EFFECTS OF LAY TRAUMA COUNSELLING ON RAPE SURVIVORS: A COMMUNITY BASED INTERVENTIONAL STUDY IN THIKA AND NAIVASHA SUB-COUNTIES – KENYA

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Effects of lay trauma counseling on rape survivors: A community based interventional study in Thika and Naivasha sub-counties – Kenya

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DECLARATION

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

Signature …………………….................... Date: …………………................

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This thesis has been submitted for examination with our approval as University supervisors.

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DEDICATION

This thesis is dedicated to the Almighty God for His own glory; to my husband Dr. Gichuru, our children: Mr. Kinyua, Mr. Mutua, Dr. Makena; our daughter in love Mercy Kinyua, and to our first grandchild Natalia Blessing Kinyua.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
CBHC	Community –Based Health Care
CBHS	Community –Based Health Services
CCC	Comprehensive Care Centre
CI	Confidence Interval
CHWs	Community Health Workers
CHEWs	Community Health Extension Workers
DSM- TR	Diagnostic Statistical Manual of Mental Disorders-Text Revised
EU	European Union
FGDs	Focused group Discussions
FOCTC	First Order Community Trauma Counselor
HIV	Human Immunodeficiency Virus
ICLRTC	Intense Community Lay Rape Trauma Counseling
MoH	Ministry of Health
NHSSP 11	The Second National Health Sector Strategic Plan of Kenya
OR	Odds Ratio
PEP	Post-Exposure Prophylaxis
PRC	Post Rape Care
PTSD	Post Traumatic Stress Disorders
RA	Research Assistant
RH	Reproductive Health
RTS	Rape Trauma Syndrome
SPSS	Statistical Package for Social Sciences
STIs	Sexually Transmitted Infections
UN	United Nations
UNAIDS	United Nations Program on HIV/AIDS
UNHCR	United Nations High Commission on Refugees

DEFINITION OF OPERATIONAL TERMS

Adolescents: Those individuals ranging from 12 to 17 years old

Adults: Individual 18 years old

Child: Individual 11 years of age

Child Friendly Environment: A counselling room with space and materials such as papers, pencils and toys, which can be used by children during the counselling session

Debrief: Refer to an informal or formal method whereby a Counsellor Supervisor or Peer Support defuses stress /tension by discussing with Trauma Counsellors their feelings (Rogers, 1959).

Effects: A change produced by an intervention.

Effectiveness: Intended change i.e. outcome of an intervention

Intense Community Lay Rape Trauma Counseling: The intervention used in this study

Magnitude: The effect of ICLRTC intervention in preventing / reducing negative mental health post rape

Psychological Health Outcomes:

Either positive or negative psychological effects, psycho-physical function or social life effects post rape.

Psychosocial Care and Support: Rape trauma counseling, formal, and informal social support systems used to aid in recovery post rape among survivors and their

families, and the help given to enable them move from the effects of rape thereby preventing and minimizing its negative effects.

Rape Trauma Syndrome (RTS):

This refers to psychological trauma after sexual violation. While RTS has similar symptoms to posttraumatic stress disorder (PTSD), it is not included in the DSM-TR. Survivors can be diagnosed with RTS by a sexual assault crisis Counselor, while a PTSD diagnosis needs to be done by a psychologist/psychiatrist. RTS has three phases, namely: acute phase, reorganization and resolution phases (Gromish, 2009).

Trauma: An emotional shock producing a lasting harmful psychological effect

Usual care /Standard Care

Trauma counseling sessions delivered by Trauma Counselors at the CCC used in post rape trauma care and support according to the Ministry of Medical Services approved protocol.

Survival:

The battle between 'mind rape' and the 'will' to find 'self' again

Survivor(s):

Children and adults post-rape. While "victims" should be treated with compassion and sensitivity, referring to them as "survivors" recognizes their strength and resilience. Throughout his study, the terms 'victim' and 'survivor' have been used interchangeably.

ABSTRACT

The negative psychological consequences of rape are profound and long-term. The psychological dysfunctional consequences of rape are more serious than its physical effects. The objective of this study was to determine effects of *lay trauma counseling* on rape survivors. Survivors were consecutively recruited (n=410), 128 in Thika sub-county the intervention arm and 282 in Naivasha sub-county the Non-intervention arm. Intervention group received both the 'standard care' and ICLRTC intervention for nine months. Data was analyzed using descriptive, Pearson's Chi-square test or Fisher Exact test to determine factors associated with each dependent variable, OR and 95% CI were used to estimate strength of association between independent and dependent variable. Results at baseline revealed a significant difference in the distribution of survivors' residence by study arm ($p<0.001$). 'Safety' and 'dissatisfaction needs were significantly different ($p=0.004$) and ($p=0.001$) respectively, in distribution among survivors by study arm at baseline. There was baseline equivalence in all selected psychological distress characteristics between the study arms ($p>0.05$). The magnitude of change in improvement of positive psychological outcomes by 3rd, 6th, and 9th month of ICLRTC intervention was higher in Non-intervention arm compared to intervention arm. Conclusion: the main needs among survivors were 'safety' and 'dissatisfaction'; and the main psychological distress characteristics were depression and RTS. The predictors of depression were *Age 12 years old, self blame* and *RTS; and* predictors of RTS were *depression* and *shame*. Recommendations: The legal-justice system and the African 'Clan of Elders Courts' ought to protect women and girls from perpetrators who live within or near their homes. PRC providers ought to be friendly while they deliver services in a sensitive manner. There is need to replicate this study under normal circumstances to find out if there will be significant difference of findings from results of this study.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

Rape (sexual violation) is a serious human rights and a primary public health concern not only in Africa but also in other countries of the world (Amnesty International, 2014; WHO, 2013). It is also a worldwide societal problem that creates significant challenges to local communities in their attempt to create an overall plan for meeting physical, emotional, psychological and social health needs of rape survivors (WHO, 2011; Mwangi and Jaldea, 2009). The impact of rape on victims comes as a devastating shock, destroying the survivors' abilities to maintain the important illusion of personal safety and invulnerability and threatens many assumptions and beliefs that the survivors may have about themselves and the world around them (Walsh, Cross and Jones, 2012). Rape survivors struggle not only with how the assault has directly affected them, but also with how it is affecting those close to them (e.g., husbands, wives, friends and family) (Decker *et al.*, 2013; Basow and Thompson (2012). Maier (2012); Basow and Thompson (2012); Christofides *et al.* (2006); George (2002); Jewkes and Abrahams (2002); Ullman and Filipas (2001); Nayak (2000); Ahrens and Campbell (2000), documented that rape survivors' experience a variety of negative social reactions from informal and formal help sources. For example, some helpers may not recognize: their limits, the harmful effects of rape, the need to respect survivors' need to express their feelings, the need for survivors to choose what family member or members or friend they wish to disclose to, the need to ask survivors the best ways of getting support, survivors' need for privacy, that survivors' healing may take time, survivors need space and energy, and that survivors should not be blamed. Survivors often feel guilty and ashamed about the rape. Therefore, the survivors would like to hear that the rape was not

their fault. These negative experiences have been termed 'the second rape' or 'secondary victimization'.

Reviews of the empirical evidence confirm that post- rape psychosocial health needs are often the least met in low resource settings. As a result, survivors are bedeviled by psychological distress reactions and dysfunctional outcomes which soon become complex because culture shapes the way post-rape psychopathologies and symptoms are experienced and communicated (Christofides *et al.*, 2006; Christofides *et al.,* 2005). The negative psychological consequences of rape are profound and long-term, permeating all aspects of life including intimate relationships, sexuality, parenting, studies or employment, and the ability to cope with other life issues. For many survivors, the psychological dysfunctional consequences of rape are even more serious than its physical effects. Foa *et al.* (2006); Erickson *et al.* (2002); Garcia-Moreno (2002); Campbell *et al*. (2001) identified different types of post rape psychological distress characteristics namely; immediate psychological reactions (lasting minutes to hours); short-term negative psychological distress characteristics (which occur during the first three months post-rape); intermediate negative psychological distress characteristics (which continue three months–to one year post-rape); and long-term psychological distress characteristics (continuing longer than one year post-rape).

Empirical evidence highlights the burden of rape as widespread and how it pervades all racial, social and ethnic groups. Rape is probably the most heinous crime which has been going on since the start of times across geographical boundaries (United Nations, 2012; WHO, 2011). It is shameful of a society we live in where every day, every hour someone or the other is facing sexual violation. Rape is a complex crime because victims are much less likely to have their complaint recorded due to the extreme social stigma or possibility because of perpetrator violence or because victims fear being disowned by their families (Amnesty International, 2014). Hence, in several parts of the world, rape is very rarely reported.

Data on the prevalence of rape vary greatly depending on country and incidence statistics are shocking. Worldwide incidence statistics by Amnesty International (2014); United Nations (2013); European Union Agency for Fundamental Rights (2013); Harrendorf, Heiskanen and Malby (2012); WHO (2012); revealed that renowned developed Western and European countries had high incidence of rape cases (rate/100,000) , for example, Sweden (63.5), Belgium (27.5), United States of America (USA) (27.3) and United Kingdom (23.2). Rape incidence statistics are commonly available in developed countries, and are becoming more common; but, the majority of rape cases in many countries go unreported which affect the accuracy of data (United Nations, 2013; Amnesty International, 2014). African countries with highest incidence of rape cases / number of police - recorded offences (rate/100,000) are South Africa (132.4), Botswana (92.9), Lesotho (82.7), Swaziland (77.5), Ethiopia (60.0), Rwanda (43.0), Congo (34 .1), Zimbabwe (25.6), Senegal (5.6), Morocco (4.8), Kenya (4.1), Mauritius (3.9), Uganda (2.1) (United Nations, 2012). The incidence of rape cases / number of police - recorded offences (rate/100,000) in Kenya is (4.8) a according to United Nation (2012) database records. Kenya police statistics on the incidence of rape reported to the police show an increasing trend: 2005 (1.9), 2006 (2.1), 2006 (2.3), 2008 (3.5), 2009 (3.8) and 2010 (4.1) (Kenya Police Crime Report, 2013). Yet, it is assumed that rape is the most highly under reported crime in Kenya (Mwangi and Jaldea, 2009). It is estimated that only 1 out of 20 women in Kenya will report a rape and only 1 in 6 will seek medical assistance (Mwangi and Jaldea, 2009). Relying on number of police recorded rape offences will therefore not provide aa accurate estimate of incidence of rape in Kenya because rape in all provinces is mostly settled out of court through 'Clan Elders' Courts;' and also, societal stigma associated with rape deters majority of women and children from reporting rape (Mwangi and Jaldea, 2009).

Research evidence has shown there are significant deleterious psychological, medical, disease burden and cost factors associated with rape trauma described in the literature. Available records estimate annual cost of crime in the USA to be around $450 billion, of

which around ($426 billion) is almost totally attributable to rape crime and it exceeds the entire $266 billion cost of the U.S. defense budget by 69% (Ustun *et al*., 2004; Miller *et al.*, 1997). Research findings report that rape is the most costly of all crimes to its victims. For example, total costs are estimated to be $127 billion a year in the USA, excluding the costs of child sexual abuse (Ustun *et al*., 2004; Miller *et al.*, 1997). Survey report by U.S. Department of Justice report the cost for each sexual assault is $110,000; because many rape victims are subjected to more than one sexual assault, therefore, the cost per rape is estimated to be $87,000. According to the USA Bureau of Justice Statistics (2010), the cost per sexual violation is further broken down as follows: Short-term medical care: $500; Mental health services: $ 2,400; Lost productivity: $ 2,200; Pain and suffering: $104,900. The pain and suffering cost is based on the following facts: one up to half of all rape victims suffer from at least one symptom of rape trauma syndrome; rape victims are four times more likely to have an emotional breakdown than are non-victims; 25% to 50% of rape victims are likely to seek mental health services and finally, victims often suffer from lifelong physical manifestations of rape trauma - the total cost of rape to victims was estimated at $18 million in 2009 (Bureau of Justice Statistics, 2010).

Walker *et al.* (1999) studied the cost of health care use by women with a history of childhood sexual abuse. One thousand two-hundred and twenty five surveys were completed and analyzed. Results found that women who reported sexual violation history had health care costs $245 greater than women with no sexual violation history. When these researchers removed the cost of mental health treatment, the differences were $119 greater for women who experienced sexual violation compared to no violation.

Studies have used objective and subjective measures of quality of life outcomes in rape victims and results have revealed rape was associated with a broad range of functional impairment including increased bed days, physical limitations, currently not working, poorer physical health status, and diminished subjective well-being (Amnesty

International, 2014; United Nations, 2012; WHO, 2011; Zatzick *et al.* (1997). These authors stated that "the difficulties associated with rape among victims extend beyond the signs and symptoms of the disorder to multiple domains in functional impairment" (Zatzick *et al.*, 1997, p. 664).

The ICLRTC intervention model used relational therapy technique in the Kenyan communities. The intervention model was adopted from the Psycho-social Care and Support Trauma Counseling Protocol (MoPHS/MoMS, 2009). The ICLRTC intervention utilized the already existing Ministry of Health Community Services structures, MoH work force and the MoH trained volunteer community based health workers (MoH, 2007). The training module (appendix A) for ICLRTC intervention model was adopted from: Psycho-social Care and Support Protocol (MoPHS/MoMS, 2009); Trainer's Manual for Rape Trauma Counselors in Kenya (MoH, 2006a); Trainer's Manual on Clinical Care for Survivors of Sexual Violence (MoH, 2006b); Training Module for CHWs (MoH, 2007). The ICLRTC intervention model implementation guide (appendix B) and report forms were adapted from the monitoring and evaluation for Community Health Services guide MoH (2007).

The Community Strategy structures for the Delivery of Level one Services made it possible, through CHWs, to implement the ICLRTC intervention model bi-monthly (appendix $C_{1)}$ in the communities for nine months. CHWs work under supervision of CHEWS (appendix C_2) who are full time MoH employees. CHEWs work under supervision of DHMTs. Front line community rape trauma counseling services are guided and supported by Trauma Counselors based at the public health facilities.

1.2 Statement of the Problem

In Kenya, rape 'the invisible crime' is the second highest reported crime (Kenya Police Crime Report, 2011; United Nations General Assembly (UN-GA), 2008). Currently, incidence of rape has reached epidemic proportions in Kenya and has been recognized as a national public health problem (The Waki Commission, 2008; FIDA-K, 2005; UN,

2005). Evidence from Amnesty International (2011); WHO (2011) revealed that a person is raped every half an hour in Kenya. Kenya police statistics on the incidence of rape reported to the police show an increasing trend: 2005 (1.9), 2006 (2.1), 2006 (2.3), 2008 (3.5), 2009 (3.8) and 2010 (4.1) (Kenya Police Crime Report, 2011). Yet, it is assumed that rape is the most highly under reported crime in Kenya (Mwangi and Jaldea, 2009). Extremely few cases of rape are reported to the Kenya Police either out of fear or shame that the society brings upon the victim or because women and children in rural areas who are victims of rape are unwillingly subjected to 'Clan Elders' Courts' (Mwangi and Jaldea, 2009). This means the number of police recorded rape offences does not provide accurate estimate of incidence of rape in Kenya. Other sources of data on rape in Kenya reveal that, one in four women is raped per minute (Amnesty International, 2011; United Nations, 2011; UNCHR, 2011). Amnesty International (2011) insist that the Kenya's official rape statistics, more than 300 rape cases per week, are doubtful because if that figure should be multiplied by 10 to account for non-reporting, (as is the case in Tanzania), the total cases would be higher. Though this figure of rape cases is high, it is also conservative in the sense that only 1 out of every 20 women report rape case in Kenya and only 1 out of 6 seek medical assistance in Kenya, meaning that the figure could be well over three times the reported figure of rape cases (Amnesty International, 2011).

Rape victims experience debilitating physical symptoms including tension headaches, stomach pains, fatigue, various gynecological problems and including chronic vaginal infections, bleeding and infertility, pain in the genital area, unwanted pregnancy and infections such as STIs, HIV, pelvic inflammatory disease (Decker *et al.,* 2013; Basow and Thompson, 2012). Although these complications can be treated medically, many women do not receive proper medical attention because few rapes cases are reported.

Injury and death rates connected with sexual violation from 2009-2010 were: 229,000 victimizations; 148,000 victims (some victims were raped more than once); 90,000 nonfatal physical injuries; 6,000 hospitalizations from injuries; and 305 deaths (Amnesty

International, 2011; United Nations, 2011). Businesses lose money through employee absences and sexual violation suits. The cost for offenders' incarceration, probation, treatment and other offender services adds to the total cost of sexual violation (Bureau of Justice Statistics, 2010).

The monetary cost for rape accompanied by a physical injury in the early 2009 was: Total cost other than mental health: $6,228; Medical: $1,367; Emergency services: $66; Productivity: $ 4,683; Administrative: $112; Total mental health cost: $36,306; Mental health medical: $4,990; Mental health productivity: $1,465; Quality of life lost to psychological injury: $29,851; Total cost for rape accompanied by physical injury was $42,534 (Bureau of Justice Statistics. 2010).

Apart from the visible physical injuries, a victim undergoes countless psychological trauma from the rape incident (Walsh, Cross and Jones, 2012). Rape not only affects victims' physical health and well-being, but is also emotionally injurious. Common symptoms include anxiety, depression, lowered self-esteem, helplessness, perceived loss of control and post-traumatic stress disorder (Erickson *et al.*, 2002; Garcia-Moreno, 2002; Campbell *et al*. 2001; Arata, 1999). Recent studies of disease burden have demonstrated the importance of post rape psychological disorders. For instance, anxiety disoders and depression were the third and fourth leading cause of disease burden respectively, accounting for 5.6% and 4.4% of total disability adjusted life years in the world (Ustun *et al*., 2004; Mark *et al.*, 1998; Miller *et al.*, 1997).

Sexual violation causes psychopathology burden which subject victims to a life of misery. Warshaw *et al.* (1993) examined the effects of sexual violation (SV) trauma on the quality of life of 688 men and women diagnosed with an anxiety disorder. Comparisons were made between subjects with no history of SV trauma, subjects with a history of SV trauma, on several outcome measures of psychosocial functioning. Generally, the results indicated that the subjects with a SV trauma history were found to have some deficits in perceived quality of life, and that rape victims are four times more likely to have emotional breakdown than non-victims.

Rape victims suffer enormous costs through repeated formal help seeking. Koss *et al.* (1991) studied the long-term consequences of criminal victimization of 390 women (74 non-victims and 316 crime victims) on physical health and utilization of medical health services. These researchers found that the greater the severity of criminal victimization during the woman's life, the higher the number of physician visits and outpatient expenses. Women who were multiply victimized visited their physician almost seven times per year, compared to non-victimized women who made an average of 3.5 visits. The cost of treating a multiply victimized woman was $401 for the index year studied, 2.5 times higher than the $161 cost of treating a non-victim. The authors also found that increases in service usage did not occur in the first year of victimization, but were delayed until the following year.

SV victims suffer theft and damage to property during violent victimization. Survey reports found that 15% of all SV victims incurred a direct economic loss from the crime, mostly due to damage to property (Bureau of Justice Statistics, 2002).Violent rape crimes of often includes theft and property damage resulting in direct monetary loss to victims. In 2009, 30% of rape crime victims lost less than $50, 11% lost from $50-$99; 16% lost $100-$249, 8% lost $250-$499, 15% lost $500 or more (Bureau of Justice Statistics, 2010). Rape victims also experience social problems, for example, survivors are denied help by their communities and whatever help they receive often leaves them feeling rape incident is ignored, survivors get hard pressed for rape details when they report rape to the police, the perpetrator gets sympathized with by the community, survivors get judged by the society, and everybody get to be told about the rape without survivor's consent (WHO, 2005; Dunkle *et al.,* 2004; Matsushita-Arao, 1997).

Despite sequelae of rape in terms of physical injuries, costs, social problems, emotional, psychological trauma and disabilities, there is no Kenyan community- based data available to identify psycho-social health need and demonstrate effects of lay trauma counseling on post rape psychological distress among rape survivors. Most research and community-based programmatic post-rape care interventions in Kenya focus more on

medical care with no attention to rape trauma counseling in the community. Many of the post-rape psycho-social care and support interventions carried out in Kenya are undocumented and remain unevaluated.

The Kenya public health facilities are supposed to give five trauma counseling sessions post rape, during the PEP dose and HIV testing period. But, during this period, survivors are not followed in the community to ensure they keep trauma counseling appointments because of complexities in low resource contexts. Hence, there is need for a lay trauma counseling intervention in order to identify psychosocial health needs and to assess the effects of ICLRTC intervention on psychological distress characteristics among survivors in the community.

1.3 Justification for the Study

This study is of clinical and public health importance. The study will iIdentify post rape psychosocial health needs at baseline, and provide evidence-based information on lay trauma counseling in the community as an intervention. The community follow-up will enable the researcher to:

i) Identify specific psychological distress outcomes
ii) Prevent or reduce post rape psychopathology among rape survivors in the Kenyan communities

Community trauma counselling is about creating new perspectives and psychological change in rape victims. According to Morrissey *et al.* (2005); and Bowling (2002), community trauma counselling aims at helping survivors: to understand rape more clearly; to identify choices for improving the post-rape situation; to make choices that fit their values, feelings and needs; and to make their own decisions and act on them. Studies, for example, by Bowling (2002); Morrissey *et al.* (2005) revealed that community lay rape trauma counseling is associated with positive psychological health outcomes among survivors.

A study by Kantor (2002) strongly associate immediate First Order Trauma Counseling (FOCTC) intervention, in the community, with positive and empowering experiences, for example, re-establishment of adaptive coping, minimized stigma (disclosure of rape); and social adjustment (utilizing counseling services, seeking support). FOCTC is also associated with immediate, short term, intermediate and long term positive psychological outcomes. First Line Community trauma counseling has also been found to help sexually abused children recover from the effects of rape, thereby minimizing long term negative effects of childhood rape. It is clear from literature review that psychopathologies as consequences of rape cannot be prevented completely, but many could be ameliorated if Front Line Caregivers in the community can deliver timely post rape psychological trauma counseling. Quality post-rape psychological First order intervention in the community plays a critical role in psychological recovery of survivors. Psychological support helps in supporting victim's transit from 'victim' (because each survivor responds to rape in different psychological dysfunctional ways) to 'survivor.' Therefore, community psychological First Aid has been found essential to deliver lay trauma counseling in order to alleviate or reduce survivors' psychological distress post rape.

In 2006, findings of an operations research by Kilonzo *et al.* (2006) found a knowledge gap because no study in Kenya had identified psychosocial health needs of victims of rape. The authors also recommended further research to gain additional information on the effectiveness of trauma counseling on psychological distress outcomes among victims of rape. The identified scientific knowledge gap highlight the need for a community based intervention study which would assess the effects of lay rape trauma counseling in improving positive psychological health outcomes among rape survivors.

To date, there is no documented study that has focused on post rape psychosocial health needs and psychological distress characteristics in the Kenyan communities despite the magnitude of rape problem in Kenya, and the evidence that only a small proportion of rape survivors seek post rape services from the health facilities (UNCHR, 2011). Considering that rape has been associated with a wide variety of psychopathology which

can be long term, the need for Lay Trauma Counseling (ICLRTC) intervention at the community cannot be overemphasized.

Hence, the psychosocial health needs and psychological distress characteristics among rape survivors in the Kenyan communities remain unknown. So, there was a critical knowledge and practice gap in the Kenyan research exploring psycho-social health needs and psychological distress characteristics among rape survivors in the community. Therefore, the justification of this research cannot be over emphasized because this was an unexplored area in research. The study compared the Intervention and Non-intervention groups' positive psychological health outcomes in order to attribute the greater change in positive post rape psychological health outcomes to the ICLRTC intervention.

1.4 Research Questions

i) What are the psycho-social health needs among rape survivors presenting in Thika sub-county andNaivasha sub-county public health facilities?

ii) What psychological distress characteristics are found among rape survivors presenting in Thika sub-county andNaivasha sub-county public health facilities?

iii) What is the effect of ICLRTC intervention on improving positive psychological health outcomes among rape survivors in communities in Thika sub-county andNaivasha sub-county?

1.5 Objectives of the Study

1.5.1 Main Objective of the Study

To determine the effects of lay trauma counseling on rape survivors in communities in Thika sub-county andNaivasha sub-county.

1.5.2 Specific Objectives

i) To identify psycho-social health needs at baseline among the rape survivors presenting in Thika sub-county andNaivasha sub-county public health facilities.

ii) To determine survivors' psychological distress characteristics at baseline, 3rd, 6th and 9th months follow up among the survivors presenting in the Thika sub-county andNaivasha sub-county public health facilities.

iii) To assess the effect of the ICLRTC intervention on improving positive psychological health outcomes among rape survivors in communities in Thika sub-county andNaivasha sub-county.

1.6 Hypothesis of the Study

Null Hypothesis: There will be no significant difference in positive psychological health outcomes between rape survivors receiving the ICLRTC intervention and those in the Non-intervention group in communities in Thika sub-county andNaivasha sub-county.

1.7 Variables

1.7.1 Dependent Variables

a) Psycho-social health needs namely; Safety needs, handling Stress, Emotional support, treatment for Sexual Violation Injuries, and Satisfaction with post-rape services.
b) Psychological distress characteristics namely; Depression, RTS, Shame, Self-blame

1.7.2 The Independent Variable

The ICLRTC Intervention model

1.7.3 Effect Modifiers/Confounders

Selected social demographic characteristics included: age, gender, residence, level of education, marital status, religion and financial status.

1.8 Expected Positive Psychological Health Outcomes

(i) Re-establishment of adaptive coping mechanisms;

(ii)Disclosure of rape;

(iii) Help seeking and utilization of community counselling services.

1.9 Conceptual Framework: Interaction among Variables

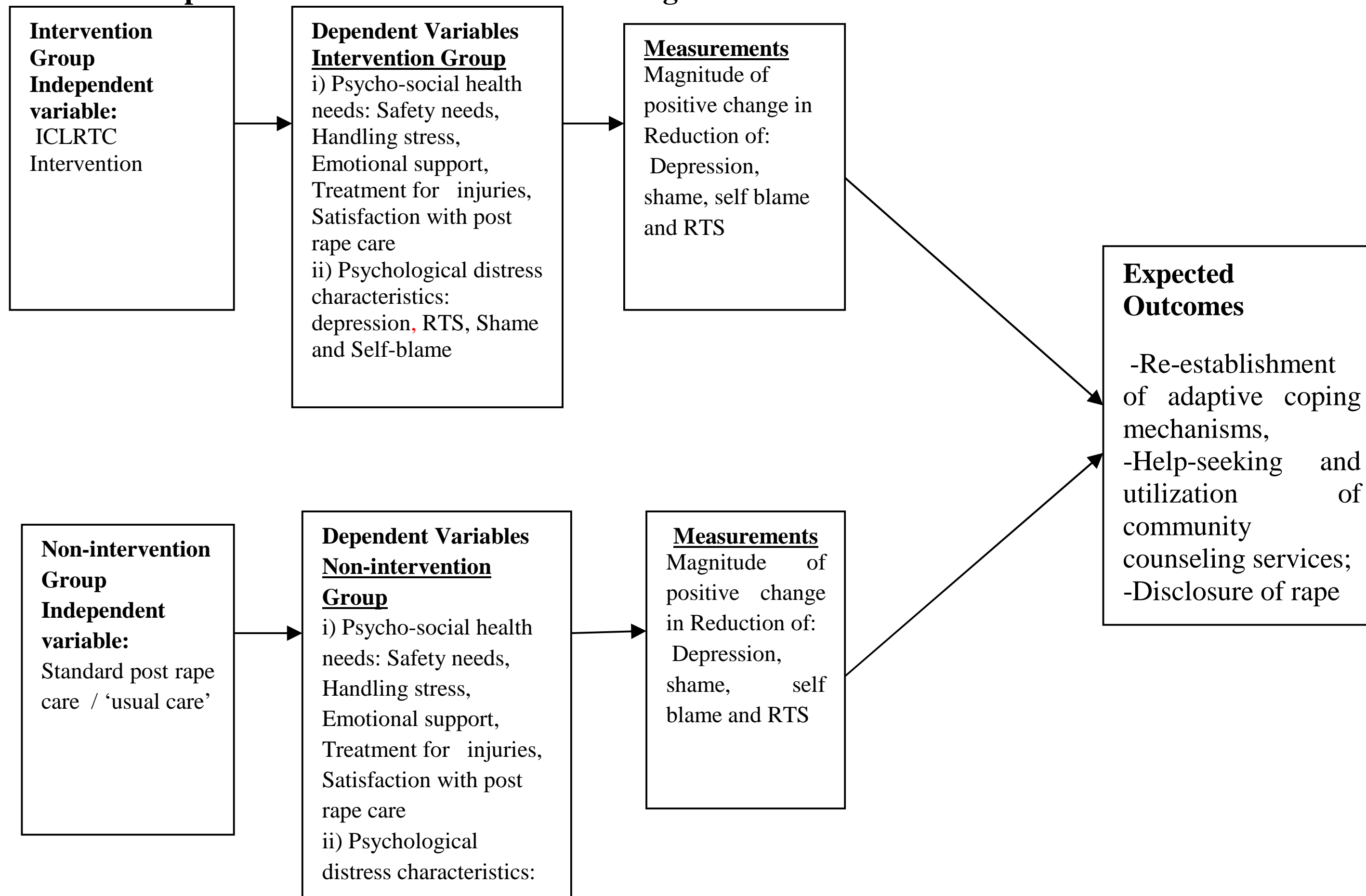


Fig. 1.1: Interaction among variables

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview of Rape

Rape is defined as "Penetration, no matter how slight, of the vagina or anus or any body part by a sex organ or object, or oral penetration by a sex organ of another person, without the consent of the victim (MoH, 2009). This includes rape of both male and female victims, and both heterosexual and homosexual rape. Sexual violation affects millions of people worldwide and represents a serious global public health problem. Risk factors, rooted in social injustices and inequities transcend geographical boundaries and individual differences (Verduin *et al*., 2013).

2.2 Global Records on Rape

Global records on rape are appalling and statistics indicate that one in five women have experienced rape in their lifetime (United Nations, 2013; Amnesty International, 2014; European Union Agency for Fundamental Rights, 2013). It is estimated that one in every four women are victims of rape, but because of the stigma associated with rape, only one in ten victims seek help (WHO, 2013). The report purports that in the USA rape occurs every 107 seconds, and that 1 in 10 male-male rapes are reported. About 3% of American men - or 1 in 33 men - have experienced completed rape in their lifetime. The case is not limited to America alone, but it is similar to every other part of the world (United Nations, 2013). The notion that men can’t be raped is probably one of the biggest myths ever. Findings of various studies (Amnesty International, 2014; United Nations, 2013; European Union Agency for Fundamental Rights, 2013; WHO, 2011) highlight child sexual abuse. About 19.7% girls and 7.9% boys face sexual violation (Harrendorf, Heiskanen and Malby, 2012). Most of the victims are either acquaintances or relatives of the perpetrator. The highest prevalence rate of child sexual abuse geographically is found

in Africa (34.4%) (Amnesty International, 2014; United Nations, 2013). Evidence from studies by (Amnesty International, 2014; United Nations, 2013; European Union Agency for Fundamental Rights, 2013; Harrendorf, Heiskanen and Malby, 2012; WHO, 2011); suggest that parents/guardians of children must always be alert and should engage in dialogues and discussions with their children, during which Knowledge about sex and sexuality as well as sexual violence can be shared between them. Only then, the child will be in a position to openly discuss such sensitive and important subjects with their parents.

According to United Nations (2012), the Western and European countries with highest incidence of rape cases / number of police - recorded offences (rate/100,000) are Sweden (63.5), Trinidad & Tobago (58.4), Jamaica (34.1), Korea (33.7), Bolivia (33.0), Costa Rica (29.8), Pakistan (28.8), Australia (28.6), Belgium (27.5), United States of America (27.3), New Zealand (25.8), United Kingdom (23.2), Brazil (24.9), Bahamas (22.7), Israel (17.5), (Norway (19.2), France (16.2), Finland (15.2), Kuwait (4.5), Palestinian Territory (3.0). In India, rape is on the increase due to decline in cultural values, and centuries' old Indian mythology (Naidu, 2007). According to Naidu, rape crime is an everyday tragedy which goes undetected as a result of non conviction of perpetrators.

In Congo, the UN record at least 200,000 cases of rape since 1996 when the conflict erupted in the region (UNAIDS, 2005); and South Africa has unenviable high rates of rape (Abdool and Brysiewicz, 2006; Jewkes and Abrahams, 2002). Research conducted in South Africa (Abdool & Brysiewicz, 2006; Christofides *et al.*, 2006); Christofides *et al*. (2005) reveal unenviable high rates of rape cases -500,000 per year.

The Kenya national incidence rate is low when compared with other countries having larger populations for example, South Africa Pakistan or even the United States; but the incidence is high compared to countries with approximately same size populations, for example. Uganda, Sudan, Tanzania, Morocco (United Nations Population Council, 2014). In Kenya, sex is taboo and therefore rape is not usually openly discussed in many communities. United Nations (2011) report that, only 15% of the total rape cases are

reported in Kenya. With this data, it can be assumed that more than half of the rape cases in Kenya are not reported (United Nations, 2011). In cases of rape, 15% of the victims are 12 years of age or younger, 29% of the victims are aged between 12-17 years, and whereas the rest are age 18 years and above (United Nations, 2011). Women aged 18-34 are the most victims of rape assaults (United Nations, 2011).

2.3 Aftermath of Rape

The impact of rape on victims is devastating.

2.3.1 Physical Effects of Rape

Evidence reveal rape victims suffer various rape associated physical injuries which include - minor bruises and chipped teeth in 33% of the victims, major injuries like gunshot wounds or broken bones in 5 % of the victims, and undetermined injuries in 61% of the victims (Amnesty International, 2011; United Nations, 2011). Survey report by U.S. Department of Justice revealed that 2% of all rapes result in the death of the victim, and that 32% of women and 16% of men raped since age 18 were physically injured in their most recent rape (Bureau of Justice Statistics, 2010).

2.3.2 Emotional Effects of Rape

Rape not only affects victims' physical health and well-being, but is also emotionally injurious (Walsh, Cross & Jones, 2012). Common symptoms post rape include anxiety, depression, lowered self-esteem, perceived loss of control and post-traumatic stress disorder (Erickson *et al.*, 2002; Garcia-Moreno, 2002; Campbell *et al*. 2001; Arata, 1999). Rape victims report phobic anxiety and avoidance and have difficulty escaping thoughts of the event up to one year post-attack (Campbell *et al.*, 2001). Rape victims often exhibit extreme fear of being alone or of strangers. Victims who had no previous sexual experience may develop debilitating fear of any future sexual activity (Foa *et al.* (2006)

2.3.3 Psychological Effects of Rape

Apart from the visible physical injuries, a victim undergoes countless psychological traumas from the rape incident. After the incident, victims are three times more likely to suffer from depression, six times more likely to suffer from post-traumatic stress disorder and four times more likely to suffer from low self esteem and to contemplate suicide (Verduin *et al.,* 2013; Campbell *et al.,* 2006). A high percentage of sexual violation victims experience a major depressive episode (Verduin *et al.,* 2013; Campbell *et al.,* 2006; Resnick *et al.*, 2005). Rape victims experience difficulty with post-victimization adjustment which exposes them to greater risk of re-victimization. In a prospective study, previous victimization was the strongest predictor of future sexual violation (Resnick *et al.*, 2005; Bulick *et al.*, 2001).

In a National Comorbidity Survey, rape trauma was found to most likely be associated with PTSD symptoms (Ahrens, *et al*., 2000; and Resnick *et al.,* 2000). The survey found that forty-six percent of women and sixty-five percent of men reporting rape developed PTSD. In another sample of sexually violated subjects, PTSD symptoms were most prevalent immediately after rape assault (Bulick *et al*., 2001).

2.3.4 Disease Burden from Rape

Undoubtedly, rape the heinous crime takes a toll on victims who report more frequent surgical procedures, poorer health perceptions, more emergency room visits and more hospitalizations (Amnesty International, 2014). Survey reports reveal that hospital emergency department personnel treat approximately 128,700 female adults annually for injuries related to rapes (Bureau of Justice Statistics, 2002). In 2009, 17.6% of rape victims received medical care in the United States of America, and they were most likely to receive medical care at an emergency room or hospital (46%), and next most likely to receive medical care at home or a neighbor's or friend's home (38.8%) (Bureau of Justice Statistics, 2010). SV is also closely associated with depression, guilt, low self esteem and anxiety disorders (Population Information Program, 2000). Other research

reports reveal that rape and childhood sexual abuse are among the most common causes of Post Traumatic Stress Disorder (PTSD) in women. The chances that a woman will develop PTSD after being raped are 50-90% (Centers for Disease Control, 2003). Research reveal that psychological injury results from 57% of completed rape, 37% of physical assaults, and 18% of robberies, and ranges from severe psychological disorder to emotional distress (Centers for Disease Control, 2003). For rape, the ratio of severe disorder to distress is 1 to 4, compared with a ratio of 1 to 8 for other crimes, and up to 20% of mental health expenditures are used to treat victims of violent rape crime (Centers for Disease Control, 2003). 25% to 50% of SV victims are likely to seek mental health services and victims often suffer lifelong physical manifestations of sexual trauma.

2.3.5 Costs of Rape

The costs of sexual violation are devastating and jeopardize the health of individuals and entire societies. Researchers have found it impossible to assess the economic toll of sexual violation. But reports available show that rape victims pay for sexual violation costs out of their own pockets, and the public pays through provision of services to victims and their significant others (United Nations, 2013). Survey reports by United Nations (2013) confirm public and private funds are spent on crisis services, medical treatment, and the criminal justice responses. Research evidence on burden of rape reveal the cost of rape crime to victims to be estimated at $450 billion a year when factors such as medical costs, lost earning, pain, suffering and lost quality of life were considered (Ustun *et al.*, 2004; Miller *et al.*, 1997; Miller *et al.*, 1996). An estimated $23 billion of the cost is attributed to lost productivity and almost $145 billion is because of reduced quality of life (Ustun *et al.*, 2004); Miller *et al.*, 1997). Violent victimizations account for 1/3 of all crimes, but account for 95% of the total cost of crime (Ustun *et al.*, 2004). Most of the cost is attributable to the intangible costs of the victim's pain, suffering and lost quality of life. About 12% of total mental health costs

are spent on rape crime victims (Mark *et al.*, 1998). Similar to these findings were results of a study by Greenberg *et al.* (1999) on annual cost of anxiety disorders. These researchers used multivariate regression analyses to analyze the costs associated with anxiety disorders. After demographic characteristics and co-morbid psychiatric conditions were controlled, the study estimated the annual costs of anxiety disorders to be approximately $42.3 billion or $1,542 per person. This figure includes nonpsychiatric medical treatment costs, psychiatric treatment costs, direct and indirect workplace costs, mortality costs and prescription pharmaceutical costs. Within the classification of anxiety disorders, PTSD and panic disorders had the highest rates of service use.

Rape causes loss of work time and productivity. Research evidence revealed that14% of rape victims lost time from work as a result of their victimization and illness; 28% of them lost 6-10 days (Bureau of Justice Statistics, 2002). Each year, victims of intimate partner rape lose an estimated 1.1 million days of activity, and the mean daily earnings lost are $69 (Bureau of Justice Statistics, 2010).

2.4 Post-rape Psychosocial Health Needs of Survivors

An alternative view defines needs in terms of nutriments (whether physiological or psychological) that are essential for survival, growth or integrity of the individual (Stork, 2008; Gansou *et al.,* 2006). This view of needs assumes that needs are innate rather than learned. If a need is innate - satisfaction is associated with people's growth and health, it is a need - if its satisfaction is not associated with such outcomes, it is merely a desire.

Self-determination theory (Stork, 2008) has proposed that individuals have three innate psychological needs; one of these is the need for relatedness, which concerns establishing a sense of mutual respect and reliance with others (Campbell *et al.,* 2006). Everyone is assumed to have these innate needs. According to Self-determination Theory (Campbell *et al.,* 2006), opportunities to satisfy the innate needs will facilitate self-motivation and effective functioning because they facilitate internalization of extant values and regulatory processes; and they facilitate adjustment because need satisfaction provides the necessary

nutriment for human growth and development (Liang *et al.,*2005). In contrast, thwarted satisfaction of the psychological innate needs will undermine motivation and have maladaptive consequences (Christofides *et al.,* 2006; Christofides *et al*., 2005; Moreno, 2002).

Review of the empirical evidence confirms that post - rape health needs are often the least met in low resource settings. As a result, survivors are bedeviled by psychological distress reactions and dysfunctional outcomes which soon become complex because culture shapes the way post-rape psychopathologies and symptoms are experienced and communicated (Christofides *et al.*, 2006; Christofides *et al.,* 2005). But, in the recent decades, there has been a proliferation of community rape crisis response programs. One aim of such programs has been to optimize the trauma counseling services that survivors receive in the aftermath of rape.

Globally, there is a move towards having specialized post rape services in an effort to improve psycho-social health care and support. This can be achieved by carefully selecting and training sensitive providers who focus on the holistic care of rape survivors (Ministry of Public Health and Sanitation/Ministry of Medical Services, 2009; Garcia-Moreno, 2002; WHO, 2003). The issues to be addressed post-rape revolve around accessibility of post rape services and consistency in the quality of health care provided. But, according to Campbell *et al.* (2006), the public health concerns should also be guided by the felt psycho-social needs/problems identified by the survivor(s) themselves.

Since the 1980's, researchers and practitioners have sought to understand how rape affects the psychological health of survivors. Researchers have also sought to develop effective psycho-therapies for promoting recovery. Most of the early research on sexual violation documented the types of mental health problems that rape survivors manifest and experience. And, more recent research has built upon that foundation to develop clinical interventions. Therefore, the purpose of this literature review is to find empirical evidence identifying psycho-social health needs which cause negative psychological outcomes and the effects of lay trauma counselling on psychological distress characteristics. Because

trauma of rape is routinely associated with extreme acute distress, survivors present with various psycho-social needs

The experience of rape erodes survivor's self-esteem and puts them at greater risk of a variety of negative psychological consequences. Evidence by Decker *et al.* (2013); Song (2012); Gracia *et al.* (2011) and Campbell *et al*. (2006), identified specific immediate post rape psycho-social health needs. For example, survivors present need to prevent sexually transmitted infections, HIV and pregnancy, need for reassurance, privacy, confidentiality, need for psychological support and for the management and documentation of sexual injuries, need to be heard and understood. In addition, other studies by Stork (2008); Gansou *et al.* (2006); Christofides *et al.* (2006); Christofides *et al*. (2005); Liang *et al.* (2005) identified other immediate psycho-social health needs among survivors', for example, need for non-judgmental support by the community (to minimize societal stigma) and need for easy access and availability of a trauma counselor.

Other earlier empirical evidence, for example, by Hustache *et al.* (2009); Campbell (2001), identified survivors' short-term psycho-social needs (Kantor, 2002). For example, need for non-judgmental support, for easy access and availability of a trauma counselor and to minimize stigma. Short term, intermediate to long-term psycho-social health needs were also identified by WHO (2005); Dunkle *et al.* (2004) include need for: informal and formal supportive responses; psycho education (to enhance acceptance of seriousness of rape crisis); disclosure of the rape ordeal, satisfactory self-image; preservation of relationships with family and friends; and preparation for uncertain future. For many survivors, these psycho-social health needs can be life long if the survivor does not get the Front Line Trauma Counseling. But unfortunately, some survivors mask these symptoms in order to cope with society. WHO (2002) recognized the need for evidence-based post-rape community service programming as an essential function for responding to post rape psycho-social health needs.

