

**PSYCHOSOCIAL INTERVENTIONS AND RECOVERY NEEDS OF SEXUAL
ASSAULT SURVIVORS IN UASIN GISHU COUNTY, KENYA**

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**A THESIS SUBMITTED TO THE BOARD OF POST-GRADUATE STUDIES
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD
OF THE DEGREE OF DOCTOR OF PHILOSOPHY IN COUNSELLING
PSYCHOLOGY, KISII UNIVERSITY**

2026

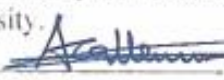
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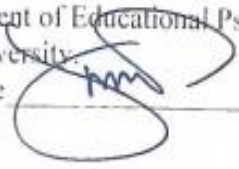
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DEDICATION

This work is dedicated to my mother, Elizabeth Cherotich Tonet (Kameetab Siratei), whose unwavering support, resilience, and sacrifice have been the cornerstone of my academic journey. I also dedicate this work to my aunts, Susana Tataa Kipsum (Bot Kongonyei) and Christina Kipsum (Bot Saramei), for their guidance, encouragement, and the values they instilled in me.

Special dedication goes to my spouse, Janet Chepsaat Tonet, for her steadfast support, patience, and understanding throughout the course of this study. To my children, Cherotich, Abby Chebichii, Kimurgor, Kipngetich, Laban Tonet, Kigen, Cheronno, and Cherop, whose presence has been a constant source of motivation and inspiration.

I further dedicate this work to my cousin, Mary Chepketer, and my niece, Irine Chepkoech, for their support and encouragement. This work stands as a testament to the collective support, encouragement, and influence of all those mentioned above.

ACKNOWLEDGEMENTS

First and foremost, I thank the almighty God for giving me good health throughout my studies. I also thank the department of psychology and school of arts, Management of Kisii university for according the opportunity to pursue my PhD studies. I further register my sincere and profound appreciation to my research Supervisors, Prof. Callen Nyamwange and Dr. Godfrey Ngeno, for their tireless support and expert advice throughout my thesis writing. Their guidance shaped my work in many ways, especially on thesis research writing and ways of data analysis. I acknowledge all the lecturers through whose hands I went while undertaking the course.

I express my heartfelt gratitude to my fellow students Pastor, Alex Malayi, Grace Mogire, and late Charles Waweru, for their unwavering support, collaboration, and encouragement throughout the course of this research. Their insights, feedback, and shared experiences greatly enriched the development of this thesis and made the journey more meaningful and enjoyable. I am equally grateful to all the respondents from Nandi and Uasin Gishu County who generously gave their time and provided thoughtful, honest, and valuable responses to my study. Their participation was instrumental in making this research possible, and I deeply appreciate their contributions. I most heartily thank the members of my family for their understanding, support, and encouragement they gave me during this study period.

I sincerely acknowledge my friends, Silas Boor & John Kiboi from Australia, Phoebe Choge and Cynthia Kipkales, for their companionship and unwavering moral support. I also extend my gratitude to Dr. Amos Magut and Wilson Barsoi for their mentorship and for their invaluable contribution in shaping this thesis, particularly in the area of data analysis.

ABSTRACT

Sexual assault is among the most distressing forms of trauma globally, often resulting in severe mental and physical health consequences. However, there is a paucity of research examining the nature of psychosocial recovery needs provided in Gender-Based Violence Recovery Centres (GBVRCs), particularly within the Kenyan context. This study aimed to investigate recovery needs and psychosocial interventions for sexual assault survivors within GBVRCs in Uasin Gishu County, Kenya. The specific objectives were to: Assess recovery needs of sexual assault survivors in Uasin Gishu County, Kenya, examine perspectives of counsellors and clients on the influence of psychosocial interventions in addressing recovery needs of sexual assault survivors in Uasin Gishu County, Kenya, analyse perspectives of counsellors and clients on the challenges of psychosocial interventions used in addressing recovery needs of sexual assault survivors in Uasin Gishu County, Kenya and explore counsellor and client perspectives on strategies for improving the psychosocial interventions used in addressing recovery needs of sexual assault survivors in Uasin Gishu County, Kenya. The study was guided by Cognitive-Behavioural theory and Ecological Systems Theory. Employing a mixed-methods approach, the study targeted 97 sexual assault survivors and 43 trauma counsellors attached to GBVRCs in Uasin Gishu County. Purposive sampling was used to select counsellors and survivors. Data were collected through questionnaires, interview schedules, and document analysis. To ensure reliability and validity, the data collection instruments were piloted in five GBVRCs in Nandi County, yielding a Cronbach's alpha of 0.8312 and a Content Validity Index of 0.85. Both descriptive and inferential statistical methods were used for data analysis, with a significance level set at $p < 0.05$. The findings indicated that the most critical recovery need identified by counsellors was the provision of information on legal options for survivors considering legal action (mean = 4.20, SD = 1.106). The study concluded that a holistic, survivor-centred approach is essential for the effective recovery of sexual assault survivors in GBVRCs. It is recommended that GBVRCs adopt a trauma-informed, integrated service delivery model that ensures physical safety, mental health support, legal advocacy, and long-term social reintegration for survivors.

Keywords: Sexual assault, Psychosocial interventions, Recovery needs, Trauma-informed care, Uasin Gishu County

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LIST ABBREVIATIONS

CPT:	Cognitive Processing Therapy
CSR:	Corporate Social Responsibility
CT:	Cognitive Therapy
CVI:	Content Validity Index
DRC:	Democratic Republic of the Congo
EFT:	Emotion Focused Therapy
EMDR:	Eye Movement Desensitisation and Reprocessing
FGM:	Female Genital Mutilation
FIDA:	Federation of Women Lawyers
GBVIMS:	Gender-based Violence Information Management System
GBVRC:	Gender-Based Violence and Recovery Centres
HIV:	Human Immunodeficiency Virus
LVCT:	Liverpool VCT Health
MBCT:	Mindfulness-Based Cognitive Therapy
MSF:	Médecins Sans Frontières
NACADA:	National Authority for the Campaign Against Alcohol and Drug Abuse
NACOSTI:	National Commission for Science, Technology and Innovation
NCRC:	National Crime Research Centre
NDMA:	National Drought Management Authority
NGEC:	National Gender and Equality Commission
OCD:	Obsessive Compulsive Disorder
PE:	Prolonged Exposure Therapy
PEP:	Post-Exposure Prophylaxis
PSS:	Psychosocial Support

PTSD:	Post-Traumatic Stress Disorder
SIT:	Stress Inoculation Therapy
STI:	Sexually Transmitted Infection
TF-CBT:	Trauma-Focused Cognitive Behavioural Therapy
UNFPA:	United Nations Population Fund
UNHCHR:	United Nations High Commissioner for Human Rights
WFP:	World Food Programme
WHO:	World Health Organisation

LIST ACRONYMS

CREAW:	Centre for Rights Education and Awareness
RAINN:	Rape, Abuse & Incest National Network
REPSSI:	Regional Psychosocial Initiative
SAFE:	Sexual Assault Forensic Exam
SGBV:	Sexual Gender Based Violence

CHAPTER ONE

INTRODUCTION

1.0 Overview

This chapter describes the background to the study, statement of the problem, purpose of the study, specific objectives, research questions, assumptions of the study, significance of the study, scope, limitations of the study, conceptual framework, theoretical framework and operational definition of key terms used in the study.

1.1 Background to the Study

Sexual assault remains one of the most pervasive violations of human rights and a major public health concern globally and within Kenya. Although both men and women experience sexual violence, women and girls are disproportionately affected. In Kenya, it is estimated that one rape case occurs every half hour (Kibet, 2020). Beyond the immediate trauma, sexual assault generates complex and interrelated recovery needs that span physical, psychological, legal, social, and economic domains. Survivors frequently suffer physical injuries, sexually transmitted infections (STIs), unintended pregnancies, depression, post-traumatic stress disorder (PTSD), and substance abuse (Temmerman et al., 2019). According to the World Health Organization (2023), survivors of sexual violence are three times more likely to experience depression, six times more likely to develop PTSD, thirteen times more likely to abuse alcohol, twenty-six times more likely to abuse drugs, and four times more likely to contemplate suicide. Importantly, survivors often experience several of these psychological and emotional consequences simultaneously (Silver et al., 2022). These statistics underscore the urgent need for comprehensive recovery mechanisms that extend beyond emergency medical treatment to sustained psychosocial, legal, and community-based support systems.

Recovery needs of sexual assault survivors are multidimensional and require contextual understanding from both international and local literature. Psychosocial and mental health needs include emotional stabilization, trauma processing, rebuilding self-esteem, restoring autonomy, and strengthening adaptive coping mechanisms. From a Cognitive-Behavioural perspective, traumatic experiences distort cognitions about safety, trust, self-worth, and control, thereby necessitating structured therapeutic interventions to reframe maladaptive thoughts and behaviours (Kanel, 2019). Ecological Systems Theory further highlights that recovery does not occur in isolation but is influenced by family systems, community attitudes, legal structures, and broader sociocultural norms. Medical needs involve management of injuries, STI prevention and treatment, and reproductive healthcare (Temmerman et al., 2019). Legal and safety needs include access to accurate information about reporting procedures, legal options, and protection from perpetrators. Economic and practical needs arise when survivors experience disruptions in education, employment, or family support systems. Cultural and contextual recovery needs are particularly pronounced in societies where stigma, silence, and victim-blaming persist. Survivors often report that community exclusion and shame are as distressing as the assault itself (Finnbakk & Nordas, 2019). Reintegration is further complicated by fear of retaliation, family dishonour, and social ostracization (Abi-Falah, 2019). Without addressing these intersecting needs, recovery remains incomplete.

International evidence emphasizes that effective recovery requires coordinated psychosocial interventions tailored to survivors' contexts. Studies conducted in Malaysia indicate that successful recovery approaches demand collaboration among government agencies, NGOs, healthcare providers, and community stakeholders (Rafferty, 2018; Cannon et al., 2020). Outcomes depend on survivors' unique needs, the quality of support provided, and the surrounding cultural environment. Rafferty (2018) stresses that continuous research and

evaluation are essential to ensure interventions remain relevant and survivor-centred. Despite this global recognition, management of sexual assault in many settings has traditionally prioritized clinical care addressing injuries, STIs, and pregnancy, while longer-term psychosocial and legal follow-up was considered secondary (Bryant-Davis, 2019). In Kenya, however, the Ministry of Health has strengthened integration of psychosocial and legal services within sexual violence response systems over the past decade to improve holistic outcomes (Ministry of Health, 2025). These frameworks align with guidance from the World Health Organization (2023), which advocates integrated, trauma-informed care.

Psychosocial interventions play a central role in restoring survivors' wellbeing. The Psychosocial Working Group (2003) and Regional Psychosocial Initiative (REPSSI) (2018) define psychosocial wellbeing as the dynamic interaction between social and psychological domains. Sexual assault disrupts this equilibrium by depleting internal coping resources and weakening social support networks. Therapeutic interventions aim to enhance how individuals think, feel, and behave toward themselves and others (Smith, 2019). They focus on modifying self-destructive behavioural patterns and rebuilding psychosocial resilience. Psychological therapeutic experiences also foster human capacity development, including self-esteem, resilience, intrapersonal competence, and renewed meaning in life (Mezzina et al., 2019). In Kenya, psychosocial interventions are commonly implemented through integrated service delivery models such as the Gender Violence Recovery Centre (GVRC) model and the Ministry of Health GBV recovery framework, which emphasize multidisciplinary collaboration among medical practitioners, trauma counsellors, and legal officers to ensure holistic survivor support. These models are aligned with World Health Organization (2023) guidelines recommending evidence-based psychological interventions to reduce PTSD, depression, anxiety, and maladaptive coping behaviours following sexual violence. Evidence suggests that structured psychosocial interventions can significantly

reduce PTSD symptoms, support emotional stabilization, rebuild survivors' self-worth and autonomy, and strengthen adaptive coping mechanisms when delivered within trauma-informed and culturally responsive frameworks (Kanel, 2019; Mezzina et al., 2019; Kibet, 2020). This demonstrates the documented significance and effectiveness of psychosocial interventions in sexual assault recovery.

Survivors' and counsellors' perspectives are critical in assessing the effectiveness of psychosocial interventions. Survivors often perceive counselling services positively when they promote trust, confidentiality, safety, cultural sensitivity, and relevance to their lived experiences (Rafferty, 2018; Cannon et al., 2020). Strong therapeutic rapport and survivor-centred approaches enhance engagement and perceived effectiveness. Conversely, perceived judgment, breaches of confidentiality, or culturally incongruent practices may undermine recovery outcomes. From the counsellors' perspective, several challenges influence service delivery. Kiruki et al. (2017) found that some counsellors lack adequate knowledge of national protocols governing sexual violence management. Masambia (2014) observed that Western counselling models remain relatively new within the Kenyan context and are not uniformly understood or accepted. Furthermore, the proliferation of counselling centres without standardized training requirements has created inconsistencies in service quality and public confusion about counselling roles. Counsellors also face heavy workloads, emotional burden, and case complexity when supporting survivors navigating medical, legal, and family systems. Despite recognition of these factors, limited empirical research has simultaneously examined both counsellors' and survivors' perceptions within GBVRC settings.

Psychosocial interventions within GBV Recovery Centres (GBVRCs) operate amid multiple structural and contextual challenges. Institutional barriers include limited staffing, funding

constraints, and infrastructural inadequacies. Operational challenges involve high caseloads, coordination difficulties across health and justice sectors, and documentation burdens. Cultural barriers such as stigma and victim-blaming attitudes discourage sustained engagement (Finnbakk & Nordas, 2019). Client-related challenges include trauma avoidance, fear of retaliation, and family pressure to withdraw cases (Abi-Falah, 2019). Conceptually, many therapeutic approaches in Kenya are grounded in Eurocentric psychological theories developed for Western populations (Cogburn, 2019). Exclusive reliance on such models may limit cultural relevance within African contexts (Ward & Plagnol, 2019). Scholars advocate integrating African psychosocial resources into mainstream therapeutic practice to enhance contextual alignment and effectiveness (Sommers-Flanagan & Sommers-Flanagan, 2018).

Evidence-based strategies for strengthening psychosocial interventions include adopting trauma-informed care models, enhancing inter-sectoral collaboration, providing continuous professional development for counsellors, ensuring structured supervision, integrating culturally sensitive approaches, and implementing systematic monitoring and evaluation mechanisms (Rafferty, 2018; Cannon et al., 2020). Reintegration strategies that prepare families and communities to reduce stigma are equally important (Abi-Falah, 2019). These strategies align with Kenya's institutional and legal frameworks, including the Constitution of Kenya, which guarantees dignity, equality, and security of the person; the Sexual Offences Act; the Protection Against Domestic Violence Act; and the National Guidelines on the Management of Sexual Violence issued by the Ministry of Health. These legal and policy instruments collectively mandate survivor-centred, rights-based, and integrated responses to sexual violence. Furthermore, guidance from the World Health Organization (2023) reinforces the importance of trauma-informed, multidisciplinary care models that integrate medical treatment, psychosocial support, legal assistance, and community

reintegration services. Together, these frameworks provide the structural foundation for strengthening psychosocial interventions within GBVRCs and ensuring that survivors receive holistic and coordinated recovery support.

Despite these policy frameworks and documented interventions, important gaps remain. Contextually, limited research has examined the specific recovery needs of sexual assault survivors within GBVRCs in Uasin Gishu County. Conceptually, few studies have comprehensively analysed the interrelationship between psychosocial, medical, legal, economic, and cultural recovery needs within integrated service settings. Methodologically, there is a scarcity of mixed-method studies capturing both counsellors' and survivors' perspectives regarding psychosocial intervention effectiveness, associated challenges, and potential improvement strategies.

Therefore, this study was necessary to analyse recovery needs of sexual assault survivors in GBVRCs in Uasin Gishu County; to examine counsellors' and clients' perspectives on the influence of psychosocial interventions; to analyse challenges associated with these interventions; and to explore strategies for strengthening psychosocial service delivery. By addressing contextual, conceptual, and methodological gaps, the study contributes evidence to inform trauma-informed, culturally responsive, and integrated psychosocial interventions within Kenyan GBVRCs, ultimately enhancing recovery outcomes for survivors.

1.2 Statement of the Problem

In Uasin Gishu County, approximately 15% of reported assault cases involve rape or defilement, yet only about half of survivors are documented as having received counselling services following medical care, raising concerns about the adequacy, continuity, and effectiveness of psychosocial interventions within Gender-Based Violence Recovery

Centres (GBVRCs) (National Crime Research Centre [NCRC], 2023). This service gap persists despite national policies mandating integrated, survivor-centred responses.

Sexual assault survivors require coordinated medical, psychological, legal, and social support to facilitate recovery. However, incomplete psychosocial engagement, limited follow-up, stigma, and service fragmentation undermine therapeutic outcomes. When trauma-related needs remain insufficiently addressed, survivors face heightened risks of persistent post-traumatic stress symptoms, depression, substance misuse, social withdrawal, disengagement from justice processes, and re-traumatization. These outcomes compromise both individual recovery and broader public health objectives.

Although psychosocial interventions constitute a central component of GBVRC services, limited empirical evidence exists regarding whether these interventions adequately address the multidimensional recovery needs of sexual assault survivors in Uasin Gishu County. Few studies have systematically examined survivors' recovery needs within integrated service settings, analysed counsellors' and survivors' perceptions of psychosocial intervention effectiveness, identified contextual and institutional challenges affecting service delivery, or explored strategies for strengthening culturally responsive and trauma-informed care. The absence of such localized and comprehensive evidence limits informed policy refinement and service improvement within GBVRCs.

Consequently, this study assessed recovery needs of sexual assault survivors, evaluate counsellors' and survivors' perspectives on the influence of psychosocial interventions, analyse challenges associated with these interventions, and analyse strategies for strengthening psychosocial service delivery within GBVRCs in Uasin Gishu County.

1.3 Purpose of the Study

The purpose of this study was to examine the psychosocial interventions and recovery needs of sexual assault survivors in Uasin Gishu County, Kenya. It was anticipated that the findings of this study would contribute to the development of policies and regulations aimed at enhancing support services for survivors.

1.4 Specific Objectives

The specific objectives of this study were to:

- i. Assess recovery needs of sexual assault survivors in Uasin Gishu County, Kenya
- ii. Examine perspectives of counsellors and clients on the influence of psychosocial interventions in addressing recovery needs of sexual assault survivors in Uasin Gishu County, Kenya
- iii. Analyse perspectives of counsellors and clients on the challenges of psychosocial interventions used in addressing recovery needs of sexual assault survivors in Uasin Gishu County, Kenya
- iv. Explore counsellor and client perspectives on strategies for improving the psychosocial interventions used in addressing recovery needs of sexual assault survivors in Uasin Gishu County, Kenya

1.5 Research Questions

- i. What are recovery needs of sexual assault survivors in Uasin Gishu County, Kenya?
- ii. What are perspectives of counsellors and clients on the effectiveness of psychosocial interventions in addressing recovery needs of sexual assault survivors in Uasin Gishu County, Kenya?

- iii. What are the perspectives of counsellors and clients on the challenges of psychosocial interventions used in addressing recovery needs of sexual assault survivors in Uasin Gishu County, Kenya?
- iv. What strategies do counsellors and clients propose for improving psychosocial interventions to better address recovery needs of sexual assault survivors in Uasin Gishu County, Kenya?

1.6 Research Hypotheses

H₀₁: Psychosocial interventions have no statistically significant influence on recovery needs of sexual assault survivors in GBVRCs in Uasin Gishu County.

H₀₂: Social-based interventions have no statistically significant influence on recovery needs of sexual assault survivors in GBVRCs in Uasin Gishu County.

H₀₃: Challenges of psychosocial intervention have no statistically significant influence on recovery needs of sexual assault survivors in GBVRCs in Uasin Gishu County.

1.7 Assumptions of the Study

This study was conducted under the following methodological assumptions:

- i. Participants provided truthful, accurate, and complete information regarding their experiences and perspectives, which was necessary to ensure the credibility of self-reported data collected through interviews and questionnaires.
- ii. Survivors and counsellors who participated in the study had sufficient exposure to psychosocial interventions within GBVRCs to meaningfully reflect on recovery needs, intervention influence, associated challenges, and improvement strategies.

iii. Gender-Based Violence Recovery Centres (GBVRCs) in Uasin Gishu County offer identifiable psychosocial interventions that can be examined, described, and evaluated within the scope of this study.

1.8 Significance of the Study

This study is significant in advancing theoretical, practical, and policy-oriented understanding of psychosocial interventions within Gender-Based Violence Recovery Centres (GBVRCs) in Uasin Gishu County.

1.8.1 Theoretical Contribution

The study contributes to existing scholarship on trauma recovery by generating localized empirical evidence on the multidimensional recovery needs of sexual assault survivors within integrated service settings. By examining the interrelationship between psychosocial, medical, legal, and socio-cultural recovery needs, the research expands context-specific knowledge on how psychosocial interventions function within Kenyan GBVRCs. Additionally, incorporating both survivors' and counsellors' perspectives strengthens conceptual understanding of intervention effectiveness, therapeutic engagement, and culturally responsive practice in non-Western contexts. The findings therefore contribute to refining trauma-informed and culturally grounded counselling frameworks applicable within sub-Saharan Africa.

1.8.2 Practical Contribution

At the practice level, the study provides evidence-based insights to improve psychosocial service delivery within GBVRCs. By analysing specific recovery needs, gaps in counselling coverage, and challenges affecting intervention implementation, the findings inform the development of structured follow-up mechanisms, improved referral coordination, culturally responsive therapeutic approaches, and enhanced counsellor training. The study

offers actionable strategies for strengthening trauma-informed counselling, improving survivor engagement and retention, and addressing barriers such as stigma, service fragmentation, and inconsistent psychosocial documentation. These insights directly support practitioners in enhancing the quality, consistency, and responsiveness of psychosocial care within GBVRCs.

1.8.3 Policy and Institutional Contribution

From a policy perspective, the study provides empirical evidence to inform government agencies, health administrators, and gender-based violence stakeholders on the effectiveness and limitations of psychosocial interventions within GBVRCs. The findings can guide refinement of national and county-level guidelines on sexual violence management, strengthen monitoring and evaluation frameworks for counselling services, and inform resource allocation decisions aimed at improving psychosocial coverage and service integration. By analysing systemic and contextual challenges, the study supports evidence-based policy adjustments to ensure that survivor-centred, trauma-informed care is not only mandated in policy but effectively implemented in practice. The study bridges the gap between policy intention and service delivery realities by generating contextually grounded evidence to strengthen psychosocial programming, improve recovery outcomes, and enhance integrated GBV response systems in Uasin Gishu County.

1.9 Scope of the Study

This study was conducted in Gender-Based Violence Recovery Centres (GBVRCs) located in Uasin Gishu County, Kenya. The geographical scope was limited strictly to GBVRCs operating within this county, and findings are therefore context-specific to this setting.

The target population comprised adult female sexual assault survivors aged 18 years and above who were receiving or had received psychosocial services in selected GBVRCs in

Uasin Gishu County. In addition, counsellors providing psychosocial services within these centres participated in the study. Male survivors, minors (below 18 years), survivors who had not accessed GBVRC services, and survivors receiving services outside Uasin Gishu County were excluded from the study.

The study examined psychosocial interventions as the independent variables, specifically focusing on psychological support interventions (such as individual counselling, group counselling, trauma-informed therapy, and follow-up support), social support interventions (including support groups and referral coordination), and strategies aimed at strengthening therapeutic interventions. The dependent variable was survivor recovery, conceptualized in terms of psychosocial wellbeing, emotional stabilization, coping capacity, and perceived progress toward reintegration.

The study did not evaluate medical treatment outcomes (for example, clinical management of injuries, HIV prophylaxis adherence), legal case outcomes (for example, prosecution success rates), or economic empowerment programs unless they directly related to psychosocial recovery processes. The research also did not compare GBVRCs across counties, nor did it assess national-level policy implementation beyond its relevance to local service delivery.

Anchored in a pragmatic worldview, the study employed a mixed-methods research approach to integrate quantitative and qualitative data in examining recovery needs, perceptions of intervention influence, associated challenges, and improvement strategies.

1.10 Limitations of the Study

This study was subject to several limitations that may influence interpretation and generalizability of the findings.

Data were collected through self-reported accounts from survivors and counsellors. Given the sensitive nature of sexual assault experiences, some participants may have withheld information, underreported distress, or provided socially desirable responses. This may affect the depth and accuracy of reported recovery experiences and perceptions of psychosocial interventions. To mitigate this limitation, participants were assured of confidentiality, anonymity, voluntary participation, and secure data handling procedures to encourage honest disclosure.

Discussing trauma-related experiences may have elicited emotional discomfort, leading to partial responses or avoidance of certain questions. This could limit the completeness of qualitative insights and affect the interpretation of recovery outcomes. To address this, the researcher employed trauma-informed interviewing approaches and allowed participants to skip questions or withdraw without penalty.

The measurement scale used to assess aspects of psychosocial intervention and recovery had primarily been validated within a pilot study and had not undergone extensive validation across diverse populations. This may limit the external validity and comparability of quantitative findings. To strengthen reliability and validity, the study applied rigorous procedures, including expert review for content validity, computation of the Content Validity Index (CVI), and factor analysis to assess construct validity.

The study was confined to GBVRCs in Uasin Gishu County. Contextual factors unique to this county such as institutional capacity, cultural dynamics, and service infrastructure may limit generalization of findings to other counties or national settings.

1.11 Theoretical Framework

This study is grounded in Cognitive-Behavioural Theory (CBT) as advanced by Aaron Beck (1967) and Rational Emotive Behaviour Therapy (REBT) developed by Albert Ellis (1955),

together with Ecological Systems Theory proposed by Urie Bronfenbrenner (1979, 1986). The integration of these theoretical perspectives is justified by the multidimensional nature of recovery among survivors of sexual assault. Recovery is neither exclusively a psychological process nor solely a social phenomenon; rather, it unfolds through the interaction between internal cognitive-emotional processes and external environmental systems. Cognitive-Behavioural Theory provides a framework for understanding how trauma shapes survivors' cognitions, emotions and behaviours, while Ecological Systems Theory offers a structural lens for examining how institutional, relational and socio-cultural contexts influence recovery trajectories. Together, these theories enable a comprehensive analysis of survivors' recovery needs, the influence of psychological and social support interventions, the institutional and systemic challenges affecting implementation, and strategies for strengthening psychosocial service delivery within Gender-Based Violence Recovery Centres (GBVRCs) in Uasin Gishu County.

1.11.1 Cognitive-Behavioural Theory

Cognitive-Behavioural Theory emerged from the foundational work of Albert Ellis (1955) and was subsequently refined through Cognitive Therapy by Aaron Beck (1967). The theory posits that emotional and behavioural responses are mediated by cognitive appraisals rather than by events themselves. In the aftermath of sexual assault, traumatic experiences frequently disrupt survivors' core beliefs concerning safety, trust, autonomy and self-worth. These distorted cognitions often manifest in symptoms such as anxiety, depression, avoidance behaviours, intrusive memories and impaired coping capacity.

Within this study, Cognitive-Behavioural Theory provides the theoretical foundation for analysing the psychological recovery needs of sexual assault survivors. The theory explains how maladaptive cognitions maintain psychological distress and how structured therapeutic

interventions can facilitate cognitive restructuring and behavioural adjustment. Psychological support interventions including trauma-focused counselling, cognitive restructuring, psychoeducation and coping-skills training are therefore theoretically grounded in CBT principles. The theory further conceptualises recovery as the progressive reduction of trauma-related symptomatology, the restoration of adaptive coping mechanisms, and the re-establishment of self-efficacy and emotional regulation.

In addition, Cognitive-Behavioural Theory informs the examination of how psychological support interventions influence recovery outcomes within GBVRCs. It provides an explanatory basis for assessing the extent to which therapeutic engagement modifies trauma-related beliefs and behavioural responses. However, while CBT offers robust insight into intrapersonal processes, it does not sufficiently account for external structural factors that may constrain or facilitate recovery. This limitation necessitates theoretical supplementation through Ecological Systems Theory.

1.11.2 Ecological Systems Theory

Ecological Systems Theory, developed by Urie Bronfenbrenner (1979, 1986), conceptualises human development and wellbeing as occurring within nested and interacting environmental systems: the microsystem, mesosystem, exosystem, macrosystem and chronosystem. The theory emphasises that individual recovery processes are embedded within relational, institutional and cultural contexts that exert both direct and indirect influence.

In the context of this study, Ecological Systems Theory provides a framework for examining the social support needs of sexual assault survivors and the broader systemic challenges affecting psychosocial intervention delivery. At the microsystem level, recovery is shaped by immediate interactions within the GBVRC, including the quality of the therapeutic

alliance, perceived safety and responsiveness of service providers. The mesosystem encompasses the coordination between GBVRCs and other institutions such as healthcare facilities, law enforcement agencies and family support structures. Effective inter-institutional collaboration enhances continuity of care, whereas fragmentation may impede access to justice and prolong psychological distress.

The exosystem includes organisational policies, staffing capacity, resource allocation and administrative procedures that indirectly influence service quality. The macrosystem refers to prevailing cultural norms, gender ideologies and societal attitudes towards sexual violence, including stigma and victim-blaming, which significantly affect disclosure, help-seeking behaviour and social reintegration. The chronosystem captures the temporal dimension of trauma, recognising that delayed reporting, prolonged legal proceedings or repeated exposure to violence may intensify long-term psychological outcomes.

Ecological Systems Theory therefore underpins the analysis of institutional, cultural and structural challenges affecting psychosocial intervention delivery within GBVRCs. It further informs the identification of strategies for strengthening psychosocial support services, including improved intersectoral coordination, culturally responsive programming, enhanced professional capacity and policy reinforcement.

1.11.3 Theoretical Integration and Relevance to Study Variables

The integration of Cognitive-Behavioural Theory and Ecological Systems Theory enables a multi-level understanding of recovery among survivors of sexual assault. Psychological support interventions are principally informed by Cognitive-Behavioural Theory, which elucidates the mechanisms through which therapeutic engagement modifies maladaptive cognitions and emotional responses. Social support interventions and systemic

strengthening strategies are grounded in Ecological Systems Theory, which explains how environmental contexts influence both service delivery and recovery trajectories.

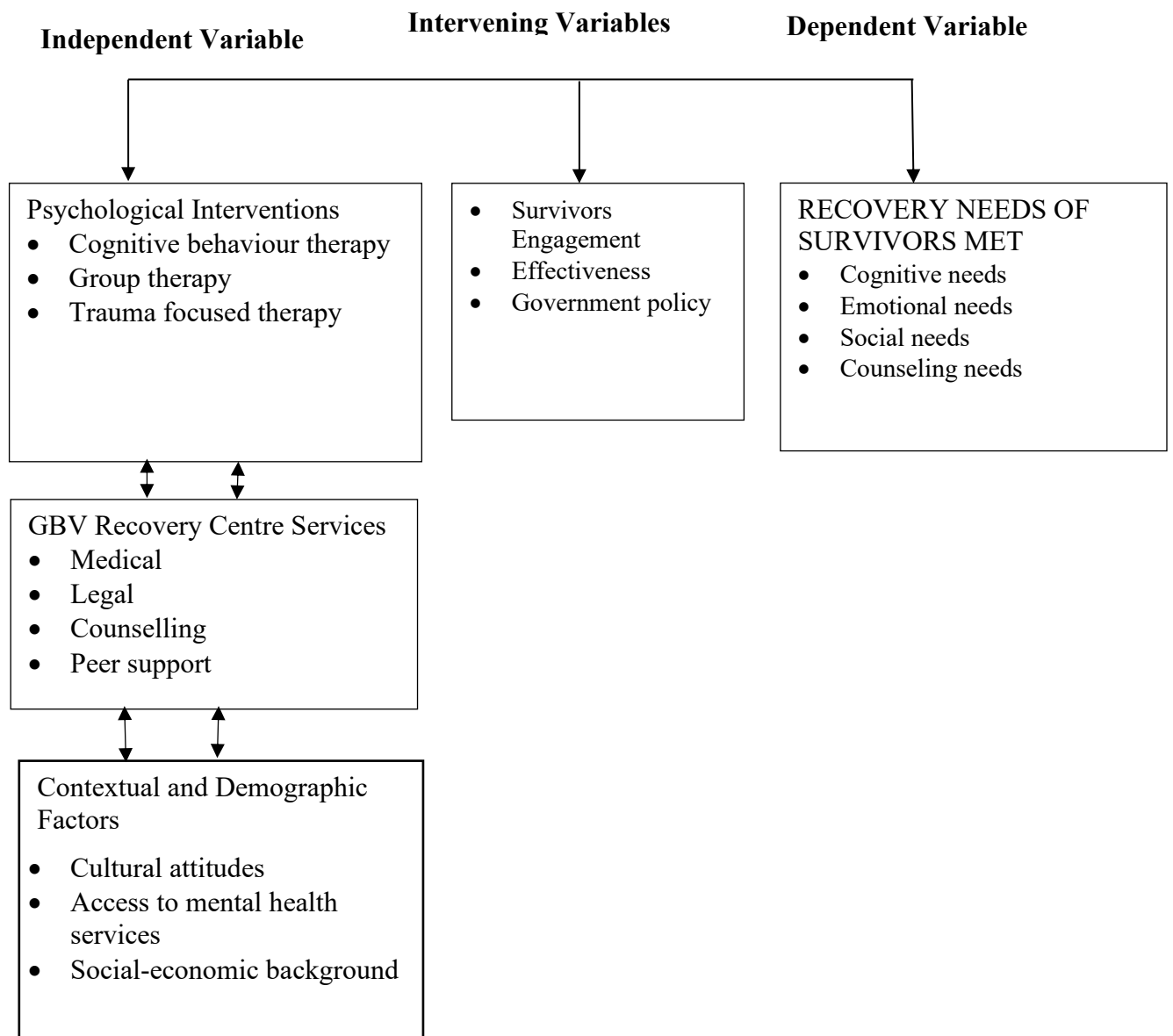
Within this framework, recovery is conceptualised as a multidimensional dependent variable encompassing psychological stabilisation, adaptive coping, social reintegration and overall wellbeing. Psychological support interventions and social support interventions constitute key independent variables, while institutional and structural challenges function as moderating factors influencing the effectiveness of intervention delivery. By integrating intrapersonal cognitive processes with environmental systems analysis, the theoretical framework ensures that recovery is examined as both a psychological transformation process and a socially embedded experience.

1.12 Conceptual Framework

This study postulates that when psychosocial support is provided in accordance with established trauma recovery manuals, survivors of assault are more likely to achieve recovery. Psychosocial support encompasses both psychological and social dimensions. Consequently, counsellors must possess advanced skills in these areas to effectively facilitate positive change. Furthermore, the psychosocial interventions should be grounded in the cultural beliefs and ideological frameworks that inform the practices of the clients or survivors. Therefore, the provision of psychosocial programmes within GBVRCs must integrate both psychological and social components. Additionally, counsellors are required to have adequate competencies to deliver the comprehensive psychosocial services that traumatised survivors may need. Finally, the readiness of communities to receive and support survivors following their discharge from GBVRCs is essential. These factors constitute the independent variables of this study.

In this study, it was conceptualized that survivors who receive psychosocial support have the potential to attain recovery, which serves as the dependent variable. Indicators of recovery include enhanced validation and understanding of emotions, mindful living, physical relaxation through the release of bodily tension, increased outreach for support, and a shift from reactive to reflective responses. Survivors who demonstrate resilience progressively acquire coping competencies that enable them to withstand new challenges. However, intervening variables may hinder the effect of the independent variable on the dependent variable. These include the disbursement of funds by the treasury, the management style of the health facility housing the GBVRC, and the involvement of unprofessional consultants who claim to assist survivors. Figure 1.1 illustrates the synthesis of the independent and dependent variables, thereby clarifying and focusing the research framework

Figure 1.1: Conceptual Framework



Source: Researcher (2025)

The conceptual framework provides the analytical foundation through which this study examines the relationship between psychological interventions and recovery needs of sexual assault survivors within Gender-Based Violence Recovery Centres (GBVRCs). It conceptualises recovery as a multidimensional outcome shaped by therapeutic inputs, mediated by behavioural and institutional processes, and conditioned by broader socio-cultural and demographic contexts. The framework is explicitly aligned with the research

objectives, which seek to assess recovery needs of survivors, examine the influence of psychological support interventions on those needs, analyse institutional and service-level factors affecting intervention effectiveness, and explore contextual conditions shaping recovery outcomes.

At the core of the framework are psychological interventions, which constitute the independent variable. These interventions include Cognitive Behaviour Therapy, Group Therapy and Trauma-Focused Therapy, all of which are structured therapeutic modalities designed to address trauma-related cognitive distortions, emotional distress and social withdrawal. The study proceeds from the analytical proposition that the nature, quality and consistency of psychological interventions significantly influence the extent to which survivors' recovery needs are met. This proposition directly corresponds to the research objective examining the influence of psychological support interventions on survivors' recovery outcomes. The framework assumes that therapeutic approaches grounded in trauma-informed and evidence-based practices are more likely to produce improvements in cognitive restructuring, emotional regulation and adaptive functioning.

The dependent variable in the framework is conceptualised as recovery needs of sexual assault survivors. Recovery is not treated as a singular outcome but as a multidimensional construct encompassing cognitive clarity, emotional stability, social reintegration, personal empowerment and sustained counselling support. This conceptualisation aligns directly with the research objective that seeks to assess the nature and extent of survivors' recovery needs. The framework assumes that recovery is achieved when measurable progress occurs across these interrelated domains. Consequently, the dependent variable serves as the empirical indicator through which the effectiveness of psychological interventions is evaluated.

The relationship between psychological interventions and recovery needs is not assumed to be direct or automatic. Rather, it is mediated by intervening variables that explain how and under what conditions therapeutic inputs translate into recovery outcomes. Survivor engagement represents a behavioural mediator, reflecting the degree of participation, commitment and active involvement in the therapeutic process. The framework advances the proposition that higher levels of engagement strengthen the positive effect of psychological interventions on recovery needs. Perceived effectiveness of interventions functions as a perceptual mediator, capturing survivors' evaluations of whether the therapy adequately addresses their trauma-related concerns. When survivors perceive interventions as relevant and culturally responsive, therapeutic outcomes are expected to improve. Additionally, GBV Recovery Centre services, including medical care, legal assistance, counselling continuity and peer support, operate as structural mediators that either reinforce or constrain the impact of psychological treatment. These intervening dimensions correspond directly with the research objective examining institutional and service-level factors influencing psychosocial intervention delivery.

Beyond these mediating mechanisms, the framework incorporates contextual and demographic factors as moderating variables. Cultural attitudes towards sexual violence and mental health, access to mental health services and socio-economic background are conceptualised as environmental conditions that may strengthen or weaken the relationship between interventions and recovery outcomes. The analytical proposition underpinning this inclusion is that recovery does not occur in isolation from broader social structures. Cultural stigma may discourage disclosure and reduce engagement in therapy. Limited-service accessibility may disrupt continuity of care. Socio-economic disadvantage may restrict survivors' ability to attend sessions or access complementary resources. These contextual

variables align with the research objective exploring systemic and environmental influences on recovery processes.

The conceptual framework articulates a structured causal pathway in which psychological interventions influence recovery needs through behavioural and institutional mediators, within socio-cultural and demographic contexts that condition overall effectiveness. The framework therefore ensures that each research objective is embedded within a coherent explanatory model. The assessment of recovery needs corresponds to the dependent variable; the examination of psychological support interventions corresponds to the independent variable; the analysis of institutional and engagement-related factors corresponds to intervening variables; and the exploration of contextual influences corresponds to moderating variables. By explicitly mapping these relationships, the framework moves beyond descriptive representation and establishes a theoretically grounded, analytically integrated structure for empirical investigation.

1.13 Operational Definition of Terms

Access to Mental Health Services: Access to mental health services refers to the availability, affordability and logistical ease with which survivors can obtain psychological support within the study area. It is examined as a moderating variable affecting intervention utilisation.

Cognitive Behaviour Therapy (CBT): CBT refers to structured counselling sessions within GBVRCs that focus on analysing and modifying maladaptive thoughts, beliefs and behavioural responses associated with sexual trauma. In this study, CBT is analysed as one modality of psychological intervention influencing cognitive and emotional recovery outcomes.

Cognitive Recovery Needs: Cognitive recovery needs refer to survivors' requirements for restructuring trauma-related beliefs, improving clarity of thought and reducing intrusive or maladaptive cognitions. These are assessed through self-reported indicators of cognitive adjustment.

Counselling Needs: Counselling needs refer to the continued requirement for professional psychological support to sustain recovery progress. In this study, this construct reflects perceived adequacy and necessity of ongoing therapeutic services.

Cultural Attitudes: Cultural attitudes refer to survivors' perceptions of community beliefs, stigma and societal norms related to sexual violence and mental health within the study context. This variable functions as a moderating factor influencing engagement and recovery outcomes.

Emotional Recovery Needs: Emotional recovery needs refer to the requirement for stabilisation and regulation of trauma-related emotions such as fear, guilt, shame and anxiety. These are measured through perceived emotional wellbeing and reduction of distress.

Empowerment Needs: Empowerment needs refer to survivors' need to regain autonomy, self-confidence, decision-making capacity and a sense of personal control following sexual trauma. These are measured through self-reported self-efficacy and perceived agency.

GBV Recovery Centre Services: GBV Recovery Centre services refer to the integrated support services available within the selected centres, including medical treatment, legal assistance, counselling continuity and peer support mechanisms. In this study, these services operate as institutional factors that may enhance or constrain the effectiveness of psychological interventions.

Gender-Based Violence (GBV): In this study, Gender-Based Violence refers specifically to sexual violence experienced by adult female survivors receiving services within Gender-Based Violence Recovery Centres. The term is used in relation to incidents of sexual assault that necessitated psychosocial intervention and therapeutic support.

