

Access denied? Exploring barriers and facilitators of gender-based violence community-based interventions for adolescent girls and young women in rural Kenya

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ABSTRACT

Gender-based violence (GBV) remains a critical challenge for adolescent girls and young women (AGYW) in rural Kenya, yet factors influencing the utilization of community-based interventions (CBIs) remain poorly understood. In Gem Sub-County, cultural practices and socioeconomic disparities often intersect to limit service efficacy and survivor engagement. This study aimed to map available CBIs and evaluate the barriers and facilitators affecting their utilization among AGYWs aged 15–24 in Gem Sub-County. Using a cross-sectional mixed-methods design grounded in the Social-Ecological Model (SEM), quantitative data were collected from 313 AGYWs across North, East, and South Gem wards via semi-structured questionnaires. Qualitative insights were gathered through in-depth interviews with survivors and key informant interviews with stakeholders, including local chiefs, healthcare workers, and law enforcement. Quantitative data were analysed using descriptive and inferential statistics (Chi-square tests), while qualitative data underwent thematic analysis. Several CBIs were identified including support groups, awareness campaigns, safe shelters, legal aid, counselling, economic empowerment and transport through guardian riders; however, only 27.2% of AGYWs were aware of these services, and utilization was remarkably low at 16.7%. Significant barriers included a lack of awareness (78%), geographic distance (20%), social stigma (19%), and systemic challenges such as corruption and limited confidentiality. Conversely, key facilitators identified were increased awareness campaigns (71%), family support (25%), and the provision of free or low-cost services (24%). Awareness and utilization varied significantly by ward ($p < 0.001$), with South Gem reporting higher engagement levels compared to North and East Gem. The study concludes that despite available CBIs for GBV in Gem Sub-County, utilization among AGYWs remains low majorly due to limited awareness and stigma. To enhance service uptake, the study advocates for localized awareness campaigns, the expansion of safe shelters, and the integration of transport solutions like "Guardian Riders." These findings provide a roadmap for policymakers to implement more equitable, context-specific GBV intervention strategies for AGYWs in rural Kenya.

Keywords: Adolescent Girls, Community-Based Interventions, Gem Sub-County, Gender-Based Violence, Kenya, Social-Ecological Model, Young Women

I. INTRODUCTION

Gender-based violence (GBV) is a global public health and human rights crisis, with Sub-Saharan Africa reporting elevated risks due to patriarchal norms, economic disparities, and cultural practices (World Health Organization [WHO], 2021). In rural settings like Gem Sub-County, cultural practices such as patriarchal norms exacerbate GBV risks (Muluneh et al., 2020). Community-based interventions (CBIs) are critical for addressing GBV, offering support through counseling, support groups, legal aid, safe shelters, economic empowerment, and transport services (United Nations Population Fund [UNFPA], 2020). In Kenya, CBIs like community health promoter programs and legal aid clinics aim to empower AGYWs, yet their availability in rural areas is limited by underfunding and poor infrastructure (Kay et al., 2024). Studies from Sub-Saharan Africa indicate that support groups and awareness campaigns are effective in reducing GBV stigma, but only 20–30% of survivors access them due to low awareness and accessibility (Abelson et al., 2019). In Tanzania, radio-based campaigns have increased CBI uptake, suggesting scalable models for Kenya (Mtaita et al., 2021). However, the specific range of CBIs available in Gem Sub-County remains underexplored, particularly for AGYWs facing unique cultural and socioeconomic challenges. This study mapped existing CBIs, identifying their scope and accessibility to inform strategies for improving service delivery in rural settings.

Barriers to utilizing CBIs for GBV are documented in Sub-Saharan Africa, with lack of awareness, stigma, and geographic inaccessibility being primary obstacles (UNFPA, 2020). In rural Kenya, studies report that 70–80% of

AGYWs are unaware of available services due to limited outreaches (Kay et al., 2024). Stigma, rooted in patriarchal norms, deters survivors from seeking help, fearing social reprisals (Muluneh et al., 2020). Systemic issues, such as corruption, underfunded services, and lack of confidentiality, further limit access, particularly in rural areas with poor infrastructure (Sidamo et al., 2023). Cultural practices, including wife inheritance, exacerbate barriers by restricting women's autonomy (Gibbs et al., 2017). These factors disproportionately affect marginalized AGYWs, such as those with lower education or socioeconomic status.

Facilitators of CBIs utilization include increased awareness, community support, and accessible services (UNFPA, 2020). In Nigeria, community-driven initiatives, including peer support and local advocacy, have increased service engagement by 25–30% (Besigye & Kabona, 2025). In Kenya, free or low-cost services and confidentiality assurances are critical enablers, particularly for rural AGYWs facing financial and social barriers (Kay et al. 2024). Community health promoters play a vital role in building trust and linking survivors to services, as seen in Siaya County (Sidamo et al., 2023). Media campaigns, such as those in Tanzania, have boosted awareness and utilization by leveraging local radio (Mtaita et al., 2021). However, the specific facilitators in Gem Sub-County, particularly for diverse AGYWs, are underexplored. This study addressed these gaps by pursuing three objectives within the Social-Ecological Model (SEM) framework, which emphasizes individual, interpersonal, community, and societal influences (Centers for Disease Control [CDC], 2021). It mapped available CBIs to understand the support landscape, explored barriers, and identified facilitators to enhance engagement.

1.1 Research Objective

1. To identify the existing community-based interventions for prevention and response to GBV among adolescent girls and young women.
2. To find out the barriers to utilization of GBV community-based interventions by adolescents' girls and young women.
3. To establish the facilitators to utilization of GBV community-based interventions by adolescents' girls and young women.

