DETERMINANTS OF HEALTH FACILITY PREPAREDNESS IN THE MANAGEMENT OF GENDER BASED VIOLENCE: A CASE OF PRIMARY HEALTH FACILITIES IN MOMBASA COUNTY

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DECLARATION

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

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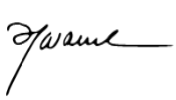
I/We confirm that the work reported in this thesis was carried out by the candidate under my/our supervision

Signed  Date 22.09.2023

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DEDICATION

This research project is dedicated to my family and colleagues who were on the forefront to encourage me throughout the journey.

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ABSTRACT

Gender based violence (GBV) is an affront to human rights and the attainment of sustainable development goals (SDGs). In Mombasa county 65% of the population live in informal settlement which exacerbate GBV due to poverty. However, health systems are not prepared to deal with the health consequences that are brought about by this vice such as injuries and trauma. To better understand the components that could improve primary health facilities' preparedness in managing this problem, this study Independent variable were to investigated the influence of budget allocation, physical infrastructure, health information management system, and professional approach. While depended variable was Primary Health Facilities Preparedness in the management of gender based violence. Relying on the Theory of Reasoned Action/Planned Behavior and the Intellectual Capital Theory, a descriptive cross-sectional research design was used to ascertain factors that affect health facility preparedness in the management of GBV. A sample of 334 health workers was selected; stratification sampling was employed to categorize them while simple random sampling was used to select respondents in each category. Primary data was collected using questionnaires, which was then analyzed through the Statistical Package for Social Sciences version 25. Correlation and multi-linear regression analysis were used respectively, while descriptive statistics were used to produce means and standard deviation from the collected data. It was found that that budget allocation and primary health facilities preparedness had insignificant correlations with value of P=.095. Further, physical infrastructure and Primary Health Facilities Preparedness insignificantly correlated with a correlation value of P=.079. Also, Health Information Management System and Primary Health Facilities Preparedness significantly and positively correlated with a correlation value P=.243. Additionally, Professionalism and Primary Health Facilities Preparedness positively and significantly correlated with a correlation value of P=.424. Based on these findings the study recommends that county government should ensure appropriate allocation of budget to improve the physical infrastructure of primary health facilities that is adequate lighting, and separate entrances and exits to maintain confidentiality. The study also recommends hospital management should enhance the health information management system that specifically addresses the management of GBV cases in primary health facilities for standardized data collection tools and protocols for recording and reporting GBV incidents. The county government should support capacity building programs focused on professionalism and ethical conduct for healthcare providers and staff members in primary health facilities in order to respond to GBV.

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LIST OF ABBREVIATIONS

CATCH Model	Commitment, Advocacy, Trust, Collaboration, Health System Support
FGM	Female Genital Mutilation
GBV	Gender Based Violence
GBVA	Gender Based Violence and Abuse
ICS	Improving Community Security
IEC	Information, Education, and Communication
IPV	Intimate Partner Violence
KDHS	Kenya Demographic and Health Survey
LMICs	Low- and Middle-Income Countries
OPD	Outpatient Departments
PHC	Primary Healthcare
SGBV	Sexual Gender-Based Violence
VAW	Violence Against Women
VDRL strips	Erovita Syphillis strips WB (VDRL)
WHO	World Health Organization

CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

Gender-based violence is a significant obstacle to achieving human rights and sustainable development goals (Zamora, et al., 2018). The World Health Organization (WHO) refers to violence as the anticipatory application or display of physical strength or force against oneself, an individual, or a group, which can result in harm, injury, death, psychological trauma, or deprivation. (World Health Organization.,[WHO], 2017). GBV affects men and women's in various ways, for both the immediate and distant future; both visibly and invisibly, and can manifest as physical, psychological or sexual abuse. The violence may be inflicted by an intimate partner or, in the case of sexual violence, by any individual.

Many men and women who experience violence seek medical treatment, providing the healthcare system with a crucial responsibility and opportunity to address gender-based violence (Pathak,et al, 2019). These men and women deserve care and support and have the right to receive the best possible healthcare. This care should be accessible at all levels of healthcare delivery, from primary care to tertiary hospital care. The healthcare system can also serve as the starting point for a network of supportive social and legal services. The initial contact a survivor has with a healthcare institution can greatly impact their psychological, reproductive, sexual, and physical, well-being, as well as their reintegration into society (van de Klundert, 2021). The goal is to provide comprehensive care for survivors at the first healthcare institution they visit and ensure prompt and efficient transfer to a better-equipped facility when necessary.

Despite the growing recognition regarding gender-based violence (GBV) as a matter concerning public health, healthcare systems have been slow to monitor, anticipate,

respond to, and prevent such violence. However, since the release of the World Health Organization's (WHO) clinical and policy guidelines for addressing GBV, several countries have implemented or adapted these principles to their healthcare systems and political contexts, even in low-resource settings (d'Oliveira, et al., 2020). The primary responsibility of healthcare systems for victims of violence is to offer supportive treatment to consequences brought about by gender base violence such as injuries. These services can provide urgent and continuing therapy, address linked problems including substance misuse and depression, and assist stop violent episodes from happening again. By exposing the effects of violence against men and women on health and promoting collaboration with other sectors, the healthcare system also plays a part in primary prevention (Chowdhury, et al., 2022).

The determinants of health facility preparedness in managing gender-based violence encompass various factors that influence the capacity of health facilities to address this critical issue (Colombini et al., 2022). By addressing determinants of health facility preparedness in managing gender-based violence, health system management strengthens service delivery through policy implementation, workforce training, resource allocation, community engagement, data collection, and integration with broader healthcare services. Policies and guidelines are implemented, protocols standardized, and reporting mechanisms improved. Training programs enhance healthcare staff's ability to support survivors. Adequate funding is advocated for comprehensive care. Community outreach builds trust and awareness. Robust data systems track prevalence and assess interventions. Integration with other sectors enhances support for survivors (Manandhar et al., 2018).

To improve healthcare system responses to gender-based violence (GBV), several models have been developed in accordance with the World Health Organization's (WHO) guidelines. Models include one-stop crisis centers where Individuals who have experienced gender-based violence can obtain access to all services related to both the reaction and avoidance of violence. Others include integrating screening for intimate partner violence into other healthcare services, training healthcare staff on how to properly respond to GBV, improving referrals between the healthcare sector, social services, legal and the police, and supplying healthcare facilities with prepackaged rape kits to help (Colombini, et al, 2017). Although there have been improvements made to the reaction to violence against women, there is a lack of evidence on whether healthcare facilities are equipped to deliver medical assistance for cases of sexual violence..

Advanced countries have made significant progress in improving their healthcare systems to provide adequate care to survivors of gender-based violence (GBV). Spain has established a comprehensive healthcare reaction to violence regarding gender, as noted by Otero-García et al. (2018). A commission was created by officials from the Ministry and National Healthcare System to provide technical assistance, coordinate efforts, and evaluate healthcare services across National Healthcare System regions (Bacchus, et al., 2012). With the support of the National Healthcare School and the Women's Institute, a training of trainers program was introduced, and a wide range of healthcare professionals, including primary care practitioners, hospital staff, emergency medical services personnel, midwives, and mental health professionals, received training (Goicolea, et al.,, 2015). Best practices for ensuring healthcare facilities have the capacity to provide care

to GBV survivors are identified, collected, and shared among regions (Koschorke, et al., 2021).

To cater to the diverse requirements of women facing gender-based violence (GBV) in low- and middle-income countries (LMICs),a comprehensive and well-integrated response from the health sector is required (Sardinha, et al., 2022). The conflict and insecurity in north-eastern Nigeria resulted in a rise in gender-based violence (GBV)., putting a strain on the health sector to handle the resulting physical and psychological injuries (Isokpan & Durojaye, 2016). Many victims of GBV in Nigeria are more likely to report to health facilities rather than police stations. However, despite efforts globally to manage GBV, many health professionals in Nigeria lack the competence to detect and manage cases appropriately. Constraints to recognizing, diagnosing, and treating GBV in Nigeria include fear of offending the affected person or their spouse, lack of knowledge on how to handle such cases, discomfort in treating them, avoidance of involvement in police cases, and time constraints.

In Uganda, the health sector has played a significant role in the response to gender-based violence (GBV) through sustained advocacy, training of healthcare providers, and technical support (Nabukeera, 2020). Financial support from donors in 2019 has led to a greater focus on GBV as a social, legal, and public health issue. The use of gender-based violence registers has become common in many facilities in Uganda, with the data being fed into the Health Management Information System (World Health Organization, 2020). However, training alone is not enough for healthcare providers to effectively respond to the needs of survivors of GBV in Uganda. Healthcare professionals encounter difficulties such as poor understanding of mental health treatment, ignorance of pertinent regulations,

a lack of time, a lack of private space in clinics, and a dearth of community referral resources. As a result, Uganda has to hold shorter and more frequent training sessions.

In Tanzania, it has been reported that the availability of GBV health services in most health centers is limited. Therefore, coordinated efforts are needed to improve the GBV services offered. Expanding integrated service models like GBV one-stop centers, which offer medical, legal, and psychosocial assistance for GBV survivors under one roof, is one way to solve the problem (Raftery et al, 2022). The Ministry of Health has acknowledged the importance of efficient healthcare services in addressing gender-based violence, and has developed the National Plan of Action for the Prevention and Eradication of Violence against Women and Children (NPA-VAWC) from 2017/18 to 2021/22 (Mtaita, et al., 2021).

In Kenya barriers to accessing comprehensive GBV services form health facilities included limited financial allocation, poor coordination of services, Insufficient training in handling sexual violence cases, inadequate referral systems, and limited follow-up engagement by health facilities. Thus on addressing barriers, it is necessary that staff training and providing specific clinical guidelines and protocol for treating survivors be prioritized (Gatuguta, et al., 2018).

In Kenya, the way in which care is provided to survivors of gender-based violence (GBV) can vary between facilities. For example, in Naivasha Sub County, services are offered in different departments like Casualty and Outpatient, Youth Centre, HIV Comprehensive care Centre, and Pharmacy, all located in different areas within the facility. However, in Thika Level 5, all GBV services are offered from all aspects of the HIV Comprehensive care Center apart from during nighttime when they can be accessed

from the Outpatient department. Despite the different approaches, services typically include taking the initial medical history, collecting specimens and performing laboratory tests, providing treatment and counseling. The study conducted by Gatuguta, et al. (2018) revealed major challenges with data recording and storage (Gatuguta, et al., 2018). Some reports were missed, particularly laboratory results for survivors, 5% of survivors' physical examination findings were not recorded, and in some cases the recorded findings were not informative enough to be used as forensic evidence.

During June 2021, Kenya made a commitment to eradicate gender-based violence, including sexual violence, before the year 2026. To achieve this goal, the Kenyan government committed to removing systemic barriers that enable GBV to persist. This includes maintaining the allocation of USD 2.79 million for GBV and female genital mutilation (FGM) in the financial year 2020/2021, with the aim of increasing the budget allocation to USD 5 million in the coming years. Additionally, a GBV fund is being established by employing a co-financing approach in collaboration with civil societies, the private sector, and other relevant parties. (Kaburu & Torsu, 2022).

The funding for gender initiatives in Kenya comes from two main sources: the national budget and international donor funding (Women, U. N. , 2021). However, a study conducted by Plan International and Save the Children found that organizations working on gender equality in Kenya are still largely dissatisfied with the level of gender funding and initiatives (PLan international & Save The Children, 2021). Kenya scored 55.1% on the gender index, but the analysis showed a poor performance in gender financing. Although there are guidelines and policies for Gender Responsive Budgeting in Kenya, there is an implementation gap, and it is difficult to track the national funding for health

facilities and programs under the Ministry of Health, including reproductive and maternal health care (PLan international & Save The Children, 2021). It is against this backdrop that this study seeks to examine the determinants of health facility preparedness in the management of gender based violence in Kenya.

1.2 Statement of the Problem

The reports from Kenya Demographic and Health Survey 2014, National Crime Research Centre 2016, and United Nations Population Report 2013 show that despite efforts by the government and its partners, gender-based violence cases are either increasing or remain unchanged (Njagi, 2017). GBV has significant negative impacts on the immediate physical, sexual, and psychological health of survivors and increases their risk of future health problems. The effects of GBV can impair survivors' ability to perform physical and mental tasks and may lead to mental health issues like post-traumatic stress disorder, substance abuse, anxiety and depression even suicide (Ford & Boyle, 2021).

In Mombasa County, 65% of the population lives in informal settlements (slums), which are home to a large portion of the county's poor and lower-middle class. Empirical evidence shows that poverty exacerbates GBV, and slums in Mombasa are becoming a hub for such violence (Bamiwuye & Odimegwu, 2014). The provision of healthcare services to GBV survivors is a critical aspect of their recovery and rehabilitation. Primary health facilities play a pivotal role in this process. However, there is a pressing need to investigate the preparedness of these facilities in Mombasa County to adequately address the healthcare needs of GBV survivors. One of the primary challenges is the limited availability and accuracy of data related to GBV cases in Mombasa County. Survivors often do not report incidents due to stigma, fear, or lack of awareness of available support

services. This underreporting may result in an underestimation of the true extent of the problem, hindering the development of targeted healthcare interventions. A comprehensive study is necessary to assess the factors contributing to underreporting and to gauge the actual prevalence of GBV cases in the county (WHO, 2021).

The preparedness of primary health facilities to respond to the healthcare needs of GBV survivors is a critical concern. This includes the availability of trained healthcare providers, the provision of forensic evidence collection, the accessibility of post-exposure prophylaxis for HIV and other sexually transmitted infections, and the adequacy of psychological support and counseling services. Challenges in healthcare system preparedness, such as staff training and resource allocation, must be identified and addressed to ensure that survivors receive timely and appropriate care. There are limited studies that investigate the enabling and constraining factors for comprehensive and integrated action on the gender-based violence (GBV). Although there is a wealth of literature that evaluates the effectiveness of health therapies for violence against intimate partners, these studies do not examine the broader health system factors and processes that could influence incorporating these measures into standard health care services (Colombini, Dockerty, & Mayhew, 2017; Feder, et al., 2011; O'Doherty, et al., 2014; Bair-Merritt, et al., 2014; O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011;). A closest study to the current one was done by Wakahe (2010) on health institutional readiness to offer comprehensive treatment to survivors of those affected by gender on the basis of gender in Kenya. The study lacked a specific focus as it focused on the entire Kenya. the current study sought to establish preparedness of primary health facilities in

the provision of healthcare to survivors of gender based violence in Mombasa County, Kenya.

1.3 Study Purpose

The study will enable to gather data on determinants of primary health facilities preparedness in the management of gender based violence in Mombasa County. This data will help in further strategies to prepare and hence service delivery of GBV management in the facility management.