Group Therapy: Group Therapy refers to professionally facilitated therapeutic sessions involving multiple survivors within GBVRCs, designed to promote shared experience, peer support and collective coping strategies. Its role in the study is to examine its contribution to emotional stabilisation and social reintegration.

Perceived Effectiveness of Interventions: Perceived effectiveness refers to survivors' subjective evaluation of the extent to which psychological interventions address their trauma-related cognitive, emotional and social needs. It is measured through structured responses indicating perceived improvement and satisfaction with services.

Psychological Interventions: Psychological interventions refer to the structured therapeutic approaches delivered within GBV Recovery Centres to address trauma-related psychological distress. In this study, they specifically include Cognitive Behaviour Therapy, Group Therapy and Trauma-Focused Therapy. These interventions constitute the independent variable and are examined in terms of type of therapy received, frequency of sessions and level of participation.

Psychosocial Interventions: In this study, psychosocial interventions refer collectively to psychological therapies and structured social support services delivered within GBV Recovery Centres to facilitate holistic recovery.

Recovery Needs: Recovery needs refer to the multidimensional psychological and social requirements necessary for healing and reintegration following sexual assault. In this study, recovery needs constitute the dependent variable and are operationalised across cognitive, emotional, social reintegration, empowerment and ongoing counselling domains.

Sexual Assault Recovery: Sexual assault recovery refers to the measurable progress made by survivors across cognitive, emotional, social and empowerment domains following participation in psychological and psychosocial interventions within GBVRCs.

Sexual Assault: Within the context of this study, sexual assault refers to the non-consensual sexual act that resulted in the survivor seeking support at a GBV Recovery Centre. The term functions as the precipitating traumatic event underlying the psychological and psychosocial recovery process examined in this research.

Social Reintegration Needs: Social reintegration needs refer to survivors' need to rebuild trust, restore interpersonal relationships and participate meaningfully in family and community contexts. These are evaluated through indicators of social functioning and perceived support.

Socio-Economic Background: Socio-economic background refers to survivors' educational level, employment status and income capacity. In this study, it functions as a contextual factor that may influence engagement in therapy and access to supportive services.

Survivor Engagement: Survivor engagement refers to the degree of active participation in therapeutic processes, including attendance consistency, involvement during sessions and commitment to applying coping strategies outside therapy. In this study, engagement functions as an intervening variable influencing the strength of the relationship between psychological interventions and recovery outcomes.

Survivors: Survivors are adult female individuals aged 18 years and above who have experienced sexual assault and are currently receiving psychological or psychosocial support within GBV Recovery Centres included in this study. The term emphasises their active engagement in recovery processes rather than passive victimhood.

Trauma-Focused Therapy: Trauma-Focused Therapy refers to specialised therapeutic sessions aimed at processing traumatic memories and reducing trauma-related symptoms. In this study, it is examined in relation to its effectiveness in addressing emotional distress and trauma symptomatology.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter provides a comprehensive review of the literature relevant to the study topic. It begins with an overview of nature of sexual assault and recovery needs of survivors. Subsequent sections examine the typical characteristics of psychosocial interventions offered to sexual abuse survivors. The chapter then addresses the challenges that may arise in the implementation of these interventions. Additionally, the role of government, counsellors and communities in mitigating such challenges are discussed. The chapter concludes with a summary of the knowledge gaps identified in the reviewed literature.

2.1 Sexual Assault

Sexual assault, as defined under Section 3 of the Sexual Offences Act in Kenya, refers to intentional and unlawful penetration without consent, including instances where consent is obtained through coercion, threats or intimidation. While this statutory definition provides the legal framework within which cases are prosecuted, empirical scholarship extends the discussion beyond legality to encompass psychological and social consequences. Li et al. (2021) argue that sexual assault produces profound emotional, psychological and behavioural sequelae affecting not only survivors but also their families and social networks. Reported consequences include flashbacks, hypervigilance, anxiety, guilt, shame, sleep disturbances and diminished self-esteem.

Although Li et al. (2021) provides a comprehensive account of trauma symptoms, their work primarily emphasises prevalence and symptomatology rather than evaluating structured intervention outcomes. This reveals an empirical gap concerning how specific therapeutic modalities influence recovery trajectories. Furthermore, much of the existing literature

adopts cross-sectional survey designs, limiting insight into the dynamic and evolving nature of recovery. The present study addresses this gap by examining how structured psychological interventions within Gender-Based Violence Recovery Centres (GBVRCs) influence multidimensional recovery outcomes.

Recovery from sexual assault is widely recognised as a complex and multidimensional process. Sinko et al. (2021) conceptualise healing as encompassing social, spiritual, cultural and psychological dimensions through which survivors integrate the assault experience into their identity while pursuing future wellbeing. Similarly, Strauss Swanson et al. (2020) emphasise that recovery is non-linear and may resemble an upward spiral rather than a fixed sequence of stages. This perspective aligns with Ecological Systems Theory, which situates healing within broader social and cultural contexts, and with Cognitive-Behavioural Theory, which highlights internal cognitive restructuring processes.

However, while these studies advance nuanced conceptual models of recovery, they tend to privilege qualitative accounts of lived experience. Although such approaches deepen understanding of survivor narratives, they often lack systematic measurement of recovery domains. Consequently, there remains limited empirical clarity regarding how cognitive, emotional, social and empowerment needs can be operationalised and assessed within structured service settings. The present study contributes by operationalising recovery needs as measurable constructs linked to specific therapeutic interventions.

The staged recovery model described by Salim et al. (2020) and Strauss Swanson et al. (2020) outlines a progression from denial to awareness, active healing and eventual integration. The initial stage of denial is understood as a protective psychological mechanism that enables survivors to maintain daily functioning by suppressing traumatic memories. The awareness stage is characterised by intrusive recollections, emotional

distress and social withdrawal, often prompting help-seeking behaviour. The subsequent healing phase involves emotional processing and gradual reintegration, while the final integration stage reflects acceptance and personal growth (Rosenthal et al., 2021).

Although stage-based models provide useful heuristic frameworks, they have been criticised for implying sequential uniformity. Empirical evidence suggests that survivors frequently oscillate between stages rather than progressing linearly (Strauss Swanson et al., 2020). Moreover, these models rarely examine how specific psychological interventions facilitate movement between stages. There is therefore a methodological gap in linking recovery stages with structured therapeutic modalities such as Cognitive Behaviour Therapy or Trauma-Focused Therapy. This study addresses this limitation by examining whether participation in distinct intervention types is associated with improvements across defined recovery domains.

Recovery is shaped not only by internal coping mechanisms but also by contextual factors. Sinko and Saint Arnault (2020) analyse societal norms, social responses to gender-based violence and the normalisation of violence as contextual determinants influencing healing. Survivors' internal experiences of shame, self-blame and fear of judgement interact with these external factors, potentially inhibiting help-seeking and therapeutic engagement.

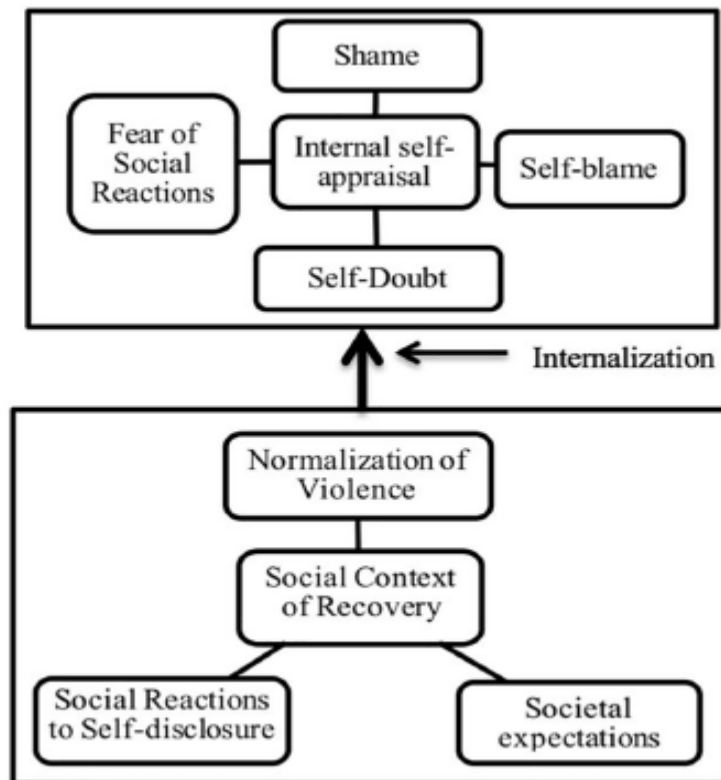
While these findings underscore the ecological dimensions of recovery, much of the literature does not empirically examine how institutional service environments mitigate or exacerbate contextual constraints. For instance, limited attention is given to how integrated services within recovery centres such as medical care, legal assistance and counselling continuity may strengthen psychological intervention outcomes. Additionally, most studies are conducted in Western contexts, raising contextual gaps regarding how recovery processes unfold within Kenyan GBVRC settings. Cultural attitudes towards sexual

violence and mental health in Kenya may influence survivor engagement differently from contexts studied by Sinko and Saint Arnault (2020). The current study addresses this contextual gap by examining psychological interventions within Kenyan GBVRCs and incorporating moderating variables such as cultural attitudes, access to services and socio-economic background.

A critical review of the literature reveals several gaps that justify the current research. Empirically, while studies such as Li et al. (2021) document psychological consequences of sexual assault, fewer investigations assess the effectiveness of specific therapeutic modalities within structured recovery centres. Conceptual discussions of healing (Sinko et al., 2021; Strauss Swanson et al., 2020) provide valuable theoretical insight but often lack operationalised recovery indicators. Methodologically, reliance on cross-sectional and purely qualitative designs limits causal inference and generalisability. Contextually, limited scholarship examines integrated psychosocial interventions within Kenyan public health settings.

These gaps directly inform the conceptual framework and methodology of the present study. By operationalising psychological interventions as independent variables, recovery needs as a multidimensional dependent variable, and engagement and institutional services as intervening factors, the study responds to the identified need for structured, context-specific analysis. Furthermore, by situating the inquiry within GBVRCs in Kenya, the research addresses contextual underrepresentation in existing scholarship. A diagram illustrating these processes is presented in Figure 2.1.

Figure 2.1: Individual and contextual influences of GBV healing



Source: Sinko and Saint Aurnalt (2020)

Figure 2.1 illustrates the interrelationships among external social influences and the internal self-appraisal of the survivors in our sample. These social influences represent forces external to the survivors that affect their self-appraisal and, ultimately, their recovery behaviours. The normalization of violence shapes societal expectations of survivors as women, as well as the social responses to their self-disclosure of violent experiences. These social values, expectations, beliefs, and behaviours are internalized by survivors to varying degrees, manifesting as internal feelings of shame, self-blame, self-doubt, and fear of judgment (Sinko *et al.*, 2021).

The ultimate goal of interventions in GBVRCs is to facilitate the recovery of survivors and support their reintegration into their previous sense of self. According to Sinko *et al.* (2021), the trauma recovery process encompasses seven primary healing domains: reconstructing

identity, reconnecting with the self, regaining power and control, cultivating worthiness, relating to others, rebuilding hope and a positive worldview, and finding peace.

Reconstructing identity involves survivors learning to understand who they are after experiencing trauma by acknowledging their strength, practicing self-acceptance, and actively rebuilding their life trajectory. Regaining power and control refers to survivors developing a sense of capability in managing their own decisions, symptoms, and recovery processes (Sinko *et al.*, 2021). Cultivating worthiness encompasses survivors fostering positive beliefs about their intrinsic value through self-reflection, participation in meaningful activities, and engagement with individuals who empower them to feel capable and deserving of respect and healing. Rebuilding hope and a positive worldview entails survivors cultivating a sense of safety and optimism regarding their future, while recognizing and appreciating the positive aspects of their lives and the world around them. Finally, finding peace involves survivors experiencing presence in their lives through sensations of lightness, calm, and tranquillity (Ong Gaffney *et al.*, 2023).

2.2 Recovery Needs of Sexual Assault Survivors

Recovery needs following sexual assault are broadly conceptualised within two interrelated domains: psychological and social. The psychological domain encompasses affective regulation, behavioural adjustment, and cognitive restructuring processes, while the social domain addresses relational, institutional, and community-based support systems that influence healing trajectories. Although this categorisation provides analytical clarity, contemporary scholarship increasingly emphasises the interdependence of these domains, suggesting that psychological recovery cannot occur in isolation from social and structural conditions (Tarzia, 2021). In the context of Uasin Gishu County, recovery is further shaped by socio-economic vulnerability, cultural norms, and institutional capacity constraints

(Kogo, 2023). This underscores the necessity of examining recovery needs within an ecological and systems-based framework consistent with the theoretical perspectives guiding this study.

2.2.1 Safety and Protection as Foundational Recovery Needs

The literature consistently identifies safety as a foundational requirement for trauma recovery. Warrington (2020) argues that physical and emotional safety form the precondition for effective psychological intervention, as ongoing exposure to threats sustains hypervigilance and trauma symptoms. In Uasin Gishu, survivors frequently reside in close proximity to perpetrators, which complicates disengagement from environments of intimidation and coercion (Kipkemboi, 2023). Although recovery centres are designed to provide protective spaces, infrastructural inadequacies, overcrowding, and inconsistent security measures undermine their effectiveness (Mutai, 2023).

While existing studies acknowledge the importance of safe environments, few empirically assess how variations in institutional safety standards influence counselling outcomes. This reveals a methodological gap concerning the moderating role of physical security and institutional preparedness in shaping psychological recovery. The present study addresses this gap by examining how service environment factors interact with psychosocial interventions to influence recovery trajectories.

2.2.2 Medical Care and Forensic Support

Immediate medical care serves both therapeutic and evidentiary functions in the aftermath of sexual assault. McLeod and Porter (2024) emphasise the dual importance of treating physical injuries and preserving forensic evidence for legal redress. Access to services at Moi Teaching and Referral Hospital has improved post-rape care availability in Uasin

Gishu, including HIV prophylaxis and emergency contraception (Kibet, 2020). However, barriers such as transportation costs, stigma, delayed reporting, and reliance on traditional or religious intermediaries impede timely access (Sepeng et al., 2019).

Although the literature recognises these barriers, limited scholarship examines how integration between medical and psychosocial services affects long-term mental health outcomes. Delays in medical intervention may not only compromise legal processes but also intensify anxiety, self-blame, and fear, thereby influencing subsequent engagement with counselling services. This study therefore considers medical service accessibility as part of the broader institutional context influencing psychological recovery.

2.2.3 Trauma Counselling and Psychological Healing

Trauma-informed counselling is central to addressing affective, behavioural, and cognitive disruptions resulting from sexual violence. Abu et al. (2024) and Ondeng (2025) document high prevalence rates of post-traumatic stress symptoms, depression, and anxiety among survivors. However, Kilonzo and Onkware (2020) note inconsistencies in counsellor training and service availability across Uasin Gishu, leading to variable quality of care.

Beyond resource constraints, cultural beliefs significantly mediate counselling engagement. Dworkin and Weaver (2021) and Amaya and Gray (2021) highlight how internalised stigma and victim-blaming narratives discourage survivors from sustained participation in therapy. Ross (2022) argues that integrating culturally resonant approaches, such as storytelling and faith-informed healing practices, may enhance therapeutic relevance. Despite these recommendations, empirical evaluations of culturally adapted counselling models remain limited. This methodological gap justifies examining how survivor-centred and culturally competent counselling approaches influence psychological recovery outcomes within GBV recovery centres.

2.2.4 Survivor Agency and Empowerment

Restoration of agency constitutes a critical psychological recovery outcome. Wyatt (2023) conceptualises empowerment as the survivor's capacity to reclaim decision-making authority following experiences of coercion and violation. However, Touquet and Schulz (2021) observe that well-intentioned family members and service providers often inadvertently perpetuate disempowerment by assuming control over legal, medical, or residential decisions.

Paschall (2023) reports that centres adopting participatory care planning models demonstrate higher retention and client satisfaction rates. Nevertheless, existing studies frequently measure empowerment through qualitative perceptions rather than structured indicators, limiting comparability across contexts. The present study operationalises empowerment as a measurable construct linked to intervention type and survivor engagement, thereby addressing this empirical limitation.

2.2.5 Legal Support and Justice Navigation

Access to justice remains a complex component of recovery. Gutto (2019) and Belisle (2024) document systemic barriers including scepticism, procedural delays, and re-traumatisation within legal processes in Uasin Gishu. Inadequate forensic procedures further undermine prosecution efforts. Lovell et al. (2025) and Sit and Stermac (2021) advocate for integrated legal aid within recovery centres to provide consistent guidance throughout judicial proceedings.

Although survivor-centred justice frameworks are increasingly promoted (Meyrick & Anning, 2025), limited research assesses how legal support services influence psychological outcomes such as perceived validation, closure, or resilience. This study considers legal assistance as part of the institutional support structure influencing overall recovery.

2.2.6 Peer Support and Social Reintegration

Social isolation significantly impedes healing. Van De Ven (2020) identifies peer validation as transformative in reducing shame and fostering belonging. In Uasin Gishu, informal peer networks exist but lack formal structure and facilitation (Mariech, 2023). Shalaby and Agyapong (2020) suggest that structured peer mentorship models can enhance resilience and collective coping.

However, empirical studies rarely evaluate long-term psychological outcomes of peer-led interventions within structured recovery settings. This contextual gap supports the inclusion of peer support as a social recovery variable within the conceptual framework of the present study.

2.2.7 Expressive and Culturally Grounded Therapies

Expressive therapies provide alternative mechanisms for processing trauma, particularly for survivors who struggle with conventional talk therapy (Coleman, 2022; Kometiani & Farmer, 2020). Malchiodi (2020) highlights the therapeutic value of art and narrative modalities in trauma integration. Within Uasin Gishu, incorporating local storytelling and cultural performance traditions may enhance engagement.

Despite theoretical endorsement, empirical evaluation of culturally grounded expressive interventions within Kenyan recovery centres remains scarce. The study therefore recognises expressive modalities as complementary psychosocial strategies warranting systematic assessment.

2.2.8 Information Provision and Educational Empowerment

Access to accurate information regarding sexual health, legal rights, and recovery pathways empowers survivors and reduces misinformation (Bowen, 2022). Ouma (2023) and Wairimu (2021) note that literacy barriers in Uasin Gishu necessitate diversified communication

formats. While information dissemination is widely recommended, limited research measures its impact on decision-making confidence or service uptake. This study integrates informational access within the broader framework of empowerment and institutional responsiveness.

2.2.9 Long-Term Support and Economic Reintegration

Ashton et al. (2021) emphasise that recovery extends far beyond crisis intervention. Yet, in Uasin Gishu, support systems remain predominantly short-term (Mwangi, 2023). Resource limitations and absence of sustained case management structures constrain continuity of care (Muthangya, 2022).

Economic dependence on perpetrators further complicates recovery. Omari (2021) and Crump (2020) demonstrate how financial vulnerability perpetuates cycles of abuse. Singh (2021) advocates vocational and microfinance initiatives tailored to survivor needs. In agricultural contexts such as Uasin Gishu, livelihood programmes linked to small-scale farming may offer sustainable reintegration pathways.

Despite recognition of economic empowerment as central to recovery, few studies systematically link economic interventions to psychological outcomes such as self-efficacy or reduced trauma symptoms. This gap reinforces the importance of examining recovery as a multidimensional construct influenced by psychosocial, institutional, and socio-economic factors.

2.2.10 Cultural Norms, Stigma, and Survivor Identity Reconstruction

Cultural norms significantly shape survivor recovery trajectories, particularly for women and girls whose social status may be closely tied to notions of sexual purity and marriageability. Tanweer (2023) observes that fear of family shame and diminished marriage prospects frequently silences survivors, limiting disclosure and delaying access to

formal services. Clark (2022) further documents the persistence of informal resolutions, including forced marriages to perpetrators and compensation arrangements, despite their illegality under Kenyan law. While such practices are often framed as mechanisms of restoring social harmony, they perpetuate injustice and undermine survivor autonomy.

Anyeko et al. (2021) highlight that survivors who ultimately access recovery centres must contend not only with trauma symptoms but also with deeply internalised stigma reinforced by community narratives. Simmons and Wong (2021) argue that recovery programmes that fail to explicitly challenge victim-blaming discourses risk reinforcing shame-based identities. However, empirical research seldom evaluates structured de-stigmatization interventions within recovery centres. This reveals a methodological gap concerning how targeted cognitive restructuring and narrative-based interventions influence self-worth and autonomy outcomes. The present study addresses this by examining whether psychosocial interventions explicitly incorporating stigma-reduction components are associated with improved psychological recovery indicators.

2.2.11 Affective Needs

The affective domain of recovery refers to survivors' emotional regulation, feelings of self-worth, motivational states, and relational attitudes that are disrupted following sexual assault. Cowan et al. (2020) argue that sexual victimization significantly impairs emotional processing, affecting survivors' capacity to regulate distress, sustain motivation, and maintain positive self-appraisals. Consistent with this, Sher (2020) identifies heightened prevalence of posttraumatic stress disorder (PTSD), depression, anxiety disorders, and suicidal ideation among survivors. While the literature robustly documents these emotional consequences, fewer studies systematically evaluate how structured psychosocial interventions within recovery centres address these affective disruptions in low-resource

contexts such as Kenya. This gap underscores the importance of operationalising affective recovery as a measurable construct within the present study.

PTSD represents one of the most frequently documented affective outcomes of sexual assault. Sareen et al. (2018) describe PTSD as comprising cognitive symptoms, such as intrusive memories and nightmares; affective symptoms, including emotional numbing and detachment; and physiological hyperarousal, such as irritability and hypervigilance. Butcher and Hooley (2018) further note that PTSD frequently co-occurs with depression, anxiety, somatization, and hostility, often manifesting in diminished interest in daily activities, insomnia or hypersomnia, fatigue, guilt, hopelessness, and impaired concentration. Although this symptom clustering is well established in clinical psychology, much of the supporting evidence derives from Western diagnostic frameworks. Limited research has examined culturally contextualized expressions of trauma symptoms among Kenyan survivors, suggesting a contextual gap in understanding how PTSD manifests and is interpreted within local cultural narratives. Addressing this limitation requires interventions that integrate evidence-based trauma models with culturally sensitive assessment tools.

Anxiety disorders constitute another prominent affective consequence of sexual assault. Renner et al. (2020) observe that survivors may develop generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, or specific phobias. Butcher and Hooley (2018) describe generalized anxiety disorder as involving persistent and excessive worry accompanied by physiological arousal symptoms, while Manjunatha and Ram (2022) characterise panic attacks as acute episodes of intense fear with somatic manifestations such as tachycardia, dizziness, and breathlessness. Obsessive-compulsive symptoms and phobic avoidance behaviours similarly disrupt daily functioning. Although diagnostic categorisations provide clinical clarity, they risk fragmenting survivor experiences into

discrete disorders rather than recognising the interconnectedness of trauma responses. Consequently, trauma-informed therapeutic models, including Cognitive-Behavioural Therapy (CBT), may offer more integrative approaches by addressing maladaptive cognitions and emotional dysregulation simultaneously.

Suicidal ideation and attempts represent one of the most severe affective consequences of sexual assault. Smith et al. (2022) report elevated lifetime prevalence of suicide attempts among survivors, linking this risk to pervasive guilt, shame, and social rejection. Sher (2020) similarly underscores the association between trauma exposure and suicidal behaviour. However, suicide risk assessment protocols are not consistently integrated into routine post-assault care in many low-resource settings. This methodological and service delivery gap highlights the need for structured screening mechanisms within GBV recovery centres to analyse high-risk individuals and ensure timely referral to specialised mental health services.

Within the Kenyan context, affective recovery is further complicated by structural and cultural constraints. Koome (2019) notes that societal stigma and limited mental health infrastructure restrict survivors' access to appropriate care, thereby prolonging psychological distress. Although institutions such as the Nairobi Women's Hospital provide comprehensive survivor-centred services (Muiruri, 2023), access remains uneven across counties. Stigma-related silence often impedes emotional disclosure, intensifying isolation and impairing trust in interpersonal relationships (O'Callaghan et al., 2021). Makario et al. (2023) highlights the role of community-based organizations such as CREAM and LVCT Health in facilitating collective healing and peer-based trust rebuilding. Nevertheless, empirical evaluation of long-term affective outcomes from such group-based interventions remains limited.

Long-term emotional recovery requires more than short-term counselling sessions. Strauss Swanson and Szymanski (2020) emphasise that psychological safety, legal protection, and decision-making autonomy are integral to restoring emotional stability. In Kenya, organisations such as FIDA Kenya and National Gender and Equality Commission provide legal aid and advocacy support; however, Githae et al. (2022) observe that prolonged judicial processes and limited shelter capacity undermine sustained protection. Furthermore, the shortage of qualified mental health professionals restricts access to advanced trauma therapies. Although CBT and trauma-focused modalities have demonstrated efficacy in reducing PTSD and depressive symptoms, Lopez (2024) argues that organisational and funding constraints limit their implementation in public GBV response systems.

Collectively, the literature confirms that sexual assault profoundly disrupts the affective domain through trauma-related symptomatology, anxiety disorders, depressive states, and suicide risk. However, significant empirical and contextual gaps persist regarding culturally adapted therapeutic delivery, systematic suicide screening, and longitudinal evaluation of intervention outcomes within Kenyan recovery centres. The present study responds to these gaps by examining how structured psychosocial interventions within GBVRCs influence affective recovery outcomes, while accounting for institutional capacity, cultural stigma, and survivor engagement as moderating factors.

2.2.12 Behavioural Needs

Sexual trauma is strongly associated with maladaptive behavioural coping patterns, particularly substance misuse. Smith et al. (2022) report that survivors of sexual abuse are three times more likely to experience depression and six times more likely to develop posttraumatic stress disorder, conditions that often coexist with substance dependence. Substance use frequently functions as a self-regulatory strategy through which survivors

attempt to suppress intrusive memories, numb emotional pain, or counteract loneliness and diminished self-worth. While this coping mechanism may provide temporary relief, it often intensifies long-term psychological distress and interferes with therapeutic engagement. Despite well-documented associations between trauma exposure and substance abuse, limited research within Kenyan GBV recovery contexts systematically evaluates integrated trauma–addiction treatment models. This reveals a methodological gap in assessing whether recovery centres screen for and address substance misuse as part of comprehensive psychosocial care.

Sexual assault also alters survivors’ behavioural patterns through avoidance and lifestyle restriction. Selby (2004) observes that victims of violent crime frequently avoid specific locations, social settings, or activities associated with perceived danger. Such avoidance may initially function as a protective strategy; however, prolonged restriction of movement and social interaction can reinforce anxiety and diminish autonomy. Therapeutic interventions must therefore address both fear-based avoidance and restoration of functional daily routines. Yet, empirical studies rarely examine how behavioural therapy components within recovery centres directly influence survivors’ reintegration into work, education, and community life. The present study considers behavioural adjustment as a measurable recovery outcome linked to structured psychosocial interventions.

Fear of retaliation constitutes a significant determinant of behavioural responses following assault. Wanjia (2019) reports that only 33.9% of survivors in Kenya disclose their experiences, largely because perpetrators are frequently known to them. This proximity generates complex fears encompassing social embarrassment, family disintegration, economic vulnerability, and physical harm. Survivors may consequently experience paralysis, indecision, or engagement in high-risk behaviours as maladaptive attempts to cope

with overwhelming emotions. Although fear-related immobility is widely recognised in trauma literature, few Kenyan studies explore structured safety planning as a behavioural intervention within recovery centres. Addressing this gap requires examining how legal protection, shelter services, and counselling intersect to reduce fear-driven behavioural constraints.

Behavioural disruption frequently manifests through sleep disturbances, withdrawal, and impaired daily functioning (Rashidi et al., 2021). Survivors in rural areas face additional structural barriers, including limited access to sustained mental health care, which prolong behavioural dysregulation. The Nairobi Women's Hospital, in collaboration with LVCT Health, has introduced behavioural therapy strategies such as journaling and mindfulness exercises to support emotional regulation (Katerere-Virima, 2023). While these initiatives demonstrate promising integration of cognitive-behavioural techniques, their reach remains geographically uneven. Stigma and low mental health literacy further discourage service uptake, underscoring the necessity for community-based behavioural interventions that extend beyond facility-based care.

Interpersonal mistrust and relational difficulties represent another behavioural consequence of sexual trauma. Gueta et al. (2020) and Arias (2021) note that survivors often struggle to establish healthy relationships, oscillating between social withdrawal and engagement in unsafe relational patterns. The CREAM provides counselling aimed at boundary-setting and healthy relationship rebuilding, while empowerment and self-defence programmes delivered by Ujamaa Africa promote confidence and personal safety (Theunissen, 2023; Wood, 2020). However, access to these programmes remains limited to specific low-income areas, indicating inequities in behavioural recovery resources. Furthermore, Dworkin and Weaver (2021) caution that absence of sustained therapeutic support increases vulnerability

to long-term consequences such as chronic depression, substance dependence, and social disengagement.

Comparative international evidence demonstrates that behavioural responses to sexual trauma are shaped by cultural and structural contexts. In India, traditional norms surrounding sexual honour intensify stigma and discourage help-seeking, leading to emotional detachment and avoidance behaviours (Tripathi, 2022). Although culturally tailored community campaigns and hotline services have been implemented, workforce shortages continue to impede sustained therapeutic engagement. In the Democratic Republic of the Congo, prolonged conflict exacerbates dissociation and hypervigilance among survivors of war-related sexual violence (Lugova et al., 2020). Humanitarian organisations such as United Nations Population Fund and Médecins Sans Frontières provide immediate and ongoing psychosocial care, yet mistrust of authorities and fragile health infrastructure limit long-term behavioural stabilisation.

Western contexts similarly reveal structural barriers influencing behavioural recovery. Iliadis (2020) notes that many Australian survivors avoid prosecution due to adversarial courtroom experiences, prompting campaigns such as Rape and Domestic Violence Services Australia to advocate trauma-sensitive legal processes. In Canada, linguistic barriers and institutional mistrust disproportionately affect ethnic minority survivors (Fante-Coleman & Jackson-Best, 2020), necessitating culturally competent and multilingual service delivery. In the Central African Republic, political instability undermines reporting mechanisms and discourages help-seeking (Mullin, 2019), reinforcing the importance of culturally grounded and survivor-centred justice frameworks.

Collectively, the literature demonstrates that behavioural consequences of sexual assault extend beyond immediate trauma responses to encompass substance misuse, avoidance,

relational instability, and disrupted daily functioning. However, significant gaps remain in evaluating integrated behavioural health models within Kenyan GBV recovery centres, particularly those that combine trauma-focused therapy, substance abuse screening, safety planning, and community-based reintegration strategies. By examining behavioural recovery outcomes within Uasin Gishu County, the present study contributes context-specific evidence on how structured psychosocial interventions can mitigate maladaptive coping patterns and promote sustainable behavioural adjustment.

2.2.13 Cognitive Needs

2.2.13.1 Disruption of Core Assumptions and Worldview

Sexual assault fundamentally challenges survivors' core assumptions about safety, control, and predictability in the world. Selby (2004) argues that resilience in pre-existing cognitive schemas plays a decisive role in determining coping outcomes, suggesting that variability in post-trauma adjustment may depend less on the event itself and more on cognitive flexibility. However, while Selby (2004) emphasizes resilience as a protective factor, the study does not sufficiently interrogate sociocultural moderators that may shape cognitive recovery. Ruback and Thompson (2001) expand this understanding by categorizing trauma-affected cognitions and demonstrating how human-induced trauma uniquely intensifies fear of crime and perceived vulnerability. Unlike impersonal traumatic events, sexual assault directly implicates interpersonal trust, thereby destabilizing survivors' worldview more profoundly. Nevertheless, their findings rely largely on generalized trauma samples rather than culturally diverse survivor populations, revealing a contextual gap in understanding how these cognitive shifts manifest in non-Western settings.

The literature consistently identifies the disruption of the "illusion of invulnerability" as a critical cognitive shift. Survivors frequently report that they never anticipated victimization,

illustrating the collapse of previously held assumptions of personal immunity. While this phenomenon is well documented, existing studies predominantly employ cross-sectional methodologies, limiting insight into how such perceptions evolve over time. Longitudinal research examining cognitive reconstruction processes remains limited, creating a methodological gap that justifies further investigation.

Self-blame emerges as another significant cognitive consequence. Ruback and Thompson (2001) contend that attributional processes may initially function as adaptive coping mechanisms aimed at restoring perceived control. However, persistent internal attributions are strongly associated with adverse psychological outcomes. Although empirical evidence confirms the link between self-blame and psychological distress, limited attention has been given to how therapeutic interventions specifically modify attributional styles across different sociocultural environments. This gap underscores the need for context-sensitive research examining how survivors reinterpret responsibility within stigmatizing communities.

2.2.13.2 Cognitive Impairment and Functional Disruption

Beyond altered beliefs, sexual assault produces measurable cognitive impairments that interfere with daily functioning (Knipschild et al., 2025). Survivors frequently experience difficulties in emotional regulation, decision-making, and precise memory recall. While Knipschild et al. (2025) establish a clear association between sexual violence and impaired cognitive performance, the reliance on clinical populations may overrepresent severe symptom presentations. Community-based survivors who do not access formal mental health services remain underrepresented in empirical literature, highlighting an empirical gap in capturing the full spectrum of cognitive consequences.

The literature further indicates that inadequate or poorly structured interventions may prolong cognitive dysfunction, thereby affecting personal, professional, and relational domains. Although trauma-informed care integrated with cognitive support is widely recommended, comparative studies assessing intervention effectiveness across resource-diverse settings remain scarce. This methodological limitation restricts understanding of how cognitive rehabilitation strategies function outside controlled clinical environments.

2.2.13.3 Post-Traumatic Stress Disorder as a Central Cognitive Outcome

Post-traumatic stress disorder (PTSD) is widely identified as the primary cognitive consequence of sexual assault (Bryant, 2019). PTSD symptoms including intrusive thoughts, flashbacks, and persistent hypervigilance disrupt attention, working memory, and executive functioning. Bryant (2019) underscores the functional impairments associated with PTSD; however, much of the supporting evidence prioritizes symptom prevalence over longitudinal functional outcomes. The National Sexual Violence Resource Centre and Dworkin (2023) report that sexual assault survivors face a significantly higher risk of PTSD compared to victims of other traumatic events, reinforcing the severity of assault-related trauma. Nevertheless, these findings are largely derived from Western epidemiological data, indicating a contextual gap regarding prevalence and presentation in low- and middle-income countries.

Cognitive-behavioural therapy (CBT) and trauma-focused interventions are consistently identified as effective treatments for PTSD. While empirical support for CBT is robust, limited research evaluates barriers to accessibility, cultural adaptability, and sustainability of these interventions in under-resourced contexts. This gap suggests the need for research that not only confirms therapeutic efficacy but also examines contextual feasibility and implementation.

2.2.13.4 Cognitive Distortions and Maladaptive Core Beliefs

Sexual assault survivors frequently develop cognitive distortions that negatively reshape perceptions of self and others (Daneshvar et al., 2022). Persistent beliefs of worthlessness, shame, and distrust contribute to prolonged depression and anxiety. The American Psychological Association acknowledges that internalized negative cognitions significantly extend emotional suffering, reinforcing the theoretical assertion that maladaptive beliefs mediate trauma outcomes. However, many studies emphasize correlational relationships without sufficiently exploring moderating variables such as social support or cultural stigma.

Shanks (2023) demonstrates the effectiveness of cognitive restructuring therapy in challenging maladaptive thought patterns. Similarly, ShirzadfardJahromi et al. (2024) provide empirical evidence supporting the efficacy of Cognitive Processing Therapy (CPT) in reducing PTSD, anxiety, and depressive symptoms. Fávero et al. (2022) and Raza and Yamamoto (2023) further highlight the psychoeducational benefits of CPT in normalizing trauma responses and mitigating self-doubt. Although these studies collectively affirm CPT's effectiveness, most rely on randomized controlled trials conducted in high-income countries. Consequently, questions remain regarding implementation fidelity, therapist training capacity, and cultural responsiveness in diverse contexts. This methodological and contextual gap informs the need for localized research assessing therapeutic adaptability.

2.2.13.5 Trauma, Memory Impairment, and Legal Functioning

Memory impairment constitutes a complex cognitive consequence of sexual assault. Fields et al. (2022) analyse fragmented recall as a common trauma response, complicating survivors' recovery and participation in legal proceedings. Ressler et al. (2022) provide neuroscientific evidence linking trauma to structural alterations in the hippocampus, resulting in hypermnesia or dissociation. While neuroscientific methodologies strengthen

biological explanations, they often neglect sociocultural and legal implications of memory fragmentation.

Importantly, limited research integrates trauma-related memory impairment with justice system dynamics. Survivors' inconsistent recall may be misinterpreted in legal contexts, yet few empirical studies examine this intersection, particularly in developing countries. This represents both an empirical and contextual gap requiring further exploration to inform trauma-sensitive legal frameworks.

2.2.13.6 Integrated Cognitive Recovery Approaches

Emerging literature supports integrative approaches combining therapy, psychoeducation, and mindfulness. Jaderek and Lew-Starowicz (2019) demonstrate that mindfulness practices reduce hypervigilance and intrusive thoughts. Mughal et al. (2024) emphasize the role of emotionally safe communication environments in fostering cognitive resilience, while Bagheri Sheykhangafshe et al. (2024) highlight the importance of trusted therapeutic and peer support systems in rebuilding trust frameworks. Although these studies suggest promising outcomes, many rely on short-term evaluations, limiting understanding of sustained cognitive recovery.

Organizations such as RAINN provide psychoeducational resources to survivors and communities, promoting trauma-informed awareness. However, evaluations often measure service delivery rather than long-term cognitive transformation, indicating a methodological gap in outcome assessment.

The reviewed literature consistently demonstrates that sexual assault disrupts cognitive schemas, impairs functioning, and increases vulnerability to PTSD and maladaptive beliefs. However, significant gaps remain. Empirically, limited research captures cognitive outcomes among survivors outside Western clinical contexts. Methodologically, cross-

sectional and short-term intervention designs restrict longitudinal insight. Contextually, structural barriers and sociocultural stigma influencing cognitive recovery remain underexplored.

These gaps justify the present study, which seeks to examine cognitive consequences of sexual assault within a specific sociocultural context. The literature informs the conceptual framework by analysing key variables, including disrupted core beliefs, PTSD symptoms, cognitive distortions, and memory impairment. It also guides methodological decisions by highlighting the need for context-sensitive data collection and analysis that moves beyond purely clinical samples.

2.2.14 Needs of Family Members, Friends, Neighbours and Community after Sexual Assault

2.2.14.1 Family System Disruption and Secondary Trauma

Sexual assault does not affect the survivor in isolation; it disrupts the entire family system, necessitating comprehensive and trauma-informed support for all affected members. The literature demonstrates that spouses of survivors diagnosed with post-traumatic stress disorder (PTSD) experience elevated psychological distress, marital conflict, diminished self-esteem, and impaired coping skills (Mental Health Foundation, 2015). Moreover, partners of rape survivors are vulnerable to secondary traumatic stress symptoms, including anger, guilt, shame, and relational instability. While these findings highlight the interconnected nature of trauma within intimate relationships, much of the evidence draws upon samples involving military families or clinical PTSD populations, potentially limiting generalizability to civilian and culturally diverse contexts. This methodological limitation suggests the need for broader family-based research that examines diverse sociocultural dynamics.

Research further indicates that trauma recovery is enhanced when survivors are embedded within supportive and trauma-informed family environments. Leaf's research underscores that healing is more sustainable when social connections, particularly close family members, are integrated into the recovery process. However, although family involvement is widely endorsed, limited empirical studies evaluate structured family-based interventions in comparison to individual therapy alone. This represents an empirical gap concerning the measurable effectiveness of systemic versus individual therapeutic approaches.

Family members frequently experience shock, anger, guilt, sadness, and helplessness. The literature consistently recommends psychoeducation and emotional validation for relatives to enhance their coping capacity (Mental Health Foundation, 2015). Nevertheless, studies often emphasize survivors' needs while insufficiently examining the psychological burden carried by caregivers. The absence of longitudinal data tracking family members' psychological adjustment over time reveals a methodological gap that warrants further investigation.

2.2.14.2 Social Network Reactions: Friends and Neighbours

The broader social network, including friends and neighbours, often experiences heightened fear and apprehension following an assault (Jennifer et al., 2020). This collective anxiety stems from perceived shared vulnerability, which can alter community functioning. Although Jennifer et al. (2020) establishes the presence of fear contagion within social environments, limited research explores how such communal anxiety may either support or inadvertently stigmatize survivors. This ambiguity indicates a contextual gap in understanding community-level psychological responses.

Whiting (2016) emphasizes that survivors frequently internalize feelings of worthlessness and self-blame, which may shift daily responsibilities to significant others. Consequently,

friends and neighbours may become informal caregivers, sometimes without adequate preparation or support. While this literature identifies the risk of overwhelm among social network members, few studies examine structured training or intervention programmes designed specifically for non-family supporters. This represents an empirical gap in evaluating preventative strategies for secondary distress among informal caregivers.

Lovell et al. (2025) and Walshe (2020) demonstrate that positive reinforcement and community advocacy significantly improve survivors' psychological outcomes and increase help-seeking behaviour. However, many studies rely on self-reported measures of perceived support rather than objective behavioural indicators of community engagement. This methodological limitation restricts the ability to assess the tangible impact of community-based support mechanisms.

