenya, Population Services International and Gender Violence Recovery Centre. 2023. Advancing Evidence for Sexual and Reproductive Health and Gender-Based Violence Programming in Kenya: Findings from Four Accelerate Program Counties. Accelerate Research Brief.

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