Assessing the Impact of the IRC Program for Survivors of Gender Based Violence in Eastern Democratic Republic of Congo.
Final Report.

Conducted with support from VTF/USAID
by
International Rescue Committee
Democratic Republic of Congo
and
The Applied Mental Health Research Group
Johns Hopkins and Boston Universities

Author
Paul Bolton

Version: October, 2009

Table of Contents

1. Introduction

1.1 Overview

This is a final report of a multi-year collaboration between the International Rescue Committee (IRC) and the Applied Mental Health Research Group (AMHR) at Johns Hopkins University (JHU) and Boston University (BU). This collaborative project involved implementation of an integrated approach to program Design, Implementation, Monitoring, and Evaluation (DIME) developed by JHU to serve program data needs and thereby inform program improvements. The DIME approach was applied to a pre-existing IRC program serving female survivors of gender-based violence (GBV) in South Kivu, Eastern Democratic Republic of Congo (DRC). The project was supported by the Victims of Torture Fund (VTF) through a subcontract with Boston University. Project activities were conducted between November 2005 and July 2009.

This report refers to the entire project. However, early project activities which are described in more detail in previous reports (referenced in the text) are described only briefly. The main foci of this report are the activities not previously reported on: the pre and post intervention assessment of program participants.

1.2 Objectives

The objectives of this collaboration were developed during an initial site visit to DRC in December of 2005 between IRC, USAID and JHU/BU faculty. They are:

> *1. Assist IRC and local partners in identifying the major psychosocial problems of populations in Eastern DRC, and in understanding local conceptions of normal functioning in order to inform IRC programs.*
>
> *2. Assist IRC and local partners to use this information to design, monitor, and evaluate the impact of programs to address these issues.*

2. Background[1]

2.1 IRC Gender-Based Violence Programming in DRC

Women and girls have been adversely affected by the protracted conflict in eastern DRC from the mid-1990s to the present. Armed parties have targeted them for acts of sexual violence, the extent and brutality of which have gained the region a reputation as one of the cruelest conflict zones for women and girls in recent history. Even when the general political situation has shown signs of improvement in eastern DRC, women and girls have continued to be disproportionately exposed to, and affected by, conflict and violence.

[1] Much of the information in this section is adapted from a previous report: 'Field-Based Testing of Tools to Assess Function Impairment and Psychosocial Problems among GBV Survivors in South Kivu, Eastern DRC' available at the USAID DEC website at http://dec.usaid.gov/).

In addition to continuing attacks (including abduction and sexual slavery) other forms of violence against women and girls are becoming more common in eastern DRC, in both the public and private spheres. These include sexual violence within families and between community members (reportedly affecting younger and younger girls), domestic violence, sexual exploitation, and prostitution.

2.2 IRC's Gender-Based Violence Program in eastern DRC: 2002-7.

Since 2002, IRC has responded to the escalating problem of sexual violence in eastern DRC by building the capacity of, and providing essential resources to, existing non-governmental organizations and community-based organizations at the grassroots level. The IRC works with these partner organizations to provide essential holistic services to survivors of sexual violence and other forms of gender-based violence (GBV) and to improve the general protection of women and girls.

In 2007, when IRC and JHU first began to conduct baseline assessments of IRC GBV program participants, that program consisted of:

- Providing technical, material, and financial support to service providers who in turn provided specialized health, psychosocial, and legal services to survivors of sexual violence and torture;

- Supporting grassroots women's projects geared towards the psychosocial support, integration, and empowerment of survivors of sexual violence by increasing educational, socio-economic, and leadership opportunities for women and girls, and encouraging community mechanisms for psychosocial support;

- Strengthening inter-agency mechanisms to develop more comprehensive and effective service delivery and referral systems that respond to the security and protection needs of women and girls;

- Advocacy with Congolese ministries and institutions, United Nations (UN) agencies and international NGOs; internationally, through channels such as the IRC's advocacy department in Washington, D.C.; the Women's Commission for Refugee Women and Children; and contributions to international news media on the topic of violence against women and girls in the DRC.

3. Early Project Activities (Summary of Previous Reports)

3.1. Qualitative Study[2]

[2] 'Qualitative Study to Identify Indicators of Psychosocial Problems and Functional Impairment among Residents of Sange District, South Kivu, Eastern DRC.' Available at the USAID DEC website at http://dec.usaid.gov/.

Activities addressing the first objective (see Objectives) were the focus of a previous report which described a qualitative assessment by IRC and JHU/BU in Sange district, south Kivu, in February, 2006. This study explored local concepts of psychosocial problems related to GBV, and of functioning. The major mental health and psychosocial problems described dealt with ongoing fear, mood disorders and anxiety, stigma and rejection, However, the study was interrupted by a forced evacuation due to security problems, forcing the truncation of the data collection activities and their completion by IRC staff without supervision by the JHU faculty. Therefore, the data were more limited in scope and reliability than would normally be the case.

3.2. Program Design

To realize the design element of objective 2, JHU/BU provided IRC and local partner staff with onsite training in an expanded version of the standard program logframe including how to use qualitative and other data to inform program design. IRC later used this approach to revise their GBV program design using the qualitative data, as well as laying out plans for program monitoring and evaluation.

3.3. Instrument Design

To realize the monitoring and evaluation element of objective 2, data from the qualitative study were used to draft an instrument to assess both function and psychosocial problems from the local viewpoint. The intent was to produce an instrument that is locally appropriate (reflects the priority problems of survivors using their own descriptive language) while also reflecting those issues that were already being addressed by the GBV program. Because there are many languages used in South Kivu, it was decided to produce the instrument in Swahili, which is a common second language in the area and therefore the most widely spoken. In collaboration with external IRC staff, JHU/BU faculty drafted the first version of the instrument. This was then reviewed by local IRC staff as well as GBV counselors and their supervisors from local partners who worked with GBV survivors. Based on this feedback, the instrument went through a series of modifications. These continued until local and external IRC GBV staff, the counselors and supervisors from the local partners, and the JHU/BU faculty agreed that the resulting draft instrument reflected important problems and areas of functioning that are consistent with both the qualitative data and the current (2007) GBV program objectives.