II. THEORETICAL FRAMEWORK

The Socio-Ecological model offered a valuable framework for understanding the factors that influence the utilization of GBV CBI by AGYWs. This model posits that human development is shaped by the interaction of factors at various levels: Individual, interpersonal, Community and societal. Sallis et al. (2008) argues that providing individuals with motivation and skills to change behavior cannot be effective if environments and policies make it difficult or impossible to choose a good behavior. Therefore, the need to create environments and policies that make it convenient, attractive, and economical to make healthful choices, and then motivate and educate people about those choices. Applied to the context of GBV and CBI utilization, the ecological model allowed the researcher to look at how factors at each level impact AGYWs' choice to seek help.

III. METHODOLOGY

3.1 Study Design

This cross-sectional mixed-methods study targeted adolescent girls and young women (AGYWs) aged 15–24 years in Gem Sub-County, Siaya County, Kenya. It integrated quantitative surveys (N=313) with qualitative in-depth interviews (IDIs) with survivors and key informant interviews (KIIs) with stakeholders to assess GBV prevalence and community-based intervention (CBI) utilization. Data was collected during school holidays, with community health promoters facilitating access to respondents, ensuring robust triangulation of statistical trends and contextual insights.

Gem Sub-County, located in Siaya County, Kenya, is a predominantly rural area with limited infrastructure, including poor road networks and sparse healthcare facilities. It comprises six wards, with three purposely selected for this study: South Gem (27.6%), North Gem (18.8%) and East Gem (17.9%). Cultural practices, such as wife inheritance, and socioeconomic challenges, like high poverty rates, contribute to GBV vulnerability and hinder access to interventions, making it a critical setting for studying CBI utilization among AGYWs.

3.2 Study Area

The target population for this study was 40,400 AGYWs who were aged between 15-24 years and residing in Gem Sub-County. It also included relevant stakeholders involved in GBV prevention and response. The study population was 313 AGYWs sampled from the 3 wards of North Gem, South Gem and East Gem Wards, along with 5 key informants and six AGYW GBV survivors selected for in-depth interviews.

3.3 Target Population

The study employed a multi-stage cluster sampling approach for the quantitative component and purposive sampling for the qualitative component. For the quantitative component, Gem Sub-County is divided into its six administrative wards. Based on the Kenya Health Information Systems (KHIS) data for September 2024, the estimated number of AGYW (15-24 years) in each ward is as shown in Table 1.

Table 1

Estimated population of AGYWs in Gem Sub-County (KHIS, 2024)

Ward	Estimated Number of AGYW	(%)
West Gem	4,709	11.7
South Gem	11,166	27.6
East Gem	7,213	17.9
Central Gem	3,544	8.8
North Gem	7,586	18.8
Yala Township	6,182	15.3
Total	40,400	100

Using purposive sampling based on wards with the largest AGYWs populations, three wards with the highest AGYWs population were selected. The selection for each ward was based on the estimated number of AGYW in each ward, as obtained from KHIS 2024. Therefore, the wards selected were South Gem (27.6%), North Gem (18.8%) and East Gem (17.9%). According to the Kenya National Population and Census Survey 2019, Gem Sub-County had a total of 44,884 households (KNBS, 2019). Thus, within each selected ward, a list of villages was obtained from the Ministry of Health with the respective household numbers. The number of villages and households selected from each ward was proportional to the ward's population size. For the qualitative component, purposive sampling and snow balling technique was used to select key informants and GBV survivors for in-depth interviews. The AGYWs were recruited through collaboration with Community Health promoters (CHPs), who were seconded by the MoH.

3.4 Sampling and Sample Size

The sample size for this study was determined using Cochran's (1977) formula for estimating sample size for proportions.

Equation (1)

$$n_o = (Z^2pq) / e^2$$

Where:

n_o = Initial sample size

Z = Standard normal deviate corresponding to the desired confidence level (1.96 for a 95% confidence level)

p = Estimated proportion of the population possessing the characteristic of interest. In this study, the estimated prevalence of gender-based violence (GBV) among adolescent girls and young women (AGYWs) was 24% (0.24).

$q = 1 - p = 0.76$

e = Desired margin of error (0.05)

Substituting the values into the formula:

$$n_o = [(1.96)^2 \times (0.24) \times (0.76)] / (0.05)^2$$

$$n_o = 283$$

Therefore, the initial sample size was 283 respondents.

Adjustment for Finite Population

Since the target population was less than 100,000, the sample size was adjusted using the finite population correction formula:

$$n = n_o / [1 + ((n_o - 1)/N)]$$

Where:

n = Adjusted sample size

n_o = Initial sample size (283)

N = Total population of AGYWs in Gem Sub-County (40,400)

Substituting the values:

$$n = 283 / [1 + ((283 - 1)/40,400)]$$

$$n = 282$$

Thus, the adjusted sample size for the finite population was 282 respondents.

Adjustment for Non-response

To compensate for possible non-response, the adjusted sample size was increased by 10% (Kish, 1965).

$$n_{\text{adjusted}} = n / (1 - \text{NRR})$$

Where:

n_{adjusted} = Adjusted sample size accounting for non-response

n = Required sample size (282)

NRR = Expected non-response rate (10% or 0.10)

Substituting the values:

$$n_{\text{adjusted}} = 282 / (1 - 0.10)$$

$$n_{\text{adjusted}} = 313.3 \approx 313$$

Accordingly, the final sample size for the study was 313 adolescent girls and young women (AGYWs).

3.4.1 Multi-Stage Cluster 1-Ward level

The proportionate allocation calculated using the formula:

Number of AGYWs in the Ward

$$n_{\text{Ward}} = \frac{\text{Number of AGYWs in the Ward}}{\text{Total number of AGYWs in the 3 Wards}} \times 100$$

Total number of AGYWs in the 3 Wards

Therefore, the distribution of the sample by ward is presented in Table 2.

