Availability and Status of Usage of the Key Resources in Gender-Based Violence and Recovery Centres in Uasin Gishu County, Kenya

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ABSTRACT

Gender-based violence (GBV) remains a critical issue in Uasin Gishu County, Kenya, where high prevalence rates demand effective survivor support. GBV recovery centres (GBVRCs) provide essential medical, legal, and psychological services but face challenges including inadequate funding, limited trained staff, and resource constraints. This study, guided by Ecological Systems Theory, examines the availability and utilization of key resources in GBVRCs. Findings indicate gaps such as lack of referral directories and secure storage for sensitive data, despite some hospitals having trauma documentation and counselling policies. The study recommends a holistic, multi-sectoral approach to enhance resource access, improve utilization, and strengthen collaboration among GBVRCs and partner agencies to ensure comprehensive care for survivors.

Key Words: Availability, Status, Usage, Key Resources, Gender-Based Violence, Recovery Centres

INTRODUCTION

Gender-based violence (GBV) is evidenced in all societies globally and manifests in sundry manners. Gender-based violence could be described as any violence that is perpetrated against a person's will to dominate women and men in society (Gaur, 2023). Moreover, it remains valid irrespective of whether they lived in conflict-ridden areas or in relative tranquillity. The UN has described violence against women as any act of violence that is perpetrated against women and is based on gender; that in turn results in actual physical injuries, or may likely lead to physical, sexual or psychological harm of women, including threats to perpetrate such violence, coercion and communicating or duping women into agreeing to live without their freedom of choice, whether this takes place in public or the intimate sphere of their existence.

Thirty-seven per cent of global females will be subjected to some violence at some point in their lives (World Health Organization, 2021). However, this rate is higher in emergencies, conflicts, and crises because vulnerability and risks are high, and family, legal, and/or community protections have eroded. All types of harm caused under GBV are physical and psychological and are also covered by the threats of violence (Violence, 1999). GBV can take various forms and can be physical, sexual or emotional, among others. Some of these include: physical violence including; Assault, slavery; Psychological violence including; verbal abuse, seclusion; Sexual violence including; Rape; Cultural violence including; Child marriage, Female Genital mutilation, Economic violence, including; withholding necessities of life; Sexual harassment, exploitation, and abuse (Graaf, 2021).

According to the UN, worldwide, one out of four women has been assaulted physically and/or sexually at least once in her lifetime via an intimate partner. At the same time, IRC studies found that it is the dominant type of VAW in different humanitarian crises. The statistics are staggering: more than 30% of the world's women and girls will fall victim to physical or sexual violence in their lifetime. Such violence, according to the United Nations (2024), was increasing to femicide, wherein at least 51,100 women in 2023 lost their lives, more than half of whom were killed by their intimate partners or family members.

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Female Genital Mutilation (FGM) and Gender-Based Violence (GBV) recovery centres are important in the support systems of the survivors and in responding to persistent challenges within the Kenyan context (Kassim, 2022). Such centres provide appendage medical services in emergencies and for making complete forensic examinations of the survivors who require medical help. They also deliver counselling and mental health services to their clients to help them overcome trauma. Legal aid is another service since recovery centres assist survivors in seeking justice through the legal channel. Crisis centres help ensure that victims of abuse can obtain support and services from shelters which provide completely safe and anonymous spaces.

To eradicate GBV, the recovery centres organize awareness-creation processes and educational sessions to educate people on GBV and how it can be controlled (Raftery et al., 2022). They require policies and laws to be changed and enacted, and they engage government and non-governmental organizations for the survivors and the perpetrators. Stakeholder involvement is crucial because recovery centres aim to transform mindsets that justify and perpetuate GBV and nurture a culture of honour and equitability (Van der Burg & Young, 2024). Also, they educate healthcare practitioners, police, security forces and teachers on how to deal appropriately and compassionately with cases of GBV.

