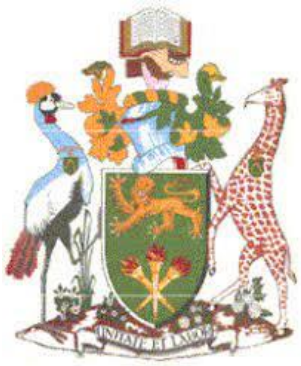

UNIVERSITY OF NAIROBI

SCHOOL OF MEDICINE COLLEGE OF HEALTH SCIENCES

DEPARTMENT OF PSYCHIATRY

MSC CLINICAL PSYCHOLOGY

HPS 916: - DISSERTATION

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OCTOBER, 2023.

HEALTH SEEKING BEHAVIOUR OF COMMUNITY HEALTH VOLUNTEERS WORKING WITH SURVIVORS OF GENDER BASED VIOLENCE IN RELATION TO BURNOUT AND VICARIOUS TRAUMA IN INFORMAL SETTLEMENTS.

A RESEARCH PROPOSAL SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF SCIENCE IN CLINICAL PSYCHOLOGY AT THE UNIVERSITY OF NAIROBI.

By;

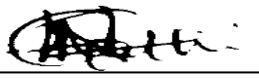
NANCY GATHI

(H56/7209/2017).

2023

DECLARATION

I declare that this thesis has not been presented for the award of degree at any University and that it's my original work.

Signed:  Date: 14/10/2023

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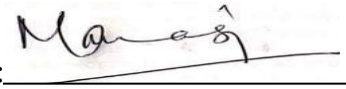
Signed:  Date: 20/10/2023

DEDICATION

First and foremost is to thank God for enabling me to complete my thesis. I dedicate this work to my Husband Elly Obwani for his sacrifice and patience during my course and our little babies, Alazne and Adiel who came into our lives during my course period.

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ABBREVIATIONS

CHVs	Community Health Volunteers.
CHWs	Community Health Workers.
CREAW	Centre for Rights Education and Awareness.
GBV	Gender-Based Violence.
NSW	Nairobi South Ward.
VT	Vicarious Traumatization.

ABSTRACT

Background: Community Health Volunteers (CHVs) close the gap between communities and the formal health system. They have a very important role in referral, health promotion, and prevention at the community level. Continuous exposure to individuals experiencing trauma may lead to provider burnout.

Study Objective: To determine the prevalence of burnout, vicarious trauma, and help-seeking behaviors of CHVs working with survivors of gender-based violence in an informal settlement in Nairobi County, Kenya.

Methods: The study used a cross-sectional mixed-method survey design to determine the prevalence of burnout and vicarious traumas experienced by CHVs working with survivors of gender-based violence in informal settlements in Nairobi County and describe their help-seeking behavior. The independent variable of this study was secondary exposure to trauma while working as a CHV in the GBV services. The dependent variables were Burnout and Vicarious Trauma and help seeking behavior.

Structured questionnaire was used to collect quantitative data, while focused group discussion (FGD) to collect Qualitative data.

Data Analysis: Quantitative data were analyzed using both descriptive and inferential statistics. Descriptive analysis involved frequencies and proportions for categorical data and mean and standard deviations for continuous variables. Comparison between categorical variables was done using Chi-Square tests and comparisons between continuous variables were done using t-tests. Analysis of qualitative data was carried out using a thematic framework approach aided by QSR NVivo 12. Results from the quantitative data and qualitative data were triangulated as much as possible for context and for more in-depth understanding of the findings.

Results: (21%) of the participants were found to have average burnout and close to 80% had low burnout levels. Females (22%) compared to the male CHVs (11%) were more likely to have average burnout. Older CHVs (21% for 41-50 years old and 25% for the >50 years old), were more likely to have average burnout compared to the younger CHVs (17% for <30 years old and 12% for the 30-40 years old). There was a significant negative correlation between compassion satisfaction score and burnout ($r=-0.52$, $p<0.001$), and a significant positive correlation between burnout and secondary traumatic stress ($r=0.54$, $p<0.001$). Both male and female CHVs were willing to seek help from a mental health profession, however most men would seek help from their spouses while women preferred seeking help from religious leaders.