Table 2

Distribution of AGYWs by ward in Gem sub-county

Ward	Number of AGYWs	Percentage	Allocated Sample Size
East Gem Ward	7,213	27.8	87
South Gem Ward	11,166	43.0	135
North Gem Ward	7,586	29.2	91
Total	25965	100	313

3.4.2 Multi-stage cluster II-Village level

This selection provided a random but proportional representation across the wards, with a total of 313 AGYWs selected for the study. Gem Sub-County has a total of 44,884 households (list of villages and number of households per village from the Ministry of Health). Therefore, the number of villages and households selected per ward is proportional to the ward's allocation as shown in Table 3.

Table 3

Distribution of sampled AGYWs by village in Gem sub-county

Ward	CHU	Village	Number of HHs	Number of HHs Sampled
East Gem Ward	Uranga	Rabuur	129	17
East Gem Ward	Lihanda	Maungo B	122	17
East Gem Ward	Uranga	Koga B	86	16
East Gem Ward	Ramula	Siandha A2	131	18
East Gem Ward	Marenzo	Mindhine A	149	19
		<i>Sub Total</i>		87
North Gem Ward	Malanga	Mahua C	113	18
North Gem Ward	Maliera	Ngolo	220	21
North Gem Ward	Lundha	Ndagaria B	155	21
North Gem Ward	Asayi	Warinda	93	14
North Gem Ward	Sirembe	Kowil B	117	18
		<i>Sub Total</i>		92
South Gem Ward	Kaudha East	Kamlugo-B1	149	18
South Gem Ward	Kaudha West	Kabura-B	160	18
South Gem Ward	Rera	Rera A	205	22
South Gem Ward	Kambare	Osir	189	19
South Gem Ward	Ndori	Nyakwere C	237	22
South Gem Ward	Kanyadet	Kanyameno A1	198	18
South Gem Ward	Onyinyore	Pala	139	16
		<i>Sub Total</i>		135
		Total		313

3.5 Data Collection

Quantitative data were collected using pretested semi-structured questionnaires administered by trained research assistants. Qualitative data were obtained through individual in-depth interviews (IDIs) with five GBV survivors and key informant interviews (KIIs) with eight stakeholders to explore contextual and systemic factors. Interviews were conducted in Luo where necessary, then transcribed and translated into English. Data collection was undertaken during school holidays with support from community health promoters (CHPs) to facilitate community entry. Households were selected using systematic random sampling by choosing every fifth household from a random starting point until the required sample size was attained. All eligible AGYW aged 15–24 years were invited to participate, and where multiple eligible respondents were present, one was randomly selected.

3.6 Data Collection Instruments and Procedure

A pretest of the data collection tools was conducted in Ugunja using 31 (10%) semi structured questionnaires to check whether the design of questions was logical, easily understood and whether the responses covered all the objectives and the time to complete the questionnaire was realistic. Areas with unclear or vague questions were duly revised. Reliability of the questionnaire was assessed using test-retest technique and Cronbach's Alpha. For the test-retest the questionnaire was administered twice to a sample of 31 individuals over a period of two weeks, selected to minimize memory bias (Lavrakas, 2008). Internal consistency was evaluated through Cronbach's alpha, which produced a value of 0.81, exceeding the conventional threshold of ≥ 0.70 .

3.7 Data Analysis

Quantitative data were analyzed using descriptive statistics (frequencies, percentages, means) to summarize CBI utilization and demographic characteristics. Chi-square tests ($\alpha=0.05$) assessed associations between variables such as age, marital status, education, and CBI utilization, with p-values indicating statistical significance. Qualitative data were thematically analyzed using a deductive approach based on the SEM, identifying key themes related to barriers and facilitators. Two researchers coded transcripts independently to ensure reliability, with discrepancies resolved through consensus. Data triangulation combined quantitative and qualitative findings to enhance validity and provide a holistic understanding.

IV. FINDINGS & DISCUSSION

4.1 Socio-Demographic Characteristics

The quantitative research targeted 313 AGYWs within Gem Sub-County. Socio-demographic characteristics as presented in Table 4 provide context for understanding GBV prevalence and CBI utilization.

Table 4

Tabulated Socio-Demographic Characteristics of Respondents (N = 313)

Characteristic	Frequency	%
Age Category		
15-17	128	41
18-20	100	32
21-24	85	27
Education Level		
College/University	31	9.9
Primary school	71	23
Secondary school	211	67
Marital Status		
Divorced/Separated	2	0.6
Married	46	15
Single	265	85
Occupation		
Employed (formal sector)	3	1
Other (please specify)	2	0.6
Self-employed	25	8
Student	206	66
Unemployed	77	25
Ward		
East Gem	91	29
North Gem	88	28
South Gem	134	43

The study findings showed that most respondents, 128 (41%), were aged between 15-17 years, followed by those aged between 18-20 years, 100 (32%), with 21-24 years being 85 (27%). In terms of education, 211 (67%) had attained secondary education, 71 (23%) had completed primary education, and 31 (9.9%) had a college or university education. Data on marital status revealed that the majority, 265 (85%), of the respondents were single, while 46 (15%) were married, and only 2 (0.6%) were divorced or separated. Employment status of study respondents indicated that 206 (66%) of the respondents were students, 77 (25%) were unemployed, and 25 (8%) were self-employed, with only 3 (1%) engaged in formal employment. South Gem had the highest proportion of respondents, 134 (43%), followed by East Gem, 91 (29%), and North Gem, 88 (28%), suggesting an even distribution of AGYWs across the sub-county.

4.1.2 Existing Community-Based Interventions (CBIs)

Various CBIs aimed at preventing and responding to GBV against AGYWs were identified in Gem Sub-County across the four SEM levels, implemented through collaboration between government agencies, NGOs, and community structures. At the individual level, counselling and psychosocial support were available at health facilities, schools, and within the community. A healthcare worker noted:

"The facilities serve as the main spaces of offering counselling services to the victims of GBV" (KII HCW, Ramula Dispensary).