Nonetheless, GBV recovery centres enable survivors to regain the functions of their lives and give them a productive role in society. These centres play a crucial role in educating women and creating awareness of GBV in order to eliminate it by going to the source. Preventing GBV has numerous economic returns since there will be less spending on treatment, people will be healthier and more productive, and communities will be safer (Botea et al., 2021). In summary, GBV recovery centres should assist the survivors to recover as well as deal with the GBV issues that prevail in Kenya, thus bringing a safer nation.

Problem Statement

The study targeted gender-based violence in Uasin Gishu County, Kenya and the social, psychological and economic implications of gender-based violence amongst survivors. According to the Kenyan National Bureau of Statistics in 2022, a report on GBV suggested that physical or sexual violence is prevalent in different parts of Kenya, with 45% of the women subjected to violence throughout their lives. In the financial year between 2023/2024, 13,606 physical and emotional violence cases and 1,456 sexual violence cases were reported in Uasin Gishu County. These statistics prove the constant occurrence of GBV in this region, hence the need for a multi-sectoral effort to address this issue. The economic implication of GBV is not negligible, as data indicate that the total spent on violence, productivity, and health costs is about 3.7 percent of the GDP of the respective developing countries (Wamue-Ngare et al., 2024).

Despite the increasing demand for support services, many GBVRCs face challenges such as inadequate funding, insufficient trained staff, and a lack of necessary medical and psychological resources. Furthermore, there is limited data on how these resources are utilized and whether they are sufficient to meet survivors' needs effectively. As a result, survivors may not receive the comprehensive care and support required for their recovery, which could hinder their chances of rebuilding their lives and integrating back into society.

This research aims to investigate the availability and status of usage of critical resources in GBVRCs within Uasin Gishu County. It will assess the extent to which the existing resources are meeting the needs of survivors, identify gaps and challenges, and explore potential solutions to improve the overall effectiveness of these centres in supporting survivors of GBV. Understanding these aspects is crucial for ensuring that GBVRCs can provide the appropriate care and assistance necessary for the recovery and empowerment of survivors in the region.

Objective

To investigate the availability and usage of critical resources in GBV and recovery centers.

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LITERATURE REVIEW

Theoretical Framework

The study was guided by Ecological Systems Theory, developed by a Russian-born American psychologist, Urie Bronfenbrenner, in 1979. Bronfenbrenner's Theory explains how multiple layers of environmental systems influence individuals. These layers influence individual behaviour and well-being, ranging from immediate family and peers (microsystem) to broader societal and policy contexts (macrosystem).

Gender-based violence Theory emphasizes the importance of the survivor's external context (such as the community in recovery centres) and external social and organizational support structures within society (Legal, medical, and social support structures). While the Theory is also based on the idea that various levels of intervention must be entwined, the focus is on recovery.

In analyzing the Social Ecological Matrix, we aim to appreciate further how resource availability across microsystems, mesosystems, ecosystems, macrosystems, and the chronosystem affects the GBV centre's capability to support survivors. This will examine how local, institutional, and societal resource support either facilitates or impedes the recovery process, with a view to determining the status and efficiency of these centres in Uasin Gishu County.

The main objection to the Theory is that the Theory provides a very complex model, and its empirical validation is almost impossible. Critics say that it may overemphasize the influence of the environment, and it is possible to underestimate the role of genetics in child development. The critique's authors also pointed out that the Theory is possibly devoid of precise mechanisms that describe how people might be different and how they can cope with their circumstances.

Assumptions of the Theory are that the interaction of multiple environmental systems influences development. These systems range from the immediate surroundings to broader societal structures. The Theory assumes that changes in one system can ripple through and affect other systems and that individuals are active participants in their development, not just passive recipients of environmental influences.

Empirical Review

Gender-Based Violence (GBV) persists as a major public health and human rights concern globally affecting the health, wellbeing and human rights of women and girls and has broad implications for individuals, families and communities (Okpokwasili, 2024). Shelters are facilities that offer different services for the GBV survivors such as; medical, legal and psychosocial support, as well as temporary shelter. All the above-mentioned centres require key resources conveniently available and properly channeled to meet the need of survivors. The research investigates the availability and use of GBV medical, psychosocial, legal, infrastructure and human resources in recovery centres in the selected countries.