Van Duin et al. (2022) further note that friends and neighbours commonly experience shock, anger, guilt, and helplessness. The literature recommends open dialogue and trauma-informed counselling to prevent the transfer of distress onto survivors. Yet, there remains limited evidence assessing whether community-based psychoeducational initiatives effectively reduce secondary trauma symptoms among supporters. This gap underscores the need for intervention-based research examining emotional management strategies within social networks.

2.2.14.3 Education, Advocacy, and Community Capacity Building

Education is consistently identified as a foundational element in strengthening community responses to sexual assault. Novotny (2023) highlights the importance of autonomy-respecting engagement strategies, while organizations such as the Rape, Abuse & Incest National Network (RAINN) provide educational materials guiding supportive practices. Although these initiatives are widely accessible, research evaluating their long-term

cognitive and attitudinal impact on community members remains limited. Most programme assessments focus on resource dissemination rather than measurable behavioural change, indicating a methodological gap in outcome evaluation.

Falzone (2021) emphasizes active listening as a protective factor that enhances survivors' emotional recovery. While trauma specialists advocate for empathetic engagement, empirical research seldom quantifies the direct causal relationship between active listening practices and survivor outcomes. This highlights an empirical gap requiring more rigorous experimental or longitudinal designs.

Belle (2024) underscores the importance of community awareness of professional services, including crisis centres, legal aid, and trauma-informed counsellors. Although directories and referral systems improve accessibility, few studies examine barriers preventing community members from utilizing these resources. Thus, a contextual gap exists regarding service navigation challenges in resource-constrained settings.

Confidentiality emerges as a central principle in trauma-informed support. Campbell et al. (2019) analyse confidentiality as critical to preserving survivor autonomy. Despite this consensus, limited research explores how breaches of privacy within close-knit communities may exacerbate stigma or secondary victimization. This gap is particularly significant in collectivist or rural contexts where privacy may be more difficult to maintain.

2.2.14.4 Prevention, Policy, and Systemic Change

Communities contribute to prevention through workshops, advocacy programmes, and public awareness campaigns (McMahon et al., 2021). These initiatives aim to challenge normative beliefs that perpetuate sexual violence and promote bystander intervention. However, programme evaluations frequently measure knowledge acquisition rather than

behavioural change or long-term reduction in assault incidence. This methodological gap complicates assessment of prevention efficacy.

White et al. (2019) argue that systemic change including policy reform and survivor protection mechanisms is essential for sustainable transformation. Decker et al. (2025) highlight the role of grassroots organizations in legislative advocacy and prevention education. While advocacy efforts demonstrate promise, empirical research rarely links policy change directly to survivor-level psychological outcomes. This disconnect represents a theoretical and empirical gap between macro-level reform and micro-level recovery experiences.

Diab and Al-Azzeh (2024) demonstrate that cultivating community-wide empathy fosters psychological safety for survivors, while Mark and Vowels (2020) emphasize that open dialogue about consent and gender equality reduces stigma. Although attitudinal shifts are theoretically associated with improved recovery environments, quantitative evidence linking cultural transformation to measurable survivor well-being remains limited. This suggests a need for interdisciplinary research integrating sociocultural analysis with psychological outcome measures.

Lorente, Vera, and Peiró (2021) further note that supporters are at risk of compassion fatigue and emotional exhaustion. While caregiver well-being is acknowledged, structured support systems for helpers are inconsistently implemented and under-evaluated. This highlights an empirical gap concerning sustainable caregiver support frameworks.

The reviewed literature establishes that sexual assault generates ripple effects across family systems, social networks, and communities. Empirically, there is substantial evidence linking supportive environments to improved survivor outcomes. However, gaps persist. First, family-based and community-level interventions remain under-evaluated using

rigorous longitudinal designs. Second, most studies are conducted in Western contexts, limiting cultural generalizability. Third, limited research examines the intersection between community stigma, confidentiality breaches, and recovery trajectories.

Methodologically, reliance on cross-sectional surveys and self-report measures restricts causal inference and long-term evaluation. Contextually, structural barriers affecting community capacity in low-resource environments remain insufficiently explored. Theoretically, while trauma-informed frameworks emphasize safety, empowerment, and social support, there is limited integration of systemic change models with psychological recovery theories.

These gaps justify the present study's focus on examining the needs of family members, friends, neighbours, and communities within a defined sociocultural context. The literature informs the conceptual framework by analysing key variables, including secondary trauma, social support quality, psychoeducation, confidentiality practices, and community advocacy. It also guides methodological choices by underscoring the importance of capturing multi-level perspectives beyond the survivor alone, thereby strengthening the coherence between theory, variables, and research design.

2.3 Psychosocial Interventions for Survivors

Survivors of sexual assault demonstrate varied psychological trajectories, with some experiencing immediate distress and others developing short- or long-term psychological disorders. Comtesse et al. (2019) argue that survivors must process not only the traumatic event itself but also the societal responses to their disclosure. This dual-layered stressor highlights the importance of interventions that address both intrapersonal trauma and social context. However, while Comtesse et al. (2019) acknowledge the influence of social

reactions, limited empirical work systematically compares outcomes across supportive versus stigmatizing environments, revealing a contextual gap in the literature.

The concept of psychosocial support (PSS) emphasizes the dynamic interplay between psychological experiences and social environments. Zhao et al. (2018) define psychosocial support as encompassing holistic practices that promote overall well-being. While this broad definition strengthens the conceptual foundation of PSS, it also introduces methodological challenges. The term “psychosocial” is frequently operationalized inconsistently across studies, sometimes referring to structured clinical therapy and at other times to informal community-based support. This definitional variability complicates comparison of intervention outcomes and limits cumulative evidence development.

Psychosocial interventions are framed as structured therapeutic processes aimed at alleviating psychological distress, reducing maladaptive behaviours, and enhancing adaptive coping through counselling or preanalysed treatment plans. Although these interventions may be delivered individually, in couples, family, or group settings, few comparative studies evaluate the relative effectiveness of these modalities for sexual assault survivors. Consequently, an empirical gap persists regarding which therapeutic configuration is most appropriate under varying trauma severities and sociocultural conditions.

The amount and duration of psychosocial intervention required vary considerably depending on trauma severity and individual coping capacity. Comtesse et al. (2019) highlight that coping outcomes are shaped not only by internal resilience but also by social validation or rejection following disclosure. However, much of the literature measures coping primarily through symptom severity scales, rather than integrating broader contextual variables such

as socioeconomic constraints or legal system engagement. This methodological limitation narrows understanding of recovery as a multidimensional process.

Furthermore, intervention research frequently prioritizes short-term reductions in psychological symptoms without assessing long-term reintegration outcomes. While immediate symptom stabilization is essential, fewer studies evaluate sustained improvements in relational functioning, occupational stability, or community participation. The lack of longitudinal designs therefore constitutes a significant methodological gap in psychosocial intervention research.

The literature emphasizes that psychosocial interventions must be administered by trained professionals in psychology, psychiatry, or social work, or by supervised trainees. This professional standard ensures adherence to trauma-informed care principles and ethical safeguards. However, Zhao et al. (2018) stress that psychosocial support should encompass broad well-being practices, suggesting that intervention may extend beyond strictly clinical settings.

Despite this recognition, limited research evaluates hybrid delivery models that combine professional oversight with community-based paraprofessional support. In resource-constrained environments, reliance solely on specialized professionals may reduce accessibility and sustainability of services. Thus, a contextual gap remains in examining scalable psychosocial intervention models that maintain therapeutic integrity while expanding reach.

The reviewed literature supports the premise that professionally conducted psychosocial interventions significantly assist survivors in navigating both trauma-related distress and social reactions (Comtesse et al., 2019). Additionally, Zhao et al. (2018) reinforce the importance of integrating psychological and social dimensions within intervention

frameworks. However, theoretical integration across studies remains inconsistent. Some research emphasizes symptom-focused clinical treatment, while others foreground community-based psychosocial approaches, without synthesizing these perspectives into a unified framework.

Empirically, strong evidence supports psychosocial interventions in reducing distress, yet comparative modality research remains limited. Methodologically, definitional inconsistencies and reliance on short-term outcomes restrict generalizability. Contextually, structural barriers affecting access to professional services remain underexplored.

These identified gaps justify the present study's focus on examining psychosocial intervention methods utilized for sexual assault survivors. The literature informs the conceptual framework by analysing trauma severity, coping capacity, social response, and intervention modality as key variables. It also guides methodological decisions by underscoring the need for context-sensitive evaluation of both psychological symptom reduction and broader psychosocial functioning outcomes.

2.3.1 Psychological Interventions

Establishing a therapeutic agreement with the survivor and conducting an initial debriefing constitute the foundational steps a therapist undertakes when providing psychological support to a sexual assault survivor. At this stage, interventions may include ensuring a conducive environment at the GBVRC, the therapist introducing themselves and clearly stating their role as a counsellor, and assuring the survivor of confidentiality. It is essential to establish the survivor's reasons for seeking support and to negotiate the duration and number of sessions, clarifying that multiple sessions may be necessary. Obtaining informed consent and explaining the survivor's right to terminate the session at any time are critical components. The therapist must also respect the survivor's preference to be attended to alone

or accompanied. Finally, an assessment should be conducted to analyse whether the survivor qualifies for medical procedures such as HIV testing and emergency contraceptive management. Throughout this process, staff should provide supportive care and allow the survivor to control the extent of disclosure and their decision regarding further psychological assistance (Zhao *et al.*, 2018).

2.3.1.1 Therapeutic Interventions

The subsequent stage involves providing therapeutic interventions for survivors of sexual assault. These interventions aim to mitigate the negative effects that may arise following an assault. According to Malamuth *et al.* (2018), such interventions include assessing the survivor's safety; analysing immediate concerns and developing plans to address them; helping the survivor understand that their reactions are normal by explaining likely psychological responses and what to expect; empowering the survivor to regain control by providing information to facilitate informed decision-making and offering various options; coordinating access to referral resources and ensuring safety; responding to suicidality; delivering concise messages to counteract self-blame and guilt; and discussing the disclosure of the assault to family and friends. These early interventions assist survivors in managing their initial reactions to the assault, thereby reducing or even preventing the onset of more severe psychological distress (Dworkin & Schumacher, 2018).

2.3.1.2 Long-Term Psychological Support

The third stage of intervention focuses on the management and prevention of more chronic symptoms. Although individuals respond uniquely to assault, most studies have concentrated on treatments addressing the three primary psychopathologies commonly associated with rape: post-traumatic stress disorder (PTSD), depression, and anxiety (Colizzi *et al.*, 2020). Trauma-focused cognitive-behavioural therapies (CBT) have been

identified as promising approaches for treating chronic symptoms following sexual assault. These therapies include cognitive processing therapy, exposure-based therapies, stress inoculation therapy, and psychoeducation. Additional treatment options comprise eye movement desensitization and reprocessing (EMDR), feminist therapy, and relational therapy (Arseneault, 2018).

2.3.1.3 Cognitive Processing Therapy (CPT)

At the core of Cognitive Processing Therapy (CPT) lies the conflict between pre-existing cognitive schemas and new information derived from the traumatic experience (González-Prendes *et al.*, 2019). CPT aims to assist clients in resolving these conflicts, which often manifest as cognitive "stuck points" that hinder recovery. Clients receive psychoeducation about information processing, specifically related to their trauma, such as rape. A written assignment facilitates exploration of the personal meaning ascribed to the traumatic event. Additionally, clients are taught to differentiate between thoughts and feelings and to recognize the connection between cognitions (i.e., self-statements) and emotions (Cooper *et al.*, 2022).

2.3.1.4 Exposure Therapy

Exposure therapy can also be implemented as imaginal exposure, wherein the individual imaginatively revisits the feared situation (Lumley & Schubiner, 2019). EMDR involves a three-pronged approach that addresses the aetiology of the traumatic event (past), the triggers of PTSD symptoms (present), and the development of coping templates for future distressing events (Palumbo *et al.*, 2020). During EMDR, the therapist employs directive questioning to desensitize the client through brief imagined exposure to the traumatic memory. The client is asked to articulate a negative or dysfunctional cognition related to the trauma and to analyse bodily locations where physical sensations are experienced. After

focusing on the traumatic memory, negative cognition, associated emotions, and physical sensations, the client undergoes bilateral stimulation (Palumbo *et al.*, 2020).

Exposure therapies aim to activate the affective and cognitive processes associated with trauma to facilitate its healthy processing. These approaches differ in the degree of contact and intensity of exposure to the feared stimulus. Some methods employ graduated exposure, involving a hierarchical series of steps from the least to the most anxiety-provoking stimuli that the individual confronts throughout treatment. In contrast, other techniques utilize a flooding approach, characterized by an abrupt and sustained confrontation with the avoided object or situation.

2.3.1.5 Stress Inoculation Therapy

Stress Inoculation Therapy (SIT) is designed to enhance survivors' coping skills and their confidence in effectively utilizing these skills in anxiety-provoking situations. It has been employed both as a treatment model to assist individuals in the aftermath of trauma and, on a preventive basis, as a method of self-inoculation against future stressors. SIT employs a three-phase, overlapping approach: conceptualization, development of strategies rehearsal, and application/follow-through. The implementation of these phases varies depending on the nature of the trauma, whether acute, time-limited stressors or prolonged, ongoing, repetitive stressors, as well as the client's available resources and coping abilities (Cruzat *et al.*, 2018).

2.3.1.6 Psychoeducation

Psychoeducation constitutes a core psychosocial intervention variable within sexual assault recovery, involving structured provision of information regarding symptoms, treatment options, coping strategies, and available services (Lomax & Meyrick, 2022). Unlike purely supportive approaches, psychoeducation combines informational empowerment with skills

development, equipping survivors and caregivers to manage both physical and emotional sequelae. Lomax and Meyrick (2022) note that delivery formats range from interactive therapist-led engagement to self-directed digital or telephonic platforms. However, while multiple media formats enhance accessibility, few comparative studies evaluate differential outcomes across delivery modalities, creating a methodological gap regarding the relative effectiveness of face-to-face versus technology-assisted psychoeducation.

Within the Kenyan policy context, the Ministry of Health, Kenya (2006) conceptualises psychoeducation as encompassing normalization of guilt, shame, and hopelessness, alongside empowerment through coping guidance. Although this framework aligns with trauma-informed principles, it is largely programmatic rather than empirically evaluated. There is limited longitudinal evidence assessing whether normalization strategies translate into sustained reductions in self-blame. This empirical gap is particularly relevant in contexts such as Uasin Gishu County, where stigma intensifies internalised shame.

Sexual assault is rooted in coercion, disempowerment, and control (Pemberton & Loeb, 2020). Feminist therapeutic approaches respond to this structural imbalance by explicitly addressing societal power inequities and fostering agency within therapeutic relationships (Jennifer & Tamra, 2020). While feminist therapy foregrounds empowerment, the literature remains largely theoretical, with fewer controlled outcome studies compared to cognitive-behavioural approaches. This imbalance reveals an empirical gap between theoretical endorsement and measurable effectiveness.

Relational theory similarly emphasises growth through connection and mutuality (Magnavita, 2000). By examining relational histories and sociocultural identity markers, relational therapy situates trauma within broader interpersonal systems. Although relational models are conceptually suited to survivors of abuse, Magnavita (2000) provides limited

context-specific evidence from low-resource environments. Consequently, the transferability of relational approaches to settings such as rural Kenya remains underexplored, revealing a contextual gap relevant to the present study.

Sexual violence produces multidimensional harm affecting psychological, emotional, and social functioning (Sigurdardottir & Halldorsdottir, 2021). Crivatu et al. (2023) emphasise that psychosocial interventions should restore self-worth and facilitate reintegration. Navajeeva (2025) further underscores the necessity of safe, non-judgmental environments, a finding echoed by Mwangi (2023) within Uasin Gishu County. However, although trauma-informed care is widely endorsed globally, empirical research rarely measures “emotional safety” as an operationalised construct, revealing a methodological limitation.

Shame reduction emerges as a critical intervention target in stigmatizing cultural environments (Salter & Hall, 2022). In such contexts, interventions incorporating psychoeducation and peer validation (Wessells & Kostelny, 2022) and cognitive restructuring through TF-CBT (Polk, 2021) have demonstrated efficacy in reframing self-blame. Nevertheless, most TF-CBT studies rely on short-term symptom scales rather than long-term reintegration indicators, limiting understanding of sustained recovery.

Emotion regulation is equally central. Serfioti et al. (2024) and Cloitre and Schmidt (2022) highlight structured emotional regulation programmes, while Ranasinha (2025) supports culturally grounded expressive modalities. Yet comparative evaluations between structured CBT-based regulation and culturally embedded expressive interventions remain limited, representing an empirical and methodological gap.

Recovery is influenced by the survivor’s broader ecological environment (Bundotich, 2020). Where perpetrators are embedded within family systems, interventions must extend beyond

individual therapy (Meli, 2023). Family therapy models (Alexander & Robbins, 2019) demonstrate improvements in communication and relational functioning, yet studies seldom isolate outcomes for sexual assault survivors specifically. Similarly, community sensitisation programmes (Bwambale et al., 2022) aim to reduce stigma, but systematic evaluations of their impact on disclosure rates remain sparse.

These findings reveal a contextual gap: while ecological and systemic interventions are theoretically endorsed, empirical data linking them directly to measurable survivor outcomes within Kenyan counties is limited.

Problem-solving therapy enhances survivor agency by breaking down post-trauma challenges into manageable steps (Nezu & Nezu, 2021; Tahan, 2023). In contexts marked by economic vulnerability, integration with empowerment initiatives strengthens recovery trajectories (Mariga, 2021). However, few studies integrate psychosocial and economic outcomes within a unified evaluation model, revealing a methodological fragmentation between psychological and socioeconomic variables. Delker et al. (2020) caution that forward-oriented interventions must balance validation with empowerment, a view supported by Profitt (2020). Yet empirical guidance on optimal pacing remains underdeveloped.

Intrusive symptoms are central to PTSD presentations (McNally, 2022). Psychoeducation demystifies these experiences (Omopo, 2024), while cognitive restructuring and grounding enhance control (Teibowei, 2025). Behavioural activation further reduces withdrawal and anhedonia (Craske et al., 2024; Abouzaid & Abdelhamid, 2024). Despite strong evidence bases, most behavioural research originates from high-income countries, limiting contextual generalisability (Duggan, 2018).

Cognitive Behavioural Therapy demonstrates strong empirical support (Morrison, 2019), particularly for structured symptom reduction. Psychodynamic therapy offers depth-oriented insight (Carlson, 2024; Voytenko & Huprich, 2025), though typically requires longer engagement. Humanistic therapy fosters self-esteem (Singh, 2023), while supportive therapy provides immediate stabilisation (Novalis, 2019). Holistic approaches address multidimensional well-being (Li, 2024). Behavioural interventions show strong conditioning-based outcomes (Hashemi et al., 2023), and positive psychology enhances resilience (Smith et al., 2021).

Group therapy (Fonagy et al., 2019), family therapy (Alexander & Robbins, 2019), and couples therapy (Gasbarrini & Snyder, 2019) extend recovery into relational domains. MBCT strengthens relapse prevention (Apolinário-Hagen et al., 2020), and resilience training promotes adaptive coping (Ronen, 2021). However, cross-modality comparative trials specific to sexual assault survivors in low-resource settings remain scarce.

Digital therapeutics such as Rejoyn demonstrate promising adjunctive effects for depression (Rostami et al., 2025; Swartz & Bylsma, 2024). Although accessibility is enhanced, evidence for digital PTSD-specific interventions in rural Kenya remains limited. Institutional initiatives in Kenya, including CREAM and GBV Recovery Centres (Kenya, 2019), school-based programmes (Griffin, 2019), community advocacy (Kwobah et al., 2021), addiction rehabilitation (Roberts, Lotzin & Schäfer, 2022), and NACADA programmes, expand service reach. However, workforce shortages and affordability constraints limit equitable access.

Empirically, substantial evidence supports psychosocial interventions, yet most studies prioritise short-term symptom reduction over long-term reintegration. Methodologically, inconsistent operationalisation of constructs such as empowerment, emotional safety, and

resilience weakens comparability. Contextually, limited Kenyan county-level evaluations restrict generalisability to Uasin Gishu.

These gaps justify the present study's focus on examining psychosocial intervention approaches within Uasin Gishu County. The reviewed literature informs the conceptual framework by analysing core variables: psychoeducation, empowerment processes, emotional regulation, environmental safety, problem-solving capacity, and modality of intervention delivery. Methodologically, it underscores the importance of integrating symptom-based measures with contextual and reintegration indicators to ensure coherence between theoretical assumptions and empirical investigation.

2.3.2 Social Interventions

Social interventions within the GBVRC environment involve creating settings and programmes that foster and sustain social ties and communal connections for survivors. When effectively implemented, these interventions provide survivors, who often carry multiple vulnerabilities, with opportunities for nurturance through ecological support systems. Such support facilitates their growth and development in a healthy and holistic manner.

Close relationships with others contribute significantly to the emotional strength of survivors. Social support influences their self-perception and worldview, thereby enhancing the cognitive components of resilience, particularly by fostering optimism and positive self-regard. Moreover, a supportive social network encourages survivors to engage in active and adaptive coping behaviours. When individuals perceive a safety net within their social networks, they are more likely to minimize the appraisal of threat and act in their own best interests, which promotes key behavioural components of resilience (Cai *et al.*, 2020).

The ecological forces relevant to this study encompass families, professionals, community members, advocacy groups, the criminal justice system, cultural influences on interventions, and the policies and laws governing the care of assault survivors (Sabri, Simonet & Campbell, 2018). It is essential that families receive counselling and pertinent information to enable them to support the survivor's coping and healing processes. Furthermore, fostering and maintaining strong relationships between the survivor and their family can facilitate the development of a robust and enduring social support network, which serves as a critical resource for promoting resilience in the aftermath of assault trauma.

2.3.2.1 Addressing Gender-Based Violence and Reintegration

The central pillar of societal challenges predominantly affecting women is gender discrimination, as identified by Dartnall and Jewkes (2013). Creating safer communities with enhanced support for women necessitates active rights advocacy in conjunction with efforts to eliminate stigma surrounding sexual violence. The reintegration of survivors into society during the recovery process is crucial, as it enables them to construct new identity profiles independent of their traumatic experiences (Finnbakk & Nordås, 2019). The success of this reintegration largely depends on community participation, wherein fellow residents provide survivors with emotional support, social and economic assistance, and foster an environment that upholds dignity and inclusion (Mirghani *et al.*, 2017).

The recovery process for survivors is optimally supported by local communities, as they possess comprehensive knowledge of cultural, legal, and familial dynamics. Survivors receive practical assistance through the provision of temporary housing and benefit from guidance navigating both formal and traditional justice systems (Abi-Falah, 2020). However, survivors frequently face ongoing threats from perpetrators, alongside challenges such as survivor guilt, social isolation, and suicidal ideation (Mirghani *et al.*, 2017). In

Kenya, many survivors of sexual violence remain dependent on their abusers, who are often family members; approximately 30% of perpetrators originate from close-knit familial relationships (Temmerman *et al.*, 2019). Consequently, security measures that incorporate community participation are essential components of effective responses to these circumstances.

Sexual violence survivors face the significant obstacle of stigma as a primary barrier to their healing process. Survivors of rape frequently encounter openly condemnatory treatment, which stems from pervasive societal beliefs regarding acceptable behaviours during sexual encounters (Schmitt *et al.*, 2021). Traditional societal norms often silence women, as they fear abandonment or the loss of assets. In Uasin Gishu, social recovery programmes prioritize the establishment of trust-based relationships between staff and survivors, alongside peer mentorship initiatives (Alarcón & Mirković, 2024). Additionally, these programmes incorporate social confidence-building activities aimed at fostering survivors' reintegration and empowerment (Holmes, 2024; Wijewardana & Dewanarayana, 2024).

Vocational training alongside daily responsibilities plays a crucial role in social recovery by fostering psychological resilience and economic stability (Hanlon *et al.*, 2021). Through engagement in basic chores and income-generating activities, survivors rediscover their sense of purpose and self-reliance. Recovery centres serve as advocates for justice by providing guidance on legal systems and challenging traditional reconciliation approaches that often neglect survivors' rights (Kakuru, 2023). Additionally, community members employ dance, music, and storytelling to facilitate cultural healing, promote joy and self-expression, and enhance social reconnection (Chen *et al.*, 2024).

GBV recovery centres provide comprehensive, whole-person medical services integrated with legal assistance, educational support, and social protection systems for their patients.

Survivors receive a range of support services, including post-exposure prophylaxis, trauma counselling, and maternal healthcare (Kassim, 2022). Initiatives such as Beyond Zero and Linda Mama have expanded healthcare access in rural areas. GBV recovery centres collaborate with government departments and non-profit organizations to establish protected service locations, thereby empowering survivors to regain control over their circumstances (Muiruri, 2023). The integration of educational programmes and social protection measures, including food assistance and safe housing, addresses both awareness needs and economic vulnerabilities (Poland-McClain *et al.*, 2024; Feroz, 2022). However, challenges persist regarding the need for sustained long-term investments to combat stigma, improve rural service distribution, and secure adequate funding to support survivor-centred recovery and prevention approaches (Sulla *et al.*, 2025).

2.3.2.2 Public Safety and Mental Health Interventions

For the realm of public safety, organizations such as Evidence Action have implemented interventions to provide safe shelter and crisis response services for survivors (Burke *et al.*, 2019). Their programmes ensure that survivors receive immediate shelter, legal assistance, and pathways to long-term recovery. Additionally, GBVRCs have collaborated with microfinance institutions to offer financial literacy and small business training to survivors. This approach facilitates survivors' financial independence, thereby reducing their risk of returning to abusive situations due to economic dependency.

Moreover, mental health interventions have become increasingly innovative through community-based peer support programmes. For example, the Friendship Bench project, originally developed in Zimbabwe and later adapted in Kenya, has been utilized to provide trauma-informed counselling for survivors of gender-based violence (Yoder-Maina, 2022). This model has significantly enhanced access to mental health care in resource-limited

settings. Carstensen, Mudhar and Munksgaard (2021) examine mutual aid networks as fundamental social interventions that emerged in response to the increase in gender-based violence (GBV) cases during the COVID-19 pandemic. This rise was largely attributed to lockdown measures and associated economic hardships. Community organizations mobilized resources to support survivors by providing essential supplies, legal assistance, and online counselling services. These grassroots efforts demonstrate that communities possess the capacity to effectively address GBV and offer immediate support to those affected.

The Gender-Based Violence Recovery Centres (GBVRCs) have collaborated with government agencies to advocate for the stricter enforcement of laws addressing gender-based violence (GBV), including the Sexual Offences Act and the Protection Against Domestic Violence Act (Muiruri, 2023). The establishment of specialized GBV courts has further enhanced the handling of cases, ensuring timely justice for survivors. However, challenges such as case backlogs, inadequate legal representation, and survivor intimidation continue to impede the effective delivery of justice. Strengthening legal frameworks and increasing support for survivors navigating the judicial system are essential to improving the efficacy of GBV-related interventions.

Furthermore, corporations and private entities have incorporated social interventions to enhance the prevention of and response to gender-based violence (GBV). According to Netshitenzhe (2024), companies such as Safaricom have launched initiatives offering free GBV helpline services, thereby ensuring that survivors can access assistance without financial barriers. Additionally, Corporate Social Responsibility (CSR) programmes prioritize funding for shelters, counselling services, and legal aid clinics, which are essential in supporting survivors as they rebuild their lives.

Collectively, these examples illustrate the diverse nature of social interventions addressing gender-based violence (GBV) in Kenya (Ebron *et al.*, 2024). By targeting critical areas such as healthcare, economic empowerment, education, and legal support, GBVRCs and other initiatives contribute significantly to fostering a safer and more equitable society. To ensure the sustainability and effectiveness of GBV interventions in Kenya, it is essential to strengthen coordination among stakeholders, increase funding, and enhance survivor-centred approaches. These measures will be crucial in addressing the multifaceted challenges posed by GBV and promoting long-term social transformation.

2.4 Challenges Facing Psychosocial Interventions in GBVRCs

A wide range of psychosocial interventions constitute essential components of the comprehensive care provided to sexual assault survivors in Gender-Based Violence Recovery Centres (Gbvrcs), addressing the emotional and psychological trauma resulting from such violence (Sinko *et al.*, 2021). However, the implementation of these interventions in Uasin Gishu County, Kenya, faces significant challenges, including societal stigma, structural limitations, and inadequate support for service providers (Tarabih & Arnault, 2024). Although psychosocial services are critical, their importance is often undervalued and they receive less support from healthcare and legal systems compared to medical and legal services. This disparity creates gaps in the recovery process for survivors. This study aims to analyse the challenges in implementing psychosocial interventions, examine gaps between theory and practice, and propose contextually appropriate strategies to enhance service delivery in the local setting.

However, the absence of continuous in-service training for counsellors and service providers constitutes a significant barrier. Specialized knowledge in trauma, crisis intervention, and culturally sensitive communication is essential; yet, most providers in Uasin Gishu engage

in little to no ongoing professional development (Muiruri, 2023). Inadequate training may result in poor-quality care and the re-traumatization of survivors (Theunissen, 2023). This challenge is further exacerbated by a lack of financial and material resources, including insufficient staffing and inadequate equipment at service centres (Kolehmainen, 2024). Such constraints adversely affect both the scope and quality of psychosocial services, leading to reduced effectiveness and compromising long-term sustainability (Nyaranga, 2022).

Further, psychosocial stigma and low awareness deter survivors from engaging with psychosocial services. In many communities, counselling is associated with mental illness or moral failure, resulting in resistance or distrust toward mental health interventions (Judy, 2023). Consequently, survivors may prefer traditional healing or religious practices, or they may be discouraged from seeking any assistance due to the stigma linked to sexual abuse (Mariga, 2021). Moreover, stigma surrounding sexual violence further inhibits help-seeking and perpetuates silence, particularly in rural areas where maintaining confidentiality is challenging (Elendu *et al.*, 2024). To reduce stigma and promote the uptake of services, Gender-Based Violence Recovery Centres (GBVRCs) must employ culturally sensitive approaches and conduct community education campaigns (Nuwagaba, 2023).

Another significant challenge is the poor coordination among service providers. Effective psychosocial care typically requires collaborative teamwork across multiple systems, including medical, legal, and social services. However, in Uasin Gishu, these services tend to operate in isolation (Pachauri & Verma, 2023). Consequently, survivors often encounter fragmented services, experience the distress of repeatedly recounting their traumatic experiences, and face delays or contradictory counselling. Additional factors undermining the quality of care include weak referral mechanisms and inconsistent case management (Onkoba, 2023). These challenges can be mitigated through the implementation of

integrated systems, the adoption of shared protocols, and the convening of regular multidisciplinary meetings, thereby ensuring survivor-centred and holistic support.

Finally, service providers themselves experience emotional exhaustion and vicarious trauma due to continuous exposure to survivors' distressing stories (Ngatane, 2021; Munyua & Ogula, 2023). In the absence of adequate supervision, peer support, or self-care infrastructures, many counsellors suffer burnout, which may lead to a loss of interest or empathy (Rokach & Boulazreg, 2022). Although awareness of these challenges among counsellors is increasing, professional stigma surrounding help-seeking causes many to endure these difficulties in silence (Schmidt & Niehaus, 2022). This study outlines institutional responses to staff wellbeing, including the provision of mental health support, supervision, and resilience-building initiatives, aimed at enhancing the quality of care provided to both survivors and service providers (Cleary & Armour, 2022).

2.4.1 Justice and Advocacy Interventions

Legal and policy barriers significantly hinder the effectiveness of psychosocial interventions in Gender-Based Violence Recovery Centres (GBVRCs). Although Kenya has enacted robust legislation, such as the Sexual Offences Act and the Protection Against Domestic Violence Act, implementation remains inadequate due to factors including corruption, limited awareness, and insufficient training among law enforcement officers (JARED, 2019). Survivors seeking justice frequently face prolonged delays, victim-blaming attitudes from police personnel, and intimidation by perpetrators. In the absence of adequate legal protection, many survivors feel unsafe pursuing counselling or therapy, fearing retaliation from their abusers. Furthermore, the lack of coordination between law enforcement agencies and psychosocial support providers undermines efforts to deliver comprehensive care, resulting in numerous cases remaining unreported or unresolved.

The accessibility of psychosocial services remains a significant challenge, particularly in marginalized and remote regions of Kenya. Numerous counties, including Turkana, Samburu, and Marsabit, have few or no functional Gender-Based Violence Recovery Centres (GBVRCs), compelling survivors to rely on informal support systems such as religious leaders or community elders. In cases of intimate partner violence, survivors are often pressured to reconcile with their abusers rather than receive professional counselling. This issue is further exacerbated by the limited number of mental health professionals in Kenya, as many counties have only a small cadre of trained psychologists or social workers. Moreover, GBVRCs frequently lack the capacity to provide long-term psychosocial support, resulting in survivors being deprived of continuous care and follow-up interventions essential for their recovery.

2.4.2 Economic Empowerment Programmes

The impact of poverty and economic dependence significantly affects the effectiveness of psychosocial interventions in Kenya. Many survivors of gender-based violence (GBV), particularly women, remain financially dependent on their abusers, which hinders their ability to leave violent relationships or seek professional assistance (Muthami *et al.*, 2017). Economic hardship often compels survivors to prioritize basic needs such as food and shelter over mental health support, resulting in prolonged trauma and emotional distress. Some GBVRCs endeavour to offer empowerment programmes, including vocational training and microfinance initiatives, to facilitate survivors' financial independence. However, due to limited resources, these programmes are frequently underfunded or inaccessible to many survivors who require them most.

The intersection of gender-based violence (GBV) and harmful cultural practices poses significant challenges to psychosocial interventions in Kenya. Practices such as Female

Genital Mutilation (FGM) and child marriage, which remain prevalent in regions including Kajiado, Narok, and West Pokot, expose numerous young girls to both physical and psychological trauma (Kaprom, 2016). Many survivors of these practices do not perceive the need for psychosocial support, as they have been socialized to regard these practices as normative cultural rites of passage. Furthermore, community resistance to external interventions complicates efforts to provide counselling and mental health services, given that some families and local leaders discourage girls from disclosing their experiences or seeking professional assistance.

The limited public awareness and low community involvement in psychosocial interventions significantly impede the effectiveness of GBVRCs in Kenya. A substantial portion of the population remains unaware of these centres and the range of services they offer, resulting in underutilization of available mental health resources. Additionally, prevalent misconceptions about therapy and mental health support contribute to survivors' reluctance to seek assistance. To overcome these barriers, community-based awareness programmes, media campaigns, and school-based interventions are essential. However, without adequate investment in public education on gender-based violence and mental health, stigma and misinformation will persist, continuing to obstruct survivors' access to necessary psychosocial care.

In the conflict-affected eastern regions of the Democratic Republic of Congo (DRC), widespread sexual violence has resulted in profound trauma among survivors, many of whom endure long-term psychological distress. Humanitarian organizations such as Médecins Sans Frontières (MSF) play a critical role in providing psychological support through counselling and trauma therapy. However, the demand for these services frequently exceeds available capacity. Numerous survivors face significant barriers to accessing care,

including long distances to recovery centres, fear of social stigma, and ongoing threats of violence. The persistent armed conflict further exacerbates these challenges, hindering the establishment of stable and comprehensive support systems. Moreover, a shortage of trained mental health professionals constrains both the quality and availability of psychosocial services, leaving many victims to cope with their trauma in isolation.

In Kenya, the management of gender-based violence (GBV) presents significant challenges for psychosocial and medical practitioners due to systemic weaknesses in service delivery. A study conducted at Nairobi Women's Hospital identified several critical issues, including limited resources, high caseloads, and inadequate training among staff, all of which impede the effectiveness of mental health and counselling interventions. Many healthcare workers lack sufficient training in trauma-informed care approaches, resulting in survivors receiving suboptimal psychological support. Additionally, the legal system poses considerable obstacles; survivors frequently encounter protracted court processes, which discourage them from pursuing justice. Moreover, cultural stigma and deeply entrenched patriarchal norms inhibit many survivors from reporting abuse or seeking professional assistance, thereby further complicating intervention efforts.

Cultural stigmatization and victim-blaming attitudes in India frequently deter survivors from seeking assistance, thereby limiting the effectiveness of psychosocial interventions. Many victims, particularly those residing in rural areas, fear social ostracism and familial rejection if they disclose their abuse or pursue counselling services. Furthermore, inadequate training among healthcare providers and the absence of standardized psychosocial intervention protocols contribute to inconsistent and, at times, detrimental responses from service providers. The country's vast population and pronounced regional disparities further complicate the implementation of uniform intervention strategies, as rural communities

often lack access to professional counselling and safe shelters. Although the government has initiated several measures, including one-stop crisis centres and helplines, a significant number of survivors remain unaware of these resources or encounter barriers that impede their access.

Despite the existence of progressive legislation addressing gender-based violence in South Africa, significant challenges persist in the implementation of effective psychosocial interventions. Systemic issues such as under-resourced healthcare facilities and a shortage of trained mental health professionals hinder the delivery of comprehensive care. Many recovery centres struggle to provide continuous support due to inconsistent funding, while mental health practitioners frequently experience burnout as a result of overwhelming caseloads. Moreover, the high prevalence of violence and the normalization of abuse within certain communities further undermine the efficacy of support services, as survivors are often discouraged from reporting incidents. Additionally, socioeconomic factors such as poverty and unemployment exacerbate survivors' vulnerability by limiting their ability to leave abusive environments, thereby perpetuating cycles of violence. Although some organizations and advocacy groups offer free therapeutic and legal assistance, the demand for these services far exceeds their availability.

In Colombia, decades of armed conflict have resulted in widespread sexual violence, with survivors frequently encountering inadequate psychosocial support due to persistent insecurity and fragile institutional frameworks (Gebrekristos, 2023). Women and girls in conflict-affected regions remain at high risk of gender-based violence; however, they often face significant barriers to accessing safe spaces where psychological assistance and legal aid are available. Key challenges include limited service availability in rural areas, cultural stigmas that discourage victims from seeking help, and ongoing security concerns that

impede the development of comprehensive support systems. Although the government has implemented initiatives such as mobile gender-based violence (GBV) response units, their reach remains constrained. Moreover, the reintegration of former combatants and survivors into society presents additional psychological challenges, as many survivors continue to reside in close proximity to their perpetrators.

The protracted conflict in Syria has resulted in numerous cases of gender-based violence, with psychosocial interventions impeded by ongoing violence, displacement, and limited infrastructure (Navarrete, 2019). Many survivors reside in refugee camps where access to professional mental health services is scarce, and social stigma inhibits open discussions regarding trauma recovery. Humanitarian organizations face significant challenges in providing consistent support due to security risks, resource constraints, and cultural barriers that discourage survivors from seeking assistance. Furthermore, Rizkalla *et al.* (2020) highlight that many women and children in displacement settings experience severe post-traumatic stress disorder (PTSD) and depression; however, there is an insufficient number of trained professionals to address their needs. The continued instability in the country further complicates the establishment of long-term psychosocial support programmes, as organizations frequently encounter funding reductions and logistical obstacles.

In Papua New Guinea, deeply entrenched cultural norms and inadequate legal protections for women present significant challenges to psychosocial interventions for survivors of gender-based violence (Naime, 2024). Domestic violence is pervasive; however, social and religious beliefs often compel victims to remain silent or reconcile with their abusers. The limited healthcare infrastructure, insufficient government funding, and scarcity of trained mental health professionals further hinder the provision of adequate support. Consequently, many survivors rely on community-based support groups rather than formal recovery

centres, which may lack the necessary expertise to deliver comprehensive psychological care. Although the government has initiated the establishment of additional gender-based violence crisis centres, these efforts remain insufficient to address the country's deeply rooted gender inequality and pervasive violence (Dale, Maki & Nitia, 2021).

A study by Alemi *et al.* (2023) highlights significant challenges faced by psychosocial interventions for survivors of gender-based violence in Afghanistan, primarily due to restrictive cultural norms that discourage women from seeking help. Many survivors fear reprisals from their families or communities upon disclosing abuse, resulting in widespread underreporting and increased psychological distress. The limited availability of trained female healthcare providers further constrains access to essential services, as societal restrictions often prohibit women from receiving care from male professionals. Additionally, ongoing conflict and political instability impede the development and implementation of comprehensive support systems, with many humanitarian organizations struggling to operate safely. Although international NGOs have endeavoured to establish women's shelters and crisis centres, these initiatives frequently encounter resistance from conservative factions that perceive them as threats to traditional values.

Adolescents face numerous psycho-social challenges, including adjusting to the death of their biological parents if they are orphans, overcoming identity issues related to their HIV-positive status, coping with stigma and prejudice from others, and managing difficulties associated with disclosing their status. For caregivers, disclosure and the lack of social, familial, and financial support have been identified as primary obstacles. Adolescents' coping mechanisms and overall well-being are influenced by factors such as medication adherence, HIV education, a future-oriented mindset, and social support. Moreover, social and financial assistance are critical in fostering supportive caregiving environments (Oye,

2024). Despite facing challenges similar to those experienced by HIV-positive adolescents in high-income countries, the delayed rollout of antiretroviral therapy (ART) and the complexities of caregiving contexts, such as poverty, stigma, and inadequately supported foster care arrangements, may impair socio-emotional coping in South Africa. Therefore, programmes aimed at promoting adolescents' mental health must adopt an ecological approach that strengthens protective factors across individual, interpersonal, community, and policy levels.

2.5 Strategies for Improving the Psychosocial Interventions Used in Addressing Recovery Needs of Sexual Assault Survivors

2.5.1 Government's Role in Enhancing Psychosocial Interventions in GBVRCs

Governments should take a leading role in ensuring that survivors receive quality care. According to Wamue-Ngare *et al.* (2023), several key strategies must be implemented by governments to guarantee effective psychosocial interventions in GBVRCs. First, governments should develop a comprehensive policy framework that clearly articulates their commitment to addressing gender-based violence (GBV) and emphasizes the critical importance of psychosocial support within GBVRCs. This framework should incorporate detailed guidelines for the implementation of effective psychosocial interventions, ensuring standardized and quality care for survivors.