1.4 Objectives

1.4.1 Broad Objective

To assess the determinants of primary health facilities preparedness in the management of gender based violence in Mombasa County of Kenya.

1.4.2 Specific objectives

i. To assess the influence of budget allocation on primary health facilities preparedness in the management of gender based violence in Mombasa County of Kenya.
ii. To determine the influence of physical infrastructure on primary health facilities preparedness in the management of gender based violence in Mombasa County of Kenya
iii. To establish preparedness of the health information management system on primary health facilities preparedness in the management of gender based violence in Mombasa County of Kenya

iv. To explore the influence of professionalism on primary health facilities preparedness in the management of gender based violence in Mombasa County of Kenya

1.5 Research Questions

i. What is the influence of budget allocation on primary health facilities preparedness in the management of gender based violence in Mombasa County of Kenya?

ii. How does the physical infrastructure influence primary health facilities preparedness in the management of gender based violence in Mombasa County of Kenya?

iii. To what extent does health information management system influence primary health facilities preparedness in the management of gender based violence in Mombasa County of Kenya

iv. What is the influence of professionalism on primary health facilities preparedness in the management of gender based violence in Mombasa County of Kenya?

1.6 Justification of the study

Health facilities play a crucial role in determining the immediate and long-term health outcomes of survivors of gender-based violence. The initial interaction a survivor has with health facilities can greatly impact their physical, mental, and psychosocial well-being, as well as their ability to reintegrate into the community. Health systems that have well established capacities in terms of adequate budget allocation, infrastructure, information systems and staff skill adequacy provides better management of GBV cases among survivors than health systems that have poor capacities.

Mombasa county was selected for the study because according to Annual Development Plan of the county 2020-2021 Inadequate availability of gender-based rehabilitation and trauma services, insufficient documentation of cases in relation to gender, and poor assessment of patients for SGBV are also issues. Cultural behaviors that are harmful, Lack of community understanding about the importance of disclosing GBV incidences on time, impoverishment, substance and drug misuse, ignorance, and misinformation. The uniqueness of this study is that it will Raise the public's consciousness of the need of disclosing domestic abuse. HCW awareness and training, as well as proactive testing Developing expertise on gender-based violence (HCW and CHV), Increase cross-sector collaboration. Improve the referral/linkage processes. More GBV centers should be established in health facilities, as well as a GBVR desk in a facility at a lower tier.. Examining the preparedness of primary health facility will guide and help to identify gap and made recommendation for effective management of GBV.

1.7 Limitations of the study

Challenges arose during the course of the research, but steps were taken to overcome them. Some of the limitations include: The respondents were reluctant to share information related to the subject matter due to fear of retaliation if the information is disclosed. To mitigate this challenge, the researcher assured the participants that the research was solely for academic purposes and they did not face any form of victimization for the information they provide. They were informed of the confidentiality measures in place to protect their information and that it only be used for academic purposes. Due to the busy nature of work at a public hospital in Mombasa County, the respondents were occupied and unable to answer the questionnaires. The researcher

addressed this by asking the administration to specifically allocate times during which the employees are less busy to collect the data. The limited time allocated for the research posed a challenge, but the researcher employed good time management skills to complete the research on time. The questions in the questionnaire was clear and simple to save time when the process of collecting data can be undertaken. The researcher visited the hospital during breaks, such as tea or lunch, or during shift changes when the staff have completed their daily tasks. The researcher will explain the significance of the study to the hospital and Mombasa County as a whole, encouraging the participants to take part.

1.8 Delimitations of the study

The study investigated the determinants of preparedness for management of GBV at primary health facilities. The study was carried out in primary health facilities in Mombasa County. Specifically, the study sought to establish how budget allocation, physical infrastructure, HIMS and professionalism influence preparedness for the management of GBV. The findings were generalizable to all primary health facilities in the Country.

1.9 Significance of the study

The study has significant implications for various stakeholders. For the County Government of Mombasa and hospital management, the results can be used to inform policies and regulations and improve existing ones, with the aim of enhancing the preparedness of primary health facilities in managing gender-based violence (GBV). The government of Kenya will also use the findings to formulate effective strategies and policies for managing GBV in public primary health facilities. The research will also

benefit human resource practitioners by providing insights into improving the professionalism of healthcare workers in managing GBV.

Academicians and scholars will use the findings as a basis for further research and discussions on preparedness of health facilities in managing GBV. The research will aid in the creation of a sustainable and effective model for adopting strategic approaches for enhancing the preparedness of primary health facilities. The outcome of the investigation will additionally expand the existing knowledge on managing GBV.

1.10 Study Assumptions

It is assumed that the participants responded to the data collection tools honestly and factually. Considering we will be collecting both quantitative and qualitative data, it is assumed that data records will be availed openly and informants provide accurate information on the interview questions.

That study also assumed that health facilities that had well established capacities in regards to adequate budget allocation, infrastructure, information systems and staff skill adequacy provides better management of GBV cases among survivors than health facilities that have poor structures in relation to the aforementioned factors.

1.11 Operational Definition of Terms

Gender Based Violence: Gender-based violence refers to any behavior or activity that results in psychological, sexual or physical pain or discomfort to an individual (Chamberlain & Levenson, 2012)

Preparedness in the Management of GBV: Refer to any efforts aimed at stopping and managing instances of gender-based violence, taking into account international human rights standards, and promoting policies and cultural

norms that will eliminate GBV, while empowering and supporting survivors (UN WOMEN, 2021)

Primary Health Facilities: These include fundamental medical services founded on feasible, trustworthy, and socially appropriate approaches and technologies, must be available to all members of the community and their families. This accessibility should involve active participation from the community, and the services should be affordable for both the community and the country to maintain throughout their developmental stages. The aim is to foster self-reliance and empowerment. (WHO, 2022)

Budget Allocation: A crucial government policy that outlines the plans for collecting revenue and utilizing public resources to accomplish the major objectives of the nation (Barroy, et al., 2018).

Physical Infrastructure: Refers to the presence and quality of public health establishments, including the quantity of establishments, the resources and features of each establishment, the distribution of these establishments, and the appropriate combination of different types of establishments that meet the health needs of the population.

Health Information Management System: A health information system is a comprehensive approach that involves gathering, processing, analyzing and utilizing health-related information to enhance the efficiency and effectiveness of healthcare services at all levels of the system through effective management (UNDP, 2022)

Professionalism: On a regular basis, use interaction, expertise, technical proficiency, clinical insight, feelings principles, and introspection in practice for the betterment of the individual being treated and the community at large (Kirk, 2007)

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The chapter reviews literatures that connect to electronic health records systems adoption on the performance of healthcare providers. The literature will specifically review quality system, record quality, service quality and knowledge quality and their influence on the performance of healthcare providers in public health facilities. The chapter will define the theoretical framework, conceptual framework as well as the research gap.

2.2 Primary Health Facilities Preparedness in the Management of Gender Based Violence

2.2.1 New Cases

There is a pressing global need to address Gender Based Violence and Abuse (GBVA), which is considered a complex and chaotic problem requiring a multi-disciplinary approach and a strong healthcare system (Hegarty & Glasziou, 2011). The World Health Organization recognizes the crucial role of healthcare in reducing the impact of GBVA, especially on children (World Health Organization, 2013). GBVA affects the welfare and health of individuals and families and society as a whole. According to global reports, one out of every three women encounters violence that is either sexual or physical from their partners. (Garcia-Moreno, 2014). The disease burden for women of childbearing age is exacerbated by GBVA and causes physical and mental harm to survivors, leading to increased healthcare utilization and loss of work days (Garcia-Moreno et al., 2014).

Temmerman et al., (2019) studied the issue of domestic violence and gender-based violence in Kenya, where it is estimated that 32% of women and 18% of men experience sexual violence before the age of 18. The paper discusses the development,

implementation, and challenges of programs to manage GBV patients, with a specific focus on the Mombasa county GBVRC. The centre has provided post-GBV care to 6,595 people reporting sexual violence, with over 90% of the perpetrators being known to the survivors. The low rate of attendance for second counseling visits suggests a need for a stronger follow-up strategy. The investigation additionally emphasizes on the gender-based violence and recovery unit at Coast Provincial General Hospital. Sexual violence is a major public health issue worldwide.

Documentation and record of new case is very vital for Primary Health Facilities Preparedness in Gender-Based Violence Management if all parts of treatment are to be fully handled, sexual abuse survivors must have sufficient documentation at their first appointment as well as for future follow-ups. These are located in the outpatient registration, records and laboratory, department. One referral hospital, one private hospital, and two provincial hospitals maintained accurate records. Because there was no unique classification for sexual assault in the outpatient record, the statistics are unclear. The ages of the survivors were likewise not documented. Because there was no unique coding for sexual assault in the laboratories, some of the values rates of vaginal; swab and screening HIV are quite high since they cover every test performed for a variety of different reasons.

According to wakahe (2007) in her study found out that Obtaining accurate It found challenging to obtain figures of survivors of sexual violence from outpatient registration or the laboratory. There was no unique categorization for sexual abuse, and survivors might enter the facility through a variety of doors, including consultants clinics, outpatient, casualties and the wards as well.

However, it was assumed that because the hospital could do these tests, they could also test the SV survivors. The only correctly preserved records in one district hospital were located Unfortunately, no records exist of persons who visited late during night or over weekends while the lab was closed, and there are no records of surviving who underwent further interventions. All of the district hospitals' records were jumbled.

According to the National Guidelines for the Management of Sexual Violence, all the victims presenting to an institution must fill out a PRC form. This legal document contains thorough information that can be used for medical and psychiatric follow-up as well as criminal prosecution of the perpetrator. These are papers created and distributed by the Kenyan government.

2.2.2 Availability of Services

Despite the fact that health services are the most frequently visited place by families experiencing gender-based violence and abuse, the healthcare sector has been slow in addressing the issue. Since physicians are the major group to whom patients desire to talk about GBVA, important response sites for GBVA comprise routine care, maternity clinics, emergency and the department for community child health. Unfortunately, only a small percentage of people exposed to GBVA are recognized in healthcare settings (Rivas *et al*., 2015).

According to Fernandes et al. (2020), Kenya has made significant advancements in the development of standards and guidance regarding GBV. The government has implemented various laws aimed at addressing GBV, including the criminalization of abuse, and has put in place a statutory duty for the police and government departments to

provide medical services and protection to survivors. However, there are still loopholes and gaps in the legal framework that need to be addressed for full comprehensive coverage.

In Kenya, several national policies have been established to address gender-based violence (GBV) and support its survivors. The National Guidelines on the Management of Sexual Violence (2014) lays out the steps for the treatment of survivors and preserving evidence, and the National Monitoring and Evaluation Framework (2016) sets indicators for monitoring and evaluation of the sectors addressing sexual violence. Additionally, the National Health Sector Standard Operating Procedures (2014) outline minimum procedures for the management of GBV in the health sector and referral mechanisms for support services. However, despite these standards, the implementation of these policies remains limited at the county level.

A policy on Sexual and Gender Based Violence has been established by the County Government and was launched in November 2017. It provides guidance for county governments to implement laws, policies, and programs to prevent and respond to SGBV and includes a Model Legislative Framework. The policy emphasizes the need for effective coordination and allocation of resources to ensure its implementation at the county level. (NGEC, 2017). UN agencies and other organizations have created additional procedures and processes to fill in perceived gaps in addressing GBV (World Bank, 2017). Additionally, organizations like LVCT Health have created their own SOPs for child sexual violence survivors.

Screening is very crucial for all gender based violence survivors; according to kagure (2007) in her study she discovered that in this particular component of care, all

institutions are underprepared. No facility has the big paper on which the survivor can stand while undressing to collect debris. Since they have no idea where or how to to keep forensic proof, hospitals do not collect it, nor do they know the proper protocol for giving testimonyThere are no safe-keeping facilities. A single hospital has cartons stuffed with forensic evidence that hasn't been assessed in months. Several of the victims who were taken to the institutions by law enforcement are given forensic evidence. There is no clear chain of custody for the individuals who forensic material was used was not first presented by the police. Many organizations have difficulties in gathering forensic evidence. The laboratory lacks functional equipment. There were no gloves at one district hospital, making examination of patients and collection of specimens difficult. There were no swab sticks at another district hospital. They couldn't construct any locally since they didn't have a working autoclave. The speculums could not be sterilized either.

W.H.O. and Kenya National Guidelines advocate collecting high vaginal swabs and rectal swabs from each SV survivor for STI screening and DNA analysis. Most institutions did not collect these, and even when they did, they did not gather them from every survivor.

2.2.3 Acceptability of Services

Garcia-Moreno et al. (2014) state that patients often seek out practitioners who are supportive and would ask about GBVA, and may make multiple visits before revealing such information. However, when patients do disclose, health professionals are often found to be lacking the necessary skills and training to respond appropriately. Stigma plays a major role in hindering reporting of GBV. For example, ACORD (2009) emphasizes that female victims who turn to the Kenyan police for help often encounter

ridicule, embarrassment, and verbal abuse. Furthermore, Njeri and Ogola (2014) indicate that in many Kenyan cultures, reporting rape to the police is considered disgraceful and inappropriate. Also, male victims and boys are reluctant to access social services due to the widespread perception that they cannot experience gender-based violence. Other variables, such as personal traits, also play a role in shaping help-seeking behavior for both women and men.

Overall, very few individuals seek help through formal channels. Only 7% of women who reported seeking help in a 2015 Kenya Demographic and Health Survey went to the police, 2.9% sought medical care, 1.7% went to a social work organization, and only 0.5% sought help from a lawyer. Women most commonly turn to their own families or their husband's families for help (65% and 31% respectively), while men most often turn to their own families (49%), followed by the police (19%) and other sources (17%) (KDHS, 2015).

2.2.4 Responsiveness

In Africa, numerous agreements and declarations have been issued to further combat GBV, including the Maputo Protocol (2003), Peoples' Rights, the Solemn Declaration on Gender Equality and the African Charter on Human and in Africa (2004), and the International Conference of the Great Lakes Region Protocol. In addition, provisions in the African Charter on the Rights and Welfare of Children also include groundwork in addressing this issue.

The Kenyan government is devoted to eradicating all manifestations of Gender Based Violence (GBV) and to guaranteeing survivors access to top-notch and accessible

services. GBV still remains a pervasive problem in the country, which presents complex and wide-reaching struggles. The Vision 2030, which acknowledges the growing cases of GBV and maps out actions to confront them, marks a deep shift. The Directorate of Gender, forming part of the Ministry of Devolution and Planning, is the main government body charged with directing initiatives to prevent and resolve GBV.