Observing the United Nations Population Fund (UNFPA) (2016), the deficiencies of human resources in GBVRCs result in the timely provision of services and the quality of care for survivors in many countries, including Kenya. Staffing problems are usually compounded by poor staff training and poor motivation of employees who work in these relatively small, and most times poorly funded and equipped centres.

Similar to other human resources, key resources for GBV recovery centers in the United States rely mostly on federal and state policies and funding institutional support (Mubiri, Frye, Williams, and Knutson, 2019). Lots of centres for GBV recovery services have been established and many of these are in a position to access several of it services whether for the survivors of intimate partner, sexual violence or human trafficking. The resources include emergency shelters, legal services, counselling, advocacy among others. The NCADV also reveals that over 2000 domestic violence programs are funded in USA every year by government grants and private contributions. However, it is noted that problem still persists with resource mobilization since most centres are non-profit bearing necessitating the fact that they often lack financial capital required to help fund the opening of more centres to cater for the increasing number of people seeking treatment. According to the

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recent data, only one of the three women survivors of domestic violence who require services for escaping the violence can access shelter because of inadequate funds (Fisher & Stylianou, 2019). Moreover, he notice the ideas of the use of technology in delivering counseling and support in this era of COVID-19 and other outbreaks, and which also expanded access but also show that not all groups have equal access to digital resources.

Osime's (2021) research conducted in Nigeria shows that gender-based violence is steadily escalating, thus the rise of recovery centers meant for survivors was observed. There is a lot of dependence on the governmental and non-governmental organization on the usage and availability of resources in these centers. The needs of such a woman include medical services which may be got from the Nigerian Ministry of Women Affairs, United Nations Women among others psychosocial services like legal Aid and Psychological Counselling which can be gotten from local NGOs. However, there is a major divide between the numbers of these resources between those that are perceived as urban and those seen as rurally based. For example, some centres in lagos and Abuja are relatively well endowed but a majority of rural regions do not have qualified human resources; equipment's, medical appliances and operational shelters. A 2021 survey done by the Nigerian National Agency for the Prohibition of Trafficking in Persons (NAPTIP), revealed that funding constraints and poor infrastructure are some of the shortfalls of the current GBV centres that many survivors have to travel long distances just to access basic services. Still, the Nigerian government has come up with some measure in passing and implementing gender-sensitive laws and policies for instance Violence Against Persons Prohibition Act (2015) proclaims GBV recovery services. The poor functioning of recovery resources in rural settings remains a key challenge in addressing disparities in support services.

This study confirms that Gender Based Violence is rife in Tanzania especially in rural settings due to cultural practices and deficiencies of such services (Gahaihi, 2023). In most of the centres that seek to address GBV, the general use of resources in these recovery centres depends on the government and cooperation with other international organizations and other civil society organization. For purposes of treatment, the government through the Ministry of Health, Community Development, Gender, Elderly and Children has established the centers of recovery particularly, in the developed regions such as Dar es Salaam and Arusha. These centres among others, provide medical, counselling, legal, and accommodation services. However, resources are not always available due random availability and nature of situations. A survey conducted in Tanzania by the United Nations Population Fund (UNFPA) estimated in 2022 that despite some of the resources that Tanzania has include avails post rape care kits and safe houses for survivors, current situation of rural areas reveals that there is severe challenge in terms of trained personnel, health facilities and legal services. Unfortunately, most survivors in these areas are often compelled to visit urban areas: an exercise that may be expensive and extremely risky. Besides, many societies look down on women experiencing any form of gender-based violence deny them the available resources. The gaps are gradually being closed by some Tanzanian civil organizations like Tanzania Women Lawyers Association (TAWLA) and non-governmental organizations such as the Women's Legal Aid Centre among others, but most of the times their functions are hampered due to issues of inadequate funds, and a congested working calendar. Training of healthcare providers and legal officers has gradually been presented as a owed area despite still being challenging in achieving improved outcomes for GBV survivors.