The government should actively promote collaboration and coordination among various stakeholders, including government agencies, non-governmental organizations (NGOs), civil society organizations, and community-based organizations. Such collaboration is essential to ensure a multidisciplinary approach to psychosocial support, integrating contributions from mental health professionals, social workers, legal experts, and survivors' support groups.

The Ministry of Health should develop standardized protocols and guidelines for psychosocial interventions within GBVRCs. These guidelines ought to encompass assessment procedures, individual and group counselling approaches, referral mechanisms, and follow-up protocols. Adherence to these guidelines is essential for maintaining consistency and ensuring quality in service delivery. The government should mobilize its agencies to collaborate and deliver services in a holistic manner. It should promote a comprehensive approach to psychosocial interventions by addressing the diverse needs of survivors. This approach must consider factors such as safety, medical care, legal support, economic empowerment, and community reintegration alongside psychosocial support.

Government agencies should actively engage communities in raising awareness about gender-based violence (GBV), its consequences, and the available psychosocial support services. This engagement can be facilitated through educational campaigns, community dialogues, and the involvement of local leaders, opinion-makers, and influencers. Furthermore, the government should establish robust monitoring and evaluation mechanisms to assess the effectiveness of psychosocial interventions in GBV recovery centres. Regular data collection, analysis, and feedback loops are essential to analyse areas for improvement and ensure accountability. Additionally, the government should promote research and innovation in the field of psychosocial interventions for GBV survivors, as this can lead to the development of evidence-based practices and the integration of novel approaches to enhance service effectiveness.

Finally, the government should ensure that psychosocial interventions within GBVRCs are survivor-centred, upholding the principles of autonomy, confidentiality, and respect for survivors' choices. It is imperative that survivors are actively involved in the design, implementation, and evaluation of these services to ensure that their needs and preferences

are adequately addressed. By adopting these strategies, governments can significantly enhance the quality and effectiveness of psychosocial interventions in GBVRCs, thereby providing more comprehensive support and facilitating the healing process for survivors of gender-based violence.

2.5.2 Counsellors' Role in Enhancing Psychosocial Interventions in GBVRCs

Being a survivor of sexual assault can be profoundly traumatic, both emotionally and physically; therefore, individualized, evidence-based psychotherapeutic interventions are essential for recovery (Cowan *et al.*, 2020). A significant challenge in this context is the necessity to equip counsellors with advanced skills to effectively perform these interventions, alongside competencies such as crisis stabilization, trauma-informed care, and a thorough theoretical understanding of trauma therapy. Effective counselling enables survivors to regain a sense of control, recognize their strength, and make autonomous decisions regarding their lives. The work of counsellors is guided by core ethical principles, including autonomy, beneficence, and integrity (Edwards & Goussios, 2021). Among the evidence-based exposure therapies that have demonstrated efficacy in treating PTSD and depressive symptoms resulting from sexual assault are Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), Eye Movement Desensitization and Reprocessing (EMDR), and psychodynamic psychotherapy (Lomax & Meyrick, 2022).

Importantly, therapy involves a critical initial phase of crisis stabilization, during which survivors are able to regain emotional and social grounding (Mansour, 2025). This process necessitates the creation of a supportive environment that respects survivors' autonomy, ensures informed consent, and fosters the development of trust. Furthermore, the counsellor facilitates access to appropriate medical, legal, and social services, including emergency care for physical injuries, HIV prevention, and legal assistance (Burns & Sinko, 2023).

Ideally, counsellors collaborate closely with local communities to reduce stigma and provide treatment that is culturally and contextually adapted to the populations they serve, taking into account societal and cultural factors that influence both risk and recovery (Bonar *et al.*, 2022).

Furthermore, counsellors must be able to recognize somatic symptom disorders, which are frequently observed among survivors of sexual assault and may manifest as internal distress, physical pain, fatigue, and other symptoms (APA, 2022). Collaboration with medical professionals is essential to ensure a comprehensive bio-psychosocial approach to treatment, thereby facilitating effective care (Li *et al.*, 2024). It is imperative for counsellors to demonstrate cultural competence and maintain self-awareness, avoiding the imposition of one-size-fits-all solutions. Additionally, to prevent burnout, vicarious trauma, and compassion fatigue among counsellors, ongoing supervision, peer support, and self-care practices are critical (Zimmer, 2025).

Third, screening and assessment are fundamental skills for trauma counsellors. Establishing trust and accurately analysing needs during initial intake assessments are crucial, while avoiding re-traumatization caused by excessive re-screening (Sinko *et al.*, 2024). It is essential that survivors comprehend and are prepared for the documentation processes required for legal proceedings; therefore, counsellors must ensure that survivors fully understand these procedures. Importantly, counsellors provide non-judgmental and empathetic emotional support, creating a safe space for survivors to process their experiences. The roles performed by counsellors in GBVRCs are integral to survivors' recovery, resilience, and overall wellbeing.

2.5.3 Community's Role in Enhancing Psychosocial Interventions in GBVRCs

All communities possess effective, naturally occurring psychosocial supports as well as sources of coping and resilience. Community-based support approaches emphasize interventions that build upon local capacities, thereby fostering resilience and strengthening the resources already existing within the systems, services, and individuals that constitute a community. According to Minckas *et al.* (2020), community members can play an active role in raising awareness about gender-based violence (GBV) and its impacts. They can organize workshops, seminars, and awareness campaigns to educate the public on GBV, its consequences, available support services, and the importance of psychosocial interventions. Such initiatives contribute to reducing stigma and encourage survivors to seek help.

Communities can collaborate with GBVRCs, non-governmental organizations (NGOs), local authorities, and other relevant stakeholders to enhance the provision of psychosocial support (Wamue-Ngare *et al.*, 2024). Through such collaboration, these actors can pool resources, share expertise, and establish effective referral systems, thereby ensuring that survivors receive comprehensive care. Furthermore, community members can contribute by volunteering their time and skills to support psychosocial interventions within GBVRCs. By undergoing appropriate training, they may serve as peer counsellors, crisis hotline operators, or support group facilitators (Qazi, 2024). The involvement and empathetic support of community members can significantly facilitate the healing process for survivors.

Communities play a critical role in advocating for policy reforms and increased funding for psychosocial interventions within GBVRCs (Temmerman *et al.*, 2019). By actively engaging with local and national policymakers, community members can influence the prioritization and allocation of resources to effectively address the psychosocial needs of survivors. Furthermore, communities can mobilize both financial and non-financial

resources to support GBVRCs. This includes organizing fundraising events, soliciting donations, and securing in-kind contributions such as clothing, toiletries, and transportation vouchers, thereby ensuring that survivors have access to essential resources throughout their recovery process (Ngare *et al.*, 2025).

Communities can establish support groups and peer networks for survivors of gender-based violence (GBV). These groups provide a safe space for survivors to share their experiences, receive validation, and build connections with others who have undergone similar trauma (Kim, 2021). Community members play a crucial role in facilitating these groups and ensuring their sustainability. Furthermore, communities can actively engage in prevention efforts aimed at addressing the root causes of GBV. As Magezi (2019) asserts, this can be achieved by promoting gender equality, challenging harmful stereotypes, and fostering respectful relationships. Through these measures, communities can contribute to reducing the incidence of GBV. Additionally, they can encourage early intervention by promoting the timely reporting of violence and facilitating access to support services.

Communities play a crucial role in the development and customization of psychosocial interventions by ensuring these are culturally sensitive and contextually appropriate. This can be achieved through the integration of local knowledge, traditions, and beliefs into the design and implementation of interventions, thereby enhancing their relevance and effectiveness for survivors within specific cultural settings (Morales & Burnett-Zeigler, 2025). By actively participating in and supporting such interventions, communities contribute significantly to fostering a society that is more responsive, compassionate, and supportive toward survivors of gender-based violence.

2.5.4 Religious Influences and Faith-Based Engagement

Religious belief systems occupy a dual role within survivor recovery ecosystems. Eytan and Ronel (2023) document how faith communities often provide emotional sustenance, hope, and a framework for meaning-making. Conversely, Prusak and Schab (2022) caution that certain theological interpretations may reinforce harmful narratives, such as framing sexual violence as divine punishment or equating forgiveness with reconciliation. These contradictory influences underscore the need for nuanced engagement with religious institutions rather than blanket endorsement or exclusion.

Crocker (2021) proposes trauma-informed pastoral training as a mechanism for aligning religious support with survivor-centred principles. In regions such as Uasin Gishu, where religious institutions hold substantial influence, partnerships between recovery centres and faith communities could enhance cultural legitimacy and accessibility of services. Nevertheless, empirical evidence examining the impact of faith-based collaboration on recovery outcomes remains limited. This contextual gap justifies investigating how culturally embedded support systems interact with formal psychosocial interventions.

2.5.5 Peer Support and Collective Healing

Peer support has been widely recognised as transformative in survivor recovery processes. Toooh (2022) argues that shared lived experience fosters forms of empathy and validation not always attainable within professional-client relationships. Perrin (2024) documents the global expansion of peer-led survivor networks that promote both individual healing and collective advocacy. Flick (2022) similarly notes that structured peer platforms can serve as spaces for skill-sharing and empowerment.

Despite strong theoretical support, peer interventions in many local contexts remain informal and under-resourced. In Uasin Gishu, structured peer facilitation models are not

consistently institutionalised within recovery centres. Shalaby and Agyapong (2020) demonstrate promising mental health outcomes from structured peer mentorship programmes; however, such models have rarely been evaluated within Kenyan GBV recovery systems. This empirical gap underscores the need to assess peer support as a measurable component of the social recovery domain within the present study.

2.5.6 Information Provision and Survivor Legal Literacy

Information asymmetry significantly affects survivor decision-making capacity. Anderson and Overby (2020) note that survivors often present at recovery centres with limited awareness of their legal rights, medical options, and psychological responses to trauma. Gregory et al. (2022) argue that survivor-centred information provision enhances autonomy and reduces vulnerability to coercion. Corboz et al. (2023) emphasise the importance of multimodal communication strategies to address literacy disparities.

While the literature advocates comprehensive educational approaches, limited research systematically measures how improved knowledge translates into behavioural outcomes such as service uptake, reporting decisions, or sustained engagement in counselling. This methodological limitation supports incorporating legal literacy and informational empowerment as operational constructs within the study's conceptual framework.

2.5.7 Physical Health and Trauma-Informed Body-Based Interventions

Physical well-being remains closely intertwined with psychological recovery. Chase (2021) contends that survivors' bodies are central to both trauma and healing, challenging the artificial separation between physical and psychological domains. Bond and Davis (2024) analyse chronic reproductive and pain-related conditions among survivors, which often remain inadequately addressed in overstretched health systems. Lanza (2020) highlights

promising outcomes from trauma-informed physical interventions such as yoga and dance-based therapies, which facilitate embodied healing.

However, most available evidence originates from high-income contexts, raising contextual questions regarding feasibility and cultural adaptation in Uasin Gishu. Additionally, few studies evaluate the integration of such body-based interventions within structured recovery centres. This contextual and methodological gap reinforces the need for holistic health pathways that connect survivors to sustained medical and psychosocial care (Porter et al., 2023).

2.5.8 Family and Community Dynamics

Family and community responses exert powerful influence on recovery trajectories. Niculaes (2024) documents how supportive families facilitate resilience and practical stability, whereas Kurian et al. (2024) caution that coercive or blaming family responses may compound trauma. McLay (2020) emphasises the importance of community-level interventions, including public awareness and survivor-led advocacy, in transforming harmful norms.

Despite recognition of family influence, limited scholarship provides structured guidance on when and how family engagement should occur within recovery programming. This gap highlights the necessity of flexible, survivor-centred engagement strategies that prioritise safety and autonomy while leveraging supportive relational networks.

2.5.9 Legal Environment and Justice System Engagement

Although Kenya's Sexual Offences Act (2020) strengthens statutory protections, implementation gaps persist (Gachoki & Mulu, 2023). Wangamati et al. (2021) document inconsistencies in survivor experiences within the justice system, while Agesa (2020)

underscores the value of court accompaniment and legal literacy support. Survivors in Uasin Gishu frequently report re-traumatisation through hostile questioning and procedural delays.

Yet, the literature seldom links justice system engagement with psychological recovery outcomes. Parti and Robinson (2021) note that respectful medical care influences survivors' willingness to report, suggesting interconnected institutional effects. This indicates the importance of examining legal support services not merely as procedural assistance but as contributors to perceived validation and empowerment.

2.5.10 Holistic and Long-Term Recovery Approaches

Qazi (2024) and Plöen (2023) advocate holistic recovery models addressing safety, health, psychosocial care, economic empowerment, peer support, and long-term follow-up. Bintliff et al. (2020) emphasise flexibility and survivor agency as core principles of sustainable recovery. Vivienne (2023) distinguishes between physical safety and psychological safety, underscoring the necessity of environments free from blame and dismissal. Hill et al. (2023) and Jones and Slater (2020) further argue for structured de-stigmatization processes within recovery programming.

Nevertheless, in Uasin Gishu, health system constraints and limited forensic capacity continue to undermine comprehensive care delivery (Embleton et al., 2023; Sepeng & Makhado, 2019). Long-term physical consequences such as chronic pain and reproductive health complications remain insufficiently addressed (Mutai, 2023). Establishing coordinated referral systems and sustained case management frameworks could bridge these gaps (Porter et al., 2023).

While existing literature recognises the multidimensional nature of recovery, few studies systematically integrate psychological, social, institutional, and cultural variables within a single analytical framework. The present study responds to this limitation by

operationalising recovery as a composite construct influenced by psychosocial interventions, institutional responsiveness, cultural context, and survivor engagement within Uasin Gishu County.

2.6 Research Gaps

The current research on psychosocial care for sexual assault survivors in GBVRCs emphasizes the integration of trauma-informed care and cognitive-behavioural therapy (CBT) alongside social support systems. However, in Uasin Gishu County, there is a limited understanding of how cultural beliefs intersect with social stigmas and influence survivors' engagement with psychosocial therapy methods. The impact of indigenous healing practices and community perceptions on survivors' experiences with formal psychosocial support remains underexplored. Koome (2019) reports that many Kenyan survivors endure persistent mental health challenges, including fear, shame, and guilt, without receiving adequate psychological support. Furthermore, Mariga (2021) highlights that some survivors perceive therapy as morally judgmental or excessively intrusive, often preferring cultural healing and religious approaches instead. This gap underscores the need for culturally sensitive research and interventions that acknowledge and integrate indigenous and community-based healing modalities within formal psychosocial care frameworks.

Survivors of sexual violence require trust and societal reintegration; however, they often face significant challenges in establishing trust, particularly when the perpetrator is a close relative or a member of their community (O'Callaghan *et al.*, 2021). These trust issues frequently lead to social withdrawal, which in turn hinders survivors' active participation in psychosocial intervention programmes. Furthermore, survivors who avoid seeking professional assistance due to stigma and fear of retaliation encounter difficulties in accessing the emotional and psychological resources essential for their healing process

(Makario, Mutui & Muhingi, 2023). This research aims to address the existing knowledge gap by examining the cultural norms that influence the effectiveness of psychosocial support services and by developing context-specific intervention strategies to enhance survivor engagement.

Psychosocial intervention analysis predominantly relies on Western psychological theories, including trauma-focused CBT and stress inoculation therapy. While existing psychosocial intervention methods have demonstrated efficacy, they inadequately address the specific interplay of sociocultural, economic, and legal challenges faced by survivors in Kenya. There is a paucity of research integrating African-centred psychological theories within the framework of psychosocial support. Awareness programmes implemented through GBVRCs at Nairobi Women's Hospital provide survivors with a safe environment to express their emotions; however, these programmes do not sufficiently accommodate individuals who avoid professional mental health services due to traditional social stigmas, as noted by Muiruri (2023). Furthermore, Makario, Mutui and Muhingi (2023) observe that survivors sustain their confidence through peer support groups, although concerns about potential attacks from perpetrators contribute to their hesitancy in fully engaging with such programmes.

Several survivors experience long-term emotional needs for healing despite lacking adequate access to ongoing psychological support (Lopez, 2024). Mental health services available to survivors of sexual assault in Kenya remain limited due to financial constraints and a shortage of qualified practitioners (Githae *et al.*, 2022). Furthermore, survivors in rural areas face additional barriers, as they often cannot access psychological care that is culturally appropriate. This research investigates how an integrated framework combining

Western and African psychological models can enhance practical intervention programmes for survivors within the Uasin Gishu communities.

Multi-faceted barriers, including budget constraints, insufficient personnel training, public stigma, and the diversification of services, impede the effectiveness of psychosocial intervention programmes at GBVRCs. Existing research generally does not examine how these challenges directly impact survivor recovery outcomes. In Kenya, legal aid organizations such as FIDA and the National Gender and Equality Commission (NGEC) provide survivors with shelter and legal support; however, the limited availability of safe havens, coupled with delays in offender prosecution, exposes many survivors to ongoing risk (Githae *et al.*, 2022). Furthermore, studies by O’Callaghan *et al.* (2021) indicate that survivors face particular difficulties in seeking help due to the profound erosion of trust that occurs when the perpetrator is a close family member.

Survivors face an elevated risk and diminished capacity to leave dangerous situations due to their economic dependence on abusive perpetrators, as noted by Hanlon *et al.* (2021). Recovery centres in Uasin Gishu allocate the majority of resources to medical and legal assistance, often at the expense of psychosocial support programmes. This allocation limits survivors' access to counselling and emotional rehabilitation services (Spano, 2023). This research aims to address practical needs by evaluating barriers to psychosocial interventions and examining survivors' perceptions, while proposing feasible intervention methods compatible with current resource capacities. Although policies for survivor care exist, their implementation is ineffective, particularly regarding the integration of psychosocial support, thus creating significant gaps between policy and practice.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This chapter outlines the methodology employed in this study. It encompasses the research design, the study area, the population investigated, sample size determination, and the sampling procedures utilized. Additionally, it details the data collection instruments and pilot study conducted to validate and assess the reliability of those instruments. The chapter further discusses key concepts related to measurement and data collection procedures that guided the researcher throughout the study. Finally, the chapter describes the methods of data analysis and the ethical considerations observed during the research process.

3.2 Research Paradigms

A research paradigm constitutes a set of beliefs, values, assumptions, and practices that guide researchers in understanding the world and approaching the inquiry process (Khatri, 2020). This study is grounded in social constructionism as its foundational research paradigm, as it elucidates how knowledge, meaning, and reality emerge through human interaction, language use, cultural upbringing, and lived experiences. Additionally, this study adopts pragmatism as its overarching research paradigm. Pragmatism emphasizes a practical and flexible approach to research, prioritizing the most effective methods, whether qualitative, quantitative, or a combination thereof, to address the research questions. In investigating recovery needs and psychosocial interventions for sexual assault survivors at gender-based violence recovery centres in Uasin Gishu, this approach facilitated the integration of diverse methodologies. Consequently, it enabled a comprehensive understanding that incorporated both subjective experiences and measurable outcomes. Pragmatism was particularly well-suited to explore how survivors and counsellors perceive

recovery and evaluate the effectiveness of interventions, as it encourages the synthesis of multiple data sources.

For data collection, the study used three instruments: a trauma counsellors' questionnaire, an interview guide for survivors, and document analysis. These instruments were developed in alignment with the research objectives and grounded in relevant literature. The study utilized a triangulation method of data collection to ensure comprehensive capture of all pertinent information. This approach enhanced the accuracy and reliability in the findings (Donkoh & Mensah (2023)). By adopting pragmatic paradigm and triangulation, the study sought to generate actionable insights for improving recovery services in Uasin Gishu County, effectively addressing both the lived experiences of survivors and the measurable impact of psychosocial interventions.

3.3 Research Design

This study adopted a convergent parallel mixed-methods survey design in order to ensure methodological alignment with the study objectives, which sought both to measure the effectiveness of psychosocial interventions and to explore survivors' lived experiences of those interventions within Uasin Gishu County. The integration of quantitative and qualitative approaches was therefore not merely methodological preference, but a strategic decision grounded in the multidimensional nature of the research variables. Whereas the quantitative strand enabled the measurement of structured variables such as perceived effectiveness, coping outcomes, emotional regulation, and satisfaction with psychosocial support, the qualitative strand facilitated in-depth exploration of how survivors interpret, internalise, and contextualise these interventions within their sociocultural realities.

The convergent parallel design was particularly appropriate because the objectives required simultaneous examination of measurable outcomes and experiential meanings. In this

design, qualitative and quantitative data are collected concurrently, analysed independently, and then merged for comparison and triangulation (Shapira & Frumos, 2022). This structure strengthened the study's internal validity by allowing convergence or divergence between statistical trends and narrative accounts to be systematically assessed. For example, while survey instruments could quantify reductions in shame or improvements in coping, qualitative interviews provided contextual explanations for why certain interventions were perceived as empowering or ineffective. Thus, the design directly supported the objective of examining both outcome patterns and underlying mechanisms of psychosocial intervention impact.

The qualitative component employed an explorative-descriptive case study approach, justified by the objective of understanding survivors' subjective experiences within GBV Recovery Centres in Uasin Gishu County. Case study methodology enables detailed, context-bound analysis of real-life settings and is particularly suitable when investigating complex psychosocial phenomena embedded within institutional and cultural environments (Maree & Che, 2020). Given that psychosocial recovery is influenced by stigma, relational dynamics, and community context, an explorative-descriptive design allowed the study to capture nuanced survivor narratives that structured instruments alone could not reveal. This approach was therefore essential for fulfilling the objective of exploring how psychosocial interventions are experienced and interpreted in practice.

The quantitative strand utilised a descriptive survey design to address objectives concerned with analysing patterns, prevalence, and relationships among key variables such as intervention type, perceived effectiveness, and psychosocial outcomes. Descriptive survey research is appropriate for systematically portraying conditions as they exist within a defined population (Mohajan, 2020). In this study, it enabled the collection of self-reported data

regarding beliefs, attitudes, coping behaviours, and perceived changes following intervention. The structured format enhanced reliability, facilitated statistical comparison, and allowed aggregation of findings across respondents, thereby addressing objectives requiring measurable evidence of intervention impact.

The integration of these designs ensured coherence between the research objectives, the conceptual framework, and the methodological approach. The mixed-methods strategy allowed the study to move beyond isolated symptom measurement toward a comprehensive understanding of psychosocial intervention effectiveness within its real-world institutional and sociocultural context.

3.4 Study Area

The study was conducted in Uasin Gishu County, one of the 47 counties in Kenya. Located in the Western region of the country, Uasin Gishu County lies at the latitude of 0.514347° , just slightly above the Equator (0°). This equatorial proximity influences the region's climate, resulting in moderate to warm temperatures throughout the year and relatively consistent day lengths. The county's longitude is approximately 35.269712° east, situating it in the eastern part of Kenya within East Africa (Appendix C). Uasin Gishu is bordered by Nandi County to the south, Kakamega County to the west, Trans-Nzoia County to the north and Elgeyo Marakwet County to the east. It is recognized as a high-potential agricultural area, particularly for the production of food and horticultural crops, and benefits from well-developed social amenities, including hospitals, hotels, and industries. The county headquarters, Eldoret town, is relatively cosmopolitan, reflecting cultural influences from nearly all regions of Kenya. Additionally, Eldoret serves as a major commercial hub in western Kenya, with the majority of residents engaged in formal employment or business activities (KNBS & Society for International Development, 2013).

This research was conducted in Uasin Gishu County due to the high prevalence of rape and defilement, as indicated by the National Crime Research Centre report (2022) indicate that rape and defilement is rampant in the county. Additionally, the county hosts a major Gender-Based Violence Recovery Centre (GBVRC) at Moi Teaching and Referral Hospital, as well as several smaller centres distributed across its six sub-counties. Furthermore, the Government of Kenya, through the National Guidelines on Management of Sexual Violence in Kenya (2014), has established a standardized framework for psychosocial support services, which all GBVRCs in the country are required to implement. Consequently, the psychosocial support services evaluated in this study are expected to be comparable to those offered in GBVRCs in other counties across Kenya.

3.5 Population of the Study

According to Creswell (2014), the target population refers to individuals who share certain characteristics that are of interest to the researcher. In this study, the target population comprised all adult female survivors of sexual assault within the county. Given the impracticality of reaching all individuals within this population, the accessible population consisted of adult female survivors of sexual assault who are enrolled in any of the seven GBVRCs in Uasin Gishu County. Additionally, the study included 43 trauma counsellors affiliated with the GBVRCs. Table 3.1 provides a summary of the accessible population.

Table 3.1: Distribution of Accessible Population in Uasin Gishu County

Name	Assault Cases/Clients	Counsellors
A	15	7
B	8	4
C	13	6
D	4	2
E	13	6
F	5	2
G	11	4
H	3	1
I	2	1
J	4	2
K	3	1
L	4	2
M	3	1
N	3	1
O	1	1
P	3	1
Q	2	1
Total (N)	97	43

Source: MoH Uasin Gishu (2024)

Table 3.1 provides an overview of the number of assault cases and counsellors available at various health facilities in Uasin Gishu County. A Total (N) of 97 assault cases were reported across the listed facilities, supported by 43 counsellors. The A recorded the highest number of assault cases (15) and had seven counsellors available. Similarly, C and E each reported 13 assault cases and had six counsellors. Smaller facilities, such as P and Q, reported fewer assault cases, ranging from one to four, with one to two counsellors available. This distribution illustrates the variability in both the incidence of assault cases and the availability of counselling resources across different health centers within the county.

3.5.1 Inclusion Criteria

Participants were included in the study if they met the following conditions:

First, survivors had to be aged 18 years and above in order to provide legally valid informed consent.

Second, survivors had to be formally registered as clients receiving psychosocial services at one of the GBVRCs in Uasin Gishu County during the data collection period. This ensured direct exposure to the psychosocial interventions under investigation.

Third, survivors had to be assessed by attending counsellors as emotionally stable and capable of participating in interviews or completing questionnaires without risk of immediate psychological harm.

For counsellors, inclusion required formal affiliation with a GBVRC in Uasin Gishu County and active involvement in providing trauma-related psychosocial support services.

3.5.2 Exclusion Criteria

Exclusion criteria applied to individuals who met the inclusion requirements but were unable to participate for specific methodological or ethical reasons.

First, survivors who were eligible in terms of age and enrolment but were experiencing acute psychological crisis, severe emotional distress, or ongoing psychiatric instability at the time of data collection were excluded. This decision was based on ethical considerations to prevent retraumatisation and ensure participant safety.

Second, survivors who met the eligibility criteria but declined to provide informed consent were excluded, in accordance with voluntary participation principles.

Third, survivors who were enrolled in GBVRCs but were unavailable during the data collection period due to relocation, medical admission, court attendance, or other logistical constraints were excluded from participation.

For counsellors, those who were eligible by role but were on extended leave, secondment, or administrative reassignment during the study period were excluded due to lack of availability for data collection.

3.6 Sampling Techniques and Sample Size

Two categories of research participants were sampled: trauma counsellors and sexual assault survivors. Lakens (2022) contends that the primary consideration in determining sample size is ensuring that it remains manageable. This principle guided the determination of the sample size for the present study, as discussed in the following sections.

3.6.1 Sample for Trauma Counsellors

Purposive sampling was employed to select trauma counsellors in Uasin Gishu County. Purposive sampling is a non-probability sampling technique whereby participants are deliberately chosen based on specific characteristics or expertise that align with the study's objectives (Gentles *et al.*, 2021). This method enabled the researcher to focus on individuals possessing relevant experience and knowledge directly pertinent to the research question. The study specifically targeted counsellors with direct experience working with survivors of gender-based violence (GBV). The expertise of these counsellors is essential for providing detailed insights into the psychological and emotional needs of survivors, the challenges encountered during counselling, and the effectiveness of various interventions. As noted by Nyimbili (2024), purposive sampling is particularly valuable in qualitative research aimed at understanding complex phenomena, as it facilitates in-depth exploration of individuals with rich and relevant experience.

Furthermore, the population of counsellors at the GBVRC is relatively small (43 individuals), rendering purposive sampling a practical and appropriate approach. Given the manageable sample size, it is feasible to select counsellors who meet specific criteria,

thereby ensuring that the sample is highly relevant to the research objectives (Lakens, 2022). In this study, priority was given to counsellors possessing specialized training in trauma counselling or extensive experience working with survivors of gender-based violence. This strategy not only facilitates the inclusion of a diverse range of perspectives but also focuses on individuals capable of providing the most insightful and applicable data for understanding the impact of psychosocial interventions on recovery.

Another significant advantage of purposive sampling is its efficiency in the utilization of resources. Given that the objective is to obtain detailed and in-depth data from individuals most knowledgeable about the subject, this approach obviates the need to survey every counsellor, a process that would be both time-consuming and resource-intensive. By deliberately selecting key informants who are most likely to provide valuable insights, the researcher can collect focused data that is both rich and directly relevant to the study's objectives (Pahwa *et al.*, 2023).

3.6.2 Sample for Assault Survivors

Ninety-seven assault survivors were purposively selected for in-depth interviews. Each of the seventeen recovery centres contributed one longest-serving client as a respondent, except for those centres with larger client populations, which provided three respondents. The survivors who had been undergoing therapy for an extended period were able to offer insider knowledge regarding how the psychosocial environment of their care facility influenced their recovery. Their perspectives were invaluable, as they possessed in-depth lived experiences and a nuanced understanding of the realities within the care environment. Furthermore, their insights were essential in ensuring that the study yielded more credible and robust findings.

Interviews and the resulting narratives enabled survivors to retell or restructure their stories in meaningful ways, facilitating the reconstruction of their identities. Additionally, these interviews allowed the researcher to analyse and explore the influences that have constrained the clients' identities.

3.7 Data Collection Instruments

Data collection instruments are tools used to gather primary data that directly address the objectives of a study (Sharma, 2022). In the present study, three complementary instruments were employed: the Counsellor Psychosocial Interventions Scale (Appendix III), a semi-structured interview guide for sexual assault survivors (Appendix IV), and a document analysis/observation schedule (Appendix V). These instruments were developed in alignment with the conceptual framework, which examines psychological and social psychosocial interventions as independent variables and their influence on recovery needs of sexual assault survivors as the dependent variable. The use of multiple instruments enabled methodological triangulation, thereby enhancing the credibility, validity, and comprehensiveness of the findings (Donkoh & Mensah, 2023). As observed by Walliman (2011), triangulation strengthens research rigour by reducing reliance on a single source of data and enabling cross-verification of evidence within complex social phenomena.

3.7.1 Counsellor Psychosocial Interventions Scale

The Counsellor Psychosocial Interventions Scale was designed to generate quantitative data regarding the extent to which psychosocial interventions address recovery needs of sexual assault survivors within GBVRCs. The instrument operationalises the key constructs of the study by measuring counsellors' perceptions of survivor recovery needs, the implementation of psychological-based interventions, the implementation of social-based interventions,

challenges encountered in service delivery, and strategies for improving psychosocial support systems.

The first section of the scale collects demographic information, including gender, age, years of counselling experience, and highest professional qualification. These variables provide contextual background that may influence professional practice and allow for descriptive statistical analysis. The second section focuses on recovery needs of sexual assault survivors. It begins with an open-ended question inviting counsellors to conceptualise recovery needs within their professional context, thereby avoiding prescriptive definitions and ensuring contextual specificity. This is followed by Likert-scale items measuring the extent to which counsellors recognise needs related to safety, medical attention, empowerment, legal support, psychoeducation, social support, reintegration, and long-term psychological care.

The third section measures the influence of psychosocial interventions and is divided into psychological-based and social-based intervention domains. The psychological domain assesses therapeutic practices such as emotional regulation support, cognitive restructuring, behavioural activation, coping skills development, resilience building, and trauma processing. The social domain evaluates relational and environmental interventions, including mentorship, legal advocacy, referral systems, reintegration support, and community engagement. Both domains utilise a five-point Likert-type scale to quantify perceived implementation and effectiveness. The fourth section explores structural and professional challenges, including limited resources, stigma, inadequate training, vicarious trauma, cultural complexity, and coordination gaps. The final section provides space for open-ended responses concerning strategies to strengthen psychosocial service delivery.

Collectively, this instrument enables systematic measurement of the relationship between psychosocial interventions and survivor recovery.

3.7.2 Interview Guide for Sexual Assault Survivors

The semi-structured interview guide was designed to obtain qualitative data reflecting survivors' lived experiences of psychosocial support within GBVRCs. While the counsellor scale captures professional perspectives on intervention delivery, the interview guide foregrounds survivor voices to examine whether and how psychosocial interventions address their recovery needs. This ensures alignment with the dependent construct of survivor recovery as experienced rather than merely reported by service providers.

The interview guide is structured around three interrelated thematic domains: recovery needs, social support interventions, and psychological interventions. Survivors are first invited to describe their personal recovery needs following the assault, including safety, emotional support, medical care, legal assistance, empowerment, and long-term stability. Subsequent questions explore experiences of social-based interventions, such as advocacy, referral systems, community support, reintegration efforts, and perceptions of safety within their social environment. The final domain examines psychological interventions, including therapeutic engagement, emotional processing, cultural sensitivity, informed consent procedures, perceived adequacy of counselling sessions, and overall satisfaction with care.

The semi-structured format allowed flexibility to probe emerging issues while maintaining consistency across interviews. In line with qualitative research principles, the guide was refined iteratively as themes emerged during data collection, with revisions ceasing upon attainment of data saturation (Diab & Al-Azzeh, 2024). This instrument provides depth, contextual nuance, and experiential validation of the psychosocial intervention processes examined quantitatively.

3.7.3 Document Analysis / Observation Schedule

Document analysis was employed to examine institutional structures, procedural compliance, and infrastructural readiness within GBVRCs. According to Davie and Wyatt (2021), document analysis enables the preservation and systematic examination of organisational records, thereby complementing self-reported data and enhancing validity. In this study, the observation schedule was used to verify the existence and operational status of key materials and protocols necessary for effective psychosocial intervention delivery.

The checklist assessed the availability of private counselling rooms, informational and educational materials, counselling standard operating procedures (SOPs), trauma assessment forms, Post-Rape Care (PRC) registers, referral directories, secure record storage systems, and documented institutional policies. Each item was evaluated for both availability and functional use, thereby enabling objective assessment of whether reported psychosocial practices were supported by adequate institutional infrastructure. The document review was conducted in accordance with ethical standards to ensure confidentiality and restricted access to sensitive records.

The interpretation of documentary findings was contextualised within Kenya's legal and health policy framework, particularly the Sexual Offences Act (2006) and the Kenya Health Policy 2014–2030, which emphasise survivor-centred care, rights protection, and strengthened health information systems. Aligning documentary evidence with these frameworks enabled assessment of policy–practice consistency within GBVRC operations.

3.8 Piloting

The researcher pre-tested the research instruments prior to the actual data collection to analyse whether the selected items effectively measured the intended constructs (Sajko, 2024). This process enabled the researcher to anticipate and rectify any potential errors in

the instruments. Pre-testing also facilitated the evaluation of the context in which the data was collected and the relevance of the topic areas addressed. Furthermore, it assisted the researcher in assessing whether the concepts and wording were clear, ensuring that the questions could be interpreted consistently by all respondents (Ivenson, 2023).

In the current study, the researcher conducted a pilot trial of the instruments by administering them to a sample of respondents comprising survivors and their counsellors from four GBVRC in Nandi County. The pilot study facilitated the identification of the strengths and limitations of the questionnaire items, interview schedule, and document checklist. Based on the results of the pilot, the researcher made necessary adjustments related to timing, translation, and technical aspects to enhance the final data collection tools. The pilot study was conducted from September to October 2024 to assess the validity and reliability of the research instruments.

3.8.1 Validity of the Research Instruments

Validity refers to the extent to which the results of data analysis accurately represent the phenomenon under investigation (Coleman, 2022). To ensure validity, the researcher meticulously included relevant items in the questionnaire, document checklist, and interview schedule. The selection of variables was guided by a comprehensive review of both national and international theoretical and empirical literature pertaining to the psychosocial management of sexual assault.

Instruments were appraised by four psychology experts in the Department of Psychology, Kisii University, using the Content Validity Index (CVI). This validation process involved soliciting perspectives of four experts to assess the extent to which the instrument measures what it purports to measure. The experts were selected based on their extensive expertise in psychosocial care for survivors of abuse. A variable was considered to possess content

validity if there was general consensus among the experts that it reflected either standard practices in rape trauma care or relevant psychosocial theories and literature (Polit & Beck, 2004). The CVI procedure required each psychologist to rate each item on a three-point scale (1 = very good, 2 = average, and 3 = very poor). These ratings were analysed by computing both the item-level CVI (I-CVI) and the scale-level CVI (S-CVI). According to Polit and Beck (2004), an S-CVI of 0.50 or higher is required for items to be considered valid.

The researcher calculated the content validity ratio (CVR) for each question in the questionnaires using the following formula:

$$\text{Content Validity Ratio} = (ne - N/2) / (N/2)$$

Where:

ne = number of subject matter experts (SMEs) panellists indicating “essential”

N = Total (N) number of SME panellists

The formula produces values ranging from 1 to -1. Values greater than zero indicate that at least half of the SMEs believe the question is essential. The content validity increases as the value approaches +1. The CVI is the average CVR score for all questions on the test. To measure the content validity of the entire test, the content validity index (CVI) was calculated as shown in Table 3.2.

Table 3.2: Results of CVI

Variables	CVI	N of Items	Comments
Recovery Needs	0.9	11	Valid
Availability of psychosocial interventions	0.8	14	Valid
Psychological based interventions	0.8	10	Valid
Social based interventions	0.9	10	Valid
Challenges of psychosocial interventions	0.9	13	Valid

The data presented in Table 3.2 indicate that all variables achieved a Content Validity Index (CVI) score of either 0.8 or 0.9, thereby demonstrating their validity based on the evaluated items. This finding suggests that the content and relevance of the items for each variable were deemed appropriate and suitable for the purposes of this study. In this study, several procedures were undertaken to ensure both quantitative validity and qualitative credibility, with particular attention to contextual appropriateness and methodological rigour.

With regard to the quantitative instrument, face validity was established through expert review by two academic supervisors from Kisii University, who evaluated the instrument for clarity, relevance, representativeness, and appropriateness for the study population. Their assessment ensured that the items adequately reflected the constructs of psychological interventions, social interventions, and survivor recovery needs as conceptualised in the study framework. Construct validity was further examined through factor analysis of the Trauma Counsellor Questionnaire to analyse whether the items clustered into theoretically coherent dimensions consistent with the conceptual framework. The dimensions assessed were derived from established literature on psychosocial interventions and trauma recovery, thereby grounding the instrument in recognised theoretical perspectives. Although the adopted questionnaire has documented psychometric properties, the researcher acknowledged that its initial validation occurred within a Eurocentric context. Consequently, revalidation was necessary to ensure cultural and contextual suitability within Kenyan GBVRC settings.

For the qualitative component, credibility was established through a systematic pilot study conducted with two sexual assault survivors in Nandi County. The purpose of the pilot was not statistical testing but to evaluate clarity, cultural sensitivity, emotional appropriateness, and the capacity of the interview guide to elicit rich and meaningful data. During the pilot

interviews, particular attention was given to participants' interpretations of key psychosocial concepts, the emotional impact of the questions, and the logical sequencing of themes. Feedback from the pilot participants functioned as a form of respondent validation at the instrument-development stage, enabling refinement before full-scale data collection.

In addition to piloting, several established qualitative trustworthiness strategies were integrated. First, the interview guide was aligned directly with the study objectives and conceptual framework to ensure content relevance and theoretical coherence. Second, questions were framed in open-ended, non-leading language to minimise researcher bias and allow participants to articulate experiences in their own terms. Third, iterative refinement of the guide occurred as data collection progressed, with minor adjustments made where emerging themes suggested the need for clarification, consistent with qualitative methodological principles (Diab & Al-Azzeh, 2024). Revisions ceased once thematic saturation was reached, indicating that the instrument was effectively capturing recurring patterns.

To enhance credibility further, interviews were conducted using trauma-informed approaches that encouraged open expression while reducing social desirability bias. Probing questions were used judiciously to deepen responses without imposing assumptions. Detailed field notes were maintained to capture contextual observations and non-verbal cues, thereby supporting interpretive depth during analysis.

The pilot study resulted in rewording ambiguous questions, restructuring the flow of the interview to improve coherence, and incorporating additional questions to address previously overlooked aspects of psychosocial care. These refinements strengthened the instrument's capacity to generate comprehensive, contextually grounded data.

Collectively, these procedures ensured methodological validity for the quantitative instrument and credibility, trustworthiness, and contextual sensitivity for the qualitative tools, thereby enhancing the overall rigour of the study.

3.8.2 Reliability

The reliability of the questionnaire was assessed using Cronbach’s alpha to analyse internal consistency. According to Izah, Sylva and Hait (2023), internal consistency is evaluated by correlating scores obtained from a single test administered to a sample of respondents. In this study, scores from each item were correlated with scores from other items within the questionnaire. Subsequently, Cronbach’s alpha coefficient was computed to assess the degree of inter-item correlation. Higher alpha values indicate greater internal consistency. Plano and Ivancova (2023) suggest that a scale demonstrates good internal consistency if its Cronbach’s alpha coefficient exceeds 0.7, a threshold adopted in this study. The reliability test results, including the Cronbach’s alpha coefficients, are presented in Table 3.3.

