

Barriers and Pathways to Healthcare Access Among Women Survivors of Gender Based Violence in Turkana County, Kenya

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ABSTRACT

Gender-based violence is a pervasive public health and human rights issue. In Kenya, over 40% of women have experienced physical mistreatment and 14% sexual assault. In Turkana County, the GBV rate stood at 42% in 2024, higher than the national average of 34%. The study aimed to determine the barriers and pathways to healthcare access among women survivors of GBV in Turkana County. Specifically, it sought to identify types of GBV experienced by survivors seeking care, assess barriers faced in accessing healthcare services, and examine steps taken by survivors in seeking care. A cross-sectional descriptive mixed-methods study was conducted at Lodwar County Referral Hospital and Kakuma Sub-County Hospital. Purposive sampling targeted 73 women GBV survivors attending the facilities. Client exit interviews provided quantitative data and a Focus Group Discussion generated qualitative data. Data were analyzed using R software; findings presented in tables, graphs, and narratives. The study found that 97% of respondents experienced physical, psychological, or sexual harm due to GBV. Major barriers included patriarchal cultural norms (99%), corruption and associated costs (96%), lack of formal referral networks (90%), financial constraints (67%), and fear of stigma or intensified abuse (62%). While 80.8% first sought care at healthcare facilities, only 49.3% did so immediately. Single survivors had 87% lower odds (OR=0.127, p=0.012) and Muslim survivors 90% lower odds (OR=0.102, p=0.010) of seeking immediate help. The model explained 23% of the variance in immediate help-seeking behavior. Qualitative data highlighted community leaders and village elders as initial contact points in many cases. The study concluded that GBV is highly prevalent in Turkana County. Survivors face significant socio-cultural, economic, and systemic barriers that delay or prevent timely healthcare access. It therefore recommends; provision of free GBV services, anti-corruption measures, strengthened referral networks, stigma reduction, family engagement, and targeted interventions for single and Muslim survivors.

Keywords: Gender-Based Violence, Healthcare Access, Barriers, Help-Seeking, Pathways

INTRODUCTION

Gender-based violence is defined as violence inflicted based on socially attributed gender disparities, which is a pervasive issue worldwide, impacting health, human rights, development, and humanitarian efforts (WHO, 2005). GBV includes sexual, physical, and psychological harm occurring within families, communities, or even when condoned by the state (IASC, 2015).

Among women, one in three worldwide have been victims of abuse, either physical or sexual, with a significant increase in humanitarian setting at 70% of women having experiences GBV, compared to 35% worldwide (WHO, 2024). Among the countries having the highest rates of non-partner sexual violence are Namibia and Tanzania, and tend to report increased rates of various forms of violence, like childhood abuse of sexual nature (another form of sexual violence between non-partners). Although men and boys can be sexual assault victims, data consistently shows that women and girls make up the majority of victims, with 1 in 3 women experiencing

violence as opposed to men and boys (UNHCR, 2016). Abuse of girls and women is still a major infringement of human right globally, cutting across all economic, social, and national borders. It is estimated that one out of three females worldwide will face physical or abuse at some point in her life (WHO, 2012).

According to estimates, one out of three women (35%) have experienced physical or sexual abuse at some point in their life, with sub-Saharan Africa having some of the highest rates of over 30% (WHO, 2019). According to Willman & Corman (2013), GBV is the most widespread type of gender inequity. It hinders progress toward development goals, such as the Sustainable Development Goal number five, which is all about empowering women and girls and attaining gender equality. One of the important goals within this goal is the elimination of all types of private and public abuse directed towards women and girls, involving trafficking and various forms exploitation, including sexual (Hall, 2015).

In Kenya, specifically among females in the 15-49 age range, over 40% have been victims of physical assault, with 14% having experienced sexual abuse. Due to stigma and fear surrounding GBV, the numbers are likely to have been underreported (KNBS, 2022). In addition, the 8,149 survivors of gender-based violence crimes that occurred in Kenya in 2021, 92% were women. (National Police Service, 2021). In Turkana County, there were 1,657 gender-based violence cases recorded between the year 2020 and 2023 (KHIS, 2023). Additionally, the 2023 Kenya Demographic and Health Survey found that Turkana County's 42% of women between the ages of 15 and 49 report having been physically abused since they were 15, which is far higher than the national average of 34%. This information was reported by the Turkana County Government during a sensitization event on gender-based violence policy and guidelines (Government, 2023)

Because of the shame linked to gender-based violence in most of Kenyan villages, women survivor of GBV frequently accuse themselves and feel afraid of being rejected by society or harmed again by the abuser if they speak up. This fear stops them from seeking help (ICRH, 2020). As a result, there is a lot of silence around gender-based violence, which prevents survivors from reporting the abuse or getting the support they need. This is partly because many women don't know that these services exist or how to access them. Most women are unaware among their basic right to live without assault or to pursue justice when violence happens (McCleary, et al., 2018).