At the relationship level, support groups brought survivors together for peer support and recovery, with initiatives like 'Kajip' nurturing young women who had experienced GBV. The DREAMS program further built GBV awareness and social networks among AGYWs:

"Initially, I didn't know anything about GBV until I was trained in one of the DREAMS meetings" (IDI Survivor, South Gem Ward).

At the community level, health facilities offered treatment and referrals within a multi-sectoral framework. Economic empowerment programs reduced vulnerability by providing financial independence:

"We have received monetary benefits to boost our businesses and more knowledge on how to handle and manage our small business enterprises" (IDI Survivor, East Gem Ward).

Guardian Riders ensured timely transport to post-violence care within 72 hours, while CMMB strengthened community response through ward-level VPRTs:

"With the help of CMMB, we created a group called the Violence Prevention and Response Team at ward level that involved various stakeholders to discuss and address GBV" (KII Chief, North Gem Ward).

At the societal level, community paralegals supported survivors through legal pathways, linking cases to pro bono lawyers, while the Child Protection Unit at Yala Police Station provided protection and psychosocial support. Community sensitization campaigns targeted AGYWs, men at high risk, and women living with HIV, though a chief acknowledged their limitations:

"There are organizations that organize such meetings, but they are never sufficient since people attend them voluntarily, and some may miss out" (KII Chief, North Gem).

Overall CBI awareness was low, with only 85 (27.2%) respondents aware of existing interventions. Ward was the strongest determinant, with South Gem recording the highest awareness (53%), followed by North Gem (44%) and East Gem (3.5%). A survivor from North Gem illustrated the consequences of low awareness:

"When I was defiled, I wasn't able to report because I initially didn't know what GBV is and further, I didn't know where to report" (IDI Survivor, North Gem).

Younger AGYWs aged 15–17 years were most aware (46%), declining with age (18–20 years: 32%; 21–24 years: 22%). Education and marital status showed minimal variation in awareness.

Despite available services, utilization was notably low, only 52 (16.7%) AGYWs reported ever using a CBI. Utilization was significantly associated with ward ($p < 0.001$) with South Gem recording the highest use (69%), followed by North Gem (31%), while East Gem reported zero utilization. AGYWs who experienced GBV utilized CBIs more (33%) than those who did not (13.4%), though this difference lacked statistical significance ($p = 0.2$). Age, education, and marital status showed no significant association with utilization. Support groups were the most utilized intervention (75%), followed by counseling (31%) and health services (29%), while transport support recorded no utilization. Notably, only 3 (3.8%) survivors reported GBV incidents to the police. Underreporting was further compounded by concealment even among service users, as one survivor recounted:

"Yes, I have gone to the hospital when my husband would beat me and leave me injured, though I would not reveal that it was an abuse from my spouse" (IDI Survivor, East Gem Ward).

Perceived effectiveness was generally positive among aware respondents with 40 (47%) rated CBIs as very effective, 31 (36%) somewhat effective, and only 7 (8.2%) not effective. South Gem had the highest positive ratings (93%), while North Gem showed mixed perceptions. Younger AGYWs (15–17 years) and those with secondary education were more likely to rate CBIs as effective. A community paralegal attributed improved effectiveness to increased reporting:

"Yes, they have been effective since we have seen increased reporting which means people have taken the issue seriously" (KII Community Paralegal, Gem Sub-County).

Tables 5 and 6 summarize CBI awareness, utilization by demographic characteristics, and utilization by CBI type respectively.

Table 5

Awareness and Utilization of GBV CBIs by Demographic Characteristics (N=313)

Characteristic	Not Aware (N=228) n (%)	Aware (N=85) n (%)	Did Not Utilize (N=261) n (%)	Utilized (N=52) n (%)	p-value ¹
Experienced Violence	—	—	62 (24)	17 (33)	0.2
Ward					<0.001
East Gem	88 (39)	3 (3.5)	91 (35)	0 (0.0)	
North Gem	51 (22)	37 (44)	72 (28)	16 (31)	
South Gem	89 (39)	45 (53)	98 (38)	36 (69)	
Age Category					0.2
15–17 years	89 (39)	39 (46)	106 (41)	22 (42)	
18–20 years	73 (32)	27 (32)	79 (30)	21 (40)	
21–24 years	66 (29)	19 (22)	76 (29)	9 (17)	
Education Level					0.9
Primary School	52 (23)	19 (22)	60 (23)	11 (21)	
Secondary School	154 (68)	57 (67)	176 (67)	35 (67)	
College/University	22 (9.6)	9 (11)	25 (9.6)	6 (12)	
Marital Status					>0.9
Single	193 (85)	72 (85)	220 (84)	45 (87)	
Married	33 (14)	13 (15)	39 (15)	7 (13)	
Divorced/Separated	2 (0.9)	0 (0.0)	2 (0.8)	0 (0.0)	

¹Pearson's Chi-squared test; Fisher's exact test. P-values reflect utilization comparisons.

Table 6

Types of CBIs utilized by AGYWs

	Characteristic	N = 52 n (%)
Individual Level	Counseling services	16 (31)
Relationship Level	Support groups	39 (75)
Community Level	Safe houses/shelters	1 (1.9)
	Legal aid services	3 (5.8)
	Transport support	0(0)
	Health services	15 (29)
	Economic empowerment programs	8 (15)
Societal Level	Education and awareness campaigns	8 (15)

Note: Percentages exceed 100% as respondents could utilize more than one CBI. N=52 reflects AGYWs who reported utilizing at least one CBI out of the total 313 respondents (16.7%).