The problems that met these criteria and were included in the instrument were:

- Fear and anxiety
- Feeling poorly treated by others
- Feelings resulting from poor treatment – shame and stigma
- Depression-like symptoms.

Areas of functioning assessed by the instrument:

- income generation
- household tasks
- child rearing

- Socializing/working/interacting with others.
- Learning new things
- Thinking.

3.4 Instrument Testing and Interviewer Training[3]

JHU/BU faculty then traveled to DRC to conduct pilot testing of the draft instrument. Normally validity and reliability testing would also have been done at this time, however there was concern by IRC that the situation in DRC with respect to logistics, security, travel, and the capacity of local partners was more difficult than in other sites and therefore that reliability and validity testing were not feasible at that time.

As part of the pilot testing, JHU/BU faculty trained 10 staff of IRC local partner organizations in the instrument and how to conduct interviews. Training included the use of a nonverbal response card: a series of drawings that represent the response categories to the function section of the instrument. Its purpose is to assist interviewees (particularly illiterate respondents) to select a response category to each function question. Interviewers also reviewed the instrument to ensure the use of words and phrases that were most likely to be understandable to local women of limited education.

The pilot study was conducted in Katana and Kabimba districts (1.5 hours travel north of Bukavu) among 60 GBV survivors who had already received services by one of IRC's local partners. Most interviewees reported feeling positive about the interview process and none reported disliking it. Many interviewees reported being pleased at being asked questions which referred to issues important to them but which no-one (or few people) had asked them before. This included some of the function questions, such as pounding cassava, cultivation, and attending church. Others appreciated being asked about the psychosocial problems, including being rejected, badly treated, suicide, thinking about what happened to them in the past, and feeling shame. When asked which questions were difficult to answer, some respondents referred to the function questions asking about difficulty in raising animals, trade and caring for children. In each case, the problem was that these were not activities for which the respondent was responsible. Despite concerns prior to the study, only 2 respondents became temporarily upset during the interview as a result of the interview process.

The main purpose of the pilot study analysis was to determine if the instrument was suitable for assessing problems affecting GBV survivors – both baseline assessments and change over time. For most questions in the pilot instrument, the mean severity scores were high enough to suggest that the issue being assessed (either symptoms or function) was a significant problem for the study sample. Since function questions refer to specific tasks there is an expectation that some respondents will not be able to answer some function questions if the question refers to activities that they do not do. However, for two function questions - trading/making money and raising animals –

[3] Field-Based Testing of Tools to Assess Function Impairment and Psychosocial Problems among GBV Survivors in South Kivu, Eastern DRC. Available at the USAID DEC website at http://dec.usaid.gov/.

the number unable to answer was large enough that these questions were considered not sufficiently relevant and were therefore removed from the instrument.

The final versions of the instrument and the non-verbal response card are included in Appendix A. The instrument includes sundry demographic and personal information and two main sections assessing dysfunction and psychosocial problems. The section on dysfunction consists of a series of questions about level of difficulty in performing tasks important for women in eastern DRC, as reported by respondents in the qualitative study. These tasks refer to care of family and contributing to the community, and to mental and physical activities and relationships with others. The section on symptoms consists of questions about the severity of problems of mood, fear and anxiety, remembrance of violent experiences, stigma and rejection by others, social withdrawal, and thoughts of harming oneself.

During and after the pilot study, JHU/BU faculty set up a database using the Centers for Disease Control's Epi-Info software program for recording interview data. A local IRC staff was trained in its use, including data entry and cleaning and simple data analysis.

4. Later Project Activities (not previously reported)

4.1 Implementation of Client Assessments at Baseline and Follow-Up

4.1.1 Baseline Assessments

After JHU/BU faculty completed the pilot study, including finalizing the instrument and interviewing materials and setting up the database, IRC staff began to implement the instrument as part of the recruitment process for women entering the GBV program. Those trained in the instrument during the pilot study continued to use it in their recruitments, while IRC staff using the JHU/BU training materials from that study to train new counselors among their local partner organizations.

Between the pilot study in October 2007 and the project wrap up visit in April 2009, IRC staff conducted interviews of new GBV program clients at baseline, repeated these interviews weeks to months later, and again after completion of the program. Because of delays in training there was a wide variation in the timing of the second interview – anywhere from weeks to months. Because of access issues related to security and program dropouts only about two thirds of those interviewed at baseline were interviewed a second time and less than one third were interviewed a third time.

As new interviewers were trained and the resulting data were entered into the database, it became clear that many interviewers were having difficulty in conducting the interviews and recording the data accurately. Data were often missing from the interview records, including demographic information. The dates attached to many interviews were clearly incorrect and some second interviews were dated prior to the third or even the first interview. There were also problems in having the interviewers generate unique codes for each interviewee, based on a standard system developed by the JHU/BU faculty. Some interviewers clearly did not understand the system while others continued to use pre-existing program coding systems for new clients, which

resulted in confusion and some clients getting several codes or the same client getting a new code for each interview. Ongoing efforts to resolve these problems in the field came to a halt when the only IRC staff trained in the data management and primarily responsible for the interviews was tragically killed. It took some time to hire a suitable replacement who then had to function without direct training until the return of PB in April 2009.

4.1.2 Follow-Up Assessments

Between the early baseline interviews conducted soon after the pilot study and the completion of this assessment in April 2009, the nature of the IRC GBV program underwent extensive changes. At the time of the pilot study the project had up to 12 local partner organizations providing a variety of economic and/or psychosocial interventions according to the partner's skills and resources. By the end of the program this had been reduced to 4 local partners who focused on psychosocial interventions and who had received training in a standard protocol by IRC. While the changes in the GBV program were well justified and appropriate, the result was also that the nature of the program being assessed was fundamentally changing during the assessment. The variety of interventions at the beginning of the assessment period, and the program changes during the assessment, make it difficult to determine what it was that the assessment was assessing.