Table 3.3: Reliability Statistics

Variables	Number of items	Cronbach's Alpha	Remarks
Recovery Needs	11	.844	Reliable
Availability of psychosocial interventions	14	.874	Reliable
Psychological based interventions	10	.817	Reliable
Social based interventions	10	.806	Reliable
Challenges of psychosocial interventions	13	.815	Reliable

Table 3.2 indicates that variables, except the last one, had Cronbach’s Alpha values above 0.8. Specifically, Recovery Needs exhibited a Cronbach’s Alpha value of 0.844, Availability of Psychosocial Interventions had 0.874, Psychological-Based Interventions 0.817, Social-Based Interventions 0.806, and Challenges of Psychosocial Interventions had of 0.815. These results demonstrate that the research questionnaires possess high internal consistency

and are therefore reliable for data collection during the main research phase. It is generally accepted that a Cronbach's Alpha coefficient above 0.7 indicates satisfactory reliability for research instruments.

For the reliability analysis, feedback from the pilot phase indicated that no major modifications were necessary regarding the reliability of the questionnaire, as the Cronbach's Alpha values were all within acceptable ranges. However, minor adjustments were made to the wording and flow of the questions to enhance clarity and facilitate more accurate responses during the main data collection phase. These revisions did not significantly affect the internal consistency but ensured that the survey would be more readily understood by the target respondents.

3.9 Data Collection Procedures

Following approval of the research proposal by the School of Arts and Social Sciences at Kisii University, the researcher sought and obtained permission from the National Commission for Science, Technology and Innovation (NACOSTI) to conduct the study in the Gender-Based Violence Recovery Centres (GBVRC) in Uasin Gishu County. Furthermore, authorization was secured from the Ministry of Health, Uasin Gishu County, as well as permission from the Ethics Committee at Kisii University.

Subsequently, appointments were scheduled with the management of the GBVRCs. Upon obtaining permission from the relevant authorities, the researcher personally administered the questionnaires to the respondents at the respective GBVRCs. Prior to data collection, informed consent was obtained from all participants, ensuring they fully understood the purpose of the study, the procedures involved, and their rights to voluntary participation and confidentiality. Participants were also informed that they could withdraw from the study at any time without any negative consequences.

Upon obtaining informed consent, the researcher introduced himself to the participants, explained the objectives of the study, and assured them of the confidentiality of their responses. Participants were encouraged to respond to the questions honestly and were requested to complete the questionnaires independently during the researcher's visits to the centres. Additionally, during these visits, the researcher conducted in-depth interviews with the longest-serving client at each GBVRC and performed document analysis to further enrich the data collected.

3.10 Data Analysis

A side-by-side comparison of the two forms of data was conducted during the analysis. This comparison involved the researcher first reporting the qualitative results, followed by a discussion of the quantitative findings derived from the questionnaire (Tracy, 2024). The findings were presented in the form of tables.

3.10.1 Qualitative Data

In-depth interviews conducted with assault survivors generated a substantial body of qualitative data. To analyse this data, a thematic analysis approach was employed, guided by Colaizzi's descriptive phenomenological method, as outlined by Morrow *et al.* (2015). The analytical process involved several key steps. Initially, all interview transcripts were carefully read multiple times to attain a comprehensive understanding of their overall meanings. Subsequently, statements pertinent to the study objectives were identified and extracted. The underlying meanings of these statements were then clarified and interpreted. Following this, the data were organized into thematic clusters, which were rigorously verified for accuracy. Finally, these themes were synthesized into an integrative and comprehensive description of the phenomenon under investigation.

The researcher subsequently distilled the exhaustive descriptions into concise, highly descriptive statements that encapsulated the essential characteristics necessary for understanding the core aspects of psychosocial care and its impact on the recovery of sexual assault survivors at the Gender-Based Violence Recovery Centre (GBVRC). To ensure credibility, the researcher returned the final thematic statements to the participants for validation, thereby confirming that their experiences were accurately represented. Throughout this process, the transcriptions and printouts of the qualitative data were read repeatedly, and synopses were written for each participant's contribution. To maintain confidentiality, each participant was assigned a unique code to protect their identity.

3.10.2 Quantitative Analysis

Quantitative research involves measuring variables in a manner that yields meaningful numerical results (Mohajan, 2020). Consequently, mathematical and statistical methods were employed in this study. Both descriptive and inferential statistics were utilized to analyse the data, particularly because Objective 3 lends itself to statistical manipulation. This is further illustrated in Table 3.4.

Table 3.4: Summary of Data Variables and Approaches

Research Questions	Independent variable	Dependent variable	Statistics
1. What are recovery needs of sexual assault survivors in Uasin Gishu County?		Recovery Needs	Mean percentages
2. What are perspectives of counsellors and clients on influence of therapeutic interventions in addressing recovery needs of sexual assault survivors in Uasin Gishu County?	Interventions	Recovery Needs	Mean, SD Pearson Correlation Coefficient Regression
3. What are the opinions of counsellors and clients on the challenges of therapeutic interventions used in addressing recovery needs of sexual assault survivors in Uasin Gishu County?	Challenges of interventions	Recovery Needs	Frequencies percentages Pearson Correlation Coefficient Regression
4. What are the viewpoints of counsellors and clients on strategies for improving the therapeutic interventions used in addressing recovery needs of sexual assault survivors in Uasin Gishu County?	Strategies for improving interventions	Recovery Needs	Frequencies percentages

3.11 Ethical Considerations

This study adhered to established national and institutional ethical requirements governing research involving human participants in Kenya. Ethical approval was obtained from the Ethics Committee of the University of East Africa Baraton, and research clearance was granted by the National Commission for Science, Technology and Innovation (NACOSTI). Authorisation to access Gender-Based Violence Recovery Centres (GBVRCs) was further secured from the Ministry of Health, Uasin Gishu County. These approvals ensured that the study complied with statutory, institutional, and professional standards regulating research practice.

Beyond procedural compliance, the study engaged with context-specific ethical risks inherent in conducting research with sexual assault survivors within clinical settings.

Survivors accessing GBVRC services often occupy socially marginalised and stigmatised positions, and participation in research may intensify vulnerabilities associated with trauma exposure, community stigma, and perceived dependency on service providers. A potential power differential also existed between participants and the research team, particularly because some research assistants were on-site counsellors. To mitigate role conflict and perceived coercion, it was clearly communicated that participation or refusal would have no influence on access to services, therapeutic relationships, or future care. Interviews were conducted in private settings separate from routine counselling sessions to reinforce voluntariness and minimise undue influence.

Informed consent was treated as an ongoing process rather than a single procedural event. Participants were provided with clear verbal and written explanations of the study's purpose, procedures, potential risks, and anticipated contributions in language appropriate to their level of understanding. They were informed of their right to decline participation, refuse to answer specific questions, or withdraw at any stage without penalty or loss of benefits. Adequate time was provided for questions before written consent was obtained. For survivors experiencing emotional vulnerability, counsellors first assessed readiness to participate to ensure that consent was both informed and psychologically appropriate.

Participant safety was prioritised given the sensitive nature of recounting sexual assault experiences. There was a foreseeable risk of psychological distress, re-traumatisation, or emotional discomfort during interviews. To address this, interviews were conducted using trauma-informed approaches, characterised by empathetic engagement, non-judgemental questioning, and flexible pacing. Participants were reminded that they could pause or terminate the interview at any time. Trained counsellors were available on-site to provide

immediate psychological support should distress arise. In addition, referral pathways were established for participants requiring follow-up support beyond the research interaction.

Confidentiality was rigorously safeguarded at multiple levels. Identifiable information was excluded from research instruments wherever possible, and unique codes were assigned to participants to anonymise data. Interview recordings, transcripts, and completed questionnaires were stored securely in password-protected digital files and locked cabinets accessible only to the research team. Data were reported in aggregate form, and any illustrative quotations were carefully screened to remove potentially analysing details. Given the relatively small number of GBVRCs within Uasin Gishu County, particular caution was exercised to avoid indirect identification of facilities or individuals through contextual descriptions.

Although participants did not receive financial compensation, refreshments were provided during interviews as a gesture of appreciation. Care was taken to ensure that such provisions did not constitute undue inducement. While no immediate material benefit accrued to participants, the study sought to contribute to improved psychosocial intervention strategies and enhanced recovery services for survivors of sexual assault, thereby offering broader social value.

In accordance with recognised research ethics standards, the study integrated principles of respect for persons, beneficence, and justice throughout the research process, including design, data collection, analysis, and dissemination (Newman & Black, 2021). By addressing both procedural and context-specific ethical considerations, the research sought to ensure that it was legally compliant, culturally sensitive, and ethically responsive to the lived realities of sexual assault survivors within GBVRC settings.

CHAPTER FOUR

DATA ANALYSIS, INTERPRETATION AND DISCUSSION

4.1 Introduction

This chapter presents an analysis of the study findings in line with the research objectives. The first section of the chapter describes the questionnaire response rate and the demographic information of the research participants. The rest of the sections presents, analyses, and interpretation of the empirical findings of the study. The chapter also discusses the findings in relation to the reviewed literature and the theoretical framework of the study.

4.2 Response Rate

The study evaluated the response rate of the respondents. The results were as presented in Table 4.1.

Table 4.1: Response Rate

Category	Responses	Frequency	Percentages
Trauma Counsellors	Responded	35	81.4
	Not responded	8	18.6
	Administered questionnaires	43	100
Sexual assault survivors	Interviewed	30	30.9
	Not interviewed	67	69.1
	Sampled	97	100

Source: Field data (2024)

N for Trauma counsellors =35

N for Sexual assault survivors =30

Table 4.1 presents data on the responses from two categories of respondents: trauma counsellors and sexual assault survivors, detailing their participation rates in the study. Among the trauma counsellors, a Total (N) of 43 questionnaires were distributed. Of these, 35 counsellors responded, representing 81.4% of the Total (N) administered questionnaires. Conversely, 8 trauma counsellors did not respond, accounting for 18.6% of the sample. This high response rate among trauma counsellors indicates a strong level of engagement with the questionnaire.

In the case of the sexual assault survivors, 97 individuals were sampled. Out of these, 30 survivors participated in the interviews, representing 30.9% of the Total (N) sample. Conversely, 67 survivors did not participate in the interviews, making up 69.1% of the sampled population. This indicates that less than half of the survivors in the sample were interviewed. The lower response rate was arrived due to saturation point which was arrived at client number 30. Nevertheless, since the participation rate exceeded 50%, it satisfied Mugenda's (2010) criterion for suitability in statistical analysis.

4.3 Demographic Information

This study examined the demographic characteristics of the respondents, including gender, age, and the highest level of professional education attained.

4.3.1 Gender of the Respondents

The study sought to analyse the gender of the respondents. The results were as presented in Table 4.2.

Table 4.2: Gender of the Respondents

Gender	Frequency	Percent
Male	9	25.7
Female	26	74.3
Total (N)	35	100.0

Source: Field data (2024)

The findings presented in Table 4.2 indicate that the majority of respondents, 26(74.3%), were female, while 9(25.7%) were male. This suggests that female counsellors constitute the predominant gender among those addressing gender-based violence in Uasin Gishu County.

4.3.2 Age Bracket of the Respondents

The study evaluated the age distribution of the respondents and Table 4.3 shows the results.

Table 4.3: Age Bracket of the Respondents

Age Bracket	Frequency	Percent
20 -29 years	6	17.1
30 -39 years	13	37.1
40 -49 years	11	31.4
Over 50 years	5	14.3
Total (N)	35	100.0

Source: Field data (2024)

Table 4.3 indicates that 6(17.1%) of the respondents were aged 20-29 years, 13(37.1%) were aged 30-39 years, 11(31.4%) were aged 40-49 years, and 5(14.3%) were 50 years and above.

4.3.3 Level of Education

The study evaluated the levels of education of the study respondents. The findings were as shown in Table 4.4.

Table 4.4: Level of Education

Level of Professional Education	Frequency	Percent
Diploma	16	45.7
Bachelor's Degree	15	42.9
Master's Degree	3	8.6
PhD	1	2.9
Total (N)	35	100.0

Source: Field data (2024)

Table 4.4 indicates that majority, 16(45.7%), of the respondents had attained diploma level education, and 15(42.9%) had attained bachelor's degree level of education. Further, 3(8.6%) of the respondents had attained master's level education while only 1(2.9%) had attained PhD level.

4.3.4 Work Experience of Counsellors

This study assessed the counselling experience of the respondents. The findings were as summarized in Table 4.5.

Table 4.5: Work Experience of Counsellors

Counselling Experience	Frequency	Percent
Under 5 years	12	34.3
5-9 years	9	25.7
10-19 years	14	40.0
Total (N)	35	100.0

Source: Field data (2024)

Table 4.5 indicates that majority, 14(40.0%), of the respondents had work experience of between 10 and 19 years as counsellors. Further, 12(34.3%) of the counsellors had worked under 5 years while 9(25.7%) had worked for 9-10 years. These statistics revealed that majority of the counsellors had relatively lengthy work experience.

4.4 Recovery Needs of Sexual Assault Survivors

The first objective of this study was to explore recovery needs of sexual assault survivors in Uasin Gishu County. To achieve this, the researcher initially examined survivors' lived experiences and their perceived recovery needs. Subsequently, counsellors' quantitative assessments of survivors' recovery needs were analysed. Finally, the alignment between counsellors' perspectives and survivor-reported themes were evaluated. Additionally, the availability and utilization status of key resources within the Gender-Based Violence and Recovery Centres were assessed and integrated into the findings. A comparison of counsellors' assessments with themes derived from survivors' qualitative responses revealed areas of agreement, disagreement, and disconnect, along with potential explanations for these discrepancies. Observations and document analysis were employed

to corroborate or challenge some of the findings. Table 4.6 presents the counsellors' findings regarding recovery needs of sexual assault survivors in these centres.

Table 4.6: Recovery Needs of Sexual Assault Survivors

Statements		SA	A	UD	D	SD	Mean	Std.
1. Ensuring a safe environment	F	14	10	4	5	2	3.82	1.27
	%	40.0	28.6	11.4	14.3	5.7		
2. Prompt medical care is important to address physical injuries	F	13	11	6	2	3	3.83	1.25
	%	37.1	31.4	17.1	5.7	8.6		
3. Access to trained professionals who specialize in, and sexual assault help survivors process their emotions and work towards healing	F	14	7	8	1	5	3.69	1.41
	%	40.0	20.0	22.9	2.9	14.3		
4. Survivors need encouragement to make decisions about their own recovery process	F	12	16	4	1	2	4.00	1.06
	%	34.3	45.7	11.4	2.9	5.7		
5. Providing information about legal options if the survivor chooses to pursue legal action	F	19	9	3	3	1	4.20	1.11
	%	54.3	25.7	8.6	8.6	2.9		
6. Connecting survivors with support groups, online forums can help them realize they are not alone and provide a network of understanding individuals	F	8	12	6	6	3	3.56	1.27
	%	22.9	34.3	17.1	17.1	8.6		
7. Creating a safe space where survivors can express themselves without fear of judgment or blame is essential	F	9	18	5	1	2	3.89	1.02
	%	25.7	51.4	14.3	2.9	5.7		
8. Providing resources and information about sexual assault, its effects, and recovery can empower survivors	F	7	12	12	3	1	3.60	1.01
	%	20.0	34.3	34.3	8.6	2.9		
9. Provision of healthy habits like exercise, nutrition, and regular check-ups contribute to a survivor's overall well-being	F	8	13	7	4	3	3.54	1.27
	%	22.9	37.1	20.0	11.4	8.6		
10. Offering accommodation at work or can help survivors regain a sense of normalcy at their own pace	F	14	7	6	5	3	3.69	1.37
	%	40.0	20.0	17.1	14.3	8.6		
11. Offering ongoing support for clients even after initial crisis intervention	F	11	14	8	1	1	3.94	0.99
	%	31.4	40.0	22.9	2.9	2.9		

Source: Field data (2024)

Table 4.7 presents the study results on the availability and usage status of the key resources in GBVRCs in Uasin Gishu

Table 4.7: Availability and Usage County. Status of Key Resources in GBVRCs in Uasin Gishu County, Kenya

Facility/Resource	Number of Hospitals with Resource	Percentage (%)	Resource Usage Status
Private quiet accessible, well-lit room	3	42.86	poor
Displayed IECs (Information, Education, Communication)	2	28.57	Poor
Counselling SOPs (Standard Operating Procedures)	4	57.14	Average
Trauma forms/Register	5	71.43	Good
PRC (Post-Rape Care) register	3	42.86	Poor
PRC drug kit (1st PEP dose, ECP)	4	57.14	Average
Lockable cabinets for storage of data tools and commodities	2	28.57	Poor
Referral directory	1	14.29	Very Poor
Centre Policies	3	42.86	Poor

Source: Field data (2024)

The findings presented in Table 4.7 indicate that only 42.86% of hospitals have private, quiet, and well-lit rooms available, and these facilities are generally underutilized. This scarcity poses considerable challenges for survivors seeking counselling, as such environments are essential for establishing a safe space where survivors feel secure enough to disclose their experiences. The absence of these facilities in more than half of the hospitals may contribute to discomfort and anxiety among survivors, thereby potentially undermining the effectiveness of counselling sessions.

The limited availability and utilization of private rooms can substantially affect the quality of counselling provided to survivors. In the absence of a secure and comfortable environment, survivors may be reluctant to disclose their experiences, thereby diminishing

the effectiveness of therapeutic interventions. This reluctance can result in prolonged recovery periods and exacerbate psychological trauma. Effective counselling necessitates an environment that fosters trust and comfort, conditions that are currently inadequate in many hospital settings.

The concept of a private, quiet, and well-lit room extends beyond mere physical space; it embodies a safe haven in which survivors can freely express themselves. Such an environment is crucial for fostering trust between the survivor and the counsellor, a foundational element of effective therapeutic intervention. In the absence of these conditions, survivors may experience feelings of exposure and vulnerability, potentially exacerbating their trauma.

The study findings align with those of Broban *et al.* (2020), who emphasize the importance of a safe and private environment for counselling survivors, noting that such settings help reduce anxiety and enhance the effectiveness of therapy. Similarly, the findings corroborate the World Health Organization (WHO, 2020), which underscores that a secure and comfortable environment is essential for delivering quality care to survivors. Both studies concur that the absence of private rooms can compromise the quality of counselling services. For example, Physicians for Human Rights (2023) highlights the significance of trained healthcare providers and accessible services, suggesting that while private rooms are important, they constitute one component within a broader array of necessary resources.

The limited availability of displayed IEC materials in only 28.57% of hospitals, coupled with their poor usage, indicates a significant lack of accessible information for survivors. This deficiency can impede survivors' understanding of their rights, the services available to them, and the procedures for seeking help. IEC materials are essential for empowering survivors by providing necessary information. Their absence may result in confusion and

misinformation, adversely affecting survivors' ability to access appropriate services. Furthermore, this lack of information can increase feelings of isolation and diminish trust in the healthcare system, ultimately compromising the quality of counselling provided. These findings underscore the urgent need for comprehensive IEC strategies within healthcare settings to enhance survivor empowerment, facilitate service utilization, and improve overall recovery outcomes.

IEC materials function as a critical link between survivors and the services they require. By providing clear and accessible information, these materials empower survivors to make informed decisions regarding their care. The absence of IEC materials indicates a gap in service delivery that can impede recovery. These findings corroborate the World Health Organization's (2020) assertion regarding the role of IEC materials in empowering survivors, suggesting that their lack can increase barriers to accessing support services. Similarly, the results align with UNICEF's (2022) emphasis on the importance of accessible information to ensure that survivors receive comprehensive care.

While more than half of the hospitals (57.14%) have established counselling Standard Operating Procedures (SOPs), the average utilization rate indicates that there is considerable scope for enhancing the consistent implementation of these protocols. Such inconsistency in applying counselling SOPs may adversely affect the quality of care provided to survivors. The variability in the execution of these standardized procedures can result in significant disparities in the quality of counselling services delivered. Standardized SOPs are critical for ensuring that all survivors receive uniform and high-quality care. Without consistent adherence to these protocols, some survivors may experience superior care compared to others, potentially influencing their recovery outcomes.

Counselling SOPs provide a structured framework for delivering consistent and high-quality care. They ensure that all survivors receive a uniform level of support, which is essential for building trust and facilitating effective therapy. The observed average usage status indicates a need for improved adherence to these protocols. UNICEF (2022) underscores the importance of standardized SOPs in guiding service delivery and guaranteeing that survivors obtain consistent support. Similarly, these findings corroborate those of ICRH Kenya (2020), which emphasize the role of SOPs in coordinating comprehensive care for survivors. This alignment further highlights that consistent implementation of SOPs is critical to achieving optimal outcomes.

The high availability (71.43%) and effective utilization of trauma forms and registers indicate robust documentation of trauma cases. Such documentation is critical for legal proceedings and the provision of targeted support to survivors. Comprehensive record-keeping through trauma forms and registers enhances the quality of counselling by ensuring that survivors receive appropriate medical and legal care. Moreover, proper documentation facilitates the monitoring of survivors' progress and the delivery of necessary support, which is essential for their recovery.

Trauma forms and registers serve as essential tools for ensuring that survivors receive comprehensive care. They facilitate both legal justice and medical treatment by providing a clear and detailed record of the trauma experienced. Such documentation is crucial for supporting survivors throughout their recovery process. The findings of this study align with those of Physicians for Human Rights (2023), which emphasize that proper documentation is fundamental to achieving legal justice and delivering effective medical care. Similarly, the results corroborate the World Health Organization's (2020) assertion regarding the importance of documentation in guaranteeing that survivors obtain appropriate care.

The limited availability of Post-Rape Care (PRC) registers, observed at 42.86%, alongside their poor utilization, reveals significant gaps in the tracking and provision of post-rape care services. Such deficiencies may result in inadequate follow-up and insufficient support for survivors. Furthermore, the suboptimal availability and use of PRC registers can undermine the quality of counselling by restricting the ability to monitor survivors' progress and deliver timely interventions. Consequently, this limitation compromises the provision of essential support and follow-up care, which are critical components for the survivors' recovery process.

The establishment of PRC registers is crucial for ensuring that survivors receive comprehensive care, encompassing both medical and psychological support. The absence of such registers indicates a significant gap in service delivery, which may impede the recovery process. The findings of this study align with those of the World Health Organization (WHO, 2020), which underscores the importance of PRC registers in facilitating holistic care for survivors. Similarly, the results corroborate the position of UNAIDS (2022), which emphasizes the necessity of effective tracking and follow-up mechanisms in post-rape care services.

While more than half of the hospitals (57.14%) possess post-rape care (PRC) drug kits, the average usage status indicates potential inconsistencies in the administration of these critical medications. Such irregularities in providing post-exposure prophylaxis (PEP) and emergency contraceptive pills (ECP) can adversely affect the quality of care delivered to survivors. These medications are essential for preventing HIV infection and unwanted pregnancies, and timely access is crucial to their effectiveness. Inconsistent administration may increase health risks for survivors. PRC drug kits constitute a vital component of post-rape care, supplying necessary medications to mitigate HIV transmission and unintended

pregnancies. The observed average usage underscores the need for improved implementation of these interventions. These findings align with UNAIDS (2022), which emphasizes the importance of timely access to PEP for HIV prevention, and with WHO (2020), which highlights the role of PRC drug kits in comprehensive care. Although PRC drug kits are critical, other factors such as counselling and legal support are equally important in the survivor's recovery process. Notably, there is no specific research contradicting the significance of consistent administration of PRC drug kits.

The limited availability (28.57%) and inadequate utilization of lockable cabinets present significant risks to data security and the integrity of medical supplies. This deficiency compromises confidentiality and adversely affects the quality of care provided. The absence of secure storage facilities may undermine the trust between survivors and healthcare providers, thereby indirectly impacting the quality of counselling by creating an environment in which survivors feel unsafe disclosing sensitive information. Lockable cabinets constitute a fundamental requirement for maintaining confidentiality and safeguarding the integrity of medical supplies. Their absence indicates a critical gap in service delivery that can erode trust and diminish the overall quality of care. The World Health Organization (2020) underscores the importance of secure storage in preserving confidentiality and preventing the compromise of medical supplies. Similarly, the International Centre for Reproductive Health Kenya (2020) highlights the essential role of secure facilities in ensuring quality care.

The extremely limited availability (14.29%) and very poor utilization of referral directories highlight significant challenges in connecting survivors with appropriate services. This deficiency can result in fragmented care and increased barriers for survivors seeking assistance. The absence of comprehensive referral directories compromises the quality of

counselling by restricting access to specialized services that survivors may require. Effective referral systems are critical to ensuring that survivors receive holistic and integrated care; their absence often leads to disjointed support. Referral directories function as essential tools for linking survivors to necessary services, and their scarcity indicates a substantial gap in service delivery that can impede recovery by limiting access to specialized care. These findings are consistent with those of Physicians for Human Rights (2023), which emphasize that effective referral mechanisms are vital for providing comprehensive care to survivors. While referral directories are undeniably important, other factors, such as community-based support networks, may also play a significant role in facilitating connections between survivors and services. Nonetheless, there is no existing research that directly challenges the importance of referral directories in ensuring comprehensive care.

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survivors and services. Nonetheless, there is no existing research that directly challenges the importance of referral directories in ensuring comprehensive care.

Thematic analysis was employed as the primary method for analysing the interview and focus group discussion data. The analysis followed the systematic phases outlined by Virginia Braun and Victoria Clarke (2021), involving familiarisation with the data, generation of initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. All interviews were transcribed verbatim, after which repeated reading was undertaken to ensure immersion in the data. Initial codes were generated inductively from participants' narratives rather than imposed a priori, although sensitising concepts drawn from the study's conceptual framework guided analytic attention. Codes were first assigned to meaningful units of text, then compared across transcripts to analyse similarities and differences. Through constant comparison, related codes were clustered into categories, which were subsequently refined into ten overarching themes representing recovery needs and experiences of psychosocial intervention.

To enhance transparency in coding, a structured coding process was followed. Each transcript was coded line-by-line during the first cycle to capture participants' explicit expressions and implicit meanings. In the second cycle, codes were reviewed to eliminate redundancy, merge overlapping concepts, and ensure internal coherence. Analytic memos were maintained to document decisions regarding code refinement, theme development, and interpretive reasoning. Member checking was conducted with selected participants to confirm that the emerging themes accurately reflected their experiences. This process strengthened credibility and reduced the risk of researcher bias.

An excerpt of the codebook is provided in Appendix X to demonstrate the progression from initial codes to broader themes. The codebook includes the code label, operational

definition, illustrative participant quotation, and the theme under which the code was ultimately categorised. For example, the initial code “fear of community stigma” was defined as expressions of anxiety about social rejection and was illustrated by statements describing avoidance of public spaces. This code was later aggregated with related codes such as “self-isolation” and “family withdrawal” under the broader theme “Social Reintegration Challenges.” Similarly, codes such as “difficulty sleeping,” “recurring memories,” and “panic episodes” were grouped under the theme “Psychological Distress and Trauma Symptoms.” Including the codebook excerpt enhances auditability and demonstrates analytic rigour.

The sampling logic for qualitative participants was purposive and criterion-based. From each facility, the longest-serving client who met the inclusion criteria was selected for interview. This decision was grounded in the assumption that clients with prolonged engagement in psychosocial care would have experienced multiple phases of intervention and could therefore provide deeper, more reflective accounts of recovery processes. Their extended exposure to services positioned them to comment not only on immediate support but also on continuity of care, reintegration efforts, and perceived effectiveness over time. This sampling strategy thus prioritised depth of experience rather than numerical representativeness.

Thematic saturation was achieved during the later stages of data collection. Saturation was analysed when successive interviews yielded no substantively new codes or thematic categories, and when additional data merely reinforced previously identified patterns. Specifically, after the final two interviews, no new dimensions of recovery needs or intervention experiences emerged, and all responses could be meaningfully accommodated within the existing thematic structure. At this point, data collection for qualitative interviews

was concluded, as further interviews were unlikely to contribute additional conceptual insight.

Through systematic coding, transparent documentation, purposive sampling logic, member checking, and explicit determination of thematic saturation, the qualitative component of this study demonstrates methodological rigour and credibility consistent with established qualitative research standards.

4.4.1 Need for Provision of Safe and Secure Environments

During the interviews, sexual assault survivors emphasized the importance of private, calm, and non-intimidating environments during treatment and evidence collection. They felt safe in such an environment and were ready to volunteer information to medical and legal teams.

This was captured well by one of the respondents thus:

“I was offered a private, safe and secured environment during treatment...”

(Survivor 17).

They also appreciated the strict security protocols in shelters, as this enhanced their sense of safety and allowed them to start healing. The following transcript captures this:

“The shelter I stayed in had strict security protocols, which helped me sleep better at night.” (Survivor 21).

The survivors indicated they harboured fears of retribution from the perpetrators of assault. The sense of safety, therefore, provided a good environment where healing could begin.

The quantitative findings, as captured in Table 4.6, also show that counsellors largely concurred on the importance of ensuring a safe environment for survivors. This was evidenced by a mean score of 3.82 on the item relevant to this theme, which aligns with perspectives of assault survivors, who emphasized the critical role of safe spaces in the

recovery process; for example, calm environments during treatment and security in shelters). However, the quantitative data also reveal a notable divergence in agreement, as reflected by a standard deviation of 1.272. While both counsellors and survivors agree on the significance of safe and secure environments in facilitating recovery, a disconnect was observed. Specifically, some survivors expressed dissatisfaction with male officers handling their cases, an issue that was not explicitly addressed in the counsellors' responses. This concern is illustrated in the following abstract from a survivor.

“Let us have a female police officer listening to our stories, male will not understand what I have gone through.” (Survivor 18)

This may reflect a lack of gender-sensitive training or awareness among staff, which hinders their ability to adequately provide a safe and secure environment. Another plausible explanation can be derived from the observation schedule (Table 4.7), which indicates that the percentage of hospitals effectively utilizing private rooms and lockable cabinets is notably low. This finding underscores the need for significant improvements in privacy and security measures for survivors.

The findings underscore the importance of a private, safe, and secure environment in the recovery process for survivors of sexual assault. A supportive environment plays a critical role in empowering survivors; when individuals feel safe and comfortable, they are more likely to seek assistance and engage cooperatively with legal procedures. These findings align with those of Brown (2021), who reported that survivors of rape and sexual assault who participated in psychosocial interventions exhibited a significant reduction in post-traumatic stress disorder (PTSD) symptoms compared to those who did not receive such interventions. The effect size reported was substantial, indicating that these interventions are highly beneficial for mental health recovery.

The results align with the findings of O'Doherty *et al.* (2023), who also noted that these interventions did not lead to increased dropout rates or adverse effects. This suggests that when survivors receive supportive care, they are more likely to remain engaged throughout their treatment, which is crucial because high dropout rates can undermine the effectiveness of recovery programmes. Furthermore, these findings enrich the results of Regehr *et al.* (2023), who advocate for tailored interventions that consider individual survivor needs and preferences. This personalized approach is essential in addressing the unique challenges faced by different survivors, including cultural sensitivities and personal trauma histories.

The results are consistent with the findings of Tener (2024), who emphasizes the importance of therapists creating a safe space for discussions when working with survivors of sexual abuse. This process involves demonstrating empathy and maintaining a non-judgmental stance, attending to the survivor's physical comfort, and conveying genuine understanding. In the absence of these elements, survivors may experience re-traumatization and feel unsafe during therapy sessions. Consequently, the interviewees encouraged counsellors to empower survivors by allowing them control over their healing process, including the discretion to analyse the extent to which they disclose their experiences.

Survivors expressed a strong desire for a non-judgmental and compassionate community, which plays a crucial role in alleviating feelings of isolation and providing essential support throughout their recovery process. The following quotations underscored the significance of such a community in fostering a sense of belonging and emotional healing:

“Being surrounded by a supportive community made all the difference...” (Survivor 30)

“Knowing I wasn't alone anymore made a big difference in my healing process.... Feeling safe again was a long journey for me. The shelter I stayed in had strict

security protocols, which helped me sleep better at night. Knowing I wasn't alone anymore made a big difference in my healing process." (Survivor 21)

This suggests that positive community interactions can significantly enhance resilience among survivors. This finding aligns with the work of King *et al.* (2022), who demonstrated that supportive relationships contribute to improved mental health outcomes by providing both emotional validation and practical assistance. Moreover, the presence of non-judgmental listeners facilitates the healing process by enabling survivors to openly process their experiences.

This finding underscores the necessity of safety and support as prerequisites for effective recovery interventions. Furthermore, these results extend the work of Burns and Sinko (2023), who consistently demonstrate that survivors require secure environments to heal effectively. In the absence of adequate support and safety, psychological interventions may be significantly less effective. Consequently, the implementation of robust safety protocols in shelters and recovery centres is essential to foster an environment conducive to healing.

Survivors emphasized the crucial role of support groups in mitigating isolation and facilitating emotional recovery. The findings underscore the importance of support groups characterized by understanding and non-judgmental listening. Such environments provide a safe space for survivors to share their experiences without fear of criticism or oversimplification. These results corroborate the findings of Won *et al.* (2021), which suggest that peer support can significantly alleviate symptoms of PTSD and depression among survivors by fostering a sense of community and belonging. The assurance of safety within these groups contributes positively to the overall recovery process. Furthermore, these findings align with those of Thomas (2021), who asserts that creating a safe, non-judgmental environment is essential for the emotional recovery of sexual assault survivors.

His research highlights that survivors are more likely to disclose their feelings and experiences when they perceive the environment as free from judgment or blame.

Safety constitutes a fundamental aspect of recovery for sexual assault survivors. The survivors' recognition of the importance of safe social spaces underscores how structured environments can facilitate the healing process. These findings align with those of Kirkner, Lorenz and Ullman (2021), who demonstrate that safe spaces significantly contribute to psychological well-being by enabling survivors to focus on recovery without the persistent fear of re-traumatization. Effective psychosocial interventions frequently incorporate the creation of secure environments as a critical component of the healing process, which is essential for fostering trust and emotional stability.

These findings align with those of Heard and Walsh (2023), who emphasized that providing ongoing support to sexual assault survivors following the initial crisis intervention is critical for long-term recovery. Their study demonstrated that sustained emotional and psychological support aids survivors in coping with the aftermath of trauma and reduces the risk of enduring mental health issues. The literature on trauma care for gender-based violence (GBV) concurs with this perspective and underscores that a compassionate and non-judgmental community not only alleviates the profound isolation frequently experienced by survivors but also fosters resilience and facilitates a more effective healing process (Diab & Al-Azzeh, 2024). Such communities establish a safe environment in which survivors can share their experiences without fear of criticism or reproach, an essential provision given the pervasive stigma and isolation often associated with sexual violence. The presence of empathetic individuals serves to validate survivors' emotional experiences, reinforce their sense of self-worth, and support the reestablishment of trust in interpersonal

relationships. Furthermore, supportive communities often provide practical assistance and resources that empower survivors to regain control over their lives.

However, the study results indicated, based on the mean and standard deviation, that the counsellors did not unanimously agree with the statement that connecting survivors with support groups and online forums helps them realize they are not alone and provides a network of empathetic individuals. This item received a comparatively lower mean score (3.56) than other items. It appears that counsellors may underestimate the value of support groups, potentially due to limited resources or a greater emphasis on individualized care rather than communal healing.

4.4.2 Access to Medical Care

Survivors emphasized the importance of immediate and compassionate medical care; however, some reported that medical examinations were traumatizing. They underscored the critical role of prompt and professional medical attention in addressing both physical and emotional traumas. This dual necessity was reflected in the quotations presented.

“Accessing medical care immediately after the assault was crucial for my recovery. The doctors were gentle and reassuring...” (Survivor 31).

This underscores the necessity for high-quality facilities that provide medical services to sexual assault survivors to be both accessible and professionally managed. There is a significant risk that some survivors may experience re-traumatization during medical examinations if these facilities fail to adhere to established protocols. For instance, one survivor reported re-traumatization when caregivers failed to adequately inform her about the procedures she was to undergo at the hospital:

“I was referred to a medical examination against my wish... i was not fully told what to expect... I was retraumatized.” (Survivor 24)

Counsellors strongly affirmed the importance of prompt medical care (Mean 3.83), although some rated its significance lower (Std. Dev. 1.248). This suggests a consensus between counsellors and survivors regarding the value of timely and professional medical intervention. However, counsellors may not fully recognize or adequately address survivors' experiences of traumatization during medical procedures, highlighting the need for trauma-informed care training. Additionally, the apparent inadequate availability and usage of key resources in Gender-Based Violence and Recovery Centres in study area (Table 4.7) warrant urgent attention. Failure to address these issues may increase the risk of survivors developing post stress traumatic disorder.

The study findings align with those of Farahi and McEachern (2021), that prompt medical care is crucial for addressing physical injuries and ensuring comprehensive support for survivors of sexual assault, particularly within the context of gender-based violence and recovery centres. Survivors are encouraged to seek medical attention immediately or as soon as possible following an assault. Timely care is essential not only for the treatment of physical injuries but also for the administration of sexual assault forensic exam (SAFE), which facilitates the collection of crucial evidence, such as DNA, that may be instrumental in legal proceedings (Freedman, 2020). Immediate medical treatment significantly enhances the chances of physical recovery and addresses urgent health concerns, including the prevention and treatment of sexually transmitted infections (STIs) and unintended pregnancies.

Seeking medical care within 120 hours (five days) following an assault is critically important for the preservation of forensic evidence (Bell, 2022). Delays in obtaining medical attention may compromise the ability to collect viable DNA evidence, which is often essential for the successful prosecution of offenders. Survivors are therefore advised to

refrain from bathing or changing clothes prior to seeking medical evaluation, in order to maximize the retention of evidentiary material.

The study results are consistent with the findings of Gewirtz-Meydan and Lahav (2020), who emphasized that immediate care often encompasses psychological support. Survivors may experience significant emotional distress, including symptoms of post-traumatic stress disorder (PTSD), anxiety, and depression. Medical professionals play a crucial role in facilitating referrals to mental health services, which are integral to the recovery process. Counselling interventions can assist survivors in processing their trauma, developing effective coping strategies, and regaining a sense of control over their lives.

Recovery centres play a crucial role in delivering a holistic approach to healing (Harris *et al.*, 2021). These centres not only provide medical care but also facilitate access to counselling services and support groups, enabling survivors to share their experiences with others who have encountered similar challenges. Such community support significantly contributes to the emotional recovery process.

One counsellor noted that survivors present with unique and often diverse needs that require careful attention from both counsellors and medical staff upon their arrival at recovery centres. Addressing these needs effectively is essential to facilitate comprehensive and individualized care:

“Recovery needs of sexual assaults survivors can vary greatly, but commonly includes access to therapy, medical care, support groups and legal advocacy. It is essential to respect each survivor’s needs and responses and empower them to make choices that feel right for them” (Counsellor 6).

The findings underscore the diverse recovery needs of sexual assault survivors, highlighting the critical importance of tailored psychosocial interventions. Survivors often require a comprehensive range of support services, including therapeutic treatment, medical care, support groups, and legal advocacy. The counsellor's assertion that "each survivor's unique journey" must be respected emphasizes the necessity of personalized approaches within recovery settings. Empirical research corroborates this perspective, demonstrating that psychosocial interventions effectively reduce symptoms of post-traumatic stress disorder (PTSD) and depression among survivors, thereby facilitating their recovery process. Consequently, it is imperative that interventions be tailored to accommodate individual survivor preferences and circumstances to optimize therapeutic outcomes.

These findings were consistent with those of Fávero *et al.* (2022), who highlighted that various psychosocial therapies not only reduce psychological distress but also do not exacerbate symptoms or result in adverse effects. However, high dropout rates from treatment were observed, indicating a need for enhanced engagement strategies. Furthermore, the study's findings align with Sousa-Gomes *et al.* (2024), who advocate for an ecologically informed trauma model that takes into account the social contexts influencing recovery. This model underscores the importance of integrating psychological support with social advocacy to address the multifaceted needs of survivors.

4.4.3 Psychological Support and Counselling

Survivors identified counselling as essential to their emotional healing, with support groups being particularly beneficial. Counselling sessions and therapeutic interventions played a pivotal role in helping them process emotions, rebuild confidence, and regain a sense of self. This significance was underscored by survivors' own testimonies, as illustrated in the following quotes:

“Counselling sessions became a safe space for me to open up without fear...”
(Survivor 26).

“Support group was helpful, allowed me to have friends who do not criticize me...”
(Survivor 23).

“Support group offered me emotional support... I was not ashamed or guilty sharing what I went through.” (Survivor 16).

It is evident that support groups provide emotional connection, reduce feelings of shame and guilt, and encourage survivors to share their experiences without fear of judgment. Counsellors concur, as evidenced by their response to the question regarding the need for survivors to have access to trained professionals, which received a mean score of 3.69, indicating moderate agreement, albeit with some variability (Std. Dev. = 1.409). Thus, both survivors and counsellors acknowledge the importance of psychological support and counselling. However, it is noteworthy that counsellors assigned only moderate importance to connecting survivors with support groups (Mean = 3.56), whereas survivors reported these groups as highly impactful. This discrepancy may reflect a lack of prioritization or insufficient resources allocated to such programmes. A review of Table 4.7 reveals a shortage of key resources in Gender-Based Violence and Recovery Centres within the study area and indicates low utilization where resources are available. These findings suggest that the need for psychological support and counselling is adversely affected by inadequate prioritization of the sources and programmes designed to provide such support.

The literature underscores the necessity of a holistic approach to recovery that integrates multiple support systems. The study findings concur with those of MacDonald and Quinlan (2022), who emphasized that access to trained professionals specializing in sexual assault

plays a crucial role in helping survivors process their emotions. Their study demonstrated that such support enhances emotional well-being and promotes healing, thereby highlighting the importance of specialized care in trauma recovery. These assertions align with the findings of Burns and Sinko (2023), who indicated that comprehensive psychosocial interventions, including trauma-focused therapies and legal support, significantly reduce symptoms of PTSD and depression among survivors. Their research revealed a substantial reduction in PTSD symptoms post-treatment for individuals receiving psychosocial interventions compared to control groups, suggesting that the integration of legal and medical services enhances overall recovery outcomes. These results are consistent with those reported by Lomax and Meyrick (2022), who argued that without addressing safety concerns, other therapeutic efforts may be compromised. The emphasis on safety as a prerequisite for recovery corresponds with research by Wilson and Foureur (2023), which indicates that survivors require a secure environment to engage effectively in therapeutic processes. A supportive living situation can enhance the efficacy of psychological interventions by providing the stability essential for emotional healing. This underscores the dual role of social support in both facilitating professional help-seeking behaviour and potentially complicating it if the support is not constructive.