4.1.3 Barriers to CBI Utilization

The study explored barriers to utilization of GBV CBIs among AGYWs in Gem Sub-County, the responses reveal mixed results influenced by demographic characteristics across all four SEM levels. Individual-level barriers were most pronounced, with lack of awareness cited by 245 (78%) of respondents. A guardian rider emphasized:

"Ignorance has been a major factor since people are not aware of their rights" (KII Guardian Rider, Gem Sub-County),

while a paralegal noted the need for broader reach through the Ministry of Education and to parents and men. East Gem recorded the highest unawareness (52%), followed by North Gem (32%) and South Gem (17%). Lack of awareness was consistently the leading barrier across all age, education, and marital status groups. Fear of stigma deterred 60 (19%) of respondents, most prominently in North Gem (15%) and among secondary school respondents (10%):

"I did not report to anyone what I was facing... I was afraid" (IDI Survivor, Yala Township Ward).

Lack of trust in service providers, cited by 22 (7%), further compounded barriers, with a chief noting:

"Most of them lose hope along the way because those who are in positions to protect them have other interests apart from upholding justice" (KII Chief, South Gem Ward).

Interpersonal barriers discouraged 45 (14%) of AGYW through family and community pressure favoring informal settlements over legal action:

"His family discouraged me and told me never to report my husband" (IDI Survivor, East Gem Ward).

Economic dependence on perpetrators further constrained survivors, most pronounced among the 21–24 years age group (8.2%) and North Gem (8%). Second-order sexual harassment also silenced advocates, with a paralegal reporting colleagues whose lives had been threatened for their advocacy work.

Community-level barriers included distance, cost, and confidentiality. Distance was cited by 64 (20%) of respondents, particularly affecting remote areas and the 18–20 years age group (7%). Financial costs deterred 44 (14%), disproportionately affecting younger AGYW (15–17 years: 6.3%) and those with primary education (9.9%). A paralegal noted survivors were charged for PRC and P3 forms, while corruption further inflated costs, with guardian riders reporting cases being thrown out after perpetrators bribed officials. Lack of confidentiality, cited by 41 (13%), eroded trust, most prominently among secondary school respondents (7.1%). Societal and structural barriers, though less frequently cited, were deeply entrenched. Cultural practices including wife inheritance, reported by 16 (5.1%), discouraged reporting:

"It's against the culture to report one's husband" (IDI Survivor, East Gem Ward).

Structural challenges including delayed court processes, resource shortages, and late reporting weakened GBV response, with a healthcare worker noting:

"Late reporting may lead to tampering of evidence or difficulties in proving the perpetrator's involvement" (KII HCW, Yala Sub-County Hospital).

Table 7 presents the distribution of barriers by age and education level.

Table 7

Barriers to CBI Utilization by Age and Education (N=313)

Barrier	Overall (n, %)	15–17 Years	18–20 Years	21–24 Years	Primary	Secondary	College/ University
Individual Level							
Lack of Awareness	245 (78.3)	34 (26.6)	35 (35.0)	29 (34.1)	12 (16.9)	77 (36.5)	7 (22.6)
Fear of Stigma/Discrimination	60 (19.2)	9 (7.0)	9 (9.0)	7 (8.2)	3 (4.2)	21 (10.0)	2 (6.5)
Lack of Confidence/Trust	22 (7.0)	0 (0.0)	1 (1.0)	6 (7.1)	2 (2.8)	3 (1.4)	1 (3.2)
Interpersonal Level							
Family/Community Pressure	45 (14.4)	5 (3.9)	6 (6.0)	7 (8.2)	2 (2.8)	12 (5.7)	1 (3.2)
Community Level							
Distance to Service Providers	64 (20.4)	1 (0.8)	7 (7.0)	6 (7.1)	2 (2.8)	12 (5.7)	2 (6.5)
Cost of Services	44 (14.1)	8 (6.3)	4 (4.0)	4 (4.7)	7 (9.9)	8 (3.8)	1 (3.2)
Lack of Confidentiality	41 (13.1)	9 (7.0)	5 (5.0)	7 (8.2)	2 (2.8)	15 (7.1)	1 (3.2)
Societal/Structural							
Cultural/Religious Beliefs	16 (5.1)	4 (3.1)	1 (1.0)	6 (7.1)	3 (4.2)	6 (2.8)	0 (0.0)

Note: Percentages are based on total respondents (N=313) for overall figures and respective subgroup sizes (15–17 years: N=128; 18–20 years: N=100; 21–24 years: N=85; Primary Educated: N=71; Secondary Educated: N=211; College/University: N=31). Multiple responses were allowed.

4.1.4 Facilitators of CBI Utilization

Several factors encouraged AGYW in Gem Sub-County to utilize CBIs, varying across ward and age group. Individual-level facilitators were most prominent, with awareness cited by 223 (71%) of respondents. Sensitization by CMMB, DREAMS, and community dialogues empowered AGYW to recognize GBV and access services:

"I had been going through GBV, but I never knew about this until I got sensitized through sessions organized by CMMB" (IDI Survivor, East Gem Ward).

Awareness was highest in South Gem (87%), lowest in North Gem (53%), and consistent across all age groups (68–73%). Service provider attitude, cited by 37 (12%), also influenced uptake, with supportive providers more prominent in North Gem (17%) than East Gem (6.6%), and relatively consistent across age groups (10–13%). Interpersonal-level facilitators centered on family and community support, cited by 79 (25%) of respondents. AGYW with strong social networks were more likely to utilize services:

"My schoolteacher counselled me and encouraged me to stay in school regardless. Even my family came together to support me" (IDI Survivor, Yala Township Ward).