In addition, the lack of a control or comparison group prevent any firm conclusions about what, if any, changes in the program clients were due to the intervention. While controlled studies are difficult to conduct in insecure and unstable environments like eastern DRC, it is exactly in these types of environments that such studies are most needed. Changes in the environment affect symptoms and functioning and when such changes occur only the presence of a control group can allow determination of what differences in pre and post intervention interviews are due to the intervention and which are due to the environmental factors.

5. Results

Despite these problems, IRC staff and partners have conducted approximately 300 first interviews. There is uncertainty about the exact number because some interviews that appear to be first interviews are marked as being second interviews. Because of this uncertainty clients with second interviews but no first interview and those with a third interview but no second interview have been removed from the database. This has left 240 useable baseline interviews available for analysis over the lifetime of the project, although many of these interviews continue to have missing data. Of these 240 interviewees, 200 had a second interview and 66 had a third interview. **The results reported throughout the remainder of this report refer to these 240 first interviews, 200 second interviews and 66 third interviews.**

Table 1 (Appendix B) shows the mean value of the responses to each task and symptom question at first, second and third interview.

5.1 Baseline interview results

Summary of the first (ie, baseline) interview results in Table 1:

- The mean age of the interviewees at baseline (first interview) was 35 years and ranged from 11-70.

- Function data show high levels of difficulty for most items. The mean values on most items are much higher than JHU/BU faculty have seen for similar items among other trauma-affected populations recruited into interventions, including others in sub-Saharan Africa.

- There is no clear pattern regarding which types of tasks are most difficult, although the data does suggest a tendency to greater difficulty with the more physically demanding tasks including child care compared with mental and social functioning.

- The data does not describe the causes of these difficulties. However, in a challenging environment like DRC dysfunction is likely to be due to a combination of factors including lack of resources, physical and mental problems, and community attitudes. The relative contribution of the effects of GBV is uncertain since we have no data for women who have not been subjected to GBV. While it is highly likely that these women have higher levels of dysfunction and symptom severity compared with other women in the same communities, we have no idea how much higher these levels are

- Symptom severity also tends to be high for most symptoms. As with the function data, the mean scores on symptoms questions are substantially higher than among other populations we have previously assessed, including those affected by trauma and/or those elsewhere in sub-Saharan Africa. Scores at baseline tend to be highest for symptoms related to anxiety and fear and lowest for symptoms referring to how the person is treated by others.

- *Overall the baseline interview data indicate a group of women struggling with high levels of dysfunction and troubling symptoms, particularly fear and anxiety.*

5.2. Results of Follow-Up Assessments

These are shown in Table 1 by comparing the mean scores for each question at first interview with the scores on the same question at second and third interview. To summarize the overall changes in function and symptoms, a total function score was calculated for each client by summing all their responses on the function items.[4] Similarly, a total symptom score was also generated in the same way. Changes in these scores (including percentage changes) are included at the bottom of Table 1. Summary of the second and third interview results in Table 1:

[4] Where clients did not respond to a function item the missing data was replaced with the mean of their responses on the other function items.

- Most clients show a reduction near one full point at second interview compared with first interview on most tasks or activities, and near half a point at third interview. Both represent substantial improvements.

- Results for the summary scores of function and symptom severity also show large sustained improvements in both between first and second interviews and between second and third interviews.

Table 2 in Appendix B shows the correlation between the number of days between interviews and the amount of change in overall function and symptom severity scores.

A. There is a substantial and highly significant correlation between the number of days between first and second interview and the magnitude of improvement in both function and symptom severity. Since the second interview occurred while the clients were still receiving the intervention this means that duration of the intervention is associated with amount of change. There are three possible explanations for this association:
    - The change is due to the intervention.
    - The change is duration to the passage of time.
    - Some combination of the two.

B. While there is a substantial change between second and third interviews on both function and symptom severity, there was no significant correlation between amount of change and the length of time between first and third and second and third interviews. Since the third interview took place at varying times after the intervention was completed, this suggests that change is related to the intervention and not to the passage of time.

Without a comparison group it is not possible to say for certain what the role of the intervention is (if any) in causing the observed improvements. However, point B above is suggestive that the intervention plays a significant role. Therefore it seems likely that the GBV program activities between 2007-9 resulted in improvements in client symptoms and function.

6. Limitations in this project and in interpreting the data

1. Without a control group it is uncertain whether the substantial changes in symptoms and function were due to the program or to other factors. In an unstable and changing environment like DRC it is possible that other factors in the lives of these women changed during the study and that these changes may have affected their mental health.
2. The accuracy of the study instrument was never established. Therefore, the extent to which the interviews provide a true measure of the level of symptomatology and dysfunction is unknown.
3. The quality of the interviewer training and interviewing were not monitored. Subsequent misunderstandings and difficulties of some interviewers in assigning unique ID numbers, recording dates and the number of the interview

(1st, 2nd, or 3rd) suggest that there are significant problems in the abilities of the interviewers.
4. There may be a bias in that those who are likely to improve were also more likely to be available for re-interview. Those who did not improve are more likely to have dropped out of the program and/or be uninterested in having a repeat interview.
5. Since the interviews were done by the same persons who provided the intervention, there may have been a desire on the part of the clients to report improvements in order to please the counselor.
6. The nature of the intervention varied according to the perceived needs of the client, and include a variety of activities such as counseling and medical referrals. Therefore, it is not possible to determine which parts of the program were responsible for the changes.

7. Conclusions Based on the Results Data

Despite the above limitations, the following conclusions can be made:

1. Those women who were recruited into the program reported high levels of symptomatology and dysfunction prior to receiving the interventions. These levels are higher than those for other trauma-affected populations we have assessed in other low resource environments.
2. As a group those women who underwent the IRC program and were reinterviewed reported large improvements in most symptoms and tasks, and in overall symptomatology and function.
3. These improvements are likely due in part to a combination of factors such as the passage of time, other changes in the environment during the study that might affect mental health, bias in terms of who was re-interviewed, and a desire to please the interviewer. However, magnitude of the changes, and the lack of association with time between interviews two and three, suggest that the program itself had a significant impact.
4. Therefore, while the IRC program was diverse in terms of its elements and who received them, the evidence from this study suggests that a service program can improve the mental health and functioning of women affected by GBV.

