Baseline Psycho-Social Health Needs among Rape Survivors: A Community-based Interventional Study in Kenya

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SUMMARY

The study assessed the psychosocial health needs and satisfaction with post rape services among survivors immediately after rape.

Objective: To assess the baseline psycho-social health needs among rape survivors presenting in Thika and Naivasha Public Health Hospitals in Kiambu and Nakuru counties respectively.

Methods and Design: A prospective quasi experimental study.

Population: 410 rape survivors were prospectively recruited consecutively in the two study sites from April 2012-February 2013. 138 (33.7%) rape survivors were recruited in intervention site where Intense Community Lay Rape Trauma Counseling (ICLRTC) intervention was given, while 272 (66.3%) survivors recruited in the control site where survivors received standard post rape care.

Procedures: Raped survivors presented to the hospital. After assessment and treatment by a clinician the survivors were referred to Comprehensive Care Centre (CCC) for trauma counselling. The assessment was carried out by Trauma Counselors with counseling experience ranging from 3-8 years. Measures were made on independent variables-basic demographic information (variables which does not change or which remain constant in the process of interaction; and dependent variables (variables which are manipulated and change during the process of interaction) depression, secondary traumatic stress, self blame and shame.

Data analysis: Data was analyzed using SPSS version 17.0. Persons' chi square, odds ratio and P value were used to measure for similarity or differences between the two study groups at baseline.

Results: In the older age group 'medication and counselling' (p=0.014) in 59 (53.6%) survivors was significant and different between the two study groups. In the younger age group 'medication and counselling' (p=0.011) in 13 (54.2%) survivors, 'medication and check-up' (p=0.046) in 8 (33.3%) survivors were significant and different between the two study groups. In both age groups there was a significant difference between the two study groups in 'dissatisfaction with the way handled by police' (p=0.007).

Conclusion: Priority need immediately post rape was 'medication and counseling'. At baseline survivors were dissatisfied with the way police handled them.

Key words: sexual abuse, post rape support, service providers, help-seeking, reporting/disclosure

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Introduction

Rape is a serious societal problem that creates significant challenges to local communities in their attempt to create an overall plan for meeting physical, emotional, and social health needs of rape survivors.[1] The effects of rape cut across aspects of public health and human rights. From the public health perspective, the issues to be addressed revolve around accessibility of the medical services and consistency in the quality of care provided. But, according to Campbell R, Townsend SW, long SM, *et al.*, the public concerns should be also guided by the self felt needs identified by the survivor(s) themselves. [1]

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 is a process that includes defining the problem, deciding to seek help, and selecting a source of support. [2] Each of these stages is influenced by individual, interpersonal, and sociocultural factors. [2-3] Help-seeking is best characterized as a dynamic process that responds to the changing context of victimized person. [4]

Evidence shows that rape victims have specific needs. These needs include prevention of HIV, other sexually transmitted infections and pregnancy; psychological support; and the management and documentation of injuries. [1] Other studies demonstrate survivors' immediate need for: reassurances, privacy, confidentiality, need to re-establish immediate coping, and need to be heard and understood. [2, 3-4] Further evidence identifies survivors' needs, for example need to minimize stigma, for non-judgmental support, for easy access and availability of a trauma counselor. [4, 5-7] Earlier empirical evidence highlights survivors' intermediate and long-term psycho-social health needs, for example, need for supportive responses from the informal and formal support systems, talking about the ordeal (disclosure); retaining a satisfactory self-image; preserving relationships with family and friends; and need to prepare for uncertain future. [2, 8-10]

Other studies have found survivors in need of mental health care to help them work through their post-assault disclosure experiences. [1, 12-13] The process of disclosing a rape, either to family and friends or community service providers, can be a difficult process and victims are not always met with supportive responses. Ullman SE, and Filipas HH, documented that rape survivors' experience a variety of negative social reactions from informal and formal help sources, for example, helpers do not recognize the harm of rape, do not respect survivors need to express their feelings, do not let survivors choose what family members or friends they wish to disclose to, do not ask how best to support survivors, do not acknowledge their limits, do not respect survivors privacy, do not respect that survivors' healing may take time, space and energy, and survivors should not be blamed. [13] Survivors often feel guilty and ashamed about what happened. 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'.