While much of the sexual violence activities focus around adults, emerging evidence suggests that children represent the disproportionate number of survivors currently

seeking psycho-social health care. Studies by Mildred and Plummer (2009); Coren, and Hutchfield (2009), show that children survivors have psycho-social health needs. For example, children have need for protection/safety, help for psychological healing, and need to participate in decision–making about post rape care. Other studies by Walsh *et al.* (2012); McPherson *et al.* (2012); McCloskey and Bailey (2000); Bennet *et al.* (2000); and Messman-Moore and Long (2000), found that rape among adults and male children is on the increase but social-cultural barriers hinder male child survivors from accessing the required post rape care services.

In Australia, a nationwide study to evaluate post- rape health services by Astbury (2006) revealed that service users commonly requested for counseling service and social support. A study by Ullman and Filipas (2001) also found common threads in the narratives of participants about their psychosocial health needs at the time of disclosure. For example, these participants expressed need for: safety and protection; emotional help whether this was months or years after the rape; emotional support; need to be believed by someone who was sympathetic; need to talk with other persons who had been raped; need for tips on how to sleep; need for anger management; need to make sense of what had happened (rape ordeal); and need to have their experiences validated. These studies found psychosocial care and support moderates long-term psycho-social health outcomes.

A number of studies (WHO, 2005; Dunkle *et al.,* 2004; Matsushita-Arao, 1997) have highlighted the social problems experienced by rape survivors. For example, rape survivors complain of being denied help by their communities and whatever help they receive often leaves them feeling rape incident is ignored. Second, survivors get hard pressed for rape details. Third, survivors get pushed to report the rape incident to police when he/she does not want to. Fourth, the perpetrator gets sympathized with. Fifth, survivors get judged, and lastly, everybody get to be told about the rape without their consent. The studies revealed other problems experienced by survivors. For example, survivors get pressurised to access counselling when not ready to; survivors are required

to answer questions about the rape when not ready; survivors are not believed about what they say about rape; lack of 'Gender Aware and Survivor –Centred' provider perceptions. Findings similar to results of these studies were revealed in a study by Ahrens and Campbell (2000), which found the process of disclosing a rape, either to family or friends or community service providers to be difficult because survivors were not always met with supportive responses. The findings revealed that survivors experienced a variety of negative social reactions from informal and formal help sources. For example, helpers do not recognize the harm done to the survivor. Second, helpers do not realise survivors' feelings about the rape are ok. Third, helpers do not respect survivors' need to express their feelings, nor let them choose what family members or friends they wish to disclose to. Fourth, helpers do not ask how best to support survivors; helpers do not acknowledge their limits. Fifth, helpers do not respect survivors' privacy. Sixth, helpers do not respect that survivors' healing may take time. Seventh, helpers do not respect survivors' space and energy, and lastly, helpers doubt and blame survivors. These negative social reactions and experiences have been associated with survivors' need for psychological help as they work through their post-rape experiences. These findings confirm results of earlier empirical evidence by Emm and McKenny (1985) which had revealed psycho-social needs of survivors. For example, survivors need to talk and think rape so that they can work through the experience; that the providers need to make it clear that they are available and willing to hear what the survivor has to say; that the providers need to show that they believe what the survivors are saying. The authors noted that **r**ape survivors often feel guilty and ashamed about the rape incident. Therefore, the survivors would like to hear that the rape was not their fault. The providers also need to believe that whatever the survivor did during the assault was the right thing to do because it saved her/his life. The study also revealed survivors' need to resume control over their bodies, feelings and lives. Survivors felt that providers should not tell them what to do nor put pressure on them to do things they are not ready for –especially having sex. Providers need to support survivors' choices, be patient with them, and avoid being overly protective which

reinforces survivors' sense of vulnerability and lack of control. The survivors' concerns about rape experience found in this study differ from the findings of a study by United Nations High Commissioner for Refugees (UNHCR, 2008); and Csete and Kippenberg (2002), among survivors of internally displaced persons (IDPs). The study tends to blame the fate of being in the camp for the post-rape psychosocial needs.

2.4.1 Post-rape Psychosocial Needs of Survivors among Internally Displaced Persons (IDPs)

A few studies (UNHCR, 2008; Csete and Kippenberg, 2002) among survivors in IDPs camps, found that survivors tended to blame lack of essential commodities while in the camp for their sexual violation. The study results revealed that women in transition camps acknowledged that psychological support and protection were best provided for survivors through community-based approach as a way of strengthening local social support mechanisms in addition to reducing any stigma from rape. The women also expressed a need for information on 'how to handle rape survivors' to be disseminated specifically to men and boys. In addition, the women and girls expressed need for secure and accessible reporting mechanisms in every IDP camp where survivors could report incidents of rape. Unlike the IDPs who could seek for any available psychological care and support within and without the transitional camps, the disabled survivors found it more difficult to access those community-based health services.

2.4.2 Post-rape Psycho-Social Needs among Disabled Survivors

People with disabilities are less likely to defend themselves from rape. Unfortunately, the healthcare system, especially in Kenya, has been found insensitive to their needs. The disabled survivors also find it more difficult to access legal-judicial services because, these systems have been found insensitive to the psycho-social health needs of people with disabilities (Frese et al., 2004). Frese *et al.* (2004) carried out an exploratory study among one hundred thirty six respondents with varying degrees of physical disabilities.

Results revealed that disabled people find access to post rape care impossible due to: lack of information, poverty and due to the negative social attitudes of the general public. These findings reveal how society ignores the disabled. Similar findings were revealed in other different studies carried out among Men who have Sex with Men (MSM) who, like the disabled, are equally judged and ignored by society because of social-cultural beliefs against homosexuality.

2.4.3 Post-rape Psycho-Social Needs among Commercial Sex Workers

In many African settings, the practice of MSM is often dismissed as un-African and against local culture. Therefore, many African countries have laws criminalizing same sex relationships. Studies among MSM by Basow and Thompson (2012); Choudhary *et al.* (2012); Franklin (2000); D'Augelli and Grossman (2001); Murphy *et al.* (2001); Golding *et al.* (2002), revealed that SMS had psycho-social health needs for: information on inherent dangers of anal sex; engendered friendly attitudes from providers; and policies that address their reproductive health needs. These studies revealed challenges that MSM experience every - day including: stigma, SMS conceal their sexual identities for fear of discrimination and violence from their families, health workers and law enforcement officers; and hostility from the public. The studies found these challenges were likely to hinder positive behaviour change among MSM.

A qualitative study among 96 female commercial sex workers by Mwangi and Jaldesa (2009) reported wide spread rape. The study found that rape among female gender of commercial sex workers was exacerbated by lack of legal support. The study also found female commercial sex workers had different psycho-social health needs including: to access timely and appropriate treatment; the need for clients to accept to use condoms; for protection from physical by from clients; for community support in order to reduce stigma and discrimination; and need to legalize prostitution to remove fear of police extortion and beatings because sex work is illegal in most African countries. The psychological and

behavioral responses of rape victims to incident of rape result to negative mental health outcomes.

2.5 Post-rape Negative Psychological Consequences

Research has focused on documenting and explaining the traumatic effects rape has on victims' lives. Apart from medical consequences of rape, rape can lead to psychological trauma and suffering. Sometimes this takes the form of mental health disorders whereas at other times it surfaces in less severe forms including but not limited to psychopathological responses. Not surprisingly, most victims exhibit high levels of psychological distress following sexual violation (Steine *et al.,* 2012; Verduin *et al.,* 2013).

The negative psychological consequences of rape are profound and long-term, permeating all aspects of life including intimate relationships, sexuality, parenting, studies or employment, and the ability to cope with other life issues (Campbell *et al.,* 2006). For many survivors, the psychological dysfunctional consequences of rape are even more serious than its physical effects.

Foa *et al.* (2006); Erickson *et al.* (2002); Garcia-Moreno (2002); Campbell *et al*. (2001) identified different types of post rape psychological distress characteristics namely; immediate psychological reactions (lasting minutes to hours); short-term psychological distress characteristics (which occur during the first three months post-rape); intermediate psychological distress characteristics (which continue three months–to one year post-rape); and long-term psychological distress characteristics (continuing longer than one year post-rape). Quality post-rape psychological First order intervention in the community plays a critical role in psychological recovery of survivors. Psychological support helps in supporting victim's transit from 'victim' (because each survivor responds to rape in different psychological dysfunctional ways) to 'survivor'.

Although the existing literature shows survivors' responses to be related in part to their own perceptions of rape, the issue of psychological dysfunctional responses certainly encompasses more than the connection between perceptions and response. In an effort to

improve the understanding of the responses of rape survivors to violation experiences, different researchers have used various frameworks for studying response patterns. One prominent approach supported by studies, for example, by Foa *et al.* (2006); Erickson *et al.* (2002); Garcia-Moreno (2002); Campbell *et al.* (2001) was to study responses according to the period of time since the sexual violation attack (i.e. immediate to short term to intermediate and long-term psychological distress characteristics responses). Immediate psychological reactions (lasting minutes to hours); short-term negative psychological distress characteristics (which occur during the first three months post-rape); intermediate negative psychological distress characteristics (which continue three months–to one year post-rape); and long-term psychological distress characteristics (continuing longer than one year post-rape).

According to Steine *et al.* (2012); Verduin *et al.* (2013); Gromisch (2009), the immediate negative psychological reactions to rape include dissociation (disorganization which include anxiety, anger); and disequilibrium (i.e. unpredictable and intense emotions, difficulty concentrating, denial, confusion, bewilderment, shock and numbness (avoidance behavior, and nightmares/flashbacks (intrusive thoughts about the rape ordeal)). These studies also identified short-term negative psychological distress outcomes (occur during the first three months post-rape) such as shame (which include denial, anger, non-disclosure), social adjustment disorder (which include self imposed withdrawal, low self-esteem, sexual dysfunction (which include lack of feelings of intimacy, sexual risk taking behavior, sexualized behavior in children)), inability to attach emotionally, and school/learning problems (drop in grades, incomplete home work) and behavior problems (aggression-fights, destructive behavior in children); self-blame (which include feelings of guilt, self-doubt, non-disclosure); rape trauma syndrome (RTS) that is, re-experiencing the trauma (uncontrollable intrusive thoughts about the rape), social withdrawal, avoidance behaviors (a general tendency to avoid any thoughts, feelings, or cues), and irritability (including hostility, rage and anger); depression (which include

denial/repression of feelings, fear, substance abuse, sleep disturbance, eating problems, loss of energy/exhaustion, and frustration/unhappiness). These studies further demonstrated that these short term negative psychological distress outcomes continued to long-term.

2.5.1 Immediate Post -rape Psychological Distress Outcomes

Experience of rape can be devastating. During rape, the activation of the sympathetic nervous system may serve to assist victims in escaping or fighting off assailants. Immediately following rape, numbing and stress-induced analgesia prevent responses to the pain of physical wounds (Feuer *et al.* 2005). From a clinical perspective, Osterman *et al.* (2001) observed that survivors of rape usually arrive at emergency service (e.g. casualty departments) in a psychologically overwhelmed state, which can be manifested in one of the three survival- mode functions, that is, anxiety (flight), anger (fight) or dissociation (freeze). Many survivors experience extreme confusion about what has happened to them. Earlier studies by Crome and McCabe (1995); Ullman and Siegel (1995); and Cohen and Roth (1987), found that most survivors of rape suffer from many uncomfortable sensations and perceptions which are in effect their interpretation of what happened during the rape ordeal. Survivors experience a state of numbness or shock because there are elements of confusion and bewilderment. These emotional reactions may be so overwhelming that many survivors deny the rape and its effects.

Another study by Resnick *et al.* (2005) found that in the acute phase, immediately following experience of rape, victims may express emotions such as fear, anger and anxiety, or may repress and control these feelings, exhibiting a calm and subdued exterior. These findings were supported by results of later studies by Jewkes *et al.* (2002; and Smith and Kelly (2001) who found that rape survivors commonly experience negative psychological difficulties such as heightened fear, disorganization and disequilibrium (unpredictable and intense emotions, difficulty concentrating), shock, confusion, and bewilderment. Another study by Resick *et al.,* (2005) found that immediately after a rape

episode, majority (96%) of victims described themselves as scared and worried, and exhibited physical shaking and trembling; 92% of respondents described themselves as terrified and confused. These researchers found that these negative psychological reactions lessened only slightly in severity two to three hours after the rape, when trauma symptoms of depression (exhaustion and restlessness) began. A qualitative study in Mexico by Saltijeral *et al.* (1998) documented dissociative behaviors, vulnerability, anxiety, unhappiness and anger as immediate post-rape responses of survivors. The duration and severity of these somatic and psychological symptoms vary among survivors, and research has clearly delineated the tremendous variability in the responses of rape survivors to their experiences. Gavey (1999) suggested that rape experiences may differ vastly from victim to victim and that, 'not all women are traumatized by rape'.

The risk of lasting psychological harm is greater in child sexual abuse if the perpetrator is a relative (i.e. incest), or if threats or force are used (Bulick *et al.* 2001). Incestual rape has been shown to be one of the most extreme forms of childhood trauma, a trauma that often does serious and long-term psychological damage, especially in the case of parental incest (Bulick *et al.* 2001). Because rape victims may suffer acute physical injuries during rape, Ahrens, *et al*. (2000); and Resnick *et al.* (2000) found that those who receive immediate medical care without trauma counseling were at increased risk of short term negative psychological distress outcomes.

2.5.2 Short to Long Term Post-rape Psychological Distress Characteristics

Beyond the immediate negative psycho-social effects of rape, studies have consistently documented the association between history of rape and short and long-term negative psychological distress problems, namely; Shame (low self-esteem, lack of motivation to seek help, lack of empathy, self imposed isolation, problematic moral behavior, display of anger, and aggression etc.); Self-blame (social isolation of survivor, inability to attach emotionally, feelings of guilt, avoidance coping); Depression (sleep problems, loss of energy, fear, eating problems, sexual dysfunction, exhaustion, frustration/unhappiness);

RTS (flashback and nightmares, anxiety, confusion, repression of feelings, attention problems).

2.5.2.1 Shame

Shame is the painful feeling of having done or experienced something dishonorable, improper or foolish. Feelings of shame are devastating and lead to social adjustment disorder in the long term. Leading researchers on the psychological causes and effects of shame point out ways in which shame can be destructive according to Breitenbecher (2006); Koss *et al.* (2002); Frazier (2003); and Whiffen *et al.* (2000). For example, survivors were found: to isolate themselves from other people; to display anger, and aggression. Tangney and Ronda (2002); and Koss *et al.* (2002) noted that shame has a special link to anger. In day-to-day life, when people are ashamed and angry, they tend to be motivated to get back at a person and revenge. In addition, shame was found to have a connection to psychological problems such as eating disorders, substance abuse, anxiety, depression, and other psychological disorders as well as problematic moral behavior. Survivors of rape often feel ashamed of the sexual violation. Some people mask these symptoms in order to cope with society. According to Messman-Moore and Long (2000); and Bennett *et al.* (2000); NIDA (2002), shame-prone children were found prone to: behavior problems including substance abuse, early sexual debut, risk taking sexual behavior, school/learning problems, and trouble with the criminal justice system. Unfortunately, in many cases these effects can be life long if the victim does not get community front line counseling care and support.

Research from earlier times has suggested that the use of avoidance coping that result in failure to seek help may manifest in negative psychological and behavioural sequelae such as low self-esteem, inaction, depression, and unsatisfying sexual relationships, attempted suicide and possible further victimization according to Santello and Leitenberg (1993); Frazier *et al.* (1995). However, other studies have documented that some coping responses by rape survivors, for example, organizing their lives around and avoiding cues

which include people, activities or memories that they have found to be distress-provoking may reduce the negative psychological distress outcomes (Foa *et al.* 1992). For example, a woman's age at the time of rape may play a role in her responses and subsequent adjustment. For instance, earlier studies by Sales, Baum and Shore, (1984); Ruch and Chandler (1983) found that older women have more difficulty in adjusting to rape events psychologically. Foley and Davies (1983) identified similar findings which they attributed to older women's reservations regarding disclosure owing to the fear of negative reactions from support sources.

Research has persistently found a relationship between being a victim of rape and subsequent alcohol and substance abuse (Kilpatrick *et al.* 1997). However, a later study by Kilpatrick, *et al*. (2000) suggested that the utilization of substances, e.g., prescription drugs and other modes of self-medication to aid sleep may be an attempt to resolve symptoms that are causing impairment of the daily functioning of survivors. Research has also identified other factors such as accessibility to alcohol and drugs, influence of peers, sensation seeking, alcoholic predisposition and risk, adherence to specific beliefs and expectations, and general arousal following consumption to contribute to the development of substance abuse after being raped (Peyser, 1999). Support groups are believed to be especially helpful to survivors because they decrease feelings of isolation, and encourage survivors to share their experiences and establish their own informal support networks (Bott *et al.,* 2004). Since rape originates from the community, it is in the community that the defense mechanisms against rape must be constructed. Survivors require community support in order to reduce stigma and discrimination which occur in form of verbal and physical abuse from the local community or close acquaintances.

Studies by Bletzer and Koss (2006); Jewkes *et al.* (2002), found that experience of rape reduces a survivors' ability to see their sexuality as something over which they have control. Survivors who experience rape in intimate relationships often find it difficult to engage in intimate sexual relationships again due to emotional injuries. However, other studies have documented that the use of avoidance coping that result in failure to seek

help may manifest in negative psychological and behavioural sequelae such as unsatisfying sexual relationships and sexualized behaviour in children (Bennett *et al.* (2000); Frazier *et al.* 1995; Santello and Leitenberg, 1993). Bletzer and Koss (2006) stated that effective community counseling interventions can assist survivors in the process of cycling through after-rape and improve participation in a world in which men and women share a co-presence, and the specific world of intimate relations that may have been curtailed by rape, and where first time sexual experience was postponed indefinitely.

2.5.2.2 Self Blame

Self blame is an act of attributing fault, censure, reproof or responsibility for anything deserving of censure. Self-blame is an important correlate of psychological functioning that is generally assessed as a form of coping (Verduin *et al.,* 2013; Breitenbecher, 2006; Filpas & Ullman, 2006; Frazier *et al.,* 2005; Gamble *et al.,* 2005). Researchers typically find a relationship between high self-blame and poorer emotional adjustment (Filpas & Ullman, 2006; Frazier *et al.,* 2005; Gamble *et al.,* 2005). High self-blame may be associated with increased severity and length of depressive episodes (Verduin *et al.,* 2013). Self-blame may also perpetuate depressive episodes in addition to serving as a symptom of an episode (Verduin *et al.,* 2013).

Although most investigators emphasize the maladaptive nature of self-blame, some researchers have investigated its adaptive effects (Branscombe *et al.*, 2003; Walsh *et al.,* 2012; Arnow, 2004). Self-blame may be adaptive to victims of rape or other severe trauma by reducing anxiety associated with control loss (Branscombe *et al.*, 2003). Thus self-blame may be associated with increases in perceived control and the psychological benefits that such increases confer (Walsh *et al.,* 2012; Arnow, 2004).

Self blame is among the most common of long-term effects of rape. It functions as an avoidance coping skill that inhibits the healing process. Studies by Verduin *et al.* (2013); Breitenbecher (2006), have found two types of self blame i.e. behavioral self blame

(undeserved blame based on actions) and characterological self blame (undeserved blame based on character). Victims who experience behavioral self blame feel that they should have done something differently at the time of rape, and therefore, the fact that they did not do it makes them feel at fault. Victims who experience characterological self blame feel there is something inherently wrong with them which have caused them to be sexually violated.

Behavioral Self blame is associated with feelings of guilt within the victim. The belief that one had control during the rape (past control) is associated with greater psychological distress, while the belief that one has more control during the recovery process (present control) is associated with less distress, less withdrawal, and more cognitive reprocessing (Steine *et al.* (2012); Filpas & Ullman (2006); Frazier *et al.* (2005); Gamble *et al.* (2005) reported that trauma counseling has been found helpful in reducing self blame, and that psycho-educational counseling help survivors learn about rape trauma stress. A helpful type of therapy for self blame is cognitive restructuring (cognitive reprocessing) where the victim is guided in taking the facts and forming a logical conclusion from them–a process that is less influenced by shame or guilt (Branscombe *et al.*, 2003). Results of studies (Walsh *et al.* 2012; Arnow, 2004), associated child sexual abuse with sexualized behavior, behavior problems and school/ learning problems.

Self blame has serious consequences on social life which can last to long term. According to Ahrens and Campbell (2000), most of the consequences are caused by re-traumatization of the rape victim through the responses of other individuals and institutions. Re-traumatization leads to secondary trauma which has variety of negative effects on the rape victim. For example, secondary trauma from responses from members of the society cause feelings of shame, self-blame and guilt, inability to attach emotionally, low self esteem, sexual dysfunction, social and self withdrawal. Rape is especially stigmatizing in cultures with strong customs and taboos regarding sex and sexuality. For example, a rape victim (especially one who was previously a virgin) may be

viewed by society as "damaged" (Ahrens & Campbell, 2000). Victims in these cultures may suffer social isolation, be disowned by family and friends, be prohibited from marrying, and be divorced if already married, or even killed by family because survivor is seen as a source of shame to the family (Matsushita-Arao, 1997). This phenomenon is known as secondary traumatization (re-traumatization).

Re-traumatization can also occur in institutions. For example, the victim is blamed for the rape by the health service providers. Community members in contact with the victim may also use inappropriate post-assault behavior or language (Campbell *et al.*, 1999). Secondary traumatization is especially common in cases of drug-facilitated, acquaintance, and statutory rape. In the context of rape, it refers to the attitude that certain victim behaviors (such as flirting or wearing sexually provocative clothing) may have encouraged the assault (Campbell *et. al.*, 1999). In extreme cases, victims are said to have "asked for it" simply by not behaving demurely. It has been proposed that one cause of victim- blaming is the ‘just world hypothesis’ (Matsushita-Arao, 1997). People who believe that the world is intrinsically fair may find it difficult or impossible to accept a situation in which a person is badly hurt for no reason. This leads to a sense that victims must have done something to deserve their fate. Another theory entails the psychological need to protect one's own sense of invulnerability, which can inspire people to believe that rape only happens to those who provoke the assault (Branscombe et al., 2003). Believers use this as a way to feel safer, that is, they believe if one avoids the behaviors of the past victims, one will be less vulnerable. Many of the countries in which victim blaming is more common, are those in which there is a significant social divide between the freedoms and status afforded to men and women.

Earlier researchers in psychology, nursing, and social work (Barkus, 1997; Holmstrom & Burgess, 1979a) demonstrated that husbands/ significant others, family, and friends of rape survivors are detrimentally affected by rape, and this effect is magnified among male partners of female victims. This makes rape survivors struggle not only with their own reactions to the rape, but also with how it is affecting those close to them. Research in

South Africa has suggested that survivors of marital rape may suffer more severe psychological trauma of a longer duration because they must live with their rapists (Nair, 1997). The study also noted that victims of repeated marital rape may suffer from learned helplessness as a consequence. Similarly, a study by Ahrens and Campbell (2000) found that rape stresses survivors' friendships with others because their friends often have difficulty understanding how and why survivors cope as they do post-rape. A community-based study to determine the benefit of trauma counseling was carried out by Wasco (2003) among 137 raped married or cohabiting women and 140 women who were both raped and battered. Results revealed that 15% of married or cohabitating women had improved wellbeing and coping following family support and as many as 60% of the raped and battered women who had multi-sessions of trauma counseling progressed better in wellbeing and had lower score of negative psychological outcomes. These findings indicate that trauma counseling decrease vulnerability to negative psychological outcomes among those at high risk of Self blame due to secondary traumatization.

2.5.2.3 Depression

Investigating the responses of survivors of traumatic incidents, Kimerling and Calhoun (1994) studied the experiences of victims one year after the incidents. The study found that survivors of rape had significantly higher levels of depression than non rape victims. In an earlier study in the USA by Burnam *et al.* (1988) on psychological effects of trauma, found that rates of depression and alcohol and substance abuse were higher among survivors of rape than among non-victims. The study also found that among those who developed major depression post-rape, 22% experienced this depression within the first year, and 40% within four years following rape, compared to 8% and 21%, respectively, of non rape victims. In contrast, a study carried out in Pakistan by Finney (2003) revealed higher mean measures of depression in rape survivors than in non-victims.

Researchers have investigated various interventions reducing the risk of depression. For example, a comparative study to determine the benefit of an early trauma counseling

intervention was carried out by Resnick *et al.* (2005), among 205 survivors, 97 of whom were in the video condition and 108 who received a standard care. Findings indicated greater decrease in depression among survivors in the video versus non-video groups. Finally, Resnick and colleagues (2005) reported that among rape victims with a prior history of rape, diagnosis of depression was significantly lower at 6-weeks post-rape among survivors who were in the video condition than among those in the Standard Care.

Results of studies by Nelson *et al.* (2002); and Dinwiddie *et al. (*2000) indicated that child sexual abuse can result in long-term psychopathology in later life. The findings revealed that psychological, emotional, and social effects included depression (Widom *et al.* 2007; Arnow, 2004), eating disorders, low self esteem, dissociative disorders, destructive behavior, criminality in adulthood and suicide (Whealin, 2007; Freyd, 2002; Arnow, 2004; Bulick *et al.* 2001).

Although suicide ideations as a response to rape is less common than other negative psychological consequences, the association between rape and suicide rates has been documented in many geographical areas including, Papua New Guinea, Scandinavia and the USA (Campbell, 2002; Mulugeta *et al.* 1998; Luster & Small, 1997). In a study based in the USA, researchers found a significantly higher rate of lifetime suicide attempts among individuals with a history of rape that had depression than in other population groups (Whiffen *et al.*, 2000: Davidson *et al.*, 1996). Other studies (Wiederman *et al.*, 1998; McCauley *et al.,* 1997) yielded similar results associating post-rape depression with suicide, even after controlling for sex, age, education, symptoms of RTS, and presence of psychiatric disorders.

2.5.2.4 Rape Traumatic Syndrome (RTS)

While RTS is associated with many different types of traumatic events (Gromisch, 2009), research has consistently shown that rape is one of the traumatic events most likely to lead to the diagnosis of RTS among survivors (Verduin *et al.*, 2013; Gromisch, 2009; Breitenbecher, 2006; Filipas and Ullman, 2006; Foa *et al.* (2006); Baker *et al*., 2005).

Studies by Martinson *et al.* (2013; Foa *et al.* (2006); and Nelson *et al.* (2002), have identified four major symptoms of rape-related RTS, namely; Re-experiencing the trauma (uncontrollable intrusive thoughts about the rape); social withdrawal; avoidance behaviors (a general tendency to avoid any thoughts, feelings, or cues); and irritability (including hostility, rage and anger). A study by Arehart-Treichel (2005); and Levitan *et al.* (2003), found RTS in children who had suffered sexual abuse manifested in anxiety disorders

Rates of life-time prevalence of RTS after rape have been found to range from 30 to 94% (Steine *et al.* (2012); Baker *et al*., 2005; and Galea *et al.,* 2002). Aprospective study by Breslau *et al.* (1999) of rape victims found that RTS characterized 94% of victims within 2-weeks post-rape, and 47% of victims within 3-months post-rape. Similarly, a study by Faravelli and colleagues (2004) in Italy found that rates of RTS among rape survivors were significantly higher than among survivors of other life-threatening trauma, 95% and 47% respectively.

Researchers have investigated various interventions reducing the risk of RTS. A study by Resnick *et al.* (2005) found that 94% of rape victims who reported to police or other authorities met symptoms criteria for RTS at 2-weeks post-rape and 50% continued to meet criteria 3-months later. Conversely, Foa *et al.* (1995) had earlier found a brief multi-session intervention (that included both imagined and in-vivo exposure) effective on RTS in the short-term among rape survivors. Results revealed significantly fewer subjects post-intervention met RTS criteria than those in the control group. Similarly, another study by Ozer *et al.* (2003) among rape survivors who had history of recent incident of rape receiving trauma counseling (an average of one month pot-rape) found that a multi-session front line trauma counseling intervention showed some efficacy relative to supportive counseling in the long-term.

2.6 Community Based Health Services Response to Post-rape Psychosocial Needs

In many settings, especially in developing countries, the health care system lacks sufficient resources to provide hospital or clinic-based services to rape survivors. Jewkes and Abrahams (2002) noted that in most developing countries such support is provided almost entirely by non-governmental organizations. However, access to these services has been found to be uneven and services can be particularly limited in settings where psychosocial needs may be greatest (most of the work being undertaken by local organizations, with limited number of trained TCs, clinical psychologists and other non-professional health workers).

Many hospitals and clinic-based services rely on referral networks to address the psychosocial health needs of survivors of rape. Campbell and Ahrens (1998) supported observations made by previous studies which had found that coordinated community programs helped survivors to gain access easily to psychosocial health care and support, and other forms of assistance. The authors identified three means by which coordination of efforts bring about improved support for rape survivors: a) improving context (i.e. replacing hostility, confusion and miscommunication with greater interaction and support between different kinds of service providers); b) keeping the perspective of the rape survivor at the forefront; and c) promoting the understanding of rape as a social issue.

McCaw and colleagues (2002) examined the effectiveness of referrals in addressing the needs of rape survivors in the USA and California. They found that women accepted and followed through on referrals for specific reasons. A related but somehow different approach described in literature by Morrison *et al.* (2004) was that of Women Police Stations (WPSs), which have been established in several Latin American countries. While the WPSs typically address the legal concerns of the survivors of rape, they also have links with state agencies and /or non-governmental organizations that provide other services such as psychological counseling. Evaluation indicated that women victims using WPSs have greater chances of receiving counseling and other services. However, it has

also been observed that the women police officers do not necessarily exhibit more supportive attitudes towards rape survivors than their male counterparts (Morrison *et al.*, 2004).

2.6.1 Rape Crisis Centers (RCCs) / Programs

Campbell and Martin (2001) noted that the basic services of RCCs include 24-hour services provision which include counseling (individual, group or support groups), legal and medical advocacy. RCCs typically rely on rape victim advocates who are often volunteers, with specific training in rape issues to help survivors navigate through the legal and medical systems. RCCs goal is to minimize any potential for re-traumatization of the survivor. Campbell and Martin (2001) found RCCs quite successful in helping victims obtain needed services and in buffering victims from victim-blaming personnel.

2.6.2 Historical Background to Post Rape Trauma Counseling Services in Kenya

The Kenya government health system operates an integrated (horizontal) approach to primary health care (MoH, 2007a). The responsibility for policy and capacity development in delivery of post rape care (PRC) services lies centrally with the government's Ministry of Medical Services (MoMS), division of Reproductive Health (RH). It functions through provincial and district systems, where the District Health Management Teams (DHMTs) are the primary units for planning and managing PRC services in the public health facilities.

Indeed, the range of skills and services that must be coordinated in order to deliver expedient, effective care to the rape survivor necessitates an integrated, multi-sectoral delivery model that may prove enormously challenging to health systems, particularly in under resourced settings (United Nations Population Fund, 2003). The other challenge is that the overwhelming majority of healthcare workers who currently provide post rape care had no specific training in the specialty (Kilonzo *et al.*, 2006).

Kenya has made important headways in laying a strong policy framework for addressing post-rape care services through the health sector. The Ministry of Health (MoH) worked in collaboration with various stakeholders to develop a health sector response to rape and sexual violence, which included development of a 'Standard of Care' for rape trauma counseling; and the 'National Training Curricular' for Rape Trauma Counselors in Kenya. Health facilities or crisis centers use the trauma counseling 'Standard of Care' (MoH, 2009), to guide Rape Trauma Counselors' practice during psycho-social care and support in health facilities.

The Second National Health Sector Strategic Plan of Kenya (SNHSSP-K II) (MoH, 2007a) recognizes the need to strengthen the health facility-community linkages. The SNHSSP II purport this is possible through effective decentralization of post rape services to the communities. The Ministry of Health views this as a community health service strategy to improve survivors' psycho-social health outcomes.

2.6.3 Community Based Health Services (CBHS)

The NHSSP 11 (2008-2012) re-introduced CBHC but has renamed it Community Based Health Strategy (CBHS). CBHS was launched in 2006 as one of the main strategies to carry out NHSSP-11. This approach was taken to ensure Kenyan communities are empowered with capacity and motivation to take up their essential role in health care delivery (MoH, 2007a). Service provision at the community unit (level 1) is organized in three tiers starting with household-based caregivers (adult members of the household) who provide the essential elements of primary health care in all dimensions and across life-cycle cohorts. These household-based caregivers are supported by Volunteer Community – Owned Resource Persons (CORPS) also known as Community Health Workers (CHWs) who are trained by MoH in many aspects of primary health care. One CHW supports 20 households. The CHW is in turn supported by a MoH trained and paid Community Health Extension Worker (CHEW). The CHEW is based at a public health

facility but assigned to supervise 25 CHWs to ensure acceptable standards of care at the community level. CHEWs are in turn supported and managed by a range of community structures and supervised under the DHMT. One objective of the community strategy is to strengthen health facility-community linkages in order to improve the health status of Kenyan communities. This is achieved through life-cycle focused health actions at household and community level (MoH, 2007a). To operationalize CBHS a series of activities have been carried out throughout the country. These activities include strengthening decentralized community health system, capacity building for CHWs and CHEWs, and strengthening intersects between facility-based and community-based health activities. Households and communities have an important responsibility to address rape survivors' psychosocial care and support at all stages in the life cycle. Therefore, community post rape care and support activities ought to be linked to health facilities for effectiveness and sustainability.

2.7 Psychological Counseling for Rape Trauma

Despite these negative psychological distress reactions and consequences, there has been consistent empirical evidence from earlier to recent researches which lament community-based post-rape psychosocial care and support services in most developing countries have been neglected (Hustache *et al*., 2009; Christofides *et al.,* 2006; Morrissey *et al.,* 2005; Gamble *et al.,* 2005; Christofides *et al.,* 2005; Morrison *et al.,* 2004; Wasco, 2003). These studies found that developing countries have limited resources which mean survivors have restricted options for post rape psycho-social services provided and these services were found to be of varied quality. This varying of quality of services is attributed to knowledge, attitudes and practice challenges faced by community health service providers as they try to meet the psycho - social health needs of rape survivors. The studies also found most developing countries neglect post rape psycho-social care and support services because of challenges. For example, the neglect is attributed to poorly developed

or unavailable community-based post-rape trauma counseling services, and the fact that majority of CHEWs and CHWs are untrained in psychological first aid, that is, First Order intervention in the community post rape. Yet, the negative post rape psychological consequences are profound and can be long-term (Steine *et al.*, (2012); Verduin *et al.* (2013). However, other authoritative western studies, for example, Hustache *et al*. (2009); Morrissey *et al.* (2005); Gamble *et al.* (2005); Wasco (2003); World Health Organization (2005), indicate that there is a strong relationship between community – based rape trauma counseling and prevention or reduction in psychopathologies among rape survivors. An observation supported by findings of a previous early empirical evidence by Burgess and Holmstrom (1979 b).

Kerr *et al.* (2003) described a 24-hours trauma counseling services offered by on-site staff dedicated to serving the psycho-social needs of the rape victims in a community-based health facility in London, England. Kerr and colleagues (2003) found that out of those patients who returned for various follow-up services, about 60% returned to seek counseling services and other psychosocial support. In an earlier study, Hague and Clarke (2002) describe efforts to improve the community health counseling and social response to survivors of rape as part of the Women Friendly Hospital Initiative in Bangladesh. This was a response to demographic studies indicating that 14% of maternal deaths in the area were associated with rape and sexual violence injuries. Conversely, an Action Aid study by Coren *et al*. (2008) to evaluate the impact of therapeutic support to children, adolescents and youth survivors revealed that majority of the survivors were resistant to traditional therapeutic methods, especially the young people, because they did not want to feel stigmatized by attending therapy sessions. But the interventions that were completely child-youth-focused (e.g. play, art and creative arts therapies, family and group work) proofed effective in meeting the needs of children and young people who were not able to engage in more traditional individual talking therapies. Whereas trauma counseling support seems to be an essential component of post-rape care, Gansou *et al.* (2006) purport there is no evidence demonstrating its benefits in low resource countries.

In many resource-poor settings, formal counselling services are not well or widely established. Therefore, according to Bott *et al.*, (2004), individual psychotherapy is a relatively high-cost intervention, and may not be a cost-effective or a feasible approach. In such contexts, community informal systems of support have been found to be of great value to the survivors. Bott *et al.* (2004) found support groups to be especially helpful to survivors because they decrease feelings of isolation, and encourage survivors to share their experiences and to establish their own informal support networks. In support of these findings, a study by Astbury (2006) found that reliable informal social support networks moderated positive psycho-social health outcomes among the survivors.

Counselors may use a combination of therapeutic approaches with survivors. A study by Campbell *et al.* (1999) found that major therapeutic approaches have been adapted and applied in post-rape trauma counseling. The common ones include Cognitive Behavioral Therapies, Cognitive Processing Therapy, Feminist Therapies, Relational Therapy, and Traditional Healing Practices.

2.7.1 Cognitive Behavioral Therapies (CBT)

Cognitive Behavioral Therapy refer to systematic desensitization, flooding, psycho-education, Prolonged Exposure Treatment (PE) and Stress Inoculation Training (SIT), all of which are aimed at systematically managing the memory of the trauma and cognitively reinterpreting it to reduce anxiety. Other cognitive techniques, such as challenging of automatic thoughts and cognitive restructuring, are sometimes used to decrease feelings of guilt, fear and depression.

Cognitive behavioral therapy consists of various applications. For example, cognitive behavioral treatments administered shortly after rape have been found to significantly improve survivors' functioning and to decrease levels of anxiety and depression (Bryant *et al.,* 1998; Bryant *et al.*, 1999). A study by Foa *et al.* (1995) found a brief, intensive multi-session CBT intervention has also been found effective in accelerating the rate of

improvement of rape – related psychopathology and in reducing depression in rape survivors who received trauma counseling within one month post-rape. Among the various approaches CBT, PE and SIT have received the most empirical support for treatment of post-traumatic stress distress (RTS) among victims of rape (Foa et al., 1999). Foa and colleagues (1999) compared PE, SIT and a combination of PE and SIT with a group on the waiting list. The study found that immediately following treatment and at 1-year follow-up, all three treatment groups experienced significant reduction in the severity of symptoms of RTS and depression compared to the group on the waiting list. Immediately after treatment, the PE group indicated more improvement in the area of general anxiety than other groups.

2.7.2 Cognitive Processing Therapy (CPT)

Cognitive Processing Therapy was designed to treat RTS resulting from rape. It consists of two components: cognitive therapy and exposure in the forms of writing and reading about the traumatic event (Resnick and Schnicke, 1993). Studies have demonstrated the effectiveness of CPT in treating RTS (Resnick *et al.*, 2002; Calhoun and Resnick, 1993). A study by Resnick *et al.* (2002) compared effectiveness of CPT and PE treatment on chronically distressed rape victims. Both approaches were found to significantly improve symptoms of RTS and depression compared to delayed treatment. Resnick and colleagues also noted that outcomes for both treatment approaches were not affected by the chronicity of the trauma, and that symptoms of RTS and depression were reduced equally after treatment. Compared to PE, CPT was more successful in remediating guilt cognitions in areas of hindsight bias and lack of justification, but was not as effective in decreasing global guilt or a general sense of wrongdoing.

2.7.3 Feminist Therapies (FT)

These therapies build on a feminist perspective that rape is a societal rather than an individual issue. The approaches of feminist therapies to recovery of psychological ill health following the experience of sexual violation revolve around helping the survivor to see her experience as part of a larger social problem.

Campbell (2001) asserted that whereas CBT deals with the immediate symptoms of fear and anxiety; feminist therapies address victims' more long-term feelings of guilt, shame and self-blame. The underlying rationale is that by helping survivors to see the societal aspects of what they have experienced, it is possible to reduce the guilt, shame and self-blame which are pervasive and often socially influenced.

She noted that many practitioners use elements of both CBT and FT in treatment interventions to reduce the short-term fear and anxiety post-rape as well as dealing with the long-term issues of guilt, shame and self-blame.

2.7.4 Traditional Healing Practices

Non-professional individuals who are believed to posses healing powers, sometimes called traditional healers, are consulted in many parts of the world for physical and psychological treatment in the aftermath of rape. Describing the experience of rape survivors in Uganda, an earlier study by Bracken *et al.* (1992) found that most African societies have an extensive network of traditional healers. This is because many forms of distress are perceived to have a supernatural dimension which cannot be adequately dealt with by modern medicine; survivors very frequently resort to such healers for help. The distress associated with trauma is often not conceptualized as a medical problem; therefore, local family networks and traditional healers are felt to be the appropriate agents to deal with it. However, the impact of these types of approaches has yet to be evaluated.

2.7.5 Relational Therapy: ICLRTC Intervention Strategy Theory

2.7.5.1 Theoretical Explication of Post-Rape Psychological Reactions

Crisis is generally defined as a temporary state of upset and disorganization, characterized by an inability to cope with a particular situation using customary methods of problem solving, and by the potential for a radically positive or negative outcome (Slakeu, 1984).