Despite the recognition of gender-based violence as a major public health concern in Turkana County, there remains a limited understanding of the specific barriers women survivors face in accessing timely healthcare. While existing data highlights the high prevalence of GBV at 42% against the national average of 35% (KDHS, 2023), low reporting rates, and poor uptake of critical services such as post-exposure prophylaxis (KHIS, 2023), few studies have explored how socio-cultural, economic, and systemic factors interact to restrict survivors' care-seeking behavior, particularly in fragile settings like Lodwar and Kakuma. A study by Mugo, Owaka, & Mutisya (2025) revealed that 60.4% of adolescent girls at Kakuma Refugee Camp experienced GBV. The research highlighted how poverty, entrenched cultural norms, and inadequate social support systems contribute to the prevalence of GBV and hinder survivors from seeking care. Another study on SGBV prevalence and correlations among Kakuma's refugee population identified factors such as economic hardship, lack of education, and systemic barriers as significant contributors to GBV incidents and obstacles to accessing support services (Ngala, 2021). Most research has focused broadly on prevalence without investigating survivor-centered healthcare gaps, the role of stigma, limited knowledge on health consequences, referral systems, and challenges unique to refugee and host populations. An example is a study conducted on SGBV prevalence and correlates among Kakuma's refugee population (Ngala, 2021).

In order to close this gap, this study looks at how these factors impact access to care, focusing on women seeking support services at Lodwar County Referral Hospital and Kakuma Sub-County Hospital. The findings will help inform policies and interventions to strengthen survivor-centered healthcare, improve referral systems, and promote community-based support mechanisms in Turkana County.

Objective of the Study

To determine the barriers and pathways to healthcare access among women survivors of Gender Based Violence in Turkana County.

Research Question

The study sought to answer the question: What are the barriers and pathways to healthcare access among women survivors of Gender Based Violence in Turkana County?

METHODOLOGY

Study Area

The was carried out at Lodwar County Referral Hospital in Turkana Central and Kakuma Sub-County Hospital in Turkana West. These sites were chosen due to their large catchment populations; 199,374 in Turkana Central and 257,818 in Turkana West as of 2022 (CIDP). Lodwar County Referral Hospital, the primary healthcare facility in Turkana, serves as a referral center, which makes it crucial for understanding the challenges women face in accessing GBV care. Kakuma Sub-County Hospital, situated in a region with a significant refugee population, provides services to both refugees and local communities, each facing unique vulnerabilities to GBV.

Study Design

The study employed a descriptive-analytic cross-sectional design, which is the most preferred for capturing a snapshot of the current situation. This design allows the gathering of information at a specific moment in time, enabling the identification of patterns, prevalence, and factors influencing GBV without requiring extended follow-up. By combining both qualitative and quantitative data, the study offered a more comprehensive awareness of the research question. Quantitative data helped to measure the impact of GBV, while qualitative methods provided deeper insights into the lived experiences of survivors, including cultural, structural, and economic challenges they face. This integration of methods ensures that the study not only quantifies the issue but also captures the nuanced context in which GBV occurs, thereby generating richer, actionable data for intervention.

Target Population

The study purposively engaged women attending Lodwar County Referral Hospital and Kakuma Sub County Hospital during the data collection period. The study population included women who were seeking services at these facilities, as they were likely to have firsthand experience of GBV. By focusing on women accessing healthcare, the study aimed to gather relevant data on their experiences, challenges, and the factors influencing their decision to seek help.

Sampling and Sample Size

Sample size is the number of observations or replicates to be included in the study from the target population. The standard Fisher et al. (1998) formula was used to determine the sample size.