While much of the sexual violence activities focus around adult women, emerging evidence suggests that children represent the disproportionate number of survivors currently seeking health care. [11] Evidence

show that children survivors have need for protection, to help heal, and need to participate in decision –making on delivery of post rape care. [11] The survivors' concerns described in the above studies differ from the findings of recent studies among survivors of Internally Displaced Persons (IDPs), who tend to blame the fate of being in the camp for the sexual violence. [2, 14-15]

People with disabilities are less likely to defend themselves from sexual violence. The disabled survivors also find it more difficult to access health and legal-judicial services because these systems have been found insensitive to the needs of people with disabilities. [16] Frese B, Moya M, & Megias J, carried out an exploratory study among one hundred thirty six respondents with varying degrees of disability, and found that disabled people find access to post rape care impossible due to lack of information, poverty and the negative social attitudes of the general public. These findings reveal how society ignores the disabled and are similar to findings of other studies done among those without disability but who are equally judged and ignored by social-cultural barriers from the same society, because they belong to vulnerable groups. [3-4, 10, 13, 17-18]

A qualitative study among 96 female sex workers by Mwangi G K, and Jaldesa GW, reported wide spread rape. [19] The study found that rape was exacerbated by gender imbalance and lack of legal support. Also, the study found sex workers had different needs, for example, need to access timely and appropriate treatment, need for protection from physical assault from clients when they ask for money, or for condom use, need for community support in order to reduce stigma and discrimination from the clients, and need to legalize prostitution to remove fear of police extortion and beatings because sex work is illegal in most countries.

Social-cultural barriers seem to hinder survivors of non-consensual sex from accessing the required post rape care services. Studies report found that rape among male children and adults is on the increase. [3-4, 10, 13, 17] The studies revealed that many men who have sex with men (MSM) were found in need of: information on inherent dangers of anal sex; engendered friendly attitudes from providers; and policies that address reproductive health needs of MSM. The studies revealed the following major problems as perceived and experienced by MSM: stigma among men who sell sex to men as a every-day challenge in their lives; MSM believe that the general society does not accept them; that they must conceal their sexual identities for fear of discrimination, stigma and violence from their families, health workers and law enforcement officers. These challenges were found to likely hinder positive behaviour change among MSM. All these survivor needs are often the least met in low resource settings. As a result, survivors are bedeviled by psychological dysfunctional health outcomes which soon become complex problems because culture shapes the way post-rape psychological problems and symptoms are experienced and communicated. Because of this complexity, few studies have focused on post rape psycho-social health needs in low resource contexts.

Research conducted in industrialized countries and in South Africa has highlighted how use of post rape health services can be a negative and dis-empowering experience for rape survivors, and this may partly explain the low levels of use. Post rape services should be provided sensitively in a coordinated and timely

manner to avoid such experience and to encourage uptake of services. [4, 10, 22]

In efforts to improve post rape services globally there is a move towards having specialized services with carefully selected, sensitive, trained providers who focus on the holistic care of rape survivors that include extensive collection of physical evidence. [22-24]

In Kenya, however, only a small proportion of rape survivors attend post rape services. [19]These services are of varied quality, and limited resources mean restricted options for provision. [4, 5, 6]The Kenya government health system operates an integrated approach to primary care, which set out the responsibilities of primary health care workers towards patients who have survived rape. 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. [20]The other challenge is that the overwhelming majority of healthcare workers who currently provide survivors with care had no specific training in the specialty. [21]

Psycho-social care and support include trauma counseling as a key component in post- rape care. Therefore, community psychological first aiders are essential in meeting the many psycho-social health needs of survivors in the community in order to improve their positive psycho-social health outcomes. For example, immediate First Order Community Rape Trauma Counseling (FOCRTC) intervention has been strongly associated with positive and empowering experiences like, for example, re-establishment of adaptive coping. [25-26, 27-31] The authors have also associate the FOCRTC with short- intermediate-long-term positive psycho-social health outcomes, for example, minimized stigma (disclosure of rape); and social adjustment (utilizing counseling services, seeking support). [27]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 negative and dis-empowering experiences.

The current study addresses some of these gaps in the literature and practice. The Psychosocial Health Needs among Rape Survivors in the Kenyan communities Study objective undertakes investigation of the research question by assessing why survivors present in the public health facilities seeking for help, their expectations are of the service providers, and satisfaction with post rape services.

Methodology

Study design and setting

This prospective quasi experimental study was carried out at Thika hospital in Kiambu County located in Central Province, and in Naivasha Hospital in Nakuru County located in Rift Valley province, from April 2012 to February 2013. The study clusters were communities served by the two public health hospitals. Thika Hospital comprehensive Care Center (CCC) was the intervention site where Intense Community Lay rape trauma Counselling (ICLRTC) intervention was given by Community Health Workers (CHWs) in the community and Naivasha was the control site where survivors received the standard post rape care in the hospital CCC. The study sites were selected across Kenyan public health facilities delivering integrated post-rape care (post rape services delivered in one day at the same hospital) by trained Trauma Counsellors.