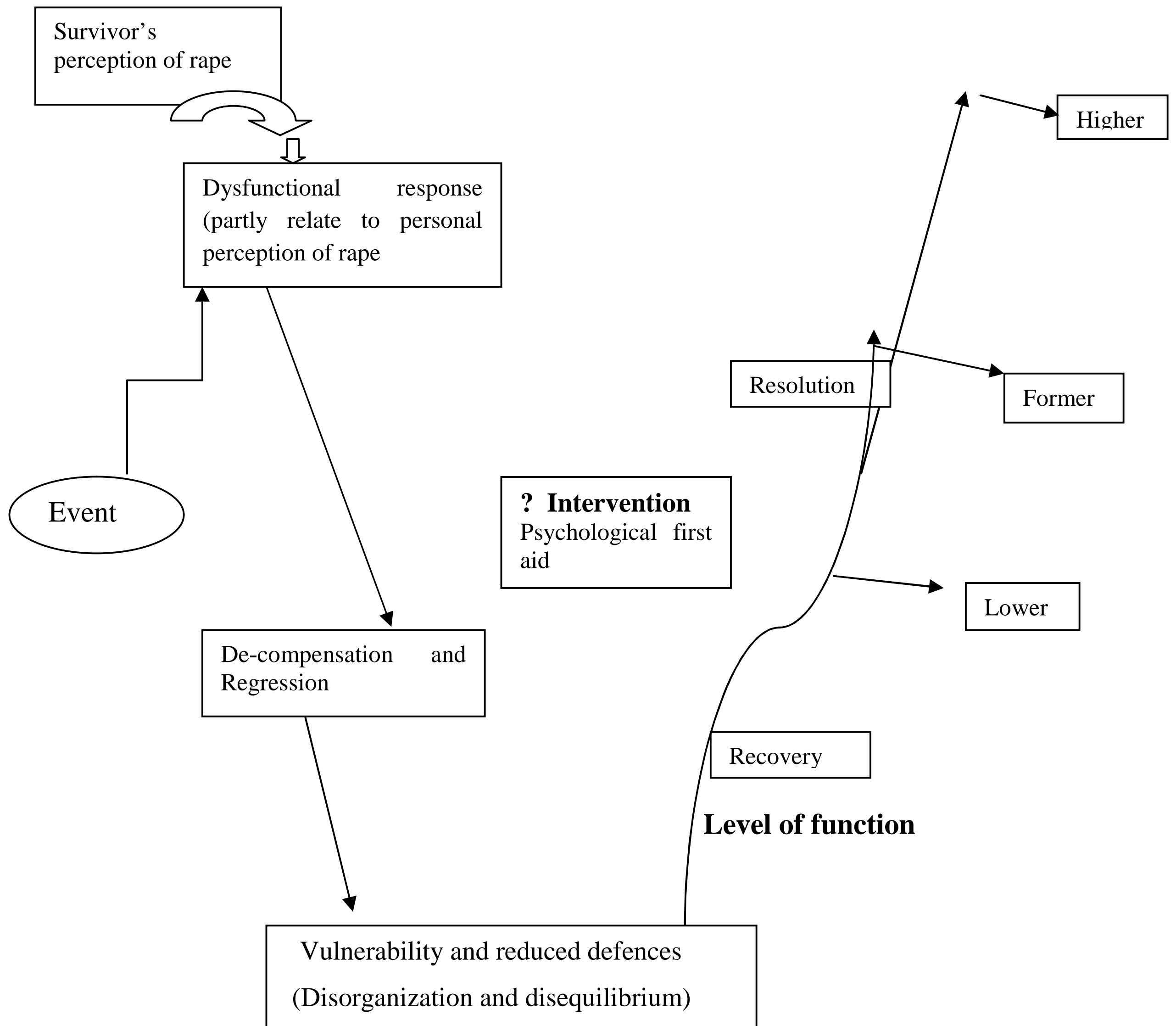
Crisis theory was developed out of studies on crisis in bereavement. It is derived from psychoanalytic theory and ego psychology (Kantor, 2002). The origin of modern crisis intervention dates back to Eric Lindeman (1942) and the Coconut Grove nightclub fire in Boston where 493 people died. His report on the psychological effects of mass deaths from the inferno on survivors and relatives/friends became the basis for theorizing on the grief process. These works focused on immediate, short term to intermediate intervention.

Caplan (1964) first formulated significance of life crises in adult psychopathology. Looking at the history of psychiatric patients he noted that during life crises, some individuals dealt with problems in a maladjusted way, and seemed to emerge from the event 'less healthy' than before. From these works, crisis centers and suicide hotlines popped up around the USA, often using peer counselors to give immediate intervention, followed by short term and intermediate psychological counseling intervention. This further incorporated the concept of outreach (in the nineteen sixties), and at the same time Community Mental Health models (CMMHCs) were developing mandating crisis services. The most significant components of CMMHCs include Pre-emptive intervention which is the primary prevention of negative consequences of a crisis; and early intervention which is the secondary prevention of negative outcomes following a crisis.

Crisis intervention has developed into the strategy of care at the time of severe disorganization resulting from trauma crisis. Crisis period is viewed as the most opportune time for immediate psychological first aid intervention because defenses and

the usual coping strategies are not working. Figure 2.1 below shows a presentation of individual response to trauma crisis.

INDIVIDUAL RESPONSE TO TRAUMA CRISIS



c Fig. 2.1: Diagrammatical Presentation of Individual Response to Trauma Crisis

(Source: Kantor, 2002)

2.7.5.2 Assumptions of Crisis Theory

According to Caplan (1964), the theory assumes that: existence of crisis is based on the individual; that usual coping mechanisms are proving to be ineffective; that crises can result from positive and negative events; that no one is immune to crisis in right circumstances; that crisis is time limited by definition; and that early intervention through immediate to intermediate psychological counseling can maximize return to normal function.

2.7.5.3 Systems Framework

Holmes and Rahe (1967); Burgess and Holmstrom (1979b) identified four typical phases of emotional reaction.

Phase I – The person has high anxiety in response to a traumatic event; if the mechanisms work, there is no crisis, if coping mechanisms do not work (are ineffective) a crisis occurs (denial, anger).

Phase II – anxiety continues to increase (shame).

Phase III - anxiety continues to increase and the person asks for help (guilt). (If the person has been emotionally isolated before the trauma they probably will not have adequate support and a crisis will surely occur). Phase IV – is the active crisis – here the persons inner resources and supports are inadequate. The person has short attention span, ruminates (goes on about it), and wonders what they did or how they could have avoided the trauma (remorse, grief and reconciliation). Their behavior is impulsive and unproductive. Relationships with others suffer. The phases may vary from person to person. The authors also identified different types of crises: situational life crises e.g., typical scenarios like rape; crisis of modern life; crisis in the schools; developmental life crises; transitional crisis; and preoccupations through the lifespan.

2.7.5.4 Principles of Crisis Intervention

First order intervention lasts minutes to hours to weeks and months, given by front line caregivers in the community in order to re-establish adaptive coping mechanisms and disclosure (Kantor, 2002). The second order intervention is referred to as ‘multimodal psycho therapy,’ also lasts weeks to months. Differences between components of the First and Second order interventions are shown in Table 2.1 below.

Table 2.1: Difference between First Order Community Trauma Counseling (FOCTC) Intervention Model and Crisis Therapy (Kantor, 2002)

First Order Community Counseling (FOCRTC) (First level intervention)	Crisis Therapy (2nd order intervention)
Venue - community setting	Health facility
Provided by lay community counselors (Front line Care givers - CHWs)	Psychotherapists and psychological counselors
Early contact/ not forced debriefings	Multi-modal crisis therapy
Easy availability and access to lay counselor	Time limited
Often generic or group oriented	More formal relationship
Attempt to minimize stigma	Subjective to survivor
Facilitates need to be heard and understood	Destabilizing
Supportive and non-judgmental	Taxed defenses
Goals: To re-establish adaptive coping and disclosure	Decision-making, Integration, Empowerment
Pre-emptive intervention -primary prevention	Assessment and psychotherapy
Early intervention –secondary prevention	Follow-up – tertiary prevention

2.7.5.5 Therapeutic Relationship during Crisis Intervention

The relationship is the therapy. According to Carl Rogers (1959), the essential qualities of a counselor (i.e. genuineness; accurate empathy, non-possessive warmth and caring, and the ability to communicate these attitudes to the survivor) help the survivors feel valued for themselves. A client treated in a genuine, non-judgmental and understanding manner will be able to understand oneself, liberate own resources, manage own life more effectively and will be able to transfer the learning to other relationships.

2.7.5.6 Techniques used in Therapeutic Relationship

The First level intervention trauma counselor uses self as an instrument (Kantor, 2002). Basic techniques are empathy, genuineness and unconditional positive regard shown through active listening, reflection of feelings and being available for the client. No diagnostic testing, interpretation, history talking, probing or questioning are done.

2.7.5.7 Reviewed Community Based Trauma Counseling Interventions

Morrissey *et al.* (2005) found community trauma counselling was helpful to survivors because survivors were able to develop life skills such as talking about sex with a partner; and ability to provide support to other survivors while preserving their own strength.

A twelve-month outcomes of trauma-informed community-based counseling intervention study by Morrissey *et al.* (2005) among 2,026 participants revealed significant differences between the interventional and comparison groups after 12 months of intense community trauma counseling intervention (with outcome measures on symptoms of depression, shame, Self-blame (guilt) and anxiety). Within group comparisons demonstrated high performance of intense community trauma counseling in the intervention arm. As demonstrated by the Chi-square value, participants in the interventional group had a higher magnitude of change in improvement of positive psychological characteristics than those in the comparison arm. Among those with severe trauma symptoms at baseline, proportionally more participants in the intervention group attained meaningful

psychological improvement. This suggests that community based trauma counseling intervention used in the study achieved results more quickly than ‘care as usual’ and the results were maintained overtime - up to one year of the intervention.

Bowling (2002) found community trauma counseling and social support as a key component for successful recovery from the psychosocial health problems among rape survivors. The study suggests that trauma counseling can include mechanisms to support survivors in interacting effectively with others in their social environments, and to integrate the survivors’ most immediate social network (i.e. family, friends and/or intimate partners) into the treatment. Bowling (2002), advices that community-based rape trauma counseling should be guided by individual survivor’s psycho-social health needs, problems and wishes. The author also observed that community trauma counseling can only be effective, if it is provided sensitively in a coordinated and timely manner to avoid psychological dysfunctional reactions and outcomes.

The study by Bowling (2002) compared community trauma counseling intervention with individual therapy, (with outcome measures on symptoms of depression, RTS, shame, self-blame and general family functioning) found that women victims who received weekly community trauma counseling intervention were significantly more likely than those who underwent individual therapy to experience a decrease in symptoms of depression, RTS and general family functioning. Within the group comparisons demonstrated high performance of the weekly community trauma counseling in the intervention arm. As demonstrated by Chi-square value, findings also revealed a higher magnitude of change in improvement of symptoms of depression, RTS, and general family functioning in the intervention arm. Therefore, trauma counseling is a key component in post- rape psycho-social care and support services.

2.7.5.8 Tools Commonly used to Measure Effects of Rape

i) Intrinsic need Satisfaction (INS Scale) (Baard, Deci, & Ryan, 2004)

The original scale (the Basic Psychological Needs Scale) has 21 items concerning the three needs for competence, autonomy, and relatedness. Scale addresses need satisfaction in general in one's life. Studies have shown the scale to be both reliable and valid (e.g., Baard, Deci, & Ryan, 2004), the scale correlated positively with psychological adjustment. The scale has 3 sub-scales –competence, autonomy and relatedness.

Limitation

Asking about satisfaction for each question lengthens the instrument and the diversity of questions reflects the difficulty of selecting appropriate answer categories.

ii)The General Health Questionnaire (GHQ) (Goldberg & Hillier, 1979)

The GHQ 12–item questionnaire that assess the extent to which survivors experience the presence of psychological distress or adjustment symptoms. The GHQ-12 has also been widely used in many countries for detecting psychological morbidity. The GHQ has been internationally validated with psychiatric and non-psychiatric patients in many settings (Brewin *et al.* 2002), in the UK English version (Ware, Snow, Kosinski and Gandek, 1993) and Chinese (Hong Kong) (Thumboo, Fong, Chan, Machin, Feng, Thio and Boey, 2002). GHQ questions took approximately 10 minutes. Each question scored 1 for 'yes' (if answer interpreted as symptom present) or 0 for 'No' (if answer interpreted as symptom not present). The GHQ leads to a score between zero and four; a higher score 2 and above reflected depression or RTS symptoms in each sub-scale, and a score equal or below one reflected absence of depression and RTS symptoms. The diagnosis made only after more than three months of ongoing symptoms during follow-up evaluation, because of delayed onset or a late exacerbation of the distress symptoms (Andrew, Brewin, Philpott & Stewart, 2007).

Limitations: The scale is partly an indicator of psychological stress and partly of physiological malaise. The scale may falsely interpret purely physical symptoms as reflecting a psychological disorder. Somatic symptoms may also not provide a consistent indicator of psychological distress across different social groups: respondents of a lower social class may both suffer more physical illness and tend to express psychological disorders in physical, rather than psychological, terms. The psycho-physiological items are more problematic: their interpretation varies from group to group, they are often closely associated with physical illness, and they are not strongly associated with the chances of receiving a psychological problem diagnosis.

iii) Rosenberg's Scale (Rosenberg, 1965)

The ROSE is a 10 item, self-report measure of shame (low self esteem). The ROSE has demonstrated high reliability has been internationally validated for use in sexual violation research (= .90, Rosenberg, 1979). High reliability was shown in a sample of undergraduates as well (= .88, Gray-Little & Williams, 1997). Sundin and Horowitz (2002) found the intrusion scales were highly reliable (intrusion =.86, avoidance = .80).

Rosenberg questions took approximately 5 minutes. Each question scored 1 for 'yes' (if answer interpreted as symptom present) or 0 for 'No' (if answer interpreted as symptom not present).The Rosenberg leads to a score between zero and four; a higher score 2 and above reflected shame symptoms and a score equal or below one reflected absence of shame symptom. The diagnosis made only after more than three months of ongoing symptoms during follow-up evaluation, because of delayed onset or a late exacerbation of the distress symptoms (Gray-Little & Williams, 1997).

Limitation of Rosenberg's Scale: The measure can be lengthy, time consuming (taking up to 30 minutes to complete), and complex. Close supervision is usually required to ensure satisfactory completion of the questionnaire.

iv) Attribution Rating Scale (ARS) (Arata, 1999).

The Attribution Rating Scale is a 25-item scale assessing the use of characterological, situational (behavioral) and societal self-blame. The ARS has demonstrated high reliability has been internationally validated for use in sexual violation research (Sundin and Horowitz, 2002). The authors also found internal subscale consistency was adequate in previous research - = .78.

ARS questions took approximately 5 minutes. Each question scored 1 for 'yes' (if answer interpreted as symptom present) or 0 for 'No' (if answer interpreted as symptom not present). The ARS leads to a score between zero and four; a higher score 2 and above reflected self blame symptoms and a score equal or below one reflected absence of self blame symptom. The diagnosis made only after more than three months of ongoing symptoms during follow-up evaluation, because of delayed onset or a late exacerbation of the distress symptoms (Sundin and Horowitz, 2002).

Limitation of ARS: The measure can be lengthy, time consuming (taking up to 30 minutes to complete), and complex. Its use is precluded for many purposes, either because sufficient time is not available or because research participants may refuse to complete the measure or do so only partially. Indeed, even when given adequate time to complete the measure, individuals may omit as many as 15% of the items, particularly those toward the end of the questionnaire. Close supervision is usually required to ensure satisfactory completion of the questionnaire.

v)The Trauma Symptom Checklist for Children (TSC-C) (Briere, 1996)

The Trauma Symptom Checklist for Children (TSC-C) was developed to identify abuse-specific issues (Briere, 1996). The TSC-C consists of 54 items with answers ranging on a 5-point scale. TSC-C has six subscales: anxiety, depression, posttraumatic stress, sexual concerns, dissociation, and anger. Internal consistency of each scale is very high, ranging from 0.80 to 0.92. The scale was adapted for this study and only eight items related to sexual violation were selected to make the depression and Rape Trauma

Syndrome sub-scales, which were used to identify reactions and likelihood of development of depression and Rape Trauma Syndrome in survivors of rape.

TSC-C questions took approximately 20 minutes. Each question scored 1 for 'yes' (if answer interpreted as symptom present) or 0 for 'No' (if answer interpreted as symptom not present).The TSC-C leads to a score between zero and four; a higher score 2 and above reflected depression and RTS symptoms and a score equal or below one reflected absence of a distress characteristics symptoms. The diagnosis made only after more than three months of ongoing symptoms during follow-up evaluation, because of delayed onset or a late exacerbation of the distress symptoms (Briere, 1996).

Limitation of TSC-C: TSC-C does not have a structured format in which specific issues are addressed in certain sessions.

vi) The Children's Attributions and Perceptions Scale (CAPS) (Mannarino et al., 1994)

The CAPS was developed by the investigators to measure certain abuse-specific issues in sexually abused children (Mannarino et al., 1994). The CAPS is a semi-structured interview which consists of 18 items; the child is asked to respond to each item on a 5-point Likert scale ranging from "never" to "always." The CAPS was developed without specific reference to abuse, so that it could be given to control subjects as well. Factor analysis demonstrated four subscales, including feeling different from peers (i.e., shame), decreased interpersonal trust, personal attributions for negative events (i.e., self-blame), and decreased perceived credibility (i.e., feeling that others do not believe you). Internal consistency ranged Treatment outcome predictors 987 from 0.64 to 0.73 for the individual scales. Test-retest reliabilities ranged from 0.60 to 0.82. The CAPS is conceptualized to measure factors which may mediate the development and maintenance of other behavioral and emotional problems.

The scale was adapted for this study and only eight items related to sexual violation were selected to make the shame and self blame sub-scales, which were used to identify

reactions and likelihood of development of depression and Rape Trauma Syndrome in survivors of rape.

CAPS questions took approximately 20 minutes. Each question scored 1 for ‘yes’ (if answer interpreted as symptom present) or 0 for ‘No’ (if answer interpreted as symptom not present). CAPS leads to a score between zero and four; a higher score 2 and above reflected shame and self blame symptoms and a score equal or below one reflected absence of a distress characteristics symptoms. The diagnosis made only after more than three months of ongoing symptoms during follow-up evaluation, because of delayed onset or a late exacerbation of the distress symptoms (Mannarino et al., 1994).

Limitation of CAPS: CAPS do not have a structured format in which specific issues are addressed in certain sessions.

2.8 Coping Responses among Survivors in the Aftermath of Rape

Coping has been defined as the use of cognitive and/or behavioral techniques to manage stress (Draucker et al., 2009; Filipas & Ullman, 2006). Coping can occur in anticipation of a negative event or be used as a tool to manage emotional responses to negative experiences. Two general types of coping have been identified in the literature, problem-focused and emotion-focused. Coping strategies influence emotional adjustment through cognitive appraisal, alteration of a situation's meaning and behavioral actions regarding the event (Draucker et al., 2009).

The association between coping and psychological functioning has been examined in many samples (Draucker et al., 2009; Filipas & Ullman, 2006; Ullman & Filipas, 2001). Researchers have found that coping mediates emotional responses to stressful life events Ullman and Filipas (2001). In one study, coping mediated all emotional responses except for worry and fear in young participants. Greater use of strategies such as planning and positive reappraisal were associated with positive mood states in older participants, and the use of strategies such as distancing were associated with less happiness (Ullman and Filipas, 2001).

A number of studies have demonstrated that in general, problem focused coping strategies are associated with positive mood states and emotion focused coping strategies are associated with negative mood states (Draucker et al., 2009; Filipas and Ullman, 2006; Ullman and Filipas, 2001). Some coping strategies may be associated specifically with greater depression likelihood (Draucker et al., 2009; Filipas and Ullman, 2006). Depressed patients used significantly fewer problem-focused coping strategies, such as support seeking, than did non-depressed participants in one study (Ullman and Filipas, 2001).

2.8.1 Adaptive Coping Strategies

Adaptive coping strategies – this refer to safe behaviours to reduce stress levels. A study by Draucker *et al.* (2009) documented that at 2 weeks post-rape, survivors who relied more on wishful thinking as a coping strategy were experiencing more severe symptoms of RTS than survivors who employed other coping strategies, for example, avoidance behaviour or acceptance of seriousness of rape. Conversely, earlier research by Foa *et al.* (1992) suggested that some coping responses used by rape survivors reduce the risk of RTS, for example, when survivors organize their lives around, or if they avoid cues like - people, activities or memories that they find to be distress-provoking. Ullman and Filipas (2001) also found coping responses such as positive distancing, optimism, and acceptance of seriousness of rape to reduce the severity of RTS symptoms. In contrast, research by Filipas and Ullman (2006) associated coping mechanisms with poor psychological outcomes. For example, the study found survivors employing coping mechanisms manifesting negative self-assessment, inaction, substance abuse and attempted suicide.

An earlierprospective study by Ullman and Filipas (2001) among rape survivors found a strong association between trauma counselling and quick recovery from psycho trauma post-rape when survivors used adaptive strategies (e.g. positive self- assessment), defences mechanisms (e.g. provision of a reason behind the rape), minimization (e.g. actively reducing thoughts of the rape incident), conscious suppression, dramatization and

proactive behaviour (e.g. changing residence). The study highlights that the use of adaptive coping strategies is an aid to successful recovery and in minimizing risks of further victimization. Filipas and Ullman (2006) recorded re-victimization rates for survivors who engaged in maladaptive coping responses as being twice as high as those for survivors who did not adopt these coping responses. However, earlier studies found older women have more difficulty in adjusting to rape events psychologically. For instance, a study by Ruch and Chandler (1983) found that a woman's age at the time of rape may play a role in her responses and subsequent adjustment. Foley and Davies (1983) also found similar findings which they attributed to older women's reservations regarding disclosure owing to their fear of negative reactions from support sources.

Coping techniques associated with less depression and anxiety post-rape include support seeking and activity (Filipas and Ullman, 2006). Rape victims in one study who coped with their assault by talking to others, writing about the experience or making significant life changes reported better post-rape adjustment (Draucker et al., 2009). In contrast to these findings, Filipas and Ullman (2006) found that greater use of active coping strategies (eg. expressiveness/social support seeking and cognitive restructuring) was associated with greater distress in victims of sexual assault. These researchers suggested that active coping may be associated with poorer adjustment in the short term but may gain efficacy as time passes post-victimization.

2.8.2 Explanation

Explanation is something that clarifies or makes clear, or the details or reasons that someone gives to make something clear or easy to understand. This coping strategy was first described by Ullman and Filipas (2001); Burgess and Holmstrom (1979a) and focused on survivors' identification of a reason for the occurrence of the rape. Although attempts by survivors of rape to make sense of their experience have been identified as an important component of recovery and an adaptive coping strategy, Filipas and ullman (2006); Lobmann *et al.* (2003) found self-blame as part of explanation not helpful to the

recovery process. They asserted that self-blame can allow the survivor to understand the event in such a way that they are able to regain feelings of control. However, research has consistently shown self-blame to be a hindrance to long – term recovery as reported by Frazier *et al.* (2005); Koss *et al.* (2002). On the other hand, earlier studies had found similar results. For example, Regehr *et al.* (1998) found behavioural self-blame to be unrelated to RTS symptom levels, but Arata and Burkhart (1998) found behavioural self-blame to be only marginally related to the severity of RTS symptom levels.

2.8.3 Avoidance

This refers an act or practice of avoiding or withdrawing from something. Research has suggested that some coping responses by rape survivors such as organizing their lives around and avoiding cues including people, activities or memories that they have found to be distress-provoking may reduce the risk of RTS (Foa, Zinbarg and Rothbaum, 1992). However, other studies have documented that the use of avoidance coping that results in failure to seek help may manifest in negative psychological and behavioural sequelae such as low self-esteem, depression, and unsatisfying sexual relationships, abuse of drugs or alcohol, and possible further victimization (Frazier, Klein and Seales, 1995; Santello and Leitenberg,1993). Conversely, it has also been found that effortful avoidance and numbing responses served to decrease distress caused by RTS (Taylor *et al.*, 1998; Litz *et al.*, 1997).

2.8.4 Help Seeking

This is defined as personal actions to promote optimal wellness, recovery, and rehabilitation. The issues to be addressed post-rape revolve around accessibility of post rape services and consistency in the quality of health care provided. But, according to Campbell *et al.* (2006), the public health concerns should also be guided by the felt

psycho-social needs/problems identified by the survivor(s) themselves. Post rape health services can be a negative and a dis-empowering experience for rape survivors. Literature suggests that victims' post-violation interactions with community service providers (e.g., nurses, doctors, police, and trauma counselors) may be traumatizing in its own way. This may partly explain the low levels of post rape services uptake. Research findings (Choudhary *et al.,* 2012; Gracia, Garcia and Lila, 2011) suggest that victims may present a wide range of issues and community service providers must be aware of the diverse negative effects of rape. Post rape services should be provided sensitively in a coordinated and timely manner to avoid such experiences and to encourage uptake of services. Therefore, it is essential for service providers' to understand survivors' post-rape health needs and how such needs can be prevented or minimized in order to inhibit psychological dysfunctional reactions which cause negative psychological distress outcomes.

Rape survivors often rely on both formal and informal resources for help and support. Formal avenues include police, health services, the criminal justice system, and legal remedies whereas informal avenues include talking to friends, relatives and clergy about the sexual violation. Help- seeking by the survivor goes through a process that includes defining the problem, a decision to seek help, and selection of a source of support (Decker *et al.,* 2013; Gracia *et al.*, 2011). Each of these stages is influenced by individual, interpersonal, and socio-cultural factors (Decker *et al.,* 2013; Gracia *et al*., 2011). According to Sabina *et al.* (2012); Nurius *et al.* (2011), help-seeking is best characterized by a dynamic process that responds to the changing context of the violated person.

Maier (2012); Basow and Thompson (2012); Christofides *et al.* (2006); George (2002); Jewkes and Abrahams (2002); Ullman and Filipas (2001); Nayak (2000); Ahrens and Campbell (2000), documented that rape survivors' experience a variety of negative social reactions from informal and formal help sources. For example, some helpers may not recognize: their limits, the harmful effects of rape, the need to respect survivors' need to express their feelings, the need for survivors to choose what family member or members

or friend they wish to disclose to, the need to ask survivors the best ways of getting support, survivors' need for privacy, that survivors' healing may take time, survivors need space and energy, and that survivors should not be blamed. Survivors often feel guilty and ashamed about the rape. Therefore, the survivors would like to hear that the rape was not their fault. These negative experiences have been termed 'the second rape' or 'secondary victimization'.

Even though survivors of rape seldom disclose their experiences immediately following the rape incident, most survivors communicate their victimization experiences to others at some point (Resnick *et al.* 2005). Survivors often seek support from informal sources such as family members, friends and church members, and a smaller portion of survivors seek formal support from Trauma Counsellors, legal and social services (Resnick *et al.*, 2000). Studies in the United States (Resnick *et al.*, 2005: Resnick *et al.,* 2000), found that American African women, in particular, prefer support from informal social networks to formal assistance. In Ghana, Amoakohene (2004); and Prah (1999), reported that disclosure of rape by both older and younger survivors was found primarily within the family, the extended family and friends. They found few survivors made a formal disclosure to the health system, police or department of welfare; and even fewer made formal disclosure to the available traditional systems such as chiefs or elders.

Earlier studies by Grasely *et al.* (1999); and Heise *et al.* (1994) revealed that rape victims made greater usage of trauma counselling services for up to two years post-rape than non-victims. They also found rape to be a more powerful predictor of visits to counsellors than other health-related factors such as alcohol use, smoking and age. However, Resnick *et al.* (2000) found that despite the physical health sequelae of rape and the increased use of medical services by survivors, there are still few rape victims who seek counselling services, especially immediately following victimization. The authors found that survivors who were seen for trauma counselling immediately after rape were likely to: have reported to the police or other authorities; have been raped by unknown assailants; have not consumed alcohol or drugs at the time of rape; have reported more physical injuries;

have perceived a serious threat to their lives; and to be concerned about pregnancy, STIs /HIV. In contrast, Mahoney (1999) found that survivors of acquaintance and marital rape were less likely to seek counselling support. In general, studies indicate that rape survivors recognize trauma counselling as an important element in their recovery.

The process of disclosing a rape, either to family and friends or community service providers can be a difficult process because survivors/victims are not always met with supportive responses. Ullman (1996a, b) documented that rape survivors experience a variety of negative social reactions from informal and formal help sources (e.g. survivors complain their report of rape is doubted or they are blamed for the rape incident). Conversely, Draucker and Stern (2000) found that informal and formal support networks post-rape have positive effects on survivors' recovery. These findings supported results of an earlier study by Routbort (1999) which found fewer rape-related psychological symptoms were noted in women who were able to talk freely about their experience, including those who experienced intimate partners' rape. While the decision to disclose rape experiences to formal or informal support networks allows victims to obtain the assistance necessary for recovery, survivors can face varying negative reactions such as victim-blaming and emotional withdrawal by survivors' partners. On the other hand, several studies document that supportive social systems which help survivors to disclose rape experience are related to lower psychological distress levels and better physical health (Golding *et al.*, 2002; Shalhoub-Kevorkian, 1999; Kimerling and Calhoun, 1994).

Current research has not provided definitive explanations for these low utilization rates, but two general possibilities have been considered. First, individual- level explanations focus on how the trauma of the assault causes severe anxiety, depression, and self blame, which interfere with proactive attempts to seek therapeutic services (Campbell *et al*. 2001; Foa and Rothbaum, 1998; Hartman, 1995). Second, other researchers have focused on extra-individual factors. Institutionalized racism and classism in social systems may deter survivors from low social-economic strata from seeking services (Christofides *et al.*, 2006; Christofides *et al*., 2005; Csete and Kippenberg, 2002;

Campbell *et al*., 2001). Although the reasons for low service utilization are not well understood, both individual and extra-individual factors probably contribute to survivors' decisions to seek psychological care services. In addition, it is possible that some survivors may not seek psychological services because they do not feel they need such assistance due to their own resiliency and or support they are receiving from their informal networks. As a result, it should be remembered that those who do obtain counselling/therapy are a self-selected group and may differ in unknown ways from others in the population of rape survivors.

There is growing evidence that community service providers, including trauma counselors, may engage in victim-blaming behaviors that significantly exacerbate victims' distress (Christofides *et al.*, 2006; Christofides *et al*., 2005; WHO, 2004) . Concerns about the helpfulness of psychological health services may prevent some survivors from seeking assistance. This is evidenced by varying results across studies (Chiara *et al.*, 2012; Li-Yu, 2012; Ullman and Filipas, 2001), indicated low rates of trauma counseling services utilization, but it appears that approximately 25%-40% of rape victims seek psychological health care.

2.9 Post -rape Care Providers' Knowledge of Rape Trauma Counseling

Health care workers providing post-rape services must be aware of the wide variety of issues rape survivors may present during help seeking. The impact of psychopathologies as consequences of rape cannot be ignored by community health workers.

A growing body of research including Campbell and Raja (1999); Campbell *et al.* (1999) suggest that rape survivors are often denied help by the formal support systems, and even if they receive help, they are often left feeling blamed, doubted, and re-traumatized. These authors found that many community health providers may be engaging in harmful counselling practices, suggesting that victims' well-being may be affected not only by rape itself, but also by post-rape help-seeking interactions. These studies recommended additional training in trauma counselling for health providers in order to address the

problem of secondary trauma. Research conducted in industrialized countries by Campbell *et al.* (2001); McCauley *et al.* (1998); and in South Africa by Sufla *et al.* (2001), highlighted how community counseling health services can be a source of negative and disempowering experience for rape survivors because of: victim-blaming, emotional withdrawal, and doubting of survivor's report by service providers. This may partly explain the low levels of efforts to improve counseling services particularly in developing countries. These findings were supported by results of a study in South Africa by Christofides *et al.* (2005) which highlighted survivors' value for sensitive trauma counselors. The study findings revealed that survivors were willing to trade off time taken to access services (time travelled) for an attribute such as sensitive trauma counseling. The findings of this study indicate that rape survivors value services run by sensitive care providers who have received special training in trauma counseling. Such providers understand the psychosocial impact of rape, rather than providers who seek to provide the geographically accessible post-rape services.

A study by Coren and Hutchfield (2008) to evaluate psychological outcomes among post-rape children and young people in England revealed a strong association between long-term positive psycho-social outcomes and training of providers in 'child and family-focused' trauma counseling. Trauma counselors were found to enable children/young people find an emotional language and a sense of identity and belonging which promoted social and behavioral stability.

CHAPTER THREE

3.0 MATERIALS AND METHODS

3.1 Study Sites

This study was carried out in sites A-Intervention (Thika sub-county) and B-Non-intervention (Naivasha) (see appendices H and I), the communities served by the two public hospitals from March 2012 to February 2013. The study sites were in two different locations separated by a buffer zone to prevent contamination of the intervention.

The two public hospitals were selected from among 19 public hospitals supposed to deliver integrated PRC services (post rape services delivered in one day at the same hospital) through specialized Trauma Counselors. But on ground check, the Principal Investigator found that although the 19 public hospitals had specialized Trauma Counselors who were supposed to deliver PRC services, only 5 public hospitals had a room space in the CCC where Trauma Counselors could attend to post rape survivors and give trauma counselling sessions. Majority of those 19 hospitals delivered PRC services in a work area (without privacy), where other patients were being attended to. Thika sub-county Level 5 hospital, Naivasha sub-county level 5 hospitals were found to have specialized Trauma Counsellors working at the CCCs, adequate and appropriate infrastructure for trauma counselling. The third hospital which was offering integrated PRC services was used to test the study tools. Two other hospitals were a long distance way from PI's residence which would have been very expensive to monitor and evaluate the research process. The other reason for selecting the study hospitals was because they had high numbers of rape cases recorded. Thika sub-county 150 cases per month andNaivasha sub-county 120 rape cases per month. With these records of rape cases, the PI was sure to recruit required sample within the recruitment period. From the available data, the prevalence and incidence of rape in the selected study communities was high when compared with other regions nationally. According to estimated rape incidence rates

and prevalence statistics from the Kenya Police (Kenya Police Crime Report, 2013) province ranked as follows: Rift Valley (24.8) 10,044 cases, Eastern (15.7) 6,359 cases, Nyanza (14.7) 5,954 cases, Western (12.2) 4,941 cases, Central (11.5) 4,658 cases, Coast (8.8) 3,564 cases, Nairobi (8.4) 3,400 cases, North Eastern (3.9) 1,580 cases. The incidence and prevalence estimates are conservative and indeed the figures could be more than three times higher if unreported cases are included.

3.1.1 Site A: Intervention Site

Intervention site covered the then Thika sub-county District (now divided into Thika sub-county and Ruiru sub-counties). These are now sub-counties in Kiambu County (appendix H). These three districts served as catchment area for the Intervention site. The Intervention site division was identified on the basis that it has many large coffee plantations where labour is provided mostly by women and children. The division has thriving illicit brew businesses. The hospital offers integrated post rape services.

Thika sub-county sub-county has a population of 200,000 persons according to the last Kenya census 2009.The area has a moderate tropical climate with sunshine most of the year and typical average temperatures of 25^0C during the day. Thika sub-county Town, an industrial town is the main urban centre of this area. The main economic activities include agricultural processing, particularly in horticulture and pineapple, macadamia nut processing, coffee, cooking oil and animal feed processing. Other industries include textile, flour mills, leather tanning, motor vehicle assemblies, cigarettes and industrial chemicals manufacturing among others. The service sector is well represented with the establishment and growth of a number of educational and financial institutions. In the Intervention site, Intense Lay Rape Trauma Counseling intervention was given by Community Health Workers (CHWs) in the households/community in addition to the standard ('the usual') post rape care.

3.1.2 Site B: Non-intervention Site

Non-intervention site coveredNaivasha sub-county division (nowNaivasha sub-county sub-county) located in the then Nakuru District (now Nakuru County) (appendix I). In theNon-intervention site survivors received only 'the usual care' or Standard post rape care in the CCC and in the community. They did not receive the ICLRTC intervention. The hospital offers integrated post rape services.

Naivasha sub-county has a population of 224,141 persons according to the Kenya census 2009.Naivasha sub-county sub-county is a dry semi-arid area with seasonal rains and water springs located high in the mountains serving as the main sources of water. The main economic activities ofNaivasha sub-county division include agriculture especially floriculture and tourism with its popular tourist attraction sites such as The Hells Gate national park and resorts, lake Nakuru national park with bird watch sites and resorts. The service industry is also well represented with many hotels and camp sites being established. The division has thriving illicit brew businesses.

3.2 Study Design

Aprospective quasi-experimental study was carried out to identify psychosocial health needs, selected psychological distress characteristics, and to evaluate the effects of an Intense Community Lay Rape Trauma Counselling (ICLRTC) intervention in improving positive psychological health outcomes among rape survivors aged 6 years old and above (see figure 3.1 below). The investigation utilized the quasi-experimental study design because it offers an opportunity to study two groups - the Intervention andNon-intervention groups, without necessarily randomizing the study subjects (Cook and Campbell, 1979). A register was developed with adequate personal details of all interviewed study respondents, which was used in tracing interviewees during the intervention and post-intervention periods.

POST RAPE PSYCHO-SOCIAL CARE AND SUPPORT: A COMMUNITY BASED INTERVENTIONAL STUDY

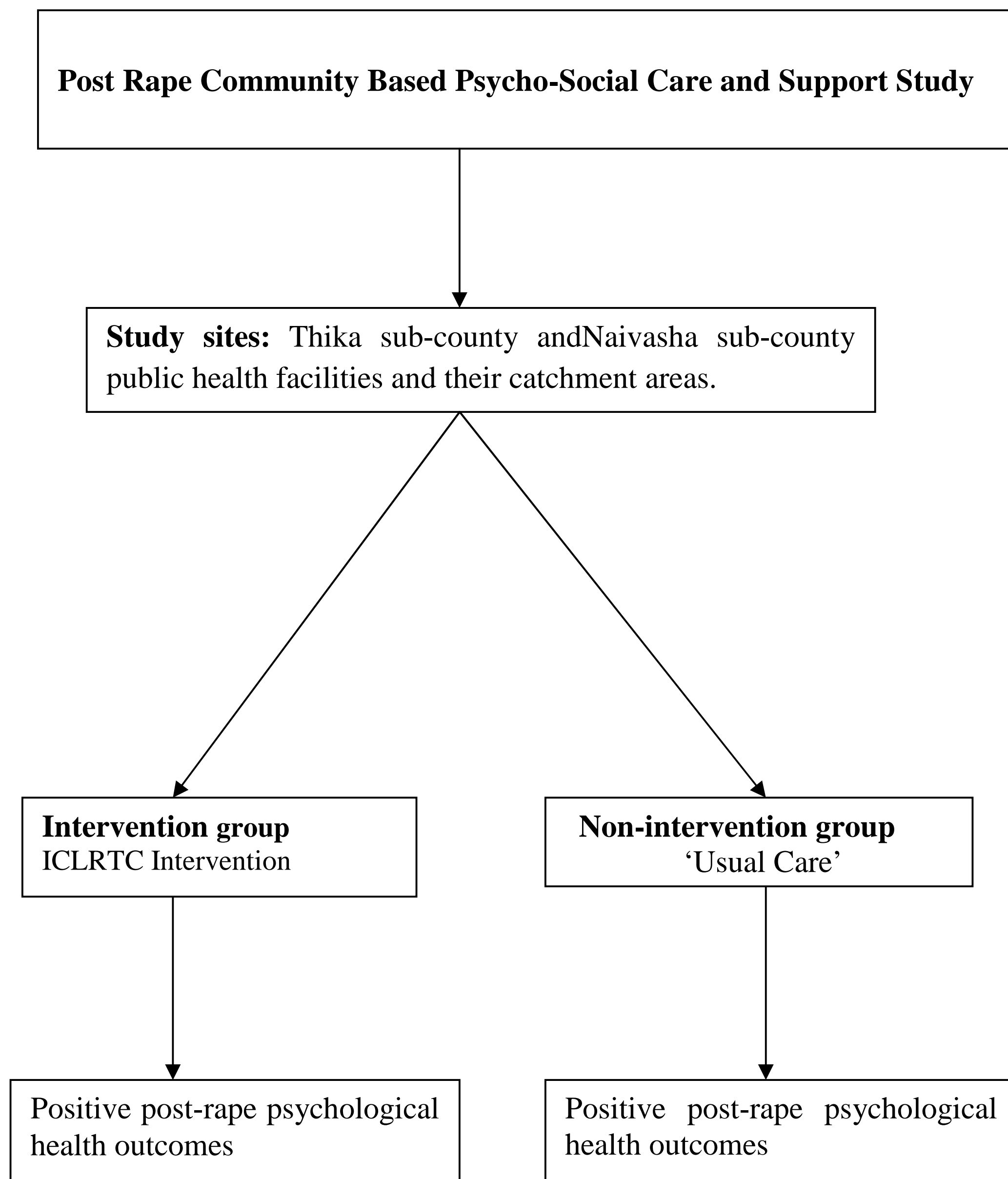


Fig.3.1: Diagrammatical Presentation of the Psycho-social Care and Support Study

3 .3 Study Population

The study population was rape survivors aged 6 years old and above who met the inclusion criteria. The study population had different characteristics in the two study sites.

3.3.1 Inclusion Criteria:

- Rape survivors aged 6 years old and above.
- Permanent residents only
- Survivors who presented to the hospitals within one week post rape.
- Survivors who signed the consent form (see appendix D_1; or child survivors for whom parents /guardians signed (see appendix D_2).
- Children 12-17 years old who passed the comprehension test (see appendix E).

3.3.2 Exclusion Criteria

- Survivors with history of abuse substances or in rehabilitation
- Survivors with history of psychiatric care
- Survivors, who were mentally challenged
- Survivors who sustained severe sexual violation injuries
- Visitors or survivors on transit
- Child survivors 12-17 years old who failed the Comprehension Test.
- Children aged below 6 years
- Survivors and parents/guardians of child survivors who declined to sign the consent form.

3.4 Sampling

3.4.1 Sampling Method

Rape survivors were recruited as they presented at the CCCs of each public hospital of the selected study site (census recruitment) and progressive phase out.

3.4.2 Sample Size Determination

Sample size was calculated based on the proportion of rape survivors experiencing at least two symptoms of each of the four psychological distress characteristics. Since no similar study had been done to estimate the prevalence of at least one of the four mentioned psychological distress characteristics in the study sites (Naivasha, Thika sub-counties public health facilities), the study proposed to use a 50% proportion of survivors with at least two symptoms of each of the four mentioned psychological distress characteristics visiting the Non-intervention site (Naivasha sub-county public health facility) and 30% of survivors with at least two symptoms of each of the four mentioned psychological distress characteristics visiting the Intervention site (Thika sub-county public health facilities). The proposed effect size was therefore 20%. The minimum sample size was calculated using Casagrande, Pike and Smith (1978) formula as follows:

$$n = \frac{\{Z_{1-r/2}\sqrt{[2P(1-P)]} + Z_{1-s}\sqrt{[P_1(1-P_1)+P_2(1-P_2)]}\}^2}{(P_1-P_2)^2}$$ (*Casagrande et al; 1978)*

Where;

n= The minimum required sample size

= Type I error (0.05)

= Type II error (0.10)

At 95% confidence interval, $_{1- /2}$ = 1.96

At 90% power, $_{1-}$ = 1.28

P_1= Estimated proportion of rape survivors receiving standard treatment (Non-intervention site) but still experiencing at least two symptoms of each of the four psychological distress characteristics after 9 months of follow-up (50%).

P_2= Estimated proportion of rape survivors receiving a new intervention in addition to standard treatment (Intervention site) but still experiencing at least two symptoms of each of the four psychological distress characteristics after 9 months of follow-up (30%).

(P_1-P_2)= The proposed effect size (20%)

$$P = \frac{P_1 + P_2}{2}$$

The proposed sample size for one group was 124. Allowing 5% attrition, the sample size was adjusted upwards to 128 for the intervention arm. A ratio of n: 2n for Intervention: Non-intervention was used in determining the number. A further upward adjustment was done for the Non-intervention group. Therefore, the minimum sample size was n=410. At baseline, the actual numbers for Intervention: Non-intervention groups was 128: 282 respectively (n=410 total participants). A power analysis revealed that the study was at 91% power.

3.4.3 Recruitment of Respondents

The study was done in two widely separated study sites to prevent contamination of the intervention.

Steps1. Health service providers (including members of DHMT, clinical officers, Professionally Trained Trauma Counsellors, Reproductive Health Coordinator,

Community Strategy Coordinator, CHEWs) in the two selected study hospitals were selected and sensitized about the study.

Step 2. Training:

a) Half day training of Trauma Counsellors in each of the study sites on how to use the mental health assessment tools.
b) One day in-house training of CHWs and CHEWs in basic trauma counselling skills and ICLRTC implementation and record keeping in the interventional site
c) One day in-house training of CHWs and CHEWs in community follow-up and record keeping in then on-intervention site

Step 3: When rape survivors presented in the selected study hospitals, they were assessed and treated by clinicians

Step 4: After clinical evaluations and treatment, clinicians referred survivors to CCC for trauma counselling.

Step 5: At the CCC, Trauma Counsellor (s) trained about the study gave usual trauma counselling to rape survivors after which, the option of joining the study was introduced.

Step 6: All survivors were recruited 72 hours post rape.