8. Recommendations/Next Steps

1.IRC and local partners should continue to use the instrument in their assessments of GBV program clients.

Currently the instrument is administered at baseline, during the intervention, and after discharge. In order to better assess the ongoing impact of the program this should be changed to assessment at baseline, upon discharge, and at least 6 month after discharge.

While continuing to use the current instrument, IRC and partners should also improve upon the current version in the following ways:

2. Expand on the original qualitative study done by IRC and JHU in eastern DRC.

IRC and local partners should repeat the initial qualitative study in multiple sites. These sites should be chosen to represent the variation in culture and circumstances throughout the area of operations of the GBV program. The initial study was conducted in one site only and was curtailed due to a security-related evacuation that occurred during the data collection. Repetition of the study at other sites will determine the robustness of the initial findings as well as informing how generalizeable the findings are to other GBV affected populations in eastern DRC.

3. Revise and test the assessment instrument.

The content of the current assessment instrument should be reviewed, based on a re-examination of the original qualitative study findings and the additional qualitative studies suggested above. The current version of the instrument was deliberately made brief due to concerns about the time it would take to conduct the interviews and therefore the burden on GBV survivors and interviewers. However, brevity was achieved by excluding some significant psychosocial problems from the original instrument. Meanwhile, counselors who conduct the interventions have expressed interest in expanding the range of issues assessed by the instrument.

The revised instrument should undergo reliability and validity testing. These were not done with the original instrument, due to IRC concerns regarding the resources this would require. Without such testing the accuracy of the instrument remains unknown. While this is common for instruments used in low resource environments, IRC and partners should not accept this state of affairs but instead should take the initiative to improve program monitoring and evaluation.

4.Repeat and Expand Training on Instrument Use.

Training on the correct use of the instrument has clearly been inadequate, based on the many problems with the completed instruments. Basic skills, such as generation of unique ID numbers, recording of dates, recording of the number of the interview (1^{st}, 2^{nd}, or 3^{rd}) are lacking and there is clearly misunderstanding of other issues such as when the interviews should be done. Most likely the problems are not associated with the original didactic instruction provided by IRC but with a failure to follow up this training with supervision including practice, review, and constant monitoring and feedback to the interviewers. Therefore, training of all persons currently using the instrument should be repeated, with a focus on the problems that have become evident, and this should be combined with supervised practice followed by ongoing field based supervision and the counselors use the instrument.

Currently counselors receive little supervision with respect to their interviewing. One member of the IRC staff is responsible for the training, supervision and data recording and analysis. But this staff has little time and opportunity to meet with the interviewers regularly. Also, this staff does not have the training to effectively

anticipate, recognize and deal with the issues that the interviewers are facing or are likely to face.

5.Expand training of IRC supervision/data staff.

IRC staff responsible for supervision of interviewers and data management should receive further training in both activities. This should include further direct training as well as ongoing distance supervision by JHU faculty or other persons experienced in these activities.

6.Standardize mental health treatment around proven intervention for the major problems affecting the women.

Counselors currently working with GBV survivors have expressed the desire for further training to deal with specific mental health and psychosocial problems. This is consistent with the literature and experience in other populations which suggest that specific mental health interventions are usually required to produce long term reduction in symptoms and improvement in function. In discussions over the last year IRC and JHU has discussed possible specific interventions to address the major problems identified in the qualitative study and by the counselors. Counselors should receive training and supervision in whichever intervention(s) are considered most likely to be feasible and effective in eastern DRC, followed by implementation of this intervention(s) under supervision.

7.Conduct a controlled trial of this intervention.

Implementation of the specific intervention in #6 (above) and of the overall GBV program should be done in the form of a controlled trial to determine the true impact of the program and its activities. This is the only way to make progress in developing programs that are feasible and effective for GBV, both in eastern DRC and elsewhere.

Appendix A: Quantitative Instrument

Draft ya Kiswahili kuhusu alama za kisaikolojia kwa muradi GBV wa IRC katika jamuhuri ya Kidemokrasiya ya Congo (Imetokana na Utafiti uliyo fanyika na BU/IRC)
Draft de la Version Française des Indicateurs Psychosociaux pour le Programme GBV de l'IRC en RDC (Produit de l'enquête qualitative BU/IRC)
Draft English Version of Psychosocial Indicators for IRC DRC GBV Program (Generated from the BU/IRC qualitative survey)

Kipindi A-Kutambuwa alama kamili za kufanya kazi
Section A-Evaluation de la Fonctionnalité
Section A-Assessment of Function

Nitasoma mapashwa mbalimbali na kazi za wanawake ambazo wengine wanawake walituambia ni za lazima kwao na wanazoweya kuzifanya.
Nita kuuliza shida ao magumu gani unapata kwa kila mapashwa ao kazi.
Utaniambiya kama hauna shida ao magumu, una shida ao magumu kidogo sana, una shida ao magumu kwa kadiri, una shida ao magumu zaidi wala una shida ao magumu sana ao hauwezi hata fanya hiyo kazi.
Je vais vous lire une liste de tâches et activités. Ce sont des tâches et activités que les autres femmes dans ce milieu nous ont dit sont importantes à savoir faire pour les femmes. Pour chacune des tâches ou activités, je vais vous demander le niveau de difficulté que vous rencontrez. Vous me direz si vous n'avez aucune difficulté, un peu de difficulté, un niveau moyen de difficulté, beaucoup de difficulté ou si souvent vous ne pouvez pas faire cette tâche.
I am going to read a list of tasks and activities. These are tasks and activities that other women around here told us were important for women to be able to do. For each task or activity, I am going to ask you how much more difficulty you are having. You should tell me whether you are having no difficulty, a little difficulty, a moderate amount of difficulty, a lot of difficulty, or you often cannot do that task.

