PSYCHOSOCIAL OUTCOMES ASSOCIATED WITH SEXUAL VIOLENCE AGAINST CHILDREN AMONG CHILDREN SEEN AT THE NAIROBI WOMEN'S AND KENYATTA NATIONAL HOSPITAL

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DECLARATION

I, Teresia Ndilu Mutavi, do hereby declare that, this is my original work carried out in fulfillment of the requirement of the degree of Doctor of Philosophy in Psychiatric Social Work (PSW) Department of Psychiatry, the University of Nairobi. I further declare that this has not been presented for the award of any other degree or to any other University.

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APPROVAL

This is to certify that I, Teresia Ndilu Mutavi, carried out the thesis work independently, under the supervision and guidance of University appointed supervisors, Professor Anne Obondo and Dr. Muthoni Mathai.

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DEDICATION

To the plight of sexually abused children

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ABBREVIATIONS

ANPPCAN	African Network for Prevention and Protection against Child Abuse & Neglect
BDI	Becks Depression Inventory
CD	Cognitive Distortions
CDI	Child Depression Inventory
CPSS	Child PTSD Symptom Scale
CRADLE	Child Rights Advisory Documentation and Legal Centre
CSA	Child Sexual Abuse
CSEC	Commercial Sexual Exploitation of Children
DSM IV	Diagnostic and Statistical Manual for Mental Disorders
GBVRC	Gender Based Violence Recovery Centre
HTQ	Harvard Trauma Questionnaire
KNBS	Kenya National Bureau of Statistic
KNH	Kenyatta National Hospital
MOU	Memorandum Of Understanding
NSPCC	National Society for the Prevention of Cruelty to Children
NWH	Nairobi Women's Hospital
PEP	Post Exposure Prophylaxis
PTSD	Post Traumatic Stress Disorder
SDQ	Strength and Difficulty Questionnaire

SSA	Sub Saharan Africa
STD	Sexually Transmitted Disease
SVAC	Sexual Violence Against Children
UCLA	University of California at Los Angeles PTSD Reaction Index
UN	United Nations
UNESCO	United Nation Educational Scientific and Cultural Organization
UNICEF	United Nations Children's Education Fund
USA	United States of America
WHO	World Health Organization
YSR	Youth Self-Report

DEFINITION OF TERMS

Psychosocial outcomes: A term used to describe the combination of psychological and social outcomes of children after the exposure of trauma. In this study psychosocial outcomes that were under study were Post-Traumatic Stress Disorder, depression, Self-esteem and school performance.

Parents/Legal guardians: This refers to the biological parents or by law people who are mandated to be the legal guardians of the children.

Sexual Violence Against Children: Sexual Violence Against Children (SVAC) is a form of sexual abuse directed at children in which adults or older adolescents sexually abuse children. In this study according to WHO (2006) sexual act with a child performed by an adult or an older child could include a number of acts namely:

- Sexual touching of any part of the body, clothed or unclothed;
- Penetrative sex, including penetration of the mouth;
- Encouraging a child to engage in sexual activity, including masturbation;
- Intentionally engaging in sexual activity in front of a child;
- Showing children pornography, or using children to create pornography;
- Encouraging a child to engage in prostitution.

Gender-Based Violence Recovery Centre (GBVRC): The GBVRC is a centre within a hospital that provides treatment to survivors' of gender based violence and their families. The centres provide free medical treatment and psychosocial support to survivors of gender-

based violence. The medical support given is the basic treatment for survivors of Gender Based Violence (GBV) which includes medical, social and psychological support.

ABSTRACT

Background: Sexual Violence Against Children has psychological, social, psychiatric and educational negative outcomes that are detrimental to the health of children and society as a whole. This study aimed at determining the psychosocial outcomes associated with Sexual Violence Against Children among children seen at Gender Based Violence Recovery Centres of the Mental Health Department Kenyatta National Hospital and The Nairobi Women's Hospital.

Objectives: To determine the incidence of Post-Traumatic Stress Disorder, the incidence of depression, the effect of SVAC on children's self-esteem and the effects of Sexual Violence Against children on their performance.

Study Design: This was a longitudinal study design using both quantitative and qualitative methods.

Methods and Tools: Research and Ethical clearance was obtained from Kenyatta National Hospital/University of Nairobi Research and Ethics Committee. The participants in this study consisted of children aged 7-17 years who had experienced sexual violence and their parent/legal guardians. Six parents/ legal guardians were purposively selected for qualitative narratives and an interview guide was used. Sample size calculation method used in the research was precision of the estimate, on the level of sampling error. The calculated sample size was 205 children who had experienced sexual violence. Study instruments included: Socio-demographic questionnaire for child and the parent, Child Post-Traumatic Stress Disorder Symptom Scale, Child Depression Inventory, Becks Depression Inventory and

Pier-Harris self-concept scale. The instruments were administered at baseline and at 3 follow-ups of 4 months interval for one year.

Data analysis: SPSS version 21 was used to analyze quantitative data and Nvivo version 12 was used for qualitative data.

Results: One hundred ninety one (191) study participants were recruited into the study of whom 23 (12%) were male and 168 (88%) were female (male: female ratio of 1:7). The mean age of the study participants was 13 years. The incidence of full PTSD was 95.3% and partial PTSD was 4.7% at baseline, at follow up 1, full PTSD was 95% and partial PTSD was 5%, at follow up 2 full PTSD was 60.7% and partial PTSD was 39.3% and at follow up 3 full PTSD was at 60% and partial at 40%. The incidence of moderate-severe depression among the children was 69.5% at baseline and mild at 30.5%, at follow up 1 severe-moderate depression was at 2.3% and mild was at 97.7%.

The incidence of high self-esteem was at 18.3%, average self-esteem was at 75.4% and low self-esteem at 6.3% at baseline, at follow up 1 high self-esteem was at 6.3%, average at 92.6% and low at 2%, at follow 2 high self-esteem was at 4.7%, average was at 92.8% and low at 2.5% and at follow up 3 there were no children with high self-esteem, average was at 98.1% and low at 1.9%. Children with moderate to severe depression on CDI/BDI were less likely to perform above average compared to those with minimal to mild depression ($p = 0.003$). The children with high self-esteem based on Pier Harris self-concept scale were 3.6 times more likely to have above average performance compared to those with low or

average self-esteem. The children performed poorly in school after the sexual violence incidence but improved in subsequent follow ups.

Conclusion: Sexual Violence Against Children has negative mental health outcomes as measured by the PTSD, depression and low self-esteem scales. These outcomes have detrimental effect to the normal development of children. Sexual Violence Against Children has also negative effect on the children's progress in school performance. There is need to minimize risk factors that would lead to poor mental health outcomes after the incidence of sexual violence on children and enhance parenting protective skills

CHAPTER ONE

1.1 Introduction

Sexual Violence Against Children (SVAC) is a psychological, social, psychiatric, educational and public health concern whose outcomes are not only detrimental to the health of a child but also the health of their families and society (Reza et al., 2009; Madu et al., 2010; WHO, 2014). Psychosocial outcomes related to SVAC demonstrate that its impact on children is deleterious and has far reaching negative consequences on children (Jewkes et al., 2010; Jaffee & Christian, 2014), and the economic burden of SVAC in any society is substantial (Corso & Fertig, 2010; Fang et al., 2012; Florence et al., 2013; Raghavan et al., 2014).

Although little is known about the magnitude of the psychosocial outcomes of SVAC in the African Region, authoritative information is scarce (Finkelhor et al., 2009). Research shows that the global estimate of prevalence of SVAC among females is 7-36% and 5-10% among males (Callender & Dartnall, 2010). Globally one billion children were exposed to violence during the year 2014 and two billion children in 2013 experienced physical, emotional or sexual violence (Hillis et al., 2016).

The United Nation Children's Education Fund (UNICEF) states that children have the right to live and grow up in a decent environment. This demands that children should attend school, enjoy good health, nutrition, live and grow in safety without any forms of sexual abuses

(UNICEF, 2013). In contrast, SVAC is perpetuated by a culture of secrecy, stigma and silence with intractable problem across societies for centuries (Kaffman, 2009; Bridgewater, 2016).

Studies show that exposure to Traumatic Events can precipitate Post Traumatic Stress Disorder and other negative mental and physical outcomes (Spitzer et al., 2009; Keyes et al., 2013; Scott et al., 2013; Olaya et al., 2014). Psychosocial outcomes associated with SVAC range from depression to Post Traumatic Stress Disorder (PTSD), low self-esteem and problems in school performance (Johnson et al., 2008; Kim et al., 2009; Vinck, & Pham, 2010). They negatively impact on the child's educational, social and psychological functioning (Sarnquist et al., 2014). Studies show that psychosocial outcomes of trauma particularly PTSD is higher in low income countries (Atwoli et al., 2015).

1.2 Background of the Study

1.2.1 Definition

The World Health Organization WHO (2010) defines SVAC as "the involvement of a child in sexual activity that he or she does not fully understand; is unable to give informed consent to or for which the child is not developmentally prepared". Children are sexually abused by adults and fellow children who, by virtue of their age or stages of development, are in a position of responsibility, trust, or power over their victims (WHO, 2006).

Sexual Violence Against Children is a behavior that exposes a child to sexual content. It covers an "array of sexual activities" with children. The forms of SVAC include asking or pressurizing

children to engage in premature sexual activities, indecent exposure of the genitals or physical contact with the children's genitals and displaying pornographic materials to them (Save the children, 2007; Whitehead, 2010).

1.2.2 Legal Frame Works

In Kenya, the Sexual Offences Act (2006) section 8 and Children's Act (2001) section 15, states that SVAC is an umbrella term describing criminal and civil offences in which an adult engages in sexual activity with a minor or exploits a minor for purposes of sexual gratification. The Sexual Offences Act (2006) further states that a child is anyone below the age of 18 years and that a child cannot consent to sexual activity with adults. The Convention on the Rights of the Child compel parties to take all appropriate legislative, administrative, social and educational measures to protect children from all forms of violence including Sexual Violence Against Children (United Nations, 1989).

1.2.3 Global Overview

Almost 15 years ago, Commercial Sexual Exploitation of Children (CSEC) in the Developing World was documented (UNICEF, 2001:24). This is child sexual exploitation for remuneration or in kind (Walker et al., 2013; Kruger et al., 2016). The masterminds in these cases are usually intermediary parents, family members, procurers (pimps) or teachers (Muyomi, 2012; Kruger et al., 2013).

Recently, the United Nations' 2015 Sustainable Development Goals set an agenda for global human development endeavours from 2015-2030. Essentially, these Goals acknowledge SVAC as a fundamental obstacle to health of the children and society as a whole. "Target 16.2 aims to end abuse and exploitation of children, and Target 5.2 aims to eliminate all forms of violence against women and girls, including sexual exploitation" (United Nations General Assembly, 2015).

1.2.4 Psychosocial Outcomes

Often, mental health problems among children are identified late and identification rates by health professionals are quiet low (Grant & Brito, 2010; Ndetei et al., 2009). Many studies indicate that children who experience sexual violence suffer physical, psychiatric, psychological, educational and social consequences (Roberts et al., 2009; Green et al., 2010). The commonest psychiatric morbidity has been found to be depression, which presents with low levels of self-esteem, poor body image, guilt, social withdrawal and little or no display of emotions (Perlman et al., 2008; Roberts et al., 2008).

Low self-esteem makes sexually abused children develop feelings of guilt and shame as the sexual abuser manipulates them to believe that it is their fault (Jonas et al., 2011; Dorahy & Clearwater, 2012). These feelings of guilt and shame among the abused children can reduce their likelihood of making a disclosure regarding their experiences with the abusers (Allnock, 2010; Alaggia & Millington, 2008; Schonbucher et al., 2012; Azad & Leander, 2015). Cultural practices also determine whether families of the children exposed to sexual violence would

report the incident to authorities (Fontes & Plummer, 2010; Bridgewater, 2016). Thus, children tend to disclose these abuses during forensic interviews when psychosocial support is provided (Lippert et al., 2009).

Sexual Violence Against Children psychologically robs children of their childhood and leisure in their formative years (Omondi, 2014). This deprivation leaves psychological, psychiatric, social and educational scars that can take many years to heal among the children (Whitehead, 2010). It is important to note that there is a connection between physical consequences and psychological outcomes (Young et al., 2011). Studies show that chronic abuse yields brain changes that lead to anxiety which manifests itself alongside with emotional instability (Mizenberg et al., 2008; Tomoda et al., 2009).

With regard to interpersonal relationships and functioning, SVAC survivors experience problems related to trust and security (Isley et al., 2008; De prince et al., 2008). Affected children may lose trust, particularly in adults and become vulnerable to further exploitation (Maniglio, 2009).

In social disturbances, the effects of early abuse may include severe social, educational and behavioral disturbances, poor control of aggressive impulses and avoiding social situations and people (Ford et al., 2008; Luthra et al., 2009). In addition, new problems at school such as difficulty in learning, poor concentration and declining grades could signify that something had happened to upset a child (Shen, 2009; Antoinette, 2010).

Consequently, it has been noted that SVAC in early childhood has been correlated with delinquency, prostitution, dependency, lower social competence, teenage substance abuse, and inability to express anger (Finkelhor et al., 2009). Victims of childhood sexual abuse, particularly males, are more likely to perpetrate violence later in life (Holcomb, 2013; Machisa et al., 2016). Sexual Violence Against Children and its consequences over children's lives make them especially prone to victimization in adulthood and it could lead to PTSD (Canton-Cortes & Canton, 2010) and Complex Post Traumatic Stress Disorder (Cloitre et al., 2009; Dorahy et al., 2009).

Intergenerational effects have also been noted with the children of victims of SVAC exhibiting more conduct and emotional problems than their peers (National Survey on violence against children, Kenya, 2010). In summary, the consequences of SVAC are apportioned to a variety of factors including; the period, time and when the abuse happened in the child's developmental stages, the frequency of the abuse, the abuser's relationship to the child, the magnitude of violence of the attack and what meaning the child attaches to the experience (Ayoub et al., 2006; Finkelhor, et al., 2007; Hornor, 2010).

1.2.5 Social Risk Factors

Studies show that SVAC occurs among all children in the society (Singh et al., 2014; Olafson, 2011). And disrupted homes where there are incidences of intimate partner violence predispose children to sexual violence (Bidarra et al., 2016). Some abusers target homes where children are neglected by their parents or those who do not have many friends since they are more likely to be

receptive to ill-intentioned adults (Turner et al., 2012). Some of the critical determinants of SVAC include parents who misuse substances, homes where many adults walk in and out and homes in which children may be left for long periods alone (Goodyear-Brown, 2012).

Hardley et al., (2008) assert that SVAC is associated with poverty, war, natural disasters and economic injustices. Other social risk factors of SVAC include disintegration of family social values and lack of protection of children at risk (UNICEF, 2001; Onyut et al., 2009). Poor systems of governance also fail to prevent injustices against children or to protect them from criminal acts (Gettleman, 2010; International Covenant on the Civil and Political Rights, 2011). Gender discrimination and double standards of morality for men and women contribute to the persistence of exploitation of children (Townsend & Dawes, 2007). In addition, societal and cultural norms related to the social position of children and their rearing practices, as well as the breakdown of immediate and extended family systems and child-headed households all contribute to children's vulnerability to Sexual Violence Against Children (WHO, 2010).

1.3 Statement of the problem

Sexual Violence Against Children transcends racial, economic, social, regional, age and sex boundaries (Fergusson et al., 2008; Akmatov, 2011; Collin-vezina et al., 2013). It is therefore, not an isolated, sporadic or distant reality, but a complex and universal problem resulting from the interaction of the individual, family, social and cultural factors (Cohen et al., 2006). Moreover SVAC has the potential for medical complications and it is associated with myriad of adverse educational, psychological and social outcomes with both short (Zinzow et al., 2009;

Danielson et al., 2010; Scott-Storey, 2011) and long term effects (Irish et al., 2010; Cutajar et al.,2010; Fergusson et al., 2013; McElroy et al., 2016).

In Kenya, the prevalence of Sexual Violence Against Children at (55%) among females is exceptionally high (Child-line, 2008). Sexual Violence Against Children is the leading in terms of reported cases at the Gender Based Violence Recovery Centres (GBVRCs) of the Mental Health Department Kenyatta National Hospital, Nairobi, and The Nairobi Women's Hospital. According to "CRADLE" Child Rights Advisory Documentation and Legal Centre (2009), the children's foundation, 79 % of girls in Kenya aged between 13 and 15 years had been sexually abused. The National Survey on Violence against Children (2010) concurs with this; it also reports that 32% of females and 18% of males experienced sexual violence during their childhood (National Survey on violence against children, Kenya, 2010).

Sexual Violence Against Children presents risks for Kenyan children. As a result of such abuse, many children live through feelings of confusion, guilt, anger, mistrust, sadness, psychological and emotional deprivation (Kenya Health Demographic Survey, 2010). Such abuses expose the children to PTSD and depression which interferes with their psychological functioning; low self-esteem which in turn interferes with the children's social functioning and poor performance in school (DSM V, 2013; Roberts et al., 2009).

In addition, when a child is sexually abused his or her education is disrupted and it has a profound impact on the ability of the child to concentrate at school (Kokonya et al., 2014). It is against this background that this study intends to determine the incidence of psychosocial

outcomes associated with SVAC among children seen at the GBVRCs of the Mental Health Department Kenyatta National Hospital, Nairobi, and The Nairobi Women's Hospital.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Prevalence

2.1.1Global trends

It is evident that Sexual Violence Against Children is a global problem and quite widespread (Stoltenborgh et al., 2011). The prevalence of Sexual Violence Against Children in the age brackets 2-14 and 15-17 years was 60.0% in North America and Latin America, 70.0% in Europe, 80.0% in Asia and Africa (Hillis et al., 2016). China had a lower prevalence of 15.3 % (Ji et al., 2013) and penetrative Sexual Violence Against Children had a prevalence of 1.0%. Similarly India had lower prevalence of SVAC at 16.7% (Mishra et al., 2016).

Sexual Violence Against Children affects all children in different age groups globally (Veenema et al., 2015). Many sexually abused children take a long time even years to disclose the abuses and some never do so altogether (Hunter et al., 2011; Townsend, 2016; Gagnier & Collin-Vezina, 2016). Studies estimate that about 223 million children (67% girls and 33% boys) have experienced traumatic SVAC globally (Pinheiro, 2006). Studies show that children from low socio-economic status will probably encounter maltreatment more compared to children from high socio-economic status (Cancian et al., 2010; Sedlak et al., 2010).

The National Society for the Prevention of Cruelty to Children (NSPCC) and Radford et al., (2011) approximates the prevalence of all forms of SVAC experience in the UK to be 24.1%. Other findings show that likely perpetrators of SVAC are family members, friends or acquaintances of the child rather than strangers (Mariathasan, 2009). Girls were at a higher risk of SVAC by family members while boys were at risk of SVAC by strangers (Maikovich-Fong & Jafee, 2010). Other studies showed that SVAC is prevalently committed by family members

(Cluver & Gardener, 2007) and instances of children engaging in prostitution (Mangoma et al., 2008; Mojola, 2011; Mmari, 2011).

Sexual Violence Against Children is common among girls than boys. Finkelhor et al., (2013), found high risk of sexual violence among girls than boys. Pereda et al., (2009) also found that the prevalence of sexual violence among females was 19.7% while for males was 7.9%. Brown et al., (2009) found that the odds of having been exposed to sexual violence were greater among girls than boys (OR: 1.29; 95% CL: 1.2-1.48; $p<0.001$). In another study, Girgira et al, (2014) found that among 267 children who were seen in two hospitals in Ethiopia after experiencing sexual violence, 75.7% were girls while 24.3% were boys. Meinck et al., (2014) found that the odds for girls experiencing sexual violence was (OR 1.85- 3.85 and $p<0.01$).

In Tanzania, among 1814 children in the age bracket 13-17 years, two thirds (63.9%) of females and a third (38.7%) of males experience sexual violence before the age of 18 years (Violence against children in Tanzania, 2009). Mandrup and Elkilit (2014) found that among 408 secondary school students in Uganda more females than males experienced sexual violence ($X^2(1,407) = 12.44$; $p < 0.0005$).

A follow up study in 5 low and middle income countries among orphaned children aged 10-13 years showed that 50.3% had experienced physical or sexual abuse by age thirteen (Gray et al., 2015). Similar findings were demonstrated by (Morantz et al., 2013; Nichols et al., 2013) that orphaned children seemed vulnerable to sexual abuse and exploitation. Studies showed that a

child with a disability had a higher risk of experiencing SVAC than a child without disability (Smith & Harrell 2013).

Pastorate executed SVAC additionally showed that boys may be particularly susceptible to abuse of this type (Roberts et al., 2004; Alaggia et al., 2008). A large-scale study on abuse allegations in the Catholic Church in the United States of America and a smaller study in Australia on allegations against Anglican clergy found that the dominant part of these allegations involved male victims. Roberts et al., (2004), found that 81% of the casualties were male while in the Australian study, 75% were also male (Parkinson et al., 2010).

2.1.2 Regional trends

Reasons for SVAC in sub-Saharan Africa

Reasons for SVAC in Sub-Saharan Africa (SSA) may be grouped into two categories; the rapid social change and the socialization of children in the African culture (McCrann et al., 2006).

2.1.2.1 Rapid Social Change

Over three decades ago, association between disintegration of clan authority as a result of inter-ethnic marriages, rural-urban migration, breakdown of traditional culture and modern social and economic forces led to the establishment of social vices such as Sexual Violence Against Children (Fraser & Kilbride, 1980; Okeahialam, 1984; Jinadu, 1986; Armstrong, 1998).

In the Traditional African Society SVAC was rare. The society had systems where children were protected through stringent taboos centered on relationships and living arrangements (Were, 2010; ANPPCAN, 2014). Cultural factors also protect children from SVAC as well as those

factors that create risks (Plummer & Njuguna, 2009). Today, the situation is different because the society has been invaded with many challenges including dysfunctional societies, shrinking income, population explosion, poverty, social ills, conflicts and civil strife and exploitation of information technologies (WHO, 2010; Were et al., 2014).

2.1.2.2 Socialization of children in the African culture

The second reason for SVAC in the SSA is the socialization of children in the African culture. Kabeberi-Macharia (1998) reports that incest is facilitated in Eastern and Southern Africa as a result of socialization pressures to children to respect parents and elders. Armstrong (1998) too, concurs that the African child's socialization of obedience to elders heightens vulnerability to Sexual Violence Against Children.

2.2 Prevalence of SVAC in Kenya

Studies showed that the prevalence of experiencing SVAC before age 18years in Kenya was 11.8% among females and 3.6% among males from 2007-2013 (Sumner et al., 2015). Data from the Nairobi Women's Hospital indicates that 55% of those violated are girls aged 0-15 years (Child line, 2008). The actual figure is thought to be higher considering that not all violations are reported. The "CRADLE" children's foundation organization in its report of 2009 indicates that over two-thirds (67%) of reported criminal cases were sexual violence against children. Sexual Violence Against Children recorded the highest number (76%) and (6%) of incest cases from (4,898) reported cases of sexual offense which showed incident rate of 5% above that reported in 2010. Odhiambo (2015) noted that according to the statistics in 2013 from the Kenya Police

Service it received, there were 3,596 Sexual Violence Against Children cases, 242 of incest and 124 of sodomy.

Kuria et al., (2013) in their study found that 28.3% of the SVAC cases seen at Kenyatta National Hospital consisted of children below 18 years from 2006-2009. Mumah et al., (2011) in their study among children in Nairobi at Kawangware slums found that 46% of the children had experienced incest and sexual abuse. Moki (2015) in her study at Naivasha District Hospital on SVAC found that 68.9% of the sexual abuse cases were also children below 18 years. Morantz et al., (2013) in their study at Western Kenya found that 8% of children's admissions at a tertiary hospital were due to child abuse.

In a study on the situation of youth and children in Kibera slums Onyango & Tostensten, (2015) noted that 80% of the youth and children experienced SVAC a decrease compared to 87.9% of the same in 2001. Mwangi et al., (2015) in their study on child sexual abuse among children between 13-17 years in Kenya, the key perpetrators of unwanted sexual touching among females were friends/classmates and relatives at 27% and 28%. Among males intimate partner sexual touching was 35.9%.

The leading (49%) forms of gender violence reported in Nairobi at the Police Station gender desks by survivors was Sexual Violence Against Children (Ombwori 2009). In the same study, the reporting rate of the survivors to the authorities was also high (86.3%).

2.3 SVAC by teachers in Kenya

Consistent patterns of violence against girls by male students and teachers as found out by the United Nations Educational Scientific and Cultural Organization (UNESCO), range from gratuitous taunts through unsolicited physical contact including touching sensitive and private body parts to serious Sexual Violence Against Children (UNESCO, 2014).

In schools where SVAC is common or unaddressed, a girl's safety and opportunities are limited. Childhood pregnancy rates in developing countries stand at 1 in 5 girls while pregnancy-related morbidities among girls aged 15-18 are the leading causes of mortalities (World Bank, 2014). Anecdotal reports show that school girls are sexually abused by their teachers in most parts of this country (Kenya) which result in pregnancies and school dropout. Moreover according to ANPPCAN (2005) most of the SVAC cases in schools in Kenya happen in the rural primary schools.

Sexual harassment to girls' participation in education has great negative impact. A study by Ireri et al., (2013) indicated that 27.7% of girls and 60% of the teachers agreed that sexual harassment had a great negative impact to girls' education. This was also highlighted by UNESCO (2007) that SVAC by teachers affects girl's participation and achievement in education.

Ndetei et al., (2015a) noted a higher stigma score among boys in primary schools with mental disorders compared to girls. Stigmatizing attitudes could have a negative effect on sexually abused children especially if the SVAC incident was known among other pupils in the school. Njoki (2009) found that students in Kenyan and Ugandan schools, 14.4% of the students had

been forced into sex by someone in the school. Fifty four percent (54%) of the students reported they knew someone who had been sexually abused in the school. However, a majority 60% did not know of any laws dealing with sexual abuse.

Sexual Violence Against Children remains a big challenge for Kenyan girls academic progress. Ruto (2009) found that when girls are impregnated by teachers an estimated 32% of the teachers faced no consequences, while paltry 25% were sacked. On the other hand, an estimated 76% of girls dropped out of school, out of whom, many opted to get married, procuring abortions and even committing suicide. Abonyo et al., (2014) found that paltry 15% of pupils in the schools in Mbita, Homabay County who took home based lunch experienced SVAC leading to the risk of attrition from school.

Wanyonyi (2014) found that 66% of the students in Kenyan secondary schools have had sex with 20.2% in disagreement and 13.5% giving no response. However, the students indicated the presence of SVAC (16.1%), incest (14.3%) and (13.5%) for prostitution among youth in secondary schools.

2.4 SVAC in the family

Intra-familial sexual abuse (incest) takes place within the nuclear or extended families (Bowman & Brundige, 2014). Stroebel et al., (2013) in their study among 2034 female participant's found that families accepting father daughter nudity increased 5 times the likelihood of father daughter incest in the family. Atindanbila et al., (2015) in their study among senior high school students in Ghana found that students who had experienced actual sex perpetrated by family members

experienced more psychological symptoms than students who experienced sex perpetrated by other people like neighbours, strangers, peer or teachers.

Boakye (2009); Kisanga, et al., (2013) found that incest often goes unreported and it is often a top secret. Lack of psychosocial support after disclosure is seen with explicit pressure on the child to recant the report (McElvaney, 2015). A large proportion (40-50%) of children who are defiled never tell anyone (Njoki, 2009; Ndungu et al., 2014).

Ndungu et al., (2014) found that the victims of SVAC who sought justice were confronted with a legal system that ignores, denies and a times condones violence against child victims while protecting the perpetrators. At times, cases reported to the police are not recorded in the occurrence book or included in SVAC statistics (Were et al., 2014). Antoinette (2010) notes that 42% of the sexually abused children in South Africa indicated that they had had negative experiences in their relationship with their father, as a result of him being the perpetrator. Similarly, Omondi (2014) noted that 60% of sexually abused children in Kenya experienced increased conflict and violence within the family as a result of having to testify in court in incest cases.

In 2010, the Kenya government documented that 32% of females and 18% of males had experienced SVAC in their childhood, 15.3% of whom were committed by family members (National Survey on Violence against Children, 2010). Ndungu et al., (2014) showed that in Kiambu County majority 77% of the perpetrators of SVAC were neighbours while 9% were the

child's parent. The study further showed that 21% of the parents opted to settle the case out of court because they lacked sufficient funds to enable them to pursue the cases further.