Step 7: Survivors who volunteered to join the study were screened by the Trauma Counsellors using the inclusion and exclusion criteria.

Trauma Counsellors consecutively recruited adult survivors and child survivors accompanied by their parents/guardians in the study. Consecutive recruitment allowed inclusion of different survivor age groups, gender and geographical locations which sufficiently represented the target population (for example, different gender, age groups, and residence e.g. survivors from urban, peri-urban and rural areas) for the purpose of answering the research questions (Hulley *et al.*, 2007).

Step 8: Survivors 18 years old and above who met the inclusion criteria signed the informed consent form with the Trauma Counselor (see appendix D_1).

Step 9: If the survivor was aged between 12 – 17 years old, the Trauma Counselors administered the 'Comprehension Test' (see appendix E). Those who passed the test co-

signed the informed consent forms (appendix D_1) together with their guardians/parents in presence of a Trauma Counselor. Those who failed the test were excluded from the study. (The children below 18 years were supposed to assent, while the parents/guardians gave the consent).

Step 10: Trauma Counselor also explained to survivors aged 6 - 11 years old and their accompanying parents/guardians about the study. Parents/guardians who agreed their children could participate signed consent forms (see appendix D_2) for the very small child survivors or co-signed with the older child survivors who could sign.

Step 11: All survivors and or parents/guardians contact address and telephone numbers were recorded.

Step 12: Survivors and parents/guardians who consented to participate in the study were introduced to the CHW covering their residential area.

Step 13: Those who refused to participate in the study continued with 'the usual care'- Standard post rape care in the CCCs in line with Psychosocial Care and Support protocol.

3.4.3.1 Intervention Site Specific Recruitment Steps

Step 13: Trauma Counselors explained survivors that they would continue with the trauma counseling sessions 'usual care' at the CCC as per given appointments dates.

Step 14: Trauma counselors explained the survivors about the ICLRTC intervention which would be given bi-monthly in the community by CHW.

Step 15: Recruitment period was within three months in order to get the desired sample.

Step 16: Trauma Counselors recruited n=150 survivors. At the end of recruitment, 22 parents/guardians declined to participate. Therefore, at baseline n=128 survivors in the selected interventional hospital.

3.4.3.2Non-intervention Site Specific Recruitment Steps

Step 13: Trauma Counselors explained survivors that they would continue with the trauma counseling sessions 'usual care' at the CCC as per given appointments dates.

Step 14: Trauma counselors explained survivors about the monthly community follow up by CHWs in order to be reminded about various appointments and treatments. Community follow up by CHWs would prevent or reduce attrition.

Step 15: Recruitment period was within three months in order to get the desired sample.

Step 16: Trauma Counselors recruited n=300 survivors. At the end of recruitment, 8 parents/guardians declined to participate. Therefore, at baseline n=282 survivors in the selected non - interventional hospital.

Survivor recruitment was carried out by Trauma Counsellors who had counselling experience ranging from 3-8 years. The study respondents in the two study groups were not marched for age and sex, since the target groups were rape survivors within the community. Hence, 6 years old and above were included in the Intervention group irrespective of sex and gender. It was therefore only fair to replicate the same criteria for theNon-intervention group to avoid introducing bias.

Recruitment continued in both sites until the minimum sample size was obtained. Flow chart for survivor recruitment is shown below in Figure 3.2.

RECRUITMENT OF SURVIVORS

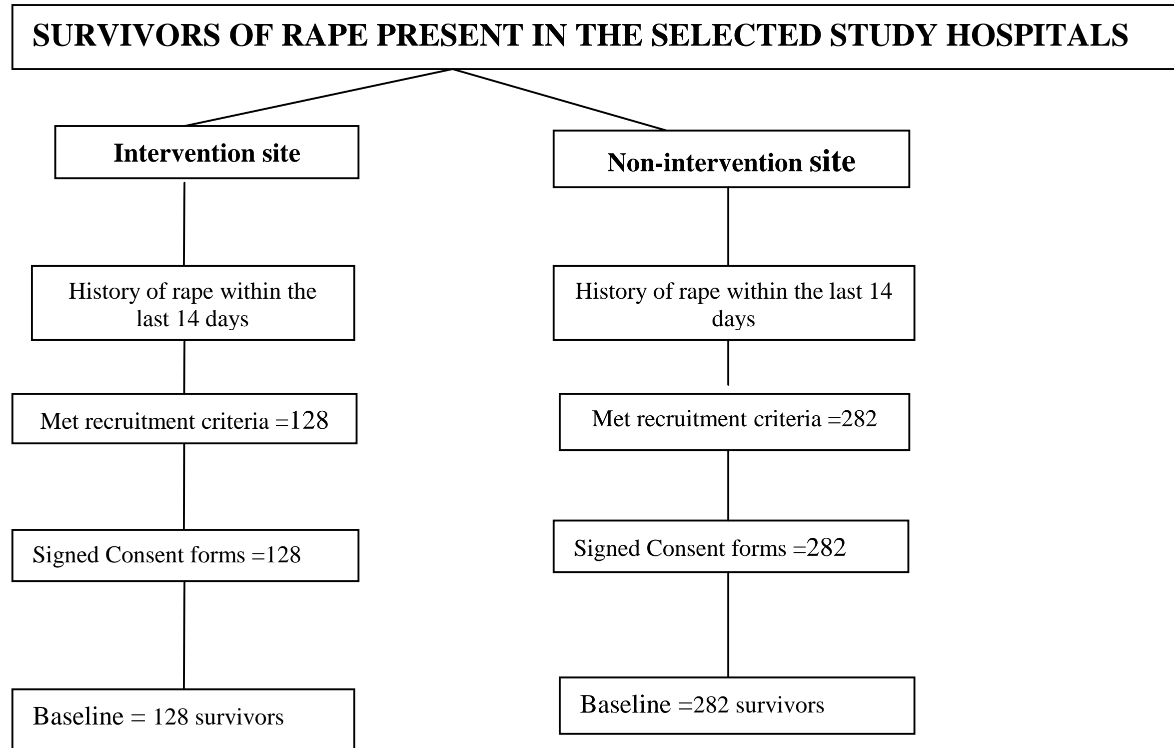


Fig.3.2: Flow of Recruitment of Survivors

3.4 Data Collection Procedures

3.5.1 Assessment Tools

Baseline (appendix F) and Follow-up (appendix G) Mental Health questionnaires were administered by trained TCs to collect baseline andprospective data respectively. The questionnaires were in both English and Swahili translations.

3.5.2 Pre-Testing of the Research Instruments

Each of the two questionnaires contained sections which were sub-scales of different assessment tools. To ensure acceptable cross-cultural adaptation, questionnaires were field-tested at Kenyatta National Hospital CCC and semantic mistakes were discussed and corrected. The final version was validated by a senior clinical psychologist and senior paediatric psychiatrist.

3.5.3 Interviews

(I) Administered Questionnaire Interviews

The TCs administered the questionnaires to study respondents gather data in the two study arms. Structured and semi-structured interview schedule (appendix F baseline and G follow-up) were administered to the study subjects by TCs who had training in post rape care and had specific training about the study.

Baseline Data Collection

The Mental Health Outcomes Baseline Questionnaire – English / Swahili Version 01.12 (appendix F) was administered at the CCCs by the trained TCs to gather data from respondents at baseline in the two study arms:

Social Demographic survey:

All participants responded to a brief demographic survey gathering data on variables such as age, gender, level of education, marital status, residence, employment status (income), and religion.

The TCs also used the questionnaire observation checklist to assess the socio-economic status of the respondents and child survivors' parents/guardians. For child survivors, TCs observed the general well-being, appearance, ability to communicate with the TCs, fluency in language used, area of residence and the physical appearance. Information was also sought on the care given to the child survivors as well as information on morbidity trends. For adult survivors, indicators were used to gauge the socio-economic status of subjects, with those not working in a paid job or not engaged in an income generating activity regarded as having no income. Data on the selected socio-demographic characteristics of survivors were only gathered at baseline.

Psycho-social Health Needs Survey:

The TCs gathered psycho-social health needs from the study respondents using Intrisic Need Satisfaction (INS) scale. This study adapted the relatedness sub-scale with seven items. The sub-scale items were narrowed to 5 items. The TCs sought information on subjects' expectations from community and health service providers. One unstructured question asked in the relatedness sub-scale during the interview included: Expectation: question one -'when you decided to come here, what is it that you expect the post rape service Provider will do for you? Or your child?' Respondents listed their expectations. The TCs also used a checklist to assess subjects' reasons as to they came looking for health services post rape. Question two: was structured and read - 'while am here, I hope to get help with…. Respondents checked all that applied from the list which included: 'safety, emotional support, ideas for handling stress, treatment for sexual injuries'. The TCs also assessed satisfaction of respondents with post rape services. Questions three: was structured and read - 'How helpful is the counselor?' Responses were ranked on 3- point Likert scale ranging from 2 = 'very helpful', 1 = 'somewhat helpful', 0 = 'not at all helpful'; Questions four: was structured and read - 'How helpful

are the health service providers? Responses were ranked on 3- point Likert scale ranging from 2 = ‘very helpful’, 1 = ‘somewhat helpful’, 0 = ‘not at all helpful’; Questions five: was structured and read - How satisfied were you with the way the police handled you?- responses were ranked on 3-point Likert scale ranging from 2 = ‘very satisfied’, 1 = satisfied’, 0 = ‘dissatisfied’; ‘Yes’ or ‘No’ question included - ‘have you reported this incident to the police? During analysis, the expectation responses were grouped into categories which were mapped into numeric values from 4 to 1. Those found to be satisfied would be regarded as help seekers who continued to utilize community trauma counseling services, and those in the process of disclosing rape to person(s) of their choice (positive psychological outcomes). Data on the psycho-social health needs of survivors were only gathered at baseline.

Assessment of the Negative Psychological Distress Characteristics:

The selected negative psychological distress characteristics of the study subjects were assessed by TCs at the CCCs at baseline.

Data on depression and RTS were gathered using General Health Questionnaire (GHQ) scale. The scale was adapted for this study and only the depression and RTS sub-scales were used. The sub-scales of depression and RTS were narrowed to 8 items.

Four ‘Yes’ or ‘No’ questions were asked in depression sub-scale which included: Question one -‘Do you have difficulty falling asleep’? Question two-‘Do you have difficulty concentrating on what you are doing?’ Question three-‘Are you feeling exhausted or loss of energy?’ Question four-‘Are you having strong feelings of frustration?’

Four ‘Yes’ or ‘No’ questions were asked in RTS sub-scale which included: Question one- ‘Are you having angry thoughts come to your mind, about the incident, against your will?’Question two- ‘Are you feeling as though the event is happening all over again?’ Question three-‘Are you having bodily reactions e.g., heart racing, stomach churning, sweatiness, dizziness, when reminded about the incident?’, Question four-‘Are you feeling irritable?’

GHQ questions took approximately 10 minutes. Each question scored 1 for ‘yes’ (if answer interpreted symptom present) or 0 for ‘No’ (if answer interpreted symptom not present). The GHQ leads to a score between zero and four; a higher score 2 and above reflected depression or RTS symptoms in each sub-scale, and a score equal or below one reflected absence of depression and RTS symptoms. During analysis, those found to score equal or below one would be regarded as re-establishing adaptive coping mechanisms (a positive psychological outcome). The diagnosis would be made during follow-up evaluation, only after more than three months of ongoing symptoms because of delayed onset or a late exacerbation of depression and RTS distress symptoms (Andrew, Brewin, Philpott and Stewart, 2007). Baseline results would determine whether the two study groups were similar or if there were any significant differences before introducing the ICLRTC intervention in the intervention arm. The baseline results would also be used as reference forprospective time – point results.

Data on shame were gathered using Rosenberg scale. The scale was adapted for this study and only the shame (low self-esteem) sub-scales was used. In the present study only 4 items related to shame (low self esteem) were used to identify reactions and likelihood of development shame (low self esteem).

Four ‘Yes’ or ‘No’ questions were asked in shame sub-scale which included: Question one- ‘Do you have a strong urge to repress feelings connected to the incident?’ Question two -‘Is your self confidence low? Question three: ‘Are you having difficulty handling anger?’ Responses were ranked on 3-point Likert scale ranging from 2 = great difficulty, 1 = some difficulty, 0 = no difficulty; question four: ‘How comfortable are you being around people?’ Responses were ranked on 3-point Likert scale ranging from 2 = very uncomfortable, 1 = uncomfortable, 0 = comfortable.

Rosenberg questions took approximately 5 minutes. Each question scored 1 for ‘yes’ (if answer interpreted as symptom present) or 0 for ‘No’ (if answer interpreted as symptom not present). The Rosenberg leads to a score between zero and four; a higher score 2 and above reflected shame symptoms and a score equal or below one reflected absence of

shame symptom. During analysis, those found to score equal or below one would be regarded as help seekers who continued to utilize community trauma counseling services, and those in the process of disclosing rape to person(s) of their choice (positive psychological outcomes). The diagnosis would be made during follow-up evaluation, only after more than three months of ongoing symptoms because of delayed onset or a late exacerbation of the distress symptoms (Gray-Little & Williams, 1997). Baseline results would determine whether the two study groups were similar or if there were any significant differences before introducing the ICLRTC intervention in the intervention arm. The baseline results would also be used as reference forprospective time – point results.

Attribution Rating Scale (ARS): The scale was adapted for this study and only items related to sexual violation were selected to make the Self-blame sub-scale which was used in this study. Four 'Yes' or 'No' questions were asked in self blame sub-scale to identify reactions and likelihood of development self blame - which included: Questions one - 'Are you feeling guilty?'Question two - 'Are you able to talk easily about the incident?' Question three - 'Are you avoiding to think about the incident?' Question four - 'Are you feeling people are unkind to you?' ARS self blame sub-scale questions took approximately 5 minutes. Each question scored 1 for 'yes' (if answer interpreted as symptom present) or 0 for 'No' (if answer interpreted as symptom not present). The ARS leads to a score between zero and four; a higher score 2 and above reflected self blame symptoms and a score equal or below one reflected absence of self blame symptom. During analysis, those found to score equal or below one would be regarded as help seekers who continued to utilize community trauma counseling services, and those in the process of disclosing rape to person(s) of their choice (positive psychological outcomes). Baseline results would determine whether the two study groups were similar or if there were any significant differences before introducing the ICLRTC intervention in the intervention arm. The baseline results would also be used as reference forprospective time – point results.

The Trauma Symptom Checklist for Children (TSC-C) (Briere, 1996) questionnaire was modified for child self report and parent report in this study. The scale was adapted for this study and only items related to child sexual violation were selected to make the 2 – 4 items each TSC-C sub-scales which were used in this study. The 8 items were used to identify reactions and likelihood of development of depression and RTS among child survivors of rape. TSC-C was administered to all child survivors who participated in the study at baseline (pre – test).

Questions on Depression included: Question one-'Is the child eating normally? Question two- 'Is the child sleeping normally? Question three: child - 'are you feeling tired? Question three- Parent- 'is the child: looking tired?' Question four - Child's appearance - responses were ranked in hierarchy of 'kempt and unkempt', child's behavior - Responses were ranked in hierarchy of 'restless', 'aggressive', 'hyperactive.'

Questions on RTS included: Question one -'Is the child irritable?' Question two-'Is the child disinterested in things she/he liked before?' Question three: Child – 'are you able to concentration on what you are doing?' Parent-'is the child concentrating?' Question four - child's mood- Responses were ranked in hierarchy of 'happy', 'sad', 'anxious', 'worried'.

The Children's Attributions and Perceptions Scale (CAPS) (Mannarino et al., 1994) questionnaire was modified for child self report and parent report in this study. The scale was adapted for this study and only items related to child sexual violation were selected to make the 2 – 4 items each CAPS sub-scales which were used in this study. The 8 items were used to identify reactions and likelihood of development of shame and self blame among child survivors of rape. CAPS was administered to all child survivors who participated in the study at baseline (pre – test).

Four 'Yes' or 'No' questions were asked in shame sub-scale to identify reactions and likelihood of development shame - which included: Question one -'is the child confident? Question two-'Is child's school performance been good? Question three-'Is the child playing normally? Question four-'Does the child get anger outbursts?'

Questions on Self blame included: Question one – Child –'are you feeling guilty?' Parent-'Is the child appearing guilty?' Question two - Child- 'are you avoiding talking about the incident?' Parent-'is the child avoiding talking about the incident?' Question three: Child -'are you avoiding activities or places or people who remind you of the incident?' Parent-'Is the child avoiding activities, places or people that remind of the incident?' Question four-'Is the child feeling that people are unkind?'Responses were ranked in hierarchy of 'always', 'often', 'occasionally', 'never'.

TSC-C and CAPS questions took approximately 20 minutes for each sub-scale. Each question scored 1 for 'yes' (if answer interpreted as symptom present) or 0 for 'No' (if answer interpreted as symptom not present). The TSC-C and CAPS leads to a score between zero and four; a higher score 2 and above reflected depression, RTS, self blame and shame symptoms and a score equal or below one reflected absence of a distress characteristics symptoms. During analysis, those found to score equal or below one would be regarded as demonstrating positive psychological outcomes (good performance at school, social adjustment behavior). Baseline results would determine whether the two study groups were similar or if there were any significant differences before introducing the ICLRTC intervention in the intervention arm. The baseline results would also be used as reference forprospective time – point results.

(a) Prospective Data Collection

The Mental Health Outcomes Follow-up Questionnaire – English / Swahili Version 01.12 (appendix G) was administered at the CCCs by the trained TCs to gather prospective data from survivors. The selected psychological distress characteristics were re-assessed in the two study arms. The interval period between the follow-up psychological assessments at CCCs in both study arms was 3 months. Sub- scales GHQ, Rosenberg's and CSA were re-administered after every 3 months, during the Follow-up1 assessment (done after 3 months) data would be used to determine magnitude of change in positive psychological outcomes among rape survivors in both study arms.

The same assessments were repeated at Follow-up2 (after 6 months) and Follow-up3 (after 9 months). Flow chart on data collection is shown below- Fig.3.3.

FLOW CHART ON DATA COLLECTION

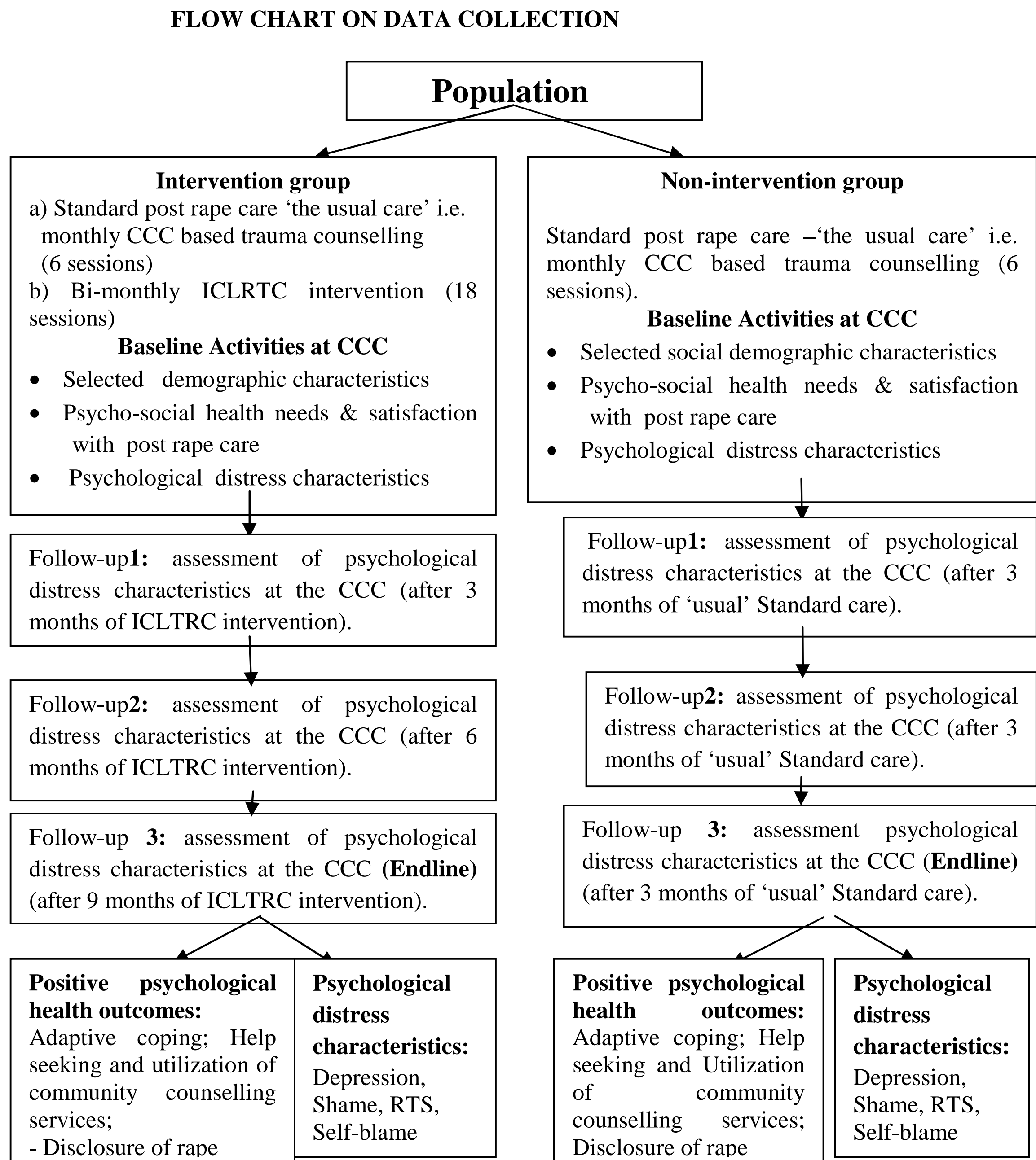


Fig. 3.3 Diagrammatical Presentation of Data Collection

3.5.4 Implementation of the ICLRTC Intervention Model

The initial care at the CCC included individual psychological support to support and improve the coping mechanisms of survivors. All survivors in the Intervention group were put on ICLRTC intervention model. CHWs had bi-monthly community lay trauma counseling sessions with each respondent. Sessions were held at survivor's/parents/guardians place of choice in the community. Duration of session ranged between 60 -90 minutes inclusive of time for pleasantries.

(i) Intense Community Lay Trauma Counseling intervention included:

a. Provision of safe and empathetic environment through therapeutic relationship so survivors and / or parents could share their experiences and feel valued for oneself;

b. active listening, allowing for expression of emotions, distress, fright, guilt, shame, anger, depressive and anxious affect;

c. allowing expression of personal views about events and distress, including cultural representations;

d. assessing familial and social consequences;

e. normalizing survivor's reactions to reassure that most of the survivors who have undergone such violence or parents whose child has been violated, are experiencing similar reactions;

f. working on coping strategies; and

g. working on acceptance and development of future perspectives and plans;

h. timely and appropriate referrals to medical legal – justice systems or to social support groups (where available) for support with individual concerns.

CHWs reminded survivors to keep all their appointments especially the one for psychological distress assessment every three months by Trauma Counselors at the CCCs. CHWs made bi-monthly reports on each study participant (see appendix C_1). These reports were used by the PI to make impressions on the implementation of the ICLRTC intervention in the community. CHWs made eighteen bi-monthly community visits to

each respondent in this study. These reports were used by the PI to make impressions on the implementation of the ICLRTC intervention in the community. CHWs made eighteen bi-monthly community visits to each respondent in this study (see Table 3.1).

(ii) Monthly Supervision by CHEWs during Implementation of ICLRTC Intervention

CHEWs made monthly observations of each CHW during a trauma counselling session in the community. They made a record of their observations and any action taken during each observed session. Nine practice observation reports were made on each CHW during the study (see appendix C_2). CHEWs held routine monthly monitoring and supervision meetings with CHWs.

Any challenges faced by CHWs during implementation of ICLRTC intervention were addressed. PI attended these meetings for quality checks. CHEWs held nine monitoring and supervisory meetings with CHWs during this study. PI used minutes of these meetings and supervisory reports to make impressions on implementation of the ICLRTC intervention in the community.

(iii) Assessment of psychological distress characteristics by TCs

The specific psychological distress characteristics were assessed by TCs at the CCC at baseline using measures of depression, RTS, shame, and self-blame. The Follow-up1 assessment of symptoms of each psychological distress characteristic was done after 3 months of ICLRTC intervention. Follow-up2 assessment was done after 6 months of ICLRTC intervention, assessment of the symptoms of each specific psychological distress characteristic was repeated. A final assessment of the symptoms of each specific psychological distress characteristics was done at Follow-up3 after 9 months (endline) of ICLRTC intervention. These assessments noted changes in symptoms of each specific psychological distress characteristic.

Table 3.1: Overview of the ICLRTC Intervention Model

ICLRTC intervention by CHWs	**Key elements of ICLRTC intervention**
a)Therapeutic relationship between CHW-counselor and survivor	a) show kindness, acceptance or unconditional positive regard, genuineness; empathy, not sympathy, attentive listening, and acceptance of survivor's perspective (survivor feel valued for oneself).
b) Support expression of feelings	b) actively listening, allowing for expression of emotions, distress, fright, guilt, shame, anger, depressive and anxious affect (re-framing the incident);
c) Connect event with emotions and behaviors	c) allowing expression of personal views about events and distress, including cultural representations (minimized stigma).
d) Enhance social support	d) assessing familial and social consequences, initiate discussion about social support networks . Help the survivor understand that the usual support people may be struggling with their own issues (adaptation, social adjustment, minimized stigma, integration, and empowered survivor).
e) Filling in missing pieces	e) normalizing survivor's reactions to reassure that most of the survivors who have undergone such violence or parents whose child has been violated, are experiencing similar reactions; Clarify misunderstandings, offer information, answer questions realistically and factually, refer difficult questions to expert, do not defend or justify care provided (minimized stigma).
f) Accept and work with survivor's perceptions	f) working on coping strategies, Prompt the survivor to tell her own story, listen with encouragement but not interrupting (re-framing the incident).
g) Reinforce positive approaches to coping	g) working on acceptance and development of future perspectives and plans. Reinforce comments by survivor that reflect a clearer understanding of the situation, plan for way forward or outline positive action to overcome distress. Counter defeatist statements (adaptation, integration, social adjustment, empowered survivor, decision making).
h) Referrals	ixh) timely and appropriate referrals to medical legal .. support group(s), further one-to-one counseling, seek specific information. Remind survivor to keep all appointments.

3.5.5 'Usual care' in Non- intervention arm

Respondents from theNon-intervention group were continuing on 'the usual care i.e. Standard post rape care' as prescribed by the Ministry of Health Psychosocial Care and Support protocol. Eventually, theNon-intervention group benefited because the CHWs reminded each survivor to attend trauma counselling sessions with TC at the CCC.

(i) Routine community follow up by CHWs

CHWs also encouraged survivors to complete human immunodeficiency virus (HIV) post-exposure prophylactic (PEP) dose. CHWs reminded survivors to keep the health facility appointments with the TCs for the assessment of psychological distress characteristics every three months, and any other medical-legal appointments.

(ii) Monitoring and evaluation by CHEWs

CHEWs monitored the follow up of survivors by the CHWs to prevent attrition. CHEWs held routine monthly monitoring and supervision meetings with CHWs. Any challenges faced by CHWs during routine follow up were addressed and written down for the PI. PI attended these meetings for quality checks. CHEWs held nine monitoring and supervisory meetings with CHWs during this study. Principal investigator (PI) used minutes of these meetings and supervisory reports to make impressions on progress of the investigation in the community.

(iii) Assessment of psychological distress characteristics by TCs

The specific psychological distress characteristics were assessed by TCs at the CCC at baseline using measures of depression, RTS, shame, and self-blame. The Follow-up1 assessment of symptoms of each psychological distress characteristic was done after 3 months of routine follow up. Follow-up2 assessment was done after 6 months of routine follow up; assessment of the symptoms of each specific psychological distress characteristic was repeated. A final assessment of the symptoms of each specific psychological distress characteristics was done at Follow-up3 after 9 months (endline) of

routine follow up. These assessments noted changes in symptoms of each specific psychological distress characteristic. Figure 3.4 below present a flow chart of participants during data collection.

Summary of Respondents during Data Collection

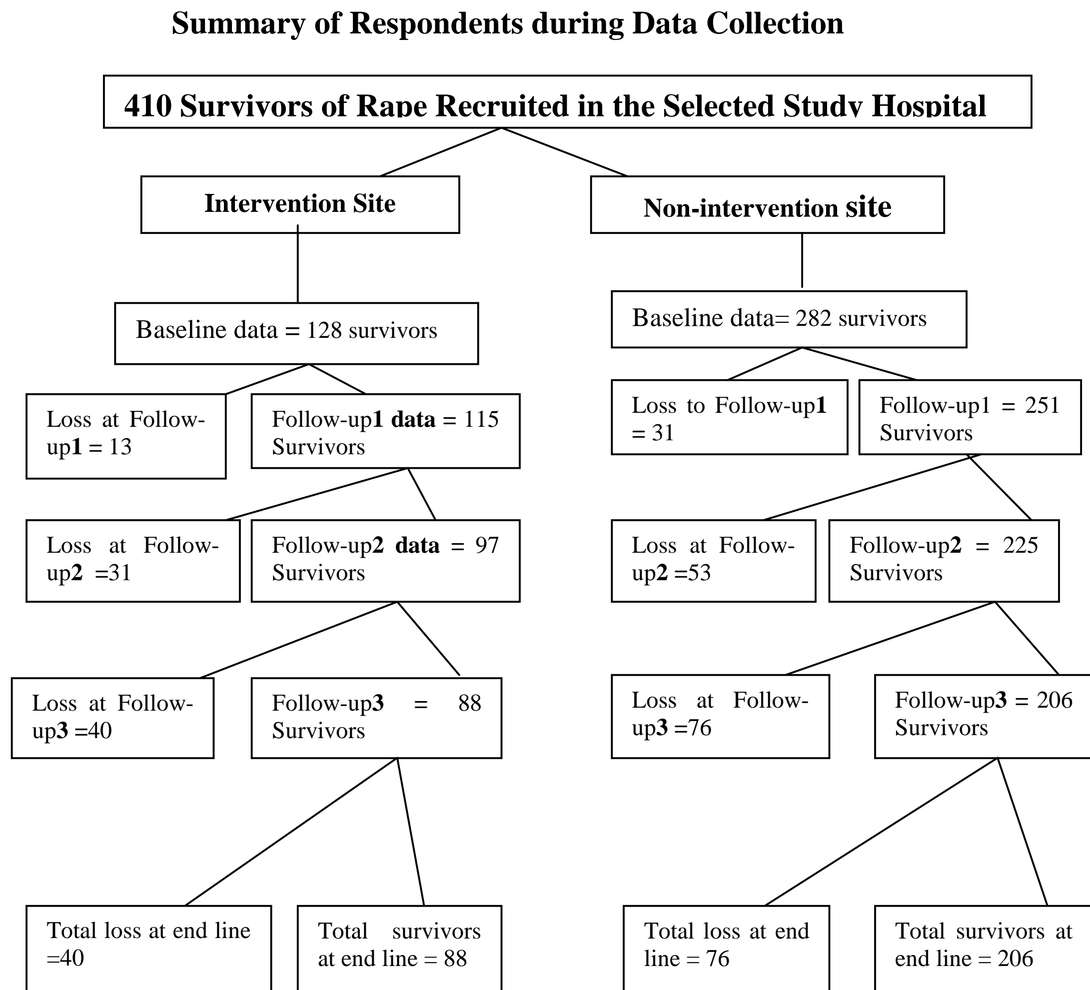


Fig.3.4: Diagrammatical Presentation of Respondents during Data Collection

3.5.6 Quality Checks

This was done by the principal Investigator and included the following activities:

- Principal investigator had to confirm CHWs received monthly observation and supervisory visits from CHEWS.
- CHEWs verified with survivors and parents/guardian of child survivors that they received bi-monthly community lay trauma counseling.
- Principal investigator visited each survivor and parents/guardians of child survivors to verify reports from CHWs and CHEWs.
- Principal investigator attended CHEWs-CHWs meetings to keep check on ICLRTC intervention implementation and to determine if there are any challenges experienced by CHWs or CHEWs during ICLRTC intervention implementation.
- The principal investigator monitored and evaluated the research process.

3.5.7 Data Collection Points

The relevant variables were measured and evaluated by trained Trauma Counsellors (TCs) at baseline, at Follow-up 1 (3 months), at Follow-up 2 (6 months) and at Follow-up 3 (9 months) endline. The selected socio-demographic characteristics and psycho-social health needs assessment data was collected only at baseline. The psychological distress characteristics data was collected during all four assessment points. A summary of data collection points is shown below in Table 3.2.

Table 3.2: Illustrative Schedule of Data Collection Points 0 - 9 Months

Type of data collected	**Type of Group from which data collected**			**Total number of data collected**
	Intervention Group	**Non-intervention group**	**Check groups**	
Baseline data:	**1**	**1**		**2**
Intervention group Follow-up data after: a) Follow-up**1** b) Follow-up**2** c) Follow-up**3**	 1 1 1			**3**
Non-intervention group Follow-up data after: a) Follow-up**1** b) Follow-up**2** **c)** Follow-up**3**		 1 1 1		**3**
Quality check data 3 Different sites i) After Follow-up**2** (Site A) ii) After Follow-up**3** (site B)			 **1** **1**	**2**

3.6 Quality Control

Quality control was ensured through training of Trauma Counselors, research assistants, CHWs and CHEWs and through very close supervision of the research team by the PI during data collection. The study tools were pre-tested on rape survivors in a neighboring sub-county to prevent contamination. Therefore, the subjects used for pre-test were not part of the main study participants.

The pre-testing ensured the necessary adjustments and corrections were made to the tools to ensure clarity and logical flow of questions and near zero errors. The completed interview schedules were checked for correctness and consistency. Interview schedules were stored in a safe place during field work. Double-entry of data was done using MS-Access to ensure accuracy.

3.7 Data Management and Analysis

3.7.1 Data management

Quantitative data from the field questionnaires was double entered into a computer database designed using MS-Access application. Data cleaning and validation was performed using Epi Info in order to achieve a clean dataset that was then exported into a Statistical Package format (IBM SPSS) ready for analysis. File back-up was regularly done in CDs and an external hard drive to avoid any loss or tampering. All the hard (paper questionnaires) and soft (entered questionnaire records) copies were stored in a lockable drawer for confidentiality.

3.7.2 Data analysis

Data analysis was conducted using IBM SPSS version 21.0 statistical software. Exploratory data techniques were used at the initial stage of analysis to uncover the structure of data and identify outliers or unusual entered values. Descriptive statistics such as proportions were used to summarize **categorical** variables while measures of

central tendency such as mean, standard deviations, and range were used to summarize **continuous** variables.

Distribution of selected demographic and psycho-social characteristics of rape survivors collected at baseline were compared between the study groups (Interventional site versusNon-intervention site) using Pearson's Chi-square test or Fisher Exact test.

In order to determine factors associated with each of the psycho-social characteristics measured at baseline, Pearson's Chi-square test or Fisher Exact test was used to test for the association at bivariate level of analysis. All the exposure variables (Independent factors) associated with the dependent variable (specific psychological distress characteristics measured at baseline) to determine which ones had significant association. Odds Ratio (OR) and 95% Confidence Interval (CI) were used to estimate the strength of association between independent variables and the dependent variable. All independent variables identified to significantly associate with 'specific psychological distress characteristics measured at baseline' at bivariate analysis were considered together in a Multivariate analysis. This was performed using Binary logistic regression where backward conditional method was specified in order to identify confounders and/or effect modifiers. Adjusted odds Ratios (AOR) together with their respective 95% Confidence Interval (CI) were used to estimate the strength of association between the retained independent factors and 'specific psychological distress characteristics measured at baseline'. The threshold for statistical significance was set at $p<0.05$.

Between groups comparison of each of the specific psychological distress characteristics measured was done by comparing specific psychological distress characteristics of the survivors between the study groups at every time point from baseline to 9th month, whereas, within groups comparison of each of the specific psychological distress characteristics was done by comparing specific psycho-social characteristics of the survivors within each study group at every time point from baseline to 9th month.

3.8 Study Limitations

The major short coming of this study was the fairly large dropout rate- overall 28% during intervention, combined with electioneering period (2012 – 2013) when rumors of tribal war and threat to evict certain communities from certain areas of residence was perpetuated by politicians. As a result, respondents living in areas where they felt threatened suddenly relocated to communities where they felt safe. Use of FGDs as a second method of collecting qualitative data was abandoned because survivors from different tribes had tension and mistrust during the first meeting which ended abruptly. FGDs data would have added value to the results. Social Support Groups (SSGs) as a second part of ICLRTC intervention was abandoned because survivors from different tribes were uncomfortable to openly share experience of sexual violation with those perceived as 'enemies.' Survivors from various tribes were suscipicious of each other during the electioneering period which made it very difficult to form SSGs. SSGs would have helped survivors cope with questions from community members about the close follow up by the CHWs. This would have alleviated or reduced psychological distress caused by intense community follow up.

Finally, the study did not explore whether our respondents were engaged in other forms of sexual violation such oral sexual intercourse.

3.9 Ethical Considerations

Prior to collection of data, the Institutional Scientific Steering Review Boards of the Kenya Medical Research Institute (KEMRI) - KEMRI Scientific Steering Committee (SSC) (appendix J), National Ethical Review Committee (NERC) (appendix K), Kenyatta National Hospital/University of Nairobi Ethics Committee and Jomo Kenyatta University of Agriculture and Technology (JKUAT) reviewed all questionnaires and procedures to ensure compliance with Institutional and National research regulations. They also reviewed all ethical concerns for the use of human subjects in research. Institutional

Review Board approval was received for the current study. Further authority was sought from Director of Medical Services (DMS) Ministry of Medical Services (MOMS) and Ministry of Public Health and Sanitation (MOPS) (appendix L), and Kenyatta National Hospital/University of Nairobi Ethics Committee (appendix M) for the pilot study. Verbal approvals were granted by District Health Management Teams, Medical superintendents (Med SUPs), District Medical Officers of Health (DMoH), Hospital Matrons, Community Strategy Co-coordinators (CSCs), Community Health Extension Workers (CHEWs) and Comprehensive Care Centre (CCCs) in all study sites on production of letter of approval from MoMS/MoPHS.

A written informed consent was sought from the study subjects through signing or the use of Right Thumb finger print. All the ethical procedures were followed in accordance with the Helsinki Declaration of 1975 (Nuffield Council on Bioethics, 2008). The participation in this study was entirely voluntary and the decision on whether to participate or not was entirely left to the survivor or parent/guardian of the child survivor. Subjects were free to participate, or withdraw from the study at any point.

The ICLRTC intervention model was started after a subject or parent/guardian of a child survivor had signed the consent form (appendix D_1 and D_2). Respondents in the interventional group had direct benefits from psychological treatment and social support. Those in theNon-intervention group benefited from encouragement and reminders to keep: the trauma counselling appointments which were part of the 'usual care'-Standard post rape care, clinical treatments appointments, clinical laboratory test/investigations, and compliance with PEP dose. Also, because they participated in this study the Kenya society will gain from the findings and recommendations.

The participants were informed that the data and information collected from them or their children was to be kept strictly confidential. All the information was kept confidential in a password–protected electronic file and access to the protected file limited to the Principal Investigator. Subjects were informed that the data were only to be shared with other parties or persons with their prior consent and authority. They were also notified that their

names or those of their children would not appear in any part of the final research report. The participants were also informed that there was no risk involved in participating in the research. The cultural norms including moral conduct and absolute respect for the respondents were observed by the researcher and research assistants during data collection. The study respondents who were found to be sick were referred to the nearest health facility for medical assistance.

CHAPTER FOUR

4.0 RESULTS AND DISCUSSION

4.1 Introduction

A total of 410 survivors of rape consented to participate in this study. Baseline total number of survivors (n= 410): 128 Intervention arm in Thika sub-county and 282 Non-intervention arm in Naivasha sub-county.

Majority of the survivors were *12 years old* and above with a mean age of 20.60 years. *Female* respondents (82.1%) dominated the study population.

The main focus of the prospective assessments was on psychological distress characteristics among the survivors. Four assessments on the psychological distress characteristics of the study participants were done at Baseline (0 Months), Follow-up1 (3 Months), Follow-up2 (6 Months), and End line (9 months). Assessments were done in order to establish changes in improvement of positive psychological outcomes 'between' and 'within' the two study groups.

During the prospective follow-up, loss at follow-up1 in both arms was 44 respondents (11%), at follow-up2 was 44respondents (11%) and at follow-up3 were 28 respondents (7%). At endline total attrition was 28% in both arms, which was 31% and 27% in the Intervention and Non-intervention arm respectively (overall 28%).
The results are presented in different sections of this chapter.

4.1.1 Social Demographic Characteristics of Survivors at Baseline

Table 4.1 presents the distribution of survivors by demographic characteristics at baseline.

There was a significant difference in the distribution of survivors' 'residence' by study arm (^{2}=32.980, df=2, p<0.001). Most of the survivors came from urban settlement (45.1%). A significantly higher proportion (p<0.001) of the survivors (65.6%) in Intervention arm were residing in urban settlement compared to 35.8% in Non-intervention arm. There was no significant difference in the distribution of 5 social demographic characteristics (*age*, *gender*, *marital status*, *employment* and *level of education*) of the survivors *(P>0.05)*.

Table 4.1: Distribution of Survivors by Demographic characteristics at Baseline

Variables	Total n= 410		Intervention n=128		Non-intervention n=282		^{2} value	df	p value
	n	%	n	%	n	%			
Age of the survivors in years									
6-11 years	74	18.0	18	14.1	56	19.9	1.999	1	0.157
12 years	336	82.0	110	85.9	226	80.1			
Gender of the survivors									
Female	353	86.1	109	85.2	244	86.5	0.138	1	0.711
Male	57	13.9	19	14.8	38	13.5			
Residence of the survivors									
Urban	185	45.1	84	65.6	101	35.8	32.980	2	**<0.001**
Peri-Urban	138	33.7	23	18.0	115	40.8			
Rural	87	21.2	21	16.4	66	23.4			
Survivor's employment status									
Employed	245	59.8	83	64.8	162	57.4	2.003	1	0.157
Unemployed	165	40.2	45	35.2	120	42.6			
Survivor's marital status									
Currently married	137	33.4	47	36.7	90	31.9	0.913	1	0.339
Currently not married	273	66.6	81	63.3	192	68.1			
Highest level of school attended									
Nursery	21	5.1	10	7.8	11	3.9	3.794	3	0.285
Primary	153	37.3	43	33.6	110	39.0			
Secondary	147	35.9	49	38.3	98	34.8			
Tertiary	89	21.7	26	20.3	63	22.3			

Key: Significant difference at p< 0.05 bolded; x^2-Chi-square value; df – degrees of freedom

4.1.2.Distribution of Survivors by Needs at Baseline

Table 4.2 presents the distribution of survivors by needs at baseline. Out of the five assessed needs i.e. *Safety, Stress*, *Emotional*, *Treatment for sexual violation in*j*ury* and *Satisfaction with post rape care*, the highest observed need was *Safety needs* whereas the least was *Treatment for sexual violation injury* accounting for 92.9% and 19.8% of all the survivors respectively. There was a significant difference in the distribution of survivors *safety needs* by study arm (^{2}=8.338, df=1, p=0.004). A higher proportion of the survivors had *safety needs* (92.9%, P<0.004); 95.4% in the Non-intervention arm compared to Intervention arm (87.5%).