The formula is given as:

$$n = z^2pq / d^2$$

Where:

n = desired sample size

z = standard normal deviation at 95% confidence level (1.96)

p = estimated proportion of the target population (0.5)

q = 1-p (0.5)

d = margin of error (0.05)

This yielded a sample size of 384. Since the study population was less than 10,000, a finite population correction formula was applied:

$$nf = n / [1 + (n/N)]$$

Where N = estimated target population (90). This gave a final adjusted sample size of 73 respondents.

A proportionate sampling technique was then used to distribute the sample across the two study sites based on data from the Kenya Health Information System. Lodwar County Referral Hospital was allocated 32 respondents while Kakuma Sub-County Hospital was allocated 41 respondents. Purposive sampling was employed to recruit women survivors of gender-based violence who were attending services at these facilities and consented to participate in the study.

Data Collection Tools

The research utilized client exit interviews to collect quantitative data of women who had accessed GBV-related services at the health facilities. The interviews provided insights into the prevalence of GBV, the types of services received, and the challenges encountered during seeking services. To complement this, an FGD was conducted in the community unit linked to Lodwar County Referral Hospital to gather more detailed qualitative information, using discussion guide. This combination of methods ensured a comprehensive understanding of both the statistical trends and the personal experiences of the study population.

Data Collection Procedures

Client exit interviews were used to collect quantitative data, which involved asking structured, close-ended questions to women immediately after they received health services. This provided measurable data on their experiences, service satisfaction, and challenges faced during care-seeking. For qualitative data, Focus Group Discussion was conducted, where selected participants engaged in guided discussion about their experiences with GBV and the obstacles people encounter when trying to get medical care support. Trained bilingual research assistants with degrees in public health moderated the discussions and conducted interviews and FGDs to ensure clear communication and accurate interpretation of responses in Nga'turkana for participants who did not understand English.

Data Analysis and Presentation

Descriptive statistics such as frequencies, percentage and measures of central tendency were used to analyze quantitative data generated from the study. The findings were presented using frequency distribution tables, graphs, pie and bar charts to enhance visualization and data interpretation. The qualitative information obtained from the study was subjected to thematic analysis, which involved detailed narratives, supported by verbatim quotations to capture participants' perspectives and provide depth to the analysis. Data analysis was conducted using R software to process and analyze quantitative data.

Ethical Consideration

Ethical approval was sought and obtained from Amref International University (AMIU/ARP/6181-3) under graduate school, before embarking on the study. Additionally, research permits were obtained from Amref Ethics Scientific and Review Committee (ESRC P1915/2025) and National Commission for Science Technology and Innovation (NACOSTI/P/25/4177471). Informed consent was secured from all participants prior to the data collection.

RESULTS

Socio-demographic Characteristics

Most of the survivors are young adults (younger than 40 years) (90.4%), married (45.2%), and poorly educated with almost three-quarters (74.0%) having only primary education or having no formal schooling.

Table 1: Demographic Characteristics of Participants

characteristic	category	freq	percent
Age	18-28 years	33	45.2
Age	29-39 years	33	45.2
Age	40-50 years	6	8.2
Age	50 years and above	1	1.4
Marital Status	Married	33	45.2
Marital Status	Single	20	27.4
Marital Status	Divorced/Separated	16	21.9
Marital Status	Widowed	4	5.5
Religion	Christianity	58	79.5
Religion	Muslim	15	20.5
Education Level	Primary education	30	41.1
Education Level	No formal education	24	32.9
Education Level	Secondary education	18	24.7
Education Level	Tertiary level	1	1.4

Types of GBV Experienced

Bivariate Analysis of GBV Types by Demographics

Comparison of the type of GBV according to marital status showed that there was a huge difference (chi-square = 18.694, $p = 0.005$). Widowed survivors had 3 reports of physical/psychological/sexual harm and 1 report of financial losses. No significant associations were found with age ($p = 0.051$), education ($p = 0.745$), or religion ($p = 0.125$).

Table 2: Bivariate Analysis of GBV Types by Demographics

GBV result in	Freq.	Percent	Cum.
Financial losses	1	1.37	1.37
Others	1	1.37	2.74
Physical, psychological or sexual harm	71	97.26	100.00
Total	73	100.00	

Barriers to Healthcare Access

Descriptive Analysis of Barriers

Individual-Level Barriers

The most common reason of not seeking help is lack of money, which was cited by 49 survivors (67.1%). One out of every five survivors (19% referred to normalization of violence against women). 5 survivors (6.9%), reported fear of hospitals.