In Kibera informal settlements in Nairobi, Waithaka et al., (2013) found that fear of family disintegration was ranked highest (66%) as the reason for failure to report the SVAC cases and about 38% of the residents failed to report cases because they lacked faith in the law enforcement structures.

Were et al., (2014) reports that 80% of the cases of SVAC committed by immediate family members were not reported to the law enforcement agencies. Slightly over half (55%) of the cases that were reported to law enforcement agencies did not go to court due to lack of sufficient evidence. In contrast, Kanyanya et al., (2007) found out that the majority (61%) of sex convicts at Kamiti prison had SVAC related convictions. Other SVAC related offences were sodomy at four percent and incest at three percent.

2.5 SVAC and Post Traumatic Stress Disorder (PTSD)

Children exposed to SVAC often meet the criteria of Post-Traumatic Stress Disorder and other psychiatric disorders (Neugebauer et al., 2009; Trickett al., 2011; D Adrea et al., 2012). Similarly, Evans et al., (2008); Payne and Edwards (2009) noted that in studies done on SVAC indicated a relationship between SVAC and trauma symptoms of PTSD in children. PTSD refers to "certain enduring psychological symptoms that occurred in reaction to highly distressing, physically disruptive events" (Seides, 2010; Danielson et al., 2010; Cloitre et al., 2010; Stein et al., 2014).

Studies show that males are more exposed to events that can be potentially traumatic such as accidents, assault or disaster than females particularly adolescents and young adults (Tolin & Foa, 2006; Norris et al., 2007) however females experienced more child sexual abuse than males with the females-male ratio in the prevalence of PTSD approximately being at 3:1 and with females reporting high levels of re-experiencing, avoidance and arousal (Ditleven & Elklit, 2010).

O' Leary & Gould (2009) cited numbing of responsiveness as an instinctive baseline function among young children subjected to SVAC. Sexually abused children, in particular, have been known to react as if the approach of a stranger were precipitating a repeat attack (O'Leary & Gould, 2009). They further emphasizes that re-experiencing can also take a somatic form in the guise of physical pain or somatoform conditions such as genital pain, irritation, infection or sexual apparatus malfunction in survivors of sexual molestation. Similarly, Harder et al., (2010); Ford et al.,(2010) reports that PTSD among children is unique from the adult disorder in that children tend to re-experience the event through play or drawing and exhibit nightmares involving monsters rather than the traumatic event.

Canton-Cortes & Canton (2010) using severity of symptom of PTSD scale demonstrated that children in Australia with histories of experiencing sexual violence reported significantly higher levels of trauma-related symptomatology. Elklit & Christiansen, (2010) in their study in Denmark using Harvard Trauma Questionnaire-Part IV (HTQ) among 148 female rape victims comprising of 12-90 years reported that 94% met the criteria of re-experiencing, 99% met the

criteria of arousal type and 90% met the criteria of avoidance. PTSD prevalence was 80% in the study.

In another study by Atwoli et al., (2014) using child PTSD checklist among orphaned and separated adolescents aged 10-18 years in Uasin Gishu County in Kenya, Sexual abuse was prevalent in households (15.0%) more than in Children's Charitable Institutions (11.5%) and the prevalence of PTSD was highest among street youth at 28.8%.

Ndetei et al., (2007) in a study on traumatic experiences among secondary school students in Nairobi using child PTSD checklist, found that 85.3% of students had full and partial symptoms of PTSD and 33% had experienced sexual abuse. In another study among 447 Kenyan secondary school students in boarding schools using a list of potentially traumatic events list and the Harvard Trauma Questionnaire part IV (HTQ), Karsberg et al., (2012) found that 88% of the adolescents had been exposed to potentially traumatizing events directly with 20% reported having been exposed to SVAC and 34% of the adolescents met the criteria for PTSD.

Syengo et al., (2008) in their study using the UCLA PTSD index for children and adolescents found that the prevalence of PTSD among 61 sexually abused children was 45% and the prevalence of psychiatric morbidity was 69%. Ombok et al., (2013) in her study among 149 sexually abused children using the UCLA PTSD index for children and adolescents found a prevalence of 50%. In her study, PTSD was associated with the degree of physical or verbal abuse during SVAC, injuries during the assault and parent-child relationships.

Children suffering from PTSD are found to have lower rates of improvement when living in a home with high levels of conflict and where interpersonal violence is present (Carr, 2004). When PTSD in male victims of SVAC is left untreated, it can lead to serious emotional and behavioral problems, including more incidents of criminal activity and violence later in life (Forouzan & Van Gijseghem, 2005; Jewkes et al., 2013; Fulu et al., 2013).

Not all children who were sexually abused have poor psychological outcomes (Wright et al., 2005; Draucker et al., 2011). Factors, such as spirituality, family and peer support, attachment style, hardiness or resiliency, as well as some coping strategies impact on the degree of recovery from Sexual Violence Against Children (Cluver et al., 2009; Ullman et al., 2010; Maniglio, 2013).

Meyerson et al., (2002) in her study among 131 adolescents who had experienced sexual violence noted that family conflict and lack of cohesion was a risk factor for developing psychological distress and depression. Cluver et al., (2009) compared children in South Africa with low perceived social support, with those with high perceived social support. Those with high perceived social support demonstrated significantly lower levels of PTSD symptoms after both low and high levels of trauma exposure.

Other causes of PTSD in Children

In Northern Uganda, it was found that despite high levels of exposure to trauma, children did not readily express their distress verbally due to their inability to translate their emotions into words

(Akello et l., 2010). Morgos et al., (2008) found that in the Darfur region (Sudan), while 75% of the children met symptom criteria for PTSD, only 20% endorsed significant grief symptoms. The large proportion (80%) who did not demonstrate significant grief symptoms may be attributed to numbing and avoidance as a separate cluster in PTSD but demonstrating deeper psychological injury to this population (Asmundson et al., 2005).

Mandrup & Elkilit (2014) in their study in Uganda among 408 students using the Harvard Trauma Questionnaire found that the prevalence of PTSD was 37.7% and 28.2% reached a subclinical level with more girls' experiencing PTSD than boys. Crombach et al., (2014) in their study in Burundi using the University of California at Los Angeles PTSD Reaction Index (UCLA PTSD Index) for children and adolescents among street children in a children's home in Bujumbura, found that PTSD was common among the former street children and impeded their progress in school. They noted among the street children that the degree of PTSD severity had a negative impact on performance in school over the years.

In India Hmmod (2011) in a study among secondary school students in Baquba using a semi structured interview based on (DSM IV) criteria, found that the rate of life time prevalence of PTSD was 27.4% and higher among females than males and also higher among students from low socio economic status.

The 5-7 year follow-up study of adolescents who survived the shipwreck of Jupiter in 1988 found that 15% still met criteria for PTSD (Yule et al., 2000). Another follow-up study found that 33 years after a landslide in Aberfan, 29% of the children still met the criteria for PTSD

(Dyregrov et al., 2006). Similarly, Pham et al., (2004) in a household study in Rwanda, eight years after the civil war, found a rate of 24.8% prevalence of PTSD.

In a study by Jenkins et al., (2015) in Nyanza in Kenya using a trauma screening questionnaire among rural household population, 46% of the population consisted of children between 0-14 years, 49% consisted of young adults and adults between 15-64 years and 5% consisted of old age adults of 65 years and above, the prevalence of PTSD was 10.6% and the conditional probability of PTSD was 26%.

Harder et al., (2012) found that impoverished youth 6-18 years living in Kibera in Kenya using the UCLA PTSD Reaction index, six months after being exposed to the 2007 post-election violence, 21% were diagnosable with PTSD in addition, youth who had experienced many traumatic events developed PTSD compared to youth who had experienced one traumatic event. Mbwayo (2012) in her study in Kenya using the UCLA PTSD index found that PTSD prevalence was 26.9% among school going children and higher in females than in males.

Kingori et al, (2014) in their study noted a strong positive correlation value of 0.041 between traumatic experience and the level of PTSD severity among children exposed to 2007/2008 post-election violence in Nakuru in Kenya. In her study children who reported a higher number of traumatic experiences scored high on PTSD. Seedat et al., (2004) compared rates of trauma exposure and PTSD symptoms among male and female adolescents in Kenya and South Africa using the child PTSD checklist. Findings showed a similar rate of exposure to severe trauma; more than 80% in both contexts, but the South African youth reported significantly higher levels

of PTSD. The South African adolescents 22.2% had PTSD compared to 5% of Kenyan adolescents.

2.6 SVAC and Depression

Experiencing childhood trauma and adversity, including SVAC, is a risk factor for depression, anxiety, and other psychiatric disorders, therefore multiple co morbid diagnosis in sexually abused children is a reality (Nyaga, 2009; Khasakhala et al., 2013). Merikangas et al., (2010) found high comorbidity of mental disorders among the American adolescents. Similarly Anees et al., (2007) found the prevalence of childhood and early adolescence mental disorders among children attending primary health care centres in Mosul, Iraq to be 37.4%.

SVAC contributes to negative emotion regulation (Walsh et al., 2010; Olafson, 2011). Moreover huge brain and hormonal changes occur as a result of early life, prolonged traumas which contribute to difficulties with memory and learning (Noll et al., 2009).

Teicher et al., (2010) observes that a traumatic experience such as SVAC changes the chemistry and even the structure of the brain. SVAC can have a more fundamental effect on the brain functioning, consequently the child's brain becomes damaged by the abuse bringing with it the vulnerability to depression (Mizenberg et al., 2008). In addition neurocognitive malfunctioning occurs where impairment as a result of PTSD has been found in children exposed to trauma (Schoeman et al., 2009).

Greater exposure to traumatic events, specifically SVAC, increases rates of depression (Trickett et al., 2011; McPherson et al., 2012). It is accompanied by very low levels of self-esteem, poor body image, guilt, social withdrawal and little or no displays of emotion (Alaggia & Millington, 2008). It is during these times that problems such as suicidal tendencies, poor eating patterns and disturbed sleep commonly occurs (Devries et al., 2011).

A US study found out that approximately 54% of cases of depression and 58% of suicide attempts among women were connected to adverse childhood experiences (Brown et al., 2007). Similarly in Spain, Monteagudo et al., (2012) in a study of high school students aged between 14-16 years, found a high prevalence of negative mood among female students who had experienced SVAC. Swanston et al., (2003) in study among sexually abused children in Australia found out that nine years after SVAC incidence, sexually abused children had depression more than non-abused children ($p=0.001$).

Antoinette (2010), reported that as many as 84% of the sample study group in South Africa indicated that they had suffered from depression at some point in time as a result of SVAC. Gelaye et al., (2009) demonstrated that Students in Ethiopia who reported experiences of any sexual violence were nearly twice as likely to be classified as having moderate depression as compared with non-abused students. Similarly, Sumner et al., (2016) in their study among 1456 boys in Kenya aged 13-24 years who had experienced sexual violence, 90% had depressive symptoms and the range of experiencing sexual violence before age 18 year was 14.8%.

Syengo et al., (2008) using the Child Depression Inventory among 61 sexually abused children found that the prevalence of depression was 46%. Mugambi & Gitonga (2015) in her study among adolescents in Kenya aged between 13-18 years found that 80% of the adolescents who had experienced a traumatic event had varying degrees of depressive mood with 89.2% experiencing difficulties in academic performance. In their study sexual harassment was among the common traumatic events.

Gurian (2012) noted that teenage girls react differently than boys to stressors in life such as SVAC and it accounts in part for their higher levels of depression in girls. Jung (2013) noted that depression in teenage which could be caused by SVAC could affect their well-being and may result in problems which include violence and suicide both in school and at home.

Wei et al., (2011) reporting on studies on Canadian school going children and adolescents noted that depressive symptoms are related to learning difficulties and dropping out of school. Depressed students lose interest in activities, disengagement from peers, school refusal and absence from school has the potential to adversely impact on their academic achievement (Bhatia & Bhatia, 2007).

Prevalence of depression in children

Ndetei et al., (2009) found that the prevalence rate for depression in Kenya is high and the detection rates were low among 408 children attending general health facilities. In their study,

the prevalence rate of depression was at 41.3% using the Child Depression Inventory (CDI) score that suggested mild to moderate depression.

Khasakhala et al., (2012) using the Child Depression Inventory found that clinically significant depressive symptoms were present at 26.4% among students in public schools in Nairobi province. In another study Ndetei et al., (2008) found clinical diagnostic scores for depression using Ndetei-Othieno-Kathuku (NOK) scale for depression and anxiety, a culture sensitive instrument for depression and anxiety were recorded in 43.7% of Kenyan children and adolescents in public secondary schools. In their study 49.3% had positive score for moderate to severe anxiety with or without depression.

Harder et al., (2014) in their study using the Youth Self Report (YSR) instrumented noted Kenyan girls to have significantly higher internalizing (anxious depressed & withdrawn depressed somatic problem scores) than boys. Mbwayo (2012) in her study using the Strength and Difficulty Questionnaire (SDQ) found that the overall prevalence of emotional problems in her study was 10.4% among students in public schools.

2.7 SVAC and Self Esteem

Guelzow et al., (2003) and Lalor et al., (2010) found that children who experienced incest suffered most from low levels of self-esteem because the abuse was perpetrated by people the children had loved and trusted. Findings on the sequelae of serial or repeated SVAC demonstrated that these types of victimization placed children and adolescents at risk of chronic and severe coexisting problems with emotion regulation, attention and cognition, dissociation,

interpersonal relationships, and low self-esteem (Briere & Spinazzola, 2009; Ford & Courtois, 2009).

Oslen et al., (2008) and Jonas et al., (2011) found that sexually abused children made assumptions about themselves. Also cognitive alterations often occurred due to SVAC and continued on into adolescence and adulthood (Ayoub et al., 2006; Nolin & Ethier, 2007).

Children who experience stigma from abuse develop both guilt and shame (Gibb & Abela, 2008; Alaggia & Millington, 2008). Some studies have investigated negative self-esteem as a possible outcome of SVAC (Turner et al., 2010, 2006; ANPPCAN, 2014). For instance, SVAC could trigger difficulties such as emotional distress, lack of confidence and low self-esteem (Sperlich & Seng, 2008).

A study was conducted by Wondie et al., (2011) among 318 child sexual abuse survivors in Ethiopia, using the Rosenberg self-esteem scale, the findings of the study showed that abused children had a lower degree of self-worth compared to non-abused children. Another study found that sexually abused children could also display inappropriate emotional responses (Lewis et al., 2007). Also Burack et al., (2006) found that maltreated children had lower self-worth and depression than their peers, which could lead to self-harm, risk taking behavior and poor performance in school. Similarly, Valentino et al., (2008) found that abused children were more likely to recall false-negative information about themselves. Besides, Daigneault et al., (2006)

reported that low self-esteem among maltreated children is a risk factor for adolescent psychopathology.

Tebbutt et al., (1997) completed a 5-year follow-up assessment among children in which the results showed that sexually abused children were more disturbed and had low self-esteem than their non-abused peers. A 9-year follow-up study by Swanston et al., (2003) showed that the sexually abused children continued to have lower levels of self-esteem compared to the control group. Kim & Cicchetti (2006) found that maltreated children experienced low self-esteem than non-maltreated children.

In their study in Burkina Faso, West Africa among 360 children, Ismayilova et al., (2016) found that children who had not been exposed to violence demonstrated significantly higher self-esteem ($b=0.92$, $SE=0.45$,$p<0.05$ and lower symptoms of trauma ($b= -3.90$,$SE=1.52$, $P<0.05$). Another study among girls aged 13- 16 years in Finland by Wiens et al., (2014) found that the girls considered good health to mean both physical health and having a good self-esteem. Additionally, good health included doing well in school, feeling good and being carefree as a whole led to self-realization (Wiens et al., 2014).

Other causes of low self-esteem in Children

Kanus (2014) in her study using the Rosenberg self-esteem scale noted that students in Nandi County in Kenya who reported that their parents abused alcohol had significantly lower level of self-esteem than those who reported that their parents did not abuse alcohol. Kanus (2013)

demonstrated that girls in Nandi County reported higher mean ratings of the direct effects such as low self-esteem of their parental alcohol abuse than boys. She concluded that boys had a higher self-esteem than the girls in relation to their parent's alcohol abuse.

Munanu & Kobia (2016) in their study among 480 secondary school students using the Rosenberg self-esteem scale compared self-esteem among the student's school type and students' self-esteem. The study found a relationship between school type and students' self-esteem ($_x^2$ (6) =456.56, p=.00).

Kinga et al., (2014) in their study among 360 high school students in Nakuru using a structured questionnaire consisting of self- esteem test, found out that there was no statistical significance in levels of self-esteem among students from single parent and dual parent families at (p value> 0.05). This suggested that self-esteem was not dependent on type of parenthood but on other factors such as parent child relationship or traumatic events. Awori et al., (2010) in their study among girls with hearing impairment in Kenya using Rosenberg self- esteem scale and school academic scores found a positive high esteem among the girls but low academic achievement.

2.8 SVAC and School Performance

Studies show that poor academic performance is common amongst children who have been sexually abused (Fry et al., 2016). When a child is being abused, his or her education is disrupted and it has a profound impact on the ability of the child to concentrate at school and that

preventing violence against children may improve educational outcomes (Devries, 2016; Sherr et al., 2016).

Children with mental health problems are more likely to miss more school compared to those who are well, (Wherry & Marrs, 2008; Kearney, 2007). Similarly Ndetei et al., (2015b) notes that the prevalence of mental disorders among Kenyan school children was at 37.7% which if not detected early could interfere with children's psychological, social and education development.

Hurwtz & Weston (2010) in their study noted that untreated depression had a significant and harmful impact on children, with strong evidence that academic learning was impeded significantly or prohibited entirely when youth suffer from mental health concerns such as depression and PTSD. Following children who had behaviour problems at school entry in East London and their achievement in high school at age 17, Rothon et al.,(2009) found that the children with mental health problems had lower academic achievement compared to those who had no disorder.

Voisin & Elsaesser (2013) indicated that in the US, the youth exposed to repeated community and family violence reported less positive school engagement and high psychological symptoms such as PTSD. Voisin et al., (2011) showed that adolescents in the US exposed to community violence and trauma, were vulnerable to a cascade of events including psychological symptoms and decreased connectedness to school. He concluded that community violence and trauma ultimately led to overall poor academic achievement.

In another study among Gambian youth, O' Donnell et al.,(2011) found that violent victimization significantly predicted post-traumatic stress symptoms and positive school climate moderated the relationship. Holt et al., (2007) indicated that youth in the US with multiple victimization and SVAC experiences emerged as the group with the most significant psychological and academic problems.

Nansasi (2010) in her Ugandan study demonstrated that the majority (80%) of the sexually abused children either dropped out of school or performed poorly in academics. Salami (2008) in his study on psychopathology and academic performance among Nigerian school adolescents, found that high school students with high psychopathology had poor academic performance.

Weaknesses in the care and support of the sexually abused children were exposed by Oswago (2014) in Kenya in which a paltry 32% received psychosocial support while 68% defaulted due to the absence of guidelines. Like Nansasi in Uganda, Oswago concluded that SVAC had impacted poorly on the children's academic performance.

Omondi (2014) demonstrated that 80% of the reported SVAC cases among Kenyan children experienced detrimental effects of the court process to their education. Many children reported a drop in their academic performance. She concluded that this is attributed to the stress and psychological trauma that occupies their mind before, during and after the adversarial trial.

2.9 Theoretical perspectives

2.9.1 Freud theory

This study was guided by Freud and Erick Erickson Blooms and Piaget theoretical perspectives. Freud (1905) proposed that psychological development in childhood takes place in a series of fixed psychosexual stages namely oral, anal, phallic,latency and genital. He believed a lot of problems were the result of experiences early in life such as sexual abuse.

2.9.2 Erik Erikson theory

Erik Erikson (1950) proposed eight stages in which a healthy developing individual should pass through from infancy to late adulthood. These stages include; autonomy versus shame, initiative versus guilt, industry versus inferiority, identity versus identity confusion, intimacy versus isolation and generativity versus stagnation. During each stage, a person experiences psychosocial crisis wich could have a positive or negative outcome for personality development hence sexually abused children may be socially and psychologically affected by the abuse.

2.9.3 Psychobiological theory

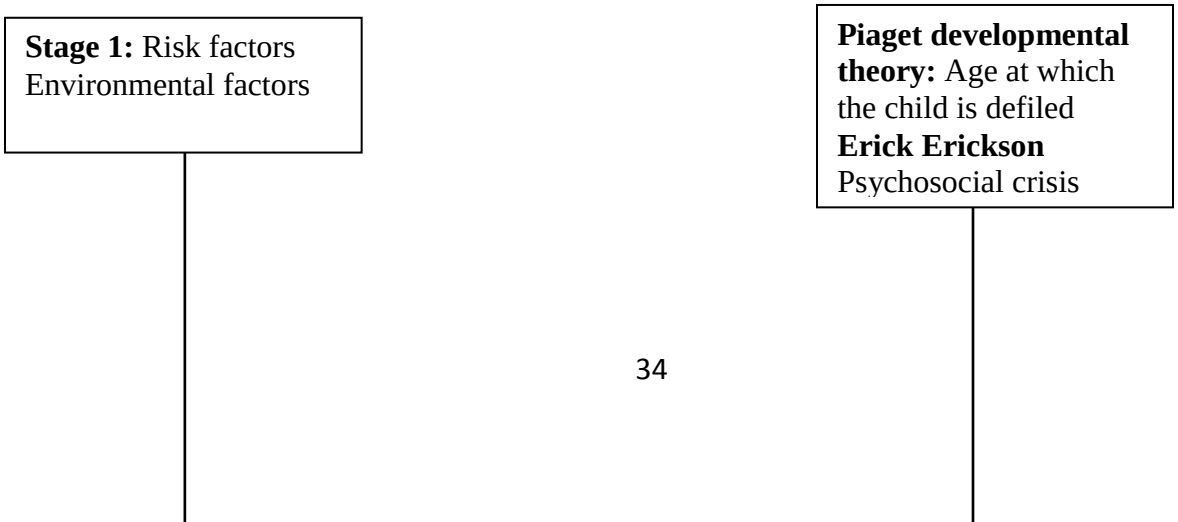
According to Bloom (1999) in her psychobiological theory asserted that patterned and predictable responses are present in our organs, including the brain. As such, children who experience sexual abuse may suffer from damage to all of their developmental systems, including their brains.

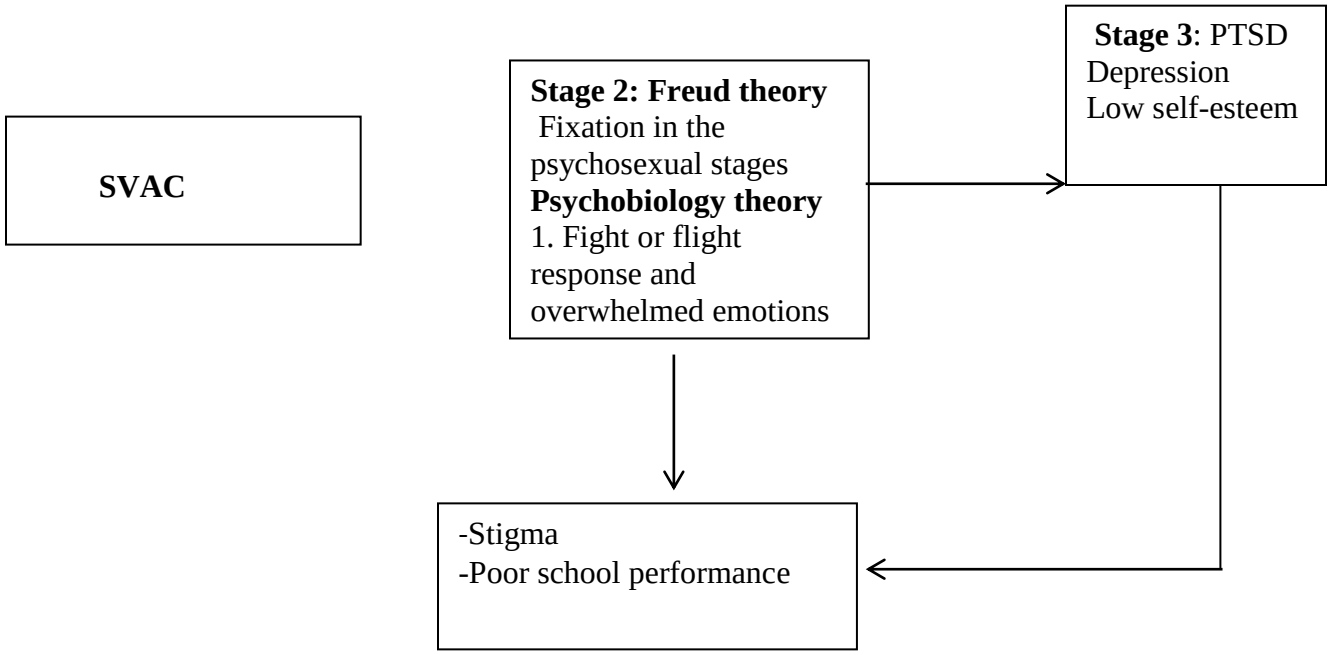
2.9.4 Piaget's developmental theory

Piaget's emphasized three stages of childhood moral development (Piaget, 1965): preoperational (preschool) (ages 0–6), concrete operational (7–13), and formal operational (adolescence) (14–19). While, preschoolers may not recognize that abuse, for example, sexual abuse is morally reprehensible, at concrete operational stage it may cause disruptions to adjustments in school and the learning process. Also, adolescents may consider their moral culpability to the effect that informed consent was not sought. Accordingly, abuse will be most harmful if it occurs in the concrete operational period.

There are varied risk factors associated with SVAC. Depression, PTSD, low self-esteem and poor performance in school are some of the outcomes associated with SVAC. The theoretical framework in this study is drawn from a combination of Freud theory and Erik Erikson theory as illustrated in figure 1 below. This framework is built on a theoretical framework whereby children who are sexually abused can be affected psychologically and socially and this depends on the age at which the SVAC has happened. It also depends on how a child conceptualizes the abuse.

Figure 1: Conceptual framework





Stage 1	*from the theoretical framework SVAC could have many social risk factors including environmental factors.*
Stage 2	*Psychosexual stages and psychosocial crisis after abuse*
Stage 3	*there are psychosocial outcomes associated with SVAC: depression, PTSD, self-esteem and school performance could be disrupted.*

(Source:Mutavi, 2017)

2.11 Justification of the study

WHO (1948) defines health as complete physical, social, emotional and psychological well-being and not merely the absence of illness, this study will inform mental health workers and scientists on the psychosocial outcomes associated with SVAC, identify gaps and find solutions.

In this regard, there is need to identify the psychosocial outcomes associated with SVAC in Kenya and the functioning of the sexually abused children. This study formed the basis for further study in the area specifically in coming up with an integrated screening instrument that screens psychosocial outcomes of Sexual Violence Against Children.

Secondly most studies done hitherto do not specifically address the issue of follow up on the SVAC cases after the treatment procedures have been given, this study focused on the follow up on the sexually abused children for a period of one year to ascertain the psychological and social functioning of the children. From available literature children who have been defiled undergo numerous psychosocial problems including psychiatric morbidity and mortality. This affects their disability adjusted years and years of life loss (WHO, 2004). This study formed the basis for further review of guidelines and mechanism for follow up on sexually abused children.

2.12 Research Question

Does SVAC have an effect on children's psychological and social functioning?

2.13 Study Objectives

Broad Objectives

To investigate the psychosocial outcomes associated with SVAC over one year period among children seen at Gender Based Recovery Centres of the Mental Health Department Kenyatta National Hospital and The Nairobi Women's Hospital.