Family support was strikingly higher in East Gem (53%) and North Gem (30%) compared to South Gem (3.7%), and increased with age, from 20% among 15–17-year-olds to 34% among 21–24 year-olds. Community-level facilitators included proximity to services, free or low-cost services, and improved service quality. Proximity was cited by 63 (20%), far more in East Gem (52%) than North Gem (10%) or South Gem (5.2%), and slightly more among older AGYWs (21–24 years: 26%). Free or low-cost services were cited by 76 (24%), most critically in North Gem (50%) where financial constraints were most pronounced, compared to South Gem (16%) and East Gem (12%). This facilitator was more important among the 18–20 and 21–24 age groups (28% each) than younger AGYWs (19%). A healthcare worker noted:

"The fact that P3 forms for GBV are free of charge encourages survivors to come to the facilities" (KII HCW, Yala Sub-County Hospital).

Improved service quality, cited by 17 (5.4%), was highest in North Gem (10%) and the 18–20 age group (7%). Societal-level facilitators included guaranteed confidentiality and cultural sensitivity. Confidentiality was cited by 55 (18%), most valued in North Gem (36%) compared to South Gem (9%) and East Gem (12%), and more important among older AGYWs (18–20 years: 27%; 21–24 years: 21%) than younger ones (7.8%). A police officer described privacy-conscious practices:

"Most of the time, I avoid having uniforms when following up on GBV cases to enhance the confidence of the victims" (KII Police Officer, Yala Police Station).

Cultural sensitivity, cited by only 11 (3.5%), was notably higher in South Gem (6.7%) than East or North Gem (1.1% each), and slightly more prominent among older AGYWs (21–24 years: 5.9%). A healthcare worker emphasized:

"Matters related to gender are a process and not a single bullet. It requires continuous mentorship of adolescent girls and ongoing education for boys" (KII HCW, Yala Sub-County Hospital).

Table 3.6 summarizes facilitators by SEM level, ward, and age group.

Table 8

Facilitators Influencing Utilization of CBIs by SEM Level, Ward, and Age Group

Facilitator	Overall N=313 n (%)	East Gem N=91 n (%)	North Gem N=88 n (%)	South Gem N=134 n (%)	15–17 Yrs N=128 n (%)	18–20 Yrs N=100 n (%)	21–24 Yrs N=85 n (%)
Individual							
Increased Awareness	223 (71)	59 (65)	47 (53)	117 (87)	93 (73)	68 (68)	62 (73)
Provider Attitude	37 (12)	6 (6.6)	15 (17)	16 (12)	13 (10)	13 (13)	11 (13)
Interpersonal							
Family/Community Support	79 (25)	48 (53)	26 (30)	5 (3.7)	25 (20)	25 (25)	29 (34)
Community							
Proximity to Services	63 (20)	47 (52)	9 (10)	7 (5.2)	22 (17)	19 (19)	22 (26)
Free/Low-Cost Services	76 (24)	11 (12)	44 (50)	21 (16)	24 (19)	28 (28)	24 (28)
Improved Service Quality	17 (5.4)	6 (6.6)	9 (10)	2 (1.5)	5 (3.9)	7 (7.0)	5 (5.9)
Societal							
Guaranteed Confidentiality	55 (18)	11 (12)	32 (36)	12 (9.0)	10 (7.8)	27 (27)	18 (21)
Cultural Sensitivity	11 (3.5)	1 (1.1)	1 (1.1)	9 (6.7)	3 (2.3)	3 (3.0)	5 (5.9)

Note: Percentages are based on total respondents (N=313). Multiple responses were allowed.

4.1.5 Diversity Considerations

Diversity factors significantly influenced CBI utilization, as shown in Table 9. Economic disadvantage was a barrier for 14.1% (n=44), particularly affecting transport and service costs, with primary-educated AGYWs (19%, n=19) and divorced/separated AGYWs (20%, n=3) reporting higher challenges. Awareness was lower among primary-educated AGYWs (88%, n=88) compared to secondary-educated (64.7%, n=97). Cultural norms, such as wife inheritance, impacted 8% (n=25), particularly in rural areas like East Gem. Single (27.5%, n=56) and divorced/separated (13.3%, n=2) AGYWs showed higher GBV prevalence, with rural settings exacerbating access challenges.

Table 9*Diversity Factors Influencing CBI Utilization (N=313)*

Factor	Overall (n, %)	Primary Educated (n, %)	Secondary Educated (n, %)	Single (n, %)	Married (n, %)	Div./Sep. (n, %)
Economic Disadvantage	44 (14.1)	19 (19.0)	19 (12.7)	28 (13.7)	13 (13.8)	3 (20.0)
Low Awareness	244 (78.0)	88 (88.0)	97 (64.7)	157 (77.0)	78 (83.0)	9 (60.0)
Cultural Norms	25 (8.0)	9 (9.0)	13 (8.7)	16 (7.8)	9 (9.6)	0 (0.0)
Rural Setting Challenges	63 (20.1)	22 (22.0)	25 (16.7)	38 (18.6)	22 (23.4)	3 (20.0)

Note: Percentages are based on total respondents (N=313). Multiple responses were allowed.

4.2 Discussion

4.2.1 Existing GBV Community-Based Interventions

Gem Sub-County implemented CBIs to address GBV among AGYWs through two central coordination structures: VPRTs and the DREAMS program. VPRTs united local leaders, health workers, and paralegals as response coordination point for GBV, mirroring Ghana's COMBAT teams, which reduced GBV through community-led prevention (Addo-Lartey et al., 2019), and consistent with Keith et al.'s (2023) findings on community engagement. The DREAMS program-built awareness through targeted training for AGYWs, paralleling Uganda's SASA! initiative (Kyegombe et al., 2014), though its narrow focus restricted broader norm-shifting, suggesting the need for community-wide dialogues across Gem's rural wards.