Despite, the current rise in advocacy against GBV cases, different studies show that many women in Kenya do not receive adequate recovery services. For many years, state and non-state organizations have opened recovery centers through which GBV survivors receive medical treatment, counseling, legal help, and temporary housing. The Kenyan central government through Ministry of Public Service, Youth, and Gender Affairs has been at the forefront of these efforts together with Implementation partners/Local/international NGOs like the Federation of Women Lawyers (FIDA-Kenya) & Kenya Red Cross Society. These organizations tend to work hand in hand so as to offer a one stop center where they offer legal assistance, medical, and even counseling services.

Synthesis and Comparative Insights

Across Kenya, the United States, Nigeria, and Tanzania, GBV recovery centres face a variety of shared challenges and contextual differences. All regions identify funding limitations as a major barrier to effective

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GBV recovery services. Kenya, Nigeria, and Tanzania report insufficient financial resources that hinder service provision and infrastructure development, particularly in rural areas. Although the US benefits from relatively more substantial federal and state funding, resource mobilization remains an issue due to the nonprofit nature of many centers, restricting expansion. Staffing shortages and inadequate training are common across all contexts, negatively impacting service quality and timeliness. Kenya and Tanzania emphasize a shortage of qualified personnel, while the US experiences workforce retention issues despite higher overall staffing levels.

Nigeria and Tanzania show stark contrasts between well-resourced urban centres and poorly equipped rural ones, leading to unequal survivor access. This divide results in rural survivors often traveling great distances to urban facilities, at significant cost and risk. Kenya and the US also experience some level of resource concentration in urban areas, though less pronounced. Legislative advances such as Nigeria's Violence Against Persons Prohibition Act (2015) and Kenya's gender-focused policies provide foundational support for GBV recovery services. The US operates within a comprehensive policy environment, funding numerous programs. Nevertheless, gaps between policy and practice remain. The US has incorporated technology in delivering counseling, especially during COVID-19, expanding access for some survivors but revealing inequities in digital accessibility. Other countries are yet to fully integrate such technological solutions due to infrastructure and access limitations.

METHODOLOGY

The study was conducted in Uasin Gishu County, one of Kenya's 47 counties, located in the Rift Valley region of the country. The research focused on Uasin Gishu County due to the high prevalence of rape and defilement cases, as indicated by the National Crime Research Centre report (2022). The county hosts a large GBVRC at Moi Teaching and Referral Hospital, alongside smaller facilities in its six sub-counties. The Kenyan government, through the National Guidelines on the Management of Sexual Violence in Kenya (2014), has established a uniform psychosocial support service framework for all GBVRCs, which the study aimed to evaluate and compare across the region. This study employed a mixed-methods approach, specifically a convergent parallel design, to collect both quantitative and qualitative data. The target population for this study comprised of 97 adult female victims of sexual assault in Uasin Gishu County, particularly those receiving services at the county's GBVRCs. Additionally, the study targeted 43 trauma counsellors attached to these centres. Two main categories of participants were sampled: trauma counsellors and sexual assault survivors. Sampling procedures were designed to ensure the collection of rich and reliable data. A census approach was used to sample respondents. Data collection was facilitated using three instruments: a questionnaire for counsellors, an interview guide for survivors, and document analysis. These instruments were developed based on the study objectives and relevant literature, ensuring triangulation to improve the accuracy and reliability of the findings. Qualitative and quantitative data were analyzed separately before being compared to identify any inconsistencies or confirmations across the findings. Thematic analysis was used for qualitative data, while descriptive statistics was applied to the quantitative data with results presented in the form of means, percentages. This study acknowledges potential limitations, including survivor bias, as participants who accessed the GBVRCs may not fully represent all survivors in the county, particularly those who do not seek formal support services. Additionally, the focus on Uasin Gishu County limits the generalizability of the findings across Kenya, given regional variations in resource availability, cultural factors, and GBV prevalence. These limitations suggest that caution should be exercised when extrapolating results beyond the study area, and further research in diverse Kenyan settings is recommended.