Specific objectives

1. To determine the socio-demographic characteristics of the sexually abused children and their parents/guardian.
2. To determine the incidence of post-traumatic stress disorders among sexually abused children.
3. To determine the incidence of depression among sexually abused children.
4. To determine the effects of SVAC on children's self-esteem.
5. To determine the effects of SVAC on academic performance in school.
6. To explore the subjective experiences of the parents of the sexually abused children

2.14 Hypothesis

SVAC is significantly associated with impairments in psychological and social functioning of children attending Gender Based Recovery Centres of the Mental Health Department Kenyatta National Hospital and The Nairobi Women's Hospital.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Introduction

This was a 12-month longitudinal study that aimed at investigating psychosocial outcomes associated with SVAC at two Gender-Based Violence Recovery Centres of excellence (Kenyatta National and Nairobi Women Hospitals) in Kenya. This chapter describes and presents the approach that was used in the study. It describes the details of the study design and process, population sample and sample size, inclusion and exclusion criteria, data collection instruments which were used to achieve the study objective, data management and analysis. It also discusses ethical consideration including privacy, confidentiality and beneficence for the benefit of the study participants.

3.2 Study Design

This was a longitudinal mixed (Quantitative and Qualitative) design data collected over a period of one (12 months) year. Being longitudinal study design, it was an investigation of psychosocial outcomes among the sexually abused children population, which was collected at three follow-up intervals of 4 months. It measured the incidence of psychosocial impairments and the change in outcomes at the individual level. The sexually abused children were assessed one month after the SVAC occurrence and they were followed up after every four months for a period of one year using the same instruments to assess for the social and psychological functioning of the children.

3.3 Study sites

The study was conducted at the Gender-Based Violence Recovery Centres (GBVRCs) of the Mental Health Department, KNH and The Nairobi Women's Hospital (NWH). These are the only two centres of excellence in GBVR in Nairobi, Kenya.

3.3.1 Nairobi Women's Hospital

The Nairobi Women's Hospital has four branches in Nairobi namely; Kitengela, Rongai, Adams Acarde and Hurligham with the main offices being at Adams. The main office is manned by a manager and five counselors. The branches are manned by two counselors including social work interns. It has another branch in Nakuru town. The Nairobi Women's Hospital's (NWH) Gender-Based Violence Recovery Centre (GBVRC) is a Gender-Violence dedicated private hospital which specializes in obstetrics and gynecological services and seeks to provide holistic care to women and their families. The GBVRC's main purpose is to bring back meaning to Gender-Based Violence survivors' lives and their families. The hospital provides free and comprehensive medical treatment and psychosocial support to survivors of gender based violence. On a daily basis, the hospital serves an average of 10 children with gender based related violence.

3.3.2 Kenyatta National Hospital (KNH)

The hospital was built during the colonial days (1901) with a purpose of rendering services to indigenous people (Africans & Indians). It was named King George Hospital Nairobi in 1952. It is currently a National, Teaching and Referral Hospital in Kenya, also serving the East and Central Africa regions. The hospital has a bed capacity of 1800 and 40,000 patients are seen in

the outpatient per month. It is manned by 2,402 medical personnel (1002 medical practitioners/ clinicians and 1400 nurses). Kenyatta National Hospital plays a major role in healthcare delivery system in the country. The hospital has efficient and effective referral system and receives referral cases for specialized healthcare from other institutions within and outside the country. The KNH is the hospital of choice for the majority of the residents in the capital city, Nairobi and the surrounding environs due to its affordability and quality of specialized care and all sexual and gender based violence services are free. The institution has a (MOU) Memorandum of Understanding with the College of Health Sciences of the University of Nairobi and serves the Kenya Medical Training College, the Ministry of Health and many other institutions of higher learning in Kenya. This is in addition to facilitating research either directly and/or through other cooperating health institutions. The hospital also participates in national health policy formulation.

The hospital has a youth centre which was started in 1990 as a project funded by pathfinder International. It was handed over to Kenyatta National Hospital in 2000. The main objective of the Youth centre was to provide the youth with preventive, promotional and curative services in order to reduce morbidity and mortality associated with high risk behaviors.

The KNH Gender-Based Violence Recovery Centre at the Mental Health Department provides comprehensive services to gender-based violence survivors. The centre was built and launched in 2008. An average of 6 sexually abused children pass through the centre every day to access dedicated and comprehensive services. The GBVRC is a one stop patient management complex.

This includes provision of emergency medical care, collection and preservation of forensic evidence, Legal Aid, medical intervention, creation of awareness about GBV, trauma counseling, outreach programmes and establishment of support groups for survivors of GBV.

3.4 Study population

The sampling frame is the population from which the sample population is drawn. In this case, the participants in this study consisted of sexually abused children aged 6½-17 years attending GBVRC of the Mental Health Department, KNH and The Nairobi Women's Hospital. A total of 205 sexually abused children and their parents/legal guardian were sampled. For qualitative data a selected number of the parents/legal guardian were interviewed.

3.5 Sample size Calculation

To determine the sample size required to estimate the true incidence rate within a relative precision of 15% with 95% confidence level a minimum of 171 sexually abused children needed to be followed up. The following formula was used to compute the sample size (Lemeshow et al, 1990).

$$n = [z_{1-\alpha/2}/\varepsilon]^2$$

Using the above formula with ε= 0.15 and z = 1.96 it follows that

n= (1.96/0.15)2

n=170.74

n=171

To cater for attrition rate which was assumed to be 20% the study followed up a minimum of sample size of 205 children. Purposive non probability sampling method was used to obtain the sample size.

3.6 Inclusion and exclusion criteria

3.6.1 Inclusion Criteria

Those who were recruited in the study were sexually abused children aged 6½-17 years and their parents/legal guardians. The criteria for recruitment into the study were that they must have registered at the KNH and NWH Gender-Based Violence Recovery Centres. The study included those who were able to understand English or Kiswahili and use of an interpreter for those who did not understand English or Kiswahili and had consented to the study and follow up. For the children below 17 years who assented to participate, the parent/legal guardians were asked to provide informed consent before participating in the study. The study also included children who were 6½ years since by the time of follow up they had attained 7 years.

3.6.2 Exclusion Criteria

The study excluded those children under 6½ years. Children above 7 years were in the pre-operational cognitive stage and were able to explain and express their feelings, remember past events of which children below 7 years may not have been able to do. The study excluded those children with severe learning disabilities as well as those whose parents did not consent to

participate in the study and follow up. The study also excluded children who were 17 and halve years since by the end of the follow up they had attained 18 years.

3.7 Tools and instruments (appendix 3)

Psychosocial assessment was carried out using the following instruments:

1. The socio demographic questionnaire
2. Sexual abuse profile questionnaire
3. Child/ youth PTSD symptom scale
4. Child Depression Inventory/ Becks Depression Inventory
5. Pier Harris self-concept scale
6. Interview guide
7. Other methods of qualitative data collections included; observation and use of available data such as patients files and school reports

3.7.1 Socio-demographic questionnaire

Socio-demographic questionnaire was used. This was a researcher-developed instrument to capture the socio-demographic characteristics of the participants in part A of the questionnaire. It captured both socio demographic of the sexually abused children and their parents. These included age, gender, highest education level attained, occupation, area of residence, marital status, income level and birth order.

3.7.2 Child/youth PTSD symptom scale CPSS

The Child PTSD Symptom Scale (CPSS) is a self-report measure designed to assess the severity of post-traumatic stress disorder among children and adolescents, ages 8 to 18 (Foa, Johnson, Feeny, & Treadwell, 2001). The measure has a total of 24 items and includes two parts; the first has 17 items and measures the type and frequency of PTSD symptoms (mapping directly on to DSM-IV criteria), while the second has 7 items and measures the degree of functional impairment these symptoms cause. A clinical cut off score of greater or equal to 11 was established by inspecting the distribution of total scale scores for children with high and low PTSD symptoms. This yielded 95% sensitivity and 96% specificity. However, clinical experiences suggest that a cut off of 15 is more appropriate for determining PTSD. A clinical cut off of 15 was used for PTSD. To meet full PTSD, DSM-IV symptom criteria category (re-experiencing, avoidance, numbing and hyper-arousal) had to be met. Internal consistency ranged from .70 - .89 for the total and subscales symptom scores. Test-retest reliability was good to excellent (.84 for the total score, .85 for re-experiencing, .63 for avoidance and .76 for hyper-arousal). Convergent validity was high: the CPSS correlated .80 with the Child Posttraumatic Stress Reaction Index (Pynoos et al., 1987). The CPSS subscales correctly classified 94.7% of the cases. Internal consistency ranged from .70 - .89 for the total and subscales symptom scores. Test-retest reliability was good to excellent (.84 for the total score, .85 for re-experiencing, .63 for avoidance and .76 for hyper-arousal). Convergent validity was high: the CPSS correlated .80 with the Child Posttraumatic Stress Reaction Index (Pynoos et al., 1987). The CPSS subscales correctly classified 94.7% of the cases.

3.7.3 Beck Depression Inventory and Child Depression Inventory

Depression among children above 16 years of age was measured using the revised Becks Depression Inventory (BDI) and the Children's Depression Inventory (CDI) was used for children aged 16 years and below. Both are self-report questionnaires, with the CDI being a downward extension of the BDI. Higher scores denote greater unhappiness or depression. The CDI has Cronbach's alpha value of.86 for psychiatric sample and .82 for paediatric medical sample.

The child/adolescent reports on a variety of symptoms including negative mood, interpersonal problems, ineffectiveness, depressed facial affect, and negative self-esteem. Written at a first-grade reading level, each version takes 10-15 minutes to complete. The parent version includes 54 items and the youth self-report includes 27 items. Parent (CDI: P) versions give multiple dimensions to assessment. Parents view the child's behaviour at home in family situations. The CDI can be scored by hand or using a software program.

Essentially, each CDI item is assigned a numerical value from 0 to 2, with the higher values attributed to more clinically severe behaviour. The total score is the sum of all the separate item scores. Reliability and validity have been established over many years of empirical research. The CDI has demonstrated consistent correlations with various syndromes, other scales, and replicated predictive relationships (Kovacs, 2008).

3.7.4 Piers-Harris children's self-concept scale

The Piers-Harris Children's Self-Concept Scale was developed for children 8 to 18 years of age and has been reported to have high internal consistency with Cronbach alpha value, ranging from .87 to .94. It is self-report questionnaire, with higher scores indicating higher self-esteem. It is composed of 60 items covering six subscales: Physical Appearance and Attributes, Intellectual and School Status, Happiness and satisfaction, Freedom from Anxiety, Behavioral Adjustment and Popularity.

In addition, two validity scales identify biased responding and the tendency to answer randomly. Test items are simple descriptive statements, written at a second-grade reading level. Children indicate whether each item applies to them by selecting a yes or no response. This usually requires just 10 to 15 minutes. It also provides a total Score that reflects overall self-concept, plus subscale scores that permit more detailed interpretation.

The Piers-Harris Children's Self-Concept Scale is commonly used in clinical settings and for research to determine specific areas of conflict, typical coping and defense mechanisms, and appropriate intervention techniques. It is an ideal choice when you need a quick but comprehensive measure of self- esteem in children or adolescents (Piers & Herzberg, 2002).

3.8 Qualitative data collection

Quantitative and qualitative techniques were combined to triangulate findings in order that they may be mutually corroborated (Bryman, 2006). Qualitative data is non-numeric in nature, it

describes the quality or attribute unlike quantitative data which rely on accumulation of facts and their translation into numbers. Qualitative methodology enable researchers to collect richer data, greater density of information, more vivid description and clarity of meaning that cannot generally be acquired through quantitative measures. Qualitative data collection approach involved interviewing the study population. This process employed good communication and rapport-building skills, the researcher presented with a non-judgmental attitude, observed verbal and non-verbal cues during interview, asked timely questions with a view to exploring emerging issues, guided the respondents through the interview process and ensured that he/she and the study participants adapted to the situation as soon as possible to reduce tension during interview. Questions posed were open-ended and structured. More information was captured on their experiences to provide new and useful and undocumented information on SVAC. Observation was employed particularly in the early stages to help guide the study, ensure quality assurance and to provide first- hand experience to the researcher.

3.9 Qualitative narrative with parent/legal guardian

Qualitative narrative with the parent/legal guardian of the sexually abused children was done. Purposive sampling method was used to select the parent/legal guardian for the qualitative narratives. An interview guide (Appendix 3) was used to establish from the parent/legal guardian how the incidence of SVAC had affected the family, relations of the child to the family, peers and neighborhood including incidences of post-traumatic stress disorder, depression, self-esteem and school performance. A parent/legal guardian from one boy and a girl was selected from the following age groups of 7-10 years, 10-14 years and 14-17 years making a total of 6 qualitative

narratives with the parent/ legal guardian. The instrument that was used to collect qualitative data from the parent/ legal guardian was interview guide.

3.10 Training of research assistants

The process began by recruiting and training two research assistants who were counselors. The counselors were holders of bachelor's degree in counseling psychology and their main responsibility was to help in the collection of the files and tracing the parents/legal guardians of the children to be recruited in the study. These two research assistants were identified with the help of the staff at the KNH mental health department GBVRC and Nairobi Women's GBVRC. They were trained by the researcher on how to identify the files for children who had been sexually abused one month after the incidence of SVAC (Appendix 2).

3.11 Recruitment procedures

Contacts of the parents/legal guardians of the sexually abused children recruited in the study were obtained from the files one month after the SVAC incidence. The children had been put on the standard treatments provided at the GBVR centres in both hospitals. Participants whose clinical status after examination was found to be in need of treatment were attended to with liaison to the clinicians at the two GBVR centres.

During the first visit, the objective of the study was explained to the participants by the researcher. The details of ethical consideration were laid down in the letter of consent namely; consent explanation, confidentiality, personal and general benefits, risk and right not to

participate and right to withdraw anytime was explained to the participants by the researcher. On the second visit since the participants were pre-selected and were eligible to participate in the study, if the child and the parent/legal guardian voluntarily accepted to participate in the study, informed consent from the parents/legal guardian and assent from the children was sought. Once informed consent and assent were obtained the socio demographic questionnaire of both the child and the parent/legal guardian was administered. On the 3rd appointment the children were assessed by the researcher using the CPSS, CDI/BDI and Pier-Harris self-concept scale. The parents CDI were also administered. This was done on a monthly basis until all the participants were recruited.

Emphasis on the need for follow up on the children for the next one year was explained to the parent/ legal guardian. The children were then followed up after every four months to document the social and psychological functioning up to a period of one year using the same instruments; CPSS, CDI/BDI and Pier-Harris self-concept scale. Observation was also used and available data such as patients files and school reports Information on academic performance was also obtained from the school report forms.

3.12 Ethical consideration

The research process began by obtaining approval from the department of psychiatry, University of Nairobi and application of research permit from KNH Research and Ethical Committee. Clearance from both hospitals was sought as well as informed consent was obtained from all the parents/legal guardian of the children who participated in this study. Assent was also obtained

from the children. Sexually abused children are vulnerable group and therefore effort was put in place to ensure that they and their parents participated voluntarily.

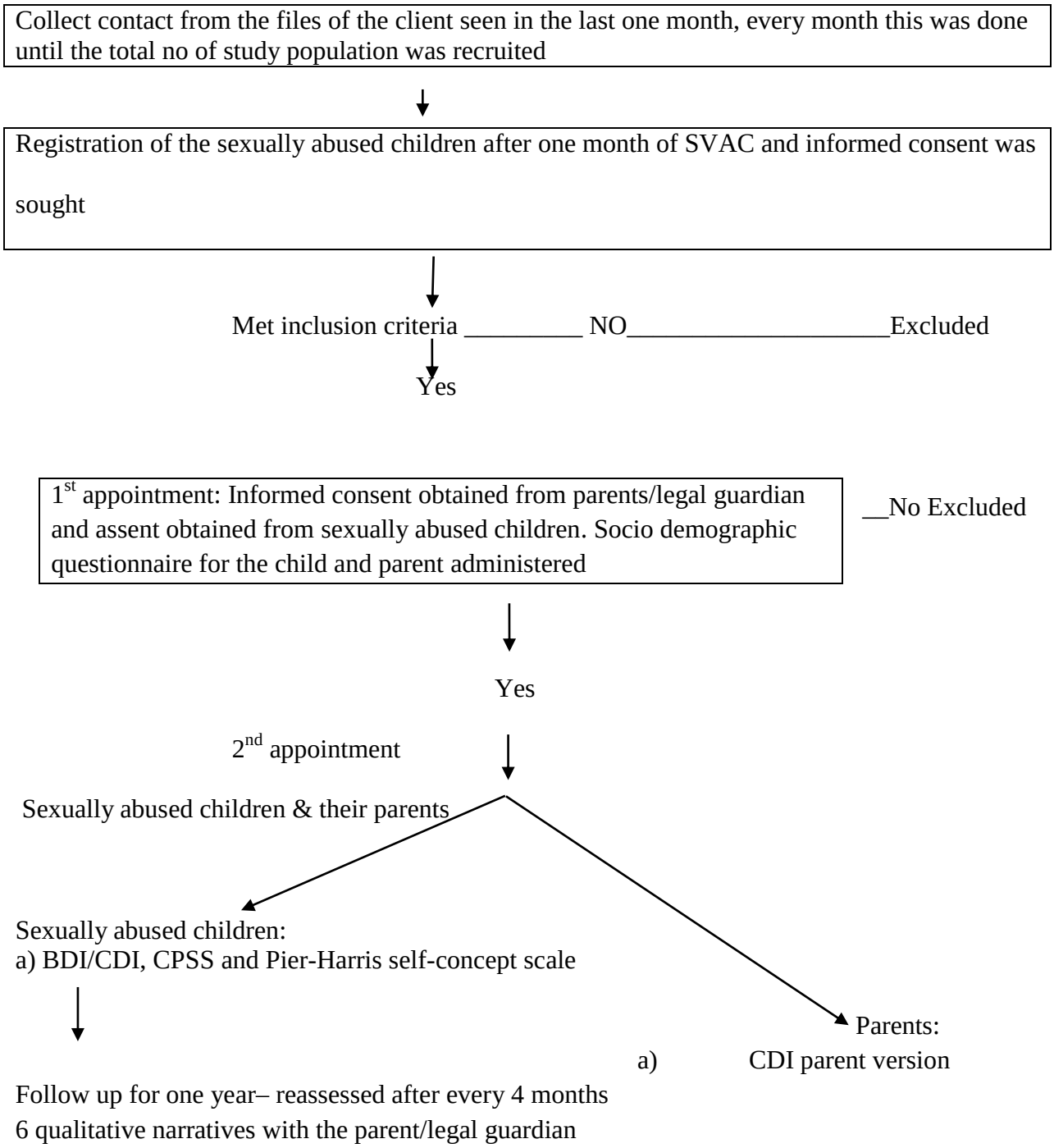
The informed consent explanation: included an explanation of the purpose of the research and the expected duration of the participants participation, a description of the procedures that were followed and the risks involved (appendix 1), namely invasion of personal and family life on questions related to psychosocial outcomes associated with SVAC.

Benefits: to the participants in the study were explained in detail. This helped in managing and improving on psychosocial development of sexually abused children and their quality of life psychologically, emotionally, socially and physically.

Privacy and confidentiality: was highly maintained throughout the study whether on a one on one basis with individual client or as a family. No identifying information appears in the thesis or subsequent journal articles. Participants were assured that the deliberations discussed during the sessions would go into the medical records and remain private and confidential. In addition they were assured that patient information can only be released on medical or legal basis if requested by a court of law.

Voluntary participation: The participants were informed that participation was on voluntary basis; refusal to participate did not attract penalty or loss of benefits to which the respondent is otherwise entitled and that the subject can discontinue participating in the study any time without penalty or loss of benefits.

Figure 2: Participants Sampling Frame and Flow during the Study (Flow Chart)



3.13 Data management

3.13.1 Data Entry for quantitative data

On receiving the data from baseline assessment, each questionnaire was secured in individual envelopes bearing the corresponding code numbers and kept in nylon/plastic bags. The overall security of the completed questionnaires laid with the researcher, to prevent data loss, damage and to enhance confidentiality of data collected. The name and the serial number were listed and saved separately from the questionnaire so that the same serial number could be used on the questionnaire with the same name for the follow ups.

Upon receiving the first, second and third follow up data, the questionnaires were serialized using similar numbers for same study ID hence following a child A from baseline data to follow up data. This enabled the comparison of sexually abused children information from baseline assessment to follow up assessment.

Data was then cleaned and kept under key and lock by the researcher before entering into the computer for analysis; this helped prevent any interference of the data collected. All data was entered into a computer system using the SPSS and analyzed using version 21.

3.13.2 Data Entry for qualitative data

3.13.2.1 Interview narrative with the mothers

Interview narratives with the parents/legal guardians generated a substantial amount of data as the selected parents/legal guardians who provided qualitative data talked about their child's incidence of SVAC. The duration of each interview was typically 15-30 minutes long and yielded between 700-1000 words of transcript each. The researcher personally transcribed the audio data providing the ideal opportunity to commence the process of analysis, as the files needed to be frequently replayed in the transcription process. The more the researcher listened to the tapes and read the personal comments the more the researcher become familiar with each text and begun to construct categories and recognized common patterns. Data was entered into the Nvivo 12 software and was thematically united and the researcher adapted to iterative approach to ascertain similarities and differences in the form of excerpts and expressions.

3.13.3 Data Analysis

Data analysis included the following:

1. Data analysis was conducted using both descriptive and inferential statistics. The descriptive statistics included calculation of means, median and percentages. The distribution in different categories was presented using frequency tables and graphs. Trends over time were presented using graphs.
2. The sexual assault profile for the children in the study including age at which abuse occurred, frequency and duration of abuse, perpetrators acts, relationship to the

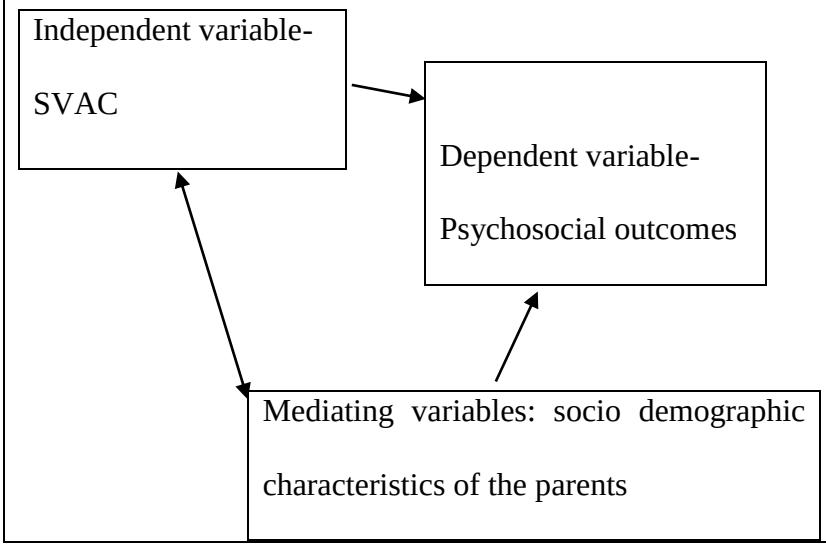
perpetrator, how long before sharing the incidence and attitude towards school after the incidence was described.

3. The academic performance of the students as recorded at the end of the term after the SVAC incidence was recorded and in this analysis, the marks were classified into: (1) below average and (2) above average.
4. A PTSD, depression and self-esteem index score was calculated for each child and a diagnosis was made on the basis of the individual score.

SPSS version 21 was used for statistical analyses. The level of statistical significance was fixed at 0.05 ($p<0.05$) with a 95% confidence level. Bivariate and multivariate logistic regression analysis was done.

Conceptual framework

Figure 3: Summary of Data Set Variables to be included in Analysis Process: Relationship between SVAC and Psychosocial Outcomes



Pretest and Quality assurance

The questionnaires were pre-tested in order to fine tune them and to estimate the amount of time it would take to administer them to the respondents. The pre-test also allowed for appropriate budgeting to ascertain the effectiveness of the questionnaires.

Table 1: Time- frame of the study July 2014-July 2015

The table 1 below indicates the time frame of the study duration of the research which began from July 2014 to July 2015.

ACTIVITY	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Proposal preparation & Presentation													
Protocol pretesting													
Ethical Committee													
Training Research assistance													
Data Collection													
Follow up 1													

Table 2: Time frame of the study August 2015 – July 2016

Table 2 below indicates the time frame of the study duration of the research which began from August 2015- to July 2016

ACTIVITY	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	
Follow up 2													
Follow up 3													
Data analysis													
Thesis writing													
Submission													

CHAPTER FOUR

4.0 RESULTS

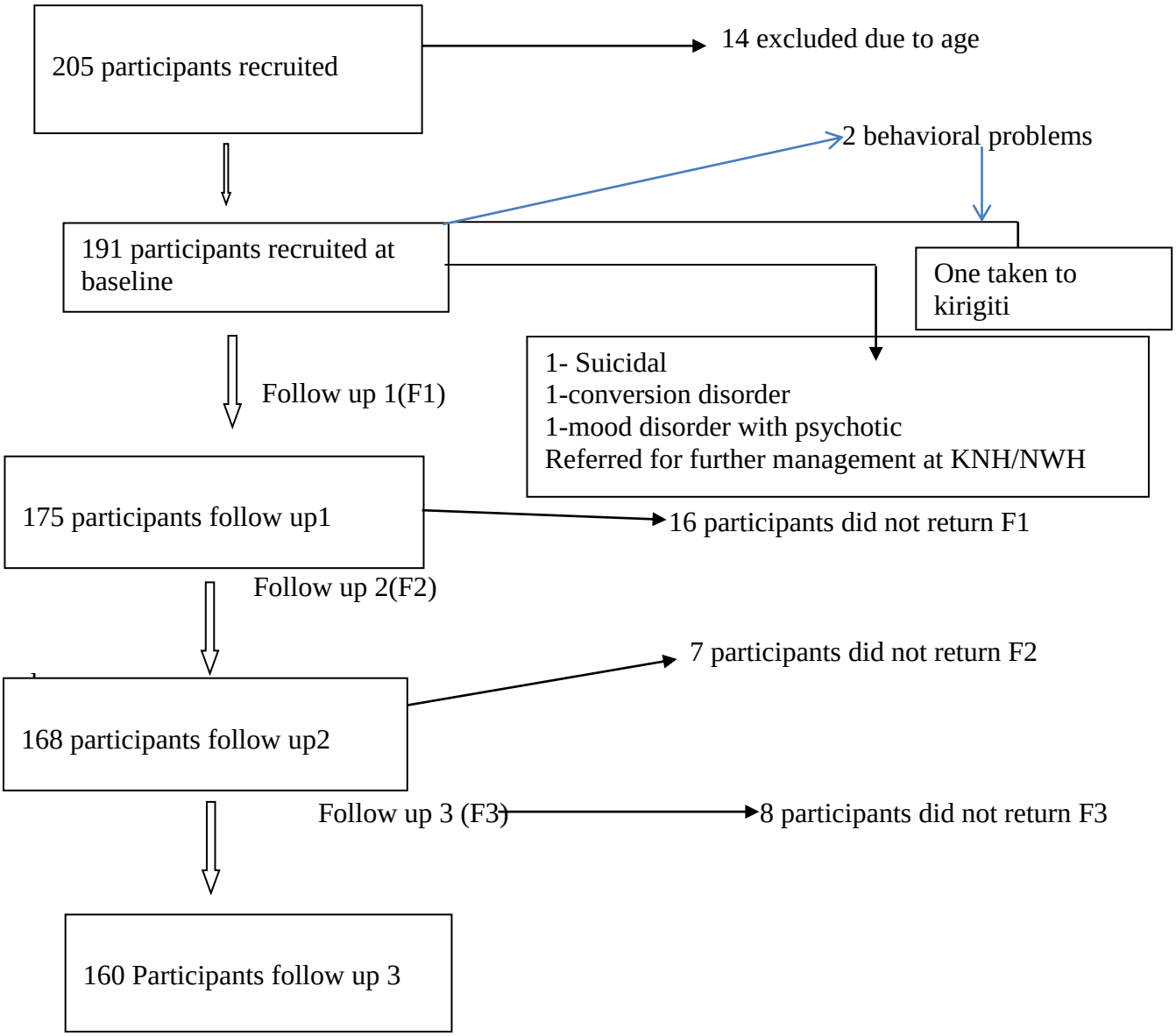
4.1 Response Rate

The study recruited 191 (93.1%) children and their parents/legal guardians) at baseline. The calculated sample size was 171 but had been increased to 205 to account for attrition. Fourteen participants had reached seventeen and half years therefore could not be included in the study because by the time of follow up they would have attain eighteen years which was beyond the study recruitment criteria. During follow up 1 a total of 175 (85.4%) participants and their parents/legal guardians participated in the study. Sixteen participants did not return for follow up 1 despite several telephone reminders. Some stated they had relocated in their rural areas.