Fear-Based Barriers

The fear of stigmatization and increased violence made 45 survivors (61.6%) not seek outside their personal network. The fear of children loss was experienced by 23 survivors (31.5%). Absence of transport was a factor among 4 survivors (5.5%), and fear of the law among 1 survivor (1.4%).

Healthcare System Barriers

This was the most prevalent barrier as 70 survivors (95.9%), due to corruption and costs, could not access it. Nonexistent formal referral networks influenced 66 survivors (90.4%), among survivors in rural areas.

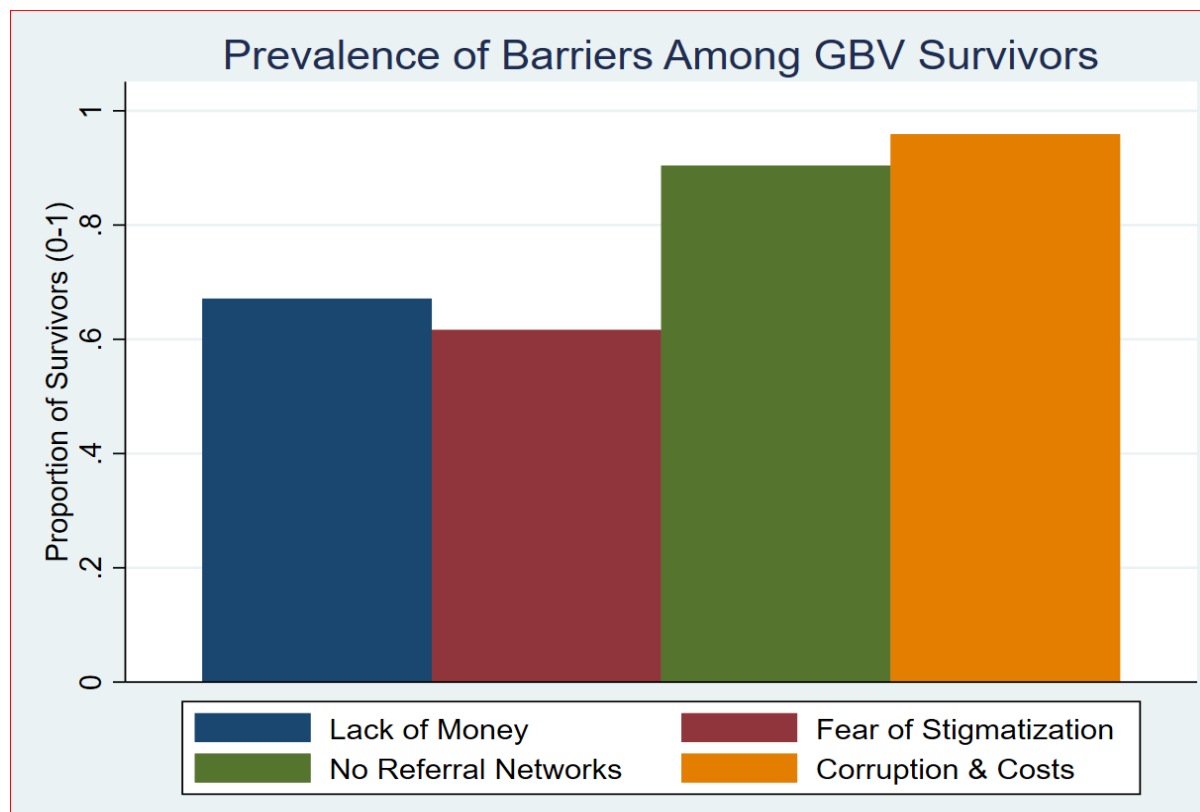


Figure 1: Descriptive Analysis of Barriers to Healthcare Access

Bivariate Analysis of Barriers

Reasons Women Hesitate to Seek Help by Age Group

The causes of hesitation differed greatly according to the age (chi-square = 80.614, $p < 0.001$). The proportion of survivors aged 18-28 years who feared stigmatization was 25/45 as compared to 18/45 in aged 29-39 years and 2/45 in aged 40-50 years.