Psychosocial support from family and society at large was identified by survivors as a crucial factor in their recovery journey. These findings are consistent with those of Kim and Kim (2020), who assert that positive familial and social interactions significantly influence a survivor's mental health trajectory and facilitate access to essential services such as counselling and legal aid. Conversely, negative or unsupportive responses from close contacts may impede survivors' willingness to seek formal assistance.

Survivors reported a range of psychological impacts, including feelings of disorientation, diminished self-esteem, and emotional exhaustion. These experiences are exemplified in the following excerpt.

“I was feeling worn out physically, mentally, and psychologically” (Survivor 19).

“I felt I was lost, sikua najipenda tena...” (Survivor 20).

These statements underscore the immediate necessity of addressing survivors' psychological well-being prior to implementing preventive health measures such as HIV post-exposure prophylaxis (PEP). Prioritizing emotional and psychological support is crucial for facilitating effective recovery. Ogbe *et al.* (2020) support this perspective, indicating that psychosocial interventions significantly reduce symptoms of post-traumatic stress disorder (PTSD) and improve mental health outcomes for survivors, thereby enabling more effective engagement with subsequent health interventions. These findings are consistent with those of Rosyida *et al.* (2024), who suggest that psychological first aid is essential in mitigating the traumatic impact of assault on survivors. Psychological first aid can be delivered through modules, psychoeducation, counselling, and coaching tailored to victims of sexual abuse. Consequently, collaboration between families and mental health professionals is imperative in administering psychological first aid to prevent survivors from experiencing trauma and depression following sexual abuse.

4.4.4 Legal and Justice Support

Survivors perceive legal support as a crucial mechanism for regaining control, achieving validation, and comprehending their rights. This perspective is exemplified in the following quotation:

“Having legal support made me feel like my voice mattered. My lawyer guided me through the process...” (Survivor 24).

This finding corroborates that of White *et al.* (2019), who assert that providing sexual assault survivors with clear information regarding their legal options significantly enhances their capacity to make informed decisions about pursuing legal action. These assertions align with those of Rose (2017), who further contends that sexual assault survivors often experience feelings of powerlessness and overwhelm; however, engagement with the legal system can facilitate the restoration of control over their lives. Moreover, pursuing legal action such as filing a report or initiating a civil case serves to hold perpetrators accountable and re-establish survivors' personal agency. White *et al.* (2019) further emphasize that legal support extends beyond procedural aspects, playing a crucial role in validation and counteracting feelings of isolation and self-doubt. Legal professionals provide essential education about the options available to survivors, including understanding criminal law, accessing protective orders, and obtaining compensation. Knowledge of survivors' rights empowers them to make informed decisions, thereby contributing to a sense of safety and self-determination. It is evident that legal support often complements other forms of assistance, such as counselling and community resources, offering a holistic approach to recovery that addresses both the legal and emotional dimensions of trauma. Consequently, a supportive framework can significantly facilitate the journey toward healing.

The absence of affordable legal resources was noted as a significant barrier to recovery. This was intimated by one survivor who had this to say:

“I need legal support which I cannot afford.” (Survivor 24)

Research indicates that only a small fraction of sexual assault survivors seek comprehensive care afterward, including legal support. For many survivors, economic challenges, coupled with a lack of accessible legal services, impede their ability to obtain legal assistance (Sourdin & McNamara, 2020). Legal support is crucial for many survivors, as it enables

them to navigate complex systems while fostering a sense of empowerment throughout their recovery journey. These findings are consistent with those of Shepp, O’Callaghan and Ullman (2020), who demonstrated that access to legal assistance significantly influences survivors’ perceptions of justice and control over their circumstances. Moreover, legal advocacy can facilitate access to other essential services, thereby reinforcing survivors’ sense of agency.

It is evident that survivors emphasize the importance of legal support in fostering a sense of validation and regaining control; however, they analyse affordability as a significant barrier to accessing such support. This perspective is corroborated by counsellors, who, in the variable assessing the need for provision of information about legal options, recorded the highest mean score (4.20), indicating strong agreement on its importance. While both groups recognize legal support as a critical component of recovery, a disconnect remains: counsellors may not fully acknowledge the financial obstacles that survivors frequently report as hindrances to obtaining legal assistance.

4.4.5 Empowerment and Autonomy

Survivors require programmes that foster decision-making, self-reliance, and empowerment. Regaining autonomy is instrumental in enabling survivors to reclaim control over their lives, as evidenced in the following responses:

“Regaining my sense of autonomy was key to my recovery. Being part of programmes that encouraged decision-making, and self-reliance helped me feel empowered...” (Survivor 29)

“I wanted to be strong not to be afraid.” (Survivor 19)

This finding underscores the critical importance of regaining autonomy as a fundamental component of the recovery process. Programmes that promote decision-making and self-reliance have the potential to significantly enhance survivors' sense of empowerment. These conclusions are consistent with those of Molero-Zafra *et al.* (2024), who demonstrate that psychosocial interventions incorporating elements of self-efficacy and personal agency contribute to improved mental health outcomes.

This aligns with the assertions of Gravelin *et al.* (2019), that sexual assault can leave survivors feeling powerless and result in a loss of control over their lives. Regaining autonomy is essential for healing, as it enables survivors to reclaim control, empower themselves, and tailor their recovery to their individual needs. Furthermore, autonomy facilitates the establishment and maintenance of personal boundaries, which is critical for creating a safe and respectful environment conducive to healing. By actively participating in decisions regarding therapy, support systems, and personal boundaries, survivors foster self-esteem and resilience. This active engagement allows them to break the cycle of helplessness, thereby gaining ownership over their recovery journey and future.

The counsellors' findings demonstrate strong agreement (mean = 4.00) with the principle of encouraging survivors to actively participate in decision-making throughout their recovery process. This aligns with survivors' responses, which emphasize the significance of regaining autonomy and exercising control over their recovery journey. Consequently, both groups exhibit a robust consensus on the importance of empowerment and autonomy in the recovery experience.

4.4.6 Role of Gender-Sensitive Practices

Survivors expressed a preference for female police officers when narrating their experiences, citing increased understanding and empathy. This is captured well in the statement below:

“Let us have a female police officer listening to our stories, male will not understand what I have gone through...hawajui kile nilipitia” (Survivor 18).

Survivors may anticipate that female officers will demonstrate greater sensitivity and be less likely to perpetuate victim-blaming narratives, a belief shaped by their prior experiences with institutional responses and prevailing societal attitudes toward sexual assault. These findings extend the work of Lorenz (2023), who argues that survivors often perceive female police officers as more capable of understanding their predicaments due to shared experiences and cultural norms surrounding women’s sensitivity to issues of sexual abuse. Moreover, the presence of a female officer can help mitigate the power imbalance frequently associated with male officers, thereby fostering an environment in which survivors feel more secure when disclosing personal information, free from the fear of criticism or misinterpretation.

This finding underscores the necessity of implementing gender-sensitive approaches within support services. Survivors often feel more comfortable sharing their experiences with female professionals, who may possess a deeper understanding of their trauma. This observation aligns with the work of Lindsay and Kolne (2022), which indicates that gender-sensitive interventions enhance trust and communication between survivors and service providers, factors that are crucial for effective healing. These conclusions are further supported by Iraola *et al.* (2024), who demonstrated that female practitioners can foster a

more supportive environment, thereby improving the overall recovery experience for women.

4.4.7 Socio-Economic Empowerment

Survivors highlighted socio-economic factors, such as financial vulnerability, as critical barriers to recovery from sexual assault. The quote below captures this:

“Social economic status affects recovery; lack of money made me accept his assistance (perpetrator) and made me vulnerable” (Survivor 25).

Socioeconomic issues constitute a significant barrier to recovery, as they increase survivors' vulnerability to exploitation and restrict their access to safe housing and essential resources. Survivors have expressed the need for alternative sources of material support, given their heightened susceptibility to manipulation by perpetrators and their agents following the assault. The literature documents that socioeconomic factors can exacerbate vulnerability to sexual violence and complicate effective resolution. For example, survivors from low-income backgrounds frequently encounter additional obstacles in obtaining safe housing and support services. These findings align with those of Burns and Sinko (2023), who indicated that such factors impede recovery efforts, underscoring the necessity of addressing socioeconomic determinants within recovery programmes.

The findings align with those of Heard and Walsh (2023), who emphasized that providing ongoing support to sexual assault survivors following the initial crisis intervention is essential for long-term recovery. Their study demonstrated that sustained emotional and psychological support facilitates survivors' coping mechanisms in the aftermath of trauma and mitigates the risk of enduring mental health complications.

The foregoing survivors emphasized the importance of consistent and empathetic support from both communities and professionals. Counsellors' responses to items affirming the

necessity of providing ongoing support to survivors yielded a high mean score (3.94), indicating that counsellors regard sustained assistance as essential. Consequently, both counsellors and survivors strongly concur on the imperative for continuous, long-term support beyond the initial crisis period.

4.4.8 Poor Multisectoral Coordination

Survivors emphasized the necessity for collaboration and integration among the various agencies and sectors responsible for supporting them, including law enforcement, healthcare, social services, and legal aid. The following statement encapsulates this need:

"From the county hospital, I was referred to Moi-Teaching and Referral Hospital where a medical examination was done on me against my wish... though they were offering legal support, which I need and cannot afford. I will not go to them"
(Survivor 24).

This highlights a lack of coordination between medical and legal services. Survivors anticipate receiving legal support in conjunction with medical care; however, they frequently encounter gaps in the integration of these services. As one survivor further noted:

"Social economic status affects recovery; lack of money made me accept his assistance and made me vulnerable" (Survivor 25).

This indicates a lack of adequate coordination among support services, such as shelter, financial assistance, and legal aid, which leaves survivors economically vulnerable and thereby exposes them to further harm.

Inadequate coordination often results in fragmented service delivery, leading to delays, gaps in care, and inconsistent support for survivors (Santos & Tschampl, 2023). This fragmentation, exacerbated by deficient interagency communication and the absence of

standardized protocols or referral mechanisms, further increases survivors' vulnerabilities and undermines the overall effectiveness of response operations. Consequently, enhancing multisectoral coordination is imperative to ensure that survivors receive timely, comprehensive, and integrated services that address their multifaceted and complex needs.

4.5 Psychosocial Interventions

The study's second objective examined how both clients and counsellors perceived the effectiveness of psychological treatments in addressing recovery needs of sexual assault survivors. Drawing on survivors' lived experiences obtained through in-depth interviews, the study first catalogued the range of available psychological interventions. Counsellors' perspectives were gathered via a structured questionnaire. A similar methodological approach was employed to assess social-based therapies. The analytical process involved thematic development from interview data, integrating insights from counsellors and document analysis on a case-by-case basis. Furthermore, counsellor responses were subjected to additional statistical analyses, including a one-way ANOVA, to evaluate the impact of psychosocial interventions on survivors' recovery and to analyse whether variations in counsellors' years of experience and levels of professional education significantly influenced their assessments of therapeutic interventions.

4.5.1 Psychological-Based Interventions Addressing Sexual Assault Survivors' Recovery Needs in GBVRCs

This section presents an integrated thematic analysis that synthesizes the survivors' narratives with the counsellors' self-reported practices. It highlights both areas of convergence and notable discrepancies between the two perspectives. Table 4.8 summarizes the findings from the assessment of counsellors' views on the role of psychological

interventions in addressing recovery needs of sexual assault survivors at the GBVRCs in Uasin Gishu County.

Table 4.8: Role of Psychological Support Intervention

Statements		SA	A	UD	D	SD	Mean	Std
1 I provide programmes that assist my clients reduce feelings of shame and humiliation that may lead to low self esteem	F	15	10	7	2	1	4.03	1.071
	%	42.9	28.6	20.0	5.7	2.9		
2 I have in place interventions that assist my clients understand how to manage powerful emotions constructively	F	10	15	4	4	2	3.77	1.165
	%	28.6	42.9	11.4	11.4	5.7		
3 I assist my clients live in an environment where they are assured of their safety and care	F	20	5	4	4	2	4.06	1.305
	%	57.1	14.3	11.4	11.4	5.7		
4 I have therapeutic programmes through which I help my clients understand how to solve problems arising from assault	F	8	14	9	2	2	3.69	1.078
	%	22.9	40.0	25.7	5.7	5.7		
5 I have helped my clients have programmes where they are inspired to get on with life regardless the assault	F	8	15	8	2	2	3.71	1.073
	%	22.9	42.9	22.9	5.7	5.7		
6 I provide my clients programmes that assist them express understanding of their feelings and emotions	F	8	16	6	4	1	3.74	1.039
	%	22.9	45.7	17.1	11.4	2.9		
7 I encourage my clients to manage their thoughts well through focusing more on positive activities and helpful thinking	F	13	12	5	2	3	3.86	1.240
	%	37.1	34.3	14.3	5.7	8.6		
8 I encourage my clients to make an effort to do things that are enjoyable, relaxing and recharging when experiencing flash backs of assault episode	F	10	14	7	2	2	3.80	1.106
	%	28.6	40.0	20.0	5.7	5.7		
9 I assist my clients explore ways of developing coping mechanisms against depressive feelings.	F	10	9	9	4	3	3.54	1.268
	%	28.6	25.7	25.7	11.4	8.6		
10 I provide my clients programmes that assist them improve their sexual functioning	F	8	12	9	4	2	3.57	1.145
	%	22.9	34.3	25.7	11.4	5.7		

Source: Field data (2024)

Survivors responded to a series of questions designed to: ascertain whether psychological interventions commence with a safe and consent-based therapy session; analyse if clients are provided with clear expectations and sufficient time to share their personal experiences; and evaluate adherence to counselling protocols, including risk assessment, disclosure guidelines, action planning, medication adherence support, emotional regulation, and culturally sensitive interactions. The analysis yielded findings that are organized into five themes, which are discussed in the following sections.

4.5.1.1 Establishing a Therapeutic Alliance and Safe Environment

Survivors consistently emphasized the critical importance of a safe and welcoming space in which they could share their experiences at their own pace. As one survivor recalled:

“Individual counselling allowed me to focus on my personal healing at my own pace. My counsellor provided a safe space to talk through my trauma...” (Survivor 8).

Another survivor added thus:

“Crisis intervention was a lifeline for me during my darkest moments. The immediate support I received helped calm me down and reassured me that I wasn’t alone. It gave me the stability I needed to go through the initial shock and start focusing on my recovery.” Survivor 22

Individual counselling provides personalized care essential for addressing the emotional and psychological needs of survivors of gender-based violence. According to Kassim (2022), individual counselling in gender-based violence recovery centres plays a pivotal role in helping survivors process their trauma. This care should include assessing a survivor’s safety; addressing immediate concerns with actionable plans; normalizing reactions and explaining expected psychological responses; empowering informed decision-making by offering options and information; facilitating access to referral resources; addressing

suicidality; delivering clear messages to counter self-blame and guilt; and guiding disclosure to family and friends. These early interventions help mitigate the initial shock of assault, thereby reducing or even preventing more severe psychological distress. Tarabih and Arnault (2024) corroborate these findings, emphasizing that individualized approaches significantly enhance recovery outcomes by creating a non-judgmental space where survivors can process their experiences. The focus on personalized care also helps alleviate feelings of isolation and self-blame, which are common among survivors.

Counsellors also reported a strong commitment to fostering such an environment, as evidenced by a high mean score of 4.06 in providing safety and care. This alignment indicates that both parties recognize the fundamental importance of safety in the healing process.

However, some survivors reported instances in which their sense of safety was compromised. This phenomenon was captured in the abstract below:

“Repeated use of words penetration, use of force or other control tactics over and over again made me to be emotionally unsettling. Questions on what I was wearing pained me internally (kuniuliza nilikuwa nimevaa aje iliniuma sana) what your wearing were” (Survivor 22).

This suggests that repeated acts of penetration and the application of force can result in significant emotional distress and trauma, thereby perpetuating a cycle of control and victimization. This assertion is consistent with the findings of Anderson and Overby (2021), whose study examines the psychological impact of sexual violence on survivors. Their research demonstrates that such experiences not only induce emotional instability but also contribute to enduring mental health challenges, underscoring the detrimental effects of power dynamics within abusive relationships.

Those working with survivors must remain cognizant of this issue to prevent re-traumatization. The abstract above clearly indicates that traumatic experiences during invasive forensic examinations undermine survivors' sense of security, highlighting a discrepancy between counsellors' perceptions of safety and the actual lived experiences of some survivors.

4.5.1.2 Empowerment, Autonomy and Reclaiming Control

One survivor reported that they engaged in self-blame following a sexual assault:

“I blamed myself for the assault – I thought it was my fault for not escaping, for not running away from the scene” (Survivor 15).

This suggests that survivors frequently internalize blame for their assault, perceiving the incident as their own fault due to an inability to escape the situation. This observation is consistent with the study conducted by Robinson and Wellman (2024), which investigates the phenomenon of self-blame among trauma survivors, particularly those who have experienced sexual assault. Their research demonstrates that self-blame can substantially impede the recovery process by engendering feelings of guilt and shame, thereby complicating healing and adversely affecting mental health.

Psychological care provided in the centres played a crucial role in assisting survivors to break free from the vicious cycle of self-blame. Survivors shared compelling accounts of regaining control over their lives, as exemplified by one individual who stated:

“Regaining my sense of autonomy was key to my recovery. Being part of programmes that encouraged decision-making, and self-reliance helped me feel empowered again...” (Survivor 1).

Another survivor reported that the structured environment within her recovery centre contributed significantly to her regaining self-control:

“I was Offered a private, safe and secured environment during treatment, the comfort I received encouraged me to report to the police, what had happened to me, I got involvement in evidence collection, and I cooperated due to calm and less hectic environment at the county SGBVC I was relaxed when interviewed” (Survivor 17)

At gender-based violence and recovery centres, the foundational principles emphasize empowerment, autonomy, and the reclamation of control. According to Dlamini (2025), these interventions are strategically designed to support survivors in reconstructing their lives by promoting active engagement in decision-making processes that restore their agency and self-identity. Furthermore, Moore and Van Vliet (2022) assert that counsellors in sexual assault recovery programmes play a crucial role in creating an environment where clients feel safe and supported. Personalized counselling empowers survivors to navigate their recovery journey, challenge maladaptive beliefs, and adopt adaptive coping strategies that enhance resilience and foster independence.

Counsellors corroborated this finding by reporting that their programmes inspire clients to “get on with life” (mean score = 3.71) and encourage positive thinking (mean score = 3.86). Kometiani and Farmer (2020) assert that counsellors play a significant role in facilitating programmes that motivate sexual assault survivors to move forward despite their traumatic experiences. Similarly, Meier and Davis (2020) emphasize the crucial role of counsellors in assisting sexual assault survivors to manage their thoughts by promoting engagement in positive activities and the adoption of constructive cognitive patterns.

Both survivors and counsellors emphasize the importance of fostering empowerment and self-reliance. However, a gap emerges in the specifics: while counsellors tend to focus on structured programmes, survivors also highlight the need for culturally sensitive practices,

such as the preference for female officers during police interactions, an aspect not explicitly addressed within counsellors' protocols. One survivor remarked as follows:

"Let us have a female police officer listening to our stories, male will not understand what I have gone through (hawajui kile nilipitia)" (Survivor 18).

4.5.1.3 Enhancing Coping Mechanisms and Problem-Solving Skills

Survivors reported that the psychological care they received provided an opportunity to enhance their coping mechanisms and problem-solving skills. One participant noted thus:

"Developing self-care routines was essential for my healing process. I learned various coping skills, like journaling and meditation, which helped me manage my anxiety and stress. Prioritizing my well-being made me feel more grounded and empowered to face each day" (Survivor, 34).

Another one added:

"Creating a safety plan was a crucial step in regaining my sense of control. It helped me outline specific actions to take if I ever felt threatened again. Knowing I had a plan in place gave me peace of mind and helped me feel more secure in my daily life" (Survivor 33).

Psychological therapy provides survivors of sexual assault with a structured and supportive environment that enhances problem-solving abilities and adaptive coping strategies (Hirsch, 2022). Grounded in trauma-informed and cognitive-behavioural frameworks, these interventions equip survivors with the skills necessary to analyse and challenge maladaptive thought patterns while fostering adaptive responses to stress. Individualized counselling sessions facilitate both immediate emotional stabilization and the development of long-term resilience, enabling survivors to manage anxiety, reframe negative cognitions, and navigate acute distress (Dlamini, 2025). Furthermore, engagement in planning and problem-solving

exercises allows survivors to anticipate potential obstacles and devise effective strategies, thereby strengthening their sense of agency and self-efficacy. This comprehensive approach mitigates the impact of trauma and empowers survivors with enduring tools to reclaim their lives, ultimately promoting recovery and sustained psychological well-being.

According to Hamrick and Owens (2020), counsellors play a crucial role in assisting sexual assault survivors to explore and develop coping mechanisms aimed at alleviating depressive symptoms. Their study revealed that the majority of counsellors believe that facilitating the identification of personalized coping strategies significantly enhances clients' capacity to manage their emotional challenges effectively.

Counsellors similarly echoed survivors' experiences by reporting the use of interventions aimed at helping clients manage intense emotions (mean = 3.77) and develop coping mechanisms to counter depressive feelings (mean = 3.54). This convergence highlights a shared recognition between both groups of the necessity to equip survivors with practical tools to navigate the emotional aftermath of assault. However, survivors' narratives occasionally indicate that these coping strategies require further individualization. One survivor remarked thus:

“The counsellors should provide more choices, listen to me, believe me, trust me and be there for me. Provide us more choices in accessing support system” (Survivor 24).

The above views suggest the need to increase tailored approaches in practice.

4.5.1.4 Facilitating Emotional Expression and Addressing Trauma

Survivors consistently reported that open communication, whether in individual or group settings, was essential for processing trauma. As one survivor noted:

“Counselling sessions became a safe space for me to open up without fear...”

(Survivor 8).

Open communication is fundamental to trauma recovery, as it enables survivors to articulate their experiences, validate their emotions, and reconstruct their personal narratives. In individual therapy, a confidential environment allows survivors to express emotions at their own pace, thereby facilitating the development of tailored coping strategies and enhancing self-esteem (Jirek, 2020). In contrast, group sessions provide a collective setting in which shared experiences alleviate feelings of isolation, normalize emotional responses, and foster mutual support. According to Jirek, this dynamic exchange not only mitigates self-blame but also cultivates resilience by empowering survivors to reclaim their narratives and rebuild trust. Ultimately, both individual and group open communication constitute essential pillars for long-term psychological well-being and recovery.

Counsellors also recognize that encouraging clients to express their feelings is a fundamental component of the recovery process, as reflected by a mean score of 3.74. This perspective aligns with Kirkner *et al.* (2021), who assert that counsellors implement programmes designed to help sexual assault survivors articulate and comprehend their emotions, which is essential for their healing. This congruence underscores the critical role of emotional expression in therapeutic interventions aimed at facilitating recovery.

Survivors reported that certain aspects of the disclosure process could be re-traumatizing. Specifically, repetitive and insensitive questioning about intimate details often led to increased emotional distress. This finding reveals a disconnect between counsellors' perceptions and survivors' experiences: while counsellors may assess their approaches as facilitating healthy expression, survivors sometimes perceive these interactions as

triggering. This discrepancy underscores the need to refine counselling practices to better support survivors' emotional well-being.

4.5.1.5 Addressing Trauma-Specific Issues and Rebuilding Sexual Functioning

Some counsellors rated their interventions for addressing specific issues, such as improving sexual functioning (mean = 3.57) and managing flashbacks (mean = 3.80), as components of a comprehensive recovery programme. However, survivors' accounts present a more nuanced perspective. For instance, one survivor described a forensic examination as "invasive (kuingiliwa) and painful (uchungu):

"Forensic examination was invasive (kuingiliwa) and painful (uchungu) especially being re-examined it brought feelings of humiliation and degrading" (Survivor 18).

Another participant reported being referred for an unwelcome medical examination, which subsequently resulted in re-traumatization:

"From the county hospital, I was referred to Moi-Teaching and Referral Hospital where a medical examination was done on me against my wish-felt so bad-I was retraumatized- thought they are offering legal support, and I need one which I cannot afford- I will not go to them" (Survivor 24).

This suggests that forensic examinations for survivors of sexual assault can be invasive and painful, often resulting in feelings of humiliation and degradation. This observation is consistent with the study conducted by Hlavka and Mulla (2020), which explores the emotional and psychological impact of the forensic examination process on survivors. Their research demonstrates that the invasive nature of these examinations may exacerbate trauma and impede the healing process, thereby underscoring the necessity for sensitive and compassionate care throughout these procedures.

These experiences reveal a gap between the intended supportive measures and their actual impact on survivors, underscoring the necessity for trauma-informed practices that prioritize consent and sensitivity. It is noteworthy that counsellors provided several insights regarding psychological care that were not explicitly mentioned by survivors. They emphasized the implementation of systematic interventions aimed at mitigating feelings of humiliation and shame; factors known to undermine self-esteem. Tailored programmes were employed to facilitate the constructive management of intense emotions, a strategy not clearly reflected in survivors' narratives. Furthermore, to address depressive symptoms and flashbacks, counsellors integrated activities designed to foster optimistic thinking and encourage engagement in pleasurable pursuits. Additionally, within the framework of comprehensive rehabilitation, some counsellors highlighted the importance of addressing post-assault sexual functioning issues. Collectively, these perspectives underscore a holistic approach that not only ensures immediate safety and support but also promotes long-term resilience and a thorough healing process.

Discrepancies between counsellors' and survivors' perspectives emerge in the analysis presented in section 4.5.1. While both groups share overarching goals of empowerment, safety, and the development of effective coping strategies, several critical differences are evident. First, survivors report instances of re-traumatization within medical and forensic settings, despite counsellors' high ratings of their efforts to create safe environments and provide structured support. Second, counsellors tend to emphasize generalized positive activity programmes and empowerment initiatives; however, survivors underscore specific cultural and gender-sensitive needs, such as a preference for female police officers, that are not adequately reflected in counsellors' self-assessments. Third, survivors' complex experiences with emotional expression suggest that therapeutic interactions intended to facilitate healing may inadvertently cause distress if not conducted with the utmost

sensitivity. These gaps highlight the necessity for further refinement of intervention protocols to better align with survivors' lived experiences.

4.5.2 Social-Based Interventions Addressing Recovery Needs of Sexual Assault Survivors in GBVRCs

This integrated analysis examines social-based interventions addressing recovery needs of sexual assault survivors, incorporating both survivors' narratives and counsellors' self-reported perspectives. For each theme, areas of convergence and divergence are identified, with survivors' quotations presented in full to substantiate the analysis. The study findings are summarized in Table 4.9.

Table 4.9: Social-Based Interventions Addressing Recovery Needs

Statements		SA	A	UN	D	SD	Mean	Std
1 I am friendly and interact well with my clients	F	13	8	7	4	3	3.69	1.323
	%	37.1	22.9	20.0	11.4	8.6		
2 I arrange to have mentors who get attached to my clients	F	11	14	5	3	2	3.83	1.150
	%	31.4	40.0	14.3	8.6	5.7		
3 I help my clients to develop interest and interact with others more	F	8	12	9	3	3	3.54	1.197
	%	22.9	34.3	25.7	8.6	8.6		
4 I encourage my clients to work hard in their daily chores	F	15	7	4	3	6	3.63	1.536
	%	42.9	20.0	11.4	8.6	17.1		
5 I show interest for my clients to get justice for wrongs suffered	F	15	5	7	3	5	3.63	1.477
	%	42.9	14.3	20.0	8.6	14.3		
6 I encourage my clients to participate in recreational activities	F	14	10	6	3	2	3.89	1.207
	%	40.0	28.6	17.1	8.6	5.7		
7 I allow my clients to participate in decision making on issues affecting them within and outside the GBVRC	F	17	8	5	2	3	3.97	1.294
	%	48.6	22.9	14.3	5.7	8.6		
8 I assist my clients have access to people with specialization in different areas who they can talk with on how to get	F	11	15	5	3	1	3.91	1.040
	%	31.4	42.9	14.3	8.6	2.9		
	F	10	14	3	5	3	3.66	1.282

9	I encourage my clients to take good care of their bodies	%	28.6	40.0	8.6	14.3	8.6		
10	I assist my clients get reintegrated smoothly into their families and communities after getting treatment and assistance	F	20	6	6	2	1	4.20	1.106
		%	57.1	17.1	17.1	5.7	2.9		

Source: Field data (2024)

4.5.2.1 Group Counselling and Peer Support

Survivors consistently underscored the value of group counselling as a space to share experiences, reduce isolation, and challenge self-blame. The following statements from survivor attest demonstrate their perspectives on group counselling:

“Group counselling helped me deal with self-blame, negative thinking that left me feeling like a victim. It made me feel empowered and be in control” (Survivor 5).

“Group counselling allows me to share my feelings and experiences in a supportive environment, which is vital for my emotional processing and healing” (Survivor 4).

“Being surrounded by a supportive community made all the difference. People who listened without judgment and offered genuine care helped me feel less alone. Their constant encouragement gave me strength to keep moving forward” (Survivor 30).

Following experiences of violence, support groups have emerged as primary means through which survivors access organised social assistance. These groups serve as valuable tools in facilitating the healing process. A substantial body of research indicates that group-based interventions significantly enhance the recovery trajectories of trauma survivors. Participation in such support groups has been consistently associated with improved healing outcomes, enabling individuals to progress more effectively along their path to recovery.

Research by Kirkner and Ullman (2021) indicates that survivors of sexual abuse benefit from social assistance in multiple ways. Generally, such support helps survivors mitigate

the detrimental effects of trauma by facilitating the development of constructive coping mechanisms. Accordingly, social support functions as a protective buffer, reducing the likelihood that victims of sexual assault will experience conditions such as depression, low self-esteem, and symptoms of post-traumatic stress disorder (PTSD) (Murn & Schultz, 2023). Furthermore, social support enables survivors to restore their sense of self-worth and promote self-care.

Group healing, encompassing both support groups and individual treatment, represents a highly effective strategy for recovery from sexual trauma (Heard & Walsh, 2023). Support groups offer survivors a sense of belonging and help to mitigate feelings of isolation. Participation in such groups can alleviate emotions commonly associated with experiences of violence, including loneliness, shame, secrecy, and stigma. Heard and Walsh further posit that group work in response to sexual abuse might help survivors articulate their thoughts, boost social support, and inspire hope. However, it should be noted that support groups were found to have some drawbacks for participants. As one survivor explained:

“Being asked to talk about my experience in a group was difficult for me” (Survivor 25).

There is a need for counsellors to listen attentively to survivors’ needs to avoid inadvertently exacerbating their situations. Frawley and McInerney (1987) aver that participation in support groups can impose a burden on individuals, as the collective experience may disrupt their personal lives. In the present study, it was observed that 20% of adult female survivors of childhood abuse who engaged in group treatment experienced increased discomfort upon hearing others recount their abuse histories. Despite these potential drawbacks, empirical evidence indicates that support groups and other group-based interventions yield long-term beneficial effects for participants (Aureli & Riva, 2020). Counsellors, meanwhile, reported

strategies that facilitate collective engagement. As shown in Table 4.9, counsellors highlighted arranging for mentors to be attached to clients (Mean = 3.83) and assisting clients in developing an interest in social interaction (Mean = 3.54). They also reported encouraging participation in recreational activities (Mean = 3.89) and promoting client involvement in decision-making processes (Mean = 3.97). An interview with one counsellor further underscored the benefits of group support:

“Fostering social connections and encouraging participation in group activities significantly enhances clients' sense of community and belonging” (Counsellor 11).

The above statement suggests that fostering social connections and promoting participation in group activities are essential for enhancing survivors' sense of community and belonging. This perspective aligns with the findings of Terry and Townley (2019), whose study investigated the positive impact of social integration on the recovery process of trauma survivors. Their research demonstrated that engagement in group activities facilitates feelings of support and connectedness, which are critical for emotional healing and the reconstruction of identity following trauma.

The assertions of Counsellor 11 further align with those of Leech and Littlefield (2011), who demonstrated that survivors participating in support groups report feeling less isolated, stigmatized, and ashamed, while also receiving increased assistance. Furthermore, research by Carey (1998) indicates that support groups represent a highly promising service for survivors, offering a secure and private environment conducive to ongoing recovery processes, as well as valuable social support.

It can be concluded that both counsellors and survivors acknowledge the critical role of peer support and group-based activities in fostering empowerment and mitigating the isolation associated with trauma. However, while survivors emphasize the importance of emotional

safety and validation derived from shared experiences, counsellors tend to focus more on structured, activity-based approaches. The narratives of survivors suggest a need for deeper emotional connection than might be inferred from the counsellors' emphasis on general engagement and mentorship. Ideally, support groups should assist members in developing coping skills by enabling them to utilize their existing abilities and acquire new ones. Nonetheless, the findings indicate that counsellors and support centres may not be fully facilitating the optimal functioning of these groups.

4.5.2.2 Institutional Social Support and Follow-Up

Survivors attributed their recovery to the ongoing social support provided by the GBVRCs staff and follow-up mechanisms. As one survivor explained:

“The social support I received from workers at the centre helped me accept that I was assaulted and that it was not my fault, and I took responsibility over my life”
(Survivor 13).

Another survivor similarly remarked on the effectiveness of follow-up support:

“Counsellors use phone call for follow up and psychological support” (Mshauri alinipigia simu na kunihakikishia mambo itakuwa mzuri) (Survivor 12).

This aligns with research indicating that centers must provide social support to assist survivors in coping with trauma. According to the Ministry of Health (2014), this support includes primary protection, which is achieved through preventative measures that ensure the recognition and safeguarding of survivors' rights via international treaties, statutory legislation, and traditional legal frameworks. Additionally, it encompasses protection through the development and implementation of robust systems and strategies designed to monitor and respond when survivors' rights are violated. This includes formal legal and justice systems, as well as healthcare, social welfare programmes, and community

mechanisms. Finally, at the operational level, services are delivered directly to address the immediate needs of women and girls who have experienced abuse, thereby facilitating their recovery and empowerment.

The quantitative findings indicate that counsellors perceive their roles as multifaceted, emphasizing both interpersonal rapport and broader systemic support. With a mean rating of 3.69, counsellors regard their friendliness and interaction skills as crucial for establishing effective client relationships, which are fundamental in therapeutic contexts. Furthermore, a slightly higher mean rating of 3.91 for facilitating access to specialized advice suggests that counsellors value connecting clients with expert resources, recognizing that comprehensive support often necessitates interdisciplinary collaboration. Notably, the highest mean score of 4.20 was reported for assisting clients with reintegration into their families and communities, underscoring the importance of long-term social support in the recovery process. This elevated rating reflects an understanding that sustainable healing extends beyond individual therapy to encompass social and familial environments. Collectively, these findings advocate for a broad-based approach in counselling practice that integrates immediate interpersonal support with systemic efforts to ensure enduring community and familial reintegration.

Table 4.9 reveals a significant deficit in basic amenities at gender-based violence and recovery centres, which likely contributes to substandard social care for survivors. This finding concurs with Gatuguta *et al.* (2018), who report that multiple barriers at both hospital and community levels result in missed treatment opportunities. Although national guidelines exist, their effective implementation is severely constrained by several factors: inadequate staff training, poor coordination among service delivery points, the absence of tailored protocols for different categories of survivors, and a lack of essential equipment such as HIV

testing kits, speculums, and rape kits. These deficiencies impede not only the delivery of quality healthcare to survivors but also the collection of forensic specimens critical for legal proceedings, thereby undermining both therapeutic and judicial processes in cases of gender-based violence.

From the foregoing, it is evident that both survivors and counsellors recognize the importance of sustained social support and follow-up as essential components of the recovery process. However, discrepancies exist between their perspectives. Survivors emphasize the value of personal connection and trust, which are fostered through ongoing, individualized interactions, such as telephone follow-ups. In contrast, counsellors tend to prioritize systematic support structures and reintegration programmes, which may not fully address the nuanced emotional needs articulated by survivors.

4.5.2.3 Environmental and Shelter-Based Support

A secure physical environment is critical to survivors' sense of safety and recovery. One survivor observed thus:

"Feeling safe again was a long journey for me. The shelter I stayed in had strict security protocols, which helped me sleep better at night. Knowing I wasn't alone anymore made a big difference in my healing process" (Survivor 21).

Another survivor also had this to say:

"After the incident, the care centre took immediate action to ensure my safety. They arranged for me to be moved to a secure shelter, away from the perpetrator. Thankfully, the perpetrator was apprehended shortly after I reported the assault. The hospital staff addressed my medical needs immediately, and everything was documented in the OB report. The most important help I received was feeling

protected and knowing that I was in a safe environment, and this allowed me to focus on my recovery" (Survivor 27).

A secure physical setting is crucial in fostering a sense of safety, which is a vital component in the rehabilitation process for survivors. According to Sit and Stermac (2021), such an environment comprises not only the structural integrity and accessibility of facilities but also design aspects that encourage privacy, dignity, and comfort. For survivors, particularly those of gender-based violence or other traumatic events, physical security is intertwined with emotional stability. When survivors are confident that their surroundings are free from hazards, they are more likely to engage in therapeutic sessions and establish trust with care providers. Moreover, a secure location may decrease the tension and anxiety associated with prior trauma, thereby promoting a more successful healing process.

Although counsellors did not explicitly address the physical characteristics of shelter in Table 4.9, their recommendations for engaging in daily chores (Mean = 3.63) and maintaining bodily self-care (Mean = 3.66) reveal an implicit recognition of the benefits of routine and self-care within a structured environment. This emphasis suggests that counsellors acknowledge the role of consistent daily practices in fostering a sense of normalcy and agency, which are essential for the psychological recovery of survivors. By encouraging clients to incorporate routine tasks and self-care practices, counsellors indirectly underscore the importance of a supportive and well-organized setting, where structured daily activities contribute to enhanced self-efficacy and overall well-being. According to Padmanabhanunni and Gqomfa (2022), promoting engagement in daily chores is a key strategy used by counsellors to cultivate responsibility and routine among sexual assault survivors. These findings align with broader literature advocating structured

environments as critical in the recovery process, highlighting how maintaining routine and self-care facilitates long-term healing and resilience among survivors (Alskaf, 2024).

Both counsellors' and survivors' perspectives acknowledge that a stable and secure environment significantly contributes to a survivor's overall recovery by providing physical safety and predictability. However, whereas survivors explicitly emphasize the critical importance of secure shelter and stringent safety protocols, counsellors tend to focus more on facilitating social reintegration and personal care activities. This divergence suggests that counsellors may potentially overlook the immediate impact of the physical environment on survivors' sense of security.

4.5.2.4 Legal and Rights-Based Support

Access to legal support and advocacy is another key aspect of social-based interventions. Concerning the implementation of this intervention in GBVRCs in Uasin Gishu County, one survivor recounted:

"Having legal support made me feel like my voice mattered. My lawyer guided me through the process, ensuring I understood my rights and options. It gave me a sense of justice and helped me regain some control over the situation" (Survivor 24).

Another survivor added thus:

"The strategies used by the care centre made me feel safe right away. I was placed in a secure location, and the police were informed, leading to the apprehension of the perpetrator. The hospital was quick to attend to my injuries, and the incident was properly recorded in the OB report. The key support I got was the assurance that both my physical safety and legal rights were being taken seriously, which gave me peace of mind during a very difficult time" (Survivor 38).

It appears that survivors may not have been adequately informed about the Sexual Offences Act, which seeks to address the increasing incidence of sexual violence. According to Aura (2017), the primary objective of this legislation is to ensure that complainants of sexual offences receive justice proportionate to the harm they have endured. Moreover, the Act provides clear definitions of sexual offences, outlines measures for their prevention, and establishes protections for all individuals against harm resulting from unlawful sexual acts. Therefore, facilitating survivors' understanding of the provisions of this Act is essential to effectively addressing their recovery needs.

Access to legal support and advocacy plays a critical role in validating survivors' experiences by formally acknowledging the injustices they have endured, thereby affirming their dignity (Herman, 1992). Such legal recognition not only provides emotional validation but also reinforces survivors' entitlement to justice. Furthermore, legal advocacy empowers survivors by equipping them with the knowledge and resources necessary to navigate complex legal systems, thereby fostering a sense of agency and self-determination (Campbell, Dworkin & Cabral, 2009). When legal advocates collaborate closely with other service providers, they contribute to building trust through transparency and accountability. This integrated support system not only validates survivors' experiences but also promotes resilience, enabling survivors to reclaim control over their lives and advance on their path to recovery.

Counsellors acknowledge the importance of integrating justice-oriented support into their therapeutic practices. Data from Table 4.9 indicate that counsellors report a moderate to high level of interest in assisting clients to obtain justice for the wrongs they have suffered (Mean = 3.63). This finding reflects an understanding that the pursuit of justice is not merely a legal process but an integral component of the healing journey for survivors. As noted by Javorka

and Campbell (2019), demonstrating interest in clients' pursuit of justice constitutes a crucial element of counselling, particularly for survivors of sexual assault. By actively supporting clients' efforts to seek redress, counsellors validate their experiences of trauma and affirm their right to be heard and treated with dignity. This approach fosters a sense of empowerment, encouraging survivors to reclaim control over their narratives and to move forward with a reinforced sense of self-worth. Furthermore, by bridging the gap between psychological support and legal advocacy, counsellors contribute to a more holistic model of care that addresses both emotional recovery and practical justice. Ultimately, this dual focus not only facilitates individual healing but also promotes systemic accountability, thereby enhancing overall resilience and recovery outcomes. It is worth noting, however, that some counsellors expressed dissatisfaction with the manner in which legal protocols are implemented. For instance, Counsellor 5 stated thus:

“We need to strengthen and change the legal system that deals with sexual assault. When you tell the survivor that prosecution is a long, tedious process, it’s psychologically damaging. The court system should be made to be helpful and not hurting.”