During follow up 2 a total of 168 (81.9%) participants and their parents/legal guardians participated in the study. Seven participants and their parents/legal guardians did not return for follow up 2 despite several telephone reminders. Lastly during follow up 3 a total of 160 (78%) participants and their parents/legal guardian participated in the study. Eight participants did not return to the 3rd follow up from the previous 168 who participated in follow up 2.

Among the study participants, two had developed behavioral problems of running away from home and one of them had been taken to kirigiti approved school. One of the study participants was suicidal, another had developed conversion disorder and another had mood disorder with psychotic features. They were all referred to the counselors and psychiatrists at Kenyatta National Hospital and Nairobi Women's Hospital for further management.

Table 3: The flow chart showing the recruitment from baseline to follow up 3



4.2 Socio-demographic characteristics of the participants

Table 4: Socio-demographic characteristics of the participants

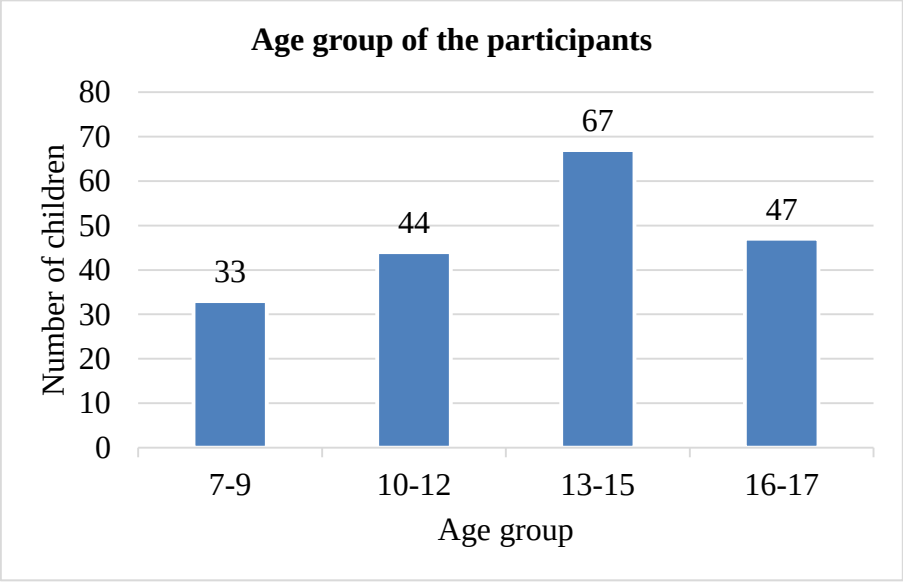
	Frequency	Percent
Attending school		
Yes	185	96.8
No	6	3.2
Total	**191**	**100**
Gender of the child		
Female	168	88
Male	23	12
Total	**191**	**100**
Education level of the children		
Primary	165	86.3
Secondary	20	10.4
Not indicated	6	3.3
Total	**191**	**100**
Have parents		
Both mother & father	144	75.4
Only mother	33	17.3
Only father	8	4.2
None	6	3.1
Total	**191**	**100**
Parents marital status		
Married	138	72.2
Separated	33	17.3
Divorced	4	2.1
Single	16	8.4
Total	**191**	**100**
Person live with		
One or both parents	161	84.3
Guardian	24	12.7
Good Samaritan	2	1.0
Not indicated	4	2.0
Total	**191**	**100**

One hundred ninety one participants (191) were recruited into the study of which 23 (12.0%) were males and 168 (88.0%) were females giving a Female: Male ratio of 7:1. Majority of the participants 144 (75.4%) had both parents, 33 (17.3%) only mother, 8 (4.2%) only father and 6 (3.1%) had no parents. Most of the parents 138 (72.2%) were married, 33 (17.3%) separated, 4 (2.1%) divorced, 16 (8.4%) Single. Over three quarters of study participants 161 (84.3%) lived with one or both parents, 24 (12.7%) with Guardians 2 (1%) with Good Samaritan, 4 (2%) did not indicate.

Table 5: Mean, median, minimum and maximum ages as well as the standard deviation of the participants

	Mean	Median	Minimum	Maximum	Standard Deviation
Age	13	12	7	17	3

Figure 4: Age of the study participants



The mean age of the study participants was 13 years, the median age was 12. The minimum age was 7 and maximum age was 17. The standard deviation was 3. Majority 67 (35.1%) were between the age of 13-15 years, 47 (24.6%) were between the age of 16-17 years, 44 (23%) were between the age of 10-12 years and 33 (17.3%) were between the age of 7-9 years.

Table 6: Birth order and siblings of the study participants

		Frequency	**Percent**
Birth Order	1	77	40.3
	2	74	38.7
	3	29	15.2
	4	8	4.2
	5	3	1.6
Total		**191**	**100**
Brothers	1	94	49.3
	2	57	29.8
	3	24	12.5
Did not indicate		16	8.4
Total		**191**	**100**
Sisters	1	68	35.4
	2	53	27.6
	3	34	17.5
	4	7	3.6
	5	2	1.4
	6	1	1
Did not indicate		26	13.5
Total		**191**	**100**

Majority of the participants 77(40.3%) are first born, 74 (38.7%) are second born, 29 (15.2%) are third born, 8 (4.2%) are fourth born while 3(1.6%) are fifth born. Most 94(49.3%) had one brother, 57(29.8%) had two brothers, 24(12.5%) had three brothers and 16(8.4%) did not indicate. Most 68(35.3%) had one sister, 53(27.6%) had two sisters, 34(17.6%) had three sisters, 7(3.6%) had four sisters, 2(1.4%) had five sisters 1(1%) had six sisters and 25(13%) did not indicate.

Table 7: Attitude of the participants regarding school after the incidence of SVAC at baseline

		Frequency	**Percent**
How did you cope with school work	Finished Homework	132	69.2
	Not Finishing Homework	53	27.7
	Not indicated	6	3.1
	Total	**191**	**100**
Attitude towards School Changed	Yes	170	89
	No	15	7.8
	Not indicated	6	3.2
	Total	**191**	**100**
Used school to escape from abuse	Yes	171	89.5
	No	14	7.4
	Not indicated	6	3.1
	Total	**191**	**100**

Most 132 (69.2%) finished homework after the SVAC incidence 53(27.7%) did not finish homework and 6(3.1%) did not indicate. Majority 170 (89%) changed their attitude towards school after the SVAC incidence, 15(7.8%) did not change their attitude towards school and 6 (3.2%) did not indicate. Majority 171 (89.5%) used school to escape from the abuse, 14(7.4%) did not use school to escape from the abuse and 6(3.1%) did not indicate.

Table 8: Socio-demographic characteristics of parents/legal guardians

	Frequency	Percent
Sex of responding parent / guardian		
Male	21	11.0
Female	170	89.0
Total	**191**	**100**
Level of education attained by mother		
Primary	96	50.3
Secondary	73	38.3
College	14	7.3
Not indicated	8	4.1
Total	**191**	**100**
Level of education attained by father		
Primary	37	19.4
Secondary	85	44.5
College	32	16.7
Not indicated	37	19.4
Total	**191**	**100**
Earnings per day of responding parent / guardian		
Less 100 shillings	58	30.4
100 shillings	71	37.2
More than 100 shillings	56	29.3
More than 200 shillings	6	3.1
Total	**191**	**100**

Majority of the parents/legal guardians 170(89%) were females and 21(11%) were males. Among the female parents/legal guardians slightly over a half 96(50.3%) had primary education 73 (38.3%) had secondary education, 14(7.3%) had attained college education and 8(4.1%) did not indicate. Among the male parents/legal guardians 37(19.4%) had primary education, 85(44.5%) had secondary education, 32(16.7%) had attained college education and 37(19.4%) did not indicate.

Table 9: Mean, median minimum and maximum ages of the parents/legal guardians as well as the standard deviation

	Mean	Median	Minimum	Maximum	Standard Deviation
Age of Parent	40	38	21	67	6

The mean age of the parents/legal guardians was 40, the median was 38. The minimum age of the parents/legal guardians was 21 and the maximum was 67 while the standard deviation was 6.

4.3 Sexual abuse profile

The sexual abuse profile is summarized in the following two tables.

Table 10: Sexual abuse profile

	Frequency	Percent
What is your relationship with the perpetrator		
Stranger	80	41.8
Acquaintance(neighbor, boyfriend, classmate)	97	50.7
Non parental care giver in position of trust	3	1.7
Biological parent	9	4.8
Non biological parent (e.g. step or foster parent)	2	1.0
Total	**191**	**100**
What acts did the perpetrator do?		
Vagina anal penetration	170	89.0
Touching the genitals	11	5.8
Non genital contact	10	5.2
Exhibitionism (removed all his clothes)	0	0
Total	**191**	**100**
What did he/she make you perform?		
Nothing	15	7.8
Touching his/her genitals	172	90.1
Oral copulation	4	2.1
Total	**191**	**100**
What was the frequency of the abusive incidence?		
Once	92	48.1
Twice	38	19.9
Three times	30	15.7
Four times	16	8.4
More than four times	15	7.9
Total	**191**	**100**

How long ago did the abuse take place		
Days	42	22.1
Weeks	5	2.1
Months	129	67.9
Years	15	7.9
Total	**191**	**100**
Who did you first tell of the sexual abuse?		
My mother	140	73.3
My father	7	3.7
My guardian	8	4.2
My friends	10	5.2
My teacher	12	6.3
None	2	1.0
Did not indicate	12	6.3
Total	**191**	**100**
Where were you taken first?		
Hospital	158	82.7
Chief's camp	3	1.6
Police station	30	15.7
Counselor	0	0
Total	**191**	**100**
After how many hours did you receive medical attention after disclosing the abuse?		
Within one hour	125	65.4
Within two hours	13	6.8
Within 12 hours	29	15.2
Within 48 hours	5	2.6
Within 72 hours	3	1.6
After 72 hours	16	8.4
Total	**191**	**100**

Slightly over a half 97(50.7%) were abused by acquaintances, 80(41.8%) by a stranger, 3 (1.7%) by a care giver, 9(4.8%) by biological parent and 2(1%) by foster parent. Majority 170(89%) of the participants experienced vaginal anal penetration, 11(5.8%) experienced touching of the genital, 10(5.2%) experienced non-genital contact.

Majority 172(90.1%) were made to touch the genitals of the perpetrator, 15(7.8%) were not made to perform any act and 4 (2.1%) were made to do oral copulation. Ninety two (48.1%) of the abuse incidence happened once, 38 (19.9%) of the abuse happened twice, 30 (15.7%) of the abuse incidence happened three times, 16 (8.4%) of the abuse incidence happened four times and lastly 15(6.7%) of the abuse incidence happened more than four times. Most 129(67.9%) the abuse had taken place over a month ago, 42(22.1%) took place over the past days, 5(2.1%) took place over a week ago and 15(7.9%) had taken place over years ago.

4.4 Effects of trauma on children

4.4.1 Incidence of PTSD using child PTSD symptom scale from June 2015 to July 2016

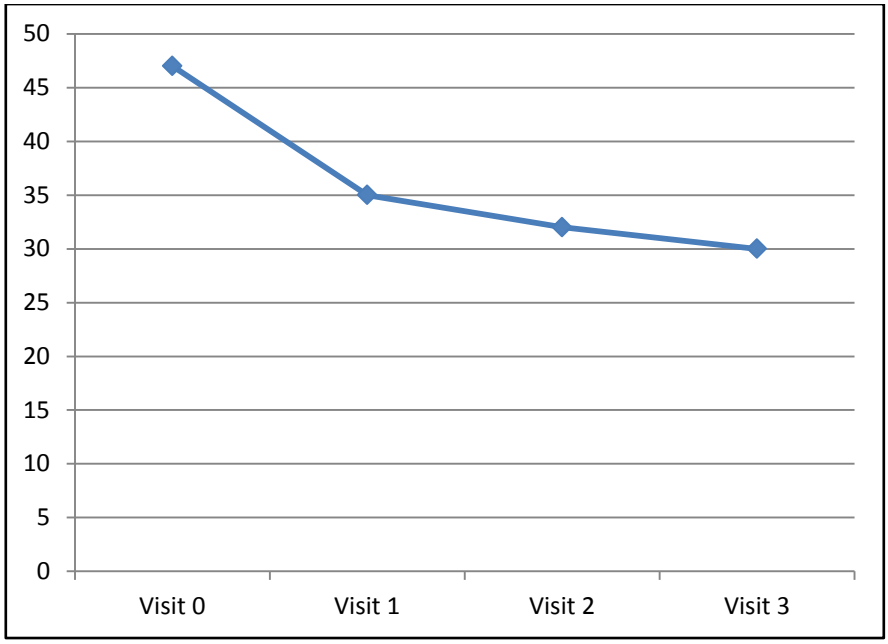
A clinical cut off of 15 was used for PTSD. To meet full PTSD, DSM-IV symptom criteria category (re-experiencing, avoidance, numbing and hyper-arousal) had to be met. Partial PTSD category comprised of participants who did not meet all the categories.

Table11: Incidence of PTSD using child PTSD symptom scale from June 2015 to July 2016

PTSD severity								
	Baseline N	**%**	**Follow up1**	**%**	**Follow up 2**	**%**	**Follow up 3**	**%**
Full PTSD	182	95.3	166	95	102	60.7	96	60
Partial PTSD	9	4.7	9	5	66	39.3	64	40
	191	**100**	**175**	**100**	**168**	**100**	**160**	**100**

At baseline 182 (95.3%) had full PTSD and 9(4.7%) had partial PTSD, At follow up 1, 166 (95%) had full PTSD and 9(5%) had partial PTSD. At follow up 2, 168(60.5%) had full PTSD and 66 (39.3%) had partial PTSD. At follow up 3, 96(60%) had full PTSD and 64(40%) had partial PTSD.

Figure 5: The mean score of PTSD over time from June 2015 to June 2016



The mean score of PTSD decreased from 47 at baseline, 35 during the first follow up, 32 during the second follow up and 30 in the third follow up.

4.4.2 Incidence of depression from June 2015 to July 2016

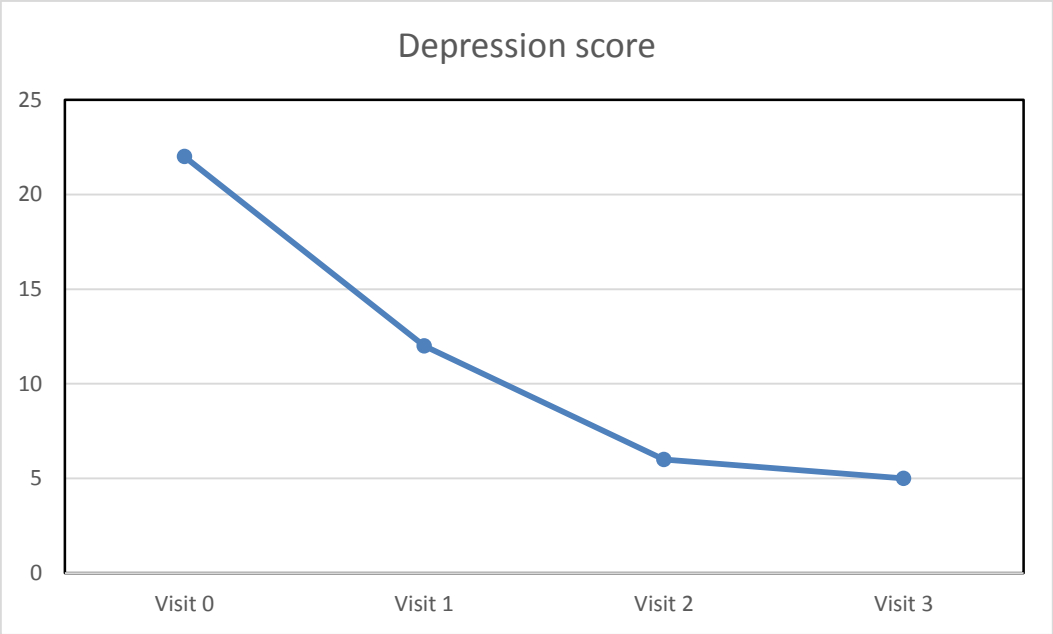
Table 12: Incidence of depression using CDI/BDI from baseline June 2015 to July 2016

		Follow- ups							
		0		1		2		3	
		N	%	N	%	N	%	n	%
Depression	Minimal	11	5.9	154	88	168	100.0	160	100.0
	Mild	47	24.6	17	9.7	0	.0	0	.0
	Moderate	109	57	4	2.3	0	.0	0	.0
	Severe	24	12.5	0	.0	0	.0	0	.0
	Total	**191**	**100**	**175**	**100**	**168**	**100**	**160**	**100**
Depression parent version	Minimal	3	1.5	8	4.5	10	5.9	15	9.3
	Mild	52	27.7	64	36.5	108	64.2	120	75
	moderate	76	39.6	72	41.3	32	19.2	12	7.5
	Severe	60	31.2	31	17.7	18	10.7	13	8.2
	Total	**191**	**100**	**175**	**100**	**168**	**100**	**160**	**100**

At baseline the prevalence of minimal depression was 11(5.9%) mild 47(24.6%) moderate 109 (57%) and severe 24(12.5%). At follow up 1 the prevalence of minimal depression was 154 (88%), mild 17(9.7%), moderate 4(2.3%), there was no severe depression among the sexually abused children in follow up 1, 2 and 3 respectively. At follow up 2 and 3, the prevalence of minimal depression was 168 (100%) and 160 (100%) respectively. There was no moderate depression in the sexually abused children in follow 2 and 3.

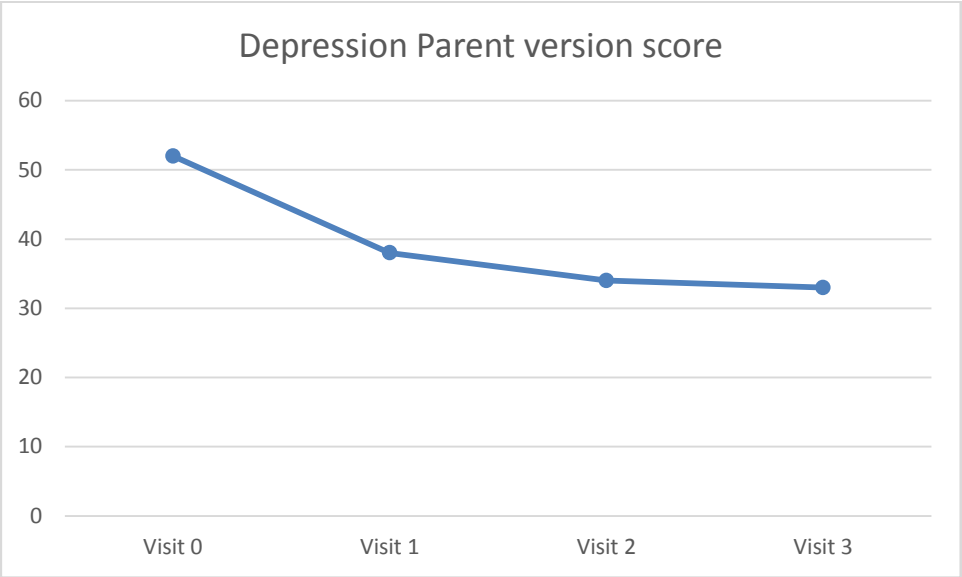
At baseline child depression inventory parent version showed minimal depression to be 3(1.5%), mild 52 (27.2%), moderate 76 (39.6%) and severe 60(31.2%).

Figure 6: The mean score of Depression using Child Depression Inventory/ Becks Depression Inventory (CDI/BDI) over time from June 2015 to June 2016



The mean score of depression decreased gradually over time, 22 at baseline, 12 during the first follow up, 6 during the second follow up and 5 during the third follow up.

Figure 7: The mean score of Depression using Child Depression Inventory Parent version over time from June 2015 to June 2016



The mean score of depression parent version decreased gradually over time, 52 at baseline, 38 during the first follow up, 34 during the second follow up and 33 during the third follow up.

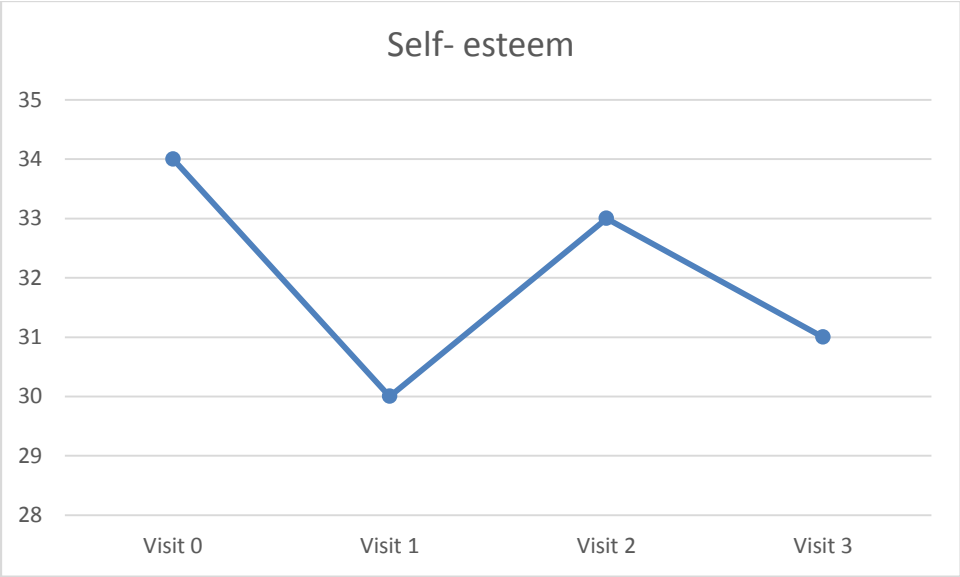
4.4.3 Incidence of Self- esteem from June 2015 to July 2016

Table 13: Levels of Self- esteem using Pier-Harris self-concept scale from baseline June 2015 – July 2016

		Baseline		Follow up1		Follow up2		Follow up 3	
		N	%	N	%	N	%	N	%
Self - esteem	Low self-esteem	12	6.3	11	6.3	4	2.5	2	1.9
	Average self-esteem	144	75.4	162	92.6	156	92.8	158	98.1
	High self-esteem	35	18.3	2	1.1	8	4.7	0	0
	Total	**191**	**100**	**175**	**100**	**168**	**100**	**160**	**100**

Majority 144(75.4%) had average self-esteem at baseline, 35(18.3%) had high self-esteem and 12(6.3%) had low self-esteem. At follow up 1, 162(92.6%) had average self-esteem, 11(6.3%) had low self-esteem and 2(1.1%) had high self-esteem. At follow up 2, 156 (92.8%) had average self-esteem, 4(2.5%) had low self-esteem and 8(4.7%) had high self-esteem. At follow up 3, 158(98.1%) had average self-esteem and 2(1.9%) had low self-esteem. There were no participants with high self-esteem at follow up 3.

Figure 8: The mean score of self-esteem using Pier-Harris self-concept scale over time from June 2015 to June 2016



The mean score of self-esteem fluctuated over time, 34 at baseline 30 during the first follow up, 33 during the second follow up and 31 during the third follow up.

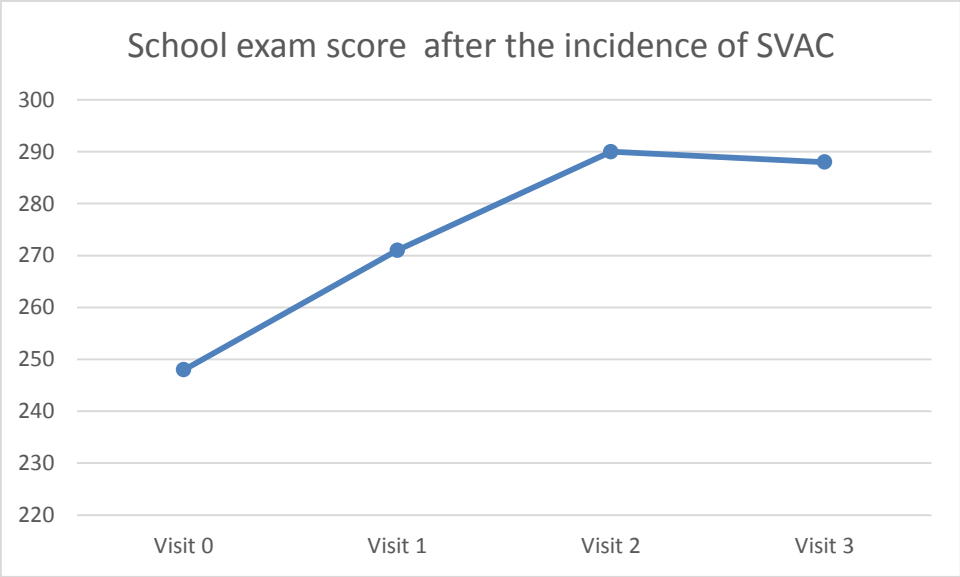
4.4.4 School performance over time from June 2015 to July 2016

Table 14: School performance over time from June 2015 to July 2016

School performance								
	Baseline N	**%**	**Follow up1**	**%**	**Follow up 2**	**%**	**Follow up 3**	**%**
Below average	103	55.7	37	21.1	28	16.7	24	15
Above average	82	44.3	138	78.9	140	83.3	136	85
Totals	**185**	**100**	**175**	**100**	**168**	**100**	**160**	**100**

At baseline over a half of the sexually abused children 103(55.7%) performed below average and 82(44.3%) performed above average. At follow up 1, 37(21.1%) performed below average with a majority performing 138(78.9%) above average. At follow up 2, majority 140(83.8%) performed above average and 27(16.2%) performed below average. During follow up 3, majority 136(85%) performed above average and 24(15%) performed below average.

Figure 9: The mean score over time of school performance of the participants from June 2015 to June 2016



School performance improved over time from 249 at baseline, 271 during the first follow up, 290 during the second follow up but slightly dropped to 288 during the third follow-up.

4.5 Bivariate and Multivariate Analysis

Table 15: PTSD in relation to socio demographic characteristics of the children at baseline (Bivariate Analysis)

	PTSD				
	Partial PTSD		Full PTSD		
	N=9		N=182		p-value
Gender	**N**	**(%)**	**N**	**(%)**	
Male	1	(4.3)	22	(95.7)	**0.930**
Female	8	(4.8)	160	(95.2)	
Age group					
7-9	2	(6.1)	31	(93.9)	**0.735**
10-12	3	(6.8)	41	(93.2)	
13-15	3	(4.5)	64	(95.5)	
16-17	1	(2.1)	46	(97.9)	
Attending school					
Yes	8	(4.3)	177	(95.7)	**0.055**
No	1	(25.0)	3	(75.0)	
School level					
Primary	9	(4.2)	158	(95.8)	**0.360**
Secondary	0	(.0)	19	(100.0)	
Have parents					
Both Mother & Father	7	(4.9)	137	(95.1)	**0.662**
Only Mother	1	(3.0)	32	(97.0)	
Only Father	1	(12.5)	7	(87.5)	
None	0	(.0)	6	(100.0)	
Parents marital status					
Married	5	(3.7)	131	(96.3)	**0.425**
Separated	2	(6.1)	31	(93.9)	
Divorced	0	(.0)	6	(100.0)	
Single	2	(12.5)	14	(87.5)	
Who do you live with					
Neighbors	0	(.0)	0	(.0)	**0.010**
Good Samaritan	1	(50.0)	1	(50.0)	
Care Giver	5	(3.1)	156	(96.9)	
Guardian	3	(12.5)	25	(87.5)	

PTSD in the sexually abused children was associated with the person the children lived with (p=0.01) at baseline.

Table 16: PTSD in relation to socio demographic characteristics of the parents at baseline (Bivariate Analysis)

	PTSD				
	Partial PTSD N=9		Full PTSD N=182		
	N	(%)	N	(%)	p-value
Gender of parent					
Male	2	(10.5)	17	(89.5)	**0.213**
Female	7	(4.1)	163	(95.9)	
Level of education of mother					
Primary	4	(4.2)	92	(95.8)	
Secondary	4	(5.5)	69	(94.5)	**0.855**
College	1	(7.1)	13	(92.9)	
Level of education of father					
Primary	1	(2.7)	36	(97.3)	
Secondary	4	(4.7)	81	(95.3)	**0.843**
College	1	(3.1)	31	(96.9)	
Income					
Less than Sh. 100 per day	2	(3.4)	56	(96.6)	
Sh. 100 per day	3	(4.2)	68	(95.8)	**0.624**
More than Sh. 100 per day	4	(7.1)	52	(92.9)	

There was no statistical significance between socio-demographic characteristics of the parents and PTSD in the children.

