



ORIGINAL ARTICLE

## A Community-based Intervention for improving Utilization of Medical Services by Rape Survivors in Refugee Camps in Zambia

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Rape survivors, Participatory group discussion, Medical services, Zambia.

### ABSTRACT

**Background:** Rape is the most common form of violence in conflict and refugee situations but because of the associated stigma few cases are reported. This study assessed the outcome of an intervention targeted at women groups on the utilization of medical services by rape survivors in refugee camps in Zambia.

**Methods:** A prospective quasi-experimental community-based intervention study was carried out in two refugee camps allocated into intervention and comparison areas. The intervention was participatory education sessions for women groups. Data was collected using the clinic records and the main outcome was the number of rape survivors who utilized and completed medical services provided at the camp clinics. Univariate, bivariate and multivariate analyses were carried out with level of significance set at 5%.

**Results:** The proportion of the rape survivors who accessed medical care within 72 hours increased significantly from 41.2% to 84.8% in the intervention area but from 31.1% to 38.9% in the comparison area, ( $p=0.005$ ). Those who completed their medical treatment and the follow-up visits increased significantly from 42.8% to 94.8% in intervention area but reduced from 38.5% to 21.4% in the comparison area, ( $p=0.002$ ). Being resident in the intervention area predicted the utilization of medical services, [OR: 3.15; 95%CI: 1.955-5.681],  $p=0.002$ .

**Conclusion:** Community-based intervention using participatory women's group discussion had a significant impact on increasing the utilization of medical services by rape survivors and should be considered for scaling up as a key intervention for increasing utilization of medical services for rape survivors especially in refugee situations.

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## INTRODUCTION

The 1951 Refugee Convention defined the term 'refugee' as a person who flees his country of origin because of a well-founded fear of persecutions for one or more of the following five reasons (also known as the "convention grounds") - race, religion,

nationality, social class or political beliefs.<sup>1</sup> The number of refugees in Africa has been on the increase in the last decade. Gender inequality in most societies especially in sub-Sahara Africa generally increases the vulnerability of women and girls to gender-based violence during humanitarian crises.<sup>2</sup> Globally, rape is the most common form of gender-based

violence in refugee camps but due to the associated stigma very few cases are reported.<sup>2</sup> Consequently, the actual incidence of the occurrence of rape is probably greater than recorded in the camps. Earlier studies have reported that prevalence of rape varies from 15-30% among refugees and utilization of medical services by survivors is very poor.<sup>3</sup>

The prevalence of sexual and gender-based violence is difficult to measure especially in conflict affected populations.<sup>4</sup> In a review of reproductive health services conducted by the United Nation High Commissioner for Refugee (UNHCR) from refugee camps, the annual number of women reporting rape was 0.2 per 1,000 among Rwandans in Ngara, Tanzania; 0.3 per 1,000 among Rwandans in Goma, Zaire; 0.5 per 1,000 among Somalis in Dadaab, Kenya; 0.6 per 1,000 primarily among the Sudanese in Uganda; and 3.1 per 1,000 among Burundian refugees in Kibondo, Tanzania.<sup>5</sup> Population-based studies in Liberia and among Burundian refugee women in Kibondo District, Tanzania reported prevalence of rape of 3.3 and 3.0 per 1,000 among the population, respectively.<sup>6-7</sup>

The rate of utilization of medical services by rape survivors vary depending on the setting where the incident occurred with more survivors accessing services in normal or post conflict setting than during conflicts. Two studies in South Kivu in the Democratic Republic of the Congo (DRC) exemplify how difficult timely access to services can be, with only 1-3% of rape survivors reporting within seventy-two hours.<sup>8,9</sup> In a post-conflict setting in Liberia, 41% of survivors who were seen at the clinics for medical care came within seventy-two hours.<sup>10</sup> The higher percentage of survivors who accessed services in a timely manner in Liberia was possibly due to the urban location and extensive awareness-raising activities within the community.<sup>10</sup> In the DRC study, the lengthy delay in seeking

care was explained mainly by patients waiting for physical symptoms to develop or worsen before they felt a need to seek medical attention as well as lack of means to access medical care.<sup>8</sup> The refugee operation in Zambia started in 1967 with the establishment of the first formal refugee settlement in Mayukwayukwa, Western Zambia for Angolan refugees.<sup>11</sup> Since the commencement of the refugee operation in the camps in Zambia various interventions including stakeholders' meetings, community sensitization and mobilization have been implemented to improve the reporting of rape and utilization of medical services by rape survivors. However, the utilization of the services by rape survivors remain poor.<sup>11</sup>