Conclusion: The level of burnout was low in this study, and satisfaction with work was associated with low levels of burnout and secondary traumatic stress, implying that most CHVs are well equipped with coping strategies and were receiving support from their supervisors.

CHAPTER ONE: INTRODUCTION AND BACKGROUND INFORMATION

1.1 Introduction

Survivors of trauma are considered a special population requiring specialized knowledge and multifaceted considerations from counselors (Brierre J., 2006). Trauma counseling was developed to help survivors deal with the adverse effects often experienced because of exposure to a negative event (Chivers-Wilson, 2006). Health workers in virtually all settings work with clients who are survivors of trauma. Over time it was noted that there were emotional consequences of working with traumatized individuals. According to the British Journal of Social Work, the concept of shared trauma was becoming popular among healthcare providers working with survivors of trauma (Tosone et al., 2014). Figley (1995) characterized this as either a form of burnout or countertransference and Stoesen (2007) called it secondary traumatic stress. McCann & Pearlman conceived the term vicarious trauma which is used to express the helpers' trauma reactions as a result of survivors' traumatic experiences (McCann, 1990). Vicarious trauma is more complicated since it concerns the reactions of the counselors/helpers during counseling (Tosone et al., 2014).

Community health volunteers (CHVs) were borne from the shortage of healthcare workers experienced globally (Hanson, 2016). The idea of a community-based health volunteer program has become popular especially in developing countries to minimize the shortage of healthcare provision in the communities (Liang Chung et al., 2017). The community health strategies implemented should address the needs of the community. In addition, it should be led by the members of the community since health problems can't be solved by distance health planners; they require a combined effort by the members of the community (Cueto, 2011). From this crisis, the need to shift tasks to less qualified health workers arose bringing about the birth of CHVs who are

trained as lay volunteers to provide health services in their communities. This is considered an important initiative that would address the shortage of health workers (Vareilles et al., 2017).

The CHV programs in Kenya began in the 1970s and are made up of community members who are nominated from within the community and are tasked with the responsibility of improving the health and well-being of the community, as well as linking community members to primary healthcare services (Aseyo et al., 2018). The community health volunteers undertake standardized training and are certified to provide health promotion services at the community level. In addition, they provide formal linkages to the healthcare system and are considered part of the healthcare providers (AMREF, 2017). There is a paucity of literature on CHV in Kenya, but a study by Kaseje et al. (2010) found that local Community Health Volunteer programs were aligned with enhancement in governance and management of the healthcare system and improved child health(Kaseje et al., 2010).

Community Health Volunteers (CHVs) responding to GBV issues and working in an informal settlement are prone to burnout and vicarious trauma due to continuous exposure to traumatic events because of response to survivors of sexual violence, and domestic violence. At the same time, some of the CHVs working as first responders may also have gone through harrowing traumatic experiences themselves. The majority of the CHVs live within the same area of operation, leaving them vulnerable and may not equally find a safe space to channel their personal challenges since the community depends on and perceive them with the ability to offer a solution and provide prompt support. The nature of their job at the community level results in psychological distress due to frustration in the process of response because of the dysfunctional reporting structure at the community level, fear due to threats from the perpetrators who live within the same area, emotionally draining as they listen to cases presented. They collaboratively work with the

administrative offices at the community level and primary health care to ensure survivors of violence receive justice and treatment. The process of justice may take longer, and most cases may drop along the way before the survivors receive justice. This affects effective interventions during response at the community level.

1.2 Background of the Study

Research has found that repeated exposure to a client's traumatic experiences affects the health professional (Center for Substance Abuse Treatment (US), 2014)(SAMHSA;, 2014). Moreover, researchers and professionals have coined the terms burnout, vicarious trauma, compassion fatigue, and secondary traumatic experiences to explain the effects of this indirect exposure to trauma (Rauvola et al., 2019)(Cocker & Joss, 2016).

Continuous exposure to individuals experiencing trauma may lead to provider burnout. Maslach described burnout as emotional exhaustion, detachment, and lack of personal accomplishment experienced by therapists/psychologists while working with survivors of gender-based violence (Maslach, 2016). Burnout occurs when an individual experiences frustration from a feeling of deficiency, and lack of control as well as reduced interest when they cannot achieve their goals and results (Valent p, 2002).