There was also significant difference in the distribution of survivor's *dissatisfaction* with post rape care by study arm (^{2}=10.524, df=1, p=0.001). A relatively higher proportion of the survivors showed *dissatisfaction* (44.6%); 50.0% in the Non-intervention arm compared to those in the Intervention arm (32.8%). There was no significant difference in the distribution of the other 3 needs of the survivors (*Stress*, *Emotional*, *Treatment for sexual violation in*j*ury)* between the study arms *(P>0.05).*

Table 4.2: Distribution of Survivors by Needs at Baseline

Variables	Total n=410		Intervention n=128		Non-intervention n=282		^{2} value	df	p value
	n	%	n	%	n	%			
Safety needs among the survivors									
Yes	381	92.9	112	87.5	269	95.4	8.338	1.00	**0.004**
No	29	7.1	16	12.5	13	4.6			
Stress needs among the survivors									
Yes	330	80.5	97	75.8	233	82.6	2.625	1.00	0.105
No	80	19.5	31	24.2	49	17.4			
Emotional needs among the survivors									
Yes	112	27.3	31	24.2	81	28.7	0.900	1.00	0.343
No	298	72.7	97	75.8	201	71.3			
Injury needs among the survivors									
Yes	81	19.8	25	19.5	56	19.9	0.006	1.00	0.939
No	329	80.2	103	80.5	226	80.1			
Dissatisfaction with post rape care among the survivors									
Yes	183	44.6	42	32.8	141	50.0	10.524	1.00	**0.001**
No	227	55.4	86	67.2	141	50.0			

Significant difference at p< 0.05 bolded

4.1.3 Psychological Distress Characteristics of Survivors at Baseline

Distribution of survivors by psychological distress characteristics was done as presented in Table 4.3.

There was baseline equivalence in all psychological distress characteristics between the study arms *(P>0.05)*.

Table 4.3: Distribution of Survivors by Psychological Distress Characteristics at Baseline

	Total n=410		**Intervention n=128**		**Non-Intervention n=282**				
Variables	**n**	**%**	**n**	**%**	**n**	**%**	**^{2} value**	**Df**	**p value**
Depression among the survivors									
Present	344	83.9	104	81.3	240	85.1	0.969	1	0.325
Absent	66	16.1	24	18.8	42	14.9			
Self Blame among the survivors									
Present	284	69.3	83	64.8	201	71.3	1.711	1	0.191
Absent	126	30.7	45	35.2	81	28.7			
Shame among the survivors									
Present	326	79.5	102	79.7	224	79.4	0.004	1	0.953
Absent	84	20.5	26	20.3	58	20.6			
RTS among the survivors									
Present	351	85.6	111	86.7	240	85.1	0.186	1	0.666
Absent	59	14.4	17	13.3	42	14.9			

Significant difference at p< 0.05 bolded

4.2 Factors Associated with Psycho-social Health Needs among Survivors at Baseline

4.2.1 Factors Associated with Safety Needs among Survivors at Baseline

Bivariate analysis

Table 4.4 presents analysis of *Safety needs* among survivors in relation to demographic characteristics at baseline. One factor *Peri-Urban Residence* of survivors was significantly associated (p=0.042) with *Safety needs* among the survivors.

There was also an insignificant association between *Safety needs* of the survivors and *female gender* (OR=2.74; 95% CI: 0.87 – 8.61; p=0.090).

Table 4.4: Safety Needs among Survivors in Relation to Demographic Characteristics at Baseline

	Need safety n=381		No need of safety n=29			95% CI		p
Variables	**n**	**%**	**n**	**%**	**OR**	**Lower**	**Upper**	**value**
Age of the survivor in years								
6-11 years	82	96.5	3	3.5	2.38	0.70	8.05	0.152
12 years	299	92.0	26	8.0	1.00			
Gender of the survivor								
Female	360	93.5	25	6.5	2.74	0.87	8.61	0.090
Male	21	84.0	4	16.0	1.00			
Survivor residence								
Urban	167	90.3	18	9.7	1.00			
Peri-Urban	133	96.4	5	3.6	2.87	1.04	7.92	**0.042**
Rural	81	93.1	6	6.9	1.46	0.56	3.81	0.444
Survivor employment status								
Employed	231	92.8	18	7.2	1.00			
Unemployed	150	93.2	11	6.8	1.06	0.49	2.31	0.878
Survivor marital status								
Currently married	132	92.3	11	7.7	1.00			
Currently not married	249	93.3	18	6.7	1.15	0.53	2.51	0.720
Highest level of school attended								
Nursery	20	95.2	1	4.8	1.71	0.20	14.68	0.626
Primary	144	94.1	9	5.9	1.37	0.49	3.80	0.551
Secondary	135	91.8	12	8.2	0.96	0.36	2.54	0.935
Tertiary	82	92.1	7	7.9	1.00			

Significant difference at $p < 0.05$ bolded

4.2.2 Factors Associated with Stress Needs among Survivors at Baseline

Bivariate analysis

Table 4.5 presents analysis of *Stress needs* among survivors in relation to demographic characteristics at baseline. One factor namely: '*Secondary level of education'* of the survivors was significantly associated (P=0.044) with occurrence of *Stress* among the survivors. There was also a strong but non-significant association between *Stress needs* of the survivors and attaining *Tertiary level of education* (OR=2.92; 95% CI: 0.99 – 8.62; p=0.052). Similarly, there was a strong but non-significant association between *Stress needs* of the survivors and *rural residence* (OR=1.95; 95% CI: 0.97 - 3.92; p=0.060).

Table 4.5: Stress Needs among Survivors in Relation to Demographic Characteristics at Baseline

Variables	Need to tackle stress n=330		Not in need to tackle stress n=80		OR	95% CI		p value
	n	%	n	%		Lower	Upper	
Age of the survivor in years								
6-11 years	64	75.3	21	24.7	0.68	0.38	1.19	0.175
12 years	266	81.8	59	18.2	1.00			
Gender of the survivor								
Female	308	80.0	77	20.0	0.55	0.16	1.87	0.439
Male	22	88.0	3	12.0	1.00			
Survivor residence								
Urban	141	76.2	44	23.8	1.00			
Peri-Urban	114	82.6	24	17.4	1.48	0.85	2.58	0.165
Rural	75	86.2	12	13.8	1.95	0.97	3.92	0.060
Survivor employment status								
Employed	195	78.3	54	21.7	0.70	0.41	1.17	0.167
Unemployed	135	83.9	26	16.1	1.00			
Survivor marital status								
Currently married	109	76.2	34	23.8	0.67	0.41	1.10	0.111
Currently not married	221	82.8	46	17.2	1.00			
Highest level of school attended								
Nursery	14	66.7	7	33.3	1.00			
Primary	115	75.2	38	24.8	1.51	0.57	4.03	0.407
Secondary	125	85.0	22	15.0	2.84	1.03	7.83	**0.044**
Tertiary	76	85.4	13	14.6	2.92	0.99	8.62	0.052

Significant difference at $p < 0.05$ bolded

4.2.3 Factors Associated with Emotional Needs among Survivors at Baseline

Bivariate analysis

Table 4.6 presents analysis of *Emotional needs* among survivors in relation to selected demographic characteristics at baseline. One of the factors, namely: '*Nursery level of education*' was identified to associate significantly (P=0.012) with *Emotional needs* among the survivors.

Table 4.6: Emotional Needs among Survivors in Relation to Demographic Characteristics at Baseline

Variables	Need emotional support n=112		Not in need of emotional support n=298		OR	95% CI		p value
	n	%	n	%		Lower	Upper	
Age of the survivor in years								
6-11 years	29	34.1	56	65.9	1.51	0.90	2.52	0.114
12 years	83	25.5	242	74.5	1.00			
Gender of the survivor								
Female	106	27.5	279	72.5	1.20	0.47	3.09	0.701
Male	6	24.0	19	76.0	1.00			
Survivor/ residence								
Urban	58	31.4	127	68.6	1.44	0.80	2.57	0.223
Peri-Urban	33	23.9	105	76.1	0.99	0.53	1.85	0.969
Rural	21	24.1	66	75.9	1.00			
Survivor employment status								
Employed	69	27.7	180	72.3	1.05	0.67	1.64	0.824
Unemployed	43	26.7	118	73.3	1.00			
Survivor marital status								
Currently married	44	30.8	99	69.2	1.30	0.83	2.04	0.251
Currently not married	68	25.5	199	74.5	1.00			
Highest level attended school								
Nursery	10	47.6	11	52.4	3.59	1.32	9.75	**0.012**
Primary	45	29.4	108	70.6	1.64	0.88	3.07	0.118
Secondary	39	26.5	108	73.5	1.42	0.76	2.68	0.274
Tertiary	18	20.2	71	79.8	1.00			

Significant difference at p< 0.05 bolded

4.2.4 Factors Associated with Treatment for Sexual Violation Injury Needs among Survivors at Baseline

Bivariate analysis

Table 4.7 presents analysis of *treatment for sexual violation injury needs* among survivors in relation to selected demographic characteristics at baseline. Five factors, *age* of the survivor (p<0.001), *gender* of the survivor (p=0.035), Survivor *marital status (p<0.001)*, *primary* (p<0.001) and *nursery (p<0.001) level of education* were identified to associate significantly with *treatment for sexual injury needs* among the survivors.

Table 4.7: Treatment for Sexual Violation Injury Needs among Survivors in Relation to Demographic Characteristics at Baseline

	Sexually injured n=81		Not sexually injured n=329			95% CI		p
Variables	**n**	**%**	**n**	**%**	**OR**	**Lower**	**Upper**	**value**
Age of the survivor in years								
6-11 years	64	75.3	21	24.7	55.22	27.59	110.51	**<0.001**
12 years	17	5.2	308	94.8	1.00			
Gender of the survivor								
Female	72	18.7	313	81.3	1.00			
Male	9	36.0	16	64.0	2.45	1.04	5.75	**0.035**
Survivor residence								
Urban	39	21.1	146	78.9	0.89	0.49	1.65	0.722
Peri-Urban	22	15.9	116	84.1	0.64	0.32	1.25	0.189
Rural	20	23.0	67	77.0	1.00			
Survivor employment status								
Employed	54	21.7	195	78.3	1.37	0.82	2.29	0.222
Unemployed	27	16.8	134	83.2	1.00			
Survivor marital status								
Currently married	52	36.4	91	63.6	4.69	2.80	7.84	**<0.001**
Currently not married	29	10.9	238	89.1	1.00			
Highest level of school attended								
Nursery	18	85.7	3	14.3	261.00	40.64	1676.23	**<0.001**
Primary	54	35.3	99	64.7	23.73	5.62	100.19	**<0.001**
Secondary	7	4.8	140	95.2	2.17	0.44	10.71	0.339
Tertiary	2	2.2	87	97.8	1.00			

Significant difference at p<0.05 bolded

Multivariate analysis

Multivariate analysis was performed in order to determine factors associated with *treatment for sexual violation injury* needs among the survivors. Five factors that associated with *treatment for sexual violation injury needs* at p<0.1 during bivariate analysis were considered together in a multivariate analysis. They include *age* of the survivor, *gender* of the survivor, *marital status* of survivor, *primary* and *nursery* level of education. Upon fitting the factors using Binary logistic regression and specifying 'backward conditional' method with removal at p<0.05, four factors were retained in the final analysis as shown in Table 4.8.

Adjusting for *age* of the survivor, *treatment for sexual violation injury needs* among the rape survivors was significantly associated with *age 6-11 years* (AOR=26.34; 95% CI: 11.30 – 61.37; p<0.001). A survivor *aged 6-11 years* was 26.34 times more likely to experience need for *treatment of sexual violation injuries* compared to one *aged 12 years.*

Male gender was significantly associated with *treatment for sexual violation injury needs* among the survivors (AOR=4.29; 95% CI: 1.28 – 14.37; p=0.018). A *male* survivor was 4.29 times more likely to need treatment for sexual injuries compared to a *female* counter part.

Primary level of education was significantly associated with *need for treatment* of *sexual violation injuries* among the survivors (AOR=5.08; 95% CI: 1.07 – 24.18; p=0.041). A survivor with *primary level of education* was 5.08 times more likely to experience need for *treatment of sexual violation injuries* compared to one with *tertiary level.*

Similarly, *nursery level of education* was significantly associated with *need for treatment of sexual violation injuries* among the survivors (AOR=16.02; 95% CI: 2.01 – 127.50; p<0.009). A survivor with nursery level of education was 16.02 times more likely to need treatment for sexual injuries compared to one with tertiary level.

Table 4.8: Factors Associated with Treatment for Sexual Violation Injury Needs among Survivors at Baseline

Variables	AOR	95% CI Lower	95% CI Upper	p value
Full model				
Age of the survivor in years				
6-11 years	29.50	11.70	74.35	**<0.001**
12 years	1.00			
Gender of the survivor				
Female	1.00			
Male	4.20	1.26	14.01	**0.020**
Survivor marital status				
Currently married	1.00			
Currently not married	1.01	0.44	2.31	0.981
Highest level of school attended				
Nursery	17.48	2.17	141.14	**0.007**
Primary	5.25	1.09	25.23	**0.039**
Secondary	1.94	0.37	10.16	0.434
Tertiary	1.00			
Reduced model				
Age of the survivor in years				
6-11 years	26.34	11.30	61.37	**<0.001**
12 years	1.00			
Gender of the survivor				
Female	1.00			
Male	4.29	1.28	14.37	**0.018**
Highest level of school attended				
Nursery	16.02	2.01	127.50	**0.009**
Primary	5.08	1.07	24.18	**0.041**
Secondary	1.98	0.38	10.28	0.415
Tertiary	1.00			

Significant difference at p<0.05 bolded

4.2.5 Factors Associated with Dissatisfaction with Post Rape Care among Survivors at Baseline

Bivariate analysis

Table 4.9 presents analysis of *dissatisfaction with post rape care* among survivors in relation to demographic characteristics at baseline. None of the factors was identified to be associated significantly with *dissatisfaction with post rape care* among the survivors. However, there was strong but non-significant association between *dissatisfaction with post rape care* and residing in *peri-urban* (OR=1.56; 95% CI: 1.00 – 2.44; p=0.051), and *rural* (OR=1.64; 95% CI: 0.98 – 2.75; p=0.058) settlements.

Table 4.9: Dissatisfaction with Post Rape Care among Survivors in Relation to Demographic Characteristics at Baseline

	Dissatisfied n=183		Satisfied n=227			95% CI		p
Variables	**n**	**%**	**n**	**%**	**OR**	**Lower**	**Upper**	**value**
Age of the survivor in years								
6-11 years	42	49.4	43	50.6	1.27	0.79	2.06	0.320
12 years	141	43.4	184	56.6	1.00			
Gender of the survivor								
Female	175	45.5	210	54.5	1.77	0.75	4.20	0.190
Male	8	32.0	17	68.0	1.00			
Survivor residence								
Urban	71	38.4	114	61.6	1.00			
Peri-Urban	68	49.3	70	50.7	1.56	1.00	2.44	0.051
Rural	44	50.6	43	49.4	1.64	0.98	2.75	0.058
Survivor employment status								
Employed	115	46.2	134	53.8	1.17	0.79	1.75	0.432
Unemployed	68	42.2	93	57.8	1.00			
Survivor marital status								
Currently married	58	40.6	85	59.4	1.00			
Currently not married	125	46.8	142	53.2	1.29	0.85	1.95	0.225
Highest level of school attended								
Nursery	6	28.6	15	71.4	1.00			
Primary	65	42.5	88	57.5	1.85	0.68	5.02	0.229
Secondary	67	45.6	80	54.4	2.09	0.77	5.70	0.148
Tertiary	45	50.6	44	49.4	2.56	0.91	7.19	0.075

Significant difference at p<0.05 bolded

4.3 Factors Associated with Psychological Distress Characteristics among Survivors at Baseline.

4.3.1 Factors Associated with Depression among Survivors at Baseline

Bivariate analysis

Table 4.10 presents analysis of *depression* among survivors in relation to demographic characteristics at baseline. Two factors *'age'* of the survivor and survivor *'marital status'* were identified to associate significantly with *occurrence of depression*.
Occurrence of depression was significantly associated with *age category 12 years* (OR=17.06; 95% CI: 9.18 – 31.70; p<0.001).
Being '*currently not married*' among the survivors showed significant association with *occurrence of depression* among the survivors (OR=3.92; 95% CI: 2.27 - 6.77; p<0.001).

There was a strong but non-significant association between *occurrence of depression* and *female gender* (OR=1.88; 95% CI: 0.96 – 3.69; p=0.061).

Similarly, there was a strong but non-significant association between *occurrence of depression* and *unemployment* (OR=1.68; 95% CI: 0.95 – 2.95; p=0.072).

Table 4.10: Depression among Survivors in Relation to Demographic Characteristics at Baseline

Variables	Present n=344 n	%	Absent n=66 n	%	OR	95% CI Lower	Upper	p value
Age of the survivor in years								
6-11 years	32	43.2	42	56.8	1.00			
12 years	312	92.9	24	7.1	17.06	9.18	31.70	**<0.001**
Gender of the survivor								
Female	301	85.3	52	14.7	1.88	0.96	3.69	0.061
Male	43	75.4	14	24.6	1.00			
Residence of the survivor								
Urban	155	83.8	30	16.2	1.35	0.70	2.58	0.368
Peri-Urban	120	87.0	18	13.0	1.74	0.85	3.56	0.131
Rural	69	79.3	18	20.7	1.00			
Survivor employment status								
Employed	199	81.2	46	18.8	1.00			
Unemployed	145	87.9	20	12.1	1.68	0.95	2.95	0.072
Survivor marital status								
Currently married	97	70.8	40	29.2	1.00			
Currently not married	247	90.5	26	9.5	3.92	2.27	6.77	**<0.001**
Highest level of school attended								
Nursery	18	85.7	3	14.3	1.03	0.26	3.98	0.970
Primary	130	85.0	23	15.0	0.97	0.46	2.02	0.928
Secondary	120	81.6	27	18.4	0.76	0.37	1.56	0.456
Tertiary	76	85.4	13	14.6	1.00			

Key: Significant difference at p< 0.05 bolded; OR – odds ratio; 95%CI -95% confidence interval

Depression status among survivors in relation to other psychological distress characteristics at baseline is presented in Table 4.11. The presence of all other three psychological distress characteristics - *Self blame*, *Shame*, and *RTS* were all significantly (P<0.001) associated with *occurrence of depression.*

Table 4.11: Depression among Survivors in Relation to other Psychological Distress Characteristics at Baseline

	Present n=344		Absent n=66			95% CI		p
Variables	**n**	**%**	**n**	**%**	**OR**	**Lower**	**Upper**	**value**
Self blame among the survivors								
Present	269	94.7	15	5.3	12.19	6.49	22.90	**<0.001**
Absent	75	59.5	51	40.5	1.00			
Shame among the survivors								
Present	306	93.9	20	6.1	18.52	9.92	34.56	**<0.001**
Absent	38	45.2	46	54.8	1.00			
RTS among the survivors								
Present	324	92.3	27	7.7	23.40	12.01	45.59	**<0.001**
Absent	20	33.9	39	66.1	1.00			

Significant difference at p< 0.05 bolded

Multivariate analysis

Multivariate analysis was performed in order to identify factors associated with *occurrence of depression* among the survivors. Seven factors that associated with *occurrence of depression* at p<0.1 during bivariate analysis were considered together in a multivariate analysis. They include *age* of the survivor, *gender* of the survivor, survivor *employment status*, survivor *marital status*, *self blame*, *shame*, and *RTS*. Upon fitting the factors using Binary logistic regression and specifying 'backward conditional' method with removal at p<0.05, three factors were retained in the final analysis as shown in Table 4.12.

Adjusting for other factors, Age 12 years was significantly associated with *occurrence of depression* (AOR=4.90; 95% CI: 2.27-10.61; p<0.001). A survivor *aged 12 years* was 4.90 times more likely to experience *depression* compared to one *aged 6-11 years*.
A *feeling of Self blame* was significantly associated with *occurrence of depression* (AOR=3.60; 95% CI: 1.64 – 7.86; p=0.001). A survivor with a *feeling of Self blame* was 3.60 times more likely to experience *depression* compared to one without.
Having *RTS* was significantly associated with *occurrence of depression* (AOR=9.15; 95% CI: 4.29 –19.53; p<0.001). A survivor with *RTS* was 9.15 times more likely to experience *depression* compared to one without.

Table 4.12: Factors Associated with Depression among Survivors at Baseline

Variables	AOR	95% CI Lower	95% CI Upper	p value
Full model				
Age of the survivor in years				
6-11 years	1.00			
12 years	2.98	1.14	7.80	**0.026**
Gender of the survivor				
Female	1.02	0.37	2.81	0.965
Male	1.00			
Survivor employment status				
Employed	1.00			
Unemployed	1.76	0.72	4.33	0.218
Survivor marital status				
Currently married	1.00			
Currently not married	1.11	0.44	2.80	0.823
Self blame among the survivors				
Present	3.66	1.66	8.09	**0.000**
Absent	1.00			
Shame among the survivors				
Present	2.42	0.92	6.37	0.072
Absent	1.00			
RTS among the survivors				
Present	8.09	3.53	18.55	**<0.001**
Absent	1.00			
Reduced model				
Age of the survivor in years				
6-11 years	1.00			
12 years	4.90	2.27	10.61	**<0.001**
Self blame among the survivors				
Present	3.60	1.64	7.86	**0.001**
Absent	1.00			
RTS among the survivors				
Present	9.15	4.29	19.53	**<0.001**
Absent	1.00			

Key: - Significant difference at p< 0.05 bolded
- AOR –adjusted odds ratio
- CI- confidence interval

4.3.2 Factors Associated with Self blame among Survivors at Baseline

Bivariate analysis

Table 4.13 presents analysis of *self blame* among survivors at baseline in relation to demographic characteristics. Three factors *age* of the survivor ($p<0.001$), *gender* of the survivor ($p=0.021$), and survivor *marital status* ($p<0.001$) were significantly associated with survivor *feeling of self blame*.

Table 4.13: Self blame among Survivors in Relation to Demographic Characteristics at Baseline

	Present n=284		Absent n=126			95% CI		p
Variables	**N**	**%**	**n**	**%**	**OR**	**Lower**	**Upper**	**value**
Age of the survivor in years								
6- 11 years	13	17.6	61	82.4	1.00			
12 years	271	80.7	65	19.3	19.56	10.14	37.74	**<0.001**
Gender of the survivor								
Female	252	71.4	101	28.6	1.95	1.10	3.45	**0.021**
Male	32	56.1	25	43.9	1.00			
Survivor residence								
Urban	127	68.6	58	31.4	1.21	0.71	2.08	0.483
Peri-Urban	101	73.2	37	26.8	1.51	0.85	2.69	0.162
Rural	56	64.4	31	35.6	1.00			
Survivor employment status								
Employed	165	67.3	80	32.7	1.00			
Unemployed	119	72.1	46	27.9	1.25	0.81	1.93	0.304
Survivor marital status								
Currently married	71	51.8	66	48.2	1.00			
Currently not married	213	78.0	60	22.0	3.30	2.12	5.13	**<0.001**
Highest level of school attended								
Nursery	17	81.0	4	19.0	2.27	0.70	7.34	0.170
Primary	113	73.9	40	26.1	1.51	0.86	2.66	0.154
Secondary	96	65.3	51	34.7	1.01	0.58	1.75	0.983
Tertiary	58	65.2	31	34.8	1.00			

Significant difference at p< 0.05 bolded

Feeling of self blame among survivors in relation to other psychological distress characteristics at baseline is presented in Table 4.14. All other three psychological distress characteristics *depression*, *Shame*, and *RTS* were all significantly (P<0.001) associated with occurrence of *feeling of Self blame*.

Table 4.14: Self blame among Survivors in Relation to other Psychological Distress Characteristics at Baseline

Variables	Present n=284		Absent n=126		OR	95% CI		p value
	n	%	n	%		Lower	Upper	
Depression among the survivors								
Present	269	78.2%	75	21.8%	12.19	6.49	22.90	**<0.001**
Absent	15	22.7%	51	77.3%	1.00			
Shame among the survivors								
Present	272	83.4%	54	16.6%	30.22	15.35	59.49	**<0.001**
Absent	12	14.3%	72	85.7%	1.00			
RTS among the survivors								
Present	270	76.9%	81	23.1%	10.71	5.60	20.51	**<0.001**
Absent	14	23.7%	45	76.3%	1.00			

Significant difference at p< 0.05 bolded

Multivariate analysis

Multivariate analysis was performed in order to identify factors associated with *feeling of self blame* among the survivors. Six factors that associated with *feeling of self blame* at p<0.1 during bivariate analysis were considered together in a multivariate analysis. They include *age* of the survivor, *gender* of the survivor, survivor *marital status*, *depression* among the survivors, *shame* among the survivors, and *RTS* among the survivors. Upon fitting the factors using Binary logistic regression and specifying 'backward conditional' method with removal at p<0.05, three factors were retained in the final analysis as shown in Table 4.15.

Adjusting for other factors, *age 12 years* was significantly associated with *feeling of self blame* among the survivors (AOR=4.65; 95% CI: 2.06 – 10.48; p<0.001). A survivor *aged 12 years* was 4.65 times more likely to experience a *feeling of self blame* compared to one *aged 6-11 years*.

A *feeling of self blame* was also significantly associated with *occurrence of depression* among the survivors (AOR=2.70; 95% CI: 1.17 – 6.22; p=0.019). A survivor with *depression* was 2.70 times more likely to experience a *feeling of self blame* compared to one without.

Experiencing shame was significantly associated with a *feeling of self blame* among the survivors (OR=11.35; 95% CI: 5.32 – 24.24; p<0.001). A survivor with *shame* was 11.35 times more likely to experience a *feeling of self blame* compared to one without.

Table 4.15: Factors Associated with Self blame among Survivors at Baseline

Variables	AOR	95% CI Lower	95% CI Upper	p value
Full model				
Age of the survivor in years				
6- 11 years	1.00			
12 years	3.82	1.59	9.13	**0.003**
Gender of the survivor				
Female	1.33	0.59	2.99	0.487
Male	1.00			
Survivor marital status				
Currently married	1.00			
Currently not married	1.39	0.75	2.59	0.300
Depression among the survivors				
Present	2.48	1.03	5.98	**0.042**
Absent	1.00			
Shame among the survivors				
Present	10.64	4.73	23.92	**<0.001**
Absent	1.00			
RTS among the survivors				
Present	1.30	0.48	3.50	0.610
Absent	1.00			
Reduced model				
Survivor/Guardian age in years				
6- 11 years	1.00			
12 years	4.65	2.06	10.48	**<0.001**
Depression among the survivors				
Present	2.70	1.17	6.22	**0.019**
Absent	1.00			
Shame among the survivors				
Present	11.35	5.32	24.24	**<0.001**
Absent	1.00			

Significant difference at p< 0.05 bolded

4.3.2 Factors Associated with Shame among Survivors at Baseline

Bivariate analysis

Table 4.16 presents analysis of *shame* among survivors in relation to demographic characteristics at baseline. Three factors *age* of the survivor (P<0.001), *gender* of the survivor (P<0.001), and survivor *marital status* (P<0.001) were significantly associated with survivor's *experience of shame.*

Table 4.16: Shame among Survivors in Relation to Demographic Characteristics at Baseline

	Present n=326		Absent n=84			95% CI		p
Variables	**n**	**%**	**n**	**%**	**OR**	**Lower**	**Upper**	**value**
Age of the survivor in years								
6- 11 years	19	25.7	55	74.3	1.00			
12 years	307	91.4	29	8.6	30.64	16.07	58.45	**<0.001**
Gender of the survivor								
Female	288	81.6	65	18.4	2.22	1.20	4.09	**<0.001**
Male	38	66.7	19	33.3	1.00			
Survivor residence								
Urban	150	81.1	35	18.9	1.45	0.79	2.66	.230
Peri-Urban	111	80.4	27	19.6	1.39	0.73	2.64	.312
Rural	65	74.7	22	25.3	1.00			
Survivor employment status								
Employed	194	79.2	51	20.8	1.00			
Unemployed	132	80.0	33	20.0	1.05	.64	1.72	0.841
Survivor marital status								
Currently married	87	63.5	50	36.5	1.00			
Currently not married	239	87.5	34	12.5	4.04	2.45	6.66	**<0.001**
Highest level of school attended								
Nursery	17	81.0	4	19.0	1.31	0.40	4.33	0.655
Primary	130	85.0	23	15.0	1.75	0.90	3.38	0.098
Secondary	111	75.5	36	24.5	0.95	0.51	1.76	0.876
Tertiary	68	76.4	21	23.6	1.00			

Significant difference at p< 0.05 bolded

Experience of shame among survivors in relation to other psychological distress characteristics at baseline is presented in Table 4.17. All other three psychological distress characteristics namely: *depression*, *self blame*, and *RTS* were all significantly (p<0.001) associated with *experience of shame* among the survivors.

Table 4.17: Shame among Survivors in Relation to other Psychological Distress Characteristics at Baseline

Variables	Present n=326		Absent n=84			95% CI		p value
	n	**%**	**n**	**%**	**OR**	**Lower**	**Upper**	
Depression among the survivors								
Present	306	89.0%	38	11.0%	18.52	9.92	34.56	**<0.001**
Absent	20	30.3%	46	69.7%	1.00			
Self blame among the survivors								
Present	272	95.8%	12	4.2%	30.22	15.35	59.49	**<0.001**
Absent	54	42.9%	72	57.1%	1.00			
RTS among the survivors								
Present	312	88.9%	39	11.1%	25.71	12.95	51.06	**<0.001**
Absent	14	23.7%	45	76.3%	1.00			

Significant difference at p< 0.05 bolded

Multivariate analysis

Multivariate analysis was performed in order to identify factors associated with *experience of shame* among the survivors. Six factors that associated with *experience of shame* at p<0.1 during bivariate analysis were considered together in a multivariate analysis. They include *age* of the survivor, *gender* of the survivor, survivor *marital status*, *depression* among the survivors, *shame* among the survivors, and *RTS* among the survivors. Upon fitting the factors using Binary logistic regression and specifying ‘backward conditional’ method with removal at p<0.05, three factors were retained in the final analysis as shown in Table 4.18.

Adjusting for other factors, *age 12 years* was significantly associated with *experience of shame* among the survivors (AOR=8.16; 95% CI: 3.69 – 18.03; p<0.001). A survivor *aged 12 years* was 8.16 times more likely to *experience shame* compared to one *aged 6-11 years.*

A *feeling of self blame* was also significantly associated with *shame* among the survivors (AOR=12.05; 95% CI: 5.44 – 26.67; p<0.001). A survivor with a *feeling of self blame* was 12.05 times more likely to *experience shame* compared to one without.

Experiencing shame was also significantly associated with *having RTS* among the survivors (AOR=10.38; 95% CI: 4.24 – 25.41; p<0.001). A survivor with *RTS* was 10.38 times more likely to *experience of shame* compared to one without.

Table 4.18: Factors Associated with Shame among Survivors at Baseline

Variables	AOR	95% CI Lower	95% CI Upper	p value
Full model				
Age of the survivor in years				
6- 11 years	1.00			
12 years	7.00	2.602	18.85	**<0.001**
Gender of the survivor				
Female	1.21	0.43	3.44	0.721
Male	1.00			
Survivor marital status				
Currently married	1.00			
Currently not married	0.94	0.38	2.35	0.899
Depression among the survivors				
Present	2.03	0.77	5.34	0.152
Absent	1.00			
Self blame among the survivors				
Present	10.95	4.86	24.64	**<0.001**
Absent	1.00			
RTS among the survivors				
Present	7.98	2.99	21.31	**<0.001**
Absent	1.00			
Reduced model				
Age of the survivor in years				
6- 11 years	1.00			
12 years	8.16	3.69	18.03	**<0.001**
Self blame among the survivors				
Present	12.05	5.44	26.67	**<0.001**
Absent	1.00			
RTS among the survivors				
Present	10.38	4.24	25.41	**<0.001**
Absent	1.00			

Significant difference at p< 0.05 bolded

4.3.4 Factors Associated with RTS among Survivors at Baseline

Bivariate analysis

Table 4.19 presents analysis of *RTS* among survivors in relation to demographic characteristics at baseline. Two factors namely: *age* of the survivor in years (p<0.001) and survivor *marital status* (p=0.001) were significantly associated with *occurrence of RTS* among the survivors.

Table 4.19: Rape Trauma Syndrome among Survivors in Relation to Demographic Characteristics at Baseline

	Present n=351		Absent n=59			95% CI		p
Variables	**N**	**%**	**n**	**%**	**OR**	**Lower**	**Upper**	**value**
Age of the survivor in years								
6- 11 years	38	51.4	36	48.6	1.00			
12 years	313	93.2	23	6.8	12.89	6.92	24.02	**<0.001**
Gender of the survivor								
Female	306	86.7	47	13.3	1.74	0.86	3.52	0.122
Male	45	78.9	12	21.1	1.00			
Survivor residence								
Urban	159	85.9	26	14.1	1.27	0.64	2.55	0.494
Peri-Urban	120	87.0	18	13.0	1.39	0.66	2.93	0.387
Rural	72	82.8	15	17.2	1.00			
Survivor employment status								
Employed	211	86.1	34	13.9	1.11	0.63	1.94	0.719
Unemployed	140	84.8	25	15.2	1.00			
Survivor marital status								
Currently married	106	77.4	31	22.6	1.00			
Currently not married	245	89.7	28	10.3	2.56	1.46	4.48	**0.001**
Highest level of school attended								
Nursery	17	81.0	4	19.0	0.73	0.21	2.51	0.614
Primary	136	88.9	17	11.1	1.37	0.63	2.97	0.427
Secondary	122	83.0	25	17.0	0.83	0.40	1.73	0.627
Tertiary	76	85.4	13	14.6	1.00			

Significant difference at p< 0.05 bolded

Occurrence of RTS among the survivors in relation to other psychological distress characteristics at baseline is presented in Table 4.20. All other three psychological distress characteristics namely: *depression, self blame,* and *shame* were all significantly (p<0.001) associated with occurrence of *RTS* among the survivors.

Table 4.20: Rape Trauma Syndrome among Survivors in Relation to other Psychological Distress Characteristics at Baseline

	Present n=351		Absent n=59			95% CI		p
Variables	**n**	**%**	**n**	**%**	**OR**	**Lower**	**Upper**	**value**
Depression among the survivors								
Present	324	94.2	20	5.8	23.40	12.01	45.59	**<0.001**
Absent	27	40.9	39	59.1	1.00			
Self blame among the survivors								
Present	270	95.1	14	4.9	10.71	5.60	20.51	**<0.001**
Absent	81	64.3	45	35.7	1.00			
Shame among the survivors								
Present	312	95.7	14	4.3	25.71	12.95	51.06	**<0.001**
Absent	39	46.4	45	53.6	1.00			

Significant difference at p< 0.05 bolded

Multivariate analysis

Multivariate analysis was performed in order to identify factors associated with *occurrence of RTS* among the survivors. Five factors that were associated with *occurrence of RTS* at p<0.1 during bivariate analysis were considered together in a multivariate analysis. They include *age* of the survivor, survivor *marital status*, *depression* among the survivors, *self blame* among the survivors, and *shame* among the survivors. Upon fitting the factors using Binary logistic regression and specifying 'backward conditional' method with removal at p<0.05, two factors were retained in the final analysis as shown in Table 4.21.

Adjusting for other factors, occurrence of RTS was significantly associated with *occurrence of depression* among the survivors (AOR=8.30; 95% CI: 3.84 – 17.94; p<0.001). A survivor with *depression* was 8.30 times more likely to *experience RTS* compared to one without.

Occurrence of RTS was also significantly associated with *experience of shame* among the survivors (AOR=11.30; 95% CI: 5.27 – 24.26; p<0.001). A survivor with *experience of shame* was 11.30 times more likely to experience *RTS* compared to one without.

Table 4.21: Factors Associated with Rape Trauma Syndrome among Survivors at Baseline

Variables	AOR	95% CI		p
		Lower	Upper	value
Full model				
Age of the survivor in years				
6- 11 years	1.00			
12 years	1.98	0.68	5.81	0.213
Survivor marital status				
Currently married	1.00			
Currently not married	1.78	0.70	4.56	0.227
Depression among the survivors				
Present	7.28	3.20	16.57	**<0.001**
Absent	1.00			
Self blame among the survivors				
Present	1.33	0.48	3.66	0.579
Absent	1.00			
Shame among the survivors				
Present	8.23	3.09	21.95	**<0.001**
Absent	1.00			
Reduced model				
Depression among the survivors				
Present	8.30	3.84	17.94	**<0.001**
Absent	1.00			
Shame among the survivors				
Present	11.30	5.27	24.26	**<0.001**
Absent	1.00			

Significant difference at p< 0.05 bolded

4.4 Assessing Efficacy of the Intervention on Psychological Distress Characteristics of Survivors

Assessment of efficacy of the intervention on psychological distress characteristics of survivors was done as presented in section 4.4. Each section presents the analysis of each psychological distress characteristic.

4.4.1 Efficacy of the Intervention on Depression among Survivors

Table 4.22 presents the efficacy of the intervention on *depression* among survivors.

Between groups comparisons revealed significant findings. At baseline, the proportion of *depression* in Intervention group (81.3%) was not significantly different from the one in Non-intervention group (85.1%), ($p=0.325$). Similarly, after three months intervention, assessment of *depression* among rape survivors at Follow-up1 revealed that the proportion of *depression* among survivors in Intervention group (60.9%) was not significantly different from the one in Non-intervention group (60.6%), ($p=0.955$). Similarly, after six months intervention, assessment of *depression* among rape survivors at Follow-up2 revealed that the proportion of *depression* among survivors in Intervention group (40.7%) was not significantly different from the one in Non-intervention group (38.1%), ($p=0.543$). Surprisingly, however, after nine months intervention, assessment of *depression* among rape survivors at Follow-up3 revealed that the proportion of *depression* among survivors in Intervention group (25.0%) was significantly higher compared to those in Non-intervention group (2.4%), ($p<0.001$).

Within group comparisons demonstrated positive outcomes in both Intervention and Non-intervention groups. Within the intervention group, *depression* among survivors significantly dropped from 81.3% at baseline to 60.9% at Follow-up1 (20.4% change), ($p<0.001$). Within the Non-intervention group for the same duration, the proportion dropped from 85.1% at baseline to 60.6% at Follow-up1 (24.5% change), ($p<0.001$). After two successive interventions, *depression* among survivors significantly dropped from 81.3% at baseline to 38.1% at Follow-up2 (43.2% change), ($p<0.001$). Within the Non-intervention group for the same duration, the proportion dropped from 85.1% at baseline to 41.8% at Follow-up2 (43.3% change), ($p<0.001$). After three successive interventions, *depression* among survivors significantly dropped from 81.3% at baseline to 25.0% at Follow-up3 (56.3% change), ($p<0.001$). Within the Non-intervention group for the same duration, the proportion dropped from 85.1% at baseline to 2.4% at Follow-up3 (82.7% change), ($p<0.001$).

As demonstrated by the ^{2} value, the magnitude of change by the 9th month was surprisingly higher in the Non-intervention arm (3rd month=41.13; 6th month=104.52; 9th month=325.50) compared to Intervention arm (3rd month=12.37; 6th month=43.83; 9th month=67.89).

Table 4.22: Depression among Survivors at Different Follow-up Visits

Follow-up visits	Total n	Total %	Intervention n	Intervention %	Non-intervention n	Non-intervention %	OR(95% CI)	p value
Baseline	**n=410**		**n=128**		**n=282**			
Depression	344	83.9	104	81.3	240	85.1	0.76(0.42-1.38)	0.325
No depression	66	16.1	24	18.8	42	14.9	1.00	
3rd Month	**n=366**		**n=119**		**n=251**			
Depression	222	60.7	70	60.9	152	60.6	1.01(0.63-1.64)	0.955
No depression	144	39.3	45	39.1	99	39.4	1.00	
			^{2} =12.37, df=1, **p<0.001**		^{2} =41.13, df=1, **p<0.001**			
6th Month	**n=322**		**n=97**		**n=225**			
Depression	131	40.7	37	38.1	94	41.8	0.86(0.51-1.44)	0.543
No depression	191	59.3	60	61.9	131	58.2	1.00	
			^{2} =43.83, df=1, **p<0.001**		^{2} =104.52, df=1, **p<0.001**			
9th Month	**n=294**		**n=88**		**n=206**			
Depression	27	9.2	22	25.0	5	2.4	13.26(4.66-46.62)	**<0.001**
No depression	267	90.8	66	75.0	201	97.6	1.00	
			^{2} =67.89, df=1, **p<0.001**		^{2} =325.50, df=1, **p<0.001**			

Significant difference at p< 0.05 bolded

4.4.1 Efficacy of the Intervention on Self blame among Survivors

Table 4.23 presents the efficacy of the intervention on *self blame* among survivors.

Between groups comparisons revealed significant findings. At baseline, the proportion of *self blame* in Intervention group (64.8%) was not significantly different from the one in Non-intervention group (71.3%), (*p=0.191*). Similarly, after three months intervention, assessment of Self blame among survivors at Follow-up1 revealed that the proportion of *self blame* among survivors in Intervention group (65.2%) was not significantly different from the one in Non-intervention group (68.5%), (*p=0.530*). Surprisingly, after six months intervention, assessment of Self blame among survivors at Follow-up2 revealed that the proportion of *self blame* among survivors in Intervention group (47.4%) was significantly different from the one in Non-intervention group (31.1%), (*p=0.005*). However, after nine months intervention, assessment of *self blame* among survivors at Follow-up3 revealed that the proportion of *self blame* among survivors in the Intervention group (15.9%) was significantly lower compared to the one in the Non-intervention group (26.2%), (*p=0.055*).

Within group comparisons demonstrated positive outcomes in both Intervention and Non-intervention groups. Within the Intervention group, *self blame* among rape survivors increased insignificantly from 64.8% at baseline to 65.2% at Follow-up1 (0.4% change), (p=0.951). Within the Non-intervention group for the same duration, the proportion dropped insignificantly from 71.3% at baseline to 68.5% at Follow-up1 (2.8% change), (p=0.489). After two successive interventions, *self blame* among rape survivors significantly dropped from 64.8% at baseline to 47.4% at Follow-up2 (17.4% change), (*p=0.009*). Within the Non-intervention group for the same duration, the proportion dropped from 71.3% at baseline to 31.1% at Follow-up2 (40.2% change), (*p<0.001*). After three successive interventions, *self blame* among rape survivors significantly dropped from 64.8% at baseline to 15.9% at Follow-up3 (48.9% change),

($p<0.001$), within the Intervention group. Within the Non-intervention group for the same duration, the proportion dropped from 71.3% at baseline to 26.2% at Follow-up3 (45.1% change), ($p<0.001$).

As demonstrated by the ^{2} value, the magnitude of change was significantly higher in the Non-intervention arm by the 6th month (3rd month=0.48; 6th month=81.15; 9th month=96.89) as compared to the Intervention arm (3rd month=<0.01; 6th month=6.85; 9th month=50.47). However, by the 9th month the magnitude of change was higher in the Intervention group, though the difference was not significant.