Kusudi ya kuelewa mbio, nina picha mbalimbali zinaonyesha shida ao magumu tafauti. *Onyesha mtu anaye jibu picha inayo tambulisha ngazi za shida. Chota kila picha kidole wakati unapoyifasiriya.*
Comme aide mémoire, j'ai ici avec moi une carte contenant des images. Chaque image représente un différent niveau de difficulté**.** *Montrez à la personne qui répond la carte qui représente les niveaux de difficulté. Indiquer du doigt chaque image au fur et à mesure que vous la décrivez.*
To make it easier to understand, I have a card here with pictures. Each picture represents a different amount of difficulty. *Show the respondent the card illustrating levels of difficulty. Point to each picture as you describe it.*

Picha ya kwanza inaonyesha mtu ambaye hana shida ao magumu. Picha ya pili inaonyesha mtu ambaye ana shida ao magumu kidogo sana. Picha ya tatu inaonyesha mtu ambaye ana shida ao magumu kwa kadiri. Picha ya ine inaonyesha mtu ambaye ana shida ao magumu zaidi, na picha ya mwisho inaonyesha mtu ambaye ana shida ao magumu zaidi hata anashindwa kufanya ile kazi. Kwa kila kazi ao mapashwa, nitakuomba ushote kidole picha ambayo inaonyesha shida ao magumu unayo kwa kufanya mapashwa ao kazi hiyo.
La première image montre quelqu'un qui n'a aucune difficulté. La deuxième montre quelqu'un avec très peu de difficulté. La troisième montre quelqu'un qui a un niveau moyen de difficulté. La quatrième montre quelqu'un qui a beaucoup de difficulté et la dernière montre quelqu'un qui a tellement de difficulté qu'elle ne peut pas du tout exécuter la tâche. Pour chaque tâche ou activité, je vais vous demander de me montrer du doigt l'image qui correspond au niveau de difficulté que vous rencontrez lorsque vous exécutez la tâche ou activité.
The first picture shows someone who has no difficulty. The second picture shows someone who has very little difficulty. The third picture shows someone who is having a moderate amount of difficulty.

The fourth picture shows someone who is having a lot of difficulty and the last shows someone who is having so much difficulty they often cannot do the task. For each task or duty, I will ask you to point to the picture which shows how much difficulty you are having in doing that task or activity.

Taja sasa kila kazi, na nyuma ya kila moja useme kama: **Katika juma (posho) mbili zilizo pita haukupata shida ao magumu, ulipata shida ao magumu kidogo sana, ulipata shida ao magumu kwa kadiri, ulipata shida ao magumu sana wala ulipata shida ao magumu zaidi hata haukuweza kufanya mapashwa ao kazi hiyo?** *Ukishota kila picha kidole ukiwa unafasiriya. Weka jibu ukizunguusha kiviringo namba inayo ambatana mapashwa ao kazi katika kibao kifwatacho.*
Lisez maintenant chaque tâche, et après chacune, posez la question : **au cours des deux semaines passées, avez-vous eu aucune difficulté, un peu de difficulté, un niveau moyen de difficulté, beaucoup de difficulté, ou tellement de difficulté que vous ne pouviez souvent pas faire la tâche?,** *tout en montrant du doigt les images au fur et à mesure. Notez la réponse en encerclant le nombre dans la case appropriée qui est à coté de l'activité ou de la tâche dans le tableau ci-dessous.*
Now say each task, and after each one say: **In the past two weeks are you having no difficulty, a little difficulty, a moderate amount of difficulty, a lot of difficulty, or are having so much difficulty that you often cannot do the task?,** *pointing to each picture as you say it. Record the response by circling the number in the appropriate box next to the activity or task in the table below.*

***Kipindi B*: Draft ya Chombo cha kutambulisha alama fulani fulani**
Section B: Draft de l'outil d'évaluation des symptômes
Section B: Draft Symptom Assessment Instrument

Nitakusomea shida ao magumu fulani fulani. Kwa kila moja, nitakuuliza ni kwa kiasi gani ilikuuzi KATIKA JUMA(POSHO) MBILI ZILIZO PITA, ukitiya na leo. Nina taka kujuwa kama shida ile haiku kuzuru hata kidogo, ilikuzuru kidogo, ilikuzuru kwa kiasi cha kadiri ao ilikuzuru sana.*(Tungeweza uliza tena '' ni kwa kiasi gani mambo yafuatayo yalikuwa shida kwako katika juma mbili zilizo pita''):*
Je vais vous lire une liste de problèmes. Pour chacun d'eux, je vais vous demander combien ce problème vous a ennuyée AU COURS DES DEUX SEMAINES PASSEES, y compris aujourd'hui. Je voudrais savoir si le problème ne vous a pas du tout, un peu, à un niveau moyen, ou beaucoup ennuyé. (Autrement, nous pouvons demander: « à quel niveau chacun des points suivants vous a posée un problème au cours des deux semaines passées? »).
I am going to read you a list of problems. For each one I am going to ask you how much that problem has bothered you IN THE LAST TWO WEEKS, including today. I want to know whether the problem has bothered you not at all, a little, a moderate amount, or a lot. (Alternatively, we could ask: 'How much has each of the following been a problem for you in the last 2 weeks).

Sema kila shida na kisha kila moja, uulize ni mara ngapi ule mtu ali sikiya vile mu juma 2 zilizo pita. Rudiliya aina zinazofwatana na kila msemwa; halafu acha mtu anayejibu acaguwe moja. Andika jibu kwa kuzunguusha kiviringo kwa namba inayo amabatana na iyo alama.
Lisez chaque point, et après chacun, demandez à la personne qui répond combien de fois elle a ressenti ce sentiment au cours des 2 semaines passées. Répétez les catégories après chaque point et laissez la personne choisir sa réponse. Notez la réponse en encerclant le chiffre dans la case appropriée/correspondante qui suit le symptôme.
Say each statement, and after each one ask how often the respondent has felt like that in the last 2 weeks. Repeat the categories after each statement and let the respondent choose one. Record the response by circling the number in the appropriate box next to the symptom.