A few studies have documented improvement in the utilization of medical services by rape survivors following various interventions involving the community.<sup>8,12</sup> In Tanzania, the International Rescue Committee (IRC) implemented a series of information, education and communication campaigns among the Burundian refugees in Tanzania targeted at community groups and community leaders.<sup>8</sup> This was aimed at drawing their attention to Sexual and Gender-Based Violence (SGBV) and promoting access to medical, psychosocial and legal services within a comprehensive reproductive health program. The project resulted in increased community awareness of sexual violence, increased reporting of incidents of sexual violence and increased services for survivors of violence.<sup>8</sup> Despite the relatively frequent occurrence of sexual gender-based violence especially rape along with the associated medical complications or consequences, there are limited studies that have identified strategies that could improve the utilization of medical services by rape survivors in conflict or humanitarian settings especially in Africa. This study evaluated the effect of a

community-based intervention using participatory education sessions with women support groups on the utilization of medical services by rape survivors in refugee camps.

## METHODOLOGY

**Study sites:** The study was conducted in two refugee camps, Maheeba and Kala in Zambia. Simple balloting was used to select 2 out of the 4 camps in Zambia and to allocate them to intervention and comparison areas. The Kala camp is located within the Kawambwa District in the Luapula Province and was established in the year 2000. The camp hosted refugees largely from Angola, with few refugees also from Somalia, Rwanda, and Burundi. The population of refugees in the camp at the time of the study was 10,626. The Maheeba camp was established in 1971 and is the biggest refugee settlement in Zambia. The camp is located within the Solwezi District in the North-Western Province of Zambia. It shares border with both Angola and Democratic Republic of Congo. The refugees in the camp are mainly from Angola, Rwanda, Somalia, Burundi and Congo. At the time of the study, there were 15,681 refugees.

The two camps Kala and Maheeba, are over 5,000km distance from one another and refugees are not usually authorized to move from one camp to another unless for specific issues related to their health so contact between the refugees in the two camps was unlikely. Each camp has a well-equipped Primary Health Care centre with at least fifteen qualified health workers including clinical officers, nurses, midwives and laboratory technician, along with other support staff and community health workers. The health facilities are located in geographical proximity to all sectors in the camps and provided 24-hour free health services which ensure access to care for all refugees in the camps. The clinics were managed by the

District Health Team with support from UNHCR and other health actors. The clinics provided comprehensive primary health care services with all the key components of primary health care. All the health workers are trained and provided with the national treatment protocol for the clinical management of rape, with monthly supportive supervision from the district health team supervisors and UNHCR and other actors in the camps

**Study design and data collection:** The study was quasi-experimental in design. Pre-intervention and post-intervention surveys were conducted over one-year duration of the project from January 2009 to February 2010 in the intervention and comparison areas.

**Intervention:** In the intervention camp (the Maheeba camp), 100 refugee women leaders were selected and trained as volunteer women group facilitators to lead the participatory educational sessions on sexual and gender-based violence with emphasis on rape in the refugee camp. The camp was divided into 25 sectional/administrative blocks and all the women leaders in the camp were briefed about the project. Four women leaders who were able to read and write were selected from each block. These women, along with the community health workers in the camp who supervised the activities of the various women's groups were trained by a team of health workers from the clinic. A simplified training manual developed from the Inter-Agency Standing Committee Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action was adopted for the training.<sup>15</sup>

The facilitators' training was held in two batches with 50 women's facilitators each per session. The training topics included: Overview of SGBV prevalence, pattern, causes/risk factors; SGBV situations in the

camp including available statistics; Feedback and discussion from the results of the baseline survey conducted; Social, psychological and health consequences of SGBV; The reporting pathway and the services available in the camp clinics for management of rape, emphasizing the benefit of early reporting for medical care in the clinic.