The legal provisions need to be made more responsive to the needs of survivors. According to Aura (2020), while the Kenyan legal framework provides mechanisms for addressing Sexual and Gender-Based Violence (SGBV), the extent to which these frameworks effectively respond to the needs of survivors remains debatable. The existing legal and policy frameworks primarily focus on prosecuting the accused, with insufficient emphasis on alleviating the conditions of SGBV survivors. Consequently, survivors often experience alienation within the criminal justice system, as the offense is treated as a crime against the state rather than a violation against the individual survivor. This approach undermines the survivor-centred justice that is essential for meaningful redress and recovery.

Both survivors and counsellors concur on the critical role of legal advocacy in reinforcing survivors' rights and fostering a sense of empowerment through the pursuit of justice. However, whereas survivors emphasize the transformative impact of legal support in reclaiming personal agency and securing emotional validation, counsellors tend to offer a more general endorsement of justice, without necessarily capturing the nuanced emotional relief that legal recognition can provide.

4.6 Challenges of Psychosocial Interventions Used in Addressing Sexual Assaults Survivors' Recovery Needs in GBVRCs

The interview conducted with survivors revealed several pertinent themes regarding the challenges of psychosocial interventions, which corresponded closely with the issues identified by counsellors in Table 4.7 and the observations of the researcher reported in Table 4.10.

Table 4.10: Challenges of Psychosocial Interventions

Statements		SA	A	UD	D	SD	Mean	Std. Dev.
1 Lack of continuous in-service training on psychosocial intervention	F	22	6	1	4	2	4.20	1.279
	%	62.9	17.1	2.9	11.4	5.7		
2 Limited resources for psychosocial interventions	F	18	6	4	2	5	3.86	1.478
	%	51.4	17.1	11.4	5.7	14.3		
3 Lack of awareness and understanding of psychosocial interventions among sexual assault survivors	F	23	4	3	1	4	4.17	1.382
	%	65.7	11.4	8.6	2.9	11.4		
4 Stigma and discrimination associated with sexual assault and psychosocial interventions.	F	23	4	2	4	2	4.20	1.302
	%	65.7	11.4	5.7	11.4	5.7		
5 Lack of coordination between our office and other service providers for sexual assault survivors	F	18	5	6	2	4	3.89	1.409
	%	51.4	14.3	17.1	5.7	11.4		
6 Dealing with the intense emotions and trauma experienced by survivors can be emotionally draining for me	F	14	6	10	2	3	3.74	1.291
	F	40.0	17.1	28.6	5.7	8.6		
7 Hearing about the survivor's experiences can lead to vicarious trauma for counsellors, which may result in symptoms similar to post-traumatic stress	F	14	6	10	4	1	3.80	1.183
	%	40.0	17.1	28.6	11.4	2.9		
8 Striking the right balance between empathy and maintaining professional boundaries is crucial but can be difficult	F	15	10	4	2	4	3.86	1.353
	%	42.9	28.6	11.4	5.7	11.4		
9 Understanding and respecting diverse cultural perspectives and beliefs regarding sexuality and trauma is essential.	F	15	5	7	7	1	3.74	1.291
	%	42.9	14.3	20.0	20.0	2.9		
10 Avoiding re-traumatization or secondary victimization of the survivor through inappropriate questioning or response	F	16	11	3	1	4	3.97	1.317
	%	45.7	31.4	8.6	2.9	11.4		
11 Navigating legal obligations, such as mandatory reporting laws, can be complex and may vary depending on jurisdiction	F	11	11	8	4	1	3.77	1.114
	%	31.4	31.4	22.9	11.4	2.9		
12 Depending on the setting, there may be limited resources available for follow-up care, referrals, or other support services	F	20	9	2	3	1	4.26	1.094
	%	57.1	25.7	5.7	8.6	2.9		
13 Counsellors must prioritize their own self-care to prevent burnout and ensure they can continue providing effective support	F	22	7	3	1	2	4.31	1.132
	%	62.9	20.0	8.6	2.9	5.7		

Source: Field data (2024)

4.6.1 Lack of Personalized Choices and Autonomy

Sexual assault survivors consistently emphasized the need for individualized support. For instance, one survivor stated thus:

“The counsellors should provide more choices, listen to me, believe me, trust me and be there for me. Provide us more choices in accessing support system” (Survivor 24).

Affirming the importance of client-centred counselling intervention, another survivor reiterated:

“Individual counselling allowed me to focus on my personal healing at my own pace. My counsellor provided a safe space to talk through my trauma and helped me develop coping strategies” (Survivor 27).

The above transcripts underscore the importance of individualizing therapy for survivors of sexual assault. The challenge identified by Survivor 24 highlights the provision of therapeutic interventions that fail to adequately address the specific needs of users. These narratives correspond with counsellors’ concerns presented in Table 4.10, particularly regarding the “lack of continuous in-service training on psychosocial interventions” (Mean = 4.20) and the “lack of awareness and understanding of psychosocial interventions among sexual assault survivors” (Mean = 4.17). This suggests that deficiencies in training and interagency coordination (Mean = 3.89) may hinder the delivery of personalized services. Furthermore, resource constraints noted in Table 4.7, where only 42.86% of centres possessing a private, quiet, and well-lit room (rated as “poor”) and the very limited availability of referral directories (14.29%), further compromise the capacity to provide tailored, client-centred interventions.

Literature underscores the necessity of providing survivors with individualized support. Such support includes therapeutic interventions delivered by counsellors, specialist sexual assault or rape support workers, advocates, or advisers who offer survivors assistance, information, and guidance. These professionals listen to survivors and facilitate the expression of their emotions and challenges. Counsellors may also provide debriefing, a process that promotes emotional processing through the recollection, ventilation, and reworking of the traumatic experience.

4.6.2 Risk of Re-traumatization through Invasive Practices

Many of the survivor participants commented that some procedures exacerbated their trauma. As one survivor recounted:

“Forensic examination was invasive (kuingiliwa) and painful (uchungu) especially being re-examined; it brought feelings of humiliation and degrading” (Survivor 18).

In post-assault care, the risk of re-traumatization among sexual assault survivors due to intrusive procedures remains a critical concern. Survivor 18 further characterized the forensic examination as both intrusive and distressing, noting that repeated examinations evoked feelings of shame and degradation. This phenomenon occurs when survivors are repeatedly subjected to processes that force them to relive their traumatic experiences, thereby intensifying emotional and psychological harm. For example, repeated use of terminology associated with penetration and force, along with invasive inquiries about their attire, resulted in significant emotional distress.

Moreover, these invasive practices not only compromise the dignity of survivors but also undermine their sense of control and safety during a critical period of recovery. Structural deficiencies exacerbate this issue; for instance, as shown in Table 4.7, only 42.86% of centres provided a private, peaceful, accessible, and well-lit room often with ratings deemed

“poor.” The absence of adequate infrastructure may further amplify the distress experienced during intrusive examinations. Consequently, it is imperative for GBVRCs to implement trauma-informed protocols that prioritize survivor autonomy, foster respectful and sensitive interactions during forensic and medical procedures, and reduce the risk of subsequent victimization.

The experiences reported by Survivor 18 resonated with the challenge noted by the counsellors, namely that of “avoiding re-traumatization or secondary victimization” (Mean = 3.97), as documented in Table 4.10. The counsellors concurred that re-traumatization risked occurring in centres where clients were predisposed to post-trauma episodes. Therefore, patient-centred sexual assault services could offer inherent therapeutic value by prioritizing survivors’ emotional and psychological well-being alongside their immediate medical and forensic needs. According to Stewart *et al* (2024), patient-centred services should integrate trauma-informed principles that acknowledge the profound impact of sexual assault. This, according to Stewart *et al.*, includes ensuring that examinations and procedures are conducted in a manner that minimizes re-traumatization, such as using sensitive language, maintaining privacy, and allowing survivors to dictate the pace of the process. These practices not only reduce immediate distress but also contribute to long-term psychological resilience.

4.6.3 Cultural and Gender Sensitivity

Cultural and gender sensitivity emerged as critical factors in the effectiveness psychosocial interventions. One survivor emphasized the necessity of gender-sensitive support:

“Let us have a female police officer listening to our stories; a male will not understand what I have gone through” (Survivor 18).

Survivor narratives underscore the imperative of incorporating cultural and gender sensitivity into effective psychological therapy. The integration of these sensitivities enables counsellors to develop tailored interventions that address the distinct challenges and stressors experienced by clients from diverse backgrounds. This individualized approach acknowledges the influence of sociocultural factors on mental health and facilitates the formulation of targeted therapeutic strategies. Furthermore, culturally and gender-sensitive practices can mitigate barriers to accessing care, such as stigma, discrimination, and negative prior encounters with healthcare systems, by fostering a more inclusive environment that validates clients' identities and experiences, thereby enhancing engagement with psychological services (Patel, 2020).

This call for culturally and gender-responsive practices aligns with counsellors' perspectives on the importance of understanding and respecting diverse cultural perspectives and beliefs regarding sexuality and trauma (Mean = 3.74), as indicated in Table 4.10. Furthermore, the poor status of resources such as displayed IEC materials (28.57%, rated "poor") and centre policies (42.86%, rated "poor") in Table 4.7 highlights the limited institutional emphasis on culturally sensitive practices, which may hinder effective engagement with diverse survivor populations.

It is evident that therapeutic interventions must be tailored to address the unique experiences and challenges individuals encounter in relation to their gender and cultural backgrounds. Integrating cultural and gender sensitivity within psychosocial treatments not only affirms survivors' identities and lived experiences but also cultivates a therapeutic environment characterized by trust, respect, and active engagement in the recovery process (Diab & Al-Azzeh, 2024).

4.6.4 Coordination and Resource Limitations

Both survivors and counsellors identified challenges related to resource constraints and the coordination of services. Survivors reported experiencing fragmented care, exemplified by one individual's account of being referred to an inappropriate facility, which resulted in re-traumatization. One survivor stated the following:

“From the county hospital, I was referred to Moi-Teaching and Referral Hospital where a medical examination was done on me against my wish-felt so bad-I was retraumatized- though they are offering legal support, and I need one which I cannot afford- I will not go to them” (Survivor 24).

Fragmented care frequently stems from systemic issues, including inadequate communication among service providers, the absence of standardized protocols, and insufficient training in trauma-informed practices. When referral processes lack proper coordination, survivors may be directed to facilities that do not possess the necessary resources or sensitivity to address their complex needs. This not only disrupts the continuum of care but also erodes survivors' trust in the healthcare system.

Moreover, the experience of being referred to an unsuitable facility can exacerbate feelings of vulnerability and powerlessness. Survivors, who are often in a fragile state, may interpret such referrals as a disregard for their unique circumstances, thereby reinforcing feelings of isolation and distress. The cumulative impact of these experiences underscores the critical need for an integrated, survivor-centred approach that prioritizes coordinated care and ensures that all service providers are adequately equipped to deliver sensitive, trauma-informed support.

The fragmented nature of care, as exemplified by the survivor's experience, reflects the counsellors' concerns regarding the “limited resources for psychosocial interventions”

(Mean = 3.86) and the “limited resources available for follow-up care, referrals, or other support services” (Mean = 4.26), as presented in Table 4.10. This situation is further exacerbated by the inadequate status of essential resources detailed in Table 4.7, including the availability of private rooms (42.86%, rated as “poor”), PRC registers, and referral directories. The cumulative effect of these deficiencies undermines service coordination and follow-up efforts, ultimately impeding the provision of comprehensive care necessary for the recovery of sexual assault survivors in Uasin Gishu County.

Ultimately, addressing the fragmentation of psychosocial care for sexual assault survivors necessitates systemic reforms, including the establishment of clear referral pathways, the enhancement of inter-agency communication, and investment in specialized training for healthcare professionals. The implementation of these measures can enable healthcare systems to provide more comprehensive support to survivors, mitigate the risk of re-traumatization, and facilitate a more effective recovery process (Strom *et al.*, 2022).

4.7 Perspectives of Counsellors and Clients on Strategies for Improving the Psychosocial Interventions used in Addressing Recovery Needs of Sexual Assault Survivors

In the domain of post-violence recovery, optimizing psychosocial interventions for survivors of sexual assault remains a critical concern, particularly within gender-based violence and recovery centres. This study elucidated the diverse perspectives of both counsellors and clients regarding strategies to enhance these interventions, with the goal of bridging the gap between clinical practice and the complex, evolving recovery needs of survivors. By integrating insights from professional practitioners and individuals directly affected by sexual violence, the research sought to foster a more relevant understanding of the factors that contribute to effective psychosocial care in the African context.

Counsellors, who operate at the frontline of intervention delivery, provide a unique vantage point on the systemic and operational challenges that impede the full realization of therapeutic objectives. Their perspectives offer critical evaluations of current methodologies, highlighting areas where institutional protocols may be inadequate and proposing innovative strategies for improvement. Conversely, clients, whose lived experiences underscore the profound impacts of sexual violence, emphasize the necessity of empathetic, tailored, and trauma-informed approaches. Their narratives not only validate the emotional complexities inherent in recovery but also underscore the importance of culturally and gender-sensitive practices in fostering a therapeutic environment conducive to healing.

This introductory analysis frames the discourse on psychosocial intervention strategies by integrating the complementary perspectives of both counsellors and clients. It emphasizes the necessity of a collaborative, interdisciplinary approach that synthesizes empirical evidence with experiential knowledge, thereby informing the development of more effective and responsive recovery frameworks.

4.7.1 Strategy 1: Enhance Personalized, Trauma-Informed Counselling

Survivors consistently called for individualized, trauma-sensitive interventions. As one survivor explained:

“Individual counselling allowed me to focus on my personal healing at my own pace. My counsellor provided a safe space to talk through my trauma and helped me develop coping strategies” (Survivor 27).

Another survivor reiterated thus:

“The counsellors should provide more choices, listen to me, believe me, trust me and be there for me. Provide us more choices in accessing support system” (Survivor 24).

These accounts underscore the necessity of adopting flexible, client-centred approaches. Counsellors themselves emphasized a “lack of continuous in-service training on psychosocial intervention” (Mean = 4.20, Table 4.10), indicating that regular, specialized training is crucial for tailoring services to individual trauma histories. Such training is also vital to minimizing the risk of re-traumatization, particularly in contexts involving invasive forensic examinations.

At the core of personalized counselling lies a comprehensive, individualized assessment that acknowledges the unique history, trauma, and resilience of each survivor (Herman *et al.*, 2021). Such assessments enable practitioners to develop interventions that are specifically tailored to address the client’s distinct emotional, psychological, and physical needs.

Trauma-informed counselling frameworks are grounded in core principles such as safety, trustworthiness, choice, collaboration, and empowerment (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022). These principles are essential in

establishing a therapeutic environment wherein survivors feel sufficiently secure to engage in the healing process without the risk of re-traumatization.

Moreover, personalized, trauma-informed counselling necessitates ongoing professional development and supervision (Goldsmith *et al.*, 2020). Continuous training in the most current evidence-based practices, alongside reflective supervision, enables counsellors to maintain the delicate balance between empathetic engagement and the preservation of professional boundaries.

Integrating these approaches into psychosocial interventions necessitates the development of collaborative, multidisciplinary networks (Chen *et al.*, 2023). By connecting mental health professionals with medical, legal, and social support services, a more holistic and coordinated model of care can be established.

4.7.2 Strategy 2: Strengthen Professional Development and Counsellor Support

Counsellors in the study pointed out critical gaps in their own professional support systems.

Concerning this, one counsellor remarked:

“Selfcare for the service providers need to be improved to avoid compassion fatigue” (Counsellor 6).

Another stressed the necessity for:

“Debriefing sessions, more training and support by other counsellor mentors”
(Counsellor 19).

Table 4.10 further indicates that prioritizing counsellor self-care is imperative (Mean = 4.31). The implementation of regular debriefing sessions, mentorship programmes, and continuous virtual training with certification, as recommended by Counsellor 11, is essential to enhance counsellor resilience and competency.

Strengthening professional development and counsellor support is imperative. The establishment of comprehensive, ongoing training programmes in trauma-informed care, ethical practice, and evidence-based interventions is essential to effectively address the complex needs of survivors. Additionally, regular reflective supervision and the development of peer support networks are critical in mitigating vicarious trauma and burnout (Bendall *et al.*, 2021).

By investing in robust professional support structures, centres can cultivate an environment conducive to continuous learning and collaboration, thereby enhancing the quality of psychosocial interventions (Strom *et al.*, 2022).

4.7.3 Strategy 3: Improve Infrastructure and Resource Availability

Resource inadequacies significantly impede the delivery of psychosocial services. As shown in Table 4.7, only 42.86% of centres possess a private, quiet, and well-lit room, a factor rated as “poor.” Furthermore, essential materials such as referral directories are available in merely 14.29% of facilities, a condition rated as “very poor.” These infrastructural deficiencies undermine the capacity to provide safe and confidential counselling sessions. As one survivor observed:

“I was offered a private, safe and secured environment during treatment...”

(Survivor 17).

Improving infrastructure and resource availability is essential for effective service delivery. Adequate infrastructure encompasses not only physical spaces but also technological and logistical systems that facilitate efficient service coordination. The absence of proper facilities can result in delays in service provision and may compromise client confidentiality (Sit & Stermac, 2021). Furthermore, constraints such as insufficient funding and staffing shortages undermine continuity of care and contribute to increased stress among counsellors

(Alskaf, 2024). Therefore, investing in modern facilities and ensuring sustainable funding are critical measures to enhance psychosocial outcomes and mitigate professional burnout.

4.7.4 Strategy 4: Foster Integrated, Multidisciplinary Coordination and Community Empowerment

Both survivors and counsellors advocated for enhanced coordination across service sectors.

A counsellor commented thus:

“Medical and legal interventions, legal operatives handling of survivors needs to be improved” (Counsellor 2).

Survivors’ accounts, such as one stating that a forced referral for a medical examination re-traumatized her (Survivor 24), highlight the urgency for integrated protocols. Additionally, community empowerment is critical. As Counsellor 10 emphasized:

“Empowerment of the community members and creating awareness in schools about sexual assaults is key in preventing it...”

An integrated, multidisciplinary framework facilitates the seamless sharing of information and resources among professionals, thereby enhancing response times and ensuring continuity of care (World Health Organization, 2023). Such coordination establishes standardized referral pathways and mitigates stress experienced by survivors. According to the World Health Organization, community empowerment further strengthens this model by providing support to survivors through local networks, reducing stigma, and fostering resilience.

4.8 Inferential Analysis

The study conducted inferential analysis using Pearson's product moment correlation coefficient and regression analysis.

4.8.1 Regression Diagnostics

Prior to conducting multiple regression analysis to analyse the predictive influence of psychosocial interventions on recovery needs, several diagnostic tests were performed to verify compliance with underlying statistical assumptions. These tests assessed normality, linearity, multicollinearity, autocorrelation, and homoscedasticity. Ensuring that these assumptions are satisfied strengthens the validity and reliability of regression results and enhances confidence in interpretation.

4.8.1.1 Normality Assumption Test Using Shapiro–Wilk

The normality assumption requires that the residuals of the regression model be approximately normally distributed. The Shapiro–Wilk test was employed because it is appropriate for small to moderate sample sizes and provides a robust test of normality.

Table 4.11: Shapiro–Wilk Test of Normality

Variables	Statistic	df	Sig.
Psychosocial intervention	.961	6	.183
Social based intervention	.750	3	.148
Challenges of psychosocial intervention	.801	4	.103

The Shapiro–Wilk results indicate that all variables yielded significance values greater than .05. Specifically, psychosocial intervention ($p = .183$), social-based intervention ($p = .148$), and challenges of psychosocial intervention ($p = .103$) did not significantly deviate from normality. Since $p > .05$ for all variables, the null hypothesis of normal distribution is not rejected. Therefore, the normality assumption was satisfied in this study. This implies that

the regression estimates derived from these variables are unlikely to be biased due to non-normal residual distribution.

4.8.1.2 Linearity Assumption Test Using ANOVA for Linearity

The linearity assumption requires that a linear relationship exists between the independent variables and the dependent variable (recovery needs). ANOVA tests for linearity and deviation from linearity were conducted.

Table 4.12: Test of Linearity

Variables	Linearity	Deviation from Linearity
Psychosocial intervention	.000	.717
Social based intervention	.000	.407
Challenges of psychosocial intervention	.000	.346

The results show that the linearity significance values are .000 for all three predictors, indicating a statistically significant linear relationship with the dependent variable. Furthermore, the deviation from linearity values are greater than .05 for all variables (.717, .407, and .346 respectively), suggesting that there is no significant non-linear pattern. Therefore, the assumption of linearity was met. In the context of this study, this confirms that psychosocial interventions and associated challenges relate to recovery needs in a linear manner, justifying the use of linear regression modelling.

4.8.1.3 Multicollinearity Assumption Test Using Tolerance and Variance Inflation Factor (VIF)

Multicollinearity occurs when independent variables are highly correlated with one another, potentially inflating standard errors and distorting regression coefficients. Tolerance values below .10 and VIF values above 10 typically indicate serious multicollinearity concerns.

Table 4.13: Collinearity Statistics

Variables	Collinearity Statistics	
	Tolerance	VIF
(Constant)		
psychosocial intervention	.212	4.723
Social based intervention	.273	3.667
Challenges of psychosocial intervention	.230	4.357

The tolerance values for all predictors exceed .10, and VIF values are below the critical threshold of 10. Although the VIF values range between 3.667 and 4.723, which indicates moderate correlation among predictors, they remain within acceptable limits. Therefore, multicollinearity was not severe enough to compromise the regression model. In this study, this suggests that psychological interventions, social-based interventions, and challenges of intervention represent related but distinct constructs contributing independently to recovery needs.

4.8.1.4 Autocorrelation Assumption Test Using Durbin–Watson

The Durbin–Watson statistic tests for autocorrelation of residuals. Values between 1.5 and 2.5 are generally considered acceptable, indicating independence of errors.

Table 4.14: Durbin–Watson Statistics

Variables	Durbin-Watson
psychosocial intervention	1.693
Social based intervention	1.889
Challenges of psychosocial intervention	2.360

The Durbin–Watson values range between 1.693 and 2.360, all of which fall within the acceptable range. This indicates that there is no significant autocorrelation in the residuals.

In practical terms, this means that the error terms in the regression model are independent, thereby satisfying another key assumption for reliable regression estimation.

4.8.1.5 Homoscedasticity Assumption Test Using Levene’s Test

Homoscedasticity requires that the variance of residuals be constant across levels of the independent variables. Levene’s Test of Equality of Error Variances was conducted to assess this assumption.

Table 4.15: Levene’s Test of Equality of Error Variances

Variables	Levene's Test of Equality of Error Variances ^a			
	F	df1	df2	Sig.
Psychosocial intervention	1.273	17	17	.312
Social based intervention	4.907	24	10	.162
Challenges of psychosocial intervention	6.570	16	18	.131

All significance values are greater than .05 (.312, .162, and .131 respectively), indicating that the variances are not significantly different across groups. Therefore, the assumption of homoscedasticity was satisfied. In the context of this study, this confirms that the variability of recovery needs remains consistent across different levels of psychosocial interventions and associated challenges.

The diagnostic tests confirmed that the assumptions of normality, linearity, multicollinearity, independence of errors, and homoscedasticity were satisfactorily met. Consequently, the multiple regression analysis conducted to examine the influence of psychosocial interventions on recovery needs is statistically appropriate and methodologically sound. The absence of major violations strengthens the credibility of the regression findings and supports valid interpretation of the predictive relationships identified in this study.

4.8.2 Correlation Analysis

Correlation is a statistical technique that shows how strongly pairs of variables are related. The correlation coefficient ranges from -1 to +1. A correlation coefficient value of -1.000 indicates a perfect negative correlation and a correlation coefficient value of +0.001 to +1.000 indicates a perfect positive correlation while a correlation coefficient value of 0.000 implies that there is no relationship between the study variables (Orodho, 2013). The correlation results for this study were as shown in Table 4.16.

Table 4.16: Correlation Analysis Results

		Recovery needs of sexual assaults	Influence of psychosocial intervention	Social based intervention	Challenges of psychosocial intervention
Recovery needs of sexual assaults	Pearson Correlation Sig. (2-tailed)	1			
Influence of psychosocial intervention	Pearson Correlation Sig. (2-tailed)	.889** 0.000	1		
Social based intervention	Pearson Correlation Sig. (2-tailed)	.894** 0.000	.830** 0.000	1	
Challenges of psychosocial intervention	Pearson Correlation Sig. (2-tailed)	.892** 0.000	.859** 0.000	.814** 0.000	1

Source: Field data (2024)

The findings presented in Table 4.16 indicate that psychosocial intervention has a positive and statistically significant correlation with recovery needs of sexual assault survivors at gender-based violence recovery centres in Uasin Gishu County ($r = 0.889$, $p < 0.05$). This result is consistent with Kassim (2022), who reported that GVRCs play a critical role in combating gender-based violence. Additionally, it was observed that some survivors preferred the Nairobi Women’s GVRC, citing perceptions that the services provided at Kenyatta Hospital GVRC were less satisfactory, potentially due to its status as a public facility.

Additionally, social-based interventions exhibit a positive and statistically significant correlation with recovery needs of sexual assault survivors in gender-based violence (GBV) recovery centres in Uasin Gishu County ($r = 0.894$, $p < 0.05$). The findings indicate a low rate of GBV case reporting to the police among women survivors, contrasted by a high

preference for seeking support from family members, local village elders, and women's groups within the community. Several barriers influence help-seeking behaviours among women survivors of GBV, including cultural beliefs, deficiencies in the legal system and justice delivery for victims, economic deprivation, high levels of stigma, and the frequent reliance on local dispute resolution mechanisms.

Finally, the challenges associated with psychosocial interventions exhibit a positive and statistically significant correlation with recovery needs of sexual assault survivors in Uasin Gishu County ($r = 0.892$, $p < 0.05$). Sinko, Goldner and Saint Arnault (2021) identified a five-factor, 35-item final model comprising sharing/connecting, building positive emotions, reflecting and creating healing spaces, establishing security, and planning for the future. Their findings demonstrated significant positive correlations between sharing/connecting and depression scores, as well as between sharing/connecting, reflecting, and establishing security with post-traumatic stress disorder (PTSD) scores.

4.8.3 Multiple Regression Analysis

At the outset of Chapter Four, it is important to restate how the key variables were operationalised and measured in order to guide interpretation of the descriptive and inferential statistics. The dependent variable, recovery needs of sexual assault survivors, was operationalised as a composite mean score derived from multiple Likert-scale items assessing needs related to safety, emotional stability, medical care, empowerment, legal support, psychoeducation, reintegration, and long-term psychological care. The independent variables comprised psychological-based interventions, social-based interventions, and challenges of psychosocial interventions, each measured through several structured items reflecting the specific dimensions outlined in the conceptual framework. All items were rated on a five-point Likert scale ranging from 1 = Strongly Disagree to 5 = Strongly Agree,

as detailed in Appendix III. Composite indices were computed by averaging item responses within each construct, with higher scores consistently indicating greater presence, stronger implementation, or higher perceived intensity of the construct measured. For interpretative purposes, mean scores between 1.00–2.33 were categorised as low, 2.34–3.66 as moderate, and 3.67–5.00 as high. This uniform scaling and scoring direction ensure clarity when interpreting means, standard deviations, correlation coefficients, and regression coefficients in the subsequent analysis.

The study employed multiple linear regression analysis to examine the combined linear relationship between the dependent variable and the independent variables: Influence of Psychosocial Intervention, Social-Based Intervention, and Challenges of Psychosocial Intervention. The results, presented in Table 4.12, indicated an R^2 value of 0.895. This suggests a strong positive effect of the Influence of Psychosocial Intervention, Social-Based Intervention, and Challenges of Psychosocial Intervention on recovery needs of sexual assault survivors. Specifically, approximately 89.5% of the variance in recovery needs of sexual assault survivors is explained by the regression model incorporating these predictors.

Table 4.17: Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.946 ^a	.895	.885	.29295

Source: Field data (2024)

4.8.7 Assessing the Fit of the Model Summary

Analysis of variance (ANOVA) was conducted to assess the overall fit of the multiple regression model to the data. The results, presented in Table 4.13, indicated that the effect of the independent variables on the dependent variable was statistically significant ($F = 88.522$, $p < 0.05$). This finding implies that the multiple regression model adequately fits

the data. Consequently, the overall regression model, which includes the influence of psychosocial intervention, social-based intervention, and challenges of psychosocial intervention, is statistically significant and has a meaningful impact on recovery needs of sexual assault survivors in Uasin Gishu County.

Table 4.18: ANOVA Test Results

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	22.790	3	7.597	88.522	.000b
	Residual	2.660	31	.086		
	Total (N)	25.450	34			

Source: Field data (2024)

4.8.5 Regression coefficients

The t-test of statistical significance was conducted for each regression coefficient to analyse the beta (β) values, which indicate the strength of the effect of each independent variable on the dependent variable. Table 4.14 presents the results of the regression analysis for the study variables. The findings reveal that psychosocial intervention had a positive and statistically significant effect on recovery needs of sexual assault survivors in Uasin Gishu County ($\beta_1 = 0.238$; $p < 0.05$). Similarly, social-based intervention demonstrated a positive and statistically significant effect on recovery needs of these survivors ($\beta_2 = 0.388$; $p < 0.05$). Additionally, challenges associated with psychosocial intervention were found to have a positive and statistically significant impact on recovery needs of sexual assault survivors in the same context ($\beta_3 = 0.300$; $p < 0.05$).

Table 4.19: Regression Analysis

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	.521	.141		3.689	.001

Psychosocial intervention	.238	.110	.272	2.157	.039
Social based intervention	.388	.110	.394	3.543	.001
Challenges of psychosocial intervention	.300	.108	.338	2.785	.009

From Table 4.19, the multiple regression equation can be expressed as:

$$Y = 0.521 + 0.238X_1 + 0.388X_2 + 0.300X_3 \dots\dots\dots \text{Equation 1}$$

At a constant level, the combined influence of psychosocial intervention, social-based intervention, and the challenges associated with psychosocial intervention on recovery needs of sexual assault survivors in gender-based violence recovery centres in Uasin Gishu County is 0.522 units. Specifically, a one-unit increase in the influence of psychosocial intervention corresponds to a 0.238-unit increase in recovery needs of sexual assault survivors. Similarly, a one-unit improvement in social-based intervention results in a 0.388-unit increase in recovery needs. Finally, a one-unit increase in the challenges of psychosocial intervention is associated with a 0.300-unit increase in recovery needs of sexual assault survivors in gender-based violence contexts.

4.8.6 Hypothesis Testing

To analyse whether psychosocial interventions significantly predict recovery needs of sexual assault survivors in GBVRCs in Uasin Gishu County, null hypotheses were formulated from the study objectives and tested using multiple linear regression analysis. Recovery needs constituted the dependent variable, while psychosocial intervention, social-based intervention, and challenges of psychosocial intervention were entered as predictor variables. The level of significance was set at $\alpha = .05$. The decision rule was that the null hypothesis would be rejected if the p-value was less than .05.

Formulated Null Hypotheses

H₀₁: Psychosocial interventions have no statistically significant influence on recovery needs of sexual assault survivors in GBVRCs in Uasin Gishu County.

H₀₂: Social-based interventions have no statistically significant influence on recovery needs of sexual assault survivors in GBVRCs in Uasin Gishu County.

H₀₃: Challenges of psychosocial intervention have no statistically significant influence on recovery needs of sexual assault survivors in GBVRCs in Uasin Gishu County.

Table 4.20: Summary of Hypothesis Testing

Hypothesis	Predictor Variable	B Value	p-value	Decision Rule ($\alpha = .05$)	Decision
H ₀₁	Psychosocial intervention	.238	.039	Reject H ₀ if $p < .05$	Rejected
H ₀₂	Social-based intervention	.388	.001	Reject H ₀ if $p < .05$	Rejected
H ₀₃	Challenges of psychosocial intervention	.300	.009	Reject H ₀ if $p < .05$	Rejected

The regression analysis indicates that psychosocial intervention has a statistically significant positive influence on recovery needs ($B = .238, p = .039$). Since the p-value is less than .05, the null hypothesis (H_{01}) is rejected. This implies that increased implementation of psychosocial therapeutic practices is associated with improved recovery outcomes among sexual assault survivors. Specifically, a one-unit increase in psychosocial intervention is associated with a .238 unit increase in recovery needs, holding other variables constant.

Similarly, social-based intervention was found to have a statistically significant positive influence on recovery needs ($B = .388, p = .001$). The null hypothesis (H_{02}) is therefore

rejected. The relatively larger B value suggests that social-based interventions have the strongest predictive influence among the three variables in the model. This indicates that advocacy, referral systems, reintegration support, and community-based mechanisms play a particularly critical role in enhancing survivor recovery.

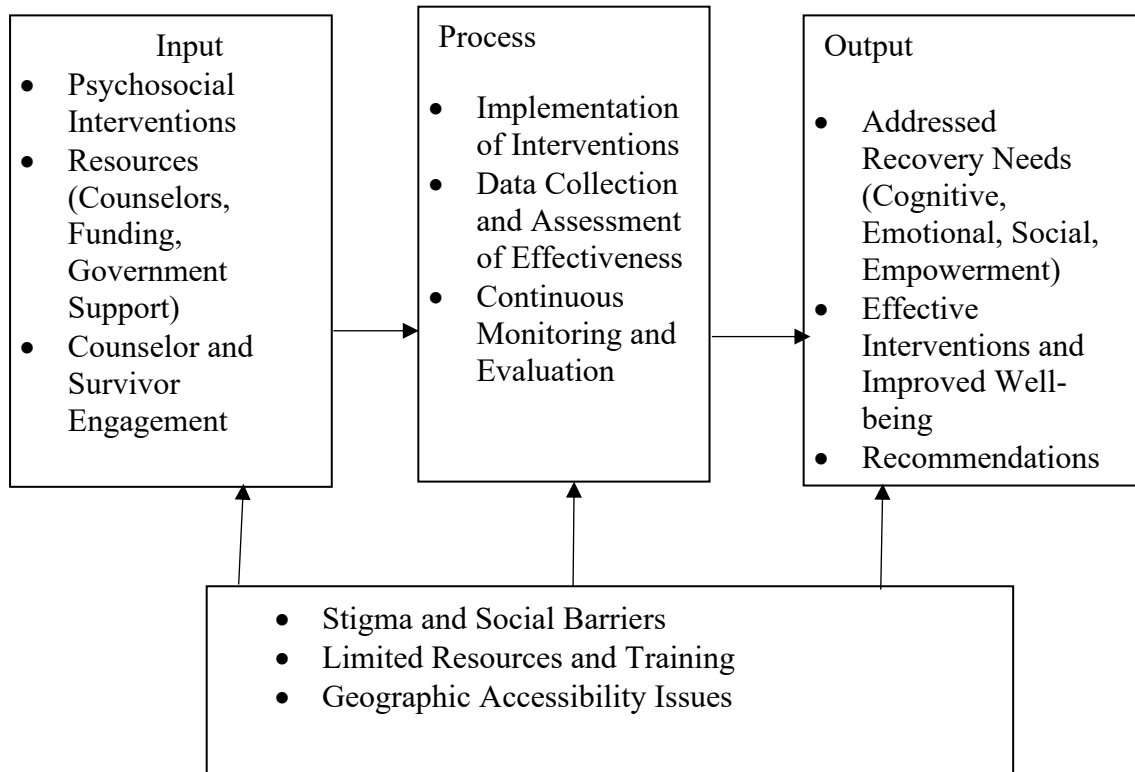
Challenges of psychosocial intervention also demonstrated a statistically significant influence on recovery needs ($B = .300, p = .009$). Since $p < .05$, the null hypothesis (H_{03}) is rejected. The positive coefficient suggests that as reported challenges increase, recovery needs scores also increase. In the context of this study, this may indicate that facilities experiencing greater implementation challenges simultaneously report heightened recognition of unmet recovery needs, suggesting areas requiring intervention strengthening.

The regression results confirm that psychosocial intervention, social-based intervention, and challenges of psychosocial intervention are significant predictors of recovery needs in GBVRCs in Uasin Gishu County. These findings provide empirical support for strengthening both therapeutic and structural dimensions of psychosocial service delivery to optimise survivor recovery outcomes.

4.8.7 Model for Analysing the Influence of Psychosocial Intervention on Recovery

Needs of Sexual Assault Survivors

Figure 4.1: Model for analysing the influence of psychosocial intervention on recovery needs of sexual assault survivors



Annotated Direct Paths to Recovery Needs (Dependent Variable):

Psychosocial Intervention → Recovery Needs $\beta = .272, p = .039$

Social-Based Intervention → Recovery Needs $\beta = .394, p = .001$

Challenges of Psychosocial Intervention → Recovery Needs $\beta = .338, p = .009$

All paths are statistically significant at $\alpha = .05$.

Legend for Figure 4.1

Arrows represent direct predictive relationships tested using multiple linear regression.

β (Standardized Beta Coefficient) indicates the strength and direction of influence. Higher absolute β values reflect stronger predictive effects.

p-value indicates statistical significance (significant if $p < .05$).

All three predictors show positive and statistically significant relationships with recovery needs.

Among the predictors, Social-Based Intervention ($\beta = .394$) has the strongest influence, followed by Challenges of Psychosocial Intervention ($\beta = .338$) and Psychosocial Intervention ($\beta = .272$).

Hypothesised Direction

The model hypothesised positive direct effects of psychosocial and social-based interventions on recovery needs. It also hypothesised that implementation challenges would significantly influence recovery needs. The regression results confirm these hypothesised directional relationships, as all predictors demonstrate statistically significant positive effects.

The model for this study on recovery needs and psychosocial interventions for sexual assault survivors within recovery centres in Uasin Gishu County is structured around four primary components: Inputs, Process, Challenges, and Output.

Inputs refer to the resources and interventions introduced into the system. In this study, the primary inputs comprise psychosocial interventions, which are categorized into psychological and social interventions. Psychological interventions include Cognitive Behavioural Therapy (CBT), Trauma-Focused Therapy, as well as individual and group counselling. Social interventions encompass peer support, social reintegration programmes,

and family and community support networks. These interventions are designed to address the cognitive, emotional, and social recovery needs of sexual assault survivors. Furthermore, essential resources such as trained counsellors, adequate recovery centre facilities, and financial or governmental support for GBVRCs are critical to the successful implementation of these interventions. The engagement of both counsellors and survivors is also vital, as active participation from both parties is necessary to achieve effective outcomes.

The process encompasses the implementation and evaluation of interventions. Counsellors deliver psychological and social support through individual therapy, group counselling, and social reintegration initiatives. Concurrently, data is systematically collected from both survivors and counsellors to assess the efficacy of these interventions. This data includes survivors' feedback concerning their recovery trajectories and the psychological impact of the interventions, as well as counsellors' evaluations of survivors' progress. Additionally, the process involves ongoing monitoring and assessment of survivors' recovery needs, ensuring that cognitive, emotional, social, and empowerment dimensions are comprehensively addressed through tailored intervention strategies.

However, several challenges may impede the effectiveness of these interventions. Stigma within the community can inhibit survivors from fully engaging with the interventions, as they may fear judgment or discrimination. Furthermore, resource limitations, such as a shortage of trained counsellors, insufficient funding for recovery centres, and inadequate access to essential therapeutic materials, pose significant barriers. Some counsellors may also encounter difficulties due to insufficient or generalized training, which can restrict their capacity to address the complex psychological needs of sexual assault survivors effectively. Additionally, the social reintegration of survivors into their communities may be hindered

by negative perceptions, while geographical accessibility remains a critical obstacle, particularly for survivors residing in remote areas with limited access to recovery facilities.

The study's findings focus on the extent to which recovery needs of sexual assault survivors are addressed. These needs encompass cognitive, emotional, social, and empowerment dimensions, with particular emphasis on restoring survivors' capacity to process trauma, regulate emotions, rebuild social relationships, and regain autonomy. Furthermore, the study evaluates the effectiveness of psychosocial interventions and their impact on the overall well-being of survivors. The findings also include recommendations for enhancing interventions, such as improving counsellor training and increasing resources allocated to recovery centres. Additionally, policy recommendations are proposed to strengthen the support systems available to survivors. These insights aim to guide future efforts in addressing recovery needs of sexual assault survivors within Uasin Gishu County and to inform broader strategies for advancing psychosocial care in gender-based violence recovery centres.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter contains the summary of the research results, conclusion, recommendations of the study. It also provides suggestions for further research as per the study objectives.

5.2 Summary of Research Findings

5.2.1 Assessing Recovery Needs of Survivors

Taken together, the quantitative and qualitative findings indicate that recovery for sexual assault survivors is fundamentally multidimensional, extending beyond medical stabilization to include emotional safety, dignity, and culturally responsive care. There was strong convergence between counsellors and survivors regarding the primacy of immediate safety, timely medical attention, and psychological support. However, survivors' narratives deepened this understanding by emphasizing that recovery begins not merely with treatment, but with the experience of being protected, heard, and respected. Collectively, the findings suggest that recovery needs are both clinical and relational: effective service delivery must integrate physical protection with emotional reassurance and cultural sensitivity to initiate meaningful healing.