Draft ya Kutambuwa alama kamili za kufanya kazi
Draft de l'outil d'évaluation de fonctionnalité
Draft Functionality Assessment Instrument

	Kiasi ya shida ao magumu kwa kufanya jukumu/kazi, Niveau de difficulté pour exécuter la tâche/activité, amount of difficulty doing the task/activity					
Kazi/Shuruli, tâches/activités, tasks/activities	**Hakuna,** aucune, none	**Kidogo sana,** Très peu, Very little	**Kiasi ya kadiri,** un niveau moyen, a moderate amount	**Mingi,** beaucoup, a lot	**Hawezi kuifanya,** ne peut pas le faire, often cannot do	**Haitumiwi,** non applicable, not applicable
A01 Kulima, cultiver/exploiter le champs, cultivating/farming	0	1	2	3	4	9
A02 Ucuruzi ao njia zingine za kuleta pesa, faire du commerce ou autres activités pour gagner de l 'argent, trading or other ways of making money	0	1	2	3	4	9
A03 Kupiga cakula, faire la cuisine, cooking	0	1	2	3	4	9
A04 Kucunga watoto, prendre soins des enfants, looking after children	0	1	2	3	4	9
A05 kupana shauri kwa wanamemba wa jamaa kwa kuishi katika amani, donner des conseils aux membres de la famille pour vivre paisiblement ensemble, giving advice to family members for living peacefully	0	1	2	3	4	9
A06 Kupana shauri kwa wengine watu wa mgini kwa kuishi na amani, donner des conseils aux autres membres de la communauté pour vivre paisiblement ensemble, giving advice to other community members for living peacefully	0	1	2	3	4	9
A07 Kubadilisha mawazo na wengine, échanger des idées avec les autres , exchanging ideas with others	0	1	2	3	4	9
A08 Kutwanga mihogo, piller le manioc**,** pounding cassava	0	1	2	3	4	9
A09 kufuga wanyama, élever les animaux**,** raising animals	0	1	2	3	4	9
A10 Kazi zingine za mikono, n'importe quels autres types de travail manuel, any other types of manual labor	0	1	2	3	4	9
A11. Kujiunga na wengine watu wa mgini kufanya kazi za mgini, se réunir avec d'autres membres de la communauté en vue d'exécuter des tâches pour la communauté**,** uniting with other community members to do tasks for the community	0	1	2	3	4	9

Kazi/Shuruli, tâches/activités, tasks/activities	**Hakuna,** aucune, none	**Kidogo sana,** Très peu, Very little	**Kiasi ya kadiri,** un niveau moyen, a moderate amount	**Mingi,** beaucoup, a lot	**Hawezi kuifanya,** ne peut pas le faire, often cannot do	**Haitumiwi,** non applicable, not applicable
A12. Kujiunga na wengine wanamemba wa jamaa kwa kufanya kazi ya jamaa, se réunir avec d'autres membres de la famille en vue de compléter des tâches pour la famille, uniting with other family members to do tasks for the family	0	1	2	3	4	9
A13 Kushirikiana na wengine ndani ya mgini, fréquenter les autres dans la communauté, socializing with others in the community.	0	1	2	3	4	9
A14 Kuomba /kupata msaada kutoka watu ao shirika wakati una uhitaji, demander/recevoir de l'aide d'autres personnes ou organisations quand vous en avez besoin, asking/getting help from people or organizations when you need it	0	1	2	3	4	9
A15 Kukamata mpango/msimamo, prendre des décisions, taking decisions	0	1	2	3	4	9
A16 Kushiriki katika kazi ao mambo mengine ya jamaa, prendre part aux activités ou évènements de famille, taking part in family activities or events	0	1	2	3	4	9
A17 kushiriki kazi ao mambo mengine ya mgini, prendre part aux activités ou évènements communautaires, **t**aking part in community activities or events	0	1	2	3	4	9
A18. Kujifunza kazi ao mambo mapya, apprendre de nouvelles notions ou techniques, learning new skills or knowledge	0	1	2	3	4	9
A19. Kujikaza na kujitoa kwa kazi /mapashwa yako, vous concentrer sur vos tâches/ responsabilités, concentrating on your tasks/responsibilities	0	1	2	3	4	9
A20. kushirikiana na watu wenye usiwowajuwa, communiquer ou faire connaissance avec des gens que vous ne connaissez pas, interacting or dealing with people you do not know	0	1	2	3	4	9
A21. kwenda kanisani ao kwenye muskiti sawa kawaida, aller à l'église ou à la mosquée comme d'habitude, attending church or mosque as usual	0	1	2	3	4	9

***Kipindi B*: Draft ya Chombo cha kutambulisha alama fulani fulani**

Section B: Draft de l'outil d'évaluation des symptômes
Section B: Draft Symptom Assessment Instrument