Table 17 (a): PTSD in relation to sexual abuse profile at baseline (Bivariate Analysis)

	PTSD				
	Partial PTSD N=9		Full PTSD N=182		
	N	(%)	N	(%)	p-value
Relationship to perpetrator					
Stranger	6	(7.9)	70	(92.1)	
Acquaintance	2	(2.0)	99	(98.0)	**0.347**
Non Parental care giver	0	(.0)	3	(100.0)	
Biological Parent	1	(11.1)	8	(88.9)	
Perpetrators Acts					
Vagina Anal Penetration	7	(4.1)	163	(95.9)	**0.167**
Touching the Genitals	2	(18.2)	9	(81.8)	
What perpetrator made victim to do					
Nothing	1	(6.7)	14	(93.3)	
Touching Genitals	7	(4.1)	165	(95.9)	**<0.0001**
Oral Copulation	0	(.0)	3	(100.0)	
Frequency of Abuse					
Once	4	(4.3)	88	(95.7)	
Twice	1	(2.6)	37	(97.4)	
Three Times	0	(.0)	30	(100.0)	**0.060**
Four Times	3	(18.8)	13	(81.3)	
More than Four times	1	(6.7)	14	(93.3)	
How long ago did the abuse take place					
Days	5	(11.9)	37	(88.1)	
Weeks	0	(.0)	4	(100.0)	**0.043**
Months	3	(2.3)	126	(97.7)	
Years	0	(.0)	15	(100.0)	
First person to tell of the Abuse					
Mother	5	(3.6)	135	(96.4)	
Father	0	(.0)	7	(100.0)	
Guardian	0	(.0)	8	(100.0)	**0.419**
Friend	1	(10.0)	9	(90.0)	
Teacher	2	(16.7)	10	(83.3)	
How long before sharing					
Same Day of Abuse	3	(2.8)	105	(97.2)	
One Day after the Abuse	1	(2.2)	45	(97.8)	
One Week after the Abuse	2	(25.0)	6	(75.0)	**0.022**
One Month after the Abuse	3	(11.1)	24	(88.9)	

PTSD in the sexually abused children was associated with what the perpetrator made the victim to do (p<0.0001), how long ago the abuse had taken place (p=0.043), how long before sharing the incidence (p=0.022).

Table 17 (b): PTSD in relation to sexual abuse profile at baseline (Bivariate Analysis)

	PTSD				
	Partial PTSD N=9		Full PTSD N=182		
	N	(%)	N	(%)	p-value
First place to be taken					
Hospital	6	(3.8)	152	(96.2)	
Chief's Camp	0	(.0)	2	(100.0)	**0.425**
Police Station	3	(10.7)	25	(89.3)	
How long before receiving medical attention					
Within 1 Hour	1	(.8)	124	(99.2)	
Within 2 Hours	0	(.0)	13	(100.0)	
Within 12 Hours	2	(6.9)	27	(93.1)	**<0.0001**
Within 48 Hours	1	(20.0)	4	(80.0)	
Within 72 Hours	0	(.0)	3	(100.0)	
After 72 hours	5	(31.3)	11	(68.8)	
How did you cope with school work					
Finishing Homework	3	(2.3)	130	(97.7)	**0.093**
Not Finishing Homework	4	(7.4)	50	(92.6)	
Attitude towards school changed					
Yes	4	(2.3)	167	(97.7)	**0.001**
No	3	(18.8)	13	(81.3)	
Used school to escape from Abuse					
Yes	4	(2.3)	167	(97.7)	**0.001**
No	3	(17.6)	14	(82.4)	

PTSD in the sexually abused children was also associated with how long it took before receiving medical attention (p<0.0001), change of attitude towards school (p<0.001) and use of school to escape abuse (p<0.001).

Table 18: Predictors of Full PTSD at baseline (Multivariate Analysis Logistic Regression)

	B	S.E.	p-value	OR	95% C.I. for OR	
					Lower	Upper
What Perpetrator Made victim do	1.483	1.209	**.220**	4.406	.412	47.093
How long ago did the abuse take place	.140	.443	**.752**	1.150	.483	2.742
How Long before Sharing	.273	.460	**.553**	1.314	.533	3.237
How long before receiving medical attention	-.734	.360	**.005**	.480	.237	.972
Attitude towards School Changed	-1.193	1.211	**.325**	.303	.028	3.255
Used school to escape from abuse	.643	1.367	**.638**	1.902	.130	27.737
Substance Use	-1.265	.686	**.065**	.282	.074	1.084

The factor that was statistically associated with prediction of full PTSD was how long it took before receiving medical attention ($p<0.005$). Children who received medical attention early were more likely to have PTSD than children who delayed in receiving medical attention.

Table 19: Depression in relation to Socio demographic characteristics of the children at baseline (Bivariate Analysis)

	Depression				
	Minimal-Mild depression N=58		Moderate-Severe depression N=133		
	N	(%)	N	(%)	p-value
Gender					
Male	8	(34.8)	15	(65.2)	**0.623**
Female	50	(29.8)	118	(70.2)	
Age group					
7-9	12	(36.4)	21	(63.6)	**0.473**
10-12	16	(36.4)	28	(63.6)	
13-15	19	(28.4)	48	(71.6)	
16-17	11	(23.4)	36	(76.6)	
Attending school					
Yes	57	(30.8)	128	(69.2)	**0.803**
No	1	(25.0)	3	(75.0)	
School level					
Primary	48	(29.1)	117	(70.9)	**0.243**
Secondary	8	(42.1)	11	(57.9)	
Have parents					
Both Mother & Father	45	(31.5)	98	(68.5)	**0.232**
Only Mother	9	(27.3)	24	(72.7)	
Only Father	4	(50.0)	4	(50.0)	
None	0	(.0)	6	(100.0)	
Parents marital status					
Married	44	(32.4)	92	(67.6)	**0.882**
Separated	9	(27.3)	24	(72.7)	
Divorced	1	(25.0)	3	(75.0)	
Single	4	(25.0)	12	(75.0)	
Who do you live with					
Good Samaritan	0	(.0)	2	(100.0)	**0.547**
Care Giver	52	(32.3)	109	(67.7)	
Guardian	5	(20.8)	19	(79.2)	

There was no statistical significance between depression in children and socio-demographic characteristics of the children.

Table 20: Depression in relation to Socio demographic characteristics of the parents at baseline (Bivariate Analysis)

	Depression				
	Minimal-Mild depression N=58		**Moderate-Severe depression N=133**		
	N	**(%)**	**N**	**(%)**	**p-value**
Gender of parent					
Male	9	(47.4)	10	(52.6)	**0.896**
Female	49	(28.8)	123	(71.2)	
Level of education of father					
Primary	26	(27.1)	70	(72.9)	**0.861**
Secondary	25	(34.2)	48	(65.8)	
College	5	(35.7)	9	(64.3)	
Level of education of mother					
Primary	11	(29.7)	26	(70.3)	**0.898**
Secondary	28	(32.9)	57	(67.1)	
College	9	(28.1)	23	(71.9)	
Income					
Less than Sh. 100 per day	18	(31.0)	40	(69.0)	**0.177**
Sh. 100 per day	17	(23.9)	54	(76.1)	
More than Sh. 100 per day	22	(39.3)	34	(60.7)	

There was no statistical significance between socio-demographic characteristics of parents and depression in children.

Table 21 (a): Depression in relation to sexual abuse profile at baseline (Bivariate Analysis)

	Depression				
	Minimal-Mild depression N=58		Moderate-Severe depression N=133		
	N	(%)	N	(%)	p-value
Relationship to the perpetrator					
Stranger	22	(28.9)	54	(71.1)	**0.898**
Acquaintance	32	(31.7)	69	(68.3)	
Non Parental care giver	1	(33.3)	2	(66.7)	
Biological Parent	3	(33.3)	6	(66.7)	
Perpetrators Acts					
Vagina Anal Penetration	51	(30.0)	119	(70.0)	**0.495**
Touching the Genitals	3	(27.3)	8	(72.7)	
What perpetrator made victim do					
Nothing	3	(20.0)	12	(80.0)	**0.379**
Touching Genitals	53	(30.8)	119	(69.2)	
Oral Copulation	2	(66.7)	1	(33.3)	
Frequency of abuse					
Once	38	(41.3)	54	(58.7)	**0.003**
Twice	11	(28.9)	27	(71.1)	
Three Times	4	(13.3)	26	(86.7)	
Four Times	0	(.0)	16	(100.0)	
More than Four times	5	(33.3)	10	(66.7)	
How long ago did the abuse take place					
Days	19	(45.2)	23	(54.8)	**0.070**
Weeks	2	(50.0)	2	(50.0)	
Months	32	(24.8)	97	(75.2)	
Years	5	(33.3)	10	(66.7)	
First person to tell of abuse					
Mother	40	(28.6)	100	(71.4)	**0.159**
Father	4	(57.1)	3	(42.9)	
Guardian	1	(12.5)	7	(87.5)	
Friend	3	(30.0)	7	(70.0)	
Teacher	5	(41.7)	7	(58.3)	

Depression in the sexually abused children was associated with frequency of abuse (p=0.003).

Table 21 (b): Depression in relation to sexual abuse profile at baseline (Bivariate Analysis)

	Depression				
	Minimal-Mild depression N=58		Moderate-Severe depression N=133		
	N	(%)	N	(%)	p-value
How long before sharing					
Same Day of Abuse	31	(28.7)	77	(71.3)	**0.274**
One Day after the Abuse	13	(28.3)	33	(71.7)	
One Week after the Abuse	5	(62.5)	3	(37.5)	
One Month after the Abuse	9	(33.3)	18	(66.7)	
First place to be taken					
Hospital	43	(27.2)	115	(72.8)	**0.060**
Chief's Camp	2	(100.0)	0	(.0)	
Police Station	12	(42.9)	16	(57.1)	
How long before receiving medical attention					
Within 1 Hour	27	(21.6)	98	(78.4)	**0.003**
Within 2 Hours	4	(30.8)	9	(69.2)	
Within 12 Hours	13	(44.8)	16	(55.2)	
Within 48 Hours	4	(80.0)	1	(20.0)	
Within 72 Hours	2	(66.7)	1	(33.3)	
After 72 hours	8	(50.0)	8	(50.0)	
How did you cope with school work					
Finishing Homework	37	(27.8)	96	(72.2)	**0.138**
Not Finishing Homework	21	(38.9)	33	(61.1)	
Attitude towards school changed					
Yes	47	(27.5)	124	(72.5)	**0.001**
No	11	(68.8)	5	(31.3)	
Used school to escaped from Abuse					
Yes	49	(28.7)	122	(71.3)	**0.039**
No	9	(52.9)	8	(47.1)	

Depression in the sexually abused children was associated with how long it took before receiving medical attention (p=0.003), change of attitude towards school (p<0.001), use of school to escape abuse (p=0.039).

Table 22: Predictors of depression in the sexually abused children at baseline (Multivariate Analysis Logistic Regression)

	Unstandardized Coefficients		Odds ratio	P value	95.0% Confidence Interval for Odds ratio	
	B	Std. Error			Lower Bound	Upper Bound
Frequency of abuse	.507	.158	1.660	**0.001**	1.219	2.261
How long ago the abuse took place	-14.379	4.240	0.779	**0.001**	0.000	0.002
How long before receiving medical attention	5.524	2.633	1.170	**0.005**	1.388	45206.67

The factors that were associated with prediction of depression were frequency of abuse ($p<0.001$), how long ago the abuse had taken place ($p<0.001$), and how long before receiving medical attention ($p=0.005$). Children who received medical attention early were more likely to be depressed compared to children who delayed in receiving medical attention.

Table 23: Self- esteem in relation to socio demographic of the children at baseline (Bivariate Analysis)

	Self- esteem				
	Low-Average self-esteem N=156		High self-esteem N=35		
	N	(%)	N	(%)	p-value
Gender					
Male	20	(87.0)	3	(13.0)	**0.485**
Female	136	(81.0)	32	(19.0)	
Age group					
7-9	27	(81.8)	6	(18.2)	**0.914**
10-12	37	(84.1)	7	(15.9)	
13-15	53	(79.1)	14	(20.9)	
16-17	39	(83.0)	8	(17.0)	
Attending school					
Yes	152	(82.2)	33	(17.8)	**0.712**
No	3	(75.0)	1	(25.0)	
School level					
Primary	138	(83.6)	27	(16.4)	**0.278**
Secondary	14	(73.7)	5	(26.3)	
Have parents					
Both Mother and Father	121	(84.6)	22	(15.4)	**0.064**
Only Mother	23	(69.7)	10	(30.3)	
Only Father	5	(62.5)	3	(37.5)	
None	6	(100.0)	0	(.0)	
Parents marital status					
Married	112	(82.4)	24	(17.6)	**0.168**
Separated	28	(84.8)	5	(15.2)	
Divorced	4	(100.0)	0	(.0)	
Single	10	(62.5)	6	(37.5)	
Who do you live with					
Good Samaritan	1	(50.0)	1	(50.0)	**0.461**
Care Giver	129	(80.1)	32	(19.9)	
Guardian	22	(91.7)	2	(8.3)	

There was no association between socio-demographic of the children and self-esteem.

Table 24: Self- esteem in relation to socio demographic characteristics of the parents at baseline (Bivariate Analysis)

	Self- esteem				
	Low-Average self-esteem N=156		High self-esteem N=35		
	N	%	N	%	p-value
Gender of parent					
Male	15	(73.7)	6	(26.3)	**0.319**
Female	141	(82.9)	29	(17.1)	
Level of Education of Father					
Primary	83	(86.5)	13	(13.5)	**0.115**
Secondary	60	(82.2)	13	(17.8)	
College	9	(64.3)	5	(35.7)	
Level of Education of Mother					
Primary	32	(86.5)	5	(13.5)	**0.376**
Secondary	72	(84.7)	13	(15.3)	
College	24	(75.0)	8	(25.0)	
Income					
Less than Sh. 100 per day	52	(89.7)	6	(10.3)	**0.005**
Sh. 100 per day	61	(85.9)	10	(14.1)	
More than Sh. 100 per day	38	(67.9)	18	(32.1)	

Self-esteem in the sexually abused children was significantly associated with the income of the parents (p=0.005).

Table 25 (a): Self-esteem in relation to sexual abuse profile at baseline (Bivariate Analysis)

	Self-esteem				
	Low-Average self-esteem N=156		High self-esteem N=35		
	N	(%)	N	(%)	p-value
Relationship to Perpetrator					
Stranger	59	(77.6)	17	(22.4)	**0.652**
Acquaintance	85	(84.2)	16	(15.8)	
Non Parental care giver	2	(66.7)	1	(33.3)	
Biological Parent	8	(88.9)	1	(11.1)	
Perpetrators Acts					
Vagina Anal Penetration	140	(82.4)	30	(17.6)	**0.812**
Touching the Genitals	8	(72.7)	3	(27.3)	
What perpetrator made victim to do					
Nothing	10	(66.7)	5	(33.3)	**0.365**
Touching Genitals	143	(83.1)	29	(16.9)	
Oral Copulation	2	(66.7)	1	(33.3)	
Frequency of abuse					
Once	68	(73.9)	24	(26.1)	**0.001**
Twice	33	(86.8)	5	(13.2)	
Three Times	30	(100.0)	0	(.0)	
Four Times	16	(100.0)	0	(.0)	
More than Four times	9	(60.0)	6	(40.0)	
How long ago did the abuse take place					
Days	28	(66.7)	14	(33.3)	**0.036**
Weeks	4	(100.0)	0	(.0)	
Months	110	(85.3)	19	(14.7)	
Years	13	(86.7)	2	(13.3)	
First person to tell of Abuse					
Mother	116	(82.9)	24	(17.1)	**0.538**
Father	5	(71.4)	2	(28.6)	
Guardian	8	(100.0)	0	(.0)	
Friend	7	(70.0)	3	(30.0)	
Teacher	10	(83.3)	2	(16.7)	
None	1	(50.0)	1	(50.0)	

Low and average self-esteem in the sexually abused children was associated with frequency of abuse ($p<0.001$) and how long ago the abuse had taken place ($p=0.036$).

Table 25 (b): Self- esteem in relation to sexual abuse profile at baseline (Bivariate Analysis)

	Self-esteem				
	Low-Average self-esteem N=156		High self-esteem N=35		
	N	(%)	N	(%)	p-value
How long before Sharing					
Same Day of Abuse	91	(84.3)	17	(15.7)	**0.772**
One Day after the Abuse	36	(78.3)	10	(21.7)	
One Week after the Abuse	6	(75.0)	2	(25.0)	
One Month after the Abuse	23	(77.8)	6	(22.2)	
First place to be taken					
Hospital	130	(82.3)	28	(17.7)	**0.526**
Chief's Camp	1	(50.0)	1	(50.0)	
Police Station	22	(78.6)	6	(21.4)	
How long before receiving medical attention					
Within 1 Hour	109	(87.2)	16	(12.8)	**0.001**
Within 2 Hours	13	(100.0)	0	(.0)	
Within 12 Hours	21	(72.4)	8	(27.6)	
Within 48 Hours	2	(40.0)	3	60.0	
Within 72 Hours	2	(66.7)	1	(33.3)	
After 72 hours	9	(56.3)	7	(43.8)	
How did you cope with school work					
Finishing Homework	110	(82.7)	23	(17.3)	**0.621**
Not Finishing Homework	43	(79.6)	11	(20.4)	
Attitude of school change					
Yes	146	(85.4)	25	(14.6)	**<0.0001**
No	7	(43.8)	9	(56.3)	
Used school to escape from abuse					
Yes	143	(83.6)	28	(16.4)	**0.012**
No	10	(58.8)	7	(41.2)	

Low and average self-esteem was associated with how long it took to receive medical attention ($p<0.001$), change of attitude towards school ($p<0.0001$) and use of school to escape abuse ($p=0.012$).

Table 26: Predictors of Low and average Self-esteem at baseline (Multivariate Analysis Logistic Regression)

	B	S.E.	p-value	OR	95% C.I. for OR	
					Lower	Upper
Frequency of Abuse	-.377	.230	**.102**	.686	.437	1.077
How long ago the Abuse taken place	.129	.292	**.659**	1.137	.642	2.014
How long before receiving medical attention	.309	.180	**.085**	1.362	.958	1.937
Attitude towards School Changed	1.603	.799	**.005**	4.967	1.038	23.758
Used school to escape from abuse	-.498	.898	**.579**	.608	.104	3.534
Income	.594	.310	**.055**	1.812	.987	3.327
Substance Use	.485	.524	**.355**	1.623	.581	4.535
How Family disagreements are sorted out	.812	.536	**.130**	2.251	.788	6.433

The factor that was associated with prediction of Low and average self-esteem was change of attitude towards school ($p<0.005$).

Table 27: School performance in relation to socio demographic characteristics of the children at baseline (Bivariate Analysis)

	School performance				
	Below average N=103		At least average N= 82		
	N	(%)	N	(%)	p-value
Gender					
Male	7	(30.4)	16	(69.6)	**0.009**
Female	96	(59.3)	66	(40.7)	
Age group					
7-9	16	(48.5)	17	(51.5)	**0.075**
10-12	23	(52.3)	21	(47.7)	
13-15	32	(50.0)	32	(50.0)	
16-17	32	(72.7)	12	(27.3)	
Attending school					
Yes	102	(55.7)	81	(44.3)	**0.871**
No	1	(50.0)	1	(50.0)	
School level					
Primary	89	(54.6)	74	(45.4)	**0.251**
Secondary	13	(68.4)	6	(31.6)	
Have parent					
Both Mother and Father	79	(56.4)	61	(43.6)	**0.335**
Only Mother	17	(53.1)	15	(46.9)	
Only Father	2	(28.6)	5	(71.4)	
None	4	(80.0)	1	(20.0)	
Parents marital status					
Married	72	(54.1)	61	(45.9)	**0.649**
Separated	21	(65.6)	11	(34.4)	
Divorced	2	(50.0)	2	(50.0)	
Others	7	(50.0)	7	(50.0)	
Who do you live with					
Good Samaritan	0	(.0)	1	(100.0)	**0.389**
Care Giver	90	(56.6)	69	(43.4)	
Guardian	10	(45.5)	12	(54.5)	

Female gender among the sexually abused children was significantly associated with below average performance (p=0.009).

Table 28: School performance in relation to socio demographic characteristics of the parents at baseline (Bivariate Analysis)

	School performance				
	Below average N=103		At least average N=82		
	N	(%)	N	(%)	p-value
Gender of parent					
Male	9	(47.4)	10	(52.6)	**0.896**
Female	94	(28.8)	72	(71.2)	
Level of education of father					
Primary	20	(55.6)	16	(44.4)	**0.206**
Secondary	52	(63.4)	30	(36.6)	
College	14	(45.2)	17	(54.8)	
Level of education of mother					
Primary	55	(59.1)	38	(40.9)	**0.449**
Secondary	37	(52.9)	33	(47.1)	
College	6	(42.9)	8	(57.1)	
Income					
Less than Sh. 100 per day	38	(70.4)	16	(29.6)	**0.020**
Sh. 100 per day	36	(52.2)	33	(47.8)	
More than Sh. 100 per day	29	(44.6)	31	(55.4)	

School performance of the sexually abused children was associated with income of the parents (p=0.02).

Table 29 (a): School performance in relation to sexual abuse profile at baseline (Bivariate Analysis)

	School performance				
	Below average N=103		At least average N=82		
	N	(%)	N	(%)	p-value
Relationship to perpetrator					
Stranger	42	(56.8)	32	(43.2)	**0.738**
Acquaintance	53	(53.5)	46	(46.5)	
Non Parental care giver	3	(50.0)	1	(50.0)	
Biological Parent	5	(62.5)	3	(37.5)	
Perpetrators Acts					
Vagina Anal Penetration	94	(57.0)	71	(43.0)	**0.500**
Touching the Genitals	4	(40.0)	6	(60.0)	
Non genital contact	5	(55.6)	4	(44.4)	
What the perpetrator made victim to do					
Nothing	9	(60.0)	6	(40.0)	**0.142**
Touching Genitals	94	(56.3)	73	(43.7)	
Frequency of Abuse					
Once	43	(47.8)	47	(52.2)	**0.091**
Twice	26	(72.2)	10	(27.8)	
Three Times	19	(63.3)	11	(36.7)	
Four Times	9	(60.0)	6	40.0)	
More than Four times	6	(42.9)	8	(57.1)	
How long ago did the abuse take place					
Days	15	(38.5)	24	(61.5)	**0.038**
Weeks	1	(25.0)	3	(75.0)	
Months	79	(62.2)	48	(37.8)	
Years	8	(53.3)	7	(46.7)	
First person to tell of the Abuse					
Mother	78	(56.5)	60	(43.5)	**0.578**
Father	3	(42.9)	4	(57.1)	
Guardian	6	(75.0)	2	(25.0)	
Friend	3	(42.9)	4	(57.1)	
Teacher	7	(58.3)	5	(41.7)	
Friends	6	(54.5)	5	(45.5)	

Poor school performance among the sexually abused children was associated with length of time that had passed since the abuse (p= 0.038).

Table 29 (b): School performance in relation to sexual abuse profile (Bivariate Analysis)

	School performance				
	Below average N=103		At least average N=82		
	N	(%)	N	(%)	p-value
How long before sharing					
Same Day of Abuse	63	(58.9)	44	(41.1)	**0.749**
One Day after the Abuse	23	(51.1)	22	(48.9)	
One Week after the Abuse	3	(37.5)	5	(62.5)	
One Month after the Abuse	13	(56.5)	10	(43.5)	
Other	1	(50.0)	1	(50.0)	
First place to be taken					
Hospital	89	(58.2)	64	(41.8)	**0.392**
Chief's Camp	1	(50.0)	1	(50.0)	
Police Station	11	(40.7)	16	(59.3)	
Other	2	(66.7)	1	(33.3)	
How long before receiving medical attention					
Within 1 Hour	75	(61.0)	48	(39.0)	**0.005**
Within 2 Hours	11	(84.6)	2	(15.4)	
Within 12 Hours	10	(35.7)	18	(64.3)	
Within 48 Hours	2	(40.0)	3	(60.0)	
Within 72 Hours	2	(66.7)	1	(33.3)	
Other	3	(23.1)	10	(76.9)	
How did you cope with school work					
Finishing Homework	74	(56.5)	57	(43.5)	**0.729**
Not Finishing Homework	29	(53.7)	25	(46.3)	
Attitude towards school changed					
Yes	101	(59.4)	69	(40.6)	**0.001**
No	2	(13.3)	13	(86.7)	
Used school to escape from Abuse					
Yes	98	(58.3)	70	(41.7)	**0.022**
No	5	(29.4)	12	(70.6)	

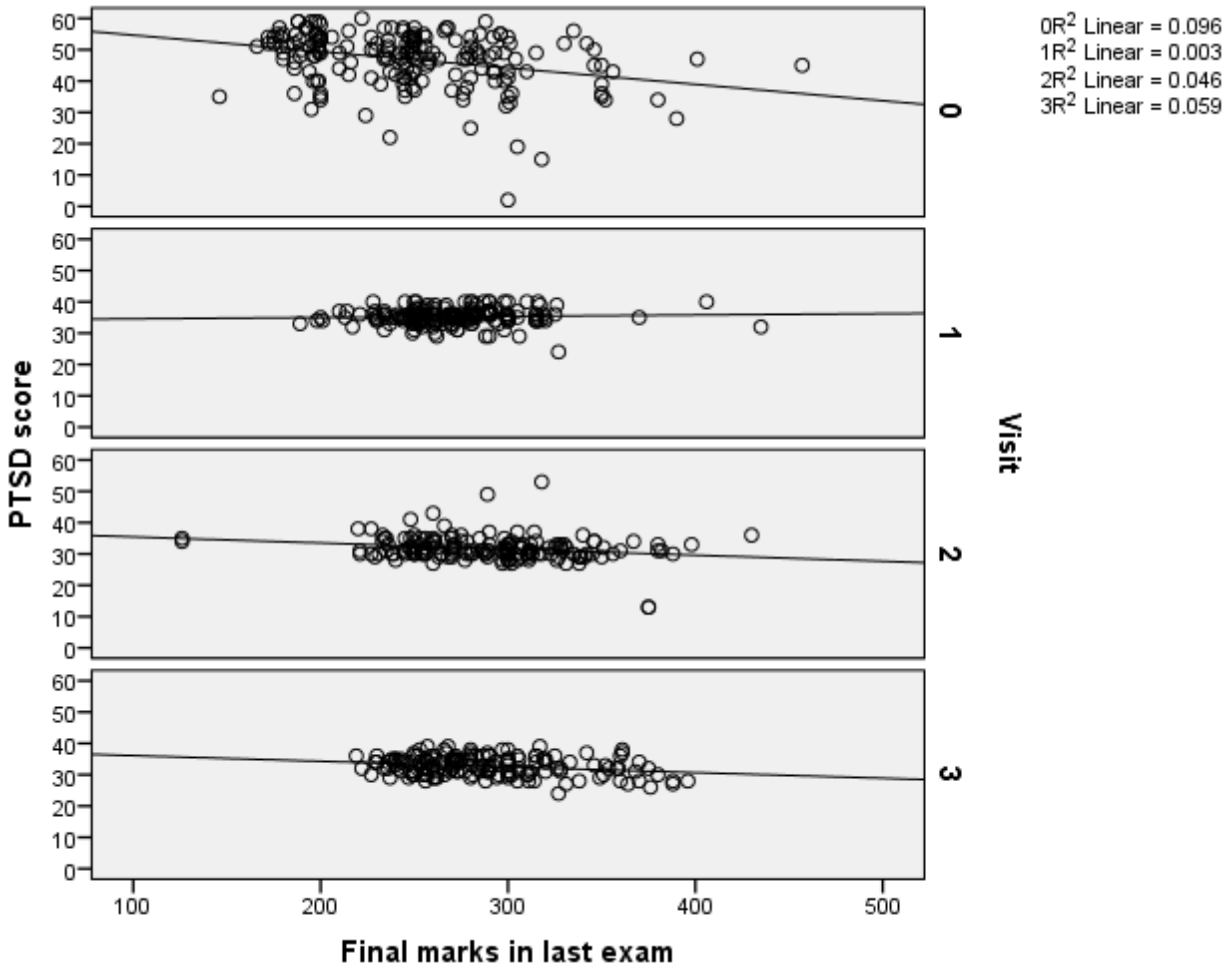
Poor school performance among the sexually abused children was associated with how long it took before receiving medical treatment (p=0.005), change of attitude towards school after the SVAC incidence (p<0.001), and use of school as an escape from abuse (p=0.022).