Table 4.23: Self Blame among Survivors at Different Follow-up Visits

Follow-up visits	Total n	Total %	Intervention n	Intervention %	Non-intervention n	Non-intervention %	OR(95% CI)	p value
Baseline	**n=410**		**n=128**		**n=282**			
Self Blame	284	69.3	83	64.8	201	71.3	0.74(0.47-1.19)	0.191
No self Blame	126	30.7	45	35.2	81	28.7	1.00	
3rd Month	n=366		n=119		n=251			
Self Blame	247	67.5	75	65.2	172	68.5	0.86(0.53-1.42)	0.530
No self Blame	119	32.5	40	34.8	79	31.5	1.00	
			^{2}<0.01, df=1, p=0.951		^{2} =0.48, df=1, p=0.489			
6th Month	**n=322**		**n=97**		**n=225**			
Self Blame	116	36.0	46	47.4	70	31.1	1.99(1.19-3.35)	**0.005**
No self Blame	206	64.0	51	52.6	155	68.9	1.00	
			^{2}=6.85, df=1, **p=0.009**		^{2} =81.15, df=1, **p<0.001**			
9th Month	**n=294**		**n=88**		**n=206**			
Self Blame	68	23.1	14	15.9	54	26.2	0.53(0.26-1.05)	0.055
No self Blame	226	76.9	74	84.1	152	73.8	1.00	
			^{2}=50.47, df=1, **p<0.001**		^{2} =96.89, df=1, **p<0.001**			

Significant difference at p< 0.05 bolded

4.4.2 Efficacy of the Intervention on Shame among Survivors

Table 4.24 presents the efficacy of the intervention on *shame* among survivors.

Between groups comparisons at baseline, the proportion of in Intervention group (79.7%) was not significantly different from the one in Non-intervention group (79.4%), (*p=0.953*). Similarly, after three months intervention, assessment of *shame* among survivors at Follow-up1 revealed that the proportion of Shame among survivors in Intervention group (78.3%) was not significantly different from the one in Non-intervention group (77.7%), (*p=0.903*). Contrary to expectation, however, after six months intervention, assessment of *shame* among survivors at Follow-up2 revealed that the proportion of *shame* among survivors in Intervention group (44.3%) was significantly higher than that in the Non-intervention group (31.6%), (*p=0.028*). But after nine months of intervention, assessment of *shame* among survivors at Follow-up3 revealed that the proportion of *shame* among survivors in Intervention group (21.6%) was not significantly different from the one in Non-intervention group (14.1%), (*p=0.110*).

Within group comparisons demonstrated high performance in both Intervention and Non-intervention groups. Within the Intervention group, *shame* among survivors decreased insignificantly from 79.7% at baseline to 78.3% at Follow-up1 (1.4% change), (p=0.785). Within the Non-intervention group for the same duration, the proportion dropped insignificantly from 71.3% at baseline to 77.7% at Follow-up1 (1.7% change), (p=0.624). After two successive interventions, *shame* among survivors dropped significantly from 79.7% at baseline to 44.3% at Follow-up2 (35.4% change), (*p<0.001*). Within the Non-intervention group for the same duration, the proportion dropped from 79.4% at baseline to 31.6% at Follow-up2 (47.8% change), (*p<0.001*). After three successive interventions, *shame* among rape survivors significantly dropped from 79.7% at baseline to 21.6% at Follow-up3 (58.1% change), (*p<0.001*). Within the

Non-intervention group for the same duration, the proportion dropped from 79.4% at baseline to 14.1% at Follow-up3 (65.3% change), (*p<0.001*).

As demonstrated by the ^{2} value, the magnitude of change was significantly higher in the Non-intervention arm by the 6th and 9th month (3rd month=0.24; 6th month=117.91; 9th month=203.66) as compared to the Intervention arm (3rd month=0.07; 6th month=30.11; 9th month=71.44).

Table 4.24: Shame among Survivors at Different Follow-up Visits

Follow-up visits	Total n	Total %	Intervention n	Intervention %	Non-intervention n	Non-intervention %	OR(95% CI)	p value
Baseline	**n=410**		**n=128**		**n=282**			
Shame	326	79.5	102	79.7	224	79.4	1.02(0.59-1.78)	0.953
No shame	84	20.5	26	20.3	58	20.6	1.00	
3rd Month	**n=366**		**n=119**		**n=251**			
Shame	285	77.9	90	78.3	195	77.7	1.03(0.59-1.85)	0.903
No shame	81	22.1	25	21.7	56	22.3	1.00	
			^{2}=0.07, df=1, p=0.785		^{2}=0.24, df=1, p=0.624			
6th Month	**n=322**		**n=97**		**n=225**			
Shame	114	35.4	43	44.3	71	31.6	1.72(1.03-2.90)	**0.028**
No shame	208	64.6	54	55.7	154	68.4	1.00	
			^{2}=30.11, df=1, **p<0.001**		^{2}=117.91, df=1, **p<0.001**			
9th Month	**n=294**		**n=88**		**n=206**			
Shame	48	16.3	19	21.6	29	14.1	1.68(0.83-3.33)	0.110
No shame	246	83.7	69	78.4	177	85.9	1.00	
			^{2}=71.44, df=1, **p<0.001**		^{2}=203.66, df=1, **p<0.001**			

Significant difference at p< 0.05 bolded

4.4 2 Efficacy of the Intervention on RTS among Survivors

Table 4.25 presents the efficacy of the intervention on *RTS* among survivors.
In between groups comparisons at baseline, the proportion of *RTS* in Intervention group (86.7%) was not significantly different from the one in Non-intervention group (85.1%), (*p=0.666*). Similarly, after three months intervention, assessment of *RTS* among survivors at Follow-up1 revealed that the proportion of *RTS* among survivors in Intervention group (74.8%) was significantly different from the one in Non-intervention group (84.1%), (*p=0.035*). After six months intervention, assessment of *RTS* among survivors at Follow-up2 revealed that the proportion of *RTS* among survivors in Intervention group (52.6%) was not significantly different from the one in Non-intervention group (45.8%), (*p=0.262*). After nine months intervention, assessment of *RTS* among survivors at Follow-up3 revealed that the proportion of *RTS* among survivors in Intervention group (35.2%) was significantly different from the one in Non-intervention group (5.3%), (*p<0.001*).

Within group comparisons demonstrated high performance in both Intervention and Non-intervention groups. Within the Intervention group, *RTS* among survivors decreased significantly from 86.7% at baseline to 74.8% at Follow-up1 (11.9% change), (p=0.018). Within the Non-intervention group for the same duration, the proportion dropped insignificantly from 85.1% at baseline to 84.1% at Follow-up1 (1.0% change), (p=0.739). After two successive interventions, *RTS* among survivors dropped significantly from 86.7% at baseline to 52.6% at Follow-up2 (34.1% change), (*p<0.001*). Within the Non-intervention group for the same duration, the proportion dropped from 85.1% at baseline to 45.8% at Follow-up2 (39.3% change), (*p<0.001*). After three successive interventions, *RTS* among survivors significantly dropped from 86.7% at baseline to 35.2% at Follow-up3 (51.5% change), (*p<0.001*). Within the Non-

intervention group for the same duration, the proportion dropped from 85.1% at baseline to 5.3% at Follow-up3 (79.8% change), ($p<0.001$).

As demonstrated by the ^{2} value, the magnitude of change was higher in the Non-intervention arm (3rd month=0.11; 6th month=88.45; 9th month=303.22) as compared to Intervention arm (3rd month=5.62; 6th month=31.91; 9th month=61.39).

Table 4.25: Rape Trauma Syndrome among Survivors at Different Follow-up Visits

Follow-up visits	Total n	Total %	Intervention n	Intervention %	Non-intervention n	Non-intervention %	OR(95% CI)	p value
Baseline	**n=410**		**n=128**		**n=282**			
RTS	351	85.6	111	86.7	240	85.1	1.14(0.60-2.24)	0.666
No RTS	59	14.4	17	13.3	42	14.9	1.00	
3rd Month	**n=366**		**n=119**		**n=251**			
RTS	297	81.1	86	74.8	211	84.1	0.56(0.32-1.01)	**0.035**
No RTS	69	18.9	29	25.2	40	15.9	1.00	
			^{2}=5.62, df=1, **p=0.018**		^{2} =0.11, df=1, p=0.739			
6th Month	**n=322**		**n=97**		**n=225**			
RTS	154	47.8	51	52.6	103	45.8	1.31(0.79-2.18)	0.262
No RTS	168	52.2	46	47.4	122	54.2	1.00	
			^{2}=31.91, df=1, **p<0.001**		^{2} =88.45, df=1**, p<0.001**			
9th Month	**n=294**		**n=88**		**n=206**			
RTS	42	14.3	31	35.2	11	5.3	9.55(4.35-22.45)	**<0.001**
No RTS	252	85.7	57	64.8	195	94.7	1.00	
			^{2}=61.39, df=1, **p<0.001**		^{2} =303.22, df=1**, p<0.001**			

Significant difference at p< 0.05 bolded

CHAPTER FIVE

5.0 DISCUSSION

5.1 Social Demographics

Baseline results demonstrate high risk of rape among adolescents, youths and females. This finding is similar to results of studies in Kenya by Mildred and Plummer (2009); and other parts of Africa (WHO, 2005), but lower compared to results 89% of a study in South African by Christofides *et al*. (2005). The study population was dominated by *female* respondents 86.1%, a reflection that *females* are at higher risk for sexual violation. This might be related to the fact that majority of the respondents were *female* who lack the strength and societal will power and support to fight sexual violation. Another probable reason may be because more than half of the f*emale* respondents were not in a *marital* relationship 66.6%. Persons who are not married are more likely to engage in sexual activities for reasons such as financial gains thus increasing their vulnerability. This has a lot of setbacks to the achievement of the 3rd and 5th MDG (UN, 2000).

Overall, 13.9 % (57) of respondents in this study were *male*. This low exposure to risk of rape among males is similar to the result of studies in Kenya – (Mildred and Plummer, 2009) in Nairobi; and (Mwangi and Jaldesa, 2009) in Wajir; of men who were sexually violated. The small number of male respondents may be explained by non-disclosure by *male* survivors for fear of community stigma and discrimination.

There was a higher incidence of rape among *urban residence* in comparison to rural residence at baseline. This finding is consistent with results of other African studies which found high risk of rape in urban and peri-urban areas (WHO, 2004).

5.2 Post - rape Psycho-social Health Needs and Dissatisfactions with post-rape services

One specific objective of this investigation was to identify the baseline psycho-social health needs among rape survivors.

Baseline results revealed survivors had varied post rape *psycho-social health needs* (Table 4.3) in both study arms. Four out of the five psycho-social needs had no significant difference between the two study arms, which meant that the two study groups were similar at baseline, (except for the *Safety need)*. These findings are consistent with results from African studies (United Nations High Commissioner for Refugees, 2003; Csete and Kippenberg, 2002) which found significant need for protective actions to prevent re-victimization if the perpetrator is a close relative living within or near the family.

Results of the current study indicated that the highest observed psycho-social need was *safety* (92.9%), which was also significantly different between the two study arms (p=0.004); whereas the least observed was need for *treatment for sexual violation injury* (19.8%) of all study participants. Results indicated that *safety need* was found to significantly associate with *peri-urban residence* (OR=2.74; 95% CI: 0.87-8.61; p=0.042). This finding is consistent with previous reports of studies by Li-Yu (2012); Chiara, Carlos, and Jennifer (2012); Christofides *et al.* (2006); WHO (2004), which highlight the importance of prevention of HIV, other sexually transmitted infections and pregnancy. Other studies also revealed reports consistent with this finding emphasize the significance of formal protective actions to prevent re-victimization especially where the perpetrator is a close relative living within or near the family (Mildred and Plummer, 2009; United Nations High Commissioner for Refugees, 2003; Csete and Kippenberg, 2002).

Results of this investigation indicated that the need for *treatment for sexual violation injury* was also high (Table 4.7 and Table 4.8). Results also indicated that need for *treatment for sexual injury* significantly associated with three factors namely; *age 6-11years* (OR=55.22; 95% CI: 27.59-110.51; p<0.001); *male gender* (OR=2.45; 95% CI: 1.04-5.75; p=0.035); *currently not married* (OR=4.69; 95% CI: 2.80-7.84; p<0.001). In the current investigation, the multiple regression analysis indicated that *age 6-11 years* old and *male gender* were the only significant predictors of need for *treatment for sexual*

violation injury. This finding is similar to previous reports of other studies by Li-Yu (2012); Chiara, Carlos, and Jennifer (2012); Christofides *et al*. (2005); and WHO (2004), which also highlight the significance of management and documentation of injuries, and post exposure prophylaxis.

The study participants in the two study arms showed significant (p=0.001) difference in *dissatisfaction* with post rape community services (Table 4.2). This finding means that survivors' experiences of negative social reactions from informal and formal sources of help, for example, victim blaming, keep survivors from disclosing rape and from health care. Rating of the perceived *dissatisfaction* with post rape services by survivors in this investigation is similar to findings of African and other studies which documented that *dissatisfaction* with community service providers' services and attitudes kept survivors from utilizing post rape services (Gracia, Garcia and Lila, 2013; Christofides *et al.*,.2006; Csete and Kippenberg, 2002), hence, relatively few survivors seek trauma counseling services following sexual violation. Studies by have shown that thwarted satisfaction of the psychological innate needs undermine motivation and have maladaptive consequences (Ryan & Deci, 2000).

5.3 Psychological Distress Characteristics

The second specific objective of this study was to find out the effect of ICLRTC intervention on post rape psychological distress characteristics, namely; *depression, feeling self blame, experience of shame,* and *having RTS*.

The results of this study revealed equivalence in all specific psychological distress characteristics among participants in the two study arms at baseline. This finding is similar to baseline results of a study by Martinson *et al.* (2013), which found the study groups similar.

Depression

Findings of this study revealed that *occurrence of depression* was significantly associated with two socio-demographic factors namely: *Age 12 years* (OR=17.06; 95% CI: 9.18-31.70; p<0.001); *currently not married* (OR=3.92); 95% CI: 2.27-6.77; p<0.001); and three psychological distress characteristics namely: *feeling of self blame* (OR= 12.19; 95% CI: 6.49-22.90; p<0.001); *shame* (OR=18.52; 95% CI= 9.92-34.56; p<0.001); and *having RTS* (OR=23.40; 95% CI:12.01-45.59; p<0.001). In the current investigation, the multiple regression analysis indicated that *age 12 years*, *feeling of self blame* and *having RTS* were the only significant predictors of *occurrence of depression*. This finding is consistent with previous research documenting a positive relationship between these characteristics (Breitenbecher, 2006; Frazier, 2003; Koss, Figueredo and Prince, 2002).

In the current investigation, results of between groups' comparisons, indicated that up to six months of intervention the proportion of *depression* was not significantly different in the two study arms; but after nine months of intervention the assessment revealed that the proportion of *depression* in the Intervention arm (25.0%) was significantly high and different compared to the Non-intervention arm (2.4%), (p<0.001). These findings revealed that the effect of ICLRTC intervention on *depression* was similar to that of 'usual care' up to six months of intervention. After nine months, the effect of the ICLRTC intervention was slower in reducing *depression* compared to the 'usual care'. These findings are consistent with results of a study by Morrissey *et al.* (2005).

In this study, results of within groups' comparisons, revealed that a significant drop in proportion of *depression* from 81.3% at baseline to 60.9% at follow-up1 (20.4% change), (p<0.001) in the Intervention group. In the Non-intervention group, the proportion dropped from 85.1% at baseline to 60.6% at follow-up1 (24.5% change), (p<0.001). This finding indicated that at follow-up1 the effect of ICLRTC intervention

on *depression* was lower than in the Non-intervention group. At follow-up2, results indicated a significant drop in proportion of *depression* from 81.3% at baseline to 38.1%, (43.2% change), p<0.001) in the Intervention group. Proportion of *depression* in the Non-intervention group also dropped significantly from 85.1% at baseline to 41.8% at follow-up2 (43.3% change), (p<0.001). Follow-up2 results indicated that change in proportion of *depression* was similar in both study arms. This means the effect of the intervention was the same as that of the 'usual care'. At follow-up3, results indicated a significant drop in proportion of *depression* from 81.3% at baseline to 25.0%, (56.3% change), p<0.001) in the Intervention group. Proportion of *depression* in the Non-intervention group also dropped significantly from 85.1% at baseline to 2.4% at follow-up3 (82.7% change), (p<0.001). This result means that by the end of nine months intervention, proportion of *depression* survivors in the Intervention arm was 10 times more than in the proportion of *depression* in the Non-intervention arm. This finding in the intervention arm, is consistent with reports of an earlier research by Koss (1993) which found that most victims exhibit high levels of *depression* in the first week after the rape, then distress peaks in severity three weeks post-rape, and continues at high levels for one to two more months before finally abating two to three months post-rape. The results of the current study is also consistent with later reports by Breitenbecher (2006); Morrissey *et al.* (2005); Frazier 2003, which found depression slow in responding to trauma counselling intervention.

Feeling of Self Blame

The results of the current study indicate that *feeling of self blame* was found to significantly associate with three socio-demographic factors namely: *age 12 years* (OR= 19.56; 95% CI: 10.14-37.74; p<0.001); *female gender* (OR= 1.95; 95% CI: 1.10-3.45; p=0.002); '*currently not married'* (OR=3.30; 95% CI:2.12-5.13; p<0.001); and three psychological distress characteristics namely: *occurrence of depression* (OR=12.19; 95% CI:6.49-22.90; p<0.001); *experience of shame* (OR=30.22; 95%

CI:15.35-59.49; p<0.001); and *having RTS* (OR=10.71; 95% CI:5.60-20.51; p<0.0, 01). In the current investigation, the multivariate analysis indicated that *age 12 years*; *occurrence of depression* and *experience of shame* were the only significant predictors of *feeling of self blame*. The results of the current study are consistent with previous research that found a positive relationship between *feeling of self blame* and *experience of shame, depression*, adolescents and adults (Filipas and Ullman. 2006; Breitenbecher, 2006; Frazier, 2003; Koss, Figueredo and Prince, 2002).

In this study, results of between groups' comparisons, indicated that after three months of intervention the proportion of *self blame* was not significantly different in the two study arms, but after six months of intervention the assessment revealed that the proportion of *self blame* in the Intervention arm (47.4%) was significantly different compared to the Non-intervention arm (31.15%), (p=0.005). This finding revealed that the ICLRTC intervention had significant effect on *feeling of self blame* compared to the 'usual care' after six months. Results indicated that after nine months of intervention the proportion of *self blame* in the Intervention arm (15.9%) was marginally significantly different from Non-intervention study arm (26.2%), (p=0.055). This finding indicated that the ICLRTC intervention was very effective in reducing *feeling of self blame* after nine months compared to the 'usual care'. These findings are consistent with previous reports of a study by Filipas and Ullman (2006); Breitenbecher (2006); Koss, Figueredo and Prince (2002).

In this study, results of within groups' comparisons, revealed insignificant increase in proportion of *self blame* in the Intervention group from 64.8% at baseline to 65.2% at follow-up1 (0.4% change), (p=0.951). In the Non-intervention group for the same duration, the proportion dropped insignificantly from 71.3% at baseline to 68.5%, (2.8% change), (p=0.489). This result indicated that the ICLRTC intervention had a negative effect on *feeling of elf blame* causing slight increase in the proportion, and is consistent with previous report by Filipas and Ullman (2006). At follow-up2, results indicated a

significant drop in proportion of *self blame* in the Intervention group from 64.8% at baseline to 47.4%, (17.4% change), p=0.009). The proportion of *self blame* in Non-intervention group for the same duration, dropped significantly from 71.3% at baseline to 31.1%, (40.2% change), (p=0.001). This finding revealed that the ICLRTC intervention started effect on *feeling of self blame* after six months. At follow-up3, results indicated a significant drop in proportion of *self blame* in the Intervention group from 64.8% at baseline to 15.9%, (48.9% change), p<0.001). Proportion of *self blame* in the Non-intervention group also dropped significantly from 71.3% at baseline to 26.2% at follow-up3 (45.1% change), (p<0.001). The results of this current study revealed that the intervention was effective on *feeling of self blame* but the onset of effect was delayed up to six months of intervention. This finding is consistent with previous reports by Filipas and Ullman (2006); Breitenbecher (2006); Koss, Figueredo and Prince (2002) which found *feeling of self blame* is long term and required a longer period of trauma counseling to resolve.

Experience of Shame

The results of the current study indicate that the *experience of shame* was found to significantly associate with three social-demographic factors namely: *age 12 years* (OR=30.64; 95% CI:16.07-58.45; p<0.001); *female gender* (OR=2.22; 95% CI:1.20-4.09; p=0.010); *currently not married* (OR=4.04; 95% CI:2.45-6.66; p<0.001); and three psychological distress characteristics namely: *occurrence of depression* (OR=18.52; 95% CI:9.92-34.56; p<0.001); *feeling of self blame* (OR=30.22; 95% CI:15.35-59.49; p<0.001); and *having RTS* (OR=25.71; 95% CI:12.95-51.06; p<0.001). In the current study, the multivariate analysis indicated that *age 12 years*, *feeling of self blame* and *having RTS* were the only significant predictors of *experience of shame*. The results of the current study are consistent with previous research (Frazier, 2003; Koss, Figueredo and Prince, 2002; D'Augelli and Grossman, 2001) that found a positive relationship

between experience of *shame* and feeling of *self blame, RTS, age 12 years* adolescents and adults.

In this study, results of between groups' comparisons, indicated that after three months of intervention the proportion of *shame* was not significantly different in the two study arms, but after six months of intervention the assessment revealed that the proportion of *shame* in the Intervention arm (44.3%) was significantly different from Non-intervention arm (31.6%), (p=0.028). This finding revealed that the ICLRTC intervention had no effect on *experience of shame* until after six months of trauma counseling. Results indicated that after nine months of intervention the proportion of *shame* in the Intervention arm (21.6%) was not significantly different from Non-intervention arm (14.1%), (p=0.110). This means the ICLRTC intervention had a negative effect on the *experience of shame* at nine months. This finding is consistent with previous reports by Frazier (2003); and Koss, Figueredo and Prince (2002); D'Augelli and Grossman (2001), which found *experience of shame*, required a longer period of trauma counseling to resolve.

In this study, results of within groups' comparisons, revealed insignificant decrease in proportion of *shame* in the Intervention group from 79.7% at baseline to 78.3% at follow-up1 (1.4% change), (p=0.785). In the Non-intervention group for the same duration, the proportion dropped insignificantly from 79.4% at baseline to 77.7%, (1.7% change), (p=0.624). This finding indicated that the ICLRTC intervention did not have any effect on *experience of shame* after three months. This finding is consistent with previous reports by Frazier (2003); Koss, Figueredo and Prince (2002). Results at follow-up2 indicated a significant drop in proportion of *shame* in the Intervention group from 79.7% at baseline to 44.3%, (35.4% change), p<0.001). The proportion of Shame in Non-intervention group for the same duration, dropped significantly from 79.4% at baseline to 31.6%, (47.8% change), (p<0.001). The results indicated that the ICLRTC intervention had effect on *experience of shame* after six months. Results at follow-up3

indicated a significant drop in proportion of *shame* in the Intervention group from 79.7% at baseline to 21.6%, (58.1 % change), p<0.001). Proportion of *shame* in the Non-intervention group also dropped significantly from 79.4% at baseline to 14.1% at follow-up3 (65.3% change), (p<0.001). This finding in the current investigation revealed that the intervention maintained its effect on *experience of shame* after six months to endline. This finding is consistent with previous results of studies by Koss, Figueredo and Prince (2002); D'Augelli and Grossman (2001), which showed *experience of shame* is long term and required a longer period of trauma counseling to resolve.

Rape Trauma Syndrome

The results of the current study indicate that the *Occurrence of RTS* was found to significantly associate with two social-demographic factors namely: *age 12 years* (OR=12.89; 95% CI:6.92-24.02; p<0.001); *currently not married* (OR=2.56; 95% CI:1.46-4.48; p=0.001); and three psychological distress characteristics namely: *occurrence of depression* (OR=23.40; 95% CI:12.01-45.59; P<0.001); *feeling of self blame* (OR=10.71; 95% CI:5.60-20.51; p<0.001); *experience of shame* (OR=25.71; 95% CI:12.95-51.06; p<0.001). In the current study, the multiple regression analysis indicated that *experience of shame* and *occurrence of depression*, were the only significant predictors of *occurrence of RTS*. The results of the current study are consistent with previous research that found a positive relationship between *occurrence of RTS*, and *experience of shame* and *occurrence of depression* (Martinson *et al.*, 2013; Steine *et al.*, 2012; Filipas and Ullman, 2006).

In this study, results of between groups' comparisons, indicated that after three months of intervention the proportion of *RTS* in the Intervention arm (74.8%) was significantly different from Non-intervention arm (84.1%), (p=0.035). After six months of intervention the assessment results revealed that the proportion of *RTS* in the intervention arm (52.6%) was not significantly different from Non-intervention arm (45.8%), (p=0.262). This finding revealed that the ICLRTC intervention had a negative

effect or intervention was not effective on *RTS* during Follow-up2. Results indicated that after nine months of intervention the proportion of *RTS* in the Intervention arm (35.2%) was significantly different from one in Non-intervention arm (5.3%), (p<0.001). The results of the current investigation indicated that the ICLRTC intervention had a positive effect on *RTS* during Follow-up3 but did not clear 35.2% proportion of the *RTS*. This finding is consistent with previous reports by Steine *et al.* (2012); Filipas and Ullman (2006); Morrissey *et al.* (2005).

In this study, results of within groups' comparisons, revealed significant decrease in proportion of *RTS* in the Intervention group from 86.7% at baseline to 74.8% at follow-up1 (11.9% change), (p=0.018). In the Non-intervention group for the same duration, the proportion dropped insignificantly from 85.1% at baseline to 84.1%, (1.0% change), (p=0.739). This finding indicated that the ICLRTC intervention showed the desired effect on *RTS*, a finding consistent with reports of a study by Morrissey *et al.* (2005). At follow-up2, results indicated a significant drop in proportion of *RTS* in the Intervention group from 86.7% at baseline to 52.6%, (34.1% change), p<0.001). The proportion of *RTS* in Non-intervention group for the same duration, dropped significantly from 85.1% at baseline to 45.8%, (39.3% change), (p<0.001). Follow-up2 results indicated that the ICLRTC intervention was having the desired effect on *RTS* shown by the rapid change in proportion of *RTS*. At follow-up3, results indicated a significant drop in proportion of *RTS* in the Intervention group from 86.7% at baseline to 35.2%, (51.5 % change), p<0.001). Proportion of RTS in the Non-intervention group also dropped significantly from 85.1% at baseline to 5.3% at follow-up3 (79.8% change), (p<0.001). This finding revealed that the intervention had positive but slow progressive effect on RTS within the study period. This finding is consistent with previous reports by Steine *et al.* (2012); Filipas and Ullman (2006); Morrissey *et al.* (2005).

The third specific objective of this investigation was to compare the Intervention and Non-intervention groups' positive psychological health outcomes in order to attribute the

greater change in positive post rape psychological health outcomes to ICLRTC intervention. The findings of this investigation demonstrated by Chi-square value (Tables 4.22, 4.23, 4.24 and 4.25), magnitude of change is higher in the Non-intervention arm as compared to the Intervention arm. This finding is consistent with findings of a study by Mwangi and Jaldea (2009), which found that intense attention on survivors attracted questions from their community members. The intense attention by CHWs could have made it difficult for the survivors to deny that a sexual violation incident took place, and this could be the reason why the Intervention arm sustained higher levels of psychological distress symptoms compared to the Non-intervention arm. However, findings in this study contrast results of studies which combined community counselling intervention with Social Support Groups and FGDs by Morrissey *et al.* (2005); Bowling (2002) where the magnitude of change was higher in the Intervention arm compared to the Non-intervention arm.

Probable reasons why results consistently show that Non-intervention arm seemed to perform better than the intervention arm include the following. In many African cultures sex is taboo and a guarded secret usually not shared (Mwangi and Jaldea, 2009), therefore, survivors in the Intervention group may have thought confidentiality about sexual violation was broken by the CHWs who come from the neighborhood. If the intervention integrated Social Support Groups, survivors would have had an opportunity to ventilate and also get an opportunity to: hear what and how other victims disclose, and how other victims have dealt with community stigma. As members of the Social Support Group, survivors in the intervention arm would have benefited from each others' support and sense of belonging, which would have helped them alleviate or reduce levels of psychological distress symptoms.

However, the results demonstrate that the effect of the intervention was significant in reducing proportions of depression but the effect was slow in causing change. This finding contrast previous reports that found higher magnitude of change in proportion of depression in the Intervention arm (Breitenbecher, 2006; Gamble *et al.*, 2005; Morrissey

et al., 2005; Frazier, 2003; Koss, Figueredo and Prince, 2002). The null hypothesis that there would be no difference in positive psychological health outcomes between rape survivors receiving the ICLRTC intervention and those in the Non-intervention group in Kenyan communities was rejected by results of this investigation. Findings from the two study arms reveal positive effects of both the ICLRTC intervention and the 'usual care' on negative psychological distress characteristics.

5.4 Strengths of this Study in Relation to Other Studies

An advantage of having four assessments namely; at baseline and three follow-up points over a period of nine months intervention is that the findings can be compared with that of other studies**.** The use of interviewers for the administration of the questionnaire enabled clarification of questions to respondents when needed. This, however, may have lead to social desirability bias. This investigation is the first in Kenya, to identify psycho-social health needs and determine four specific psychological distress characteristics among survivors of rape in Kenya communities.

5.5 Weaknesses of this Study in Relation to Other Studies

From an African perspective, questions on sexual violation and intimacy are taboo, and in this study proved difficult to answer, especially for men interviewed by female trauma counsellors. Using a structured questionnaire with closed questions and limited response options is not optimal to obtain reliable data on psycho-social health needs and negative specific psychological sequel post rape.

5.5 Implications for Practice

The findings of this study have several practical implications. Results of this study revealed a significant *need for safety* and *dissatisfaction* with post rape services' among survivors**.** The need for *safety* means that the community will need to emphasize the significance of formal protective actions to prevent re-victimization especially where the

perpetrator is a close relative living within or near the family. Results of this study have shown that many survivors had *dissatisfaction* with post rape services because of the negative social reactions from formal support sources, which may inhibit them from subsequent help seeking for sexual violation-related problems.

The results of this study revealed that the lay trauma counseling in the community is effective on specific negative psychological distress characteristics after six months of ICLRTC intervention. This means that the MoH PRC trauma counseling protocol will need review with an aim to extend the sessions up to a year in order to be able address survivors varied negative psychological distress problems. The results of this study revealed that the intense community lay rape trauma counselling had significant improvement in positive psychological outcomes among survivors in the Intervention arm. This implies that professionals and community service providers involved in rape trauma counselling need to work to counteract *victim blame* and *doubt of survivors*, while still maintaining respect for survivors and their caregivers. Professionals and community service providers should also be alert to the possibility that, if they *blame* and *doubt* the survivors, that could affect the *care givers'* appreciation of the negative effect of rape. Thus, this could result in failure of care givers' to recognize the need for trauma counselling for the survivor.

CHAPTER SIX

6.0 CONCLUSSIONS AND RECOMMENDATIONS

6.1 CONCLUSIONS

In conclusion, the main psychosocial health needs among the rape survivors were *safety* and *dissatisfaction*, and the main psychological distress characteristics among the rape survivors were *depression* and *RTS*.

The significant predictors of depression were *age 12 years old, feeling of self blame* and *having RTS.* The proportion of depression in the Intervention arm was 10 times more than the proportion in the Non-intervention arm, after nine months of ICLRTC intervention. *Depression* was also found to take three months of trauma counseling before finally starting to resolve slowly.

The significant predictors of *RTS* were *occurrence of depression* and *experience of shame.* The proportion of *RTS* in the Intervention arm was 9 times more than the proportion in the Non-intervention arm, after nine months of ICLRTC intervention.

As demonstrated by the Chi-square values, the magnitude of change in positive psychological outcomes was significantly higher in the Non-intervention arm by the 3rd, 6th and 9th months compared to the Intervention arm.

The results of the study rejected the Null Hypothesis because the ICLRTC intervention did not significantly improve the positive psychological outcomes among rape survivors in the Intervention group more than in the Non-intervention group.

6.2 RECOMMENDATIONS

The following recommendations are made from the results of this study:

Action Recommendations

(i) The legal-justice system need to make ease the burden of proof when dealing with rape cases so that perpetrators can be punished to keep them away from their victims.

(ii) The society need to protect women and girls from 'clan elder courts' which traditionally judge rape cases in favor of the perpetrator who is usually required to compensate rape with a small token.

(iii) The study recommends PRC providers should be friendly and services delivered in a sensitive and coordinated manner.

Recommendations for Further Research

(i) Given the unique conditions of pre-election and election violence, this study needs to be replicated under normal circumstances to compare findings with current results to find out if there will be significant differences between the two study arms.

(ii) There is need for a prospective community Intervention study to find out the point at which the psychological distress characteristics were fully resolved.

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APPENDICES

APPENDIX A

TRAINING MANUAL FOR COMMUNITY-BASED LAY RAPE TRAUMA COUNSELORS

BY

BEATRICE GICHURU

MARCH 2011

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ACRONYMSAND ABBREVIATIONS

ANC - Antenatal clinic

ART - Antiretroviral Therapy

CHW - Community health worker

CHEW-Community health extension worker

FP - Family planning

MIS - Meaningful involvement of survivor

M&E -Monitoring and Evaluation

MCH -Maternal and child health

CSP -Community Service providers

STI -Sexually Transmitted infection

VCT -Voluntary counseling and testing

INTRODUCTION

Rape trauma counseling is a key component in comprehensive post-rape care services. The goal of this course is to equip CHWs and CHEWs with lay rape trauma counseling skills and knowledge to empower rape survivors live more productive lives and reduce risk of negative mental health outcomes. This manual provides CHWs and CHEWs with skills for long-term support, especially where rape trauma stress has developed into post-traumatic stress disorder. This manual provides a program that equips trainers to prepare CHWs and CHEWs to reach out to rape survivors in a sensitive and compassionate way. It is intended to provide structure and guidance to the trainers. The manual is divided into two modules, which include theory in module 1, and practice and demonstration of counseling skills in module 2. It has a course purpose and objectives, an overview of different topics, and teaching methods. This manual should provide quality training for CHEWs/CHWs in lay rape trauma counseling.

COURSE STRUCTURE

Module 1

Module 1 is a half -day residential training. It is the first time CHEWs, CHWs and facilitators meet. This is a theoretical phase, although participants will prepare a referral directory at the start of this module, which will be reviewed at the end of the module. Participants will be assessed on their skills and participation in class.

Module 2

Module 1 is an afternoon residential training. Trainers will demonstrate individual survivor and group's lay rape trauma counseling in community settings. Participants

will perform return demonstration by practicing peer counseling – individual and group - in order to learn how to counsel a survivor in community settings. An experienced rape trauma counselor observes at least four peer trauma counseling sessions. Participants are required to see at least two child counseling demonstrations, and to perform return demonstration. Participants will share their experiences and learn from each other. Participants will keep a diary of each session. CHWs will practice filling in bi-monthly Community Lay Rape Trauma Counseling report, CHEWs will practice filling in monthly observed practice forms (see annex 1).

OBJECTIVES

Broad objective

By the end of this course participants should be able to give lay rape trauma counseling to survivors of rape and their families in their communities.

Specific objectives

By the end of each module the participants should:

Module 1

- Develop an awareness of personal values, gendered belief and attitudes and their influences on services for survivors.
- Develop skill in lay trauma counseling rape survivors for:
  a) Preventing immediate crisis;

  b) Preparing survivors to deal with the criminal justice system;

  c) Ongoing support;

Module 2

- Develop the skills and awareness of participants in dealing with and reflecting on the complexity of issues emerging during community lay rape trauma

counseling.

- Develop the capacity to support survivors through the health and justice systems.
- Provide the participants with an opportunity to develop themselves in lay rape trauma counseling skills.
- Maintain the necessary records following the ICLRTC intervention guidelines on community follow up of survivors.
- Facilitate information exchange, sharing and learning from each participant's experience.
- Provide a supportive environment for supervision and counseling for the CHWs.
- Appropriate referral, where possible

COURSE PREPARATION

Participants: Each class should have not more than 40 participants.

Note: A participant who is selected but does not meet the selection criteria will be turned away.

Trainers: At least two trained and practicing rape trauma counselors will be trained in ICLRTC intervention. Then they will facilitate training of CHEWS/CHWS in lay rape trauma counseling course.

Venue: Modules 1 and 2 will be residential. All arrangements such as food and entertainment will be finalized two weeks before the course starts.

Course evaluation

The trainer will need to evaluate the course using the following:

- Participant activities in modules 1 and 2
- Course evaluation at the end of the day (at the end of module 2).

ONE DAY IN-HOUSE TRAINING

MODULE 1

INTRODUCTION AND CLIMATE SETTING

Time 15 minutes:

Objectives

Participants get to know each other, bond and contract as a group, and:

1. Develop safety and comfort with each other.
2. State their expectations of the course.

Key content

Introductions:

- Group norms and expectations
- Course content andTeaching methods
- Participants negotiate start, break, lunch, finish times and ground rules creating a learning environment.

Activity 1: Introductions

Methods

Welcome the participants to the training. Participants introduce themselves by saying their name, where they come from and what they would like the rest of the class to know about them, such as what they like and don't like.

1. Each participant gives the introduction while seated in a circle,

KEY POINT

Learning names gives value to each group member. It is important to start with an activity that will help the group start bonding in the first session.

Activity 2: Group norms and expectations

Objective

1. Establish how the group will work together throughout the 5 days.

Method

While seated in a round, participants state what they wish each person to observe. This will give each person the boundaries to work with one another.

Learning point

The facilitators should not impose ground rules on the participants but should encourage them to come up with their own norms. However, the facilitator may need to contribute, such as if participants come up with schedules that will not allow the trainers to finish the course on time.

Activity 3: Course content

Objective

1. Introduce the class to the content to be covered during the 5 days and what the entire course entails.

Method

Participants share their expectations for the training and write all of them. The facilitator goes through the expectations and explains, in each case, any that may not be met and why. The trainers need to explain the details of the whole course. Then they must focus on the objectives for module 1.

List the 'course objectives' on a flipchart, so participants can see which expectations will be met. If there are any that the training cannot meet, the facilitator should explain that from the start. This will enable the group to have a clear picture of what they should get by the end of the training. The facilitator gives each participant a copy of the timetable.

Activity 4: Teaching methods

The facilitator highlights the different teaching methods that will be used.

UNIT 1: SELF-AWARENESS AND PERSONAL DEVELOPMENT

Objectives

By the end of unit 1, participants should be able to:

1. Demonstrate an awareness of their gender identities.
2. Describe how socialization and gendered experiences influence systems.
3. Question gender and other power inequalities and facilitate attitude change.
4. Reflect on values, attitudes and beliefs about rape and examine how they influence preventing rape and providing care services to survivors.

Key content

- Awareness of self as a gendered person and influence system
- Socialization and gender experience
- Understanding rape.

Activity 1: Awareness of the self as a gendered person

Time: 10 minutes

Method

The participants, in small groups, share the story of their lives, focusing on experiences that created or reinforced the awareness they were either male or female and what effect these experiences had. Then, in the whole group each participant will say one important point from the discussion.

Learning points

- All persons have had different experiences and undergone varied socialization, influencing how they view life and the world; it will be the same with survivors.
- All persons and all social, legal, and political systems are developed and sustained by people with these different experiences, who also shape the systems. This is important to remember when supporting rape survivors in the community and through the legal systems.

Activity 2: Socialization and gendered experience

Time: 10 minutes

Method

The participants reflect on the exercise they did on 'awareness of the self as a gendered person' (above). The facilitator asks them, either in whole or in gender groups, to answer:

- What have been the influences of socialization on the world around me?
- Is there anything about this world that I described that I would like to see change? If so, what?
- In what ways could I be an agent of this change?

Learning point

Socialization and gendered experiences shape the world in different ways and each person, including a survivor, is part of them. There are aspects of the world we live in each of us would like to see differently. We all have a responsibility, to our survivors and ourselves, to shape our immediate worlds to facilitate empowering our survivors and ourselves.

Activity 3: Question gender and other power inequalities

Time: 5 minutes

Method

The facilitator guides discussion on how gender inequality is manifested in different communities and its effects. The group can also suggest ways these inequalities can be addressed.

UNIT 2: SELF-AWARENESS AND PERSONAL DEVELOPMENT WITH RAPE TRAUMA STRESS

Objectives

By the end of unit 2, the participant should be able to:

1. Identify varied reactions to rape crisis and stress.
2. Identify self-reaction during crisis.
3. Elaborate ways of handling survivors with different reactions after being raped.

Key content

- Exploring and understanding rape trauma stress
- Exploring the classifications of rape trauma stress
- Reaction and crises management

Activity: Explore and understand rape trauma

Time: 10 minutes

Method

Participants reflect on personal experiences. Each participant should select an event they remember as traumatic and share it with the group, including what the initial reaction was and current feeling. The facilitator needs to set an environment of support and safety, allowing each participant to share. At the end, the facilitator should start a discussion on the lessons learned. Reactions to immediate, short- intermediate-and long-term trauma should be discussed.

Activity: Self-reaction to crisis

Method

The facilitator provides participants with role plays. Participants play a role in the traumatic scene and describe how they would react and how they feel about the situation. With the active participation, the facilitator uses flipcharts to enhance classifying reactions into physical, emotional, psychological, social and behavioral. Traumatic experience effects should be highlighted.

Learning points

- Counselors must understand the effects and reactions from trauma to be able to support survivors with varied symptoms.
- Different people react differently to similar situations. To help them, counselors need to handle each survivor as unique and respect the survivor's reactions.
- Trauma manifests itself with diverse short- and long-term effects. Survivors will experience high trauma when they visit the health facility. The counselor should support them appropriately, especially when decisions are required.

CONTENT: RAPE TRAUMA STRESS

Very often after a rape, people will say things to the survivor, such as 'It's over now, you must get on with the rest of your life.' Or they will not understand why, six months after the rape, the survivor is still suffering. Rape begins with the physical act, during which the victim concentrates on surviving. After the assault, the struggle to comprehend what has happened begins. It’s meaning floods over the survivor, who must find a way to return to life, body and self. Rape is as much a destruction of 'self as a physical invasion. The battle between 'mind rape' and the will to find self again is called survival.

Rape trauma syndrome

'Rape trauma syndrome' is the medical term for the response survivors have to rape. It is similar to traumatic stress disorder. People who are defiled and people who get sodomized also experience this syndrome.