D'oliveira et al. (2020) found areas of present policy and practice that require improvement, particularly in the areas of leadership, governance, the structure of the health care system, and the health workforce. Additionally, GBV is seen as a lower priority and has not gotten the same amount of governmental acknowledgment as other health concerns. The implementation of the DV policy by both managers and providers has been hindered in large part by the absence of clear direction at the federal and municipal levels. It has also been challenging for medical professionals to devote enough time to GBV due to the organizational structure of the PHC system in So Paulo, which prioritizes the quantity of consultations and household visits as the key performance measures.

Ramadan (2021) focused on a cohesive and equity-based health system can improve the delivery of essential services and contribute to management of GBV process in conflict settings in Cameroon, DRC, Mali, and Nigeria. The study found that there was subnational variation in access, quality, and coverage of GBV patients care. The study concluded that combinations of multiple measures is necessary while investigating disparities. Having better results in a health In Africa, numerous agreements and declarations have been issued to further combat GBV, including the Maputo Protocol (2003), the African Charter on Human and Peoples' Rights, the Solemn Declaration on

Gender Equality in Africa (2004), and the International Conference of the Great Lakes Region Protocol. In addition, provisions in the African Charter on the Rights and Welfare of Children also include groundwork in addressing this issue.

The Kenyan government is devoted to eradicating all manifestations of Gender Based Violence (GBV) and to guaranteeing survivors access to top-notch and accessible services. GBV still remains a pervasive problem in the country, which presents complex and wide-reaching struggles. The Vision 2030, which acknowledges the growing cases of GBV and maps out actions to confront them, marks a deep shift. The Directorate of Gender, forming part of the Ministry of Devolution and Planning, is the main government body charged with directing initiatives to prevent and resolve GBV.

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Responsiveness toward gender-based violence integrate a multi sectoral agencies link the relationship between all of the divisions that ought to have a role in the survivor's overall oversight is fractured or non-existent. Yet it is not unexpected that a great deal of institutions does not fill out the PRC forms. These documents form the basis for filling P3 forms, which are used by the police department for prosecution. It's no surprise that the vast majority of abusers are never convicted.

Kagure (2007) in her study discovered that Police brought a number of survivors, and legal action may have been taken. There was no participation of the police or judicial system within the facility for people who are not brought by police. PRCI forms that might be useful are not filled. P3 forms are filled for persons who have been hauled in by the police. P3 forms are done on specified days in some universities, and a fee is required for this service. Three of the fourteen institutions [23%] routinely complete PRCI forms and deliver them to survivors so that they may follow up with the police.

2.3. Budget Allocation and Preparedness in the Management of Gender Based Violence

2.3.1 Government funding

In the study by Usdin et al. (2020), the impact of budgeting on the readiness to address gender-based violence (GBV) in South Africa was investigated. The study found that although South Africa passed legislation on GBV and domestic violence in 2008, its implementation has been slow and met with frustration. The study emphasized the importance of coalition building, advocacy, and the role of NGOs in addressing GBV. Additionally, it was concluded that the budgeting process plays a crucial role in the preparedness to manage GBV in South Africa and ongoing efforts are needed to secure sufficient financing and resources to effectively address GBV.

In short, the difficulty in estimating government spending on gender-based violence is due to the lack of specific, dedicated funding for it. Instead, funds for various initiatives related to GBV, such as provision of shelters, training of prosecutors, and debriefing of police officers, come from broader funding categories. This makes it hard to track the spending and determine if it has been sufficient or if there are any financial gaps in addressing GBV.

The state faces hidden costs associated with gender-based violence, such as the salaries of officials involved in assisting victims and arresting perpetrators. The cost of a protection order also involves some hidden salary expenses. The state provides partial funding to various organizations to deliver services to survivors, and in order to have a complete picture of spending on GBV, the Departments need to clarify their funding related directly to GBV.

2.3.2 Budget Amount

Kenya has committed to increasing its financing and budget allocation in order to avoid and respond to violence associated with gender. To distribute resources domestically among many sectors, this entails reforming and putting into practice laws, policies, and multi-sector national action plans. For FY2020/2021, Kenya wants to maintain its present resource allocation and set up co-financing methods to enhance support for activities that take gender into account. The government has pledged to spending USD 23 million on GBV prevention and response by 2022, and then, using a co-financing mechanism, USD 50 million by 2026. Kenya has specifically committed to maintaining its USD 2.79 million budget allocation for GBV and FGM in the FY2020/2021 fiscal year and gradually raising the minimum budget commitment to USD 5 million in subsequent years.

The Kenyan government plans to implement an accountability framework to keep track of its spending on the prevention and reaction to gender-based violence. They aim to invest 100 million Kenyan shillings annually in research and innovation for GBV by 2026. Over the past few years, an average of 23% of the total county budget allocation has gone to the health department. The department's total health expenditure was 6.9 billion Kenyan shillings for 4 years from 2013 to 2017. Most of the recurrent expenditure was compensation for employees, which accounted for 83% compared to the recommended 50-60%. Only 17% of the department's spending was for development. There have been instances where the health budget needs have not been met across all facilities due to a lack of funding from the government. The budget for the health

department is mainly funded from four sources: national shareable revenue (69%), conditional grants from the national government (25%), external grants and loans (1.3%), and local revenue, mainly user fees from county public hospitals (4.4%).

2.3.3 Amount Disbursed

Consignado et al. (2022) studied the role budget allocation in the preparedness in Gender-Based Violence Management in Philippines. The findings of a study suggest that policies for setting up village-level desks for addressing cases of violence against women (VAW) are being implemented, but the officers lack equipment and resources. The officers also face limitations in their ability to effectively fulfill their responsibilities due to their age and education, as there are no clear qualifications required to be an officer. The study recommends amending national or local policies to include basic qualifications for officers in budgeting and managing allocated funds, as well as a clearer system for orienting the officers to their roles and responsibilities.

Resources have been allocated by Mombasa County to attain universal health coverage. For the fiscal year 2018–19, the county administration authorized a budget totaling Ksh 13.6 billion, an 8% increase from the prior year. Of the overall budget, the health department received Ksh 3.3 billion. Additional financing for the department came from local tax collections that wasn't included in the overall county budget. The municipal revenue for health in the fiscal year 2018/19 was Ksh 647 million. The county's overall budget was made up of around 24% of health appropriations. The local revenue forecast climbed from Ksh 360 million the year before to Ksh 647 million, indicating the possibility for future development and protection against any changes in the national allocation. Budget absorption for personnel expenses (PE) was 99.7% in 2018–19, compared to 98.6% for use of goods and

services, which includes operations and maintenance. Estimates put the overall financing from implementing partners at $4.2 billion.

2.3.4 Amount Available

In Laisser et al.'s (2021) highly detailed study on the influence of the amount available in the preparedness of managing gender-based violence in Tanzania, it was discovered that 39 healthcare workers had undergone intensive training on gender-based violence policies and financial management prior to their involvement in managing GBV care. Almost half (48.7%) of these healthcare workers were deemed to be highly experienced and adept in budgeting and financial management. Ultimately, the study concluded that the healthcare workers saw financial budgeting as an invaluable tool when it came to implementing GBV programs and policies in public hospitals.

In a related study conducted by Johnson (2014), the influence of finances on the preparedness of managing gender-based violence in Australia was further examined. Here, it was found that a greater level of funding resulted in better GBV related policies and management.

The study focused on the health care providers of services in the public health services in Sydney. The analysis discovered that, in contrast to the experiences of Canada and the United States, courts in Australia were mostly constituted by legislation or by the government utilizing already-existing statutory provisions and sizable resources. The study also discovered that judges make use of their position of power to make victims feel at ease in court, to show sympathy for their suffering, and to mobilize resources for their care and state protection. Additionally, it has been determined that therapeutic

jurisprudence advises judges to take into account the favorable or unfavorable effects that their decisions and actions have on the parties who appear before them, and that it is advised that excessive fines for domestic violence offenders be avoided.

2.4 Physical Infrastructure and Preparedness in the Management of Gender Based Violence

2.4.1 Premises

Keesbury et al. (2012) conducted a study on the physical infrastructure where Kenya and Zambia have "one-stop centers" for gender-based violence. The study aimed to assess the effectiveness and cost-effectiveness of these centers when it comes of victims' health and legal results, and identify lessons learned for future implementation. The study found that the one-stop center model, which provides comprehensive services in one location, was gaining popularity as a a method for combating sexual and gender-based violence (SGBV). The study offers valuable insights and recommendations for policymakers and program managers looking to introduce or adapt the one-stop centre model in their own countries. The study concluded that physical infrastructure was important in the success of these centres in Kenya and Zambia.

2.4.2 Medical Facilities/supplies

The study conducted by Rybarczyk et al. (2021) painted a bleak picture of the medical supplies accessible to victims of sexual assault in the Democratic Republic of the Congo's eastern region. It was revealed that, despite the necessity of these supplies for proper care, the difficulty of the situation meant that the resources available were limited. To improve the quality of health care, providers urged for an increase in training and

education, as well as greater awareness of the need to also consider male survivors. These findings are indicative of the necessity to undertake a comprehensive needs assessment that is tailored to the local environment. Therefore, governments and other authorities must take proactive steps to increase the quality of life for Gender-based violence victims in the Eastern Democratic Republic of the Congo.

Chikowe et al. (2018) the infrastructure readiness of rural health centers in Malawi for managing gender-based violence (GBV). The study concentrated on the accessibility of materials and information for diagnosing and treating diabetes. The findings showed that most rural health centers in Malawi lacked essential commodities for screening, diagnosing, and treating diabetes, hindering their ability to effectively manage the increasing burden of this disease.

2.4.3 Equipments

Wambui (2018) conducted a study to assess the infrastructure preparedness in Kenya's prosecution of gender-based and sexual violence (SGBV). The findings showed that There were examination rooms in two teaching and referral hospitals offered privacy for SGBV survivors. 75% of the four provincial hospitals also had private examination rooms in their outpatient departments (OPD), while 25% only had a curtained-off area and no privacy for patients, including SGBV survivors, who were publicly interviewed while waiting in line with others. The study emphasized the importance of providing a relaxing and comfortable environment for SGBV survivors during interviews and examinations. The World Health Organization (WHO) recommends that all rooms where SGBV Those being inspected ought to have both audio and visual privacy. Thus, the

examination area should have lockable doors, offer safety and privacy, and have both visual and audio privacy.

2.4.4 Laboratory Services

Chikowe et al. (2018) studied the infrastructure readiness of rural health centers in Malawi for managing gender-based violence (GBV). The study found that the diagnostic services for GBV and DV were available in the consultation room, and communication, education and information materials were placed in the waiting area. The laboratory services were also installed and functioning effectively. However, none of the health facilities had visible IEC materials about the treatment and management of GBV. The study concluded that the infrastructure preparedness of rural health centers is important for managing GBV in Malawi.

The Mombasa County's 2020/2021 Annual Work Plan proposed the procurement of laboratory supplies for health centers and dispensaries. These supplies include containers for collecting stool and urine, pregnancy test strips, VDRL strips, haemoglobin cuvettes, anti-A, anti-B, and anti-D solutions, and urinalysis strips.

The study by Wambui (2018) found that the infrastructural preparedness for sexual and gender-based violence (SGBV) prosecution in Kenya was lacking in the area of laboratory and forensic preparedness. All of the institutions lacked the necessary resources, such as large paper for survivors to stand on during examination, proper storage facilities for forensic evidence, and functional equipment in the laboratory. The study found that many institutions were unable to collect and preserve forensic evidence due to a lack of knowledge on proper procedures and storage. This also posed a challenge

for maintaining the chain of custody of forensic material. Additionally, some essential items were missing in district hospitals, such as gloves and swab sticks, making examination and collecting specimens difficult. The study highlights the need for improvement in laboratory and forensic preparedness in the prosecution of SGBV cases in Kenya.

2.5 Health Information Management System and Preparedness in the Management of Gender Based Violence

2.5.1 Information Technology and Communication System

Philbrick et al. (2022) did a study on the application of ICT in the management of SGBV focusing on DRC, Cambodia, Kenya, Nepal, Lebanon. The study involved searching 20 databases using relevant search terms. Of the 10 English-language articles found, 4 were systematic literature reviews that focused on the utilization of Technology towards SGBV mitigation and/or intervention among girls and women. However, None of the research that were eligible revealed findings on the efficacy of ICT in preventing SGBV, but instead focused on the outcomes such as feasibility, access to services, and others related to the development of the interventions. The study found that ICT was found to be significant in avoiding and treatment of SGBV in the mentioned countries.

2.5.2 Electronic Health Records

Previous research conducted by Rosmalen-Nooijens et al. (2021) highlighted the critical role of predictive systems in addressing gender-based violence (GBV) and its impact on mental health. Particularly, a high correlation between GBV and mental disorders was observed in women. It was further uncovered that those exposed to trauma during childhood were more likely to become victims or perpetrators of violence in their

adulthood. The highest prevalence of violence was seen in women who had been subjected to nonsexual trauma in their childhood (55.77%). In summary, the study concluded that predictive systems are essential for managing GBV and its related mental health implications. Additionally, providing early support to those exposed to violence has the potential to impede intergenerational transmission of violence and GBV, as well as improve mental health amongst individuals affected by GBV. Thus, the evidence proves the worth of effective prediction systems in significantly mitigating gender-based violence and its impact on mental health.

2.5.3 Electronic Medical Records

Caine and Hanania (2013) investigated the impact of health information in electronic medical records on the protection and management of victims/patients of gender-based violence (GBV) in Canada. The study used a card sorting task, a questionnaire, and Interviews were conducted with 30 patients with records that were housed in an electronic medical record system. The results showed that most of the patient's records contained sensitive health information, and none of them reported wanting should make available to all possible recipients all of the information included within their electronic health record. There was a varying preference for sharing different types of information and with different recipients, with participants showing a preference for sharing less sensitive information and not sensitive information. The study concluded that GBV victims/patients should have control over their electronic medical record privacy and have the ability to choose whoever is privy to their private information.

2.6 Professionalism and Preparedness in the Management of Gender Based Violence

2.6.1 Skills

Hegarty et al. (2020) carried out a qualitative meta-synthesis study to explore the impact of health practitioners' preparedness in addressing domestic violence and abuse. The research concluded that health practitioners are crucial in detecting and responding to gender-based violence/domestic violence abuse. To enhance health practitioners' preparedness in addressing GBV/DVA, the study devised the CATCH Model (Commitment, Advocacy, Trust, Collaboration, Health System Support). This model could be used to modify facilitation strategies to strengthen the ability of the health system to handle intimate partner violence.

2.6.2 Counselling

Aljomaie et al. (2022) found that the primary aspect of healthcare provided by nurses was screening for domestic violence. However, the study found that nurses had limited knowledge about supporting individuals experiencing domestic violence and there was inconsistency in their education and skill levels for detecting these individuals. The study emphasized the need for better education and support for nurses to provide adequate healthcare to those affected by domestic violence.