Shida, problèmes, problems	**Hata kamwe,** pas du tout, not at all	**Kidogo,** un peu, a little bit	**kiasi ya kadiri,** un niveau moyen, a moderate amount	**Mingi,** beaucoup, a lot
B01.Kupoteza hamu ya kula, perte d'appétit, loss of appetite	0	1	2	3
B02. Kukosa usingisi, insomnie, insomnia	0	1	2	3
B03. Mwenye kusikiya woga, avoir peur, being afraid	0	1	2	3
B04. Kuwa na woga wa kupatwa na magonjwa, avoir peur de tomber malade, being afraid to be infected by diseases	0	1	2	3
B05. Kukumbuka yenye ilikufikiyaka ao yenye ulionaka hata bila kupenda, vous rappeler de ce qui vous est arrivé ou vue même quand vous ne le voulez pas, remembering what happened to you or what you saw, even when you don't want to	0	1	2	3
B06. Kusikiya sawa unateswa na mume, vous sentir maltraitée par le mari, feeling badly treated by husband	0	1	2	3
B07.Kusikiya kuteswa na wengine watu wa jamaa, vous sentir maltraitée par les autres membres de la famille, feeling badly treated by other family members	0	1	2	3
B08. Kusikiya kuteswa na watu wa mgini, vous sentir maltraitée par les membres de la communauté, feeling badly treated by community members	0	1	2	3
B09. Kusikiya haya, avoir honte**,** feeling shame	0	1	2	3
B10. Kusikiya ume tupiliwa na kuachiliwa na mume ao mchumba, vous sentir rejetée et delaissée par le mari ou le fiancé, feeling rejected by husband or fiancée	0	1	2	3
B11. Kusikiya kutupiliwa na kuachiliwa na watu wote, vous sentir rejetée et delaissée par tout le monde, feeling rejected by everybody	0	1	2	3
B12.Kusikiya kama umeaciliwa na kusipoitikwa ressentir la stigmatisation, feeling stigma	0	1	2	3
B13. Kuwaza sana juu ya mambo yaliyo kufikiya, penser trop à ce qui vous est arrive, thinking too much about what happened to you	0	1	2	3
B14. Kuwaza sana juu ya mengine mambo yenye kukuuzi, penser trop aux autres choses qui vous tourmentent, thinking too much about other things that upset you	0	1	2	3

Shida, problèmes, problems	**Hata kamwe,** pas du tout, not at all	**Kidogo,** un peu, a little bit	**kiasi ya kadiri,** un niveau moyen, a moderate amount	**Mingi,** beaucoup, a lot
B15.Kujikunja ku wepeke ao kukataa kushiriki na wengine, vous replier sur vous-même ou vouloir vous soustraire, "withdrawing into yourself" ("going inside of yourself")	0	1	2	3
B16. Kukosa matumaini, vous sentir désespérée, feeling hopeless	0	1	2	3
B17. Kuwaza juu ya kujiuwa, penser à vous suicider, thinking about killing yourself	0	1	2	3
B18. Kujisikiya mwenye makosa, vous sentir coupable, feeling guilty	0	1	2	3
B19. Kuwaza juu ya kujifanyia vibaya, penser à vous faire du mal, thinking about hurting yourself	0	1	2	3
B20.Kutafuta kukimbiya watu wengine ao kujificha, vouloir éviter d'autres personnes ou se cacher, wanting to avoid other people or hide	0	1	2	3
B21. Kukosa hamu ya kufanya kazi ao mambo yenye yalikuwa yakikufurahisha hapo mbele, perte d'intérêt dans les activités ou les choses qui vous intéressaient autrefois, loss of interest in activities and things that used to interest you.	0	1	2	3

IRC DRC GBV Assessment Instrument:
Nonverbal Response Card for Function*

Hakuna shida ao magumu
Aucune difficulté
No difficulty

Shida ao magumu kidogo sana.
Un peu de difficulté
Very little difficulty

Shida ao magumu kwa kadiri
Un niveau moyen de difficulté.
A moderate

Shida ao magumu Zaidi.
Beaucoup de difficulté
A lot of difficulty

Shida ao magumu sana hata hawezi kuifanya.
Tellement de difficulté qu'il ne peut pas le faire.
So much, cannot do it.

*Adapted by IRC/Bukavu, Democratic Republic of Cong

IRC DRC GBV Assessment Instrument :
Nonverbal Response Card (symptoms)*

Hata kamwe,
pas du tout,
not at all

Kidogo,
un peu,
a little bit

kiasi ya kadiri,
un niveau moyen,
a moderate
amount of
difficulty.

Mingi,
beaucoup,
a lot

*Adapted by IRC/Bukavu, Democratic Republic of Congo

Appendix B: Results Tables

Table 1: Mean Values for each variable at First, Second and Third Interview[1]

Task or Symptom[2]	Number of interviewees with valid response	Number of interviewees with response missing	Mean of Valid Responses (%change[5])
TASK[3]			
Cultivating.1	240	0	2.8829200
Cultivating.2	201	39	1.9738455
Cultivating.3	68	172	1.6176471
Making money.1	240	0	2.9247693
Making money.2	201	39	1.9793044
Making money.3	68	172	1.5545151
Cooking.1	240	0	2.2763910
Cooking.2	201	39	1.6094527
Cooking.3	68	172	1.2350000
Caring for children.1	240	0	2.6390833
Caring for children.2	201	39	1.8582090
Caring for children.3	68	172	1.6316176
Advising family members.1	240	0	2.3115417
Advising family members.2	201	39	1.4539801
Advising family members.3	68	172	.8848529
Advising others in community.1	240	0	2.2791250
Advising others in community.2	201	39	1.4396020
Advising others in community.3	68	172	1.1017647
Exchanging ideas with others.1	240	0	2.1190711
Exchanging ideas with others.2	201	39	1.2134328
Exchanging ideas with others.3	68	172	.7041176
Pounding casava.1	240	0	2.4906667
Pounding casava.2	201	39	1.6670647
Pounding casava.3	68	172	1.7966176
Raising animals.1	240	0	2.7200824
Raising animals.2	201	39	1.9598678
Raising animals.3	68	172	1.2405935
Other physical labor.1	240	0	2.6712037
Other physical labor.2	201	39	1.6191542
Other physical labor.3	68	172	1.1845588
Working with others community tasks.1	240	0	2.2353657
Working with others on community tasks.2	201	39	1.3503980
Working with others on community tasks.3	68	172	.9066176
Working with family on family tasks.1	240	0	2.2418165
Working with family on family tasks.2	201	39	1.2608458
Working with family on family tasks.3	68	172	.8367647
Socializing.1	240	0	1.9948194
Socializing.2	201	39	1.1822388