Study population

In this longitudinal comparative study 410 rape survivors were conservatively recruited at each public hospital's CCC.

Method:

Raped survivors presented to the hospital. After assessment and treatment by a clinician the survivors were referred to CCC for trauma counselling. 410 rape survivors were prospectively recruited consecutively in the two study sites. 138 (33.7%) rape survivors were recruited in intervention site where Intense Community Lay Rape Trauma Counseling (ICLRTC) was given by CHWs, while 272 (66.3%) survivors recruited in the control site where survivors received standard post rape care in the CCC according Ministry of Health post rape care services protocol. At the CCC the Trauma Counsellors administered a Comprehension Test (CT) to survivors 12–17 years old. Those who did not passed the test were excluded from the study. Those who passed the CT were included. Trauma Counsellors explained survivors about the study and informed consents were obtained. Child survivors (7–11 years old) were assisted by their parents/guardians to sign the consent. Parents/guardians signed for child survivors aged 4–6 years old. Trauma Counsellors administered baseline questionnaire, on first contact, to survivors (if not in crisis). Child survivors (7–11 years old) were assisted by their parents/guardians to answer questionnaire questions. Parents answered questions on behave of child survivors aged 4–6 years. Baseline data was collected on survivor's psychosocial pathological reactions and outcomes post rape. But, if the child and parent/guardian were in crisis, the questionnaire was administered within 3 days post child rape. The assessment was carried out by Trauma Counselors with counseling experience ranging from 3–8 years. Measures were made on independent variables –basic demographic information (variables which does not change or which remain constant in the process of interaction; and dependent variables (variables which are manipulated and change during the process of interaction) depression, secondary traumatic stress, self blame and shame.

Data Analysis

The data was compiled and analyzed using SPSS version 17.0. Persons' chi square, odds ratio and P value were used to measure for similarity or differences between the two study groups at baseline. P–value of less than ≤ 0.05 was considered significant. Odds Ratio (OR) <1 was considered protective at 95% CI if the upper limit was <1.

Ethical Considerations

Ethical approvals were sought and given by KEMRI Scientific Ethics Committees, KEMRI/ERC, and KNH/UoN Ethical Committees. Permission to carry out this study was sought and given by the MoH–Reproductive Health Division and MoPS–division of Community Health. Individual verbal consents were given by various community leaders. Individual informed written consent was obtained from each study participant. Those who gave written consent were recruited to participate in the study.

Results

Socio demographics of study population

A total of 410 survivors were recruited for the study. Age range was 4 to 55 years with a mean age of 20.60 ± 9.88 years. In the 12 years and above age group79 (24.9%) were married, 239 (75.27%) were single, 185 (57.6%) of the survivors were working and 136 (42.4%) did no work. Of 185 survivors who worked,

120 (64.9%) worked full time and 65 (35.1%) worked part time. Christianity was the predominant religion of the respondents 322 (99.1%), Islam 2 (.6%) survivors and pagan 1 (.3%) survivor.

Gender: There was no statistical significant difference between intervention and non-intervention groups in gender distribution. Out of the total survivors recruited 57 (13.90%) were males and 353(85.61%) were females with a female to male ratio of 6:1. Gender distribution consisted of 4-11 years age group made up of 14 (77.8%) females and 4 (22.2%) males in the intervention group compared to 49 (74.2%) females, and 17 (25.8%) males in the control group. In the 12 years and above age group there were 95 (86.4%) females and15 (13.6%) males in the intervention group compared to 193 (90.2%) females, and 21 (9.8%) males in the control group.

Age: Age range was 4 to 55 years with a mean age of 20.60 ± 9.88 years. There is no statistical significant difference between the two study groups in age 4-11 years and age 12 years and above distribution. A high proportion of survivors 326 (79.51%) were aged 12years and above, and the rest 84 (20.48%) were aged between 4-11 years old.

Level of education: There was a statistical significant difference between the two study groups in children 4-11 years old who attended primary school (p=0.004).

Religion: There was no statistical significant difference between the two study groups in survivors who were Christians in both age groups.

Marital Status: There was no statistical significant difference between the two study groups in marital status.

Work: There was no statistical significant difference between the two study groups in survivors who worked for a pay.

Residence: There was a statistical significant difference between the two study groups in survivor who lived in urban areas (p=0.027) in 73 (66.4%).