Participants kept a learning diary throughout the training, noting key learning points, training methods and notes for further action. After the training, each of the group facilitators met with a group of 30-40 refugee women of reproductive age group in their sections/blocks and held monthly meetings with them to discuss relevant sexual and gender-based violence (SGBV) issues as taught during the training. They used the training guide and Information Education Communication (IEC) materials provided to facilitate the discussions on the medical implications of rape, the need for and the benefit of seeking medical care at the camp clinic immediately after the SGBV.

The facilitators used a wide variety of methods including participatory exercises, group discussions, role-plays, story making, picture making and story narration during their monthly meetings. The women who participated in the women meetings were provided with IEC materials to discuss with other women in their sections to increase awareness even among women who did not participate in the monthly meetings. The monthly meeting of each of the women's groups was held at times agreed to by the facilitators and the women in designated places in the different sections/blocks in the intervention camp over the twelve-month study period. The community health workers attached to each of the blocks/sections assisted in supervising the women group meetings. A total of 100 women groups were established in the camps, four from each of the

25 sections/blocks with each meeting lasting between 3-4 hours per session.

In the control group (the Kala camp), monthly community sensitization meetings facilitated by the SGBV taskforce members (who were selected refugees in the camps trained on prevention, reporting mechanism and available services for survivors of sexual and gender based violence) targeted at women, men, youth and community leaders was conducted in each of the section/block in the camp during the study period. This monthly sensitization was also continued in the intervention area. The standard treatment protocol for rape in the clinics included provision of HIV post-exposure prophylaxis (PEP); emergency contraception to prevent pregnancy; antibiotic to prevent sexually transmitted infection and psychosocial counselling. The PEP requires weekly follow up visit to complete the 28 day course of treatment.<sup>14</sup>

**Outcome measures:** The main outcome measures were the number of rape survivors (individuals raped) who reported early (within 72 hours of the rape) at the health facilities for medical services and the number completing treatment and follow up visits. The medical treatment provided was based on the Interagency Protocol for Clinical Management of Rape.<sup>15</sup>

The effect of the intervention was assessed by comparing these variables before and after the intervention in the intervention and comparison areas.

**Data collection:** The data was collected through review of the Health Information System (HIS) register and the clinic medical records on SGBV in the primary health care clinics in the two selected refugee camps. The data for the 12-month period prior to the beginning of the project was used as the baseline (pre-intervention) data while the 12

months following the start of the intervention was the outcome (post-intervention) data. The key indicators collected were: number of rape cases reported and presented within 72 hours of occurrence; number of rape survivors commenced on medical treatment and numbers of rape survivors who completed the course of treatment and follow up visits. A data extraction form was used to capture key information about the survivors from the clinic registers and survivors' medical records in the camp clinics. The information collected monthly included the number of survivors who were seen at the health facilities, the time of reporting to the clinic, the services provided and follow up attendance record from both intervention and comparison areas.

**Data Analysis:** The data were double-entered using Epidata 3.0 and analyzed using SPSS version 21. Univariate analysis was done by generating frequencies of the variables and bivariate analysis was done using chi-square test and Z test. Z test was used to test for the difference in the utilization and completion of medical services by rape survivors between the baseline and end line in the intervention and comparison groups. Chi square test was used to compare the factors associated with timely reporting (within 72 hours after the rape incident), utilization of medical services, commencement and completion of the treatment by rape survivors in the two study areas at baseline and end line and the level of significance was 5%, two sided. Multivariate regression model was used and the independent variables used for the analysis were length of stay in the camp, educational status of the survivors and the study area while the dependent variables were timely reporting at the health facilities, utilization and completion of treatment used as the dependent variables.