According to a study by Wambui (2018) on the infrastructural preparedness for the prosecution of sexual and gender-based violence in Kenya, psychological management for survivors of GBV is inadequate. The study found that psychosocial care is poor 75% of district hospitals and 25% of provincial hospitals, with inadequate counseling rooms and staff members who are not sensitized to the issue of sexual violence. Only one

provincial hospital had a diagram directing survivors to the appropriate steps, and the number of counselors at private hospitals was insufficient. Only 32% of institutions had follow-up sessions, and counseling was often not done or was only a minor part of the medical examination. The debriefing process of counselors and other personnel dealing with sexual violence was either nonexistent or disorganized in most institutions, with only a few hospitals having structured debriefing sessions.

2.6.3 Training & Experience

Cuadrado-Gordillo and Parra (2021) conducted a qualitative analysis to explore the role of healthcare professionals in the diagnosis and treatment of gender-based violence in adolescent dating in Spain. 95 primary healthcare professionals were interviewed in Extremadura, and the findings revealed their paramount role in detecting and screening for this issue. The responses of these doctors exposed the strengths and flaws in Spanish public health protocols, illustrating what needs to be improved for the best comprehensive care of victims. Ultimately, the conclusion was that healthcare providers are a key element in the management and medico-legal protection of adolescents against gender-based violence in Spain.

The study conducted by Fernandes et al. (2020) looked at the gap in gender-based violence (GBV) service provision in Kenya at the county level. The results of the study showed that the level of training received by health providers, court officials, police, social workers, community health workers, and paralegals varied greatly among the counties of Kisumu, Bomet, Kitui, and Kwale. In Kisumu, health providers had sporadic training and staff turnover was noted as a challenge. The study showed that more training

and refresher courses are needed for all the stakeholders to provide better services for victims of GBV.

2.6.4 Team work

Mphephu and du Plessis (2021) conducted a study on professional nurses' experiences in delivering medical treatment to women suffering violence based on gender in South Africa. The results showed that the contributors were eager to provide assistance, however their level of competence and the difficult work environment affected their engagement with these women. The participants emphasized the significance of cross-disciplinary and cross-sectoral collaboration, and highlighted the challenges of the life world making it harder for the women to divulge their experiences of gender-based violence. Mphephu and du Plessis (2021) also found that due to gaps in government structures and a lack of coordination between organizations, communities feel neglected and tend to rely on biased local networks and "kangaroo" courts. There is a need for recognition of social workers by the government and greater data collection and sharing for better understanding of changing patterns in GBV cases. The study concluded that there is potential for greater visibility and support for social workers in communities and for better data collection and sharing to inform approaches to GBV challenges.

2.7 Theoretical Framework

2.7.1 Theory of Reasoned Action/Planned Behavior

The Theory was developed by Fishbein and Ajzen in 1975, and proposed that partaking in an action is determined by the objective of the action, which is influenced by one's attitude towards the behavior and the norms of society or subjective standards. It has been

established that the Theory of Planned Behavior is efficient in predicting and explaining behaviors such as smoking, drinking, using medical services, nursing, abusing substances, and more. This concept insists that an individual's surroundings, including social and environmental factors, and their sense of control are contributing factors when it comes to the subjective norms. A positive attitude towards behavior and favorable subjective norms tend to increase the likelihood of behavioral changes caused by sheer intentions (Fishbein & Ajzen, 1975).

Ajzen and Driver (1991) conducted a review of 16 studies that attempted to determine the effectiveness of TPB-based interventions for predicting behavioral changes; the review pointed out that perceived behavior, subjective norms and attitude possess a significant impact on the development of behavioral intentions. As per the Theory of Planned Behavior, behavior is impacted by intentions, which are generated by three aspects: perceived behavior, subjective norms and attitude. The TPB is a psychological doctrine that links beliefs to behavior.

As per the theory, the actions of healthcare professionals, patients, carers, and other members of the community can be described by subjective norms (Ajzen, 2011). These ideas have been used in a variety of health-related disciplines, including media campaigns against drugs, tobacco use interventions, and compliance with asthma counseling and treatment. The TPB has been instrumental in improving the predictability of intentions in areas such as leisure, exercise, and diet. This study will use the TPB as its foundation to explain the planned actions of health facilities in the preparation as well as the care of victims of violence based on gender.

2.7.2 Intellectual Capital Theory

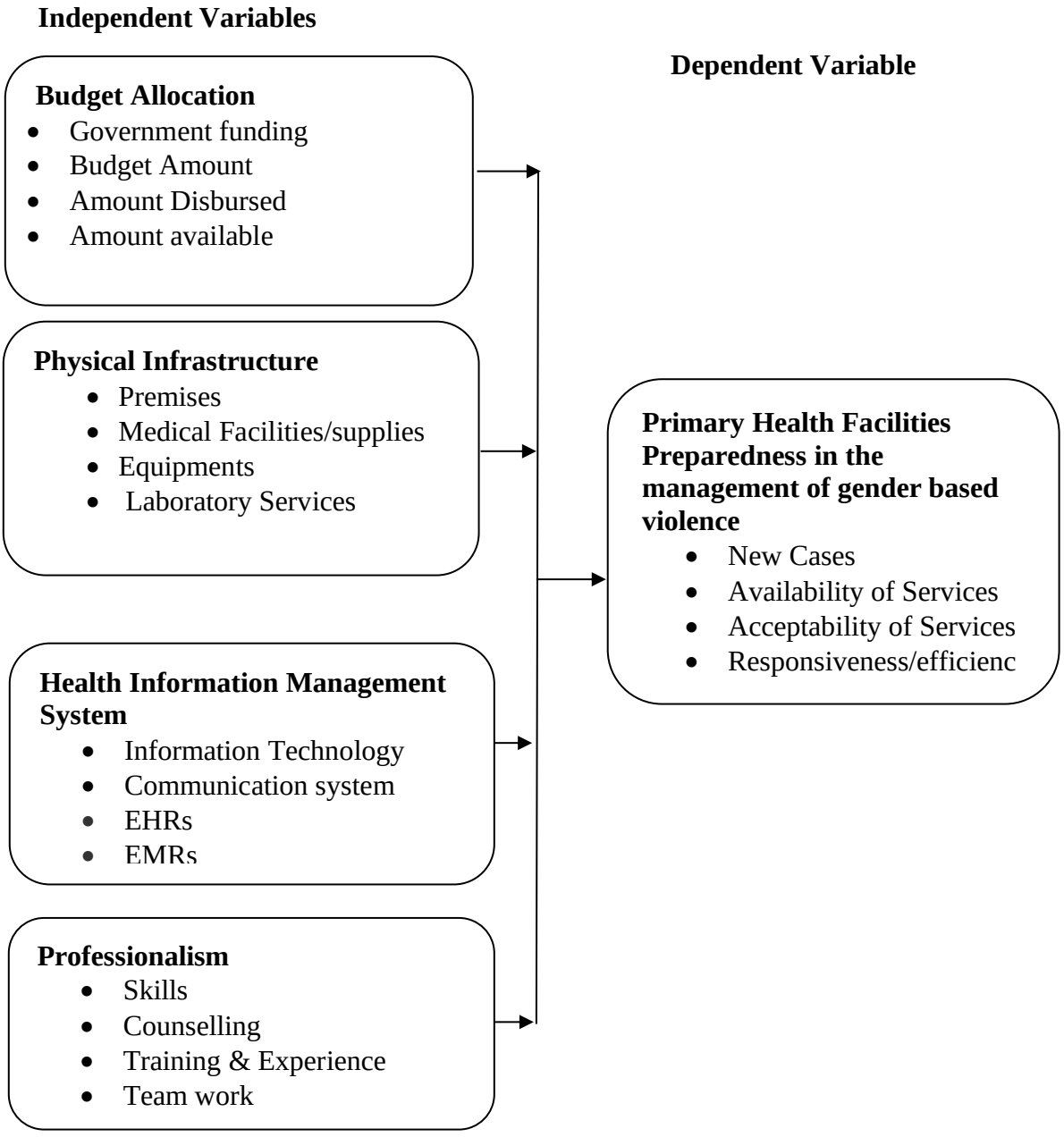
The theory of nursing intellectual capital helps us gain a better understanding of how nursing expertise impacts organizational and patient outcomes. It consists of two components, nursing structural capital and nursing human capital. The nurses' collective knowledge, abilities, and experience comprise nursing human capital, while nursing structural capital incorporates practice standards, care plans, and technologies that enable the provision of evidence-based care. Different elements, including the number of employees and the promotion of continuous learning and professional development, can affect its impact (Covell & Sidani, 2013) additionally, using the most advanced diagnostic technologies more effectively can also contribute to improved outcomes and greater quality for patients.

Investing in nursing human capital has been proven to advance patient outcomes and create a better work environment. Covell and Sidani (2013) reported on the successful application of the theory of nursing intellectual capital to the treatment of gender-based violence cases, where advanced educational programs proved beneficial in providing health workers with information and awareness needed to properly care for patients. Overall, this theory aims to create the capacity to better manage patients across health systems, regardless of their health condition.

2.8 Conceptual Framework

The connections between the study variables are illustrated using a framework (Mugenda & Mugenda, 2009) as presented in figure 2.1 below;

Figure 2.1:
Conceptual Framework.



2.9 Research Gap

Johnson (2014) investigated the impact of financing on the preparedness in managing gender-based violence in Australia. There are significant shortages in service provision, especially for victims of rape and sexual violence, and services are not available enough to reach rural areas. The shortage of human and financial resources is a major challenge for these services. Gender-based violence must be recognized as a national problem, not just a problem for women. Resources are not the issue; rather, it is how they are distributed. The ability to evaluate how government spending and revenue decisions affect both women and men is provided by gender-responsive budgeting. This study aims to address the issue of budgeting, financing, and the funds available for managing GBV in Kenya. Van Rosmalen-Nooijens et al. (2021) examined the role of GBV/DV predictive systems in managing gender-based violence and related mental disorders. However, the study did not explore the relationship between childhood trauma, GBV, and mental disorders. The present study will encompass all victims of GBV in Mombasa County.

In their groundbreaking research, Mphephu and du Plessis (2021) exposed a grave difficulty for professional nurses in South Africa: providing meaningful, compassionate women who have been victims of violence based on gender. Out of this dire situation arose an opportunity to examine the resources – both of the financial and human variety – required for providing the most effective gender-based violence management in Mombasa County, Kenya. However, most studies examining determinants of health facility preparedness for managing gender-based violence have been done within the confines of countries deemed more 'developed', thus creating an obvious gap in understanding the complexities of the issue within Kenya’s unique context. This study

aims to fill this gap by examining the determinants of health facility preparedness in managing gender-based violence in Mombasa County, Kenya. In Kenya, traditional cultural beliefs place women in a submissive role to men, which has led to suffering and a lack of speaking out for help. This study aims to address this issue by focusing on all victims of gender-based violence, regardless of age, gender, or race.

2.10 Summary of literature review

The chapter covered the Reasoned Action/Planned Behavior and Intellectual Capital theories as the models underpinning the study. In addition, the chapter covered the studies done in the past in regard to the study objectives. Also the section presents that conceptual framework, research gaps and the summary of the chapter.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

The chapter entails the method and procedures followed in fulfilling the purpose of this study. The chapter specifically covers the design of the study, population, location, tool for data collection and the data analysis methods.

3.2 Research design

The study employed descriptive cross-sectional research design in establishing the factors influencing health facility preparedness in the management of gender based violence. A descriptive survey study entails of procedures of realizing raw data from the respondents through questionnaires. The design is aimed at describing particular features common in target population organizations, elements, individuals and objects by the use of a questionnaire (Kothari, 2014). According to Cooper and Schindler (2010), descriptive research aims to describe the "what," "where," and "how" of a situation, phenomenon, occurrence, or relationship.

3.3 Target Population

According to Borg and Gall (2012), the population refers to the entire group of individuals or objects that is utilized in a comprehensive and thorough study. It encompasses all elements possessing notable features relevant to the study. The study focus health workers working Mombasa county primary health facilities including the hospital administrators, medical officers, clinical officers, nurses, counsellor, psychiatrists, pharmacists and lab technicians working at primary health facilities in Mombasa county (Level 2, Level 3 and Level 4). According to Mombasa county annual work plan 2020/2021, there are 2028 health workers at primary health facilities in the county as presented in table 3.1 below.

Table 3.1:

Target Population

Category	Population
Hospital Administrators	16
Pharmacists	42
Lab Technologists	159
Medical officers	147
Physiotherapists	35
Clinical Officers (general)	108
Nurses	1495
Health Records & Information Officers	26
Total	**2028**

3.4 Sample Size and Sampling Technique

Sampling is the process of picking a subset from a larger population so that the results will be extended to the entire population. Sampling will be done in both probabilistic and non-probabilistic approaches. All persons and components under evaluation have equal odds of being evaluated under probabilistic criteria, whereas in a non-probabilistic method, inclusion and exclusion procedures are clearly defined. The study employed stratification sampling in which facilities for study were selected (per sub-county one facility each in level 2,3,and 4) and the random sampling approach for healthcare workers as per the stratified cadres where all the elements had equal chances of being chosen. The sample size was realized by applying the formula Yamane (1967).

$$n = \frac{N}{1 + N(e)^2}$$

Where: N = Population size

n = sample size

e = Margin error of the study

Sample size therefore will be

$=\frac{2028}{1+2028(0.05)^2} = \frac{2028}{1+2028(0.0025)} = \frac{2028}{1+5.07} = \frac{2028}{6.07} =$ 334 which is 16.4% of the target population. This was proportionally distributed as presented in table 3.2.

Table 3.2:

Sample size

Category	Population (N)	Sample (n)
Hospital Administrators	16	3
Pharmacists	42	7
Lab Technologists	159	26
Medical officers	147	25
Physiotherapists	35	6
Clinical Officers (general)	108	18
Nurses	1495	245
Health Records & Information Officers	26	4
Total	**2028**	**334**

3.5 Instrumentation

A questionnaire was used in collecting the necessary data aimed at fulfilling the purpose of this study. The questionnaire contained closed questions. It contained five sections Part A to Part F where part A covered the respondents' demographics aimed at confirming their eligibility to participate in the study. Part B to F contained items on the study variables. A 5-point Likert's scale was used to measure the level of agreement on the various statements under each study variable.

3.6 Pre-Test

In the process of developing a questionnaire, a pretest is a major step in improving the internal consistency and the structure of the study tool (Kothari, 2014).