Community Health Volunteers (CHVs) act as intermediaries between members of the community and formal health systems. They play a major role in fostering good health and preventing the spread of diseases by creating awareness. This in turn leads to better outcomes at the household and community level. CHVs provide health education and referrals for a wide range of services and provide support and assistance to communities, families, and individuals with preventive health measures and gaining access to appropriate curative health and social services. A Community Health Volunteer also improves individual and community capacity including health

promotion by creating awareness and educating the members of the community on matters of health. A review of definitions by 3 African countries indicates that most definitions agree with that of the WHO but add some specific elements. In Kenya for instance, community health workers are known as community health volunteers (CHVs) and they have the role of a mobilizer, promoter of development, and motivator of positive change.

Community health volunteers play a major role in health advocacy. There is increasing evidence that CHVs can improve access to primary health care and improve health outcomes among the members of the community (Aseyo et al., 2018). They contribute to improving and promoting good health among the community members. Moreover, they make referrals and link individuals to points of care whenever necessary (Uta Lehmann, 2007).

Community health volunteers play a major role in health service delivery at the community level. As health workers, they are engaged in several community-level interventions with minimal psychological support to take care of their well-being. The research focused on CHVs responding to GBV issues and working in the Mukuru informal settlements. CHVs are prone to trauma due to continuous exposure to traumatic events as a result of response to survivors of sexual violence, and domestic violence.

1.3 Statement of the Problem

In Kenya, approximately 45% of women between the ages of 15-49 have had a traumatic experience (KNBS, 2014). A study by Dimovitz in a GBV recovery center in the capital city of Kenya found that most of the respondents who reported to the center resided in informal urban settlements or slum areas of Nairobi (Dimovitz, 2015).In developing countries such as Kenya, there is a lack of human resources to sustain the social and health needs of the community. The government has recognized that there is a need to be met and has integrated into the health

provision the services of CHVs as a part of task-shifting to help address this shortage. Many of the survivors of GBV are linked to health workers in their communities, and in many cases, the CHVs are tasked with providing intervention after their traumatic experience and follow-up. CHVs have been found to play a major role in nurturing positive healthy behaviors and the prevention of health problems (Liang Chung et al., 2017).

CHVs responding to GBV issues and working in an informal settlement are prone to trauma due to continuous exposure to traumatic events because of response to survivors of sexual violence, and domestic violence. At the same time, some of the CHVs working as first responders also may have gone through traumatic experiences. This continuous and frequent exposure to a client's traumatic experiences places the CHV at risk of developing vicarious trauma. Moreover, little is known about the experience of secondary trauma among healthcare workers in Kenya. Although CHVs are not trained to deal with such delicate issues they are often tasked with providing much-needed trauma intervention to trauma survivors due to the lack of skilled personnel. This increases their risk of exposure. This study aimed to provide insight into the consequences and experiences of CHVs working with GBV survivors.

1.4 Research Question

1.4.1 The General Question

What is the prevalence of burnout, vicarious trauma, and help-seeking behavior of CHVs working with survivors of gender-based violence in an informal settlement in Nairobi, Kenya?

1.4.2 Specific Questions

1. What are the socio-demographic characteristics of CHVs working with survivors of gender-based violence in an informal settlement in Nairobi County?

2. What is the prevalence of burnout and vicarious trauma among CHVs working with survivors of gender-based violence in informal settlements in Nairobi County?
3. What is the help-seeking behavior of CHVs working with survivors of gender-based violence in informal settlements in Nairobi County?
4. What is the association between socio-demographic factors, burnout, and vicarious trauma?

1.5 Objectives of the Study

1.5.1 General Objective

To determine the prevalence of burnout and vicarious trauma as well as explore help-seeking behaviors of CHVs working with survivors of gender-based violence in an informal settlement in Nairobi County, Kenya.

1.5.2 Specific Objectives

1. To determine the socio-demographic characteristics of CHVs working with survivors of gender-based violence in an informal settlement in Nairobi County.
2. To determine the prevalence of burnout and vicarious trauma among CHVs working with survivors of gender-based violence in informal settlements in Nairobi County.
3. To assess help-seeking behavior for CHVs working with survivors of gender-based violence in informal settlements in Nairobi County.
4. To determine the association between socio-demographic factors, burnout, and vicarious trauma.