Table 30: Predictors of poor school performance at baseline (Multivariate Analysis Logistic Regression)

	Coefficient	S.E. of coefficient	p-value	OR	95% C.I. for OR	
					Lower	Upper
Gender	1.243	0.500	**0.01**	3.466	1.302	9.228
How long ago has the abuse been going on	-0.348	0.190	**0.067**	0.706	0.486	1.025
How Long receiving medical attention	0.004	0.155	**0.978**	1.004	0.742	1.360
Attitude towards School Changed	2.072	0.865	**0.01**	7.943	1.457	43.303
Used school to escape from abuse	0.077	0.723	**0.916**	1.080	0.262	4.449

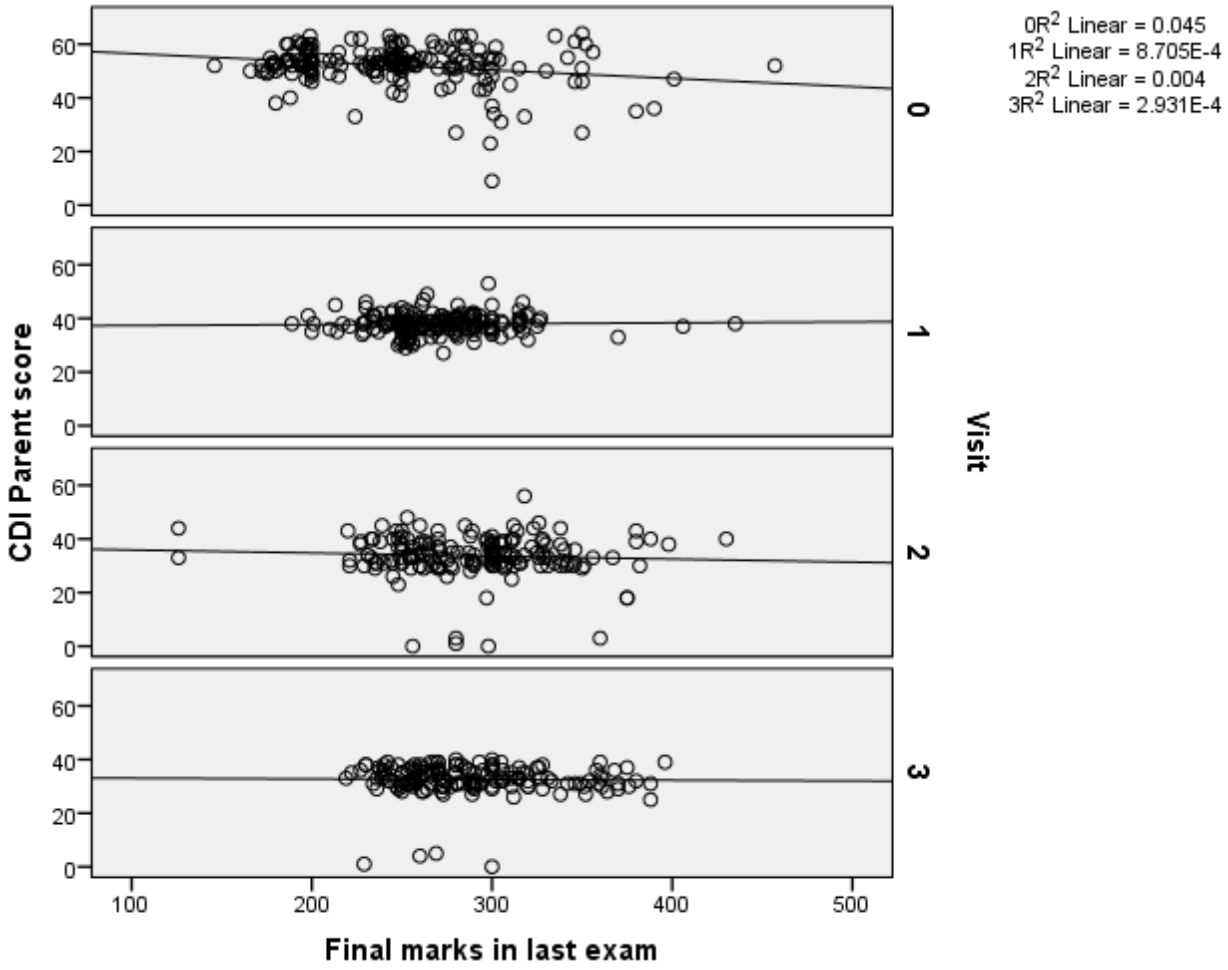
The factors that were found to be statistically associated with prediction of poor school performance were: Female gender (p< 0.01) and change of attitude towards school (p< 0.01). Male sexually abused children were 3 times more likely to score above average marks than female sexually abused children OR=3.5 [95% CI of OR 1.3-9.2], p=0.01.

Figure 10: PTSD score in relation to school performance from baseline to follow up 3



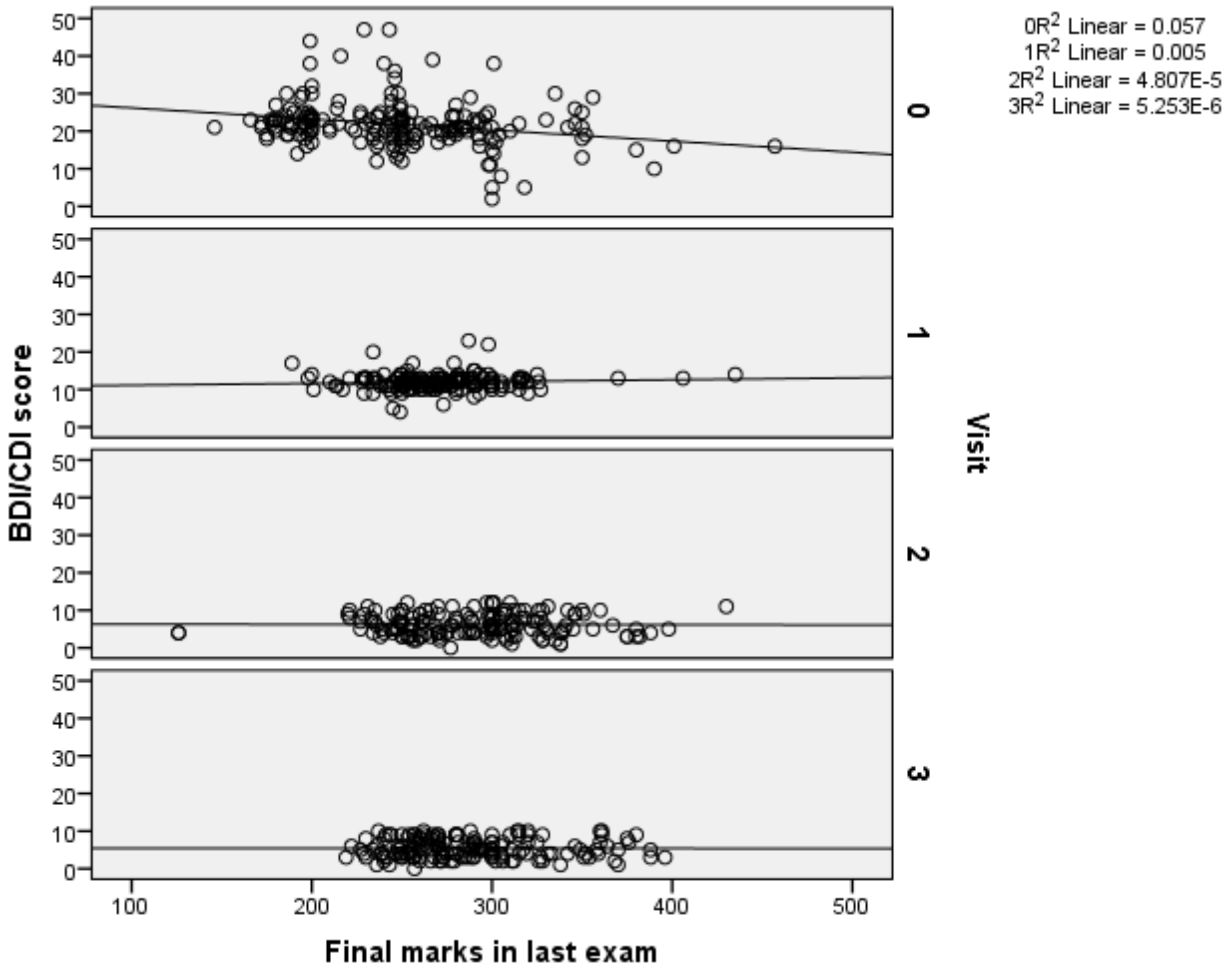
Decreasing PTSD score is associated with increase of school performance among the participants from baseline to follow up 3.

Figure 11: Depression according to parents in their children from baseline to follow up 3



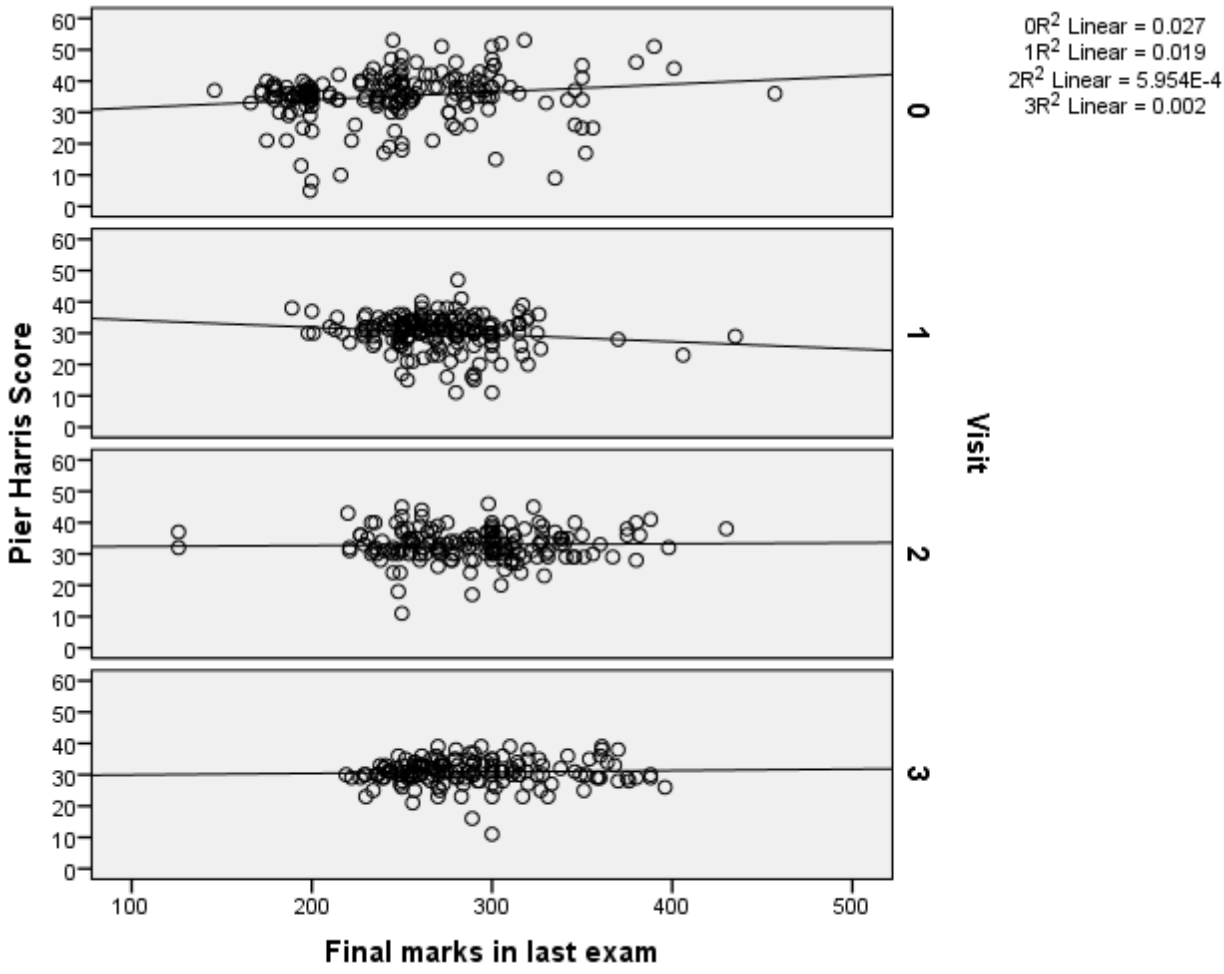
Decreasing parental view of depression among the sexually abused children is associated with increase of school performance among the participants from baseline to follow up 3.

Figure 12: Depression score in relation to school performance from baseline to follow up 3



Decreasing depression score is associated with increase of school performance among the participants from baseline to follow up 3.

Figure 13: Self-esteem score in relation to school performance from baseline to follow up 3



Average self-esteem is associated with increase of school performance among the participants from baseline to follow up 3.

Table 31: School performance in relation to PTSD, depression and self-esteem at baseline (Bivariate Analysis)

	School performance			
	Above average N (%)	**Below average N (%)**	**OR (95% CI)**	**P**
PTSD				
Partial PTSD	5(55.6)	2(22.2)		
Full PTSD	77(42.3)	101(55.5)	0.30(0.06-1.61)	**0.162**
CDI/BDI				
Minimal-Mild depression	35(60.3)	23(39.7)		
Moderate-Severe depression	47(35.3)	80(60.2)	0.39(0.20-0.73)	**0.003**
Pier Harris self-concept scale				
Low-Average self-esteem	61(37.9)	94(58.4)		
High self-esteem	21(70.0)	9(30.0)	3.60(1.54-8.37)	**0.003**

There was a significant association between school performance and both CDI/BDI and Pier Harris self-concept scale. Children diagnosed with moderate to severe depression on CDI/BDI were less likely to perform above average compared to those with minimal to mild depression (p = 0.003). The children with high self-esteem based on Pier Harris self-concept scale were 3.6 times more likely to have above average performance compared to those with low or average self-esteem.

Table 32: School performance in relation to PTSD, depression and self-esteem at Follow up 1 (Bivariate Analysis)

	School performance			
	Above average N (%)	Below average N (%)	OR (95% CI)	P
PTSD				
Partial PTSD	6(85.7)	1(14.3)		
Full PTSD	132(78.1)	36(21.3)	0.61(0.07-5.24)	**0.653**
CDI/BDI				
Minimal-Mild depression	136(79.1)	36(20.9)		
Moderate-Severe depression	2(50.0)	1(25.0)	0.53(0.05-6.00)	**0.608**

During the first follow up majority of children had minimal to mild depression on CDI/BDI .

There was no significant association between PTSD and performance at school (p = 0.653)

Table 33: School performance in relation to PTSD, depression and self-esteem at Follow up 2 (Bivariate Analysis)

	School performance			
	Above average N (%)	**Below average N (%)**	**OR (95% CI)**	**P**
PTSD				
Partial PTSD	58(87.9)	8(12.1)		
Full PTSD	82(81.2)	19(18.8)	0.60(0.24-1.45)	**0.254**
CDI/BDI				
Minimal-Mild depression	140(83.3)	27(16.1)	0.53(0.05-6.00)	**0.743**
Pier Harris self-concept scale				
Low-Average self-esteem	133(83.1)	26(16.3)		
High self-esteem	7(87.5)	1(12.5)	1.37(0.16-11.60)	**0.774**

None of the diagnoses showed a significant association with school performance at second follow up.

Table 34: School performance in relation to PTSD, depression and self-esteem at Follow up 3 (Bivariate Analysis)

	School performance			
	Above average N (%)	**Below average N (%)**	**OR (95% CI)**	**P**
PTSD				
Partial PTSD	36(90.0)	4(10.0)		
Full PTSD	100(83.3)	20(16.7)	0.56(0.18-1.74)	**0.312**
CDI/BDI				
Minimal-Mild depression	3(75.0)	1(25.0)		
Moderate-Severe depression	133(85.3)	23(14.7)	1.93(0.19-19.34)	**0.577**

There was no significant association between school performance and either PTSD (p = 0.312) or BDI (p = 0.577) during the third assessment follow up.

4.6 QUALITATIVE DATA

4.6.1 Characteristics of parents/legal guardians and the children

Five parents (5 mothers) and a guardian of seven children attending gender based recovery centers participated in the key informant interviews. Of the six parents or guardians of children attending gender based recovery centers, five reported that the child was sexually abused by a person known to the victim and this was most commonly neighbors but also persons entrusted to care for the children including a father and pastor also perpetrated sexual violence. All the perpetrators were adult males and they sexually abused both male (2) and female (5) children, and a vulnerable child with mental disability. One parent reported that two of her children – a boy and girl – had been sexually abused yet they did not disclose even after repeated sexual abuse as did a boy who was repeatedly sexually abused by a neighbor who also used the child for trafficking drugs and other substances. The child victims of repeated SVAC by the same perpetrator did not report the SVAC because of threats issued by perpetrators.

Table 35: Characteristics of participants in key informant interview

	N
Relationship with child	
Mother	**5**
Grandmother	1
Totals	**6**
Characteristics of the children	**N**
Perpetrator of sexual violence known to the children	5
SVAC linked to drugs and other substances	1
Vulnerable children (mental disability)	1
Totals	**7**

Key informant (qualitative narratives with parents/legal guardians)

The study comprised of care givers of 5 girls and 2 boys from the following age groups of 7-10 years, 10-14 years and 14-17 years making a total of 6 narratives as follows;

K1- Mother, age of child, girl (7-10)

K2- Mother, age of child, boy (7-10)

K3- Mother, age of child, girl (10-14)

K4- Mother, age of child, girl (10-14)

K5- Grand -mother, age of child, girl (14-17)

K6-Mother, age of children (10-14 boy and 14-17 the girl).

4.6.2 Background of the sexually abused children and their parents/legal guardians

SVAC incidence 1 girl age 15 years

The defiled girl was 15 years and in class eight and an only child. She lived with her mother and stepfather for a while before coming to live with her grandmother. She currently lives with her

grandmother who was given custody of the child through the chief of the area where they lived. They used to disagree with the stepfather and used to have many challenges and that's why she came to live with her grandmother. She was progressing well in school and was happy about life before the SVAC incidence. She says the SVAC incidence has brought about shame with the other children and that's why she runs away from home. The perpetrator was unknown to the child. Her grandmother was 46 years and a businesswoman operating a shop outside the plot where they lived. The grandmother was not married and had four children including the mother of her granddaughter.

SVAC incidence 2 girl age 13 years

This girl was 13 years with mental disability (mental retardation). She was sexually abused by a person known to her. She is the first born among three siblings, her sister is 10 years and the brother is 7 years while the last born is six months. She was in class 5 and used to go to school before being taken to kirigiti rehabilitation centre by the police due to running away from home and wandering on the streets at night. She did not have the behaviour of running away from home before the SVAC incidence. The mother was a single mother who was 40 years and unemployed.

SVAC incidence 3 girl age 8 years

This girl was 8 years. She is the first born girl in a family of three children. Her brother was 10 years and her younger sister was 6 years. They lived as a family consisting of the mother, father and her siblings before the SVAC incidence. On examination by the doctors her hymen had been broken an indication that this could not have been her first SVAC incidence. She looked sad

during the interview though the mother reported that she was always in jovial mood and played with the other children and her siblings. She is in class 2 and she was defiled by her biological father. She says the SVAC has made her neighbors to ask her many questions which made her sad. They have however moved from that estate to another where neighbors are not aware of the incidence. She also changed school because other children teased her after they knew about the SVAC incidence. Her father separated with the mother due to the SVAC incidence, currently the father is in jail and he was 37 years. Her mother was 35 years and used to work in a cleaning company before the incidence of SVAC, she lost her job because of the many off duty permissions she had to request to attend to her daughter's needs.

SVAC incidence 4 girl age 14 years

The girl was 14 years old and was in class 8, She was sexually by a neighbor who was unknown to her. She enjoyed life and was doing well in school and preparing to do her exams. She had come home from school with her friends who had visited her. After the SVAC incidence, she became pregnant, circumstances forced her not to continue with school, she attempted suicide and she was impregnated by the person who defiled her. The mother was a single parent aged 42 years old and unemployed.

SVAC incidence 5 boy age 14 years

The boy was 10 years and was sexually abused by a person unknown to him but who lived in their neighborhood. His mother was married to the boy's father but is now separated but the father does not leave far from them. The child is able to visit the father during school holidays. The boy looked withdrawn and sad though he says he enjoys life. He is in school and the

performance is average. The boy is an only child of the mother and currently the mother is single after separating with the father. The mother was 45 years old and was engaged in doing small businesses of selling vegetables.

SVAC incidence 6 boy age 8 years and a girl aged 14 years

This is a case of an 8 year old boy and a sister who is 14 years old. The boy looks happy but the girl looks sad. They belong to the same mother and were defiled by a pastor together with other children. The pastor belonged to the church that the family used to attend service on Sundays. The boy is in school but the girl was affected by the SVAC incidence since she became pregnant and was not able to continue with school. The mother was a single parent aged 39 years old and was engaged in doing small businesses.

4.7 Results of the qualitative narratives

4.7.1 Academic performance

Poor performance emerged as a major impact of SVAC on academic progression of school age children and this manifested through deteriorating school grades, repetition of academic year, absenteeism or dropouts. Parents reported below average performance in school examination. Indeed in one case a child who had been sexually abused attempted the final national examination after being absent from school for a prolonged period following the SVAC, and was unable to attain the points required to proceed to high school within the formal educational system. As a result the mother opted to enroll the child in a vocational training institution where her performance continued to be poor.

"My daughter was in class 8, she has since not been able to go to school but she went to do the (national) exam and got 197 (out of a possible 500) marks in Kenya Certificate of Primary Examination. My son is still in school and his performance was affected by the SVAC. I have taken my daughter for catering course. The SVAC has affected her school performance … I would have taken her to form 1 (secondary school)." [Key informant 6]

The poor performance in school work was perceived by both parents who reported having taken action to stem the deteriorating performance. The remedial actions included making school visits to discuss performance and in a specific case the parent and teachers organized remedial out-of-hours lessons to help the child keep up with the academic requirements while adjusting to the impact of SVAC on academic performance. Both parents and teachers were convinced that deterioration in performance was linked to SVAC based on their assessment of the child performance prior to the SVAC and immediately after the SVAC.

"My daughter's educational performance has gone down since the SVAC incident… She is normally among the last in her class. Before the incident she was better but now she has dropped. I have gone to school and talked to the teacher and we have agreed to have her go for tuition (remedial teaching) to see if it will help her" [Key Informant 1]

4.7.2 Depression

The responses of key informants showed a clear impact of SVAC on the emotional wellbeing of children and depression. Despite the absence of formal assessment for or probing specific signs of depression in children during the interviews the caregivers mentioned signs that pointed to

depression in children following SVAC. Depression was manifested through parental or guardian reports of anxiety, hopelessness and depressive symptoms like anger, irritability, sleep changes and loss of interest in daily activities in the affected children. The children also had difficulties functioning and enjoying life the way they did before the incident.

"She (my grandchild) was admitted to the hospital for two weeks, she had trouble falling asleep… she has problems concentrating in school, she is easily angered, and has lost the closeness I used to have with her … she runs away from home for hours without knowing where she is going… she has lost interest in school. The problems started after her SVAC." [Key informant 5]

"The drugs (PEP and EP) which my daughter was given did not help her since she contracted HIV and became pregnant … when she (sexually abused child) learnt she was HIV positive she was very devastated. She has not been able to go to school, she is sad all the time, she eats poorly, she has lost weight and she just feels tired all the time. She keeps on having nightmares and she has lost hope in life. She attempted suicide once but I have talked to her. " [Key informant 4]

The depression was aggravated in victims who apart from suffering SVAC either contracted STDs or STIs and also in those who conceived as a result of the SVAC. There were cases in which sexually abused children contracted HIV and also conceived despite receiving post exposure prophylaxis and emergency contraception. A participating mother reported a previous

suicide attempt in a child who contracted an STD, and also conceived following SVAC, dropped out of school and manifested signs of depression.

"My daughter got pregnant with the pastor…one day my daughter told me she would rather take rat and rat (poison) to kill herself. She then told me that the pastor used to pray for them (her and other children), but in the process they were sexually abused and… I took my daughter to hospital and it was confirmed she was pregnant. My daughter could not believe she was pregnant. My daughter also told me the same thing used to happen to her brother… (Both) were treated since they had contracted an infection… My daughter was emotionally disturbed by the SVAC incident. She has attempted suicide once. She feels like crying most of the time…" [Key informant 6]

4.7.3 Self-esteem

From the responses in the key informant interviews it was apparent that the information regarding SVAC incidents became known both within neighborhoods where the affected children reside and in the schools they attended soon after the incidents. This was related to caregivers' reports that schools attended by children were close to their residence. As a result there were reports of stigma both at school and home and in the caregiver's view these resulted in low self-esteem among sexually abused children. Caregivers reported cases where adults within neighborhoods questioned victims of sexual violence to obtain information around the incident while in schools sexually abused children were taunted by colleagues impacting on their self-esteem.

"The child was admitted to hospital for two weeks and she was having nightmares and had difficulties falling asleep… my child had a problem staying in the plot (residential area) since other children could tease her and they knew about the SVAC incident and this affected her self-esteem. Women (neighbors) used to call her and ask her to tell them what happened that night. I shifted and went to another house and started struggling by myself." [Key informant 1]

4.7.4 Social relationships

SVAC came with significant strain on social relationships and family wellbeing. The most drastic changes in family and social relations were reported when the perpetrator was a family member. Such cases ended up in marital breakup, loss of financial stability especially when the perpetrator happened to be the main provider for the family, and also impacted on the relationships between the defiled child and other family members who commonly reported strained relations with victims related to his/ her adjustment to the SVAC experience.

"The SVAC of my child has made me lose my job since I have been borrowing permission every now and then either to go to court or to attend to my daughter's issues…. My children were in private school and I have been forced to take them to public school. The SVAC has caused breakup of my marriage since my husband was the one supporting us"…. I shifted and went to another house and started struggling by myself [Key informant 2]

CHAPTER FIVE

5.0 DISCUSSION

This discusses the findings of the study and compares them with findings of other studies makes conclusions, notes limitation and makes suggestions.

5.1 Summary of Findings

The study using different questionnaires found that children under study had varying psychosocial outcomes resulting from the sexual violence incidence. The incidence of PTSD, depression, low-average self-esteem and poor performance in school was high among sexually abused children with incidence of PTSD being the highest (95.3%) at baseline and follow up 1 (95%), (60.5%) at follow up 2 and (60%) at follow up 3. The incidence of depression was high at baseline. Severe depression was at (12.5%) and moderate depression was at (57%). Self–esteem was (18.3%) high, (75.4%) average and (6.3%) low at baseline, at follow up 1, the self-esteem among the sexually abused children was (1.1%) high, (92.6%) average and (6.3%) low, at follow up 2, (4.7%) high, (92.8%) average and (2.5%) low and at follow up 3, None of the children had high self-esteem with majority 98.1% having average self-esteem and (1.9%) having low self-esteem. The children performed poorly in school after the sexual violence incidence but improved in subsequent follow ups.

The study found that girls experienced more sexual violence incidences than boys at a ratio of 7:1 and the mean age was 13. The study found that (67.6%) of the parents earned less than 2$ US

dollars a day an indication that most of the parents were from low socio-economic status. The study found that 136 (70.8%) of the parents viewed their children as having moderate and severe depression at baseline, 103 (59%) at follow up 1, 50(29.9%) at follow up 2 and 25(15.7%) at follow up 3.

At baseline analysis the results of the specific objectives of the study were as follows:

Specific objective 1 socio-demographic characteristics girls experienced SVAC incidence more than boys at a ratio of 7:1.