Table 1: Rape Survivors Reasons for Seeking Health Care by Age

Intervention versus Control	N (%)		95% CI		
4-11years:	**18**	**OR**	Lower	Upper	**P Value**
Medication	3(12.5%)	0.293	0.042	1.746	0.125
Medication + checkup	8(33.3%)	0.164	0.017	1.273	0.046
Medication + counseling	13(54.2%)	0.146	0.022	0.502	0.011

In the 4-11years age group, there was for there was a statistical significant difference between the two study groups in 'medication + check-up' (p=0.046) in 33.3% survivors. The need for 'medication + counselling' (P=0.011) in 38.8% survivors which was statistically significant and different between the two study groups.

Table 2: Rape Survivors Reasons for Seeking Health Care by Age

	N (%)	OR	95% CI		P Value
Intervention versus control					
>12 years:					
Medication	23(20.9)	1.083	0.524	2.258	0.846
Medication+ checkup	12(10.9)	0.482	0.167	1.371	0.132
Medication+ counseling	59(53.6)	0.047	0.182	0.906	0.014

In the older age group, there was significant difference between the two study groups in 53.6% (p=0.014) survivors.

Table 3: Rape Survivors Expectations from Health services by Age

Intervention versus control	N	%
>12 years:	**110**	
Safety for myself	95	86.3%
How to deal with stress	85	77.2%
Emotional support for myself	98	89%
My injuries	16	14.5%
Connect with others	91	82.7%
Arrest of perpetrator	53	48.1%

In the older age group, the prominent expectations from health service providers by survivors in intervention group compared to control group were 'emotional support' by 98 (89%) survivors, 'safety' by 95 (86.3%) survivors, and expectation to be 'connected with other survivors' by 91 (82.7%) survivors.

Table 4: Rape Survivors Expectations from Health services by Age

Intervention versus control	N	%
4-11years:	**18**	
Safety for my child	15	83.3%
Child's health needs	15	83.3%
How child can deal with stress	12	66.6%
Emotional support for my child	17	94.4%
Injuries on the child	15	83.3%
Connect with others	14	77.7%
Arrest of perpetrator	16	88.8%

In the younger age group, the prominent expectations from health service providers by survivors in the intervention group compared to control group were 'provision of emotional support' by 17 (94.4%) survivors, 'arrest of perpetrator' by 16 (88.8%) survivors, and expectation for 'safety for the child', 'child's health needs', 'care for injuries' which had similar results by 15 (83.3%) survivors.

Table 5: Satisfaction with PRC Services among Adult Survivors

Variable	Total (n=110)			(95% CI)		
	N	%	OR	Lower	upper	P value
Intervention versus control						
>12 years old and above If health providers are helpful						
Sometimes helpful	37	33.6%	0.615	0.364	1.418	0.042
Very helpful	**Reference**					
Reported to the police? No	50	46.7%	0.779	0.485	1.253	0.332
Yes	**Reference**					
Satisfied with the way the police handled you?						
Satisfied	3	5.3%	0.896	0.432	1.854	0.723
Dissatisfied	29	50.9%	0.191	0.036	0.725	0.007
Very satisfied	**Reference**					

In the older age group, there was statistical significant difference between the two study groups in satisfaction with 'help by health service providers' (P=0.042) in 37 (33.3%) survivors, and dissatisfaction 'with the way handled by police' (P=0.007) in 29 (50.9%) survivors.

Table 6: Satisfaction with PRC Services among child Survivors

Variable				(95% CI)		
	N=18	%	OR	Lower	upper	P value
Intervention versus control						
4-11 years						
If health providers are helpful?						
Sometimes helpful	1	20%	0.339	0.019	3.831	0.636
Very helpful	**Reference**					
If reported to the police?	3	17.6%	0.760	0.173	3.340	0.715
Satisfied with the way police handled you? Satisfied	3	17.6%	0.896	0.434	1.255	0.729
Dissatisfied	14	82.4%	0.193	0.038	0.722	0.007
Very satisfied	**Reference**					

In the younger age group, there was statistical significant difference between the two study groups in dissatisfaction 'with the way handled by police' (P=0.007) in 14 (82.4%) survivors.