Physical symptoms of rape trauma syndrome

- Shock, in which the survivor feels cold, faint, confused and disoriented, trembles, nauseous and sometimes vomits
- Resulting pregnancy
- gynaecological problems include irregular, heavier and painful periods, .viginal discharge, bladder infections and sexually transmitted diseases
- Bleeding and infection from tears or cuts in the vagina or rectum
- A soreness of the body, bruising, grazes and cuts
- Nausea and vomiting
- Throat irritation and soreness from forced oral sex
- Tension headaches
- Pain in the lower back and in the stomach
- Sleep disturbances, including difficulty sleeping or feeling exhausted and needing more sleep than usual
- Eating disorders, including not eating, eating less or eating more than usual

Behavioral symptoms of rape trauma syndrome

• Crying more than usual • Difficulty concentrating

• Restless, agitated and unable to relax or feeling listless and unmotivated

• Not wanting to socialize or see anybody or socializing more than usual, to fill up every minute of the day

• Not wanting to be alone • Stuttering and stammering more than usual

• Avoiding anything that reminds victim of the rape • More easily frightened or startled than usual • Very alert and watchful • Easily upset by small things

• Problems with family, friends, lovers and spouses from irritability, withdrawal and dependence • Fear of sex, loss of interest in sex or loss of sexual pleasure

• Change in lifestyle • Increased substance abuse • Increased washing or bathing

• Denial, behaving as if the rape did not occur, trying to live life as it was before the rape

Psychological symptoms of rape trauma syndrome

• Increased fear and anxiety • Self-blame and guilt

• Helplessness, no longer feeling in control of life • Humiliation and shame

• Lowered self-esteem, feeling dirty • Anger • Feeling alone and that no one understands

• Losing hope for the future • Emotional numbness • Confusion • Memory loss

• Constantly thinking about the rape • Having flashbacks to the rape, feeling it is happening again • Nightmares • Depression • Developing suicidal ideas

Managing rape crisis

• Give psychological first aid • Refer survivor for trauma counseling • Refer for medical management

There are many influences on how each rape survivor copes with the experience and how long the symptoms may be present.

These include:

• Support systems, such as referral to health care provider and counselor, family support and spiritual support

• The relationship with the offender • The violence used • Social and cultural influences

• Previous experience with stress • Ability to cope with stress

• Attitude of those immediately contacted after the rape.

How the lay trauma counselor can offer support

The lay counselor can offer the survivor support by:

- Creating a supporting environment in which to share the experience
- Exploring and addressing survivor concerns
- Addressing survivor fears about health care, family and social consequences
- Addressing the fears and concerns of the guardian or parent for a child survivor

Survivors will not respond in the same ways. While most survivors experience these symptoms, some may experience only a few and others none at all. We must be careful not to judge by the symptoms whether someone has been raped. Because most survivors are afraid to tell anyone, it is important to treat everyone who says they have been raped as if they were.

Almost all rape survivors suffer severe and long emotional trauma because:

• The rape is sudden. • It is perceived as life threatening.

• Its apparent purpose is to violate the survivor's physical integrity and render the survivor helpless. • The survivor is forced to participate in the crime.

• The survivor cannot prevent the assault or control the assailant, normal coping strategies failed, and the survivor becomes a victim of someone else's rage and aggression.

The trauma is usually compounded by myths, prejudice and stigma associated with rape. Survivors who have internalized these myths fight feelings of guilt and shame. The

burden can be overwhelming, especially when other people reinforce the myths and prejudices. All legal, medical and police procedures must not cause further trauma to survivors, who must be given all possible support to overcome and survive the ordeal.

UNIT 3: LAY RAPE TRAUMA COUNSELLING

Objectives

By the end of unit 3, participants should be able to:

1. Discuss their understanding of the goals, principles and values of lay counseling.
2. Highlight expected issues survivors will be dealing with after rape that require counseling support.
3. Analyze the role of the lay counselor in helping survivors deal with the concerns and issues they face.
4. Demonstrate knowledge on the skills, techniques and approaches when counseling rape survivors, their partners, and families.

Key content

- Counseling, its principles and goals
- Expected counseling issues for rape survivors
- Techniques and approaches to lay counsel rape survivor

Activity 1: Counseling, its principles and goals

Time: 10 minutes

Method 1

The whole group offers suggestions what counseling is and what it entails. Discuss counseling principles, values and expected outcomes. Write these on flipcharts and display them for the rest of the course.

CONTENT: LAY COUNSELLING

Counseling' is a structured conversation between people that assists one participant to work through particular problems or conflicts, explore feelings and find ways to resolve

or cope with them. Lay counselors encourage people to recognize and develop their coping capacity, so they can deal more effectively with problems.

While the term 'lay counseling' may be unfamiliar to some, the behavior is probably common in all cultures. Lay counseling not only helps people with their immediate problems, it can help them to recognize and draw upon their own resources for future problems.

Goal

Lay counseling helps create new perspectives and change. It may help people feel differently about a situation or change their behavior, such as practicing safer sex; or change something in their environment, such as setting up a support group.

Lay counseling aims to help people:

- Understand their situation more clearly.
- Identify options for improving the situation.
- Make choices that fit their values, feelings and needs.
- Make their own decisions and act on them.
- Cope well with a problem.
- Develop life skills, such as being able to talk about sex with a partner.
- Provide support for others while preserving their own strength.

Principles and values

Lay counselors uphold the values of integrity, impartiality and respect. They also uphold the principles of autonomy, beneficence, justice, avoidance of harm, and fidelity to specific situations. They have a responsibility to the survivor, to themselves, their colleagues, the community and the law.

Activity 2: Expected counseling issues for rape survivors

Time: 10 minutes

Method

Participants, in groups of three, read short case studies that highlight different scenarios of rape and discuss the possible issues and concerns the survivor may have.

Concerns may include:

- Fears of the personal effects of rape, including health consequences
- Feelings the survivor may have, such as shame, stigma, blame, guilt and fear of being alone, talking to people and walking about
- Relationships with immediate family, including partner, siblings and parents
- Societal concerns, such as stigma, social sanctions and discrimination.

Note: If this activity takes longer, participants may be asked to use these questions as an assignment and discuss them in groups.

Learning points

- Each survivor will present diverse issues and concerns. The counselor needs to acknowledge these different fears while supporting the survivor in dealing with immediate concerns.
- The counselor needs to support the survivor in dealing with fears and **NOT** provide advice on how to deal with them. This includes:

i) Supporting the survivor to make informed decisions.

ii) Enabling the survivor to cope better with the issues arising through exploration with minimum challenge.

iii) Helping the survivor develop coping skills.

iv) Providing support to the survivor while preserving own strength.

v) Referring the survivor appropriately.

UNIT 4: LAY RAPE TRAUMA COUNSELLING ISSUES

Objectives

By the end of unit 4, the participant should be able to:

1. Highlight expected survivor and lay counselor issues arising after rape.
2. Discuss the issues the survivor would require counseling support after rape.

Key content

- Disclosure
- Confidentiality
- Shared confidentiality
- Giving information
- Ongoing support lay counseling.

Activity 1: Disclosure

Time: 10 minutes

Method

All the participants share their understanding of disclosure. The group discusses each example and how to inform the survivor about disclosing the rape. Use the following examples:

- A married woman who has been raped
- A child who was raped by the parent
- A man who is about to marry a woman and he is gang raped

Disclosing a rape or sexual assault can be quite challenging, especially when the survivor is not ready to tell anyone about it, be it parents, spouse or friend. The lay counselor needs to help the survivor realize and understand what disclosure is all about and why it is important to find a way to disclose the rape to someone they choose and who can give them support. The lay counselor will need to work with the survivor on how to go about disclosure but should accept survivor's pace and not coerce the survivor into doing anything uncomfortable or that the survivor is unready to do.

CONTENT: DISCLOSURE

The relationship between a lay counselor and the survivor is a contract. This contract, written or oral, means the information disclosed by the survivor to the lay counselor is confidential. There are exceptions to this contract and every lay counselor sometimes

walks the fine line between exceptions and information misuse. The responsibility for disclosure should always remain with the survivor and or parent/guardian. High trust between individuals sustains a high disclosure; low trust results in low disclosure. Counseling begins with disclosure and is characterized by trust, self-doubt, and even shame by some survivors. In a safe environment, survivors feel comfortable with each counseling session, relax their defenses and begin to share more personal details of what happened. The lay counselor should help survivors gain control of their emotions and reactions, and to make connections from past abuse to present symptoms.

Activity 3: Self-disclosure

Self-disclosure

Self-disclosure' is when the lay counselor reveals something personal about themselves to the survivor.

Time: 10 minutes

Method

The facilitator explains what self-disclosure is and asks the group to brainstorm on what the benefits and disadvantages might be.

Learning points

Benefits

- Self-disclosure might help survivors develop a new perspective towards their problems.
- Self-disclosure might reduce a sense of isolation and bring a sense of universality.

Disadvantages

- Self-disclosure might take attention from the survivor to the lay counselor.
- The counselor might assume that because both have experienced the same thing, they both respond the same way.
- The survivor might want more information than the lay counselor is willing to

give.

Note: The survivor is not bound by confidentiality to the lay counselor.

CONTENT: SELF-DISCLOSURE

- Self-disclosure is a challenging skill.
- Self-disclosure is where helpers constructively share some of their own experiences, behavior and feelings with survivors.
- Self-disclosure happens when the lay counselor communicates personal characteristics to the survivors with every look, movement, emotional response, sound and word.
- Self-disclosure can make survivors see helpers as less well adjusted or can frighten survivors.
- Instead of helping, self-disclosure might place another burden on survivors.
- In some instances, self-disclosure can be appreciated by survivors.

Benefits

- By disclosing something about yourself, you may help free survivor to talk about themselves.
- Appropriate self-disclosure may prevent the lay counselor from appearing to be too interested.
- Self-disclosure may contribute to the lay counselor being perceived as a real human being, rather than hiding behind a phoney or defensive facade.
- By the lay counselor sharing experiences, survivor may get a different perception of their problems and how to deal with them.
- Self-disclosure helps survivors know that others have undergone the same crisis, so they are not alone.

Dangers

- Survivors usually have enough problems without having to carry the lay

counselor’s burden too.

- Survivors may ask themselves, 'Why is the lay counselor telling me this?' and attribute negative reasons for disclosure.
- Vulnerable survivors tend to perceive their helpers as strong people and may become anxious about evidence to the contrary.
- Inappropriate disclosure may shift the focus of the session from the survivor to the lay counselor.
- Some helpers may, either intentionally or unintentionally use self-disclosure to manipulate survivors to meet their own needs for approval, intimacy and sex (Jones 2000).

Activity 4: Confidentiality

Time: 10 minutes

Method

The whole group brainstorms to define confidentiality.

One definition: Confidentiality is the agreement of the counselor not to share anything that is said or done in the counseling room with anyone else without the express permission of the survivor.

Learning point

Confidentiality is challenged in many different settings. Lay counselors need to be continuously aware of it.

CONTENT: CONFIDENTIALITY

Confidentiality is the agreement by the counselor not to share anything said or done in the counseling room with anyone else without the express permission of the survivor.

Confidentiality enables the survivor to feel safe in the counseling session. Confidentiality protects the survivor after the counseling session. Confidentiality promotes trust between the survivor and the lay counselor.

Confidentiality can be broken in some circumstances, when there is a danger to self or others.

Lay counselors need to be very careful if they break confidentiality, because it can destroy the reputation of counseling.

Activity 5: Shared confidentiality

Time: 10 minutes

Method

The whole group discusses what 'shared confidentiality' means. Then participant pairs explain to each other how they would explain shared confidentiality to a survivor.

Learning points

Although lay counselors are required by the counseling code of ethics to maintain confidentiality of all survivors' issues, it becomes hard to do this with rape because survivor post-rape care uses diverse services and referrals, hence the need for shared confidentiality. The lay counselor must tell this to the survivor or parent/guardian, so that they can understand what shared confidentiality is and why it is important. The lay counselor must seek to assure the survivor the information will be disclosed only to people who will assist and facilitate effective treatment.

CONTENT: SHARED CONFIDENTIALITY

Shared confidentiality is confidentiality shared with others. These others might include family members, loved ones, caregivers and trusted friends. This shared confidentiality is at the discretion of the survivor.

Activity 6: Giving information

TIME: 10 minutes

Method

Participants practice how to give information and not advice. Participants identify examples of giving advice rather than information, such as 'you need to dress well' and 'you will have to go for an HIV test'.

Learning point

Lay counselors should not give survivors advice on what to do or not do because it will impose on survivors the counselor's way to handle issues. Lay counselors should give survivors all the information they need and let them make informed decisions.

Activity 7: Ongoing lay counseling support

Time: 10 minutes

Method

The facilitator gives a lecture on assuring survivors they will be given ongoing monthly counseling so that they can share with the lay counselor whenever they have issues. Lay counselors will need to do appropriate referrals to any other place or person, such as a social support group, comprehensive care centre, post-test club or home-based care, where they can be given support.

LEARNING POINT

The lay counselor should establish a supportive relationship with the survivor to offer support as the survivor works through issues. However, both the survivor and the lay counselor need to understand the boundaries of a supportive relationship.

CONTENT: ONGOING LAY COUNSELLING SUPPORT

Ongoing counseling should be given to all rape survivors. Issues to be addressed include

Exploration

- How have the survivor and survivor's family been coping?
- What are the survivor's fears and concerns?
- Was the rape disclosed?

Reducing risk

- Sexual exposure since the rape
- Risk reduction strategies the survivor adopted

Drug adherence

- Survivors feelings about the drugs taken (HIV positive)

- ARV side effects
- Importance of adherence

The lay counselor also needs to consider referring the survivor for further clinical care and management when necessary.

UNIT 5: LAY RAPE TRAUMA COUNSELING SKILLS

Objectives

By the end of unit 5, the participants should be able to:

1. Identify key skills required in counseling rape trauma survivors
2. Demonstrate the skills.

Key content

- Establishing counseling skills.
- Practicing counseling skills

Activity 1: Establishing counseling skills

Time: 10 minutes

Method 1

Each participant writes on the flipchart counseling skills they know. The group goes through the list to establish whether all skills have been listed and whether they are counseling skills.

Method 2

The group briefly discusses lay counseling skills: support and attending skills. Discuss how these skills are applied, their merits, demerits, effectiveness in different situations and potential challenges.

Supporting skills

-Genuineness

-Active listening

-Empathy

-Physical attending

-Unconditional positive regard

Using the identified skills, the facilitators choose which to concentrate on. The exercises develop skills. Each exercise should conclude with a group discussion, highlighting lessons learned and how it felt to apply the skill. The exercises may take time through to the next session. The facilitators will need to factor them in, depending on participant needs.

LEARNING POINTS

- Many skills are available and each lay counselor needs to know which can be best applied to support survivors.
- Support and attending skills are very important when counseling survivors and challenge skills should be avoided. (These challenge skills are used cautiously by professional trauma counselors).

Activity 2: ACTIVE LISTENING

Time: 10 minutes

Method

Ask participants to pair with the person next to them. Each person should talk for 3 minutes about anything, such as something recently done, experienced, enjoyed or interested in. The other person listens actively for 2 minutes, then stops listening actively for 1 minute. The facilitator signals the end of 2 minutes. Participants swap roles.

The whole group discusses:

- How they recognized that they were being listened to
- How it felt to be listened to and not to be listened to
- How you showed you listened or did not listen

Showed listening

The person leaned forward, sat close, kept eye contact, nodded, smiled,
stayed still, asked questions and stayed quiet.

Showed not listening

The person fidgeted, looked around the room, sat back, did not look at the speaker, stopped asking questions and looked bored.

LEARNING POINT

It feels great to be listened to and humiliating not to be listened to. Survivors, just like counselors, can tell from body language when they are being listened to and when not. This will influence the counseling session, and support given to the survivor. Active listening is a key attending skill.

Content: Active listening skills

Active listening involves not just receiving sound, but, as much as possible, understanding its meaning. It uses receiver and sender skills to show you have understood (Jones 2000). It is listening to the words and content.

PURPOSE

- Active listening is essential for establishing rapport.
- Active listening improves the counselor's understanding of the survivor.
- Active listening expresses compassion, which will help the survivor open up.
- Active listening establishes trust and can bridge differences between survivor and lay counselor.

For counseling to flow, the lay counselor must listen actively.

MODULE 2

UNIT 6: CHILD LAY RAPE TRAUMA COUNSELLING

Objectives

By the end of unit 6, participants should be able to:

1. Define 'children' and-provide guidance for counselors on how to deal with children.

2. State the phases of child sexual abuse.

3. Draw distinctions between child and adult counseling.

4. Describe the skills, techniques and approaches to counsel children alone or accompanied by parents or guardians.

Note: 'Children' are those about 12 or fewer years of age.

Key content

- Understanding children
- Phases of child sexual abuse
- Differences between child and adult counseling
- Type of skill required when counseling children.

Activity 1: Understanding children

Time: 10 minutes

Method

The facilitator asks participants to remember, when they were 5-12 years, two adults in their life; one was someone they liked and one was someone they did not like. Participants list the qualities each had and reasons why they liked or did not like them. The whole group discusses these qualities, how they influenced the relationship with that person and how they influenced participant lives. Participants tell what they feel about the same people today.

The facilitator asks participants to think of someone they talked to or confided in when they were young. Participants discuss the reasons for confiding in that person and what the person told them.

Learning point

Understand how people in different circumstances relate to adults. Understand how to build relationships with child survivors.

Activity 2: Phases of child sexual abuse

Time: 10 minutes

Method

The trainers should explain the different phases of child sexual abuse and their signs.

Learning points

Most children are violated by people they know.

Materials: Handout on child counseling

CONTENT: PHASES OF CHILD SEXUAL ABUSE

Child sexual abuse over an extended time typically involves five phases:

1) The **engagement phase** is usually subtle and non-violent. The child is usually enticed and coerced by gifts, preferential treatment, money or affection by the perpetrator.

2) The **secrecy phase** is usually a continuation of the physical contact and mental coercion begun in the first phase. A perpetrator will also test a child's ability to keep 'little secrets' before demanding secrecy for sexual contact or conduct. The child is made to feel guilty and ashamed, and is reminded of their participation to help seal the silence.

3) The **coercion phase** is characterized by increased pressure on the child to keep the abuse secret. At this stage, advanced sexual contact and threats of violence are often made. The perpetrator may also tell lies to a child, alleging that telling about the abuse can only lead to negative consequences.

4) The **disclosure phase** is when the child either tells someone about the abuse or the abuse is discovered. Many years may elapse between the third and fourth phases.

5) The **validation phase** affirms the child's feelings about the abuse. During this phase, it is vital that the child is believed and the responsibility for the assault be placed firmly and solely on the assailant. Rape is never the victim's fault. Also, every effort must be made to protect the child from further abuse and retaliation for telling.

Recovery from rape

The sexual assault of a child by a stranger may be an isolated incident. With stranger assaults, the child survivor may not have to deal with trust and safety within the family. A child's recovery from assault by a stranger can be more rapid than an attack by a caretaker or a relative. The speed and success of the child survivor's recovery depends largely upon the degree to which four factors played a role in the violation:

1) Degree of intimacy and acquaintance between the survivor and the assailant

Contrary to popular myth, rapists are generally not strangers lurking in the bushes. Most child sexual assaults involve perpetrators known to the survivor, such as a caregiver or a family acquaintance. Most incest involves a father and a daughter. The entire family is often dysfunctional in incest cases. Rape by a relative or caretaker involves more traumas to the child survivor because the child's trust has been betrayed and the sense of safety within the family is disrupted. The child may also feel betrayed by other family members, such as the mother and siblings, who they feel could or should have intervened, but chose not to.

2) The time over which the abuse occurs

Long-term, repeated abuse, characteristic of incest, is more traumatic to the child survivor than a single assault, characteristic of stranger assault, because long-term abuse may involve extreme psychological pressure, causing confusion and guilt in the child. A child is more likely to report a one-time event to parents or other caregivers, who may help the child understand what happened.

3) The relative intrusiveness of the abuse

Generally incest involves abusive contact progressing from lesser, though still traumatic contact, such as sexual talk, showing pornography, and unwanted affection or contact, to more intrusive and penetrative abuse. The more intrusive the contact, such as penetration, oral sex and genital fondling, the more traumatic it can be for child survivors.

4) The way the child was engaged in 'sexual' activity

Although physical violence will exacerbate the assault trauma for the child, a child survivor who was tricked into sexual activity may have more difficulty recovering from the assault. As with adult survivors who were not physically harmed, others may not believe an emotionally overpowered child survivor as readily and may feel the child could have done something to stop or prevent the abuse.

Activity 3: Differences between child and adult counseling

Time: 10 minutes

Method

The facilitator divides participants into groups of four and provides them with the case study 'Emily was raped last night'. The groups read the study and answer the questions at the end.

The groups present their answers to the whole group. The whole group discusses the responses. The facilitators should highlight:

- Counseling issues for guardians and parents
- Skills needed to counsel and why to use them
- Differences between child and adult counseling

Learning points

Different skills need to be applied when counseling children than when counseling adults because the traumatic effects differ. Children will not always communicate directly and require patience and understanding. Lay counselors need to learn body language and use it. Trust has to be built between the counselor and the child for the child to open up. Counselors need to know their own limitations, especially when counseling a child, because it can invoke high emotions. Where necessary, lay counselors should refer child survivors to where they can get more psychological support e.g. clinical/child psychologist

CONTENT: COUNSELLING CHILDREN

- The basic principles of counseling children are the same as for adults.
- Counseling may be provided to children individually or as part of family counseling.
- Counseling a child requires establishing a relationship between the child and the counselor, called 'joining'. The methods depend on the age of the child.
- Counseling children requires skill in talking and listening to them.
- Many tools can be used to help communicate with children, including /drawing, telling stories, play and drama.

Basic principles of counseling children

Counseling aims to help people cope better with situations they face. Lay counselors' help children cope with their emotions and feelings and help them make positive decisions.

Doing this involves:

- Establishing a relationship with the child
- Helping the child tell the story
- Listening carefully
- Providing correct information
- Helping the child make informed decisions
- Helping the child recognize and build on strengths
- Helping the child develop a positive attitude towards life

It does not involve:

- Making decisions for the child
- Judging, interrogating, blaming, preaching, lecturing or arguing
- Making promises that cannot be kept
- Imposing beliefs on a child

Types of counseling for children

- 'One-to-one counseling' may be individually provided to children and young people.
- 'Group counseling' may also be provided to a child as part of family counseling.

Counseling skills required in child counseling

If adults wish to counsel a child, they first need to establish a relationship with the child, called 'joining'. The methods depend on the age of the child and are very different from methods used with adults. For example, for a child under five years, the lay counselor may get on the floor to play a game the child likes. Talking with and listening to children and young people requires special skills and approaches and may use telling stories, drawing, drama and games.

Other issues

Adults counseling children and young people need to be aware of their own feelings towards issues that might come up. They should be aware of their own beliefs on culture, tradition, religion and gender. They should avoid imposing these on the child. They also must know the rules regarding confidentiality. These should be made clear to the children in a way appropriate for their age. In many cases, counseling may reveal issues that require action. The lay counselor may need to act on behalf of the child on some issues, a form of *local aduocacy.*

Activity 4: Type of skill required in counseling children

Time: 10 minutes

Method

The whole group offers short suggestions on the skills to be used with child survivors. Then in groups, participants discuss and share their feelings on the case studies and what they would do as lay counselors.

Learning points

Most counseling skills can be used, with sensitivity. The lay counselor needs to be patient and understanding when handling children.

CONTENT: EFFECTIVE COUNSELLING FOR AN ABUSED CHILD

Table 1. Effective counseling for an abused child

DO'S

1. Believe the child 2. Create a rapport with the child 3. Show a measure of trust
4. Let the child relate to you as a fellow human being 5. Show some accessibility and reliability
6.Assure the child reasonable confidentiality 7.Be realistic and explain what is likely to happen
8.Exhibit professionalism 9.Ensure privacy is obtained so the child can talk in confidence
10.Agree at the onset the time it will take . 11.Keep proper physical space
12.Be sensitive to any reactions from the child 13.Empathize 14.Maintain a lifeline with the child by assuring the child can always come back
15.Be in control of your emotions 16.Be patient: let the child go at their own pace, listen carefully and patiently and with understanding 17.Be wise, warm and sensitive 18.Evaluate your own thoughts and behavior 19.Create a relaxed atmosphere 20.Be impartial and objective 21.Be knowledgeable
22.Accept the child as she or he is 23. Show commitment 24.Be real and know where your competence or assistance is no longer useful.

DONTS.

1.Do not ask accusing questions 2.Do not be overly informal 3.Do not be judgemental
4.Do not be impersonal, but do keep a professional distance 5.Do not miss appointments, read or talk on the phone when the child is talking to you 6.Do not give information about the child unless professionally required 7.Do not assure the child about matters that you cannot control
8.Do not be too personal with the child and do not create dependency by personalizing the relationship
9.Do not interview in an open space, likely to have interruptions 10.Do not appear to be in a hurry
11.Do not take personal liberties, such as hugs and pecks, especially if you are of the opposite sex
12.Do not react negatively to any negative reaction of the child 13.Do not sympathize

14.Do not feel frustrated that the child does not open up 15. Do not break down 16. Do not pressure the child to speak nor rush the child 17. Do not keep interrupting 18. Do not project or transpose personal experience 19. Do not be judgmental 20.Do not mislead

21. Do not be ignorant on how to relate with others; lack of understanding of child behaviour will not help

22. Do not go to a room from which the child wants to leave as soon as possible 23.Do not offer assistance if you cannot be committed 24.Do not make referral without the child's or parents/guardian's consent.

Adapted from Odhiambo and Maganya, Making Schools a Safe Horizon for Girls (2004)

CONTENT: SEXUAL ASSAULT AND COUNSELLING CHILDREN

Although assailants abuse children for many of the same reasons they assault adults, the needs of the child survivor may often be different from those of the adult survivor.

With children or adolescent survivors, the lay counselors should:

- Assure survivors they are not to blame for the assault.
- Tell survivors they believe them.
- Tell survivors they are safe now and they did the right thing by telling.
- Assure survivors they did not deserve the assault and abuse, for example, by being out after curfew or going somewhere without permission.
- Address survivors' concerns and feelings of confusion, shame, fear betrayal, and guilt.
- Communicate with the children in a way they can understand.
- Not force children to talk about their experiences when they are not ready.

Sexual assault and abuse of children can take varying forms. It can be perpetrated by individuals acquainted with the child, may occur over a short or a long time and may be accompanied by various physical violence.

Child survivors and parents

Child survivors will often be very concerned about their parents. They are extremely sensitive to their parents' emotions and may internalize some of the stress and anger the parent experiences. Especially in incest, children may be concerned about breaking up the family.

Assure child survivors that, whatever happens, they are not to blame. Do not promise, however, that their parents do not blame them for the assault. Although it may be difficult to accept, parents may blame children.

Child rape victims are greatly affected by fear, confusion and stress and are overwhelmed by all that happens. Being the centre of a controversy can be a burdensome challenge, bringing unwanted attention, scrutiny and focus. As a result, some child victims may say they lied about an assault, in an attempt to stop the controversy or, in many cases, to protect the perpetrator from being prosecuted. Changing a position or story does not necessarily mean that a child was not a rape victim.

The law requires all cases of child abuse, in any form, to be reported to the authorities. Unfortunately, the system often does not work on behalf of the victim. There is no guarantee that the child will be protected after reporting the incident to the proper authorities.

Parents may need a resolution, action or result pertaining to the sexual victimization of their child. As with any survivor of rape, counselors must to focus on the needs and interests of the survivor first. For many child victims the legal system, for example, may only traumatize and victimize them more.

UNIT 7: RAPE AND LEGISLATION

Objectives

By the end of unit 7, the participants should be able to:

1. Discuss legislation on rape.
2. Discuss interpretations and applications of legislation and requirements on rape.

3. Discuss the information to give to survivors to prepare them to deal with the criminal justice system.

Note: A legal resource person will do this session.

Key content

- Defining rape, what the law says
- Roles and responsibilities of counselors towards rape survivors
- Practicing counseling skills.

Activity 1: Legislation defining rape

Note: This session's method depends on the resource person. If possible, arrange to have a lawyer present this session to answer any questions that emerge in the discussions. Issues that need to be covered include:

- The various definitions of diverse sexual violations in legal documents.

Learning points

The local meanings and understandings of rape often vary from those in legislation. Health workers need to be aware of these differences and support survivors in their search for justice.

Legal gaps exist, so attaining justice for survivors may be difficult or virtually impossible. Counselors need to prepare survivors for these challenges. Counselors need to understand how litigation works and to inform survivors, including what to expect at police stations, what forms they will have to fill out, what are survivor rights and obligations.

CONTENT: DEFINITION OF RAPE

'Rape' is 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting including but not limited to home and work' (WHO 2002).

Rape includes sexual contact by one person to another against their will. It may include forced penetration of the vagina or anus with a penis or other object; touching the perineum; oral sex by placing the mouth or tongue on a person's vagina, penis or anus; rubbing a penis, hand or other object against another person's perineum; and performing such acts with an animal. However, the law defines all these activities differently.

Key words

Carnal knowledge

'Carnal knowledge' within legal discussions is a penile-vaginal penetration. While the anus and mouth are orifices that could also be penetrated by a penis, when these other orifices are mentioned, 'against the order of nature' is added in the law.

Against the order of nature

The law presumes sexual behavior should be between adults of the opposite sex. Natural acts include only a penis and a vagina. Therefore when sexual activity, including penetration, is outside this assumption, it is regarded as unnatural and described as 'against the order of nature'. Consent is not considered.

Penetration

'Penetration' is the partial or complete insertion of the genital organs of a person into the genital organs of another person.

Other types of sexual offences include

• Gang rape • Indecent act with child or adult • Child trafficking • Child sex tourism

• Child prostitution • Child pornography • Exploitation of prostitution • Trafficking for sexual exploitation • Prostitution of persons with mental disabilities

• Sexual offences relating to position of authority and persons in position of trust

• Sexual relationships that predate position of authority or trust

• Deliberately transmitting HIV or any life-threatening sexually transmitted disease.

• Administering a substance with intent • Cultural and religious offences • Not disclosing conviction for sexual offences.

UNIT 8: CARE OF COMMUNITY LAY RAPE TRAUMA COUNSELORS

Objectives

By the end of unit 8, the participants should be able to:

1. Define stress
2. Establish stress causes in counselors
3. Discuss different reactions to stress
4. Discuss skills, techniques and strategies for managing stress by counselors and survivors

Activity 1: Defining stress

Time: 10 minutes

Method

Participants offer suggestions to define stress and the facilitator gives them the correct definition.

Learning points

Stress is an emotional response to new or difficult situations. It is healthy and necessary. How people react to stress varies greatly. Some will find certain situations much more stressful than others. How people respond to stress also varies greatly.

Activity 2: Identifying the causes of stress

Time: 10 minutes

Method

In two groups, participants discuss stress:

Group 1: The issues that can make one experience stress in counseling.

Group 2: Reactions to stress, classified into behavioral, physical and emotional.

Activity 3: Common reactions to stress

Time: 15 minutes

Method

In three groups, participants discuss and list how people react to stress. Each group is given a category: behavioral, physical or emotional. Each group will share their findings with the whole group, where everyone will also give their suggestions.

Activity 4: How to manage stress

Time: 10 minutes

Method

The whole group discusses some ways they coped with stressful situations. The facilitator then guides them through the content on managing stress.

Learning point

Each person experiences stressful times, but how stress is dealt with affects the person's life. This applies to sessions.

Content: Managing stress

Stress

'Stress' is a body response to either too much pressure or too little pressure.

STRESS = HIGH DEMANDS + HIGH CONSTRAINTS + LOW SUPPORT

Causes

Causes can be as diverse as the dynamics that surround daily life. They can be traumatic events, chronic difficulties or conflicts.

Sources of stress for the counselor can be:

• Feelings of inadequacy •Dissatisfaction with the social system •A survivor sero-converting after PEP •Self blame •Weak support systems for the survivor •Transference

•Survivors failing to open up during the session or keeping silent •The counselor controlling the session agenda rather than the survivor.

Reactions to stress

Physical reactions

•Tiredness •Palpitations •Pain and tightness in the chest •Indigestion • Breathlessness

•Nausea •Headaches •Sweating •Trembling •Rapid weight gain or loss •Vomiting

Emotional reactions

•Amnesia •Mood swings •Anger •Guilty •Drained •Helplessness •Hopelessness •Loss of confidence •Lack of self esteem •Withdrawal •Self-blame •Nervousness •Depression •Hallucinations •Fear

Behavioural reactions

• Accident prone •Poor work •Increased irritability • Impaired speech

• Physically careless •Forgetfulness •Change in lifestyle •Change in sleeping pattern •Increased consumption of alcohol and drugs •Overeating or under-eating

Chronic effects of stress

• Psychosomatic illness •High blood pressure •Depression •Accidents •Poor performance at work •Low self-esteem and loss of confidence •Marital breakdown and strained relationships

NB: If you have any of these signs, talk with your healthcare provider.

MANAGING STRESS

Caring for survivors can make you feel good about yourself. But it can also cause stress. Too much stress can harm your own health. Here are some things you can do to manage the stress of rape trauma counseling.

Stay healthy. Try to eat well, rest, and be physically active each day

Talk about it. It can help to share your anger, fears, and sadness with someone who is not part of the situation. Sometimes it helps to talk with a friend, minister, rabbi, counselor, or health worker.

Take time out. Try to find someone to help so you can take a break. Get out on your own. Do something for yourself that you enjoy.

Realize you are not alone. Finding a support group for caregivers can help. It allows you to meet and talk with people who are going through many of the same things you are. They understand how you feel.

Breathe deeply. Take a few minutes to sit in a quiet room and think only about your breathing. Take some deep breaths. Listen to the sounds they make as you shut out all else from your mind. Doing this can help lower stress and worry. It's a small way to make a big difference

Stay active. Exercise is good for the body and the soul. It lowers stress and boosts your energy. You don't have to go to a gym to exercise. You can stay active by walking each day. You can dance, ride a bicycle, work in a garden, or do anything else you enjoy that keeps you moving.

WHEN TO SEEK FOR HELP

Unmanaged stress leads to burnout. Some symptoms of burnout

• Extreme and continuous exhaustion • Intense and prolonged sense of helpless and hopelessness • Withdrawing from society • Giving up about life • Deep and prolonged sadness • Apathy-lack of concern for self and others

If any of the symptoms above are present one should seek specialized help from a professional counselor, or ones supervisor (for referral).

UNIT 9: ETHICAL PRINCIPLES IN COMMUNITY LAY TRAUMA COUSELING

Objective

At the end of unit 9, the participant will be able to:

1. Apply ethical principles during IRTC intervention.

Time: 10 minutes

1) Respect for the uniqueness of the person

No two people are alike; each case study should include individual survivor issues.

2) Confidentiality

• All survivor names should be changed to disguise the survivor's identity and should be written in the case preamble.

• Appropriate, respectful names and terms should be assigned; avoid 'rape victim' for a survivor who has been raped.

• Facility and agency names may or may not be disguised. If they are disguised, this should be stated in the preamble.

3) Respect for the dignity of persons

- The names selected should be culturally congruent and avoid any taint of ridicule.
- Survivors are to be referred to by their disguised full name throughout the case reporting, unless some exception is introduced.
- The same disguised, names should be retained for all the subsequent sessions and case study write-ups.

4)Veracity

- Counselors need to present a truthful account and accurate data.
- Very sensitive material that has no bearing on the case should be omitted.

UNIT 10: RESPONSIBILITIES OF A COMMUNITY LAY RAPE TRAUMA COUNSELOR

Objective

By the end of unit 10, the participant will be able to:

a) Explain the responsibilities of a community lay rape trauma counselor.

Activity 1: Responsibilities of counselors towards rape survivors

Time: 10 minutes

Method

Participants discuss the following questions as a whole group in smaller groups:

- What is my role as a lay counselor in supporting rape survivors?
- What is my role in preparing the survivor for the criminal justice system?
- What information would I be required to give a survivor in any session?
- What is my responsibility in supporting the survivor in dealings with the justice system?

- With regard to providing information and confidentiality?

1) Inform the survivor on health and legal services and their purpose.

- Establish that a PRC 1 was filled in.
- Establish that the survivor was given the 3-page original PRC 1 form.
- Ask whether the survivor was aware if the doctor filled out any other forms.
- Discuss the examination, documentation and the purpose:
  i) Establishes crime and provides evidence
  ii) Necessary for police investigation
  iii) Necessary for court and litigation
- Discuss the P3, ensuring the survivor knows the duplicate PRC 1 will be attached to the P3 form. The survivor must keep the PRC 1 in its original form.

Note: If the survivor is being abused within the homestead, discuss the fact that the PRC 1
Form may get 'lost'.

- Discuss disclosing the rape and whom the survivor can rely on for support.

2) Inform the survivor on preventive therapy when asks about them.

• HIV, STIs and pregnancy • Discuss preventing HIV • Risk of HIV infection
• Discuss preventing STIs • Preventing combination of STIs • Discuss preventing pregnancy
• ARVs side effects common and mild, rarely severe • Survivor must know screening may be required • Dosage, side effects and effectiveness of emergency contraceptives • Discuss options of pregnancy termination or child adoption
• Establish survivor's understanding of transmitting HIV and STI and pregnancy.

3) Inform the survivor on legal issues

- Reporting and litigation

- Discuss whether survivor intends to report and the rationale
- Encourage reporting to the police, knowing it provides legal support, if the survivor might wish to report later. However, remember survivors have their rights and can make informed decisions.
- Discuss the reporting procedure
- Record in Occurrence Book
- Sign a written statement. Survivors should sign only after they are completely satisfied that what is written represents them.
- Survivor may need writing support, especially if not very literate.
- Discuss survivor reporting concerns and issues.
- Refer survivors appropriately, some to the officer, others to legal support groups

The survivor should expect:

- Cross-examination on many occasions by different people
- An identification parade, but can demand anonymity
- Their story to be challenged and disbelieved in the court
- The case to take some time, with many court visits

The rights and responsibilities of the survivor

• To be accompanied by an officer of chosen gender to the health facility

• To tell nothing but the truth.

Note: Explore survivor concerns and issues regarding reporting. Refer the survivor appropriately, for instance, to legal support groups.

Unit 11: Referral Linkages and Care of Rape Survivors

Objective

By the end of unit 11, participants will be able to identify service points for appropriate referrals to enhance the care of survivors.

Method

Time- 10 minutes

Why referral system?

• When services or resources within reach are not able to meet the survivors immediate need.

• For specialized management in the next stage of care e.g. the PLHIV condition is deteriorating, for PMTCT, STI Treatment, etc

• For continuity of care from health facility downwards to the family or community, e.g. for adherence support, disclosure, support groups, etc.

• When the caregiver has limitation in meeting certain needs of the PLHIV, e.g. emotional, spiritual, legal, economic, etc.

• In cases where the acute phase of care has been dealt with and is deemed safe to transfer care to other caring services/organization within the community.

Activity 1: Social mapping

The participants to compile a list of agencies in their communities involved in providing post-rape care.

IDENTIFYING AVAILABLE REFERRAL POINTS

Group participants from the same geographical area and identify the working referral sites. Group presentations and plenary discussions. Keep directory of all the identified working referral sites in your locality.

SUPPORT GROUPS

It's a group of people coming together to share challenges, experiences and roles they have in common. Support groups create a safe and open space for people to come out of isolation and reduce stigma by giving infected and affected persons a place to come together and share. It

is an important driver to strengthening referrals between the community and health facilities. Beneficiaries of post-rape support groups are survivors, families and friends affected by it and workers caring for survivors.

ADVANTAGES OF SUPPORT GROUPS

A support group offers many advantages to its members including:

- Medical and clinical knowledge
- Practical advice and experience sharing
- Emotional and spiritual support
- Promoting prevention, encourages healthy living, and can be classrooms where treatment literacy is cultivated
- Allows members to come together to learn, to share and when necessary grieve and celebrate. It's a good avenue to advocate and implementing preventative and management planned strategies.

ROLES OF SUPPORT GROUPS IN PROMOTING POSITIVE MENTAL HEALTH OUTCOMES

They act as advocates to each other and the community. Directly and indirectly educate communities on planning strategies and gathering resources messages. They are supportive and willing to listen. They respect personal differences, recognize commonalities and draw on collective strengths.

UNIT 12: MONITORING AND EVALUATION OF THE COMMUNITY RESEARCH

OBJECTIVE

By the end of this unit 12, the participants will be able to:

- Use community data tools,
- Participants will be able to implement participatory evaluation of activities at community level.

Time 15 minutes

LEARNING OBJECTIVES

By the end of this unit participants will be able to:

- Discuss the importance of good recording and reporting for activities at community level
- Identify the main data collection and reporting tools for research activities at community level
- Discuss importance of data utilization for decision making
- Describe the information flow from community to research office.

Monitoring

Monitoring is a routine process of tracking the prograrn progress, it's a continuous process and advices the implementers/ Managers whether to change the strategies or not.

Evaluation

Evaluation is a periodical process aimed at showing whether the interventions being implemented are making a difference and are achieving the distressed results.

IMPORTANCE OF MONITORING AND EVALUATION

- Demonstrating accountability
- Sharing progress and results with stakeholders
- Modification and discontinuation of interventions that are not effective or efficient
- Enable project personnel to plan effectively Motivate community and staff involved

RECORD KEEPING

Recording is a process of documenting information about provider's activities and services. Examples of records are weekly research guide, questionnaire, dairies, etc. Record keeping is the process of storing or keeping custody of information for planning and future reference.

IMPORTANCE OF RECORDS

It is difficult to keep all the information about a variety of survivors and activities in one's head. Once recorded, information will help us communicate our activities to our supervisors and other stakeholders. This will support the identification of priority problems for planning purposes. Written records also provide evidence needed for monitoring and evaluating community health activities.

CHARACTERISTICS OF GOOD RECORD KEEPING

Consistency- maintain a standard format in recording and reporting

Accuracy-ensure correct information is captured

Timeliness - should be done immediately after an activity

Reliability-providing actual information that can be validated

INFORMATION GATHERING PROCESS

The members of the community will provide most of the information we need.

Gathering that information requires:

1. **Listening** - Listen to what people say about their health and ask all you need to know about their health.
2. **Observation** - Observe health related issues e.g. food availability, nutrition status, stigma and discrimination and other health indicators
3. **Counting** - check and record services, commodities or events, e.g., how many condoms are distributed, No. of condom dispensers are in a given community, number of support groups and enrolment.

How to keep records

Records can be kept using various ways and methods (tools). Among these are questionnaires, community follow up research guide.

A register is a book in which specific:

- Information and services provided are documented, e.g. age, sex, type of service provided.
- CHWs write their daily schedules, activities
- Other observations made while providing services.

A record is an important document that should be confidential and safe guarded at all times. In order to achieve these records should be:

- Safe guarded against unauthorized persons
- Secured from damage by water, fire, rodents, termites, etc
- Handled carefully to avoid unnecessary wear and tear and malicious damage
- Made available to supervising authorities.

UNIT 13: PRACTICING LAY RAPE TRAUMA COUNSELING SKILLS

Time: 270 minutes

Method 1

Participants use the following scenarios for role playing different counseling sessions. The participants form groups of three or four, depending on each role play. Participants should choose their roles. Each play should have an observer, a lay counselor and a survivor. Participants employ the various counseling skills discussed. Role plays may include, but are not restricted to

- An adult (female or male) either alone or accompanied by the police
- An adult (female or male) accompanied by their partner, significant other or family member
- A child under 5 years, assaulted by a relative with whom they live
- A mentally retarded survivor brought in by a family member
- A commercial sex worker
- A teenager accompanied by the parent.

After 10 minutes of role playing, the facilitator asks each group to discuss

- Which skills did the lay counselor use?
- How were these skills used? Were they appropriate?
- What issues did the survivor present? How did the lay counselor address them?
- What issues did the partner, significant other or family member present? How did the counselor address them?
- Did the survivor feel helped by the lay counselor?
- Were there any difficulties in applying certain skills?
- What could have been done differently? How?

Note: Each participant should provide feedback from their own point of view (annex 5), identifying what was useful and good about the session and what could be improved, before discussing it with other group members.