RESULTS

Resource Availability

The study findings revealed most of the hospitals have trauma forms which show that there is near about 71.43% hospital which has a proper format to document the trauma cases. In counseling SOPs, 70 percent of the hospitals have formal policies and guidelines for trauma counseling as indicated by 57.14% of the hospitals participating in this study.

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Few hospitals have referral directories which are important for providing other related services to the survivors, (14.29%). This can greatly underscore a major deficiency in availing enhanced survivor services.

A minor number of hospitals (28.57%) still lack storage with locked cabinets to store data and medical commodities, that is, there seems to be no private room to detail sensitive material such as patient data, which could be compromised.

Status of Usage

The trauma forms are recognized to be useful where they are obtainable and the management of such hospitals acknowledges their usefulness in providing professional assessment and documentation of cases of trauma.

Of the hospitals that responded, 42.86% have privately and quietly located, easily accessible, well-lit rooms which are being used optimally in offering a private space that is safe and comfortable for survivors during their care.

The referral directories available in a few hospitals have low utility revealing poor practice regarding systems to help survivors gain access to other service.

Also, regarding the availability of the lockable cabinets we have the following conclusion: the lockable cabinets are not closed, which means that even if they are placed in the access areas of the clinics, they are not used systematically to store the locked documents, medical supplies, etc.

Although there are counseling SOPs, the frequency of use is moderate, suggesting nonuniform compliance of these SOPs across the hospitals.

The stock of PRC kits is fairly moderate, but the extent to their use is moderate as well which means not all hospitals are making full use of them as part of their standard processes.

There is policy implementation in some hospitals since 42.86% of them has the policy, although the implementation is also average; it thus suggests that the said policies are not very strictly complied with across the different settings.

Interpretation

Despite a reasonable number of hospitals having private rooms, the low availability of lockable cabinets suggests that many hospitals may lack the necessary secure storage for sensitive materials. This could jeopardize the confidentiality of survivor data and personal items.

The very low availability and poor usage of referral directories (only in 14.29% of hospitals) is a major concern. Referral directories are essential for connecting survivors with broader healthcare services, social support, and legal assistance, and the lack of this resource limits the scope of survivor care.

DISCUSSION OF FINDINGS

To some extent, there is an agreement between the findings of this study as the availability of private, quiet, accessible and well-lit rooms for survivors is observed in 42.86 % of the GBVRCs. These rooms as used in the consumption were rated as “Good”. The survivor operational space, ideally is a brightly lit private room because after having just escaped from the perpetrator or undergoing counseling or seeking medical attention, the survivor needs a safe place to heal. Overall, the lower number of such rooms means a lack of availability of an appropriate setting for survivors, which is the reason to develop more amenities of this type in GBVRCs.

A total of 28.57% of the GBVRCs had put up Information, Education, and Communication IEC materials, with usage reported as ‘Poor’. That is why IECs are required to receive a large variety of information by survivors on their rights, available services, and prevention measures. The low utilization and scarcity of the IEC materials indicate that these centres fail to provide information sufficiently to the survivors and the entire

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community. This may help explain why there is comparatively little knowledge of the GBV services and the use of available assets.

Overall, 57.14% of the GBVRCs had developed counselling SOPs in their current workings with usage rated as "Average". SOPs play an important of particular concern to the delivery of effective, humane, and consistent services across institutions. Still, it is evident that over half the centres follow these procedures since the average rating indicates they may not be strictly followed or else, the quality of counselling services may differ. This may cause discontinuity of care and treatment among the Survivors which might be due to the implementation gap.