Table 3: Reasons Women Hesitate to Seek Help by Age Group

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Reasons women hesitate to seek help outside their personal network after experie	Age				Total
	18 - 28..	29 - 39..	40 - 50..	50 year..	
Fear of losing thei..	6	14	3	0	23
Fear of stigmatizat..	25	18	2	0	45
Fear of the law	0	0	0	1	1
Lack of transport t..	2	1	1	0	4
Total	33	33	6	1	73

Pearson chi2(9) = 80.6139 Pr = 0.000

Steps Taken in Seeking Care

Descriptive Analysis of Steps Survivors take in Seeking Care

Most of the survivors (59 survivors, 80.8%) used to obtain help at healthcare facilities first. The initial contact with 7 survivors (9.6%), 4 (5.5%), and 3 (4.1%) was with community leaders, family members, and police stations respectively.

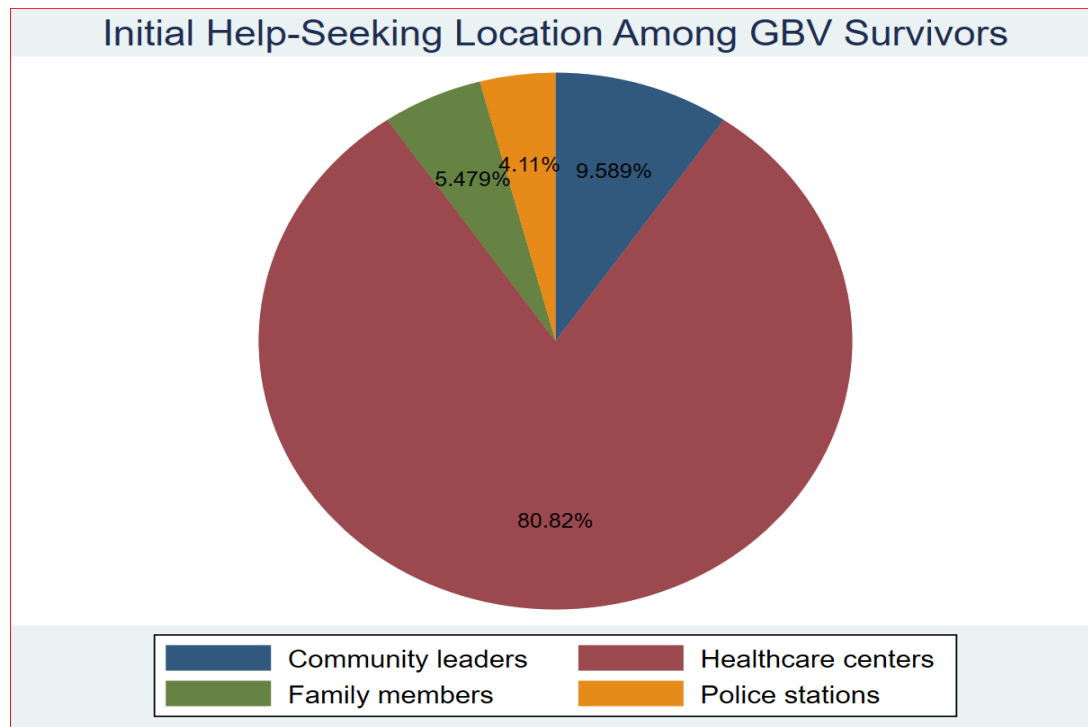


Figure 2: Descriptive Analysis of Steps Survivors take in Seeking Care

Bivariate Analysis of Steps Survivors take in Seeking Care

There was a significant relationship between circumstances that lead to help seeking and both age (chi-square = 36.010, $p < 0.001$) and marital status (chi-square = 48.401, $p < 0.001$). Women who were younger (23 survivors aged 18-28 years) and single women (16 survivors) tended to seek help after being victimized by strangers