Each group should present their discussions and answers to the whole group. The facilitators should pick key concerns and skills for further practice.

LEARNING POINT

Different survivors will be in the community with different trauma. Lay counselors need to know how and when to apply different counseling skills for each case. Survivors require flexibility in the skills used. Some are accompanied and feel threatened by the company; some cannot communicate effectively, such as people who cannot speak either Kiswahili or English well or who are deaf, dumb, or retarded.

Method: Participants in groups of three role play a counseling session using different scenarios:

- A teenager comes alone for counseling
- A survivor sero-converts immediately after completing the PEP dose
- A 3-year-old girl defiled by a 13 year-old boy are brought in together for counseling by their parents.

- A difficult survivor who does not display any emotion or is mentally challenged

The whole class and the facilitator observe and give feedback during the last 30 minutes. Facilitators should support feedback sessions to enhance skill building. Trainers will use this session to assess lay counselor skills. The whole class gives feedback to each other.

Activity 1: Observed practice learners' guide (repetitive)

Aspects of survivor service assessed:

- Explain to the survivor what to expect
- SOLER: Sit, Open, Lean forward, Eye contact, Relax
- Use at least seven counseling skills
- Discuss a risk-reduction plan
- Ensure survivor understood meaning of test result
- Discuss disclosure of test results and assault
- Support survivor to develop an action plan
- Deal positively with survivor's emotional reaction
- Give the three core conditions to the survivor throughout the session
- Give adequate time for the survivor to air out issues
- Discuss referral options with survivor
- Assess available social support
- Conduct a survivor-centered session.

Appendix B

Intense Community Lay Rape Trauma Counseling Implementation Guide

March 2011

Table of Content

Acronyms and Abbreviations

Bi-monthly Community Lay Counseling Guide for CHWs

Bi-monthly Community Support Services Guide for CHWs

Monthly Practice Observation Guide for CHEWs

Acronyms and abbreviations

ANC- Antenatal Clinic

ART- Antiretroviral Therapy

CHW- Community Health Worker

CHEW- Community Health Extension Worker

CSP- Community Service Providers

EC- Emergency Contraceptive

FP- Family Planning

ICLRTC- Intense Community Lay Rape Trauma Counseling Intervention

MIS- Meaningful Involvement of Survivor

M&E- Monitoring and Evaluation

MCH- Maternal and Child Health

SOLER- Sit, Open, Lean Forward, Eye Contact, Relax

STI- Sexually Transmitted Infection

VCT- Voluntary Counseling and Testing

ICLRTC Intervention Implementation Guide

Annex 1

Bi-Monthly Community Lay Counseling Guide for CHWs

Aspects of ICLRTC intervention being implemented:

1. Explain to the survivor what to expect in the session.
2. SOLER: Sit, Open, Lean forward, Eye contact, Relax
3. Use at least seven counseling skills
4. Perform a risk assessment correctly
5. Deal positively with survivor's emotional reaction
6. Give the three core conditions to the survivor throughout the session
7. Give adequate time for the survivor to air out issues 60 minutes
8. Give the survivor adequate information on
    - Risk reduction plan.
    - meaning of test results
    - availability of the survivor's social support
9. Discuss disclosure of test results and rape with the survivor, or with the parent /guardian.
10. Discuss referral options with the survivor, or parents/guardian
11. Support survivor to develop an action plan
12. Prepare the survivor for the criminal justice system
13. Discuss issues of drug adherence with the survivor
14. Deal with own emotional reactions
15. Conduct a survivor centered session

Annex 2

BI-Monthly community counselling guide for CHW

Aspects of ICLRTC intervention to the survivor being implemented:

1. How to disclose:

a) Assist survivor to make a plan for disclosure
   - Who to tell
   - When to tell
   - Why to tell
   - Potential reactions

b) Inform survivor disclosure facilitates survivor to receive support from their partners or parent or friends and other systems available.

c) Ask for any questions from survivor or parent/guardian and address them.

d) If one cannot disclose, link them to a trained counselor to assist them in disclosure.

2. Sustain risk reduction behavior among survivors
   a) Assist survivor to:
      - Make deliberate effort to minimize risk of HIV transmission if positive or to minimize risk of acquisition if negative.
      - Understand risk reduction starts from within self (internal urge).
      - Encourage use of condom if opt to engage in sex, to protect self from STIs, HIV
      - Use FP to protect self from unintended pregnancy
      - Improve quality of life by improving ones self esteem.
   b) Ask for any questions from survivor or parent/guardian and address them
3. i) Assess for substance and alcohol use
   a) Ask the survivor:
      - Do you drink beer, wine, or other alcohol beverages?
      - What do you drink?
      - How many days in a week do you drink?
      - When you drink, how many drinks do you usually have?
   b) Ask the survivor:

- Do you inject yourself?
- What do you inject yourself with, how often?

c) Do you sniff any substance?
d) Do you smoke?
e) Do you chew miraa?
f) Support survivors who are using alcohol or other substances to stop or reduce intake.
g) Ask for any questions from survivor or parent/guardian and address them.

ii) Alcohol and substance abuse

a) Assist survivor understand taking tobacco and illicit drugs while on ARVs is extremely dangerous because they can cause harmful reactions, and can also
   - Cause survivors to neglect their overall health and self-care
   - Cause survivors to be more likely to engage in risky sexual behaviors.
   - Lead to non adherence to HIV medications if survivor is positive.

4. Assess parent or guardian input among child survivors.
5. Assess safety of survivor and of P_3 form
6. i)Ask survivors or parent/guardian about drug adherence:
   - Are you (or the child) on any medication?
   - What medication do you take?
   - Have you ever skipped/missed a dose in the past week/month?
   - How many times did you miss a dose of this medication in the past week/month?
   - When was the last time you missed a dose?
   - What were the reasons that made you miss the dose?

b) Support survivor or parent/guardian to strictly stick to ARVS dosage and prescribed schedule of taking medication.

c) Support survivor or parent/guardian to stick to other treatment schedule including hospitals, doctor's appointments, nutrition advice, etc

d) Inform survivor or parent that non-adherence stops ARVs from being effective, and increases the risk of the virus developing resistance to medications.

ii) Assist survivors with adherence

a) Discuss reasons for non adherence
b) Engage treatment supporter or family member for assistance.

c) Use adherence aids where available.
d) Ask for any questions from survivor or parent/guardian and address them.

7. a) Assess for STIs
   b) Discuss how poor hygiene may also lead one to get infected with STIs
   c) Advice symptomatic survivors to abstain from sex until after completion of treatment

   d) Advice survivors to use condoms to prevent the possibility of transmitting or acquisition of STIs

   e) Support disclosure to and treatment of partner(s).

   f) Ensure treatment adherence

   g) Give condoms

8. Ask for any questions from survivor or parent/guardian and address them
9. Assist survivor plan for the future including family planning
10. Assess for pregnancy status and intentions:
    a) For women:
       - Ask if pregnant
       - If she is not pregnant, is she on any contraceptive, or does she desire contraceptive?
       - If pregnant, ask about her pregnancy intentions.

    c) Ask for any questions from survivor or parent/guardian and address them
11. Set goals with the survivor not for the survivor:
    - Set one reasonable goal at a time
    - Set realistic goals with the survivor
    - Help the survivor make a plan for achieving his goals
    - Talk through the possible barriers to achieving the goal
    - Arrange anything the survivor needs to follow the plan and meet the set goal.
12. Address any questions from survivor or parent/guardian promptly and/or appropriate referral:
    - Refer for HIV test at 3 and 6 months
    - Refer to social support groups for meaningful involvement of survivor.
    - Refer to counselor or another clinician for further counseling if there are issues hindering correct and consistent condom use.

- Refer survivors who use alcohol/substances heavily to health facility for further counseling and support.
- Refer for adherence counseling and support (if necessary).
- Refer for STI treatment
- Refer to comprehensive care clinic.
- Refer for abortion or child adoption.
- Refer to ANC
- Refer to community legal-justice system, to police, anti-rape advocacy groups.

Annex 3

Monthly Practice Observation Guide for CHEWs

Name of CHW---------------- Session number------------ Survivor ID number------------
Location number-------------------

Please score as follows: 0= not done, 1= attempted with little success, 2= achieved fairly, 3= achieved successfully, N/A=not applicable.

Aspects of IRTC intervention to the survivor being assessed	score	Comments
1.Explained to the client what to expect------------------------ 2.SOLER: Sit, Open, Lean forward, Eye contact, Relax----- 3.Used at least seven counseling skills--------------------------- 4.Performed a risk assessment correctly------------------------- 5.Discussed risk reduction plan---------------------------------- 6.Ensured survivor, or parent/guardian understood meaning of result--- 7.Discussed disclosure of test results and rape--------------- 8.Ensured survivor, or parent/guardian develops an action plan---- 9.Dealt positively with survivor's, or parent /guardian's emotional reaction--- 10.Gave the three core conditions to the survivor, or parent/guardian throughout the session----------------------- 11.Gave adequate time (60 minutes for the survivor, or parent /guardian to air out issues------------------------------ 12.Discussed referral options with survivor, or parent/ guardian---- 13.Assessed availability of social support-------------------- 14.Conducted survivor centered-session----------------------		
Session start--------------- Stop time------------- Date----------------------- Name of supervisor------------------------------------- Supervisor's signature---------------------		

APPENDIX C_1

Bi-monthly ICLRTC Intervention visit report

District /County------------ Site no------- CHW's name **----------------------------------** Month----- Year-----																						
Date	Survivor ID	Age	Sex	New	Revisit	Weekly lay rape trauma counselling															Referral to	Remarks
						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15		

Report Number.......................... **Comments...**
………
………
All reports are to be submitted monthly to the supervisor before the 5th of every month.
Date submitted ________

1. Re -established coping (i.e. composure, calm, sober, concentrating) and acceptance of seriousness of rape i.e. acceptance of trauma counseling, HIV test, PEP, EC, and PEP adherence.

Or

Dissociation (disorganization i.e. anxiety, anger), disequilibrium (difficulty concentrating and denial, confusion, bewilderment, shock, and numbness (i.e. avoidance behavior, and nightmares (i.e. intrusive thoughts about the rape ordeal)).

2. Minimized stigma (i.e. disclosure of rape, active at routine work in adults, good school grades, actively playing, and obedience in children), (i.e. coping better with rape encounter, optimistic, good mood, good night sleep).

Or

shame (which include denial, anger, non-disclosure); self-blame and guilt (which include self-doubt, non-disclosure); PTSD (which include increased arousal (i.e. fear, anxiety, anger, irritability, hostility, and startle responses); depression (which include denial, fear, substance abuse, and sleep disturbance); social adjustment disorder (refusal to utilize counseling services, refusal of help, self imposed withdrawal, low self-esteem, internal stigma, and school/learning and behavior problems in children); sexual dysfunction (which include lack of feelings of intimacy, sexual risk taking behavior, and sexualized behavior in children); and secondary trauma (which is a result of social stigma and victim-blaming).

3. Adaptation (re-framing the incident and understand themselves), empowered survivor (liberate their resources), integration (transfer their learning to other relationships, and joining relationship in children), social adjustment (utilizing counseling services, seeking help, disclosure), decision making by the survivor (manage their lives more effectively), and survivor feels valued for themselves.

Or

shame (which include denial, anger, non-disclosure); self-blame and guilt (which include self-doubt, non-disclosure); PTSD (which include increased arousal (i.e. fear, anxiety, anger, irritability, hostility, and startle responses); depression (which include denial, fear, substance abuse, and sleep disturbance); social adjustment disorder (refusal to utilize counseling services, refusal of help, self imposed withdrawal, low self-esteem, internal stigma, and school/learning and behavior problems in children); sexual dysfunction (which include lack of feelings of intimacy, sexual risk taking behavior, and sexualized behavior in children); and secondary trauma (which is a result of social stigma and victim-blaming).

APPENDIX C_2

CHEW - Monthly Practice Observation Guide

Name of CHW---------------- Session number------------ Survivor ID number------------
Location number------------------- Report Number......................

Please score as follows: 0= not done, 1= attempted with little success, 2= achieved fairly, 3= achieved successfully, N/A=not applicable.

Aspects of IRTC intervention to the survivor being assessed	score	Comments
1.Explained to the client what to expect------------------------ 2.SOLER: Sit, Open, Lean forward, Eye contact, Relax----- 3.Used at least seven counseling skills--------------------------- 4.Performed a risk assessment correctly------------------------- 5.Discussed risk reduction plan---------------------------------- 6.Ensured survivor, or parent/guardian understood meaning of result--- 7.Discussed disclosure of test results and rape--------------- 8.Ensured survivor, or parent/guardian develops an action plan 9.Dealt positively with survivor's, or parent /guardian's emotional reaction--- 10.Gave the three core conditions to the survivor, or parent/guardian throughout the session---------------------- 11.Gave adequate time (60 minutes for the survivor, or parent /guardian to air out issues------------------------------- 12.Discussed referral options with survivor, or parent/ guardian--- 13.Assessed availability of social support-------------------- 14.Conducted survivor centered-session----------------------		
Session start--------------- Stop time------------- Date----------------------- Name of supervisor------------------------------------- Supervisor's signature---------------------		

All reports are to be submitted monthly to the supervisor before the 5th of every month.

Date submitted ________

APPENDIX D_1

Informed Consent Form for Survivors 12 years old and above

Introduction

Hello, my name is Beatrice Gichuru. I work for Kenya Methodist University. I am a conducting this student research.

Title of study: Community-based Intervention study: effects of trauma counselling on rape survivors-Kenya.

Study Objective: The aim of this study is to establish psycho-social health needs and impact of IRTC intervention on rape survivors, and make recommendations for comprehensive post-rape psycho-social care and support.

Risks/discomfort: The risks of participating in the study will be reduced by excluding those likely to suffer adverse psychological effects (see exclusion criteria) and by monitoring for adverse psychological effects. Discomforts such as breaches of confidentiality, stigma, and discrimination, are acceptable in relation to the likely benefits. One aspect of minimizing risk will be maintenance of participants' confidentiality.

Benefits: this study will reveal survivors' psychosocial needs which are unknown in Kenya. The study will also reveal the effectiveness of ICLRTC intervention in preventing or reducing negative psychosocial health outcomes among rape survivors in Kenyan communities; and why the intervention should be adopted in community post rape care.

Alternative to participating:

Survivors or parents/guardians will be informed that they have been chosen to participate in the study because they had come to the healthcare facility for post rape services. Participants/parents/guardian will be made to understand that declining to participate in the study will not compromise their healthcare and that they may withdrawal from the study at any time.

Confidentiality: Participants/parents/guardians will be assured that all of their answers will be kept strictly secret. To protect participants confidentiality, databases that contain personal identities will be stored on secure servers, with access restricted and audited. Participants will be informed that, once the questionnaires are anonymously transcribed, they will be kept in a locked cabinet for five years, after which they will be destroyed by the researcher; but the anonymized text would be kept as long as will be necessary. Participants/parents/guardians will be informed that the researcher and field staff have a moral and legal obligation to override confidentiality to prevent harm in situations of child sexual violation, certain infectious diseases like HIV infection.

Voluntaries: TO READ ALOUD. Your participation is completely voluntary but your experiences could be very helpful to others who have suffered this incident like you in Kenya. You have the right to stop the interview at any time, or to skip any questions that you don't want

to answer. There are no right or wrong answers. Some of the topics may be difficult to discuss, but many survivors have found it useful to have the opportunity to talk. Do you have questions?
Time: the interview takes approximately one hour to complete.
Do you agree to participate?

1. Yes 2.No

Is now a good time to talk? It's very important that we talk in private. Is this a good place to hold the interview, or is there somewhere else that you would like to go?
To be completed by interviewer
I certify that I have read the above consent procedure to the participant
Signed:…………………………………… Date ……………..

To be completed by participant

Signed:……………………………………Date ………………

Kiambatisho D_1

Ridhaa Fomu Utangulizi watu wazima au watoto walio pita mhutiani wa kuelewa

Kichwa ya utafiti: Jumuiya ya makao Intervention utafiti: madhara ya majeraha ushauri nasaha juu ya waathirika wa ubakaji-Kenya.

Hello, jina langu ni Beatrice Gichuru. Mimi kazi kwa ajili ya Kenya Methodist University. Mimi ni mwanafunzi kufanya utafiti huu.

Madhumuni ya utafiti: Lengo la utafiti huu ni kuanzisha mahitaji ya afya ya kiakili na kijamii na matokeo ya IRTC kuingilia kati juu ya waathirika wa ubakaji, na kutoa mapendekezo kwa ajili ya huduma ya kina baada ya ubakaji ya kiakili na kijamii na msaada.

Naideresha hii utafiti kwa eneo yenu hili kujua afya na hali ya maisha ya wale wamebakwa.

Umechaguliwa kuhuzika na tafiti hii kwasababu ulikuja kwa kituo hiki za afya.

Nataka nikwakisie taarifa zote kubaki siri. Sitaweka recodi yoyote ya majina au anuani.

Una haki ya kuacha mahojiano wakati wowote, au kwa skip maswali ambayo hutaki kujibu. Hakuna majibu sahihi au makosa. Baadhi ya mada inaweza kuwa vigumu kujadili, lakini waathirika wengi wamegundua ni muhimu kuwa na nafasi ya kuzungumza.

Soma kwa sauti - ushiriki wako ni hiari kabisa lakini uzoefu yako inaweza kuwa inasaidia sana na wengine ambao walikufa tukio kama wewe katika Kenya.

Je, una maswali?

Wakati: mahojiano inachukua takribani saa moja kamili.

Je, unakubali kushiriki? **1. Ndiyo** **2.No**

Ijazwe na muoji

Nakubali kuwa nimesoma juu ya ridhaa ya utaratibu wa mshiriki,

Saini: ... ... Tarehe ... ...

Kukamilika na mshiriki:

Saini: ... ... Tarehe ... ...

Kwa wale hawajwi kusoma au kwadika: Kidole…………………… Tarehe…………..

Ukiwa na maswali nifikie kama ifuatavyo: Saduku la barua 850 Thika sub-county;. Simu ya lununu 0729425373. Barua pepe: betgichuru@yahoo.co.uk

Ukipenda kujua haki yako ya kuhuzika na utafiti huu uliza maswali kwa:

KEMRI/ Ethics Review Committee, P.O. Box 54840-00200 Nairobi. Simu: 0202722541; 2713349. Simu ya lununu 0722205901, 0733400003. Faxi 0202720030 Barua pepe: director@kemri.org

APPENDIX D_2

Informed Consent Form for Children 6-11 years of age

Introduction

Hello, my name is Beatrice Gichuru. I work for Kenya Methodist University. I am a conducting this student research.

Title of study: Community-based Intervention study: effects of trauma counselling on rape survivors-Kenya.

Study Objective: The aim of this study is to establish psycho-social health needs and impact of IRTC intervention on rape survivors, and make recommendations for comprehensive post-rape psycho-social care and support.

Risks/discomfort: The risks of participating in the study will be reduced by excluding those likely to suffer adverse psychological effects (see exclusion criteria) and by monitoring for adverse psychological effects. Discomforts such as breaches of confidentiality, stigma, and discrimination, are acceptable in relation to the likely benefits. One aspect of minimizing risk will be maintenance of participants' confidentiality.

Benefits: this study will reveal survivors' psychosocial needs which are unknown in Kenya. The study will also reveal the effectiveness of ICLRTC intervention in preventing or reducing negative psychosocial health outcomes among rape survivors in Kenyan communities; and why the intervention should be adopted in community post rape care.

Alternative to participating:

Survivors or parents/guardians will be informed that they have been chosen to participate in the study because they had come to the healthcare facility for post rape services. Participants/parents/guardian will be made to understand that declining to participate in the study will not compromise their healthcare and that they may withdrawal from the study at any time.

Confidentiality: Participants/parents/guardians will be assured that all of their answers will be kept strictly secret. To protect participants confidentiality, databases that contain personal identities will be stored on secure servers, with access restricted and audited. Participants will be informed that, once the questionnaires are anonymously transcribed, they will be kept in a locked cabinet for five years, after which they will be destroyed by the researcher; but the anonymized text would be kept as long as will be necessary. Participants/parents/guardians will be informed that the researcher and field staff have a

moral and legal obligation to override confidentiality to prevent harm in situations of child sexual violation, certain infectious diseases like HIV infection.

Voluntaries: TO READ ALOUD. Your participation is completely voluntary but your experiences could be very helpful to others who have suffered this incident like you in Kenya. You have the right to stop the interview at any time, or to skip any questions that you don't want to answer. There are no right or wrong answers. Some of the topics may be difficult to discuss, but many survivors have found it useful to have the opportunity to talk. Do you have questions?

Time: the interview takes approximately one hour to complete.

Do you agree to participate?

1. Yes 2.No

Is now a good time to talk? It's very important that we talk in private. Is this a good place to hold the interview, or is there somewhere else that you would like to go?

To be completed by interviewer

I certify that I have read the above consent procedure to the participant

Signed:…………………………………… Date ……………..

To be completed by Child

Signed:……………………………………Date ………………

To be completed by parent/guardian

Signed:……………………………………Date ………………

Kiambatisho D_2

Ridhaa Fomu Utangulizi –Watoto Na Watoto ambao awakupita mhutiani wa kuelewa

Kichwa ya utafiti: Jumuiya ya makao Intervention utafiti: madhara ya majeraha ushauri nasaha juu ya waathirika wa ubakaji-Kenya.

Hello, jina langu ni Beatrice Gichuru. Mimi kazi kwa ajili ya Kenya Methodist University. Mimi ni mwanafunzi kufanya utafiti huu.

Madhumuni ya utafiti: Lengo la utafiti huu ni kuanzisha mahitaji ya afya ya kiakili na kijamii na matokeo ya IRTC kuingilia kati juu ya waathirika wa ubakaji, na kutoa mapendekezo kwa ajili ya huduma ya kina baada ya ubakaji ya kiakili na kijamii na msaada.

Naideresha hii utafiti kwa eneo yenu hili kujua afya na hali ya maisha ya wale wamebakwa.

Umechaguliwa kuhuzika na tafiti hii kwasababu ulikuja kwa kituo hiki za afya.

Nataka nikwakisie taarifa zote kubaki siri. Sitaweka recodi yoyote ya majina au anuani.

Una haki ya kuacha mahojiano wakati wowote, au kwa skip maswali ambayo hutaki kujibu. Hakuna majibu sahihi au makosa. Baadhi ya mada inaweza kuwa vigumu kujadili, lakini waathirika wengi wamegundua ni muhimu kuwa na nafasi ya kuzungumza.

Soma kwa sauti - ushiriki wako ni hiari kabisa lakini uzoefu yako inaweza kuwa inasaidia sana na wengine ambao walikufa tukio kama wewe katika Kenya.

Je, una maswali?

Wakati: mahojiano inachukua takribani saa moja kamili.

Je, unakubali kushiriki? **1. Ndiyo** **2.No**

Ijazwe na muoji

Nakubali kuwa nimesoma juu ya ridhaa ya utaratibu wa mshiriki, au mzazi / mlezi

Saini: ... ... Tarehe ... ...

Kukamilika na mshiriki:

Saini: ... ... Tarehe ... ...

Kwa wale hawajwi kusoma au kwadika: Kidole…………………… Tarehe…………..

Kukamilika na mzazi / mlezi

Saini: ... ... Tarehe ... ...

Kwa wale hawajwi kusoma au kwadika: Kidole…………………… Tarehe…………..

Ukiwa na maswali nifikie kama ifuatavyo: Saduku la barua 850 Thika sub-county;. Simu ya lununu 0729425373. Barua pepe: betgichuru@yahoo.co.uk

Ukipenda kujua haki yako ya kuhuzika na utafiti huu uliza maswali kwa:

KEMRI/ Ethics Review Committee, P.O. Box 54840-00200 Nairobi. Simu: 0202722541; 2713349. Simu ya lununu 0722205901, 0733400003. Faxi 0202720030 Barua pepe: director@kemri.org

APPENDIX E

COMPREHENSION TEST (TEST OF UNDERSTANDING)

FOR PARTICIPANTS AGED 12 -17 YEARS OF AGE

1. What year were you born? (Ulizaliwa mwaka gani?)
2. Can you read and write? (Unaweza kusoma na kuandika?)
3. In what language (s) can you read? Write? (unaweza kusoma kwa ligha gani? Na kwandika?)
4. What language do you understand best when spoken? (Ni lugha gani unaelewa vizuri inapo ongewa?)
5. What language do you speak best (ni lugha gani unayo iongea vizuri kabisa?)
6. Have you ever heard about HIV/AIDS? (umewahi kusikia kuhusu virusi vya ukimwi?) **NOTE: if she/he has never heard, stop the test.**
7. From where did you hear? (Ulisikia wapi?)
8. What did you hear? (ulisikia nini?)
9. How can one get infected with HIV? (Mtu anawezakupata virusi vya ukimwi aje?) **Check if they mention sexual intercourse/tabia mbaya/**
10. How can one prevent themselves from getting infected with HIV? (Mtu anaweza kujikinga kwa njia gani?) **Check if they mention condom use**

APPENDIX F

Mental Health Outcomes Baseline Questionnaire – English/Swahili Version 01.12

FACILITY CODE: KIAMBU COUNTY: 01 NAKURU COUNTY: 02

Survivor Code……................ Interviewer Code (e.g. 01A)……………

Professional qualification………… Years of exp. in trauma counselling…….

Date of Interview……... ………… **Interview Start Time**..……………….....

INSTRUCTIONS FOR USE BY TRAUMA COUNSELLOR

Please read the instructions carefully before administering this questionnaire to the participant.

PART 1: To be used for **ALL** participating survivors (children to be assisted by parent/guardian)

PART 2: To be used **ONLY** for survivors above 12 years of age

PART 3: To be used **ONLY** for survivors 6-11 years of old

INTERVIEWER TO READ THIS TO PARTICIPANT:

Thank you for your help in accepting to answer these questions. Although dong this is voluntary, your answers to these questions will help this study identify areas the services could be improved. Please answer questions honestly- there are no right or wrong answers. Your answers are anonymous and very important.

PART 1: TO BE USED FOR ALL STUDY PARTICIPANTS

SECTION A: SOCIAL--DEMOGRAPHIC INFORMATION CONFIDENTIAL

<table>
<tr><td colspan="4">COUNTY……………………….………..… DISTRICT……………..…………………………..
LOCATION…………………………….…...…SUB-LOCATION……..………..…………………</td></tr>
<tr><td colspan="3">FACILITY NAME…………………………..</td><td>LEVEL:
Sub-county (L4)…......County (level 5)…….</td></tr>
<tr><td>RESIDENCE
Unahishi mahali gani</td><td colspan="3">Name..
URBAN…………………………….
PERI-URBAN………………………….
RURAL……………………………….</td></tr>
<tr><td colspan="4">LANGUAGE OF INTERVIEWER: ……………………………………………………………......................
HOME LANGUAGE OF RESPONDENT: …………………………………………………......................
INTERPRETER'S LANGUAGE……...……………………………………………………………………</td></tr>
<tr><td colspan="2"><u>DATA DOUBLE ENTRY AND CLEANING</u>
FIRST KEYED BY
NAMES:……………………………DATE:………………………</td><td colspan="2">SECOND TO KEY IN
NAMES…………………….. DATE….………</td></tr>
</table>

1A1	How old were you at your last birthday? Ulizaliwa mwaka gani na mwezi gani?	Age……. Female ☐	Male ☐
1A2	How long have you been living continuously in the current place of residence? Umeishi mahali hapa (jina) mfululizo kwa muda gani?	Years ☐	Months ☐
1A3	What is the highest level of school you attended? Ni kiwango gani kipi cha juu cha shule ulichofika?shule ya msingi,chuo cha ufundi,secondari,chuo cha kadiri ama chuo kikuu	☐ Nursery ☐ Primary ☐ Secondary ☐ College (middle level) ☐ University	

This section to be answered by survivors and parents/guardian of child survivor

Question				
1A4 Are you married? Umeuoa?	Yes	No	N/A	Refused to answer
1A5 Are you separated? Umetengana na mpenzio?	Yes	No	N/A	Refused to answer
1A6 Are you divorced? Umewachana na mpenzio?	Yes	No	N/A	Refused to answer
1A7 What do you for a living? Unafanya Kazi	Yes	No	N/A	Refused to answer

SECTION B: POST RAPE HEALTH NEEDS

1B1. When you decided to come here, what is it that you expect the post rape service Provider to do for you? ....

Or your child? ....

Ulipoamua kutembelea kituo hiki ni mambo gani ulitarajia/ulidhani hutapata/hutazaidiwa nayo? ……………………………………………………………………………………

1**B2.**	While am here, I hope to get help with: (check all that apply to you/your child: there are no 'right' or 'wrong' answers) Sasa hivi ningependa nipate uzaidizi kwa namna hii	☐ Safety for myself (usalama wangu binafsi) ☐ Safety for my child (usalama kwa ajili ya mtoto wangu) ☐ Emotional support for myself (jinsi ya kukambiliana na hisia zangu) ☐ Ideas for handling stress in my life (mbinu na mawazo ya kushughulikia matatizo katika maisha yangu) ☐ Emotional support for my child (jinsi ya kukabiliana na hisia za mtoto wangu) ☐ Treatment for sexual violation related injuries (jinsi ya kukambiliana na majeraha yangu ya ukiukaji kijinsia)

	Satisfaction	☐ Treatment for Child's sexual violation injuries (jinsi ya kukabiliana na majeraha ya mtoto wangu kwa kuthulumiwa kimapenzi)
		with post rape care services
1B3	How helpful is the counselor? Mshauri amekuwa wa msaada kiasi gani?	☐ Very helpful ☐ Somewhat helpful ☐ Not at all helpful

1B4 How helpful are the health service providers? Wahudumu wa afya wanahusaidizi wa kuridhisha/kutosha/mwafaka?	☐ Very helpful ☐ Somewhat helpful ☐ Not at all helpful
1B5 Have you reported this incident to the police? Uliwasiliana na polisi kuhusiana na tukio hili?	☐ Yes ☐ No

1B6	How satisfied were you with the way the police handled you? Uliridhishwa na jinsi polisi waliweza kuhudumia mtoto wako?	☐ Very satisfied? ☐ Satisfied? ☐ Dissatisfied?

END OF PART 1

To complete the interview:

1. **Go to part 2 if the survivor is above 12 years old**

OR

2. **Go to part 3 if the survivor is 6-11 years old**

PART 2

To be used ONLY for survivors above 12 years old

SECTION D: Depression

The following reactions sometimes happen after people have been involved in a traumatic incident. Please indicate whether or not you have experienced any of the following since the incident.

2D1	Yes	No
a. Are you having difficulty falling a sleep? (ugumu kupata usingizi au kukaa usingizini)	☐	☐
b. Are you having difficulty concentrating? (ugumu kuzingatia jambo Fulani)	☐	☐
c. Are you having feelings of exhaustion or loss of energy (Unajihisi mchofu na mnyonge?)	☐	☐

d. Are you having strong feelings of frustration? Unaona huwezi kukambiliana na kuchanganyikiwa na una raha?	☐	☐
SECTION E: RTS		
2E1		
a. Are angry thoughts coming into your mind, about the incident, against your will? .(mawazo/fikira za kukera kuhusiana na tukio lililokupata kinyume na mapenzi/matarajio yako)	☐	☐
b. Are you feeling as though the incident was happening all over again? .(kaimu au hisia kwamba tukio hilo lafanyika sasa hivi tena)	☐	☐
c. Are you having bodily reactions (heart racing, stomach churning, sweatiness, dizziness) when reminded of the incident? (athari mwilini kama vile kupigwa na roho haraka,asidi kwa tumbo,kutokwa na jasho,kuzunguzungu dhidi ninapokumbuka tukio hilo)	☐	☐
d. Are you feeling Irritable? (hasira nyingi kupindukia)	☐	☐

SECTION F: SELF BAME

2F1

a. Are you having feelings guilt?
Je,unajihisi hauna maana au mwenye hatia ?

Yes | No

b. Are you able to talk easily about the Incident? .
(kuzungumza kwa urahisi juu ya tukio hilo)

Yes | No

c. Are you avoiding thinking about the incident? Umejizuia/umefungia mawazo yote kuhusu tukio hilo?

Yes | No

d. Are you feeling that people are unkind to you?
Unaona watu hawakupendi ama hawakujali kwa njia yeyote?

Yes | No

SECTION G: SHAME

These questions ask how much difficulty you have had in handling unpleasant feelings.

	Question	Response
2G1	Are you having difficulty handling anger? Unapokuwa mwenye hasira wewe hujituzaje?	☐ Great difficulty ☐ Some difficulty ☐ No difficulty
2G2	Do you have a strong urge to repress feelings connected with the incident (hisia za kukasirisha/kukera kuhusiana na tukio hilo)	☐ **Yes** ☐ **No**
2G3	Is your self-confidence low? Heshima yako ya kibinafsi imedidimia?	☐ **Yes** ☐ **No**
2G4	How comfortable are you feeling being around people? Unastarehe vipi unapokaa na watu wengi?	☐ Very uncomfortable ☐ Uncomfortable ☐ Comfortable

End Part 2

PART 3

TO BE USED ONLY FOR SURVIVORS 6-11 YEARS OLD

SECTION I: Shame

	Question		
3H-1	a. Is the child confident before people? Mtoto ana najihisi amejiamini mbele ya watu?	**Yes**	**No**
	b. Has the child's school performance been good? Matokeo ya mtoto huyu ya shule inapendeza?	**Yes - Good**	**No - Poor**
	c. Is the child playing normally? Mtoto ana: Anacheza kawaida?	**Yes**	**No**
	d. Does the child get anger outbursts? Je, wajihisi ukiwa na hasira nyingi ?	**Yes**	**No**

SECTION I: Depression

31 **1.**Is the child eating normally?
Anakula kwawida?

Yes **No**

3I **2.**Child's:
appearance
(Usafi)
behavior
(Tabia ya motto)

- ☐ Kempt
- ☐ Unkempt
- ☐ Restless
- ☐ Aggressive
- ☐ hyperactive

3I **3.**Is the child sleeping normally
Analala kawaida?

Yes **No**

Interviewer to guide the child in this section, parent /guardian to/can prompt child to answer

3I 4**.** Parent**:** Is the child looking tired or exhausted? Child: are you feeling tired or without energy?
Unajihisi mnyonge na mchofu?

Yes **No**

SECTION J : RTS

3J1	Is the child irritable? Analialia?	**Yes** **No**
3J2	Is the child disinterested in thing she/he liked before? umeweza kupoteza hamu ya vitu/mambo ulikua unapenda mbeleni?	**Yes** YeS **No**
3J3	Chid: are you able to concentrate on what you are doing? Parent: is the child concentrating on what he/she doing? Kuwa makini na mkusanyiko kwa motto	
3J4	Mood of the child: Hisia za mtoto	☐ Happy ☐ Sad ☐ Anxious ☐ Worried

SECTION K: Self – blame

These questions ask how you are getting along with people.

3K1	Is the child feeling that people are unkind? Unafikiria watu hawakuhurumii kamwe?	☐ Always ☐ Often ☐ Occasionally ☐ Never
3K2	Parent: Is the child avoiding activities or places or people that remind him/her of the incident? Child: are you avoiding activities or places or people that remind you of the incident? Je,unaepuka shughuli,maeneo,au watu wanaokukumbusha tukio hilo?	☐ Yes ☐ No
3K3	Is the child appearing guilty? Je,unajihisi hauna maana au mwenye hatia ?	**Yes** **No**
3K4	Is the child avoiding talking about the incident? Je,umeepuka kuzungumzia tukio hilo?	**Yes** **No**

END OF PART 3

End of Questionnaire

Interview Finish Time………………

Thank the participant for their time

NB: Check if interview start time is indicated

THANK YOU

APPENDIX G

Mental Health Outcomes Follow-up Questionnaire – English/Swahili Version 01.12

FACILITY CODE: KIAMBU COUNTY: 01 NAKURU COUNTY: 02

Survivor Code……................ Interviewer Code (e.g. 01A)……………

Professional qualification………… Years of exp. in trauma Counselling………..

Date of Interview……... …………… **Interview Start Time**...…………….

INSTRUCTIONS FOR USE BY TRAUMA COUNSELLOR

Please read the instructions carefully before administering this questionnaire to the participant.

PART 1: To be used for **ALL** participating survivors (children to be assisted by parent/guardian)

PART 2: To be used **ONLY** for survivors above 12 years of age

PART 3: To be used **ONLY** for survivors 6-11 year old

INTERVIEWER TO READ THIS TO PARTICIPANT:

Thank you for your help in accepting to answer these questions. Although dong this is voluntary, your answers to these questions will help this study identify areas the services could be improved. Please answer questions honestly- there are no right or wrong answers. Your answers are anonymous and very important.

PART 1: TO BE USED FOR ALL STUDY PARTICIPANTS

SECTION A

NB: Retrieve information from the PRC register to complete this section

Survivor's baseline Code				
Follow-up visit	**At 3-month**	**At 6-month**	**At 9-month**	
Date of interview				

SECTION B

COUNTY…………………….……….…. COUNTY……………..………………………….. LOCATION…………………………..….SUB-COUNTY……..………..…………………	
FACILITY NAME…………………………..	LEVEL: Sub-County (L4)……… County (L5)…...........
SECTION C	
DATA DOUBLE ENTRY AND CLEANING **FIRST KEYED BY** NAMES:……………………………DATE:………………………	**SECOND TO KEY IN** NAMES…………………….. DATE….………

END OF PART 1

To complete the interview:

1. **Go to part 2 if the survivor is 12 years and above**
2. **Go to part 3 if the survivor is 6-11yars old**

PART 2

To be used ONLY for survivors above 12 years old

SECTIOND: DEPRESSION

The following reactions sometimes happen after people have been involved in a traumatic incident. Please indicate whether or not you have experienced any of the following since the incident.

2D1	Yes	No
a. Are you having difficulty falling a sleep? (ugumu kupata usingizi au kukaa usingizini)	☐	☐
b. Are you having difficulty concentrating? (ugumu kuzingatia jambo Fulani)	☐	☐
c. Are you feeling exhaustion or loss of energy Unajihisi mchofu na mnyonge?	☐	☐
d. Are you having strong feelings of frustration? Unaona huwezi kukambiliana na kuchanganyikiwa na una raha?	☐	☐

SECTION E: RTS

2E1

	Question		
a.	Are you having angry thoughts come into your mind about the incident against your will? (mawazo/fikira za kukera kuhusiana na tukio lililokupata kinyume na mapenzi/matarajio yako?)	☐	☐
b.	Are you feeling as though the incident was happening al over again? (kaimu au hisia kwamba tukio hilo lafanyika sasa hivi tena?)	☐	☐
c.	Are you having bodily reactions (heart racing, stomach churning, sweatiness, dizziness) when reminded about the incident? (athari mwilini kama vile kupigwa na roho haraka,asidi kwa tumbo,kutokwa na jasho,kuzunguzungu dhidi ninapokumbuka tukio hilo?)	☐	☐
d.	Are you feeling irritable? (hasira nyingi kupindukia)	Yes	No

SECTION F: SELF-BAME

2F1 a. Are you having feelings of guilt? **Yes** **No**
Je,unajihisi hauna maana au mwenye hatia ?

b. Are you able to talk easily about the incident? **Yes** **No**
(kuzungumza kwa urahisi juu ya tukio hilo)

c. Are you avoiding thinking about the incident? **Yes** **No**
Umejizuia/umefungia mawazo yote kuhusu tukio hilo?

d. Are you feeling that people are unkind to you? **Yes** **No**
Unaona watu hawakupendi ama hawakujali kwa njia yeyote?

SECTION G: SHAME

These questions ask how much difficulty you have had in handling unpleasant feelings.

2G1 Are you having difficulty handling anger?
Unapokuwa mwenye hasira wewe hujituzaje?

- ☐ Great difficulty
- ☐ Some difficulty
- ☐ No difficulty

2G2	Are you having a strong urge to repress feelings connected with the incident? (hisia za kukasirisha/kukera kuhusiana na tukio hilo?)	**Yes** **No**
2G3	Is your self-confidence low? Heshima yako ya kibinafsi imedidimia?	**Yes** **No**
2G4	How comfortable are you feeling being around people? Unastarehe vipi unapokaa na watu wengi?	☐ Very uncomfortable ☐ Uncomfortable ☐ Comfortable

End Part 2

End of interview with a survivor 12years and above

Time Interview completed………………

Thank you

PART THREE
TO BE USED ONLY FOR SURVIVORS 6-11 YEARS OLD

SECTION H: SHAME

3H-1	a. Parent:Is the child confident before people? Child: Are you confident before people? Mtoto ana najihisi amejiamini mbele ya watu?	**Yes**	**No**
	b. Has the child's school performance been good? Matokeo ya mtoto huyu ya shule inapendeza?	**Yes-Good**	**No-Poor**
	c. Is the child playing normally? Mtoto ana: Anacheza kawaida?	**Yes**	**No**
	d. Does the child get anger outbursts? Je, wajihisi ukiwa na hasira nyingi ?	**Yes**	**No**

SECTION J: DEPRESSION

3J1	Is the child eating normally? Anakula kwawida?	**Yes**	**No**
3J2	Child's: appearance (Usafi) behavior: (Tabia)	☐ Kempt ☐ Unkempt ☐ Restless ☐ Aggressive ☐ hyperactive	
3J3	Is the child sleeping normally Analala kawaida?	**Yes**	**No**

Interviewer to guide the child in this section, parent /guardian to/can prompt child to answer

3J4	Parent: Is the child looking tired or without energy? Child: Are you feeling tired or exhausted? Unajihisi mnyonge na mchofu?	**Yes**	**No**

SECTION K : RTS

3K1	Is the child irritable? Analialia?	**Yes** **No**
3K2	Is the child disinterested in thing she/he liked before? umeweza kupoteza hamu ya vitu/mambo ulikua unapenda mbeleni?	**yes** **No**
3K3	Parent: Is the child having difficulty concentrating when doing something? Child: Are you having problems concentrating in what you are doing? Kuwa makini na kusanyiko kwa mtoto	**Yes** **No**
3K4	Mood of the child: Hisia za mtoto	☐ Happy ☐ Sad ☐ Anxious ☐ Worried

SECTION L: SELF BLAME

	These questions ask how you are getting along with people.	
3L1	Parent: Is the child feeling that people are unkind? Child: Are you feeling that people are unkind to you? Unafikiria watu hawakuhurumii kamwe?	☐ Always ☐ Often ☐ Occasionally ☐ Never
3L2	Parent: Is the child avoiding activities or places or people that remind him/her of the incident? Child: Are you avoiding activities or places or people that remind of the incident? Je,unaepuka shughuli,maeneo,au watu wanaokukumbusha tukio hilo?	☐ Yes ☐ No
	Parent: Does the child appear guilty? Child: Are you feeling guilt?	**Yes** **No**

3L3	Je,unajihisi hauna maana au mwenye hatia ?	Yes	No
3L4	Parent: Is the child avoiding talking about the incident? Child: Are you avoiding talking about the incident? Je,umeepuka kuzungumzia tukio hilo?	**Yes**	**No**

END OF PART 3

End of the Questionnaire

Interview Finish Time………………

Thank the participant for their time

NB: Check if interview start time is indicated

THANK YOU

THIKA SUB-COUNTY MAP

Site A: Intervention site

APPENDIX I

NAIVASHA SUB-COUNTY MAP

Site B: Non-intervention site

APPENDIX J: ETHICAL APPROVALS