3.6.1 Reliability of Research Instruments

It focuses on whether the study tool would produce similar results when filled a number of times on the same issues. The research tool was tested for reliability by subjecting some of them to some subjects with similar characteristics as that of the target population but are not part of the sample to be studied. Data for reliability testing had to be collected at least twice and level of correlation between parallel forms tested. In this study, the Cronbach alpha coefficient was utilized to determine dependability. In the words of Sekaran and Bougie (2016), the Cronbach Alpha coefficient runs from 0 to 1, and when it is equivalent to or more than 0.7, the results of the research are considered suitable for extrapolation to a broader population. Hence, a pretest for reliability was performed on 15 hospital staff working at the Miritini CDF Health Centre with the goal of identifying and resolving whatever discrepancies, ambiguities, or omissions that contributed to the overall quality of the data obtained in the main study. Miritini CDF Health Centre was used as it was not part of the main study and was assumed to exhibit similar conditions as health facilities enshrined in the study.

3.6.2 Validity of Research Instruments

Focuses on whether the study tool really measures the study aims to measure. The researcher made sure the study instrument has empirical validity, face validity and construct validity by the help of researchers and supervisors.

3.7 Data Collection procedure

The researcher used questionnaires which were self-administered to health workers in the primary health facilities in Mombasa County. The 'drop and pick on the spot' approach was used to promote the response rate. The researcher always provided the respondents an additional week to finish the questionnaire any who was unable to do so within the first week (s) was added another week. Three weeks passed between the data collecting and cleaning procedure. It was done to give enough time to gather accurate data for analysis and reporting.

3.8 Methods of Data Analysis

The purpose of this study was explored quantitatively by employing Statistical Package for Social Sciences (SPSS) version 25. Raw data was acquired from the field, sorted, cleaned, coded, and entered to elucidate the following statistical outputs: percentiles, means, and standard deviations. Graphs and tables were created to visually display and interpret the results. Pearson correlations were also used to evaluate the relationship between the study variables, while multiple regression ran to assess the power of the independent factors as predictors of the dependent variable. This led to the utilization of the following model to highlight the existing association between the independent and the dependent variables.

$$\mathbf{Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \varepsilon}$$

Where;

Y = Preparedness in the Management of Gender Based Violence

$\mathbf{X_1}$ = Budget Allocation

$\mathbf{X_2}$= Physical Infrastructure

$\mathbf{X_3}$ = Health Information Management System

$\mathbf{X_4}$ = Professionalism

While β_1, β_2, β_3 and β_4 are coefficients of determination and ε is the error term.

3.9 Ethical Considerations in Research Involving Human Participants

The researcher sought approval from Kenya Methodist University through SERC and NACOSTI. A letter was also sent to the county government of Mombasa – department of health. The researcher informed the respondents that the study was purely academic and any data given was only used for such purposes. Additionally, the researcher made it clear that taking part was entirely voluntary and that participant had the right to withdraw from the process at any time. Allaying any doubts or apprehensions, the researcher emphasized that the aims and objectives of the study were only academic in nature. No one will coerce the participants to take part in the study. The study made the respondents to sign informed consent before making a choice to take part in the study. Finally, the study guaranteed the confidentiality and privacy of the respondents by observing the principles of anonymity.

CHAPTER FOUR: RESULTS AND DISCUSSION

4.1 Introduction

For data quality assurance purpose, analysis of this study data collected passed through data management phases of data clean up, reduction, differentiation and expansion while editing, coding, and tabulation maintained to detect any errors. Data entry was done through use of SPSS version 26 where correct variable specifications and codes were verified for all entries. Descriptive statistics of mean, mode, median and standard deviations were used to analyze data obtained from the study instrument to generate tables, figures and charts/graphs used in presentation of the results while the interpretations done in prose.

4.2 Pre-test Results

The researcher conducted a pretest study at a pretest for reliability was performed on 15 hospital staff working at the Miritini CDF Health Centre with the goal of identifying and resolving whatever discrepancies, ambiguities, or omissions that contributed to the overall quality of the data obtained in the main study. The Miritini CDF Health Centre was used as it will not be part of the main study and is assumed to exhibit similar conditions as health facilities enshrined in the study. The study used Cronbach's alpha in measuring the internal consistency of the study tool. The results are presented in table 4.3.

Table 4.1:

Reliability Result

	Cronbach's Alpha	N of Items	Conclusion
Budget Allocation	.854	9	scale reliable
Physical Infrastructure	.924	16	scale reliable
Health Information Management System	.971	12	scale reliable
Professionalism	.984	9	scale reliable
Primary Health Facilities Preparedness	.978	7	
Overall	**.988**	**53**	**Instrument reliable**

4.3 Response Rate

The study sample of 334 healthcare workers in Mombasa county had an impressive response rate of 81.7%, as documented in Table 4.3. This response rate is quite high and exceeds the threshold of 70% Sugenda and Mugenda (2009) noted as necessary for analysis and generalization. Moreover, looking further into the results of the same table, it's revealed that the five items in question had an alpha coefficient of 0.988, highlighting not only the impressive response rate, but also the high internal consistency of the tool reponsible for the data collection. Internal consistency is a must-have for any reliable analysis and reporting, and the figure of 0.988 indicates that the tool used was more than adequate.

Table 4.2:
Response Rate

	Frequency (N)	Percentage (%)
Completed questionnaires	273	81.7
Uncompleted questionnaires	61	18.3
Total	**334**	**100.0**

4.4 Demographic Information

The background information considered were the respondents' gender, age, highest level of education, period of time working at Mombasa county primary health facilities. The findings are presented in table 4.5.

Table 4.3:

Respondents Demographic Information

Characteristic	Frequency	Percent
Gender		
Male	159	58
Female	114	42
Total	**273**	**100**
Age bracket		
18-29 years	28	10
30-39 years	119	44
40-49 years	91	33
Above 49 years	35	13
Total	**273**	**100**
Level of Education		
Certificate level	62	23
Diploma level	124	45
Graduate/Degree	58	21
Postgraduate	29	11
Total	**273**	**100**
Duration of service as HCW		
0-5 years	78	29
6-10 years	120	44
11-15 years	55	20
Over 15 years	20	7
Total	**273**	**100**

Table 4.5 show that there were 159 male (58%) in comparison to 114 females (42%), implying that males dominate the health sector in terms of staffing the Mombasa county health facilities.

Furthermore, the results uncovered that 119 (44%) of the respondents were aged between 30-39 years, 91 (33%) were between 40-49 years, 35 (13%) were over 49 years, and 28 (10%) were between 18-29 years. This implies that the majority of health professionals working in Mombasa county health facilities were of an age group, with the optimal age, skills, and energy required for productivity, focus, and personal growth.

The outcomes of this survey indicate that the respondents had achieved appropriate professional training for healthcare workers, depending on their individual cadres. Nearly half of the respondents had a diploma as the highest level of education (45%), with 23% being certificate holders, 21% holding a first degree, and 11% possessing a postgraduate qualification.

This implies that most of the respondents had served in the facility for a minimum of five years (44% having served between 6-10 years, 29% having served 0-5 years, 20% having served 11-15 years, and 7% having served over 15 years). They were therefore deemed knowledgeable about determinants of health facility preparedness in the management of gender based violence in Mombasa county. These outcomes highlight the importance of ensuring healthcare professionals have adequate preparation to manage gender based violence cases effectively.

4.5 Budget Allocation

The study used mean and standard deviation in analyzing the data. The mean score provides a measure of the central tendency of a dataset, while the standard deviation measures the variability or spread of the data around the mean. In the analysis, the scale was collapsed to form two categories of Yes and No to the statements where the strongly disagree, disagree and neutral responses were combined to form the No response while the agree and strongly agree response were combined to create the yes response. Using these measures, analysts better understood the distribution of the data and identify any outliers or unusual values that may need to be investigated further. The results are tabulated in Table 4.6 below;

Table 4.4:
Budget Allocation

Statements	NO n(%)	YES n(%)	Mean	Std. Deviation
Government funding for primary health facilities in the management of gender-based violence is adequate.	142(52)	131(48)	3.2894	1.50262
The allocation of government funds for gender-based violence management is fair and equitable across primary health facilities	87(32)	186(68)	3.3150	1.35705
Government funding has a positive impact on the training and capacity building of health workers in primary health facilities to manage gender-based violence.	75(28)	198(72)	3.6886	1.18591
The current level of government funding is sufficient to meet the needs of primary health facilities in the management of gender-based violence.	216(79)	57(21)	2.1136	1.45708
The amount of budget allocated for primary health facilities in the management of gender-based violence is adequate.	149(55)	124(45)	3.2198	1.15175
An increase in budget would significantly improve the preparedness of primary health facilities in managing gender-based violence	5(2)	268(98)	4.7253	.44720
The current amount of budget allocated for gender-based violence management is sufficient to meet the needs of primary health facilities.	198(72)	75(28)	2.7179	1.11025
The amount of budget allocated for gender-based violence management should be increased	36(13)	237(87)	4.5824	.90423
The allocation of a larger budget for gender-based violence management would significantly improve the ability of primary health facilities to handle such cases.	39(14)	234(86)	4.5128	.89567

Table 4.6 show that majority 142(52%) of the respondents disagreed that government funding for primary health facilities in the management of gender-based violence is adequate and 186(68%) agreed that the allocation of government funds for gender-based violence management is fair and equitable across primary health facilities. In addition,

198(72%) agreed that government funding had a positive impact on the training and capacity building of health workers in primary health facilities to manage gender-based violence and 216(79%) disagreed that the current level of government funding was sufficient to meet the needs of primary health facilities in the management of gender-based violence. Further, 149(55%) disagreed that the amount of budget allocated for primary health facilities in the management of gender-based violence was adequate and 268(98%) agreed that an increase in budget could significantly improve the preparedness of primary health facilities in managing gender-based violence. Moreover, 198(72%) disagreed that the current amount of budget allocated for gender-based violence management was sufficient to meet the needs of primary health facilities and 237(87%) agreed that the amount of budget allocated for gender-based violence management had to be increased. Finally, majority 234(86%) of the respondents agreed that the allocation of a larger budget for gender-based violence management could significantly improve the ability of primary health facilities to handle such cases. Evidence suggests that participants in the study were familiar with financing and budgeting when it comes to the preparedness for managing gender-based violence. According to Usdin et al. (2020), the budgeting process impacts South Africa's ability to handle GBV, and further action is necessary to acquire adequate money and resources. Laisser et al. (2021) promotes the notion that health care workers view the budgeting tool as beneficial in implementing strategies and regulations related to GBV in public hospitals. Johnson (2014) also determine that the government expenditures for programs targeted at combatting gender-based violence are insufficient.

4.6 Physical Infrastructure

A 5-point Likert scale of "strongly disagree" to "strongly agree," asked respondents give their views on physical infrastructure-related statements. This enabled the researchers to assess the centrality of the data, employing the mean score as an indicator, and the standard deviation as a gauge of variability or spread around the mean. This not only helped analysts to better understand the pattern of the data points, but also drew attention to any discrepancies that may warrant further investigation. The 5-point scale was condensed to two, forming "Yes" and "No" categories, with the strongly disagree, disagree, and neutral responses bundling together to create the "No" response, and the agree and strongly agree answers forming the "Yes" response. The data was presented in the table below: 4.7.

Table 4.5:
Physical Infrastructure

Statement	**NO n(%)**	**YES n(%)**	**Mean**	**Std. Deviation**
The hospital facilities' premises (e.g. lighting, signage, waiting areas) provide a safe and welcoming environment for gender-based violence victims	55(20)	218(80)	3.7070	.99365
The hospital facilities' premises promotes the confidentiality and privacy of gender-based violence victims seeking services	19(7)	254(93)	4.2051	.55078
The hospital facilities' premises provide adequate space and resources for staff to conduct examinations and assessments for gender-based violence victims	56(21)	217(79)	4.2051	.40454
The hospital facilities' premises affects the comfort and safety of gender-based violence victims during examinations and assessments	68(25)	205(75)	4.2491	.43328

Availability of medical supplies (e.g. rape kits, emergency contraception, PEP kits) affects the ability of the facilities to provide prompt and appropriate care for gender-based violence victims	21(8)	252(92)	4.1319	.51895
The availability of medical supplies affects the quality of care provided to gender-based violence victims	19(7)	254(93)	4.1099	.71923
The availability of medical supplies affect the staff's ability to provide trauma-informed care to gender-based violence victims	72(26)	201(74)	3.6190	.95560
The availability of medical supplies influences the likelihood of gender-based violence victims seeking care from the facility	47(17)	226(83)	3.7656	.82915
The availability of medical supplies impact the facilities' ability to provide comprehensive care to gender-based violence victims (e.g. medical, mental health, and social services)	55(20)	218(80)	4.0513	1.17461
The availability of medical supplies impact the facilities' ability to document and report gender-based violence cases to appropriate authorities.	59(22)	214(78)	4.1502	1.27019
The availability of laboratory services (e.g. STI testing, pregnancy testing) affects the ability of the facilities to provide comprehensive care to gender-based violence victims	73(27)	200(73)	4.1209	1.26754
Availability of laboratory services affects the quality of care provided to gender-based violence victims	54(20)	219(80)	4.1905	1.23088
Availability of laboratory services affect the staff's ability to diagnose and treat gender-based violence victims	76(28)	197(72)	4.1758	1.12387
Availability of laboratory services impact the likelihood of gender-based violence victims seeking care from the facility	17(6)	256(94)	4.7216	.44903
Availability of laboratory services impact the facilities' ability to provide prompt and appropriate care to gender-based violence victims	55(20)	218(80)	4.2564	1.24860
Availability of laboratory services impact the facilities' ability to document and report gender-based violence cases to appropriate authorities	35(13)	238(87)	4.4029	1.08071

From table 4.7 majority 218(80%) of the respondents agreed that the hospital facilities' premises (e.g. lighting, signage, waiting areas) provided safe and welcoming environment for gender-based violence victims and 254(93%) agreed the hospital facilities' premises promoted the confidentiality and privacy of gender-based violence victims seeking services. In addition, 217(79%) agreed that the hospital facilities' premises provided adequate space and resources for staff to conduct examinations and assessments for gender-based violence victims and 205(75%) agreed that the hospital facilities' premises affected the comfort and safety of gender-based violence victims during examinations and assessments. Additionally, 252(92%) agreed that availability of medical supplies (e.g. rape kits, emergency contraception, PEP kits) affected the ability of the facilities to provide prompt and appropriate care for gender-based violence victims. Also, 254(93%) agreed that the availability of medical supplies affected the quality of Gender-based abuse victims are given care and 201(74%) agreed that the availability of medical supplies affected the staff's ability to provide trauma-informed care to gender-based violence victims. Moreover, 226(83%) agreed that the availability of medical supplies influenced the likelihood of gender-based violence victims seeking care from the facilities and 218(80%) agreed that the availability of medical supplies impacted the facilities' ability to offer victims of violence based on gender with thorough treatment (e.g. medical, mental health, and social services). In addition, 214(78%) agreed that the availability of medical supplies impacted the facilities' ability to document and report gender-based violence cases to appropriate authorities and 200(73%) agreed that the availability of laboratory services (e.g. STI testing, pregnancy testing) affected the ability of the facilities to offer victims of violence based on gender with thorough treatment

victims. Additionally, 197(72%) availability of laboratory services affected the staff's ability to diagnose and treat gender-based violence victims and 219(80%) agreed that availability of laboratory services affected the quality of Gender-based violence victims are cared for.. Further, 256(94%) agreed that availability of laboratory services impacted the likelihood of gender-based violence victims that sought for care from the facilities and 218(80%) strongly agreed that availability of laboratory services impacted the facilities' ability to provide prompt and appropriate care to gender-based violence victims.