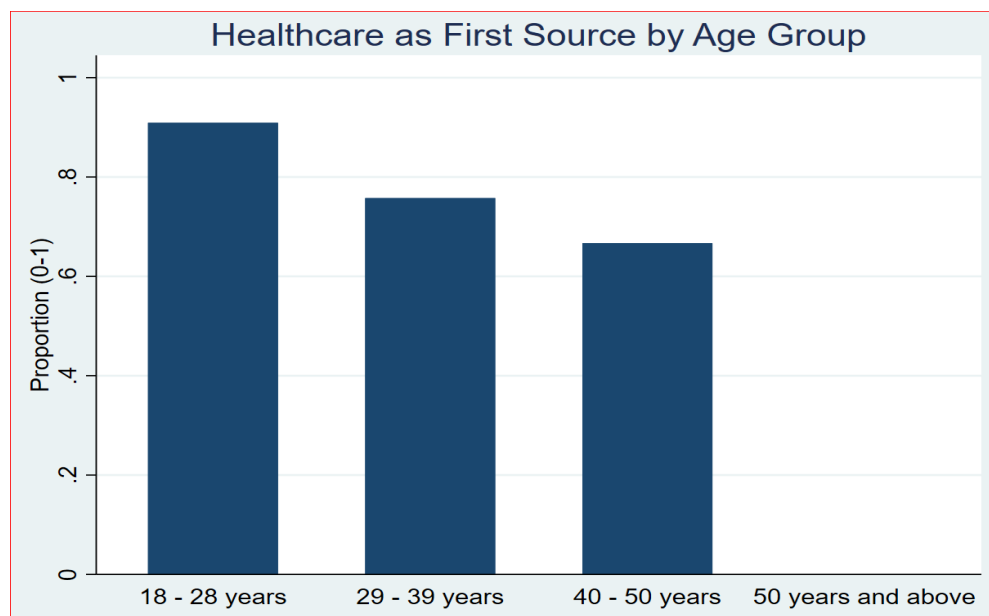


Figure 3: Bivariate Analysis of Steps Survivors take in Seeking Care

Multivariate Regression Analysis

Binary logistic regression showed that single survivors had 87% lower odds of seeking immediate help (OR = 0.127, p = 0.012) and Muslim survivors had 90% lower odds (OR = 0.102, p = 0.010) compared to their reference groups. The model explained 23% of the variance in immediate help-seeking behavior.

Logistic Regression Equation

$$\text{Logit P} = 0.869 + 0.820(\text{Stranger}) - 0.533(\text{Age 29–39}) - 0.889(\text{Age40–50}) + 0.428(\text{Married}) - 2.062(\text{Single}) - 0.767(\text{No Formal}) + 0.435(\text{Secondary}) - 2.285(\text{Muslim})$$

Table 4: Logistic Regression Odds Ratios for Predictors of Immediate Help-Seeking Among GBV Survivors

Logistic regression		Number of obs = 66				
Log pseudolikelihood = -35.066643		Wald chi2(8) = 18.99				
		Prob > chi2 = 0.0149				
		Pseudo R2 = 0.2289				
immediate_seek	Odds ratio	Robust std. err.	z	P> z	[95% conf. interval]	
perpetrator_stranger Stranger	2.270419	1.584808	1.17	0.240	.5780247	8.917963
age_numeric 29 - 39 years	.5871133	.5264049	-0.59	0.553	.1012829	3.40336
40 - 50 years	.4110509	.7387898	-0.49	0.621	.0121343	13.92441
marital_numeric Married	1.533748	1.184939	0.55	0.580	.3373924	6.972248
Single	.127223	.1044079	-2.51	0.012	.025469	.6355066
Widowed	1	(empty)				
education_numeric Tertiary level	1	(empty)				
No formal education ..	.4644211	.3560011	-1.00	0.317	.1033773	2.086406
Secondary education	1.545025	1.48628	0.45	0.651	.2344761	10.18058
religion_numeric Muslim	.1017785	.0901364	-2.58	0.010	.0179399	.5774195
_cons	2.385425	1.78074	1.16	0.244	.552251	10.30374

Note: **_cons** estimates baseline odds.

DISCUSSION

The distribution of ages observed in this study, where most survivors were between 18 and 39 years, is consistent including results from several earlier investigations that indicate an increased frequency of gender-based violence among women in the reproductive age group. For example, a study conducted by Okyere et al, discovered that women aged 25-39 years were more inclined to report experiences of intimate partner abuse in contrast to older women (Okyere et al., 2024) findings of KNBS 2022 revealed that over 40% females aged exposed to various types of violence based on gender (KNBS, 2022). Nearly half of the respondents were married, followed by those who were unmarried and divorced or separated. These findings differed with those of KDHS (2023) which showed that divorced, separated, or widowed women were more probable to ask for assistance as opposed to married women and never-married women (KDHS, 2023). The study further reported that higher levels of education were positively associated with help-seeking behavior, as educated women were more likely to seek assistance compared to those with no education (Melkam et al., 2024).