Psychosocial support, accessed by the majority of AGYWs through counselling and support groups, aligned with Kenya's integrated post-rape care models (Friedberg et al., 2023) and South African community-based interventions (Jewkes et al., 2021). However, the absence of sustained trauma-focused therapies limited long-term recovery outcomes, as evidenced by inconsistent trauma results in India (Patel et al., 2017), underscoring the critical need for integrated long-term counselling approaches in this rural context.

Legal aid reached only 5.8% of AGYWs and police reporting stood at just 3.8%, far below Uganda's legal empowerment models (Mueller et al., 2019). Cultural normalization of violence and fear of retaliation eroded trust in legal systems, consistent with Bangladesh findings (Naved et al., 2018), while Gem's rural setting amplified distrust beyond urban Kenyan levels (Kaske et al., 2021). The Guardian Riders transport initiative recorded zero uptake due to low awareness and infrastructure challenges, contrasting with Lebanon's 40% service access increase through subsidies (UN Women, 2023; Pronyk et al., 2006). Economic empowerment reached only 15% of survivors (Eggers Del Campo & Steinert, 2022), lacking gender norm integration unlike successful Ugandan models, suggesting VSLAs expansion alongside community dialogues could reduce economic vulnerability among AGYWs.

Safe spaces, including the CPU, reached only 1.9% of AGYWs, limited by accessibility challenges and police distrust, echoing Haitian rural barriers (Logie et al., 2021) and contrasting with multi-facility models elsewhere (Garcia-Moreno et al., 2021). Healthcare support recorded 29% uptake, consistent with Malawian findings (Undie et al., 2016), but remained constrained by underfunded facilities, reinforcing the need for increased resource allocation across Gem's wards.

Overall, only 27.2% of respondents were aware of CBIs and 16.7% utilized them, mirroring resource-constrained outcomes in rural Peru (Guedes et al., 2016). A stark geographical divide — 53% awareness in South Gem versus 3.5% in East Gem — paralleled rural-urban disparities documented globally (Gibbs et al., 2017). Unlike findings linking higher education to increased CBI utilization (Yount et al., 2017), consistent utilization patterns across age groups pointed to unique structural barriers, including limited communication channels and cultural stigma around GBV disclosure.

Perceptions of effectiveness were mixed: 47% rated programs as very effective, 36% as moderately effective, and 8.2% as ineffective, varying across wards and age groups. While broadly consistent with Ugandan community-led interventions rated highly effective by 50% of participants (Keith et al., 2023), Gem's outcomes diverged from evidence emphasizing male engagement and consistent funding as critical drivers of sustained effectiveness (Lwamba et al., 2022). The 8.2% ineffectiveness rating reflected persistent funding gaps consistent with sustainability warnings (Chatterji et al., 2020), suggesting that mobilizing equitable funding is essential to improving outcomes across all wards in Gem Sub-County.

4.2.2 Barriers to Utilization of GBV CBIs

The utilization of CBIs for GBV among AGYWs in Gem Sub-County faced multiple barriers shaped by demographic, geographic, and socio-cultural factors. Lack of awareness was the most significant barrier, with 78% of AGYWs unaware of available CBIs, far exceeding South Africa's 24% (Bradbury-Jones et al., 2021) and Nepal's 50% (Acharya & Dhakal, 2024). This reflected Gem's rural isolation and limited outreach, as a local chief highlighted challenges in reaching communities. Geographical disparities were pronounced across wards, contrasting with Mtaita et al.'s (2021) Tanzanian study, where culturally adapted radio campaigns achieved 70% awareness. Younger AGYWs

(15–17 years) and those with primary education reported the highest unawareness, aligning with Kay et al. (2024) Kenyan findings, suggesting school-based campaigns, local radio, and community leader engagement could promote CBI utilization in underserved areas.

Physical distance and transport barriers were cited by 20% of respondents, aligning with Ellsberg et al. (2015) and Muuo et al. (2020) on rural access challenges. Healthcare workers noted delays in referral systems even in relatively accessible areas. Unlike Musambayi et al.'s (2016) Nairobi study, where urban proximity mitigated distance barriers, poverty's interplay with distance (Heise et al., 2002) was particularly pronounced in Gem, suggesting that expanding transport programs and community outreaches are essential to ensure AGYW's can access health and legal services.

Financial barriers affected 14% of respondents, encompassing costs for medical reports, transport, and justice system bribes. The average cost of post-GBV care was estimated at Kshs. 16,500 (NGEC, 2016), a heavy burden in Gem's high-poverty context (Statista, 2025). Married AGYW's (8.7%) faced greater financial challenges than single AGYW's (4.5%), reflecting economic dependence consistent with Sidamo et al. (2023), suggesting subsidized services and anti-corruption measures are critical to improving access for marginalized AGYW's.

Stigma and discrimination deterred 19% of respondents, particularly in North Gem, where cultural norms prioritizing family honor discouraged reporting. Institutional stigma, including healthcare worker-shaming of survivors, aligned with McCleary-Sills et al.'s (2016) findings. Married AGYW's (11%) experienced more stigma than single AGYW's (7.5%) due to family expectations. Mtaita et al.'s (2021) Tanzanian study demonstrated stigma reduction through community sensitization, a strategy underutilized in Gem. Gem's "kangaroo courts," acknowledged by chiefs, suppressed reporting, unlike Kyegombe et al.'s (2014) Ugandan SASA! program, which reduced GBV through norm-shifting dialogues, suggesting the need to engage traditional and religious leaders.

Distrust in service providers was reported by 7% of respondents, stemming from corruption, lack of confidentiality, and victim-blaming, consistent with Rockowitz et al. (2023). A survivor's account of a healthcare worker blaming her for her pregnancy echoed UN Women's (2020) findings in Pakistan. Gem's rural context amplified distrust due to limited provider accountability, unlike Tilahun et al.'s (2012) Ethiopian trained-provider model, suggesting that training providers on confidentiality and survivor-centered care is critical to restoring confidence. Fear of retaliation was pronounced in Gem's close-knit communities, where paralegals reported being attacked for advocating for survivors, unlike Mtaita et al.'s (2021) Tanzanian study, highlighting the need for community-based protection strategies to reduce re-victimization risks.