Specific objective 2 it was found that there was a high incidence of PTSD (95.3%) at baseline.

Specific objective 3 it was found that there was a high incidence of severe and moderate depression (69.5 %) at baseline.

Specific objective 4 it was found that the sexually abused children had average scores of self-esteem which fluctuated over time in the subsequent follow-ups.

Specific objective 5 it was found that the sexually abused children performed poorly in school as a result of sexual violence incidence but their school performance improved over time.

Specific objective 6 it was found that the parents in their subjective experiences after their children sexual violence, the children had both social and psychological negative outcomes including the children being infected with HIV/AIDs, pregnancies and family break-ups.

5.2 Hypothesis

In this study, assumption was made that SVAC was significantly associated with impairments in psychological and social functioning of children attending Gender Based Recovery Centres of the Mental Health Department Kenyatta National Hospital and The Nairobi Women's Hospital.

The hypothesis for this study was accepted. SVAC was significantly associated with psychological and social impairments of children as this is evident by the high incidence of PTSD (95.3%) at baseline and in the follow ups. There was a high incidence of severe and moderate depression (69.5 %) at baseline. The sexually abused children had average scores of self-esteem. They also performed poorly in school as a result of SVAC incidence but their school performance improved over time.

The parents in their subjective experiences after their children SVAC felt that the children had both social and psychological negative outcomes including the children being infected with HIV/AIDs, pregnancies and family break-ups.

5.3 Socio demographic characteristics and SVAC

This study carried out a larger sample size of 191 sexually abused children than the previous studies. Syengo et al., (2008) study comprised of 61 sexually abused children while Ombok et al., (2013) study comprised of 149 sexually abused children and Oswago (2014) study comprised of 100 sexually abused children.

The mean age of (13) years in the current study was comparable to Ombok et al., (2013) & Syengo et al., (2008) study where the mean age was 11.1 & 14.8 years respectively. This concurs with a report from (Child line, 2008) that 55% of Sexual Violence Against Children were girls aged between 0-15 years. The findings of the current study are comparable to Ombok et al., (2013) & Syengo et al., (2008) that 89% of these children experienced vaginal anal penetration. Majority 67.6% of their parents earned less than 2 dollars a day an indication that the parents had low socio-economic status. This was similar to a study done by (Cancian et al., 2010 & Sedlak et al., 2010).

In the current study, children who had experienced sexual violence and were under the care of married couples had lower levels of moderate to severe depression 67.7% compared to divorced couple where the depression was 75% among the children. However there was no statistical significance difference obtained between marital status and depression. This is consistent with study findings by Ombok et al., (2013) who reported similar findings that negative mental health outcomes were more prevalent among children from divorced and separated parents at 52% and less among married couples at 40%.

The study findings indicate that male sexually abused children were 3 times more likely to score above average marks than female sexually abused children OR=3.5 [95% CI of OR 1.3-9.2], p=0.013. In contrast other studies done in Kenya by Ombok et al., (2013) and Syengo et al., (2008) did not evaluate gender and their school performance in relation to their sexual abuse experience.

This study confirms that sexual abuse is common among girls than boys. One hundred and sixty eight girls and 23 boys experienced sexual violence in the current study. This is consistent with previous studies on sexual abuse of children in Kenya Ombok et al., (2013) & Syengo et al., (2008) as well as International studies (Finkelhor et al., 2013; Pereda et al., 2009; Brown et al., 2009).

5.4 Post-Traumatic Stress Disorder and SVAC

Children who have experienced sexual violence experience PTSD. The findings of the current study that the incidence of PTSD at baseline was at (95.3%) and (95%) at follow up 1 is consistent with study finding by Ndetei et al., (2007) who found the prevalence of PTSD among secondary students who had experienced traumatic event to be 85.3%. Elklit & Christiansen (2010) in their study among sexual assault victims found the prevalence of PTSD at 80%. The incidence of PTSD found among the sexually abused children in the current study at follow up 2 (60.5%) & follow up 3 (60%) is consistent with previous findings by (Syengo et al., 2008 & Ombok et al., 2013). In their study the prevalence of PTSD among sexually abused children was (45%) and (49%) respectively. However, the difference could be due to the fact that Ombok et al., (2013) and Syengo et al ., (2008) study captured children at different stages of their recovery following sexual abuse introducing possible biases related to duration of present PTSD episode.

The current study collected data both at Kenyatta National Hospital and Nairobi Women's Hospital. Similarly, Syengo et al., (2008) study was done from Nairobi Women's Hospital while Ombok et al., (2013) study was done at Kenyatta National Hospital. Syengo et al., (2008) and

Ombok et al., (2013) used a similar instrument of UCLA PTSD scale whereas the instruments used in this study was Child PTSD Symptom Scale (CPSS). This study used a comparable instrument used by Ndetei et al., (2007) which maps directly on the DSM-IV criteria.

In this study, children who received medical care early were significantly more likely to have PTSD. This finding is surprising given the requirement that cases of sexual violence report within 72 hours to receive post exposure prophylaxis against HIV and contraceptive prophylaxis. Other studies on PTSD done among children do not report this, but again did not look for this factor. This raises the question of retraumatization. Studies have shown thant previous popular method of acute psychological treatment and debriefing was found to be responsible for retraumatization and has been discredited. There is then the need to review the treatment methods in these health facilities.

This study found that SVAC was a risk factor to the development of PTSD and this was consistent with other studies (Kar and Bastia, 2006 & Fincham et al., 2009). Similar findings were by Evans et al., (2008) & Payne et al., (2010) who found that there was a relationship between SVAC and trauma symptoms of PTSD in children. All the children in the study had experienced sexual violence and majority (95.3%) developed PTSD at baseline. This is comparable to that of Ndetei et al., (2007) where 91% of their study participants had experienced traumatic event and 85.3% developed PTSD. More over, according to Bloom (1999) in her psychobiological theory she asserted that patterned and predictable responses are present in our

organs, including the brain. As such, children who experience sexual abuse may suffer from damage to all of their developmental systems, including their brains resulting into PTSD.

The findings of this study that there was no significant difference in age, both young and older children experienced PTSD after exposure to a traumatic event was similar to a study by Ndetei et al., (2007) and harder et al., (2012). However this differs significantly with study by Mbwayo (2012) and Giannopoulou et al., (2006) who found that younger children suffer more from PTSD compared to older children and adolescents. This could be attributed to the difference on the type of traumas that the children in the different studies were exposed to.

In this study sexually abused children developed PTSD and still had PTSD during follow up 3 compared to a study done by Teicher and Samson (2013). In their study sexually abused children in Germany had four times the odds of developing PTSD compared with the general population of children who experienced other forms of maltreatment and the children still were diagnosable for PTSD from follow up 3, one year after the sexual violence incidence. The likelihood of developing PTSD was greater than the likelihood of developing any other outcomes investigated such as depression (Munzer et al., 2016). In contrast a study by Alisic et al., (2014) found that one in 4 sexually abused children developed PTSD after exposure to SVAC and interpersonal trauma.

The current study findings of presence of PTSD in follow up 3 is consistent with other studies done on sexual violence against children. PTSD was maintained over time due to trauma related shame, SVAC was a trauma associated with shame over time (Amstadter & Vernom 2008;

Oktedalen et al., 2014). Prolonged psychological trauma was also found in by Kokonya et al., (2014) in Kenya among children who had experienced sexual violence. In their study they noted that SVAC is accompanied by deeper prolonged psychological trauma and that PTSD in SVAC was more traumatic psychologically than ordinary trauma.

This study found that sexually abused adolescents attempted suicide which was consistent with a study by Kar et al., (2007) who found that children and adolescents with PTSD have high ideation of suicide. One of the parents stated the following.

"My daughter was emotionally disturbed by the sexual abuse incident. She has attempted suicide once. She feels like crying most of the time".(K1)

5.5 Depression and SVAC

Children who have experienced sexual violence have very high incidence of depression. The incidence of severe and moderate depression found among the children in the current study at baseline 69.5% is comparable with study findings by (Mugambi & Gitonga, 2015 & Sumner et al., 2016) where 80% & 90% of the children and adolescents had varying degrees of depression due to sexual abuse. Gelaye et al., (2009) found that students who had experienced sexual violence were twice more likely to experience depression than non- abused students. Munzer et al., (2016) found that children who have experienced sexual violence had an elevated risk of developing depression. The findings of this study that sexually abused children develop depression after the incidence of sexual violence is consistent with study findings by (Teicher et

al., 2010 & Mizenberg et al., 2008). Trauma in children changes the chemistry and even the structure of the brain consequently the child's brain becomes damaged by the abuse bringing with it the vulnerability to depression. One of the parents/legal guardians stated the following about her child

"She has not been able to go to school, she is sad all the time, she eats poorly, she has lost weight and she just feels tired all the time. She keeps on having nightmares and she has lost hope in life. She attempted suicide once but I have talked to her. "(K1)

The current study finding is comparable to study findings by (Syengo et al., 2008). In their study the prevalence of depression among children who had experienced sexual violence was (46%). The difference could be due to the time the two data were collected. Data collection for the current study was done one month after the incidence of sexual violence while in Syengo et al.,(2008) study, data was collected at different stages of the participant's recovery. Ndetei et al., (2009) also found that the prevalence of depression among children was at 41.3%.

In this study, children who received medical care early were significantly more likely to have PTSD. This is surprising finding given the requirement that cases of sexual violence report within 72 hours to receive post exposure prophylaxis against HIV and contraceptive prophylaxis, other studies on depression done among children do not report this, but again did not look for this factor. This raises the question of retraumatization. Studies have shown thant previous popular method of acute psychological treatment and debriefing was found to be responsible for

retraumatization and has been discredited. There is then a need to review the treatment methods in these health facilities.

The frequency of abuse and how long the abuse had taken place was statistically associated with depression in this study. This was consistent with previous study by (Ombok et al., 2013) who found an association between frequency of sexual abuse, how long the abuse took place and mental disorders. However in Syengo et al., (2008) study, they did not find any association between depression and frequency of abuse.

This study found that there was a decrease of depression over time in the children and an increase of the children's school performance. Ndetei et al., (2015) found that mental disorders in children if not detected early could interfere with the children's psychological, social and education development and early treatment of mental disorders in children improved their psychosocial functioning.

At baseline moderate-severe depression among the children was 69.5% which was comparable to the parent's view of moderate–severe depression at 70.8%. However during the follow ups parents had still the perception that their children had depression. This is consistent with a study by, Dunju and Lutz (2016) who found that parents developed symptoms of distress in response to their child's exposure to traumatic events. Alisic et al., (2016) also found that parents experienced secondary trauma as a result of their children being exposed to trauma. Fivush (2007) found that parental emotional display had an impact on their children.

Similarly, Morris et al., (2012) found an association between parental responses to trauma in the children and depression in the children. A positive family or social environment after children experience SVAC is associated with reduced risks for negative psychological outcomes (Kinnally et al., 2009). Negative appraisals of trauma in children among the caregivers and dysfunctional strategies to control the perceived threat are hypothesized to maintain negative mental health outcomes (Ehlers et al., 2003). And increased parental distress after their children have experienced a traumatic event is associated with high levels of psychological distress among the children (Scheeringa et al., 2015).

Bhatia & Bhatia (2007) in their study found that depressed students' lost interest in activities, disengaged from peers, refused school and were absent from school which had the potential to adversely impact in their academic achievement. Sexual violence against children is associated with school disruption and it has profound impact on the ability of the child to concentrate at school. This is in line with findings of the current study as majority of the children performed poorly at baseline due to the sexual violence. Similar findings were by Fry et al., (2016). Holt et al., (2007) found that youth in the US who had experienced sexual violence emerged as the group with the most significant academic problems.

The study findings that the sexually abused children experienced co-morbidity are comparable to (Syengo et al., 2008; Nyaga, 2009 & Khasakhala et al., 2013). Comorbidity range from PTSD, depression, acute stress disorder, dysthymic disorder, Oppositional defiant disorder, bipolar

disorder and attention deficit hyperactivity disorder. However this study screened for PTSD and depression and the impact of SVAC on self-esteem and school performance.

5.6 SVAC and Self esteem

This study found that SVAC was associated with low and average self-esteem in children. Seventy five point four percent (75.4%) of the study participants had average scores of self-esteem while (18.3%) had low self-esteem at baseline. The study findings are consistent with findings by Burack et al., (2006) who found that maltreated children had lower self-worth than their peers which could lead to self-harm, risk taking Behavior and poor performance in school. This is also comparable to a study by Wondie et al., (2011) among child sexual abuse survivors in Ethiopia that showed that sexually abused children had a lower degree of self-worth compared to non-abused children.

The study findings are consistent with a study done in India among rural adolescent girls who had average and low self-esteem Nagar et al., (2008) and self-esteem was correlated with educational status of the girls. Similarly, Pullmann & Allik (2008) found that Estonian students had low and average scores of self-esteem. Also, Kim & Cicchetti (2006) found that physical and emotional abuse including SVAC predicted initial levels of self-esteem. These findings are consistent with study findings that show that females who had experienced child sexual abuse had negative appraisals of themselves and had developed PTSD (Dyer et al., 2013).

There is significant association between low and average self-esteem and change of attitude towards school in the current study, however previous studies have not reported significant associations between low and average self-esteem and change of attitude towards school. The significance could be explained by the fact that the environment of the child after experiencing sexual abuse could be source of stigma hence affecting the child especially if the sexual abuse is known among her or his fellow students. One of the parent/legal guardians noted the following in her child.

"*My child had a problem staying in the plot (residential area) since other children could tease her and they knew about the sexual violence incident and this affected her self-esteem".*

This study found that sexually abused children performed poorly in school as a result of the sexual abuse incidence and this poor performance in school impacted on their self-esteem. This is consistent with study by Gachungi (2005) among secondary school students who noted that low self-esteem was a risk factor for poor academic performance among school going children. Fathi-Ashtiani et al (2007) & Aryana (2010) in their study among adolescents and students found that positive self-esteem had an impact on academic achievement and increase in self-esteem was related to decrease of anxiety and depression. Seka (2012) in her study noted that a psychological problem is another problem that sexually abused children experience which undermines their self-esteem.

5.7 SVAC and Academic performance

This study found that SVAC was associated with low academic performance at baseline. The findings are consistent with other study findings on sexual violence among children and their education performance. Nansasi (2010) in her Ugandan study found that the majority (80%) of the sexually abused children either dropped out of school or performed poorly in academics after experiencing sexual violence. Similarly, Oswago, (2014) in her study among sexually abused children in Kenya found that they performed poorly in school after experiencing SVAC. Ndetei et al., (2015b) indicated that mental disorders in children if not detected early could interfere with the children's psychological, social and education development. Mbwayo, (2012) also found that there was an association between mental health problems such as PTSD and low academic performance among children and adolescents. One of the parents in the current study had indicated the following about her child.

"Before the incident she was better but now she has dropped. I have gone to school and talked to the teacher and we have agreed to have her go for tuition (remedial teaching) to see if it will help her".(K6)

This study found that when a child is abused, his or her education is disrupted. This is because abuse has profound impact on the ability of the child to concentrate at school. Similar findings were reported by (Jamir et al., 2014). Devries, (2016) found that Sexual Violence Against Children is associated with different outcomes with children who experience more violence being more likely to doing poorly in school. Sherr et al., (2016) found that preventing Sexual

Violence Among Children improves school performance. Similarly, Fry et al., (2016) found that preventing Sexual Violence Against Children improves their educational outcomes.

Studies suggest that children with mental health problems are likely to miss more school days compared to those who are well (Wherry & Marrs, 2008; Kearney 2007). Myer et al., (2009) found an association between mental disorders with termination of education among adolescents in South Africa. Similar findings were by Leach & Butterworth (2012) in Australia. Holt et al., (2007) found that youth in the US with multiple victimization and SVAC experiences emerged as the group with the most significant psychological and academic problems. This indicates that mental disorders in children and adolescents interfere with their education performance. One of the parent/legal guardians in the current study had indicated the following.

"My daughter's educational performance has gone down since the sexual violence incident… She is normally among the last in her class".(K1)

Wei et al., (2011) noted that on studies done on Canadian school going children and adolescents that depressive symptoms are related to learning difficulties and dropping out of school including depressed children having more time off from school compared to those without depression. Hurt et al., (2001) in a study among 8 years old children in America who had experienced traumatic events such as SVAC and had PTSD missed school more compared to those without PTSD and they also achieved below average in their academic work.

This study found that when children are defiled it has adverse effect on the children to perform well in school. This compares to the study findings in the US by Carrell & Hoekstra (2009) who found that children exposed to domestic violence including SVAC experienced inattentiveness in class, truancy and low academic performance as a result of SVAC and exposure to violence.

This study finding compares with study finding by Slade and Wissow (2007) on maltreatment and adolescent academic performance. Slade and Wissow (2007) found that those adolescents in the US middle and high school students who experienced more intense childhood maltreatment and SVAC were associated with greater probability of having low GPA p=0.001, and had problems completing homework assignments (p=0.007).

The study findings that sexually abused children experienced difficulties in competing homework compares to study findings by Albano et al., (2003). Students with mental disorders are more likely to doubt their academic competence thus interfering with their ability to complete assignments. This can lead to underachievement, problems related to concentrating in school work and doing homework. The time these students spend academically engaged is also affected by the incidence of SVAC as the PTSD and depression triggers overwhelming thoughts which impede their concentrations. This explains the reason why the children in the current study performed poorly after the incidence of SVAC.

Mwangi (2013) in her study notes that SVAC robs children of their childhood which impacts on their education progress. Maniglio (2009) found that SVAC was associated with decline in academic performance as well as learning difficulties. The current study also found that sexually

abused children reported a drop in their academic performance. Omondi (2014) demonstrated that 80% of the reported SVAC cases among Kenyan children had a negative effect to their education due the need to attend the court processes.

5.8 Other social outcomes associated with SVAC from the qualitative data

This study found that SVAC could result to pregnancy and HIV exposure which affects the education performance of the girls. These study findings are similar to study conducted by Seka (2012) in which she found that girls suffered more from sexual abuse and most girls exposed to sexual violence turned to be HIV positive or have children. The World Bank report notes that childhood pregnancy rates in developing countries stand at 1 in 5 girls (World Bank, 2014). In another study (Mwangi, 2013) found that 0.54% boys and 0.84% of girls were HIV positive as a result of the SVAC and 1.6% became pregnant. In the same study 0.4% boys and 1.2% girls got Sexually Transmitted Diseases as a result of experiencing SVAC. Parents/legal guardians noted the following from their children.

"The drugs (PEP and EP) which my daughter was given did not help her since she contracted HIV and became pregnant".(K4)

"My daughter also told me the same thing used to happen to her brother… (Both) were treated since they had contracted an infection".(K6)

"My daughter could not believe she was pregnant".(K6)

Mwangi (2013) in her study noted that sexually abused children experience psychological problems including running away from home which may predispose children to being violent later in life particularly boys. In her study 67% had psychological problems. One of the parents/legal guardians in the current study stated the following.

"She runs away from home for hours without knowing where she is going".(K1)

This study compares to Omondi (2014) & Ndungu et al., (2014) who found that the victims of SVAC who sought justice were confronted with a legal system that ignores, denies and at times condones violence against child victims while protecting the perpetrator. One of the parents/legal guardian noted the following.

"The sexual violence of my child has made me lose my job since I have been borrowing permission every now and then either to go to court or to attend to my daughter's issues".(K2)

This study found that children with disability are vulnerable to being defiled as one of the children had disability. This compares to a study by smith & Harrell (2013) who found that a child with a disability has a higher risk of experiencing sexual abuse than a child without disability.

5.9 Conclusion

Sexually abused children seen at Nairobi Women's and Kenyatta National Hospital have mental health problems as measured by the PTSD, depression and self-esteem scales. Children who were seen early experienced re-traumatization and therefore were much more likely to develop

PTSD and depression. Male sexually abused children were more likely to perform above average than female sexually abused children. Children performed poorly in school after the incidence of SVAC and also expererenced other problems such as pregnancy, HIV AIDs, homes that are disrupted and dropping out of school. Girls are more at risk of experiencing SVAC than boys. Screening of children PTSD and Depression after SVAC incidence can be important as a prevention of mental health problems in children. Parents of children who have been sexually abused need psychosocial support to deal with the trauma in their children.

5.10 Limitation of the study

The research is only within two hospitals in the Country; due to this the results might only be generalized within the area of study.

5.11 Strength of the study

Data was collected one month after the SVAC incidence reducing the risk of recall bias and gives the closest representation of the participant's perspective.

5.12 Recommendations

1. Screening for PTSD and depression should be done among the sexually abused children including follow up of screening in subsequent visits.
2. Consideration of parental distress when treating children exposed to trauma.
3. Children with school failure should be assessed for the occurrence of SVAC.
4. Review policy and guidelines' regarding the procedure after a child has experienced sexual violence to reduced re-traumatization.

5. Capacity building on the teachers and school children on prevention and the procedures after a child has experienced sexual abuse.
6. Minimizing risk factors that would lead to poor mental health outcomes after the incidence of sexual violence on children and enhance parenting protective skills.
7. Social workers should be involved in treating sexually abused children to help them deal with psychosocial issues

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APPENDICES

APPENDIX 1: Consent Forms

CONSENT FORMS FOR PARTICIPANTS IN THE STUDY OF PSYCHOSOCIAL OUTCOMES ASSOCIATED WITH SVAC AMONG CHILDREN SEEN AT KENYATTA NATIONAL HOSPITAL AND NAIROBI WOMEN'S HOSPITAL.

CONSENT EXPLANATION:

My name is Teresia Ndilu Mutavi, a PhD student in Psychiatric Social Work at the University of Nairobi at the College of Health Sciences, Department of Psychiatry. I have chosen to write my dissertation on "**Psychosocial outcomes associated with SVAC among children seen at Gender Based Violence Recovery Centres of the Mental Health Department Kenyatta National Hospital and The Nairobi Women's Hospital**". I have selected you and your child to be one of the participants of the study.

I am interested in finding out how common these problems are among the sexually abused children and thereafter plan ways on how best to handle those problems in the sexually abused children. I ask if you would like to be part of this research study. If you agree, I would like to ask you some questions. In the study the children will be asked to complete four questionnaires while you as the parent will be asked to complete two questionnaires.

The first questionnaire is on socio- demographic characteristics, which has been developed by me the researcher for this particular study for you as the parent or legal guardian and for the

child. The next three questionnaires are internationally used instruments. One will be on depression on the children as per the parents/ legal guardian's observation on the child. The other instruments will be on Post-Traumatic Stress Disorder, depression on children and self-esteem. I will also require the report card for the child on her school performance. Apart from the highly confidential information from the child and you as the parent/ legal guardian, there will be no physical procedures.

The children will then be followed up after every four months using the same instruments for a period of one year, following your agreement to participate in the research study; you can still refuse to answer any questions. You can stop being in the study at any time. There will be no loss of benefits or any victimization whatsoever.

Risk/discomfort: Some of the questions, especially those to do with the SVAC of your child, this may be uncomfortable and make you remember painful experiences.

Benefits: Results of post-Traumatic Stress Disorder, depression, school performance and self-esteem of the children will be ready within one year as you continue with your treatment. The result can help us plan treatment for the sexually abused children at Kenyatta National Hospital and Nairobi Women's Hospital. The results will also help us learn how to better treat SVAC cases. There will be no other benefits or any other financial incentives for taking part in the study. You will not be paid to take part in the study.

Confidentiality: What I talk about and your results will be kept private to the extent allowed by law. To protect your privacy, I will keep the records under a code number and not your name. We will keep the records in a safe place and only staffs attending to you in this clinic are allowed to look at them.

To be in this study is your choice. If you do not want to participate in the study, you will still get the best possible medical care here at the centre. If you participate in the study, but then have questions or decide you do not want to go on in it, you can withdraw. If you decide that you do not want to go on in the study, you will still get the best possible medical care at the centre. If you have questions about your rights as a participant you can call on the researcher,

Teresia Mutavi, 0722391236 or

Ethics Research Committee

Secretary, 0722392219 or

726300-9 or P.O. BOX 20723,

Nairobi, Kenya.

CONSENT EXPLANATION FOR PARENTS/GUARDIANS

Consent form: consent for parent/guardian of the sexually abused children

My name is Teresia Ndilu Mutavi, a PhD student in Psychiatric Social Work at the University of Nairobi at the College of Health Sciences, Department of Psychiatry. I have chosen to write my dissertation on "**Psychosocial outcomes associated with SVAC among children seen at Gender Based Violence Recovery Centres of the Mental Health Department Kenyatta National Hospital and The Nairobi Women's Hospital**". I have selected you and your child to be one of the participants of the study.

I am interested in finding out how common these problems are among the sexually abused children and thereafter plan ways on how best to handle those problems in the sexually abused children. I ask if you would like to be part of this research study. If you agree, I would like to ask you some questions. In the study the children will be asked to complete four questionnaires while you as the parent will be asked to complete two questionnaires.

The first questionnaire is on socio- demographic characteristics, which has been developed by me the researcher for this particular study for you as the parent or legal guardian and for the child. The next three questionnaires are internationally used instruments. One will be on depression on the children as per the parents/ legal guardian's observation on the child. The other instruments will be on Post-Traumatic Stress Disorder, depression on children and self-esteem. I

will also require the report card for the child on her school performance. Apart from the highly confidential information from the child and you as the parent/ legal guardian, there will be no physical procedures.

The children will then be followed up after every four months using the same instruments for a period of one year, following your agreement to participate in the research study; you can still refuse to answer any questions. You can stop being in the study at any time. There will be no loss of benefits or any victimization whatsoever.

Risk/discomfort: Some of the questions, especially those to do with the SVAC of your child, this may be uncomfortable and make you remember painful experiences.

Benefits: Results of post-Traumatic Stress Disorder, depression, school performance and self-esteem of the children will be ready within one year as you continue with your treatment. The result can help us plan treatment for the sexually abused children at Kenyatta National Hospital and Nairobi Women's Hospital. The results will also help us learn how to better treat SVAC cases. There will be no other benefits or any other financial incentives for taking part in the study. You will not be paid to take part in the study.

Confidentiality: What I talk about and your results will be kept private to the extent allowed by law. To protect your privacy, I will keep the records under a code number and not your name.

We will keep the records in a safe place and only staffs attending to you in this clinic are allowed to look at them.

To be in this study is your choice. If you do not want to participate in the study, you will still get the best possible medical care here at the centre. If you participate in the study, but then have questions or decide you do not want to go on in it, you can withdraw. If you decide that you do not want to go on in the study, you will still get the best possible medical care at the centre. If you have questions about your rights as a participant you can call on the researcher,

Teresia Mutavi, 0722391236 or

Ethics Research Committee

Secretary, 0722392219 or

726300-9 or P.O. BOX 20723,

Nairobi, Kenya.

CONSENT FORM

PARTICIPANTS ID.....DATE.....

Parent/ guardian's name:.....

Parent/ guardian's statement

The above study has been explained to me and I agree to take part and have my child take part. If I change my mind, I understand that my child will continue to receive medical care.

Parent/ guardian's signature:.....
(Or mark of consent)

Witness signature:.....

Investigator signature:.....

Parent/guardian may sign or provide verbal consent in the presence of a witness who then signs.

ASSENT EXPLANATION FOR CHILDREN

I will read this assent to the child at the time of enrolment.

Introduction

Although I got the permission of your parent/legal guardian to talk to you, I want to explain to you what I want so that you can decide yourself whether you want to participate.

My name is Teresia Ndilu Mutavi, a PhD student in Psychiatric Social Work at the University of Nairobi at the College of Health Sciences, Department of Psychiatry. I have chosen to write my dissertation on "**Psychosocial outcomes associated with SVAC among children seen at Gender Based Violence Recovery Centres of the Mental Health Department Kenyatta National Hospital and The Nairobi Women's Hospital**". I have selected you to be one of the participants of the study.

I am interested in finding out how common these problems are among the sexually abused children and thereafter plan ways on how best to handle those problems in the sexually abused children. I ask if you would like to be part of this research study. If you agree, I would like to ask you some questions.

In this study I will ask you to complete four questionnaires. The first questionnaire is on socio-demographic characteristics, which has been developed by me the researcher for this particular

study for you as the child. The next three questionnaires are internationally used instruments. The instruments will be on Post-Traumatic Stress Disorder, depression on children and self-esteem. I will also require your report card to check on your school performance.