**Ethical clearance:** Ethical approval was obtained from the Ministry of Health Lusaka

while the permission was sought from the health facilities in the camps to access the clinic records of survivors seen over the duration of the project ensuring confidentiality. In line with the national protocol, the privacy, consent and confidentiality of the rape survivors was considered by the health workers who saw them in the clinics. After the study, the intervention was introduced into the control group.

## RESULTS

Table 1 shows that in the intervention area the number of the rape survivors who presented at the clinic for medical care within 72 hours of the incident and commenced on treatment increased significantly from 7 (41.2%) at baseline to 39 (84.8%) at the end of the follow-up period with estimate of change of 43.6% ( $p=0.005$ ). In the comparison area, the number of rape survivors who presented at the clinic for medical care within 72 hours of the incident and commenced on treatment increased from 13 (31.0%) survivors to 14 (38.9%) of the survivors at end of follow up with estimate change of 7.9%, ( $p=0.465$ ). The net intervention effect (difference in intervention area from baseline to end line minus difference in comparison area from baseline to end line) was 35.7%.

In the intervention area, the number of rape survivors commenced on treatment who completed their treatment and follow up visit increased significantly from 3 (42.8%) at baseline to 37 (94.8%) at the end of follow up period with estimate change of 52%,  $p=0.020$ . However, in the comparison group the number of rape survivors commenced on treatment who completed their treatment and follow up visit reduced from 5 (38.5%) at baseline to 3 (21.4%) as the end of follow up period with a negative estimate of change - 17.1%, ( $p=0.330$ ). The net intervention effect (difference in intervention area from baseline

to end line minus difference in comparison area from baseline to end line) was 69.1%. Table 2 shows the factors related to early presentation for medical services among rape.

The number of years of education and the number of years of being resident in the camp were not significantly associated with seeking medical care early. However, being a resident of the intervention camp was associated with reporting early for care.

**Table 1: Utilization of medical services by rape survivors between intervention and comparison areas at baseline and end line**

Variable	Intervention		Estimate of change (%)	Z-Test (p-value)	Comparison		Estimate of change (%)	Z-Test (p-value)
	Baseline N=17 n (%)	Final N=46 n (%)			Baseline N=42 n (%)	Final N=36 n (%)		
<b>Presentation within 72hours</b>	7 (41.2)	39 (84.8)	43.6	3.461 (0.005)	13 (31.0)	14 (38.9)	7.9	0.734 (0.465)
<b>Commenced on treatment</b>	7 (41.2)	39 (84.8)	43.6	3.461 (0.005)	13 (31.0)	14 (38.9)	7.9	0.734 (0.465)
<b>Completed course of treatment and follow up visits</b>	3 (42.8)	37 (94.8)	52.0	3.76 (0.002)	5 (38.5)	3 (21.4)	-17.1	0.968 (0.33)

**Table 2: Factors associated with timeliness of presentation (presentation within 72 hours of the incident) at the clinics for medical services by rape survivors**

Variables	Timely presentation at the clinic N=53 n (%)	Late presentation at the clinic N=29 n (%)	Total N=82 n (%)	Test Statistic ( $\chi^2$ )	p-value
<b>Level of education</b>					
No formal	30 (66.7)	15 (33.3)	45 (100.0)		
Formal	23 (62.2)	14 (37.8)	37 (100.0)	4.65	0.24
<b>Number of years in camp</b>					
<4	33 (64.7)	18 (35.3)	51 (100.0)		
≥4	15 (48.4)	16 (51.6)	31 (100.0)	3.7	0.32
<b>Study Area</b>					
Intervention camp	39 (84.8)	7 (15.2)	46 (100.0)		
Comparison camp	14 (38.9)	22 (61.1)	36 (100.0)	19.25	0.011

Table 3 presents the results of the analysis exploring factors associated with completion of required treatment. Even though a larger proportion of rape survivors who had some formal education completed the course of

treatment, this was not statistically significant (p=0.24). Likewise, completion of treatment and follow up visits was also not significantly associated with length of time in the camp. The study area was the only significant factor

associated with completion of treatment and follow up visits with 95.0% of the rape survivors in the intervention area completing their treatment and follow up visits compared to 42.9% in the comparison area, ( $p=0.013$ ). Residing at the intervention camp was the only predictor of timely presentation and utilization of medical services by rape survivors in this study. Rape survivors who lived at the intervention area were 3 times as likely to present within 72 hours of the rape [OR: 3.15; 95%CI: 1.955-5.681],  $p=0.002$ . Other variables including age, and length of time living in the camp were not found to predict the utilization of medical services for rape (Table 4).