1.6 Research Hypothesis

Health-seeking behavior of community health volunteers after secondary exposure to trauma is more likely to prevent burnout and vicarious trauma.

1.7 Justification of the Study

Although the existing empirical literature is limited and has largely focused on clinicians who treat clients who are traumatized, it appears that working with traumatized clients can have a negative impact on the service providers (McCann, 1990).

Currently, there are an increasing number of reported cases of gender-based violence in Kenya which is attributed to the effects of the COVID-19 pandemic since a majority of the people are now working from home while others have lost their jobs. Although CHVs get minimal training making them more vulnerable to trauma there are not enough adequate measures to give them psychosocial support when they are working with trauma survivors. This study highlights this need by determining the levels of such trauma consequences. This research has unearthed the experience of vicarious trauma and its associated factors in CHVs as a result of extreme exposure to GBV cases reported and responded to within an informal settlement. The research highlights the need for psychosocial support and other possible measures that can be put in place to mitigate the effects of secondary exposure to traumatic experiences among Community Health Volunteers.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

The multiple roles assigned to Community Health Volunteers at the community level may result in adverse psychological effects if they lack psychosocial support to enable them to cope effectively. At the same time, the inability to access other health services may also affect their holistic well-being which may reduce their productivity and timely services as assigned at the household and community level.

2.1 Characteristics of Trauma

Trauma occurs when an individual experiences harrowing event /events, or incidents that are physically or emotionally detrimental or terrifying. This experience affects the individual's ability to function normally (Wall et al., 2016). Harrowing experiences are often unforeseen. In addition, the cause of the events varies and may be man-made or natural e.g., earthquakes, chronic illness, etc. According to Javidi (2012), trauma affects everyone regardless of age, gender, and social status (Javidi H, 2012).

A traumatic experience has been described as an event that causes extreme upset, temporarily overwhelms an individual's resources to cope, and leads to long-term psychological symptoms(Briere, 2015). Atwoli et al, (2013), defined trauma as "any event that is outside of the usual realm of human experience that is markedly distressing e.g., evokes reactions of intense fear, helplessness and horror" (Atwoli et al., 2013). On the other hand, the individual's harrowing experience dictates the extent of the trauma, and whether the event is traumatic or not (Sui, 2016). In addition, trauma affects the individual's life in significant ways and each experiences it differently.

Trauma can affect individuals, families, groups, and communities. Experiencing the event broadly engulfs an individual's and/or community's capacity to cope and brings about fear, tension, and helplessness (Trauma-Informed Care- TIC, 2014). After the occurrence of a harrowing event, the survivor may develop symptoms such as anxiety, dissociative amnesia, lack of concentration, lack of sleep, and derealization (APA, 2013). The duration and frequency of the traumatic experience are among the factors that predict whether the symptoms the individual experiences will resolve or get worse and develop into post-traumatic stress disorder (PTSD). Moreover, the degree of the reaction to the event, feelings about the condition/situation, and the level of help received by the victims as well as their support systems are considered factors that may affect the possibility of one developing PTSD (Javidi H, 2012).

The symptoms one experiences after a traumatic event hinder the course of treatment and recovery. Survivors need to develop strategies that promote self-protection to enable them to deal with symptoms that may arise as a result of the negative experience (Muskett, 2014). When trauma goes untreated, related symptoms interfere with the individual's health-seeking behaviors leading to other health problems that hinder engagement in treatment; and make relapse more likely (Farrugia et al., 2011). As such, trauma-informed services have become a hallmark for managing the consequences brought about by exposure to adverse events (SAMSA, 2019).

2.2 Trauma and Gender-Based Violence

Gender-based violence (GBV) refers to harmful acts directed at an individual based on his or her biological sex, gender identity, or being either masculine or feminine. In addition, it includes physical, sexual, and psychological abuse (Silove et al., 2017), and it affects people of either gender disregarding their social standing (NGEC, 2018). Studies have shown that women and girls are the most vulnerable. However, men and boys also experience gender-based violence (GBV).