Finally, 238(87%) agreed that availability of laboratory services impacted the facilities' ability to document and report gender-based violence cases to appropriate authorities.

The results suggest that respondents are cognizant of the importance of physical infrastructure in supporting their efforts to manage gender-based violence. This finding affirms Keesbury et al. (2012), who observed that physical infrastructure played a key part in the construction of 'one-stop facilities' for violence based on gender in Zambia and Kenya. Similarly, Rybarczyk et al. (2021) discovered that medical supplies were critical for caring for survivors of sex and discrimination based on gender in following the conflict Eastern Democratic Republic of Congo. The presence of such variables in varying degrees demonstrates that, when it comes to the success of interventions against gender-based violence, diversity is key.

4.7 Health Information Management System

In the analysis, the scale was collapsed to form two categories of Yes and No to the statements where the strongly disagree, disagree and neutral responses were combined to form the No response while the agree and strongly agree response were combined to

create the yes response. The study also used mean and standard deviation in analyzing the data. The mean score provides a measure of the central tendency of a dataset, while the standard deviation measures the variability or spread of the data around the mean. Using these measures, analysts better understood the distribution of the data and identify any outliers or unusual values that may need to be investigated further. The results are tabulated in 4.8 below;

Table 4.6:
Health Information Management System

Statement	NO n(%)	YES n(%)	Mean	Std. Deviation
Information technology solutions helps to increase the availability of gender-based violence-related data in primary health facilities	56(20)	217(80)	4.0183	1.20494
Information Technology improves the documentation and tracking of gender-based violence cases in primary health facilities	39(14)	234(86)	4.3773	.72289
Implementation of information technology solutions enhances the privacy and confidentiality of gender-based violence survivors in primary health facilities	18(7)	255(93)	4.2747	.57649
Information technology helps in facilitating referral of gender-based violence survivors to appropriate support services in primary health facilities	57(21)	216(79)	3.9524	.97086
Information technology enhances the accountability and monitoring of gender-based violence cases in primary health facilities	55(20)	218(80)	3.9231	1.28250
Communication systems can improve the efficiency of primary health facilities in responding to gender-based violence cases	38(14)	235(86)	4.3223	.70615
Communication systems to increases the availability of gender-based violence-related data in primary health facilities	36(13)	237(87)	4.3480	.70173
Communication systems improves the documentation and tracking of gender-based violence cases in primary health facilities	18(7)	255(93)	4.2674	.57356

Implementation of Communication systems enhances the privacy and confidentiality of gender-based violence survivors in primary health facilities	19(7)	254(93)	4.4762	.62454
EHRs helps to increase the availability of gender-based violence-related data in primary health facilities	40(15)	233(85)	4.1868	.66827
EHRs improves the documentation and tracking of gender-based violence cases in primary health facilities	73(27)	200(73)	4.1978	.83428
Implementation of EHRs enhances the privacy and confidentiality of gender-based violence survivors in primary health facilities	18(7)	255(93)	4.6960	.58713

Results presented in Table 4.8 above show that 217(80%) of the respondents agreed that information technology solutions helped to increase the availability of gender-based violence-related data in primary health facilities and 234(86%) agreed that information technology improved the documentation and tracking of gender-based violence cases in primary health facilities. Further, 255(93%) agreed that implementation of information technology solutions enhanced the privacy and confidentiality of gender-based violence survivors in primary health facilities and 216(79%) agreed that information technology helped in facilitating referral of gender-based violence survivors to appropriate support services in primary health facilities. Additionally, 218(80%) strongly agreed that information technology enhanced the accountability and monitoring of gender-based violence cases in primary health facilities and 235(86%) agreed that communication systems improved the efficiency of primary health facilities in responding to gender-based violence cases. In addition, 237(87%) agreed that communication systems to increase the availability of gender-based violence-related data in primary health facilities and 255(93%) agreed that communication systems improved the documentation and tracking of gender-based violence cases in primary health facilities. Further, 254(93%)

strongly agreed that implementation of communication systems enhanced the privacy and confidentiality of gender-based violence survivors in primary health facilities and 233(85%) agreed that EHRs helped to increase the availability of gender-based violence-related data in primary health facilities.

In evaluating the responses to a recent survey, it was found that 73% of respondents agreed EHRs improved the documentation and tracking of gender-based violence cases in primary health care facilities, and an even higher 93% agreed with the notion that EHRs enhanced the privacy and confidentiality of survivors. This implies knowledge about the importance of health information management systems for the preparedness in the management of gender-based violence. These findings are in line with prior studies that have identified the significance of information and communication technology in both Gender- and sexual violence prevention and response in a variety of countries. Additionally, predictive systems based on gender-based violence have been found to have a significant part in the governance of such violence as well as consequential mental disorder. Lastly, the study finds correlation with the idea that women in particular with or without sensitive records prefer that their information is spread less comparably to those with less-sensitive information.

4.8 Professionalism

The study used mean and standard deviation in analyzing the data. The mean score provides a measure of the central tendency of a dataset, while the standard deviation measures the variability or spread of the data around the mean. Using these measures, analysts better understood the distribution of the data and identify any outliers or unusual values that may need to be investigated further. The results are tabulated in 4.9 below;

Table 4.7:
Professionalism

Statement	NO n(%)	YES n(%)	Mean	Std. Deviation
Staff skills does improve the efficiency of primary health facilities in responding to gender-based violence cases	18(7)	255(93)	4.6740	.78587
Staff skills improves the documentation and tracking of gender-based violence cases in primary health facilities	8(3)	265(97)	4.3736	.48465
The enhancement of staff skills improves the privacy and confidentiality of gender-based violence survivors in primary health facilities	19(7)	254(93)	4.5092	.62493
Staff skills improves the quality of care for gender-based violence survivors in primary health facilities	18(7)	255(93)	4.0806	.45466
Nurses' experience is sufficient in GBV care	18(7)	255(93)	4.1465	.50780
The health practitioners have sufficient skills in managing GBV cases	12(4)	261(96)	4.7509	.43328
Counselling is available in all levels of the healing process	18(7)	255(93)	4.2418	.56894
Training is provided through workshops/seminars on providing care in better approaches	55(20)	218(80)	4.0549	.98177
Team work is achieved through multidisciplinary approach in managing the GBV cases	73(26)	200(74)	3.9560	1.29687

Table 4.9 above the results shows that majority 255(93%) agreed that staff skills improved the efficiency of primary health facilities in responding to gender-based violence cases and 265(97%) agreed that staff skills improved the documentation and tracking of gender-based violence cases in primary health facilities. In addition, 254(93%) agreed that the enhancement of staff skills improved the privacy and confidentiality of gender-based violence survivors in primary health facilities and 255(93%) agreed that staff skills improved the quality of care for gender-based violence survivors in primary health facilities. Further, 255(93%) agreed that nurses' experience was sufficient in GBV care and 261(96%) agreed that the health practitioners had

sufficient skills in managing GBV cases. Moreover, 255(93%) agreed that counselling was available in all levels of the healing process and 218(80%) agreed that training was provided through workshops/seminars on providing care in better approaches.

It has been found that two-thirds of respondents (74%) agreed that team work and a multidisciplinary approach to the management of gender-based violence (GBV) cases was achieved. This result implies that the participants were aware of the importance of professionalism and how it can help to promote preparedness in the face of gender-based violence. These findings line up with those established by Hegarty et al. (2020), who stated that health practitioners can play an important role in the identification and response to GBV/DVA. They also agree with Aljomaie et al. (2022), who argued that nurses should be better educated and more organizationally supported to effectively respond to and provide healthcare for those affected by domestic violence. In addition, the results are in line with Cuadrado-Gordillo and Parra (2021), who discovered that medical caregivers were a key part of managing GBV in Spanish adolescent dating. Lastly, the findings align with Mphephu and du Plessis (2021), who found that healthcare providers possessed a compassion and a willingness to provide nursing care.

4.9 Primary Health Facilities Preparedness

The scale of five-point likert was collapsed to form two categories of Yes and No to the statements where the strongly disagree, disagree and neutral responses were combined to form the No response while the agree and strongly agree response were combined to create the yes response. The study also used mean and standard deviation in analyzing the data. The mean score provides a measure of the central tendency of a dataset, while the standard deviation measures the variability or spread of the data around the mean. Using

these measures, analysts better understood the distribution of the data and identify any outliers or unusual values that may need to be investigated further. The results are tabulated in 4.10 below;

Table 4.8:
Primary Health Facilities Preparedness

Statements	NO n(%)	YES n(%)	Mean	Std. Deviation
Primary health facilities have the necessary infrastructure to effectively manage gender-based violence cases	11(4)	262(96)	4.5897	.49278
Primary health facility staff are well-trained in managing gender-based violence cases	18(7)	255(93)	4.4066	.79951
Availability of essential medical supplies and equipment has improved primary health facility preparedness in managing gender-based violence cases	21(8)	252(92)	4.2601	.81017
Availability of counseling and support services has improved primary health facility preparedness in managing gender-based violence cases	73(27)	200(73)	3.9853	1.46521
Primary health facilities have the necessary confidentiality and privacy measures in place to manage gender-based violence cases	77(28)	196(72)	3.7070	1.09906
Availability of relevant policies and guidelines has improved primary health facility preparedness in managing gender-based violence cases	72(26)	201(74)	3.6117	1.10287
The new cases have greatly reduced	132(7)	141(51)	3.4103	1.12468

Table 4.10 shows that majority 262(96%) of the respondents agreed that primary health facilities had the necessary infrastructure to effectively manage gender-based violence cases and 255(93%) agreed that primary health facility staff were well-trained in managing gender-based violence cases. Moreover, 252(92%) agreed that availability of

relevant policies and guidelines had improved primary health facility preparedness in managing gender-based violence cases and 200(73%) agreed that availability of essential medical supplies and equipment had improved primary health facility preparedness in managing gender-based violence cases and 196(72%) agreed that primary health facilities have the necessary confidentiality and privacy measures in place to manage gender-based violence cases.

In addition, 201(74%) agreed that availability of relevant policies and guidelines had improved primary health facility preparedness in managing gender-based violence cases while 141(51%) agreed that the new cases of GBV had greatly reduced. The respondents were well informed on the status of the health facility preparedness in the management of gender based violence. The findings are in line with Fernandes et al. (2020) that Kenya has made significant advancements in the development of standards and guidance regarding GBV. In addition, the findings are in line with Ramadan (2021) that there were variations in the access, quality, and coverage of GBV patients care.

4.10 Inferential Statistics

The bivariate and multivariate analysis were performed to establish the relationship that exhibits between the study variables.

4.10.1 Bivariate Analysis

The direction and degree of correlation between two different variables was explored. To investigate the dependability and connection between these factors, Pearson correlations were employed. The tabulated results are presented in Table 4.11.

Table 4.9:
Bivariate Analysis

		Budget Allocation	Physical Infrastructure	Health Information Management System	Professionalism	Primary Health Facilities Preparedness
Budget Allocation	Pearson Correlation	1	.223**	.354**	.027	.095
	Sig. (2-tailed)		.000	.000	.653	.116
	N	273	273	273	273	273
Physical Infrastructure	Pearson Correlation	.223**	1	-.157**	.473**	.079
	Sig. (2-tailed)	.000		.009	.000	.196
	N	273	273	273	273	273
Health Information Management System	Pearson Correlation	.354**	-.157**	1	.519**	.243**
	Sig. (2-tailed)	.000	.009		.000	.000
	N	273	273	273	273	273
Professionalism	Pearson Correlation	.027	.473**	.519**	1	.424
	Sig. (2-tailed)	.653	.000	.000		.000
	N	273	273	273	273	273
Primary Health Facilities Preparedness	Pearson Correlation	-.095	.079	-.243**	.024	1
	Sig. (2-tailed)	.116	.196	.000	.689	
	N	273	273	273	273	273

**. Correlation is significant at the 0.05 level (2-tailed).

The findings in Table 4.11 above shows that budget allocation and primary health facilities preparedness had insignificant correlations with value of *P*=.095. Further, physical infrastructure and Primary Health Facilities Preparedness insignificantly

correlated with a correlation value of *P*=.079. Also, Health Information Management System and Primary Health Facilities Preparedness significantly and positively correlated with a correlation value *P*=.243. Additionally, Professionalism and Primary Health Facilities Preparedness positively and significantly correlated with a correlation value of *P*=.424.

The findings agree with Usdin et al. (2020) that the budgeting process plays a crucial role in the preparedness to manage GBV in South Africa and ongoing efforts are needed to secure sufficient financing and resources to effectively address GBV. In addition, the findings agree with Keesbury et al. (2012) that physical infrastructure was important in the success "one-stop centres" in Zambia and Kenya for violence based on gender. Further, the study agrees with Chikowe et al. (2018) that infrastructure preparedness of rural health centers is important for managing GBV in Malawi.

4.10.2 Multivariate Analysis

In order to analyze the joint predictive power of independent components in the preparedness of primary health facilities for Gender-Based Violence Management in Mombasa County of Kenya, the researcher employed a linear model with ANOVA of regression and coefficients of determination. The model summary is presented in Table 4.12. To gain further insight, the researcher also conducted a detailed study on the association between the variables with an aim to examine the predictive power of the pre-existing model.

Table 4.10:
Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.801[a]	.642	.583	.10882

a. Predictors: (Constant), Professionalism, Budget Allocation, Physical Infrastructure, Health Information Management System

Professionalism, budget allocation, physical infrastructure and health information management system each independently bear great influence over 64.2% of health facility preparedness when it comes to handling gender based violence in Mombasa County, as is evidenced by its R2 value. This goes to show that other elements contribute to the other 35.8% of health facility preparedness managing gender based violence in the same area. To this end, more research is highly encouraged to identify what other inducing factors can play a role in this 35.8%.