Almost all respondents (97%) in this study reported experiencing physical, psychological, or sexual harm as a consequence of gender-based violence, while only a small proportion reported financial losses (1.4%) or other unspecified outcomes (1.4%). These findings are consistent with existing literature indicating that gender-based violence primarily results in physical, sexual, and psychological harm to survivors. Global research highlights that gender-based violence is widely recognized as causing severe physical, sexual, and mental health outcomes, including depression, anxiety, sexually transmitted infections, and other long-term health complications (Stein et al., 2025). Fear-related concerns dominated reasons for hesitating to seek help. Fear of stigmatization and intensified abuse was reported by 62% of respondents, while 32% cited fear of losing their children. Constraints such as lack of transport to go seek services were reported by 5.5%, and fear of the law by 1.4%. The study findings concurred with those of International Center for Research on Women, which found out that women fear being held accountable for the violence, particularly in cases of rape. They also worry about being stigmatized by their community or facing financial hardships if they report violence to the police, particularly when it involves their spouses or male companions. These women are wary that violence might get worse or that reporting it could lead to separation and a loss of financial assistance (ICRW, 2015).

More participants from an FGD confirmed the same.

“Gender-based violence is when your husband is controlling and demanding that you don’t engage in certain economic or social activities like women groups, and when you defy the rules, you get a beating as a result of that. This is common in most of the household; it results to physical abuse or even death”. Participant 1

“GBV is when you go to the forest to fetch firewood or makoma, you meet a group of men who tend to beat or even rape you. That is common to women to especially here”. Participant 2

Among respondents who delayed or avoided seeking help, lack of money was the predominant reason (67%). Normalization of violence against women was reported by 26%, while fear of hospitals accounted for 6.8% of responses. In their study, McCleary et al., (2018) found some similarity that socio-cultural challenges comprising of lack of knowledge among women about their freedom to seek justice and live without fear of violence, the normalization of assault within the community, and the fear of being blamed or stigmatized for reporting sexual violence were some of delayed reasons to seeking help (McCleary, et al., 2018).

This was confirmed by qualitative data which showed that money was a major contributor to lack of justice.

“When seeking justice from the chief or the police, in most cases, they demand bribes, and if you lack money to give you don’t get justice”. Participant 9

Nearly all respondents (99%) identified patriarchy, defined as male authority over women across social domains, as a key cultural belief hindering help-seeking among survivors of gender-based violence. Only a small proportion (1.4%) cited capitalism-related individualism as a contributing cultural factor. These findings mirror that of a study by Lee & Hadeed (2019), who revealed that social and cultural barriers especially patriarchy, a belief system that justifies male dominance over women, play a major part in preventing GBV survivors from seeking help and obtaining the necessary services (Lee & Hadeed, 2019)

The most commonly reported contributors to continued violence were outdated cultural norms, economic dependence, and substance abuse, reported by 79% of respondents. Limited access to education for women was reported by 11%, while poor healthcare services (2.7%), lack of police presence (1.4%), and other factors (5.5%) were less frequently reported. Similar to the study findings, a report by USAID (2016), showed that gender-based violence in Kenya is mostly caused by cultural and traditional practices that promote violence against women. Some of the practices include; Female Genital Mutilation, where girls undergo harmful procedures that lead to long-term health complications. Wife inheritance whereby widows are forced to marry a male relative of their deceased husband, which increase vulnerability to abuse and exploitation. Child and forced marriage to girls especially in pastoralist communities, which limit their education opportunities and expose them to early pregnancies and domestic violence. These deeply ingrained practices make it challenging to change the attitudes that allow such violence to persist.

Focus group discussion also revealed that village elders often served as the first point of support for survivors in the community.

“When an incident happens at the village level, we start seeking help from the village elders, then go to the chief, then to the police station”. Participant 11

Limitation of the study

This study was limited by the small sample size (n=73) to provide statistical power. The wide confidence intervals were due to the small cell sizes of certain demographic groups (age 50+, widowed, tertiary education). In addition, the cross-sectional research design cannot create causality.

CONCLUSION

This study demonstrates that gender-based violence is highly prevalent in Turkana County, with survivors facing multiple, interconnected barriers to healthcare access. While most survivors eventually reach healthcare facilities, significant delays are common due to socio-cultural, economic, and systemic challenges. To address these issues, it is recommended that comprehensive free GBV services including medical care, counseling, and legal support be provided. Formal referral networks between health, police, legal, and community services should be strengthened, while anti-corruption measures and accountability mechanisms in both justice and health systems must be implemented. Community-wide stigma reduction and awareness campaigns should be conducted, alongside targeted interventions for single women and Muslim survivors. Furthermore, economic empowerment programs aimed at reducing financial dependence on perpetrators, as well as enhanced training of healthcare workers on survivor-centered care, are essential to improve healthcare access and support for GBV survivors in Turkana County.