## DISCUSSION

There are very limited studies that have reported on the rate of utilization of medical services by rape survivors and the rate varies depending on the setting where the incident occurred with more survivors accessing services in normal or post conflict settings than during conflicts. This study found baseline utilization rate of medical services by rape survivors to be low in both the intervention and comparison areas. The utilization rate however increases significantly and double in the intervention area but no changes in the comparison area at the end of the study. The baseline values reported here is much higher than what was reported in two studies conducted in a conflict setting in the Democratic republic of Congo (DRC) where service utilization rate was reported to be 1% and 3% in the respective studies.<sup>8-9</sup> However, studies in post-conflict Liberia and an urban slum in Nairobi reported utilization rate of 41% and 73%, respectively among rape survivors who accessed services within seventy-two hours of the incident.<sup>10, 15</sup> The higher percentage of survivors accessing medical services in a timely manner in Liberia and the Nairobi studies was reported to be

probably due to the urban location of the clinic and geographical proximity of the clinics to the community and the extensive awareness-raising activities within the community.<sup>10, 15</sup> The delay in access to services in the DRC studies was attributed to patients waiting for physical symptoms to develop or worsen before seeking medical attention and lack of means to access the available medical services.<sup>8-9</sup>

The effectiveness of medical care in improving outcomes in rape survivors depends on the completion of follow-up visits and course of treatment in line with the protocol, however high attrition rates have been reported in many studies done. In this study at baseline, 21.4% of the rape survivors in the comparison area and 42.8% in the intervention area who commenced treatment completed the course of treatment and follow up visits. This is similar to a study in Nairobi which reported less than a third of the patients completing the 28 days follow up visit and course of treatment.<sup>16</sup>

Another study conducted in a community-based programme mobile clinics project in the DRC found that 72% of patients returned for the first follow-up visit, with a dramatic drop for the second and third visits by more than 60%.<sup>16</sup> This drop was said to have occurred despite the provision of mobile clinic consultation four times during one month and the authors suggested that this might be related to patients "feeling better" and not understanding the need for follow-up consultations.

At the end of the study period, the number of rape survivors who presented to the camp clinics for medical services doubled the number reported at the baseline assessment in the intervention area while there was no appreciable difference in the number of survivors who accessed services in the comparison area.

**Table 3: Factors associated with the completion of treatment and follow up by rape survivors**

Variables	Completion of Treatment N=43 n (%)	Incomplete treatment N=10 n (%)	Total N=53 n (%)	Test Statistic ( $\chi^2$ )	P value
<b>Level of education</b>					
No formal	27 (79.4)	7 (20.6)	34 (100.0)	2.42	0.35
Formal	16 (84.2)	3 (15.8)	19 (100.0)		
<b>Number of years in camp</b>					
<4	24 (72.7)	9 (27.3)	33 (100.0)	3.9	0.25
$\geq$ 4	19 (95.0)	1 (5.0)	20 (100.0)		
<b>Study Area</b>					
Intervention area	37 (95.0)	2 (5.0)	39 (100.0)	10.28	0.013
Comparison area	6 (42.9)	8 (57.1)	14 (100.0)		

N=53 - This is the number of rape survivors who reported timely at the clinics and who were commenced on treatment