4.10.2.1: Analysis of Variance (ANOVA)

Table 4.13 below presents the analysis of variance;

Table 4.11:
Analysis of Variance (ANOVA)

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	8.633	4	2.158	12.913	.000[b]
	Residual	44.791	268	.167		
	Total	53.424	272			

a. Dependent Variable: Primary Health Facilities Preparedness

b. Predictors: (Constant), Professionalism, Budget Allocation, Physical Infrastructure, Health Information Management System

According to outcomes presented in Table 4.13 above, the p-value (sig.) was 0.000 ($p<0.05$) indicating that professionalism, budget allocation, physical infrastructure and

health information management system had statistically significant effect on the health facility preparedness in Gender-Based Violence Management in the primary health facilities in Mombasa county at 95% confidence level. The F crucial at the 5% level of significance was 12.913, which was more than.05, indicating that the null hypothesis was rejected whereas the other hypotheses were accepted..

4.10.2.2 Coefficients of Determination

The outcomes of multivariate regression analysis are presented in Table 4.14 below;

Table 4.12:
Coefficients of Determination

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	**Std. Error**	**Beta**	**t**	**Sig.**
1	(Constant)	7.556	.671		11.266	.000
	Budget Allocation	.264	.059	.275	4.442	.000
	Physical Infrastructure	.180	.104	.130	1.733	.084
	Health Information Management System	.929	.138	.561	6.722	.000
	Professionalism	.482	.111	.385	4.342	.000

a. Dependent Variable: Primary Health Facilities Preparedness

Regression equation was:

$Y = \beta_0 + \beta_1X_1 + \beta_2X_2 + \beta_3X_3 + \beta_4X_4 + \varepsilon$ became:

Y = Preparedness in the Management of Gender Based Violence,X1 = Budget Allocation,X2= Physical Infrastructure,X3 = Health Information Management System,X4

= Professionalism and While β1, β2, β3 and β4 are coefficients of determination and ε is the error term..

$$Y = 7.556 + .264X_1 + .180X_2 + .929X_3 + .482X_4 + \varepsilon$$

Taking all factors into consideration, the primary health facilities preparedness in the management of gender-based violence is predicted to be 7.556. Interestingly, an influx of data reveals that even a slight rise in budget allocation could cause a .264 increase in the primary health facilities preparedness in the management of gender-based violence; while a unit increase in Physical Infrastructure has the potential to cause a .180 decrease in primary health facilities preparedness. Stirring the pot further, Health Information Management System causes a .929 increases, and Professionalism, a .482 increase in the same.

According to the results, a unit change of X1 (Budget Allocation) = .264 will result in a change of 7.556 Preparedness in the Management of Gender Based Violence; X2 (Physical Infrastructure) = .180 will result in a change of 7.556 Preparedness in the Management of Gender Based Violence; X3 (Health Information Management System) =.929 will result in a change of 7.556 Preparedness in the Management of Gender Based Violence and X3 (Professionalism) =.929 will result in a change of 7.556 Preparedness in the Management of Gender Based Violence .

At a significance level of 95%, the results showed that budget allocation, Health Information Management System, and Professionalism had significant values of .000 each, making them the most significant factors in influencing primary health facilities

preparedness in the management of gender based violence. Furthermore, Physical Infrastructure proved to be an insignificant determinant with a significance value of .084.

The findings are in line with Laisser et al. (2021) that the health care workers perceived the budget tool to be advantageous in the implementation of GBV programs and policies in public hospitals. Also, agree with Rosmalen-Nooijens et al. (2021) that predictive systems play a crucial role in managing GBV and its related mental health issues and suggested that providing early support to children exposed to violence could help prevent the intergenerational transmission of violence and GBV, and improve the mental health of individuals affected by GBV. Also, agree with Caine and Hanania (2013) that GBV victims/patients should have control over their electronic medical record privacy and have the ability to choose who has access to their sensitive information. Further, the findings agree with Cuadrado-Gordillo and Parra (2021) that medical care givers play a significant role in the management from a medical standpoint, of violence based on gender throughout teenage relationships in Spain. Finally, the findings agree with Mphephu and du Plessis (2021) that there is potential for greater visibility and support for social workers in communities and for better data collection and sharing to inform approaches to GBV challenges.

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The chapter presents findings' summary, conclusions and recommendations and arears for further research.

5.2 Summary of Findings

The influence of budget allocation, physical infrastructure, health information management system and professionalism on primary health facilities preparedness in the management of gender based violence was studied with a focus on Mombasa County of Kenya.

5.2.1 Budget Allocation

The study found that government funding for primary health facilities in the management of gender-based violence was adequate and that the allocation of government funds for gender-based violence management is fair and equitable across primary health facilities. In addition, the study found that government funding had a positive impact on the training and capacity building of health workers in primary health facilities to manage gender-based violence and the study found that the current level of government funding was sufficient to meet the needs of primary health facilities in the management of gender-based violence. Further, the study found that the amount of budget allocated for primary health facilities in the management of gender-based violence was adequate and that an increase in budget could significantly improve the preparedness of primary health facilities in managing gender-based violence. Moreover, the study found that the current amount of budget allocated for gender-based violence management was sufficient to meet the needs of primary health facilities and that the amount of budget allocated for gender-

based violence management had to be increased. Finally, the study found that the allocation of a larger budget for gender-based violence management could significantly improve the ability of primary health facilities to handle such cases.

5.2.2 Physical Infrastructure

The study found that the hospital facilities' premises (e.g. lighting, signage, waiting areas) provided safe and welcoming environment for gender-based violence victims and that hospital facilities' premises promoted the confidentiality and privacy of gender-based violence victims seeking services. In addition, the study found that the hospital facilities' premises provided adequate space and resources for staff to conduct examinations and assessments for gender-based violence victims and that the hospital facilities' premises affected the comfort and safety of gender-based violence victims during examinations and assessments. Additionally, the study found that availability of medical supplies (e.g. rape kits, emergency contraception, PEP kits) affected the ability of the facilities to provide prompt and appropriate care for gender-based violence victims. Also, the study found that the availability of medical supplies affected the quality of care provided to gender-based violence victims and that the availability of medical supplies affected the staff's ability to provide trauma-informed care to gender-based violence victims. Moreover, the study found that the availability of medical supplies influenced the likelihood of gender-based violence victims seeking care from the facility and that the availability of medical supplies impacted the facilities' ability to provide comprehensive care to gender-based violence victims (e.g. medical, mental health, and social services). In addition, the study found that the availability of medical supplies impacted the facilities' ability to document and report gender-based violence cases to appropriate

authorities and 162(59%) strongly agreed that availability of laboratory services affected the staff's ability to diagnose and treat gender-based violence victims. Further, the study found that availability of laboratory services impacts the facilities' ability to document and report gender-based violence cases to appropriate authorities.

5.2.3 Health Information Management System

The study found that information technology solutions helped to increase the availability of gender-based violence-related data in primary health facilities that information technology improved the documentation and tracking of gender-based violence cases in primary health facilities. Further, the study found that implementation of information technology solutions enhanced the privacy and confidentiality of gender-based violence survivors in primary health facilities and that information technology helped in facilitating referral of gender-based violence survivors to appropriate support services in primary health facilities. Additionally, the study found that information technology enhanced the accountability and monitoring of gender-based violence cases in primary health facilities and that communication systems improved the efficiency of primary health facilities in responding to gender-based violence cases In addition, the study found that communication systems to increase the availability of gender-based violence-related data in primary health facilities and communication systems improved the documentation and tracking of gender-based violence cases in primary health facilities. Further, the study found that implementation of communication systems enhanced the privacy and confidentiality of gender-based violence survivors in primary health facilities and that EHRs helped to increase the availability of gender-based violence-related data in primary health facilities. Additionally, the study found that EHRs improved the documentation

and tracking of gender-based violence cases in primary health facilities and that implementation of EHRs enhanced the privacy and confidentiality of gender-based violence survivors in primary health facilities.

5.2.4 Professionalism

The study found that staff skills improved the efficiency of primary health facilities in responding to gender-based violence cases and that staff skills improved the documentation and tracking of gender-based violence cases in primary health facilities. In addition, the study found that the enhancement of staff skills improved the privacy and confidentiality of gender-based violence survivors in primary health facilities and that staff skills improved the quality of care for gender-based violence survivors in primary health facilities. Further, the study found that nurses' experience was sufficient in GBV care and that the health practitioners had sufficient skills in managing GBV cases. Moreover, the study found that counselling was available in all levels of the healing process and that training was provided through workshops/seminars on providing care in better approaches. Additionally, the study found that team work was achieved through multidisciplinary approach in managing the GBV cases.

5.2.5 Health Facilities Preparedness on Management of Gender Based Violence

The study found that primary health facilities had the necessary infrastructure to effectively manage gender-based violence cases and that primary health facility staff were well-trained in managing gender-based violence cases. Moreover, the study found that availability of relevant policies and guidelines had improved primary health facility preparedness in managing gender-based violence cases and that availability of essential

medical supplies and equipment had improved primary health facility preparedness in managing gender-based violence cases and that primary health facilities have the necessary confidentiality and privacy measures in place to manage gender-based violence cases.

From the regression equation, the study found that taking all factors (professionalism, budget allocation, physical infrastructure, health information management system) to be constant at zero, the primary health facilities preparedness in the management of gender based violence would be 7.556. At the 95% significance level, it was found that budget allocation, health information management systems, and professionalism were the significant factors that drove a measurable improvement in the primary health facilities preparedness related to gender-based violence. This effect was indicated by the respective, significant values of .000. Conversely, an increase in physical infrastructure was found to have an insignificant effect on primary health facilities' preparedness in the management of gender-based violence; this was supported with a .084 significance value. Subsequently, a unit rise in budget allocation revealed a .264 augmentation in primary health facilities' preparedness in the management of gender based violence, whilst a rise in physical infrastructure corresponded to a .180 decrease in primary health facilities' preparedness in the management of gender based violence. In addition, a unit growth in the health information management system led to a .929 increase in the primary health facilities preparedness in the management of gender based violence, and a unit raise in professionalism discerned a .482 upsurge in the primary health facilities preparedness in the management of gender based violence.

5.3 Conclusion

The study concludes that government funding for primary health facilities in the management of gender-based violence was adequate and that the allocation of government funds for gender-based violence management is fair and equitable across primary health facilities. In addition, the study concludes that government funding had a positive impact on the training and capacity building of health workers in primary health facilities to manage gender-based violence and the study concludes that the current level of government funding was sufficient to meet the needs of primary health facilities in the management of gender-based violence. Further, the study concludes that the amount of budget allocated for primary health facilities in the management of gender-based violence was adequate and that an increase in budget could significantly improve the preparedness of primary health facilities in managing gender-based violence.

The study concludes that the hospital facilities' premises (e.g. lighting, signage, waiting areas) provided safe and welcoming environment for gender-based violence victims and that hospital facilities' premises promoted the confidentiality and privacy of gender-based violence victims seeking services. In addition, the study concludes that the hospital facilities' premises provided adequate space and resources for staff to conduct examinations and assessments for gender-based violence victims and that the hospital facilities' premises affected the comfort and safety of gender-based violence victims during examinations and assessments. Additionally, the study concludes that availability of medical supplies (e.g. rape kits, emergency contraception, PEP kits) affected the ability of the facilities to provide prompt and appropriate care for gender-based violence victims. Also, the study concludes that the availability of medical supplies affected the

quality of care provided to gender-based violence victims and that the availability of medical supplies affected the staff's ability to provide trauma-informed care to gender-based violence victims.

The study concludes that information technology solutions helped to increase the availability of gender-based violence-related data in primary health facilities that information technology improved the documentation and tracking of gender-based violence cases in primary health facilities. Further, the study concludes that implementation of information technology solutions enhanced the privacy and confidentiality of gender-based violence survivors in primary health facilities and that information technology helped in facilitating referral of gender-based violence survivors to appropriate support services in primary health facilities. Additionally, the study concludes that information technology enhanced the accountability and monitoring of gender-based violence cases in primary health facilities and that communication systems improved the efficiency of primary health facilities in responding to gender-based violence cases In addition, the study concludes that communication systems to increase the availability of gender-based violence-related data in primary health facilities and communication systems improved the documentation and tracking of gender-based violence cases in primary health facilities.

The study concludes that staff skills improved the efficiency of primary health facilities in responding to gender-based violence cases and that staff skills improved the documentation and tracking of gender-based violence cases in primary health facilities. In addition, the study concludes that the enhancement of staff skills improved the privacy and confidentiality of gender-based violence survivors in primary health facilities and

that staff skills improved the quality of care for gender-based violence survivors in primary health facilities. Further, the study concludes that nurses' experience was sufficient in GBV care and that the health practitioners had sufficient skills in managing GBV cases. Moreover, the study concludes that counselling was available in all levels of the healing process and that training was provided through workshops/seminars on providing care in better approaches. Additionally, the study concludes that team work was achieved through multidisciplinary approach in managing the GBV cases.

The study concludes that primary health facilities had the necessary infrastructure to effectively manage gender-based violence cases and that primary health facility staff were well-trained in managing gender-based violence cases. Moreover, the study concludes that availability of relevant policies and guidelines had improved primary health facility preparedness in managing gender-based violence cases and that availability of essential medical supplies and equipment had improved primary health facility preparedness in managing gender-based violence cases and that primary health facilities have the necessary confidentiality and privacy measures in place to manage gender-based violence cases.

From the regression equation, the study concludes that taking all factors (professionalism, budget allocation, physical infrastructure, health information management system) to be constant at zero, the primary health facilities preparedness in the management of gender based violence would be 7.556.

A recent study confirmed that a unit increase in budget allocation can lead to a .264 boost in primary health facility preparedness in the management of gender based violence, a

unit increase in physical infrastructure results in a .180 decrease of such preparedness and a unit increase in health information management system brings a .929 surge in primary health facility preparedness. Lastly, a unit increase in professionalism plays a role in increasing the primary health facility preparedness by .482.

At the significance level of 95%, the study concludes that budget allocation, health information management system and professionalism were significant factors in influencing the primary health facilities preparedness in Gender-Based Violence Management with significant value of .000 each. The study also suggests that the physical environment was a minor predictor of the primary health facilities preparedness in the Management of Violence based on Gender with significance value of .084.

5.4 Recommendations

The study recommends that the county and sub-county health management team work together with the facility management teams to:

i) Lobby allocation of more funds for management of GBV cases in primary health facilities in Mombasa County.

ii) Ensure maintenance of appropriate security measures, adequate lighting, and separate entrances and confidentiality and prevent further harm or distress to survivors seeking care.

iii) Enhance information technology for standardization of data collection tools and protocols for recording and reporting GBV incidents.

iv) Support capacity building programs focused on professionalism and ethical conduct for healthcare providers and staff members in primary health facilities in responding to GBV cases.