Socializing.3	68	172	.7352941
Getting help from others.1	240	0	2.6885149
Getting help from others.2	201	39	1.8454811
Getting help from others.3	68	172	1.1585376
Making decisions.1	240	0	2.3819583
Making decisions.2	201	39	1.5119403
Making decisions.3	68	172	1.1791176
Taking part in family activities.1	240	0	2.2608194
Taking part in family activities.2	201	39	1.3790050
Taking part in family activities.3	68	172	.8183824
Taking part in community activities.1	240	0	2.2231111
Taking part in community activities.2	201	39	1.3023881
Taking part in community activities.3	68	172	1.0919118
Learning new things.1	239	1	2.4121309
Learning new things.2	201	39	1.4781966
Learning new things.3	67	173	1.0801493
Concentrating on tasks.1	240	0	2.2650755
Concentrating on tasks.2	201	39	1.3843284
Concentrating on tasks.3	68	172	1.2352941
Dealing with strangers.1	240	0	2.0036250
Dealing with strangers.2	201	39	1.2628588
Dealing with strangers.3	68	172	.8195588
Attending church/mosque.1	240	0	1.8096915
Attending church/mosque.2	201	39	1.0049981
Attending church/mosque.3	68	172	.7485294
Symptom[4]			
Loss of appetite.1	240	0	2.0416667
Loss of appetite.2	200	40	1.0850000
Loss of appetite.3	66	174	.5757576
Insomnia.1	238	2	2.2394958
Insomnia.2	199	41	1.1859296
Insomnia.3	66	174	.6212121
Fearful.1	240	0	2.3125000
Fearful.2	197	43	1.2131980
Fearful.3	66	174	.6969697
Afraid of being infected.1	238	2	2.4159664
Afraid of being infected.2	199	41	1.1155779
Afraid of being infected.3	66	174	.6060606
Intrusive memories of bad events.1	240	0	2.5583333
Intrusive memories of bad events.2	199	41	1.4874372
Intrusive memories of bad events.3	66	174	.9393939
Badly treated by husband.1	237	3	1.6708861
Badly treated by husband.2	199	41	1.0050251
Badly treated by husband.3	65	175	.5230769
Badly treated by others in family.1	240	0	1.6916667
Badly treated by others in family.2	198	42	1.0555556

Badly treated by others in family.3	66	174	.5757576
Badly treated by others in community.1	240	0	1.5666667
Badly treated by others in community.2	195	45	1.0000000
Badly treated by others in community.3	66	174	.6666667
Feeling shame.1	237	3	2.1097046
Feeling shame.2	201	39	1.0298507
Feeling shame.3	67	173	.5373134
Feeling rejected by partner.1	239	1	1.7071130
Feeling rejected by partner.2	201	39	.9800995
Feeling rejected by partner.3	67	173	.5074627
Feeling rejected by everyone.1	240	0	1.6625000
Feeling rejected by everyone.2	201	39	1.0049751
Feeling rejected by everyone.3	67	173	.5522388
Feeling stigma.1	239	1	1.7489540
Feeling stigma.2	200	40	1.0600000
Feeling stigma.3	67	173	.5373134
Thinking too much about traumatic events.1	240	0	2.4916667
Thinking too much about traumatic events.2	199	41	1.4070352
Thinking too much about traumatic events.3	67	173	.9253731
Thinking too much about other things.1	240	0	2.2333333
Thinking too much about other things.2	199	41	1.4070352
Thinking too much about other things.3	67	173	1.2089552
Withdrawal.1	240	0	1.7375000
Withdrawal.2	201	39	.9900498
Withdrawal.3	67	173	.6119403
Feeling hopeless.1	238	2	1.9033613
Feeling hopeless.2	201	39	1.0597015
Feeling hopeless.3	67	173	.6716418
Feeling suicidal.1	235	5	1.1744681
Feeling suicidal.2	200	40	.6500000
Feeling suicidal.3	67	173	.3731343
Feeling guilty.1	237	3	1.3417722
Feeling guilty.2	200	40	.8500000
Feeling guilty.3	67	173	.5522388
Thinking of hurting self.1	237	3	1.2194093
Thinking of hurting self.2	200	40	.7100000
Thinking of hurting self.3	67	173	.4029851
Wanting to avoid others.1	237	3	1.7130802
Wanting to avoid others.2	201	39	.9751244
Wanting to avoid others.3	67	173	.3432836
Lost interest in things.1	240	0	2.1791667
Lost interest in things.2	201	39	1.1293532
Lost interest in things.3	67	173	.6865672
Total function.1	240	0	49.8217
Total function.2	201	39	31.7366 (36.3%)

Total function.3	68	172	23.5456 (25.9%)
Total symptoms.1	240	0	39.5250
Total symptoms.2	201	39	22.2338 (43.8%)
Total symptoms.3	67	173	13.0299 (41.4%)

1. 240 respondents had a first interview, of which 200 had a second interview and 66 had a third interview.

2. 1, .2, and .3 refers to responses at first, second and third interview respectively.

3. The response categories for questions on tasks are:
   0=no difficulty with that task.
   1=a little difficulty
   2=a moderate amount of difficulty
   3=a lot of difficulty
   4=often cannot do the task
   Therefore, a mean score on a task near 2 (for example) indicates that on average respondents felt they were having a moderate level of difficulty with that task.

4. For symptom questions, the response categories are:
   0=not at all bothered by this symptom
   1=bothered a little bit
   2=bothered a moderate amount
   3=bothered a lot
   Therefore, a mean score on a symptom near 1 (for example) indicates that on average respondents felt they were bothered a little bit by that symptom.

5. Compared with previous interview.

Table 2: Pearson Correlation Between Duration of Intervention and Amount of Change in Function and Symptom Severity*

	Number of days between interviews 1 and 2	Number of days Between interviews 2 and 3	Number of days between interviews 1 and 3
Change in total Function score	197 .319 (.000)	68 .097 (.433)	66 -.119 (.343)
Change in total Symptom score	197 .305 (.000)	67 -.032 (.80)	65 -.113 (.372)

* The top number in each cell represents the number of interviewees with valid data. The first figure below is the Pearson correlation between days and change in score. The figure in brackets is the statistical significance of the results.