Apart from the highly confidential information from you and your parent/legal guardian, there will be no physical procedures. I will then follow you up after every four months using the same instruments for a period of one year, following your agreement to participate in the research study; you can still refuse to answer any questions. You can stop being in the study at any time. There will be no loss of benefits or any victimization whatsoever.

Risk/discomfort: Some of the questions, especially those to do with your SVAC, this may be uncomfortable and make you remember painful experiences.

Benefits: Results of post-traumatic stress disorder, depression, school performance and self-esteem of the children will be ready within one year as you continue with your treatment. The result can help us plan treatment for the sexually abused children at Kenyatta National Hospital and Nairobi Women's Hospital. The results will also help us learn how to better treat SVAC cases. There will be no other benefits or any other financial incentives for taking part in the study. You will not be paid to take part in the study.

Confidentiality: What I talk about and your results will be kept private to the extent allowed by law. To protect your privacy, I will keep the records under a code number and not your name. We will keep the records in a safe place and only staffs attending to you in this clinic are allowed to look at them.

To be in this study is your choice. If you do not want to participate in the study, you will still get the best possible medical care here at the centre. If you participate in the study, but then have questions or decide you do not want to go on in it, you can withdraw. If you have questions about your rights as a participant you can call on the researcher,

Teresia Mutavi 0722391236 or

Ethics Research Committee

Secretary 0722392219or 726300-9 or

P.O. BOX 20723, Nairobi, Kenya.

ASSENT FORM

PARTICIPANTS ID.....DATE.....

Name of child:.....DATE.....

Name of child (signature or mark of consent).....

To be signed by witness

The above statement has been read to the child and the child agrees to participate in the research project.....Date.....

Name of witness (print).....

Name of witness (signature or mark of consent)

Investigator signature:.....

Consent form: consent for parent/guardian of the sexually abused children who will provide qualitative data

My name is Teresia Ndilu Mutavi, a PhD student in Psychiatric Social Work at the University of Nairobi at the College of Health Sciences, Department of Psychiatry. I have chosen to write my dissertation on "**Psychosocial outcomes associated with SVAC among children seen at Gender Based Violence Recovery Centres of the Mental Health Department Kenyatta National Hospital and The Nairobi Women's Hospital**". I have selected you to be one of the participants of the study.

I will be interested in finding out some of the experiences you have undergone as a result of the incidence of your child's SVAC. I will ask if you would like to be part of this research. If you agree I would like you to share how the SVAC incidence of your child has affected his or her relationship with the family. Her or his education performance after the incidence and any signs you have noted that you could attribute to the SVAC incidence. These questions will be about your child's SVAC, you can still refuse to answer any question. You can also stop being in the study at any time.

Risk/discomfort: Some of the questions, especially those to do with your child's SVAC may be uncomfortable.

Benefits: The result can help us plan treatment for the sexually abused children at Kenyatta National Hospital and Nairobi Women's Hospital. The results will also help us learn how to better treat SVAC cases. You will not be paid to take part in the study.

Confidentiality: What I talk about and your results will be kept private to the extent allowed by law, to protect your privacy, I will keep the records under a code number and not your name. We will keep the records in a safe place and only staffs attending to you in the centre are allowed to look at them.

To be in this study is your choice. If you do not want to participate in the study, you will get the possible medical care here at the centre. If you participate in the study, but then have questions or decide you do not want to go on in it, you can withdraw. If you have questions about your rights as a participant, you can call the researcher,

Teresia Mutavi - 0722391236

Ethics Research Committee

Secretary 0722392219, or 726300-9 or

P.O. BOX 20723, Nairobi, Kenya.

CONSENT FORM

PARTICIPANTS ID.....DATE.....

Parent/ guardian's name:.....

Parent/ guardian's statement

The above study has been explained to me and I agree to take part. If I change my mind, I understand that my child will continue to receive medical care.

Parent/ guardian's signature:.....

(Or mark of consent)

Witness signature:.....

Investigator signature:.....

Parent/guardian may sign or provide verbal consent in the presence of a witness who then signs.

APPENDIX 2: Training Manual

Training manual for research assistants

Contents of the training

Introduction

This study will be carried out at Gender Based Violence Recovery Centres of the Mental Health Department Kenyatta National Hospital and The Nairobi Women's Hospital. It is a longitudinal study and the researcher will carry it out in one year (12 month) at interval of four months using the same instruments.

Definitions of terms

SVAC: SVAC is a form of sexual abuse directed at children in which adults or older adolescents sexually defile children for their sexual stimulation.

Child sexual abuse: In this study according to WHO (2006) sexual act with a child performed by an adult or an older child could include a number of acts namely:

- Sexual touching of any part of the body, clothed or unclothed;
- Penetrative sex, including penetration of the mouth;
- Encouraging a child to engage in sexual activity, including masturbation;
- Intentionally engaging in sexual activity in front of a child;
- Showing children pornography, or using children to create pornography;
- Encouraging a child to engage in prostitution.

The files the research assistants to collect for the study

The files the research assistants to collect for the study are for the children who registered at the Nairobi Women's Hospital gender based recovery centre and Kenyatta National Hospital at the mental department gender based recovery centre. The participants for the research will be contacted one month after the SVAC incidence.

Ethical Considerations

It is important to act as ethically as possible. Issue of confidentiality and privacy while handling the clients files will be emphasized by the researcher to the research assistants.

APPENDIX 3: Tools and Instruments

Questionnaire for the child

Part A: Socio- demographic

Participant 1D _____ Date of interview: dd.....mm.....yr.....

Interview start time_____

(Circle the correct response number where applicable)

First I am going to ask you about some basic information about yourself, your family and where you are from.

1. Gender: 1. Male_____ 2.Female_____

1. Date of birth :dd.....mm.....yr.....

Approximate age in years and months if actual birthdate not known: .....

3. Place of birth:1. Nairobi 2. Machakos 3.Kiambu 4. Nakuru

5. Others Specify.....

4. What is your nationality?

Kenyan.....1 Tanzanian.....2Ugandan.....3

Other.....4 Specify:.....

5. What is your ethnicity?

Mijikenda.....1 Kisii.....9

Luhya.....2 Kalenjin.....10

Luo.....3 Samburu.....11

Kikuyu.....4 Bajuni.....12

Kamba.....5 Swahili.....13

Masai.....6 Arab.....14

Meru.....7 Asian.....15

Embu.....8 Other.....16 Specify: .....

6. Are you attending school? 1. Yes 2.No ***(if no skip to Q8)***

7. If yes, which level? 1. Primary 2.Secondary

8. Do you have parent(s)

1. Both mother and father 2.Only mother 3.Only father4. None

9. What is your parents' marital status?

1. Married 2. Separate 3. Divorced4. Others,Specify_____

10. Who do you live with?

1. Good Samaritan 2. Neighbors 3. Friends 4. Care giver

5. Guardian 6. Other(s), specify_____

11. What is your birth order in your family? _____

12. How many a) brothers_____ b) sisters _____ do you have?

13. What level of education did your mother or father attain?

Education level	**Mother**	**Father**
None	1	1
Primary	2	2
Secondary	3	3
College	4	4

Part B: Nature of the sexual abuse

14. What is your relationship with the perpetrator?

1. Stranger
2. Acquaintance(neighbor, boyfriend classmate
3. Non parental care giver in position of trust
4. Biological parent
5. Non biological parent
6. Non biological parent e.g step or foster parent
7. Other(s), specify_____

15. What acts did the perpetrator do?

1. Vagina anal penetration 2. Touching the genitals

3. Non genital contact 4. Exhibitionism (removed all his clothes)

5. Other(s), specify _____

16. What did he/she make you perform?

1. Nothing 2. Touching his/her genitals 3. Oral copulation

4. Other(s), specify_____

17. What was the frequency of the abusive incidence?

1. Once 2. Twice 3.Three times 4.Four times

5. More than four times

18. For how long has the abuse taken place?

1. Days 2. Weeks 3. Months 4. Years

19. Who did you first tell of the sexual abuse?

1. My mother 2. My father 3.My guardian

4. My friends 5.My teacher 6.None

7. Other(s), specify _____

20. How long did it take before sharing the abuse with the above mentioned person?

1. Same day of abuse 2. One day after the abuse

3. One week after the abuse 4.One month after the abuse

5. Other(s), specify_____

21. Where were you taken first?

1. Hospital 2.Chief's camp 3.Police station

4. Counselor 5.Other(s), specify_____

22. After how many hours did you receive medical attention?

1. Within one hour 2.Within two hours

3. Within 12 hours 4.Within 48 hours

5. Within 72 hours 6. Others, specify _____

23. Since the sexual SVAC happened, what position have you been in class

Position	**Last term**	**2nd previous term**
1-10	1	1
11-20	2	2
21-30	3	3
Among the last	4	4

24. What final score did you attain in the last previous school exam?

1. 200 marks 2. 250marks 3. 300marks 4. 350marks 5. 400marks 6.450 marks

25. How did you cope with your school work?

1. Finishing homework
2. Not finishing homework
3. Others Specify.....

26. Did your attitude towards school and the activities you took part in change after the abuse?

1. Yes 2. No 3.If so, in what way? .....

27.Were there times that you used school as a means of escape from the abuse?

1. Yes 2. No

Questionnaire for the parent

Part A: Socio- demographic

Participant 1D _____ Date:dd.....mm.....yr.....

Interview start time_____

(Circle the correct response number where applicable)

First I am going to ask you about some basic information about yourself and where you are from.

1. Gender: 1. Male_____ 2. Female_____

2. Date of birth:dd..... mm.....yr.....

Approximate age in years if actual birthdate not known: .....

3. Place of birth: 1. Nairobi 2. Machakos 3.Kiambu 4. Nakuru

5.Others Specify.....

4. What is your nationality?

Kenyan.....1 Tanzanian.....2 Ugandan.....3

Other.....4 Specify:.....

5. What is your ethnicity?

Mijikenda.....1	Kisii.....9
Luhya.....2	Kalenjin.....10
Luo.....3	Samburu.....11
Kikuyu.....4	Bajuni.....12
Kamba.....5	Swahili.....13
Masai.....6	Arab.....14
Meru.....7	Asian.....15
Embu.....8	Other.....16 Specify: .....

6.What is your highest level of education?

Primary....1 Secondary...2 College....3 University.....4

7. How much do you earn?

1. Less than a 100/= a day 2.100/= a day 3. More than a 100/= a day

8.Do you take any of the following?

1. None 2. Smoke bang 3. Smoke cigarette

4. Drink alcohol 5. Chew miraa

6. Other(s), specify_____

9.How do you sort out disagreements in the family?

1. By talking 2. By fighting

3. Don't know 4. Other(s), specify_____

BECK'S DEPRESSION INVENTORY Scale (BDI) for children above 16 years

Identification Number ……

Now I would like to ask you about your feelings. Some people feel sad, some people feel happy and some people have feelings somewhere in the middle. [SHOW VISUAL ANALOGUE SCALE OF FACES WITH FEELINGS] **It is normal to feel all of these feelings. Please tell me honestly which statement in each group best describes the way you have been feeling <u>during the past two weeks,</u> including today.**

(Circle the correct response number where applicable)

The first groups of statements are about …

1. Sadness

I do not feel sad 0

I feel sad much of the time ….....1

I am sad all of the time 2

I am so sad or unhappy that I can't stand it…...**3**

DK 7

Refused..... 8

The next statements are about REPEAT THIS LEAD IN FOR ALL GROUPS]

2. Pessimism

I am not discouraged about my future..... 0

I feel more discouraged about my future than I used to be. 1

I do not expect things to work out for me..... 2

I feel my future is hopeless and will only get worse **3**

DK 7

Refused..... 8

3. Past Failure

I do not feel like a failure..... 0

I have failed more than I should have. 1

As I look back, I see a lot of failures **2**

I feel I am a total failure as a person.. 3

DK 7

Refused..... 8

4. Loss of Pleasure

I get as much pleasure as I ever did from the things I enjoy. 0

I do not enjoy things as much as I used to..... 1

I get very little pleasure from the things I used to enjoy.....2

I cannot get any pleasure from the things I used to enjoy **3**

DK 7

Refused..... 8

5. Guilty Feelings

I do not feel particularly guilty..... 0

I feel guilty over many things I have done or should have done.....**1**

I feel quite guilty most of the time 2

I feel guilty all of the time 3

DK 7

Refused..... 8

6. Punishment Feelings

I do not feel I am being punished 0

I feel I am being punished 1

I expect to be punished 2

I feel I am being punished **3**

DK 7

Refused 8

7. Self -Dislike

I feel the same about myself as ever.. 0

I have lost confidence in myself.....**1**

I am disappointed in myself... 2

I dislike myself 3

DK 7

Refused 8

8. Self-Criticalness

I do not criticize or blame myself more than usual 0

I am more critical of myself than I used to be.....1

I criticize myself for all of my faults **2**

I blame myself for everything bad that happens..... 3

DK 7

Refused 8

9. Suicidal Thoughts

I do not have any thoughts of killing myself 0

I have thoughts of killing myself, but I would not carry them out.....**1**

I would like to kill myself 2

I would kill myself if I had the chance 3

DK 7

Refused 8

10. Crying

I don't cry anymore than I used to..... 0

I cry more than I used to..... 1

I cry over every little thing 2

I feel like crying, but I can not cry **3**

DK 7

Refused 8

11. Agitation

I am not more restless or wound up than usual 0

I feel more restless or wound up than usual 1

I am so restless or agitated that it is hard to stay still 2

I am so restless or agitated that I have to keep moving or doing something**....3**

DK 7

Refused 8

12. Loss of Interest

I have not lost interest in other people or activities... 0

I am less interested in other people or things than before 1

I have lost most of my interest in other people or things **2**

It is hard to get interested in anything 3

DK 7

Refused 8

13. Indecisiveness

I make decisions about as well as ever 0

I find it more difficult to make decisions than usual 1

I have much greater difficulty in making decisions than I used to....2

I have trouble making any decisions **3**

DK 7

Refused 8

14. Worthlessness

I do not feel I am worthless 0

I do not consider myself as worthwhile and useful as I used to 1

I feel more worthless as compared to other people **2**

I feel utterly worthless 3

DK 7

Refused 8

15. Loss of Energy

I have as much energy as ever..... 0

I have less energy than I used to have.....1

I do not have enough energy to do very much..2

I do not have enough energy to do anything ….**3**

DK 7

Refused..... 8

16. Changes in Sleeping Pattern

I have not experienced any change in my sleeping pattern... 0

I sleep somewhat more than usual..... ....1a

I sleep somewhat less than usual..... ....1b

I sleep a lot more than usual 2a

I sleep a lot less than usual 2b

I sleep most of the day 3a

I wake up 1-2 hours early and can't get back to sleep..... .....**3b**

DK 7

Refused..... 8

17. Irritability

I am no more irritable than usual..... 0

I am more irritable than usual 1

I am much more irritable than usual.. .....**2**

I am irritable all the time 3

DK 7

Refused 8

18. Changes in Appetite

I have not experienced any change in my appetite 0

My appetite is somewhat less than usual..... ....1a

My appetite is somewhat greater than usual.. ....1b

My appetite is much less than before **2a**

My appetite is much greater than usual 2b

I have no appetite at all 3a

I crave food all the time 3b

DK 7

Refused 8

19. Concentration

I can concentrate as well as ever 0

I can not concentrate as well as usual 1

It is hard to keep my mind on anything for very long **2**

I am irritable all the time 3

DK 7

Refused 8

20. Tiredness or Fatigue

I am no more tired or fatigued than usual..... 0

I get more tired or fatigued more easily than usual 1

I am too tired or fatigued to do a lot of the things I used to do **2**

I am too tired or fatigued to do most of the things I used to do 3

DK 7

Refused 8

Child/Youth PTSD Symptom Scale CPSS for children (7-17 years)

Identification Number ……

Please circle 0, 1, 2 or 3 for how often the following things have bothered you in the last two weeks: (0-Never;1-Once in a while; 2-More than half the time; 3-Almost always)

No		Never 0	Once in a while 1	More than half the time 2	Almost Always 3
1	Having upsetting thoughts or images about the event that came into your head	0	1	2	3
2	When you didn't want them to.	0	1	2	3
3	Having bad dreams or nightmares.	0	1	2	3
4	Acting or feeling as if the event was happening again.	0	1	2	3
5	Feeling upset when you think about or hear about the event.	0	1	2	3
6	Having feelings in your body when you think about or hear about the event.(heart beating fast, upset stomach, breaking out in a sweat)	0	1	2	3

7	Trying not to think about, talk about or have feelings about the event.	0	1	2	3
8	Trying to avoid activities or people, or places that remind you of the event.	0	1	2	3
9	Not being able to remember an important part of the upsetting event.	0	1	2	3
10	Having much less interest or not doing the things you used to do.	0	1	2	3
11	Not feeling too close to the people around you.	0	1	2	3
12	Not being able to have strong feelings (being able to cry or feel really happy).	0	1	2	3
13	Feeling as if your future hopes or plans will not come true.	0	1	2	3
14	Having trouble falling or staying asleep.	0	1	2	3
15	Feeling irritable of having fits or anger.	0	1	2	3
16	Having trouble concentrating.	0	1	2	3
17	Being overly careful (checking to see who is around you).	0	1	2	3
18	Being jumpy or easily startled.	0	1	2	3

Please circle 1 for YES or 2 for NO if the problems you marked interfered with:

1. Saying prayers 1. Yes 2. No

2. Doing chores 1. Yes 2. No

3. Friendships 1. Yes 2. No

4. Hobbies/Fun 1. Yes 2. No

5. Schoolwork 1. Yes 2. No

6. Family relationships 1. Yes 2. No

7. General happiness 1. Yes 2. No

Child depression inventory--Parent Version

Identification Number …….

Please circle the correct number that best describes your child in the PAST TWO WEEKS.

0 - Not true 1 – Sometimes 2 – True

No		**Not true** **0**	**Sometimes** **1**	**True** **2**
1	S/he felt miserable or unhappy.	0	1	2
2	S/he didn't enjoy anything at all.	0	1	2
3	S/he was less hungry than usual.	0	1	2
4	S/he ate more than usual.	0	1	2
5	S/he felt so tired s/he just sat around and did nothing.	0	1	2
6	S/he was moving and walking more slowly than usual	0	1	2
7	S/he was very restless.	0	1	2
8	S/he felt s/he was no good anymore.	0	1	2
9	S/he blamed her/himself for things that weren't his/her fault.	0	1	2
10	It was hard for her/him to make up her/his mind.	0	1	2
11	S/he felt grumpy and cross with you.	0	1	2
12	S/he felt like talking less than usual.	0	1	2

13	S/he was talking more slowly than usual.	0	1	2
14	S/he cried a lot.	0	1	2
15	S/he thought there was nothing good for her/him in the future.	0	1	2
16	S/he thought that life wasn't worth living.	0	1	2
17	S/he thought about death or dying.	0	1	2
18	S/he thought her/his family would be better off without her/him.	0	1	2
19	S/he thought about killing her/himself.	0	1	2
20	S/he didn't want to see her/his friends.	0	1	2
21	S/he found it hard to think properly or concentrate.	0	1	2
22	S/he thought bad things would happen to her/him.	0	1	2
23	S/he hated him/herself.	0	1	2
24	S/he felt s/he was a bad person.	0	1	2
25	S/he thought s/he looked ugly.	0	1	2
26	S/he worried about aches and pains.	0	1	2
27	S/he felt lonely.	0	1	2
28	S/he thought nobody really loved her/him	0	1	2
29	S/he didn't have any fun at school.	0	1	2
30	S/he thought s/he could never be as good as other kids.	0	1	2

31	S/he felt s/he did everything wrong.	0	1	2
32	S/he didn't sleep as well as s/he usually sleeps.	0	1	2
33	S/he slept a lot more than usual.	0	1	2
34	S/he wasn't as happy as usual, even when you praised or rewarded her/him.	0	1	2

Assessment Date: dd ……mm…….yr…….

Interview guide for qualitative narratives with parents/legal guardian

Social

How has the incidence of SVAC of your child affected his/her relationship with following?

1. Father
2. Mother
3. Legal guardian
4. Siblings
5. Any other

How has the incidence of SVAC of your child affected the child school performance?

Depression

What are some of the signs and symptoms you have noted in your child that you could attribute to the SVAC?

Self- esteem

How has the SVAC affected your child self-esteem?

CDI – CHILDREN DEPRESSION INVENTORY (for children below 16 years)

Name…….**Identification Number** ……

Date of birth: Day ___ Month ___ Year _____

Approximate age in years and months if birthdate not known :…….

(Circle the correct response number where applicable)

Gender: 1. Boy 2.Girl

Today's Date: Day _____ Month ___ __ Year _____

Number of brothers and sisters: a) Brothers_____ b) Sisters _____

Position in order of birth _____

Religion: 1. Protestant _____ 2. Catholic _____ 3.Muslim _____4. Others specify _____

This form lists feelings and ideas in groups. From each group, pick one sentence that describes youbest for the **past two weeks.** After you pick a sentence from the first group go on to the next group. There is no right or wrong answer. Just pick the sentence that best describes the way you have been recently. Put a circle around the letter of the sentence that best describes how you feel.

Here is an example of how this form works. Try it. Put a circle around the letter next to the sentence that best describes your feelings and ideas in the **past two weeks.**

Example: (1) I read books all the time (2) I read books once in a while (3) I never read books

==========

1. (1) I am sad once in a while

   (2) I am sad many times

   (3) I am sad all the time

2. (1) Nothing will ever work out for me

   (2) I am not sure if things will work out for me

   (3) Things will work out for me okay.

3. (1) I do most things o.k.

   (2) I do many things wrong

   (3) I do everything wrong

4. (1) I have fun in many things

   (2) I have fun in some things

   (3) Nothing is funny at all

5. (1) I am bad all the time

   (2) I am bad many times

   (3) I am bad once in a while

6. (1) I think about bad things happening To me once in a while

   (2) I worry that bad things will happen to me

   (3) I am sure that terrible things will happen to me

7. (1) I hate myself

   (2) I do not like myself

   (3) I like myself

8. (1) All bad things are my fault

   (2) Many bad things are my fault

   (3) Bad things are not usually my fault

9. (1) I do not think about killing myself

   (2) I think about killing myself but I

would not do it

(3) I want to kill myself

10. (1) I feel like crying every day

(2) I feel like crying many days

(3) I feel like crying once in a while

11. (1) Things bother me all the time

(2) Things bother me many times

(3) Things bother me once in a while

12. (1) I like being with people

(2) I do not like being with people many times

(3) I do not want to be with people at all

13. (1) I cannot make up my mind about things

(2) It is hard to make up my mind about things

(3) I make up my mind about things easily

14. (1) I look o.k.

(2) There are some bad things about my looks

(3) I look ugly.

15. (1) I have to push myself all the time to do my school work

(2) I have to push myself many times to do my schoolwork.

(3) Doing schoolwork is not a big problem

16. (1) I have trouble sleeping every night

(2) I have trouble sleeping many nights

(3) I sleep pretty well

17. (1) I am tired once in a while

(2) I am tired many days

(3) I am tired all the time

18. (1) Most days I do not feel like eating

(2) Some days I do not feel like eating

(3) I eat pretty well

19. (1) I do not worry about aches and pains

(2) I worry about aches and pains many times

(3) I worry about aches and pains all the time

20. (1) I do not feel alone

(2) I feel alone many times

(3) I feel alone all the times

21. (1) I never have fun at school

(2) I have fun at the school only once in a while

(3) I have fun at school many times

22. (1) I have plenty of friends

(2) I have some friends but I wish I had some more

(3) I do not have any friends.

23. (1) My schoolwork is all right

(2) My schoolwork is not as good as before

(3) I do very badly in subjects I used to be good in

24. (1) I can never be as good as other kids

(2) I can be as good as other kids if I want to

(3) I am just as good as other kids

25. (1) I usually do what I am told

(2) I do not do what I am told most times

(3)I never do what I am told

26. (1) Nobody really loves me

(2) I am not sure if anybody loves me

(3) I am sure that somebody loves me

27. (1) I get along with people

(2) I get into fights many times

(3) I get into fights all the time

Pier- Harris self-concept scale for all the children (8-18 years)

THE WAY I FEEL ABOUT MYSELF

PIERS-HARRIS 2

Autoscore ™ Form

Clients name (or ID) :_____

Today's Date:_____Age_____

Gender (circle one) Female Male Grade_____

School:_____

Teacher's name (optional) :_____

Race/Ethnicity: Asian Hispanic White

Black Native American Other

DIRECTIONS

Here are some sentences that tell how some people feel about themselves .Read each sentence and decide whether it tells the way you feel about yourself. If it is true or mostly true for you, circle the word yes next to the statement. If it is false or mostly false for you, circle the word no. Answer every question even if some are hard to decide. Do not circle both yes and no for the same sentence. If you want to change your answer, cross it out with an X and circle your new answer.

Remember that there are no right and wrong answers. Only you can tell us how you feel about yourself, so we hope you will mark each sentence the way you really feel inside.

1. My classmates make fun of me…… Yes No
2. I am happy person……. Yes No
3. It is hard for me to make friends…….. Yes No
4. I am often sad……... Yes No
5. I am smart…….……Yes No
6. I am shy……...……..Yes No
7. I get nervous when the teacher calls on me……. Yes No
8. My looks bother me……. Yes No
9. I am a leader in games and sports …….. Yes No
10. I get worried when we have tests in school…… Yes No
11. I am unpopular……Yes No
12. I am well behaved in school……Yes No
13. It is usually my fault when something goes wrong. Yes No
14. I cause trouble to my family…….. Yes No
15. I am strong…… Yes No
16. I am an important member of my family……. Yes No
17. I give up easily…… Yes No
18. I am good in my school work…… Yes No
19. I do many bad things…… Yes No
20. I behave badly at home……..…Yes No
21. I am slow in finishing my school work……. Yes No
22. I am an important member of my class…… Yes No
23. I am nervous…….. Yes No

24. I can give a good report in front of my class…….Yes No

25. In school I am a dreamer…….…. Yes No

26. My friends like my ideas……. Yes No

27. I often get into trouble……..…... Yes No

28. I am lucky……... Yes No

29. I worry a lot …… Yes No

30. My parents expect too much of me……. Yes No

31. I like being the way I am……..……. Yes No

32. I feel left out of things ……..…. Yes No

33. I have nice hair……. Yes No

34. I often volunteer in school…….…….. Yes No

35. I wish I were different…….. Yes No

36. I hate school……. Yes No

37. I am the last to be chosen in games and sports…. Yes No

38. I am often mean to other people…… Yes No

39. My classmates in school think that I have good ideas Yes No

40. I am unhappy…… Yes No

41. I have many friends……. Yes No

42. I am cheerful…… Yes No

43. I am dumb about most things……... Yes No

44. I am good looking……. Yes No

45. I get into a lot of fights……. Yes No

46. I am popular with boys……. Yes No

47. People pick on me……. Yes No

48. My family is disappointed in me…….. Yes No

49. I have a pleasant face…… Yes No

50. When I grow up, I will be an important person… Yes No

51. In games and sports I watch instead of play……. Yes No

52. I forget what I learn……..…… Yes No

53. I am easy to get along with…… Yes No

54. I am popular with girls…….. Yes No

55. I am a good reader…… Yes No

56. I am often afraid…… Yes No

57. I am different from other people…… Yes No

58. I think bad thoughts……. Yes No

59. I cry easily…… Yes No

60. I am a good person…… Yes No

Budget

Item	Input time (days)	Units/ Pax	Total units/pax	Cost/unit	Cost	Total cost
PERSONNEL						
Research assistants	50	2	2	500	25,000	25,000
Biostatistician	50	1	1	1000	50,000	50,000
Data entry clerks	30	3	3	500	45,000	45,000
Sub-total						**120,000**
Questionnaire production						
Questionnaires	820	10	10	5	42,000	42,000
Cartridge		5	5	5000	25,000	25,000
File		40	40	250	10,000	10,000
Sub total						**77,000**
Equipment & materials						
Paper rims		20	20	500	500	10,000
Writing materials						20,000
Transport to KNH and NWH	240	1	1	600	600	144,000
Approval/permit fee						5,000
Sub-total						**179,000**
Communication (air time & e-mails)						
Researcher						30,000
Field staff						10,000
Sub-total						**40,000**
Report writing						
Production of copies		8	8	3000	24,000	24,000
Sub-total						**24,000**
Total						
15% contingency						10000
Grand total						**450,000**