**Table 4: Predictors of timely presentation at the clinic for utilization of medical services by rape survivors.**

Variables	Odds Ratio	p-value	95% Confidence Interval	
			Lower	Upper
<b>Level of education</b>				
No formal	0.75	0.242	0.469	1.211
Formal	1			
<b>Age (years)</b>				
<35	1.433	0.117	0.874	2.243
$\geq$ 35	1			
<b>Number of years of stay in camp</b>				
<4	1.281	0.741	0.682	1.713
$\geq$ 4	1			
<b>Location</b>				
Intervention camp	3.15	0.002	1.955	5.631
Comparison camp	1			

This is similar to the finding from earlier studies that examined the effectiveness of community-based awareness programs on service utilization by rape survivors. A study in three Afghan refugees' camps where a community-based GBV prevention and response initiative was instituted through monthly awareness sessions for the refugees' camps male and female health committee and community elders, 24 SGBV survivors were reported to utilize medical services after a year of intervention compared to none before the project in the targeted camp.<sup>12</sup> Likewise a community based intervention programme targeted at community leaders, in refugee camps in Tanzania aimed at evaluating the utilization of the newly introduced HIV post exposure prophylaxis in the clinical

management of rape survivors in Kibondo refugee camp, reported the number of survivors seeking care increased from 55% to 94%.<sup>18</sup>

In this study, intervention area had a significant positive effect on the number of rape survivors who presented within 72hours and completed the course of treatment at the final assessment when compared with the baseline. In the comparison area, there was reduction in the number of survivors who completed treatment at the end of the study. This is similar to a study which involved community participation in the management and control of sexual and gender based violence among refugees in three refugee camps in Pakistan, the proportion of rape

survivors who reported for medical services and completed their course of medical treatments and follow up increased by between 65% and 81% in the three camps respectively following various community based interventions.<sup>12</sup>

This study found age and level of education not to be predictors of post rape medical care which is similar to findings from other studies in non-refugee setting.<sup>19, 20</sup> However, a longitudinal national survey among women found that reporting the rape to police or other authorities was associated with receipt of post rape medical care though not assessed in this study.<sup>18</sup>

A national survey among women rape survivors reported that the majority of women who received and completed post-rape medical services had knowledge about the medical complication and consequence of rape and where and what services were available.<sup>21</sup> The national survey concluded that education is needed to increase rape acknowledgment, awareness of post-rape services and recognition of the need to treat rape related health problems.<sup>21</sup>

The role of participatory women groups in improving the utilization of maternal and newborn health services by women especially in resource-strain population have been reported in many studies though not for health service utilization for survivors of sexual and gender-based violence.<sup>22-23</sup> Studies done in non-refugee settings in Eritrea and Nepal on the use of community mobilization through participatory women's groups reported associated significant improvements in knowledge of safe motherhood practices and use of essential maternity services and improve birth outcomes in poor rural communities.<sup>22-23</sup> The focus of this study using participatory learning approach among women groups was to reinforce the

knowledge and attitude of the women in the intervention camp on the medical complication and consequence of rape and where and what services were available in the camp for rape survivors.

### **Limitations of the study**

This study is based on clinic records and subject to the limitations associated with studies utilizing routine data. The accuracy of the number of rape survivors is limited by the fact that rape was underreported in the study setting. The number of survivors reported in the clinics does not represent all the cases in the communities as some may have reported to other places like the police or not reported at all. As with other pre- and post-intervention surveys, this study has also limitation in relation to the duration of any program that focuses on behavior change though the intervention was for a year but may not be enough for community to truly internalize the information presented and demonstrate true change. The small sample size may have accounted for the lack of statistical significance in many of the analyses. Despite these limitations, this study has implications for programme and service provision for this population of rape survivors in refugee camps and conflict affected settings.

### **Conclusion**

This study showed that community based intervention using participatory women's group discussion had a significant impact on the utilization of medical services by rape survivors in the camp clinics. There has been increasing international recognition that communities can make deep and lasting contributions to their own health and well-being. Participatory community programmes similar to that used in this study have been shown to result in significant improvements in maternal and newborn health across diverse settings around the world. Community

engagement should be an integral part of interventions for SGBV in at risk populations. The public health implication of the study is that community based participatory women's group approach can be taken to scale up and used as key intervention in increasing utilization of health services including medical services for rape survivors.

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