Conflict of Interest

The authors declares no conflict of interest.

Data Availability

The data supporting the findings of this study are available from the corresponding author upon reasonable request.

REFERENCES

1. WHO. (2005). Multi-country study on women's health and domestic violence against women. Geneva: WHO.
2. IASC. (2015). Guidelines for gender-based violence interventions in humanitarian settings: The IASC Taskforce on gender in humanitarian assistance. Geneva.
3. WHO. (2024). Addressing violence against women and achieving the Millenium Development Goals. Geneva: WHO.
4. UNHCR. (2016). Sexual violence against refugees: Guidelines on prevention and response. New York: UNHCR.
5. WHO. (2012). Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence. New York: WHO.
6. WHO. (2019). Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. WHO. (2021). Gender based violence in a public health issue using a health systems approach. Retrieved September 9, 2024
7. Willman, A., & Corman, C. (2013). Sexual and gender-based violence: What is the World Bank doing and what have we learned?: A strategic review. Washington, DC: The World Bank.
8. Hall, A. (2015). Sexual and gender-based violence in the sustainable development goals.
9. KNBS. (2022). Kenya Demographic and Health Survey.
10. Service, N. P. (2021). Annual Report.

11. KHIS. (2023). Gender Based Violence Cases recorded in Turkana County between 2020 to 2023.
12. Government, T. C. (2023). Gender Based Violence policy and guidelines report from KDHS.
13. ICRH. (2020). Facing violence: Unveiling sexual and gender based violence issues in Kenya. International Centre for Reproductive Health.
14. McCleary, S., Namy, S., Nyoni, J., Rweyemamu, D., Steven, E., & Salvatory, A. (2018). Help-seeking pathways and barriers for survivors of gender-based violence in Tanzania: Results from a study in Dar es Salaam, Mbeya and Iringa Regions. *Engender Health*.
15. KDHS. (2023). Kenya Demographic and Health Survey.
16. KHIS. (2023, May 5). Kenya Health Information System. Kenya.
17. Mugo, M., Owaka, I., & Mutisya, R. (2025). Gender-Based Violence and Associated Factors Among Adolescent Girls in Kakuma Refugee Camp, Turkana County, Kenya. *African Journal of Empirical Research*.
18. Ngala, P. E. (2021). Prevalence and Correlates of SGBV among Refugees in Kakuma Refugee Camp, Turkana County, Kenya.
19. Okyere, J., Dosoo, A. K., Ayebeng, C., & Dickson, K. S. (2024). Dynamics of violence disclosure among women in Kenya: trends, changes and associated factors. *Journal of Health, Population and Nutrition*, 43(1). <https://doi.org/10.1186/s41043-024-00702-4>
20. Melkam, M., Asnake, A. A., Mekuria Negussie, Y., Bezie, M. M., Asmare, Z. A., Asebe, H. A., Seifu, B. L., & Fente, B. M. (2024). Help-seeking behaviors and determinant factors among women exposed to intimate partner violence in East Africa based on recent demographic and health survey data: a multilevel analysis. *Frontiers in Psychiatry*, 15. <https://doi.org/10.3389/fpsy.2024.1402704>
21. Stein, C., Flor, L. S., Gil, G. F., Khalil, M., Herbert, M., Aravkin, A. Y., Arrieta, A., Baeza de Robba, M. J., Bustreo, F., Cagney, J., Calderon-Anyosa, R. J. C., Carr, S., Chandan, J. K., Chandan, J. S., Coll, C. V. N., de Andrade, F. M. D., de Andrade, G. N., Debure, A. N., DeGraw, E., ... Gakidou, E. (2025). The health effects associated with physical, sexual and psychological gender-based violence against men and women: a Burden of Proof study. *Nature Human Behaviour*, 9(6). <https://doi.org/10.1038/s41562-025-02144-2>
22. Lee, Y. S., & Hadeed, L. (2019). Intimate partner violence among Asian immigrant communities: Health/mental health consequences, help seeking behaviour, and service utilization. *Trauma, Violence and Abuse*, 143-170.
23. USAID. (2016). Gender-based violence.