Discussion

Sample Characteristics

Rape is common among children and school going adolescent and youth. It is therefore not surprising to find majority of the survivors to be in the age group 4–55 years with a mean age of 20.60 ± 9.88 years. This is similar to findings in other studies in other parts of Africa which found risk of rape to be highest among adolescents and the youth. [1, 8–9, 11, 20] However, studies in Congo–Brazzaville [6] and in Gauteng SA [7] reported a slightly higher mean age of 23 years among rape survivors. This study was dominated by female respondents and this is a reflection of the fact that females are still at the receiving end of sexual violation. This has a lot of implications/setbacks to the achievement of goals of the 3rd, 4th and 5th Millennium Development Goals (MDG). Majority of the rape survivors 12 years and above 67(61.5%) worked full time. Of particular note is the fact that primary and secondary school pupils/students were exposed to high risk of rape particularly in urban intervention site compared to control site. The findings are consistent with results of other African studies which found high risk of rape in urban areas. [6–9, 20] The proportion of female survivors in this study was far higher than the 39.5% in a study in Congo–Brazzaville. [6] This might be related to the fact that majority of our 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 female respondents were not in a marital relationship as persons who are not married are more likely to engage in sexual activities for reasons such as financial gains thus increasing their vulnerability.

Overall, 13.9 % respondents in this study were male. This high exposure to risk of rape among males is similar to the result of studies in Kenya Wajir of men who were sexually violated. [20] The small number of male respondents may be explained by non–disclosure by male survivors for fear of community stigma and discrimination. This study found that the two groups were not significantly different in demographic characteristics at baseline.

Help–seeking

Baseline data reveal survivors had varied needs post rape. There was increased need for 'medication and counseling' in the intervention compared to control in 4–11 years old children (P=0.011), and in the older age group (p=0.014). The findings confirmed the importance of prevention of HIV, other sexually transmitted infections and pregnancy and of psychological support in order to re–establish immediate coping as mentioned by Li–Yu S, and Chiara S, Carlos AC, and Jennifer LS. [32–33] Medication and check up was significant in the younger age group (p=0.046) in intervention compared to control group. The finding confirmed the significance of management and documentation of injuries, Post Exposure Prophylaxis and trauma counseling for parents. [5, 32–33] These first priority needs deferred significantly between the two study groups.

Survivors immediate Expectations from Service Providers

There was high expectation for immediate formal 'emotional support' in both age groups (children 94.4%; >12 years of age 89%) in intervention compared to control group. The finding confirmed the importance of trauma counseling and social support

because rape has been described as the worst form of human violation in the history of mankind which scorches deep into the soul of the victim and its physical aftermaths simmer of untold suffering. [5, 32-33] In the younger age group expectation for formal protective actions - 'arrest of perpetrator'(88.8%), 'safety needs'(83.3%), 'connecting with other people' (77.7%), and 'information on how to reduce stress' (66.6%), was high in the intervention group compared to control group. These findings confirmed the significance of formal protective actions to prevent re-victimization especially where the perpetrator is a close relative living within or near the family, or a neighbor, or child's teacher; [11] and to re-etablish adaptive coping mechanisms. [32] In the older age group, there was high expectation of 'information on safety needs' (86.2%), and expectation to 'connect with other people' (82.7%) in the intervention group compared to control group. These findings confirmed the importance of survivors finding ways of confronting violence in their lives, some of the ways can include informal and formal help-seeking in order to re-establish adaptive coping mechanisms. [32-33] Data does not show any significant difference, in expectations for protective actions and information on networking, between the two study groups.

Perceived Satisfaction with Post Rape Services

There was significant deference in dissatisfaction with the after care services by police and health service providers between the two study groups (P=0.007) in both age groups. The rating of services of police and health service providers by survivors in this study is similar to findings of a study which documented that rape survivors' experience a variety of negative social reactions from informal and formal help sources for example, helpers do not recognize the harm done to the rape victim. [13] This finding is consistent with results from a study in Africa, which found trauma associated with rape is often accompanied by chronic health system problems of difficult access and inconsistent quality of care. [4]This study found that the two groups were not significantly different at baseline.

Limitations

Our study has the following limitations: First, information on what happened immediately following the rape relied on reports by respondents or their parents/guardians who may be prone to recall bias. Second, mental health evaluation was done between 0-3 days post-rape when respondents were still very traumatized. Thirdly, in the African culture, sexual issues are sensitive or taboo and respondents may not give information freely about their sexual experiences despite the assurance of confidentiality. Finally, we did not explore whether our respondents were engaged in other forms of sexual violation such oral sexual intercourse.

Conclusion

Baseline data indicates that there is increased exposure to risk of rape in the two age groups, being female in primary or secondary school, and if a Christian living in urban the intervention site. Demographic characteristics at baseline did not differ significantly between the two study groups. The prominent need immediately post rape was 'medication and counseling' which was significant and different between the two study groups. Majority of the survivors went seeking for help expecting 'emotional support' from post rape service providers. Baseline data also revealed that survivors in both age groups were dissatisfied with the way police handled them.

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