The forms/registers of trauma was seen in all the 14 reviewed GBVRCs and the usage was considered 'Good.' Trauma forms and registers are helpful in capturing survivor's cases and identifying progress and continuity. The high percentage of availability and the positive status of usage also suggest that nearly all the GBVRCs are adequately handling case management records of their survivors.

PRC was offered in 42.86% of the interviewees, whereby the usage was rated at "poor" of the GBVRCs. For purposes of documenting the administration of the initial post rape care and medications, the PRC register is very essential. This indicates that while this resource is available in some centres, perhaps the manner in which it is utilized may be inadequate, and therefore may result in fragmentary or patchy level of care for survivors. This may lead to inadequate documentation of care; and inadequate progress of follow up care, of survivors of sexual violence.

PEP RB first dose Kits and ECP were available in 57.14% of the GBVRCs and they were used and rated as "average." These are very useful in avoiding spread of HIV and pregnancy in cases of rape. The "Average" usage raises concerns that, even though there are centres with these kits, their distribution or usage may not be uniform or properly employed across the board maybe due to shortages of resources or inadequate knowledge among the staff.

Among the GBVRCs identified only 28.57% had lockable cabinets for securing data tools and commodities while usage was rated as Poor. This results in issues of stock out, lack of proper storage facilities for survivors 'information, and medical supplies as well as commodities. This greatly exposes the program to risks that are capable of compromising the integrity of the services provided; particularly in sensitive issues touching on the survivor and prescription of drugs.

Among the GBVRCs, 14.29% had a referral directory in which the usage was rated "Very Poor." A referral directory is an essential tool that helps in the provision of referral services and other differentiated service delivery. Their low overall supply and usage indicate that quite a number of GBVRCs lack adequate resource to properly enable them provide appropriate referrals, hence disjointed care and delayed healing for survivors.

A total of 42.86% of the GBVRCs responded that they had written center policies and usage was rated as 'Average'. It is necessary to adopt such policies to set out the working procedures as well as to guarantee equal quality of services. The 'Average' status indicates that there are programmes and policies in place yet these are not perhaps effectively enforced or complied with perhaps due to the lack of staff awareness or perhaps enabled monitoring.

CONCLUSION

The study concluded that comprehensive support of survivors of sexual assault in Uasin Gishu County entails the use of some essential resources. The research indicated that despite the existence of available trauma forms and counseling SOPs, privacy and referral systems are still lacking. The low availability of referral directories and lockable cabinets speaks volumes about the degree to which struggling to meet the survivor's needs.

Further, on special equipment they established that trauma forms and private rooms are effective, but the effectiveness of referral directories and lockable cabinets is still low. These gaps indicate that, despite

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significant success at raising awareness and offering new forms of support to victims, the mechanisms already in place must be utilized more effectively in order to deliver adequate and complete care.

In addition, this study stressed the importance of a holistic model when working with survivors. This involves protection from physical harm, as well as support of clients' emotional needs, provision of medical and legal services by appropriate linkage. If we are to effectively cater for the needs of sexual assault survivors then a comprehensive approach that incorporates elements noted above is mandatory.

RECOMMENDATIONS

The study recommends increase the availability and accessibility of key resources, including comprehensive referral directories prominently posted in all GBV recovery centres, so survivors can easily access health, legal, and psychosocial support services. Expand secure storage options such as lockable cabinets to protect sensitive survivor information and medical supplies. Conduct regular orientation and training sessions for GBV centre staff to ensure trauma forms and SOPs are used effectively. Increase awareness among staff regarding proper documentation and secure storage of survivor cases to improve data protection and service delivery.

Foster better multidisciplinary collaboration between GBV recovery centres, health care facilities, legal assistance providers, and other relevant agencies. Such integrated teamwork is vital for comprehensive survivor support. To sustain and expand these improvements, active advocacy for increased government and donor funding is necessary. Specific strategies should be developed for mobilizing resources, including lobbying for policy reinforcement, budget allocation, and partnerships with private and civil society sectors to ensure GBVRCs are adequately resourced and supported.

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