5.2.2 Perspectives on the Influence of Psychosocial Interventions

Across both data strands, psychosocial interventions were consistently perceived as central to survivor recovery. Quantitative trends demonstrated a positive and significant influence of psychosocial and social-based interventions on recovery needs, while qualitative accounts explained how these interventions help survivors process trauma, rebuild coping capacity, and regain autonomy. Taken together, the findings indicate that structured counselling, peer support, and community-based mechanisms function not only as therapeutic tools but as

empowerment pathways. At the same time, qualitative insights revealed an important nuance: interventions that are not carefully paced or culturally attuned may inadvertently trigger distress. This convergence highlights that while psychosocial interventions are broadly effective, their impact depends heavily on personalization, sensitivity, and survivor-centered implementation.

5.2.3 Perspectives on the Challenges of Psychosocial Interventions

The findings collectively reveal a tension between the theoretical strength of psychosocial frameworks and the practical realities of implementation. Quantitative results showed that challenges significantly influence recovery outcomes, and qualitative evidence illuminated how these challenges manifest in lived experience. Survivors described episodes of re-traumatization during forensic procedures and insensitive interactions, while counsellors pointed to systemic constraints such as limited resources, insufficient trauma-informed training, and fragmented interagency coordination. Taken together, these findings indicate that implementation barriers are not peripheral issues but structurally embedded factors that directly shape recovery trajectories. The convergence between statistical trends and personal narratives underscores that improving survivor outcomes requires addressing systemic, procedural, and cultural gaps alongside therapeutic techniques.

5.2.4 Evaluating Strategies for Improving Psychosocial Interventions

Both quantitative patterns and qualitative perspectives point toward the need for a more integrated, multidisciplinary, and trauma-informed service model. Survivors emphasized the importance of choice, compassion, and respect for cultural and gender identity, while counsellors advocated for structured referral systems, continuous professional development, and stronger coordination mechanisms. Taken together, the findings indicate that strengthening psychosocial interventions is less about introducing entirely new models and

more about enhancing coherence, consistency, and responsiveness within existing systems. The emphasis on infrastructure, training, and interagency collaboration reflects recognition that sustainable recovery outcomes depend on both relational competence and institutional capacity.

5.2.5 Interlinking Summary Reflections

Taken together, the quantitative and qualitative findings indicate a clear pattern: psychosocial and social-based interventions positively shape recovery outcomes, yet their effectiveness is moderated by systemic and contextual challenges. There is strong convergence between counsellors' assessments and survivors' lived experiences regarding what works, what fails, and what requires improvement. Recovery emerges as a dynamic process influenced by therapeutic quality, environmental safety, institutional coordination, and cultural sensitivity.

Collectively, the findings suggest that enhancing recovery outcomes in GBVRCs in Uasin Gishu County requires a holistic approach that integrates evidence-based psychosocial care with strengthened infrastructure, trauma-informed practice, and survivor-centered service design. The study therefore moves beyond analysing isolated factors and instead reveals an interconnected system in which interventions, challenges, and improvement strategies operate as mutually reinforcing components of survivor recovery.

5.3 Conclusion

This study set out to examine the influence of psychosocial interventions on recovery needs of sexual assault survivors in Gender-Based Violence Recovery Centres (GBVRCs) in Uasin Gishu County. The conclusions presented below are directly aligned to each study objective and are interpreted through the lenses of Cognitive Behavioural Theory (CBT) and the Ecological Model. The conclusions move beyond description to clarify what the findings mean theoretically, practically, and contextually.

5.3.1 Conclusion in Relation to Objective One: Recovery Needs of Survivors

The study concludes that recovery needs of sexual assault survivors are multidimensional and embedded within both psychological and socio-environmental contexts. Survivors require immediate physical safety and medical attention, but sustainable recovery is strongly associated with emotional validation, dignity, and culturally sensitive care environments.

From a Cognitive Behavioural perspective, recovery is facilitated when survivors are supported in stabilizing distress, restructuring trauma-related cognitions, and rebuilding adaptive coping mechanisms within safe therapeutic settings. From an Ecological Model perspective, recovery needs are shaped not only by individual trauma responses but also by environmental conditions, including institutional safety, community attitudes, and cultural norms.

Thus, recovery cannot be conceptualized solely as symptom reduction; rather, it reflects an interaction between internal cognitive-emotional processes and external systemic supports. In the context of Uasin Gishu County, strengthening facility standards and culturally responsive environments is associated with improved readiness for psychological healing.

5.3.2 Conclusion in Relation to Objective Two: Influence of Psychosocial Interventions

The study concludes that psychosocial and social-based interventions are positively associated with improved recovery outcomes among survivors. These interventions contribute to recovery by facilitating cognitive reframing, emotional regulation, coping skill development, and social reintegration mechanisms that are consistent with Cognitive Behavioural Theory. Structured counselling, peer support, and empowerment-focused programmes support survivors in challenging maladaptive beliefs such as self-blame and shame, thereby enhancing psychological adjustment.

Simultaneously, the Ecological Model explains the significant contribution of social-based interventions, as recovery is influenced by interpersonal relationships, institutional responsiveness, and community-level support systems. The findings indicate that interventions are most effective when they operate across multiple ecological layers individual, relational, institutional, and societal.

However, the evidence also suggests that when interventions are poorly calibrated or insufficiently trauma-informed, they may be associated with emotional distress. Therefore, psychosocial interventions contribute to recovery not simply through their presence, but through their quality, personalization, and contextual sensitivity.

5.3.3 Conclusion in Relation to Objective Three: Challenges of Psychosocial Interventions

The study concludes that systemic and procedural challenges are significantly associated with variations in recovery outcomes. Barriers such as inadequate trauma-informed training, limited resources, fragmented service coordination, and experiences of re-traumatization reflect weaknesses at multiple ecological levels.

From an Ecological Model perspective, these challenges illustrate how institutional and structural factors shape individual healing trajectories. Recovery is therefore not solely analysed by survivor resilience or therapeutic technique but is influenced by the broader service delivery environment.

From a Cognitive Behavioural standpoint, re-traumatizing practices and insensitive procedures may reinforce maladaptive trauma cognitions, thereby undermining therapeutic progress. The findings indicate that unresolved systemic constraints weaken the overall effectiveness of psychosocial care.

Accordingly, improving recovery outcomes requires strengthening institutional capacity, professional competence, and interagency coordination rather than focusing exclusively on individual counselling processes.

5.3.4 Conclusion in Relation to Objective Four: Strategies for Improvement

The study concludes that integrated, multidisciplinary, and trauma-informed strategies are associated with stronger alignment between survivor needs and service delivery. Continuous professional development, structured referral pathways, culturally responsive care, and survivor participation in decision-making reflect both CBT principles of empowerment and the Ecological Model's emphasis on system-level collaboration.

The findings suggest that sustainable recovery frameworks are those that operate across ecological layers supporting survivors cognitively and emotionally while simultaneously enhancing institutional coherence and community responsiveness. In the context of Uasin Gishu County, strengthening interagency networks and embedding trauma-informed standards within GBVRCs is associated with a more responsive and contextually grounded recovery model.

5.3.5 Overall Theoretical and Contextual Conclusion

Taken together, the study demonstrates that recovery among sexual assault survivors is associated with an interaction between cognitive-behavioural processes and ecological systems. Psychosocial interventions contribute to recovery by supporting cognitive restructuring, emotional stabilization, and adaptive coping (CBT), while their effectiveness is shaped by relational, institutional, and socio-cultural environments (Ecological Model).

The findings therefore affirm that survivor recovery is neither purely psychological nor purely structural; it is relational, systemic, and context-dependent. In Uasin Gishu County, strengthening trauma-informed counselling practices while addressing institutional and community-level constraints is associated with more comprehensive recovery support.

5.3.6 Methodological Caveat

This study advances theoretical understanding by demonstrating that effective recovery support for sexual assault survivors requires the integration of cognitive-behavioural therapeutic mechanisms with ecological system strengthening. Practically, it underscores the need for trauma-informed, culturally responsive, and institutionally coordinated service models within GBVRCs to enhance survivor-centered recovery processes.

5.4 Recommendations

5.4.1 Recommendations for Practice

Gender-Based Violence Recovery Centre (GBVRC) managers, in collaboration with County Health Administrators, should institutionalize standardized trauma-informed service protocols within all centres. The findings indicated that although psychosocial and social-based interventions are positively associated with recovery needs, inconsistencies in delivery and instances of re-traumatization weaken their effectiveness. To address this gap, centres should develop written trauma-informed care guidelines, strengthen informed

consent procedures prior to forensic and counselling processes, and implement structured client feedback systems. These measures would enhance service sensitivity and align practice with both Cognitive Behavioural principles of emotional stabilization and the Ecological Model's emphasis on safe institutional environments.

GBVRC managers should also formalize integrated referral pathways linking medical, legal, and psychosocial services. The study revealed that fragmented interagency coordination is associated with gaps in continuity of care and survivor distress. Establishing clear referral directories, appointing case coordination officers within centres, and holding quarterly interagency meetings would strengthen collaboration and reduce service fragmentation. Such integration reflects the Ecological Model's recognition that recovery is shaped by multiple interconnected systems rather than isolated therapeutic encounters.

Additionally, counsellors and social workers within GBVRCs should institutionalize professionally facilitated peer support groups. Since social-based interventions demonstrated the strongest association with recovery outcomes, structured peer networks can enhance social reintegration and empowerment. These groups should operate under trained facilitation, incorporate psychoeducation modules grounded in trauma-informed Cognitive Behavioural Therapy (CBT), and provide safe spaces for shared healing. This approach supports both cognitive reframing processes and ecological-level social support mechanisms.

5.4.2 Recommendations for Policy

The Ministry of Health, together with the County Government of Uasin Gishu and the National Treasury, should prioritize targeted funding to improve infrastructure and resource allocation within GBVRCs. The findings underscored that safe, private, and culturally sensitive environments are foundational to survivor engagement and psychological

stabilization. Annual county health budgets should therefore include provisions for upgrading facility infrastructure, ensuring secure data storage systems, and maintaining adequate Information, Education, and Communication (IEC) materials. Establishing minimum operational standards for GBVRC accreditation would further institutionalize these improvements.

The Ministry of Justice, in collaboration with the Ministry of Health, should integrate structured legal support services within GBVRC frameworks. Survivors reported distress associated with forensic and reporting procedures, suggesting systemic gaps that influence recovery experiences. Deploying trained legal liaison officers within centres and developing survivor-friendly reporting guidelines would minimize re-traumatization and strengthen ecological-level support systems. Clear policy guidelines on mandatory reporting should also balance legal obligations with the emotional protection needs of survivors.

Furthermore, the Ministry of Health, working with professional counselling regulatory bodies, should develop national trauma-informed psychosocial intervention standards for GBVRCs. Variations in service quality and training preparedness were associated with inconsistencies in recovery support. Establishing standardized competencies, supervision requirements, and ethical safeguards would promote uniformity in service delivery and align institutional practice with evidence-based psychological frameworks.

5.4.3 Recommendations for Training and Capacity Building

The Ministry of Health, in collaboration with professional counselling bodies and GBVRC management, should implement mandatory periodic training in trauma-focused Cognitive Behavioural Therapy and culturally responsive care. The findings suggest that effective recovery is associated with counsellors' ability to facilitate cognitive reframing, emotional

regulation, and empowerment. Biannual workshops and competency-based certification requirements would strengthen counsellors' preparedness and enhance intervention quality.

County Health Departments and legal agencies should also conduct joint interagency case-management and survivor-response simulations. Since fragmented coordination was associated with implementation challenges, structured multidisciplinary training sessions would enhance communication, clarify referral pathways, and promote integrated service delivery.

In addition, GBVRC managers should establish formal clinical supervision and counsellor wellness programmes. Emotional fatigue and limited preparedness were identified as challenges affecting service quality. Monthly supervision sessions, peer consultation forums, and structured debriefing mechanisms would support reflective practice and reduce secondary traumatic stress, thereby sustaining therapeutic effectiveness.

5.4.4 Recommendations for Further Research

Future research should employ longitudinal designs to examine how psychosocial interventions are associated with recovery outcomes over time. Because this study utilized a cross-sectional design, causal and temporal relationships could not be established. Long-term follow-up studies would clarify the sustainability of trauma-informed interventions and analyse predictors of enduring recovery.

Comparative multi-county studies are also recommended to enhance generalizability. Since the present study was limited to Uasin Gishu County, examining service delivery models across different counties would provide broader contextual insights and inform national policy formulation.

Experimental or quasi-experimental studies evaluating specific trauma-focused CBT interventions are further recommended. Such designs would permit stronger inference regarding the effectiveness of particular therapeutic approaches and contribute to evidence-based policy development.

Finally, future research should incorporate broader ecological stakeholders, including policymakers, law enforcement officers, and community leaders, to better understand systemic influences on survivor recovery. Additional qualitative studies examining discrepancies between survivor experiences and counsellor self-assessments would also clarify communication gaps and cultural competence dynamics affecting service delivery.

Collectively, these recommendations emphasize coordinated action at practice, policy, training, and research levels. Consistent with Cognitive Behavioural Theory and the Ecological Model, improving recovery outcomes for sexual assault survivors requires strengthening both individual-level therapeutic processes and systemic-level institutional structures within GBVRCs.

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APPENDICES

Appendix I: Informed Consent for Sexual Assault Survivors

Title of the Study

Psychosocial interventions and recovery needs of sexual assault survivors in Uasin Gishu County, Kenya

Introduction

You are being invited to participate in a research study conducted by Micah Kipchirchir, aimed at understanding recovery needs and psychosocial interventions provided to sexual assault survivors like yourself within recovery centres in Uasin Gishu County. Your participation will help improve support services and inform policies that better meet survivors' needs.

Purpose of the Study

To examine recovery needs of sexual assault survivors and the effectiveness of psychosocial interventions in recovery centres in Uasin Gishu County.

Procedures

If you agree to participate, you will be invited to take part in a face-to-face interview lasting approximately 45–60 minutes. The interview will involve questions about your experiences with the recovery process and the psychosocial support you have received. With your permission, the session may be audio-recorded for accuracy.

Voluntary Participation

Your participation is entirely voluntary. You may choose not to participate or withdraw at any time without any penalty or loss of benefits to which you are otherwise entitled.

Risks and Discomforts

Some questions may be personal and could cause emotional discomfort. You may skip any question or stop the interview at any time. Counselling support will be available should you feel distressed.

Benefits

While you may not benefit directly from participating, your involvement will contribute to improving services for future survivors.

Confidentiality

All information you provide will be kept confidential. Your identity will not be disclosed in any reports or publications. Data will be securely stored and accessible only to the research team.

Compensation

There is no monetary compensation for participation. However, refreshments may be provided during the interview.

Contact Information

If you have questions about this study or your rights, please contact:

Micah Kipchirchir, +254 722 292654, micahtonet@gmail.com

Consent

I have read (or have had read to me) the information above. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I voluntarily agree to participate in this study.

Participant's Name: _____ **Signature:** _____ **Date:** _____

Researcher's Name: _____ **Signature:** _____ **Date:** _____

Appendix II: Informed Consent for Trauma Counsellors

Title of the Study

Psychosocial interventions and recovery needs of sexual assault survivors in Uasin Gishu County, Kenya

Introduction:

You are invited to participate in this research study which aims to explore recovery needs of sexual assault survivors and the role of psychosocial interventions provided by counsellors within recovery centres in Uasin Gishu County.

Purpose of the Study

To gain insight into perspectives of trauma counsellors on the effectiveness, challenges, and potential improvements in psychosocial interventions for sexual assault survivors.

Procedures

You will be asked to complete a questionnaire and/or participate in an interview lasting approximately 45–60 minutes. Your responses will focus on your experiences and views regarding counselling practices and interventions.

Voluntary Participation

Your participation is voluntary, and you may withdraw at any time without any consequences.

Risks and Benefits

There are minimal risks involved. Your participation may contribute to improving psychosocial services and policies benefiting survivors.

Confidentiality

Your responses will be kept confidential. No analysing information will be published or shared outside the research team. Data will be securely stored.

Compensation

There is no financial compensation for participation.

Contact Information

For questions about the study or your rights as a participant, please contact:

Micah Kipchirchir, +254 722 292654, micahtonet@gmail.com

Consent:

I have read and understood the information provided. I have had all my questions answered and voluntarily agree to participate.

Participant's Name: _____ **Signature:** _____ **Date:** _____

Researcher's Name: _____ **Signature:** _____ **Date:** _____

Appendix III: Counsellor Psychosocial Interventions Scale

Section One: Demographic Information

1. Your Gender:
Male _____ Female _____
2. Your Age:
20 years - 29yrs _____ 30 yrs-39 years _____ 40-49 years _____ Over 50 years _____
3. Years of Counselling Experience:
Under 5 years _____ 5-9 years _____ 10-19 years _____ over 20 years _____
4. Highest Level of Professional Education Completed:
Untrained Certificate _____ Diploma _____
Bachelor's Degree _____ Master's Degree _____ PhD _____

Section Two: Recovery Needs of Sexual Assault Survivors

1. What are recovery needs of sexual assault survivors?
.....
.....
.....
2. Please respond to what extent do you agree that the following are recovery needs of sexual assault survivors you have encountered by ticking the appropriate code.

Use the code below:

- 1= Strongly Agree
- 2= Agree
- 3= Not sure
- 4= Disagree
- 5= Strongly Disagree

Statements	1	2	3	4	5
1. Ensuring a safe environment is paramount					
2. Prompt medical care, including a forensic exam if desired, is important to address physical injuries and potential health risks					
3. Access to trained professionals who specialize in trauma and sexual assault can help survivors process their emotions, cope with trauma, and work towards healing					
4. Encouraging survivors to make decisions about their own recovery process is crucial					
5. Providing information about legal options and assistance navigating the legal system, if the survivor chooses to pursue legal action					
6. Connecting survivors with support groups, online forums, or local organizations can help them realize they are not alone and provide a network of understanding individuals					
7. Creating a safe space where survivors can express themselves without fear of judgment or blame is essential					
8. Providing resources and information about sexual assault, its effects, and recovery can empower survivors and those around them					
9. Encouraging healthy habits like exercise, nutrition, and regular check-ups can contribute to a survivor's overall well-being					
10. Offering accommodations or flexibility in work or academic settings can help survivors regain a sense of normalcy at their own pace					
11. Recognizing that healing is a journey, not a destination, and offering ongoing support even after initial crisis intervention is crucial					

Section Three: Influence of Psychosocial Interventions in Addressing Recovery Needs of Sexual Assault Survivors

This section assessed your opinions about role of psychosocial interventions in addressing recovery needs of sexual assault survivors in gender-based violence and recovery centre.

1. Psychological Based Intervention

Please respond the extent to which psychological based intervention address recovery needs of sexual assault survivors in gender-based violence and recovery centres by ticking the appropriate code.

Use the code below:

- 1= Strongly Agree
- 2= Agree
- 3= Not sure
- 4= Disagree
- 5= Strongly Disagree

Statements	1	2	3	4	5
12. I provide programmes that assist my clients reduce feelings of shame and humiliation that may lead to low self esteem					
13. I have in place interventions that assist my clients understand how to manage powerful emotions constructively					
14. I assist my clients live in an environment where they are assured of their safety and care					
15. I have therapeutic programmes through which I help my clients understand how to solve problems arising from assault					
16. I have helped my clients have programmes where they are inspired to get on with life regardless the assault.					
17. I provide my clients programmes that assist them express understanding of their feelings and emotions					
18. I encourage my clients to manage their thoughts well through focusing more on positive activities and helpful thinking					
19. I encourage my clients to make an effort to do things that are enjoyable, relaxing and recharging when experiencing flash backs of assault episode					
20. I assist my clients explore ways of developing coping mechanisms against depressive feelings.					
21. I provide my clients programmes that assist them improve their sexual functioning					

Any other intervention

.....

2. Social Based Intervention

Please respond to the extent the social based intervention address recovery needs of sexual assault survivors in gender-based violence and recovery centres by ticking the appropriate code.

Use the code below:

1= Strongly Agree

2= Agree

3= Not sure

4= Disagree

5= Strongly Disagree

	1	2	3	4	5
1. I am friendly and interact well with my clients					
2. I arrange to have mentors who get attached to my clients					
3. I help my clients to develop interest and interact with others more					
4. I encourage my clients to work hard in their daily chores					
5. I show interest for my clients to get justice for wrongs suffered					
6. I encourage my clients to participate in recreational activities					
7. I allow my clients to participate in decision making on issues affecting them within and outside the GBVRC.					
8. I assist my clients have access to people with specialization in different areas who they can talk with on how to get information or advice about something					
9. I encourage my clients to take good care of their bodies					
10. I assist my clients get reintegrated smoothly into their families and communities after getting treatment and assistance in GBVRC					

Section Four: Challenges of Psychosocial Interventions Used in Addressing Recovery Needs of Sexual Assault Survivors

Use the code below:

1= Strongly Agree

2= Agree

3= Not sure

4= Disagree

5= Strongly Disagree

Question	1	2	3	4	5
1. Lack of continuous in-service training on psychosocial intervention					
2. Limited resources for psychosocial interventions					
3. Lack of awareness and understanding of psychosocial interventions among sexual assault survivors					
4. Stigma and discrimination associated with sexual assault and psychosocial interventions					
5. Lack of coordination between our office and other service providers for sexual assault survivors					
6. Dealing with the intense emotions and trauma experienced by survivors can be emotionally draining for me					
7. Hearing about the survivor's experiences can lead to vicarious trauma for counsellors, which may result in symptoms similar to post-traumatic stress disorder.					
8. Striking the right balance between empathy and maintaining professional boundaries is crucial but can be difficult.					
9. Understanding and respecting diverse cultural perspectives and beliefs regarding sexuality and trauma is essential.					
10. Avoiding re-traumatization or secondary victimization of the survivor through inappropriate questioning or response.					
11. Navigating legal obligations, such as mandatory reporting laws, can be complex and may vary depending on jurisdiction.					
12. Depending on the setting, there may be limited resources available for follow-up care, referrals, or other support services.					
13. Counsellors must prioritize their own self-care to prevent burnout and ensure they can continue providing effective support.					
14. Counsellors must prioritize their own self-care to prevent burnout and ensure they can continue providing effective support.					

Section Five: Strategies for Improving the Psychosocial Interventions Used in Addressing Recovery Needs of Sexual Assault Survivors

1. Highlight any area of psychosocial provision to the sexual assault survivors that you feel you need to improve on;
.....
.....
2. In your opinion what can be done in the following areas to improve the provision of psychosocial interventions
 - a. Experience in psychosocial intervention providers.
.....
.....
.....
 - b. Resources for psychosocial interventions
.....
.....
.....
 - c. Awareness and understanding of psychosocial interventions
.....
.....
.....
 - d. Stigma and discrimination associated with sexual assault
.....
.....
.....
 - e. Coordination between psychosocial intervention providers and other service providers for sexual assault survivors
.....
.....
.....
3. Suggest ways in which counsellors like you can be assisted to acquire more skills, knowledge, and awareness on psychosocial provision to sexual assault clients
.....
.....
.....

Appendix IV: Interview Guide for Assault Survivors in GBVRC

Topic:

Greetings

- Introduction of the interviewer and the interviewee
 - Explanation of the topic
 - Assurance
 - Obtaining permission from the participants to tape record the interview deliberations
1. What are your recovery needs as sexual assault survivor?

.....
.....

- ✓ *Safety and Security*
- ✓ *Medical Attention*
- ✓ *Counselling and Therapy*
- ✓ *Empowerment and Autonomy*
- ✓ *Legal Support*
- ✓ *Supportive Community*
- ✓ *Empathy and Non-Judgmental Listening*
- ✓ *Education and Awareness*
- ✓ *Physical Well-being*
- ✓ *Flexible Work or Academic Arrangements*
- ✓ *Long-Term Support*

Social Support Interventions

Questions and Prompts

1. How was the nature of the strategies used by the care centre to address your immediate safety needs after the incident?
 1. *Was the perpetrator apprehended?*
 2. *Where were you taken?*
 3. *Was incident addressed immediately by hospital and captured in OB?*
 4. What important help have you gotten through the said strategies?
2. What assessment was made to your issues on contribution of social, cultural and environmental influences?
 - ✓ *Community values, beliefs and traditions on rape.*
 - ✓ *Socio-economic inequality.*
 - ✓ *Salient attributes of the victim's natural support system.*
 - ✓ *The actions and understandings of family and friends, caregivers, and other significant individuals and groups.*
 - ✓ *Cultural constructions of ethnicity and gender.*

3. Comment on current access to advocacy and support groups
 - ✓ *What support or assistance to survivors are you aware of?*
 - ✓ *What support and assistance have you sought in the past?*
 - ✓ *How did you find out the support?*
 - ✓ *How is the legal representation?*
 - ✓ *Are you aware of the Information on your rights?*
4. How do you view your safety going forward?
 - ✓ *Threatened thus afraid for life.*
 - ✓ *Shame, stigma, blame, guilt and thus fear of being alone.*
 - ✓ *Talking to people and walking about.*
 - ✓ *Poor relationships with the immediate family, including partner, siblings and parents.*
5. In your own assessment, how do issues covered in 1-4 above influence your recovery from the trauma arising from the assault? Cite practical scenarios

Psychological Interventions

6. Comment on the beginning session of therapy
 1. *Was consent sought by your helpers before you started receiving therapy?*
 2. *Was the therapist welcoming and provided safe space?*
 3. *Were you told what to expect in the session?*
 4. *Were you given time to explain yourself?*
7. Comment on the following counselling protocols
 - ✓ Risk assessment/reduction performed (pre-and post-test HIV counselling,)
 - ✓ Disclosure protocols
 - ✓ Plan of action
 - ✓ Assistance on drug adherence
 - ✓ How emotional reactions are dealt with
 - ✓ Adequacy of time for the client to interact with counsellor
 - ✓ Cultural sensitivity of approaches
8. What are the major weaknesses of psychosocial support services in your institution?
9. Give suggestions on how to improve psychosocial support services provided to survivors in order to aid in their recovery.

Does your community fully engage and prepare to take ownership of the integration issue in order to facilitate healing of survivors?

Prompts:

- ✓ *community are aware of the cultural, religious, and familial context in which the assault occurs.*
- ✓ *Communities assist in finding safe havens for survivors.*
- ✓ *Community secures the physical safety of a survivor after being discharged from GBVRC.*
- ✓ *The community have plans in place to protect disempowered survivors from the risk of further abuse.*
- ✓ *Communities have capacity to respond to assault through possessing clear understanding on essence of healing from sexual violence*

Appendix V: Document Analysis / Observation Schedule for GBVRC

	AVAILABILITY		STATUS OF USAGE
	YES	NO	
Private quite accessible, well-lit room			
Displayed IECs,			
Counselling SOPs			
Trauma forms/Register			
PRC register:			
PRC drug kit---1 st PEP dose, ECP			
Lockable cabinets for storage of data tools and commodities			
Referral directory			
Centre Policies			

Appendix VI: Permit Application Letter from Kisii University



KISII UNIVERSITY-ELDORET CAMPUS
OFFICE OF THE DEPUTY DIRECTOR ACADEMICS STUDENT AFFAIRS

Phone: 0720094039

Email: directoreldoret@kisiiversity.ac.ke

P. O. Box 6434- 30100

ELDORET - KENYA

REF: DAS/60346/15

14th September, 2023

The Director
National Commission for Science
Technology & Innovation (NACOSTI)
NAIROBI

Dear Sir/Madam,

REF: MICAH KIPCHIRCHIR REG NO. DAS/60346/15

The above subject refers;

The above named is our bonafide student of Kisii University-Eldoret Campus pursuing a **PhD** course in **Counselling Psychology** in the School of Arts and Social Sciences.

He is working on his research titled, "**Assessment of Psychosocial Interventions on Recovery Needs of Sexual Assault Survivors in Uasin Gishu County, Kenya**" in partial fulfillments for the requirement of the PhD Degree award.

We are kindly requesting your office to provide him with the necessary assistance in data collection and completion of his research.

Any assistance offered to the student will be highly appreciated. Please do not hesitate to call the undersigned for any verification.

Thank you.

Prof. Dr. Maloba E. Were

DEPUTY DIRECTOR ACADEMIC STUDENT AFFAIRS

ED/pao

Tel: 0727150070

Email: dr.were@kisiiversity.ac.ke



Appendix VII: Permit Application Letter from Ethics Committee



OFFICE OF THE CHAIRPERSON
INSTITUTIONAL SCIENTIFIC ETHICS REVIEW COMMITTEE
UNIVERSITY OF EASTERN AFRICA, BARATON
P.O. BOX 2500-30100, Eldoret, Kenya, East Africa

B0103102023

October 3, 2023

TO: Micah Kipchirchir
Kisii University

Dear Micah,

RE: Assessment of Psychosocial Interventions for Addressing Recovery Needs of Sexual Assault Survivors in Gender-Based Violence and Recovery Centres in Uasin Gishu, Kenya.

This is to inform you that the Institutional Scientific Ethics Review Committee (ISERC) of the University of Eastern Africa Baraton has reviewed and approved your above research proposal. Your application approval number is UEAB/ISERC/01/T0/2023. The approval period is from October 3rd, 2023 – October 3rd, 2024.

This approval is subject to compliance with the following requirements;

- i. Only approved documents including (informed consents, study instruments, MTA) will be used.
- ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by the Institutional Scientific Ethics Review Committee (ISERC) of the University of Eastern Africa Baraton.
- iii. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to the Institutional Scientific Ethics Review Committee (ISERC) of the University of Eastern Africa Baraton within 72 hours of notification.
- iv. Any changes, anticipated or otherwise that may increase the risks or affected the safety or welfare of study participants and others, or affect the integrity of the research must be reported to the Institutional Scientific Ethics Review Committee (ISERC) of the University of Eastern Africa Baraton within 72 hours.
- v. Clearance for export of biological specimens must be obtained from relevant institutions.
- vi. Submission of a request for renewal of approval at least 60 days prior to the expiry of the approval period. Attach a comprehensive progress report to support the renewal.
- vii. Submission of an executive summary report within 90 days upon completion of the study to the Institutional Scientific Ethics Review Committee (ISERC) of the University of Eastern Africa Baraton.

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology, and Innovation (NACOSTI) <https://oris.nacosti.go.ke> and also obtain other clearances needed.


Sincerely yours,


Prof. Catherine Amimo, PhD
Chairperson, Institutional Scientific Ethics Review Committee



A SEVENTH-DAY ADVENTIST INSTITUTION OF HIGHER LEARNING
CHARTERED 1991


Appendix VIII: Research Authorization Letters


REPUBLIC OF KENYA


NATIONAL COMMISSION FOR
SCIENCE, TECHNOLOGY & INNOVATION

Ref No: 509254 Date of Issue: 26/September/2023

RESEARCH LICENSE



This is to Certify that Mr.. MICAH KIPCHIRCHIR of Kisii University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Uasin-Gishu on the topic: ASSESSMENT OF PSYCHOSOCIAL INTERVENTIONS FOR ADDRESSING RECOVERY NEEDS OF SEXUAL ASSAULT SURVIVORS IN GENDER-BASED VIOLENCE AND RECOVERY CENTRES IN UASIN GISHU, KENYA for the period ending : 26/September/2024.


License No: NACOSTI/P/23/29701

509254
Applicant Identification Number

Walter
Director General
NATIONAL COMMISSION FOR
SCIENCE, TECHNOLOGY &
INNOVATION

PROCEED FOR COUNTY COMMISSIONER
04/10/23 UASIN GISHU COUNTY

Verification QR Code



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Scan the QR Code using QR scanner application.

See overleaf for conditions

Appendix IX: Ministry of Education Authorization Letter



REPUBLIC OF KENYA
MINISTRY OF EDUCATION

State Department for Early Learning and Basic Education

Email: cdeuasingishucounty@gmail.com

: cdeuasingishucounty@yahoo.com

When replying please quote:

County Director of Education,

Uasin Gishu County,

P.O. Box 9843-30100,

ELDORET.

Ref: No. MOE/UGC/TRN/9/VOLL.V/29

4TH OCTOBER, 2023

Micah Kipchirchir: REG NO. DAS/60346/15

Kisii University – Eldoret Campus,

P.O Box 6434-30100

ELDORET.

RE: RESEARCH AUTHORIZATION.

In reference to your License Ref no. **NACOSTI/P/23/29701** dated 26th September, 2023 from National Commission for Science, Technology and Innovation (NACOSTI), you are hereby granted the authority to carry out research on **Assessment of psychosocial interventions for addressing recovery needs of sexual assault survivors in gender – based violence and recovery centres Period Ending 26th September 2024,** Within Uasin Gishu County.

We take this opportunity to wish you well during this data collection.

Mibei K. Andrew

For: County Director of Education

UASIN GISHU.



Appendix X: County Government Nandi Authorization Letter

COUNTY GOVERNMENT OF NANDI



DEPARTMENT OF HEALTH



Telephone
When replying
Please quote

County Director of Health
Nandi County
P.O. Box 5
KAPSABET

Ref: No: CDH/NDI/2021/R.A/3

05/10/2023

Micah Kipchirchir
Kisii University- Eldoret Campus
P.O. Box 6434-30300

Dear Sir,

RE: APPROVAL OF RESEARCH STUDY IN NANDI COUNTY

The above subject matter refers;

Reference is made to your letter dated 5th October 2023 on request to conduct Pilot research in Nandi County "*Assessment of psychosocial interventions for addressing recovery needs of sexual assault survivors in gender- based violence and recovery centers period ending 26th September 2024*".

Having obtained approvals from the National Commission for Science, Technology and Innovation (NACOSTI) and Research Ethics Committee (REC) of the Kisii University, you are hereby permitted to commence Research study in Nandi County for the Period ending 26th September 2024.


N.K. Korir
For: County Director for Health Services
Nandi



Appendix XI: County Government Uasin Gishu Authorization Letter

REPUBLIC OF KENYA
COUNTY GOVERNMENT OF UASIN GISHU
DEPARTMENT OF HEALTH SERVICES

Email: info@uasingishu.go.ke
Website: www.uasingishu.go.ke



When Replying, Please Address to:
Chief Officer Preventive &
Promotive
Uasin-Gishu County
P.O. Box 40 – 30100

REF: UGC/COH-P&P/EXTN./10/23(3)

Date: 4th October, 2023

Micah Kipchirchir: REG NO. DAS/60346/15
Kisii University – Eldoret Campus
P.O Box, 6434-30100
Eldoret

Dear Micah,

RE: APPROVAL OF RESEARCH STUDY IN UASIN GISHU COUNTY

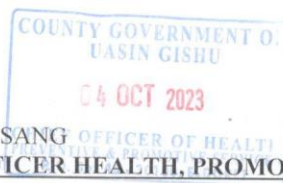
The above subject matter refers.

Reference is made to your letter dated 4th October 2023 on request to conduct research in Uasin Gishu County on “*Assessment of psychosocial interventions for addressing recovery needs of sexual assault survivors in gender – based violence and recovery centres period ending 26th September 2024*”.

Having obtained approvals from the National Commission for Science, Technology and Innovation (NACOSTI) and Research Ethics Committee (REC) of the Kisii University, you are hereby permitted to commence Research study in Uasin Gishu County for the period ending 26th September 2024.

At the end of your research period, you are required to submit a copy of your findings to the office of the undersigned.

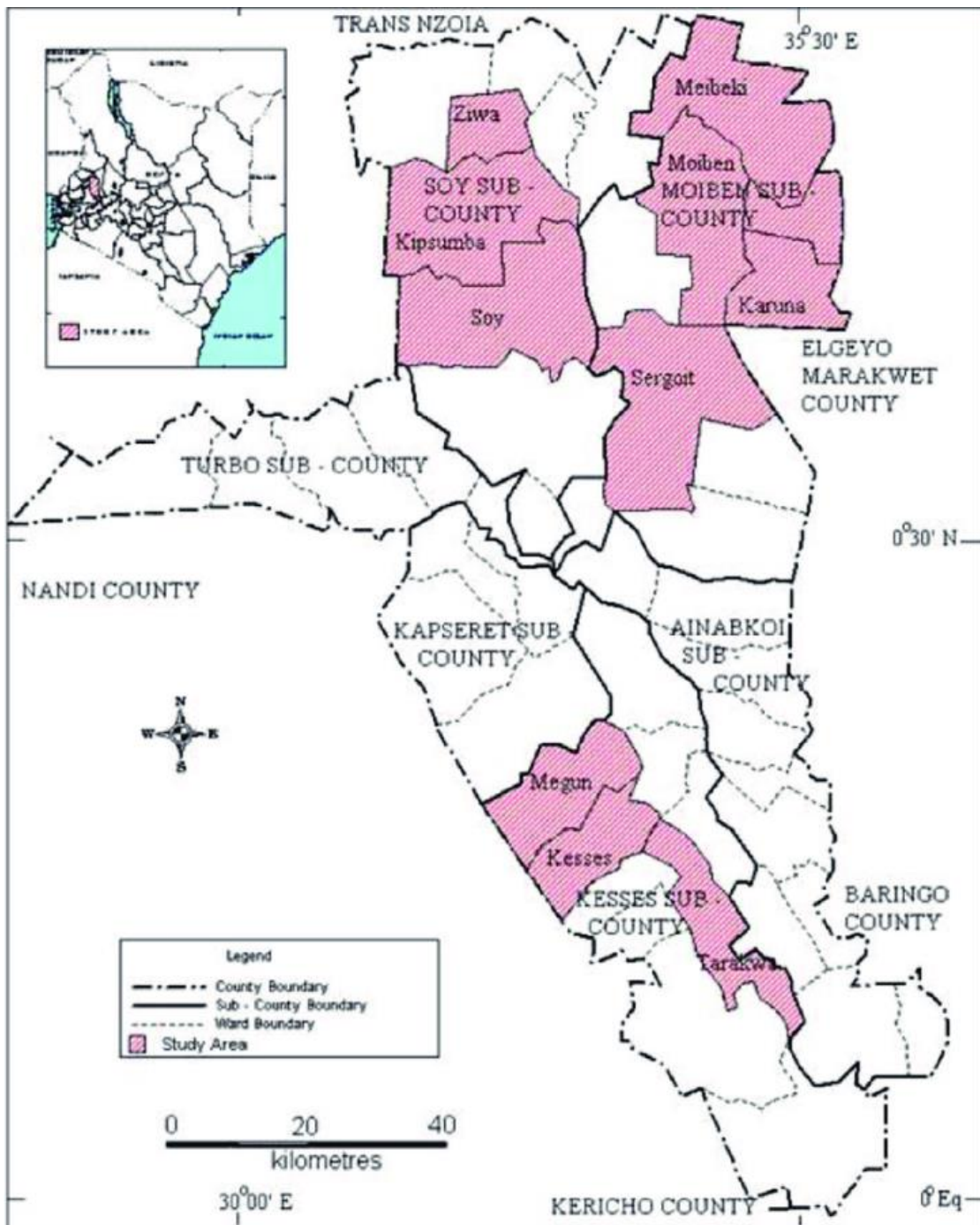
Thank you.



DR. JOYCE SANG **OFFICER OF HEALTH**
CHIEF OFFICER HEALTH, PROMOTIVE & PREVENTIVE SERVICES

Copy to:
CECM, Health Services
Chief Officer – Clinical Services

Appendix XII: Map of Uasin Gishu County



Appendix XIII: Map of Uasin Gishu County-Kenya



Applying Bronfenbrenner's Ecological Model to Psychosocial Interventions for Sexual Assault Survivors: A Case Study of Resource Availability and Utilization in Gender-Based Violence Recovery Centers in Uasin Gishu County, Kenya

¹Micah Kipchirchir, ²Prof. Callen Nyamwange & ³Dr. Godfrey Ngeno

^{1,2}Kisii University, Kenya, ³Moi University, Kenya

To Link this Article: <http://dx.doi.org/10.6007/IJARBSS/v15-i5/25505> DOI:10.6007/IJARBSS/v15-i5/25505

Published Date: 19 May 2025

Abstract

Survivors of sexual assault face numerous challenges that significantly impact their recovery, including physical and psychological trauma, societal stigma, and inadequate access to essential services. Gender-Based Violence (GBV) recovery centers play a crucial role in addressing these challenges by providing comprehensive medical, psychological, and legal support. These centers serve as critical resources for survivors, offering a safe space for healing and recovery. This study utilizes Bronfenbrenner's Ecological Model as the conceptual lens to analyze the multifaceted influences on survivor recovery. This model emphasizes the importance of understanding the various systemic levels micro, meso, exo, macro, and chrono that interact to shape the experiences of survivors. By applying this framework, we can better understand how different factors contribute to or hinder recovery efforts. The focus of this research is to explore how Bronfenbrenner's model informs psychosocial interventions across multiple systemic levels. By examining each level of the ecological model, we can identify specific areas where interventions can be enhanced to better support survivors of GBV. This approach highlights the interconnectedness of individual experiences and broader societal factors in shaping recovery outcomes. The study reveals significant gaps in resource availability within GBV recovery centers. For instance, only 42.86% of centers have adequate private rooms to ensure confidentiality for survivors, while 71.43% have trauma forms available for documentation. These findings indicate that effective survivor-centered care requires consistent access to immediate resources. Additionally, limited inter-organizational collaboration was noted, with only 14.29% of centers utilizing referral directories, undermining comprehensive support for survivors. In conclusion, Bronfenbrenner's Ecological Model provides a structured approach to understanding and addressing gaps in recovery services for sexual assault survivors. By recognizing the interplay between various

School Of Postgraduate

PSYCHOSOCIAL INTERVENTIONS AND RECOVERY NEEDS OF SEXUAL ASSAULT SURVIVORS IN UASIN GISHU COUNTY, KE...

 PSYCHOSOCIAL INTERVENTIONS AND RECOVERY NEEDS OF SEXUAL ASSAULT SURVIVORS IN UASIN GISHU COUNTY, KENYA

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