5.5 Suggested Areas for Further Research

The four independent variables (professionalism, budget allocation, physical infrastructure and health information management system) were found to influence 64.2% of the health facility preparedness in Gender-Based Violence Management with the primary health facilities in Mombasa county as represented by the R2. Indicating that factors outside this study influence 35.8% of the health facility preparedness in Gender-Based Violence Management in the primary health facilities in Mombasa county. Hence, further study should be conducted aiming at determining the other factors that influence 35.8% of the health facility preparedness in Gender-Based Violence Management in the primary health facilities in Mombasa county.

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APPENDICES

Appendix I: Questionnaire

SECTION A: Demographic Information

1. What is your gender?

   Female [ ] Male [ ]

2. What is your age in years? _____

3. What is your highest education level?

   Certificate level [ ] Diploma level [ ]

   Graduate/Degree [ ] Postgraduate [ ]

4. For how long have you worked in your position? _____

Section B: Budget Allocation

5. Using a scale of 1-5 where SD-strongly disagree, D- disagree, N-Neutral, A-Agree and SA-Strongly agree, kindly indicate your agreement level to the statements below that relate to budget allocation.

Statements	**SD**	**D**	**N**	**A**	**SA**
Government funding					
Government funding for primary health facilities in the management of gender-based violence is adequate.					
The allocation of government funds for gender-based violence management is fair and equitable across primary health facilities					
Government funding has a positive impact on the training and capacity building of health workers in primary health facilities to manage gender-based violence.					
The current level of government funding is sufficient to meet the needs of primary health facilities in the management of gender-based violence.					
The amount of budget allocated for primary health facilities in the management of gender-based violence is adequate.					
An increase in budget would significantly improve the					

preparedness of primary health facilities in managing gender-based violence					
The current amount of budget allocated for gender-based violence management is sufficient to meet the needs of primary health facilities.					
The amount of budget allocated for gender-based violence management should be increased					
The allocation of a larger budget for gender-based violence management would significantly improve the ability of primary health facilities to handle such cases.					

SECTION C: Physical Infrastructure

6. Using a scale of 1-5 where SD-strongly disagree, D- disagree, N-Neutral, A-Agree and SA-Strongly agree, kindly indicate your agreement level to the statements below that relate to Physical Infrastructure

Statements	**SD**	**D**	**N**	**A**	**SA**
The hospital facilities' premises (e.g. lighting, signage, waiting areas) provide a safe and welcoming environment for gender-based violence victims					
The hospital facilities' premises promotes the confidentiality and privacy of gender-based violence victims seeking services					
The hospital facilities' premises provide adequate space and resources for staff to conduct examinations and assessments for gender-based violence victims					
The hospital facilities' premises affects the comfort and safety of gender-based violence victims during examinations and assessments					
Availability of medical supplies (e.g. rape kits, emergency contraception, PEP kits) affects the ability of the facilities to provide prompt and appropriate care for gender-based violence victims					
The availability of medical supplies affects the quality of care provided to gender-based violence victims					
The availability of medical supplies affect the staff's ability to provide trauma-informed care to gender-based violence victims					

The availability of medical supplies influences the likelihood of gender-based violence victims seeking care from the facility					
The availability of medical supplies impact the facilities' ability to provide comprehensive care to gender-based violence victims (e.g. medical, mental health, and social services)					
The availability of medical supplies impact the facilities' ability to document and report gender-based violence cases to appropriate authorities.					
The availability of laboratory services (e.g. STI testing, pregnancy testing) affects the ability of the facilities to provide comprehensive care to gender-based violence victims					
Availability of laboratory services affects the quality of care provided to gender-based violence victims					
Availability of laboratory services affect the staff's ability to diagnose and treat gender-based violence victims					
Availability of laboratory services impact the likelihood of gender-based violence victims seeking care from the facility					
Availability of laboratory services impact the facilities' ability to provide prompt and appropriate care to gender-based violence victims					
Availability of laboratory services impact the facilities' ability to document and report gender-based violence cases to appropriate authorities					

Section D: Health Information Management System

7. Using a scale of 1-5 where SD-strongly disagree, D- disagree, N-Neutral, A-Agree and SA-Strongly agree, kindly indicate your agreement level to the statements below that relate to health information management system.

Statements	**SD**	**D**	**N**	**A**	**SA**
Information technology solutions helps to increase the availability of gender-based violence-related data in primary health facilities					
Information Technology improves the documentation and tracking of gender-based violence cases in primary health facilities					
Implementation of information technology solutions enhances the privacy and confidentiality of gender-based violence					

survivors in primary health facilities					
Information technology helps in facilitating referral of gender-based violence survivors to appropriate support services in primary health facilities					
Information technology enhances the accountability and monitoring of gender-based violence cases in primary health facilities					
Communication systems can improve the efficiency of primary health facilities in responding to gender-based violence cases					
Communication systems to increases the availability of gender-based violence-related data in primary health facilities					
Communication systems improves the documentation and tracking of gender-based violence cases in primary health facilities					
Implementation of Communication systems enhances the privacy and confidentiality of gender-based violence survivors in primary health facilities					
EHRs helps to increase the availability of gender-based violence-related data in primary health facilities					
EHRs improves the documentation and tracking of gender-based violence cases in primary health facilities					
Implementation of EHRs enhances the privacy and confidentiality of gender-based violence survivors in primary health facilities					

SECTION E: Professionalism

8. Using a scale of 1-5 where SD-strongly disagree, D- disagree, N-Neutral, A-Agree and SA-Strongly agree, kindly indicate your agreement level to the statements below that relate to professionalism

Statements	**SD**	**D**	**N**	**A**	**SA**
Staff skills does improve the efficiency of primary health facilities in responding to gender-based violence cases					
Staff skills improves the documentation and tracking of gender-based violence cases in primary health facilities					
The enhancement of staff skills improves the privacy and confidentiality of gender-based violence survivors in primary health facilities					

Staff skills improves the quality of care for gender-based violence survivors in primary health facilities					
Nurses' experience is sufficient in GBV care					
The health practitioners have sufficient skills in managing GBV cases					
Counselling is available in all levels of the healing process					
Training is provided through workshops/seminars on providing care in better approaches					
Team work is achieved through multidisciplinary approach in managing the GBV cases					

Section F: Primary Health Facilities Preparedness

9. Using a scale of 1-5 where SD-strongly disagree, D- disagree, N-Neutral, A-Agree and SA-Strongly agree, kindly indicate your agreement level to the statements below that relate to primary health facilities preparedness

Statements	**SD**	**D**	**N**	**A**	**SA**
Primary health facilities have the necessary infrastructure to effectively manage gender-based violence cases					
Primary health facility staff are well-trained in managing gender-based violence cases					
Availability of relevant policies and guidelines has improved primary health facility preparedness in managing gender-based violence cases					
Availability of essential medical supplies and equipment has improved primary health facility preparedness in managing gender-based violence cases					
Primary health facilities have the necessary confidentiality and privacy measures in place to manage gender-based violence cases					
Availability of counseling and support services has improved primary health facility preparedness in managing gender-based violence cases					
The new cases have greatly reduced					

THANK YOU FOR PARTICIPATING

Appendix II: Research Permit NACOSTI

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION

Ref No: **990214**

Date of Issue: **13/August/2023**

RESEARCH LICENSE

This is to Certify that Ms.. PHYLLYS KEMUNTO ONKOBA of Kenya Methodist University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Mombasa on the topic: DETERMINANTS OF HEALTH FACILITY PREPAREDNESS IN THE MANAGEMENT OF GENDER BASED VIOLENCE: A CASE OF PRIMARY HEALTH FACILITIES IN MOMBASA COUNTY. for the period ending : 13/August/2024.

License No: **NACOSTI/P/23/28417**

990214

Applicant Identification Number

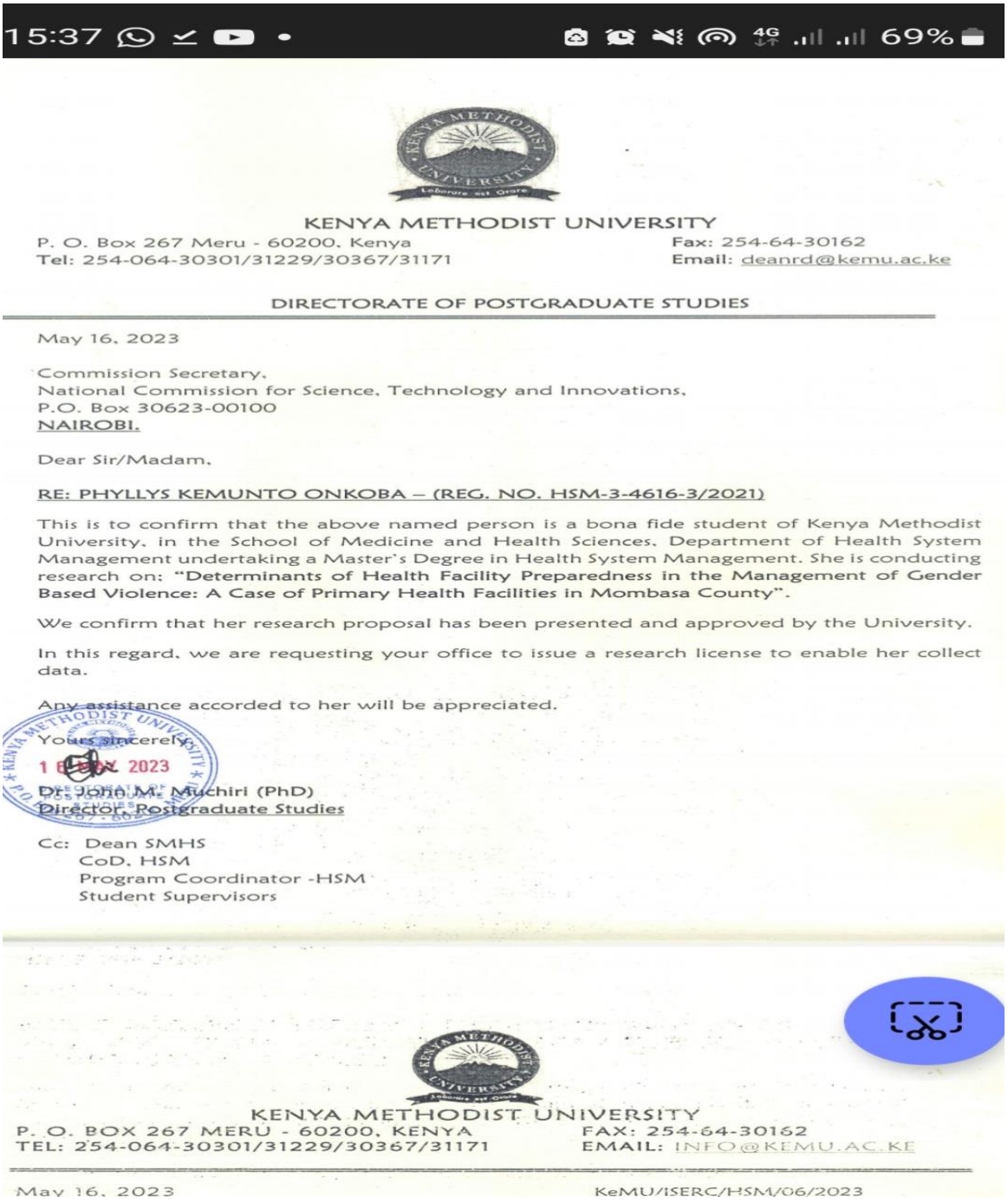
Director General
NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

See overleaf for conditions

Appendix III: KEMU Introduction letter



KENYA METHODIST UNIVERSITY
P. O. Box 267 Meru - 60200, Kenya
Tel: 254-064-30301/31229/30367/31171
Fax: 254-64-30162
Email: deanrd@kemu.ac.ke

DIRECTORATE OF POSTGRADUATE STUDIES

May 16, 2023

Commission Secretary,
National Commission for Science, Technology and Innovations,
P.O. Box 30623-00100
NAIROBI.

Dear Sir/Madam,

RE: PHYLLYS KEMUNTO ONKOBA – (REG. NO. HSM-3-4616-3/2021)

This is to confirm that the above named person is a bona fide student of Kenya Methodist University, in the School of Medicine and Health Sciences, Department of Health System Management undertaking a Master's Degree in Health System Management. She is conducting research on: **"Determinants of Health Facility Preparedness in the Management of Gender Based Violence: A Case of Primary Health Facilities in Mombasa County"**.

We confirm that her research proposal has been presented and approved by the University.

In this regard, we are requesting your office to issue a research license to enable her collect data.

Any assistance accorded to her will be appreciated.

Yours sincerely,

1 [illegible] 2023

Dr. John M. Muchiri (PhD)
Director, Postgraduate Studies

Cc: Dean SMHS
CoD, HSM
Program Coordinator -HSM
Student Supervisors

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May 16, 2023 KeMU/ISERC/HSM/06/2023

Appendix IV: Mombasa County Department of Health Research Approval

OFFICE OF THE COUNTY CHIEF OFFICER
MEDICAL SERVICES

Email : cohealthmsa@gmail.com
When replying please quote

P O Box 90441 – 80100
Msanifu Kombo Street,
MOMBASA

Ref: COH/MSA/RSC/(13)2023

31st May, 2023

Phyllys Kemunto Onkoba
Mombasa.

RE: REQUEST FOR APPROVAL TO CARRY OUT RESEARCH

We refer to your letter on the above subject, requesting for approval to collect data for your project on **'Determinants of health facility preparedness in the management of Gender Based Violence: A case of primary health facilities in Mombasa County, Kenya'.**

This office has no objection to your request and hereby approves the same. The facilities where the exercise will be conducted (listed below) are requested to give the necessary support.

1. Jomvu S.C: Jomvu Model H/C and Mikindani MCM;
2. Changamwe S.C: Port Reitz SCH, Bokole CDF H/C and Magongo MCM;
3. Mvita S.C|: Tudor SCH, Mvita HC, Khaderbhouy and Majengo Dispensary;
4. Likoni S.C: Likoni SCH, Mbuta Model H/C and Mtongwe Dispensary;
5. Nyali S.C: Mlaleo H/C, Bamburi and Kongowea Dispensaries;
6. Kisauni S.C: Shimo Main H/C, Junda and Shimo Annex.

On completion of the survey **you are required to disseminate the findings to the County Health Management Team** for the recommendations to be considered.

Thank you.

02 JUN 2023

DR KHADIJA SOOD SHIKELY, HSC
COUNTY CHIEF OFFICER, MEDICAL SERVICES
COUNTY GOVERMENT OF MOMBASA.

Copy: All SCMOH – **Mombasa County**

Medical Superintendent: **Port Reitz, Tudor & Likoni S.C. Hospitals.**