4.2.3 Facilitators of GBV CBI Utilization

CBI utilization among AGYW's in Gem Sub-County was enhanced by several individual, interpersonal, community, and societal factors. Increased awareness, cited by 71% of AGYW's, was the primary facilitator, driven by CMMB, the DREAMS program, and Chief barazas through community dialogues and peer education. This aligned with Uganda's comic-based interventions (Logie et al., 2023) and Kenya's Colour Fest art therapy (UNFPA Kenya, 2023), empowering survivors to recognize GBV and seek help. Awareness was more prevalent among 15–17-year-olds and 21–24-year-olds (73%) than 18–20-year-olds (68%), due to targeted school and community interventions, suggesting expanding campaigns to schools, markets, and religious centers could address gaps in underserved areas.

Family and community support facilitated CBI uptake for 25% of AGYW's, strongest in East Gem but weaker in South Gem, unlike Nigeria's cohesive social networks (Besigye & Kabona, 2025). Survivors described emotional and practical assistance from family and teachers, aligning with Kansime (2017) and the DRC's COMPASS intervention (Falb et al., 2016). A survivor recounted a teacher's encouragement to remain in school after pregnancy, mirroring DREAMS mentorship in Kenya (Saul et al., 2018). Younger AGYW's (15–17 years) relied on family and teachers, while older ones (21–24 years) engaged women's groups and health promoters (Besigye & Kabona, 2025), suggesting peer support clubs and community events could strengthen fragile social networks.

Proximity to service providers enabled 20% of AGYW's to access CBIs, with health facilities serving as hubs for care and counselling, as seen in the DRC's Safe Spaces intervention (Falb et al., 2016). Married AGYW's (39%) prioritized proximity due to mobility constraints (Luoga et al., 2025), suggesting community linkages could ensure more equitable access. Affordability motivated 24% of AGYW's, with college-educated and married AGYW's prioritizing free services, challenging Duvvury et al.'s (2013) assumption that education ensures economic security and aligning with DREAMS' subsidized services (Saul et al., 2018). Free P3 forms and medical waivers mirrored Tanzania's model, though donor dependency raised sustainability concerns, suggesting the need for institutionalized funding and expanded subsidies.

Confidentiality enabled 18% of AGYW's to seek services, countering stigma and retaliation fears, most valued by divorced/separated AGYW's, aligning with WHO's (2013) emphasis on survivor-centered care. Healthcare workers and police emphasized strict privacy, resonating with Albayrak et al.'s (2022) Syrian refugee camp study, suggesting formalizing privacy protocols is essential to enhance uptake. Cultural sensitivity, cited by 3.5% of AGYW's, enhanced CBI utilization, aligning with studies in Zambia (Banda, 2019).

Service quality was cited by 5.4% of AGYWs and varied across wards, with North Gem (10%) rating higher than South Gem (1.5%), reflecting resource disparities. Survivors valued skills training within CBIs, like Ghana's interventions, suggesting enhanced provider training and equitable resource allocation could improve access. Positive provider attitudes encouraged 12% of AGYWs, with younger AGYWs (15–17 years: 15%) valuing teacher support and older ones (21–24 years: 14%) appreciating police empathy, addressing UN Women's (2020) distrust concerns. The absence of reported institutional perpetrators, unlike Beyene et al.'s (2019) Nigerian study, may reflect trust-building within CBIs, suggesting training providers in empathy and expanding community-based support roles could enhance trust across wards.

V. CONCLUSIONS & RECOMMENDATIONS

5.1 Conclusion

This study investigated the factors influencing the utilization of CBIs for GBV among AGYWs aged 15–24 years in Gem Sub-County, Kenya, through the lens of the Socio-Ecological Model (SEM). GBV. At the individual level, various CBIs were available, but limited awareness significantly hindered utilization, with support groups being the most accessed intervention. Lack of awareness and fear of stigma emerged as the most significant individual-level barriers, while increased awareness and positive provider attitudes were the strongest facilitators. At the interpersonal level, family and community pressure discouraged AGYWs from utilizing formal CBIs, with informal settlements preferred over legal recourse. Conversely, strong social networks served as a critical facilitator, with AGYWs receiving family support more likely to access available services. At the community level, distance from service providers and confidentiality concerns limited CBI uptake, particularly in remote wards. Proximity to services and free or low-cost services facilitated utilization, though these varied considerably across wards. At the societal level, cultural norms, financial costs, and structural barriers such as corruption restricted access, particularly for married AGYWs. Guaranteed confidentiality and cultural sensitivity of providers emerged as key facilitators at this level. These findings challenged the assumption that proximity alone ensures service utilization, as stigma and cultural norms often drove AGYWs to avoid local services. Individual and interpersonal factors disproportionately affected CBI utilization compared to societal-level factors, though the latter remained significant among economically vulnerable AGYWs.

5.2 Recommendations

Establish Ward-Level GBV Surveillance Systems: Integrate GBV indicators into CHP reporting across Gem sub-County wards. Strengthen linkages between schools, health facilities, and community structures to improve reporting among AGYWs (15–17). Create a centralized directory of GBV services available in Gem sub county (health, legal, psychosocial) and share it through CHPs, NGAO, and digital platforms. Pilot transport vouchers or expand Guardian Riders to support discreet referrals. Link AGYW groups with VSLAs and formalize referral pathways through schools and faith-based institutions.

Declaration of Interest

The authors declare that they do not have any known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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