According to Montesanti (2015), gender-based violence is rooted in structural inequalities between men and women and is characterized by the use and abuse of physical, emotional, and financial power and control (Montesanti, 2015). Global estimates of gender-based violence are staggering. The World Health Organization (WHO) noted that 35 percent of women globally have experienced some form of violence, Intimate Partner Violence (IPV) sexual violence (WHO 2013). Moreover, Gender-based violence (GBV) is considered a major cause of infirmity and death among women aged 15–44 years (United Nations Women, 2011).

In Kenya, it is estimated that 45% of women aged 15-49 have been subjected to physical violence since age 15, with 20 % of them stating that they have gone through physical violence within the 12 months before the survey and 39% of them reported the violence (physical and sexual) to be executed by their partners(KNBS, 2014). In the current report, consequences of the measures to combat the COVID pandemic, including lack of money, and food, have also intensified the vulnerability of women and girls to various forms of violence. Moreover, some women have started to sell their bodies to earn a living. The Centre for Rights Education and Awareness (CREAW) recorded a 64% increase in the number of victims of gender-based violence calling their GBV helpline to request assistance, i.e., between the months of March and May 2020. On the other hand, government statistics have also shown an increase in the number of domestic violence since March 2020 when the beginning of the COVID-19 pandemic in Kenya.

There is a scarcity of data on emotional, psychological, and economic violence because most studies tend to be focused on quantifying the prevalence of physical and sexual violence. Survivors of GBV experience varied consequences that affect their health and well-being (Ondicho, 2018).

The experience or exposure to gender-based violence is often traumatic to the individual. GBV can be experienced directly or as a bystander. Various forms of GBV can occur as separate and discrete events or as frequently repeated events that heighten the trauma experienced over time.

2.3 Prevalence of Burnout and Vicarious Trauma among Community Health Volunteers

Kokonyaet al. (2014) carried out a study to establish the prevalence rate of and factors associated with burnout syndrome among medical workers at the Kenyatta National Hospital, Nairobi. The study considered 345 medical professionals and nurses who have been employed at the hospital for at least six months. Burnout syndrome was found to be highly prevalent, with a crude prevalence rate of 95.4%. Both sociodemographic factors and work environment factors were found to strongly contribute to this syndrome. The burnout syndrome was greater than 95.0% for sociodemographic factors, and 'self-factors' accounted for 14.0%. Patients and their relatives accounted for 40.5% while the work environment contributed the largest proportion (55.5%) to the overall burnout intensity scores.

Ndetei et al. (2008) undertook a study to establish burnout in staff working at the Mathari psychiatric hospital where the study adopted a cross-sectional descriptive study design. A questionnaire was used to collect data on the work environment and the socio-demographic characteristics and the Maslach Burnout Inventory-Human Services and General Survey. The results of the study showed that 99% of the respondents reported low to high emotional exhaustion whereas 87.8% reported depersonalization. Low accomplishment was reported by 38.6% while 61.4% reported average to high personal accomplishment. Low morale, heavy workload, number of years worked, number of own children, and young age, as work and non-work-related factors, were positively associated with diverse burnout syndromes. Relationships with family, society, and work were, overall, rated as average.

According to a study done in Brazil, to assess the presence of Burnout Syndrome in Community Health Agents in the municipality of Aracaju, Sergipe, Brazil, the result indicated that 57.7% had a moderate or severe degree of emotional exhaustion;51.8% had a moderate or severe degree of depersonalization and 59% moderate to high personal involvement at work.59.9% did not show a tendency to Burnout Syndrome, 10.8% had a moderate tendency and 29.3% had characteristics of Burnout Syndrome(Saude Colet et al., 2014).

A study done in Tanzania to evaluate the level of burnout and vicarious trauma among community health workers offering palliative care indicated that on average, participants reported high satisfaction ratings, and had higher scores than the validation group, which included the students and health care professionals studying or working at IDDH in the compassion fatigue scale (2.42 vs. 1.55, $p < 0.01$) but no burnout.

2.4 Help-Seeking Behaviors among CHVs

Gichimu, Rono, and Kihara (2021) conducted a study on mental disorders and help-seeking behavior among adults attending Nyeri County Referral Hospital in Kenya. The results of the study showed that respondents were likely to seek help from a doctor (M=3.01, SD= 0.97) and parent (M=3.01, SD=1.092). Other popular choices included intimate partner (M=2.99, M=1.066) mental health professionals (M=2.92, SD=1.066) and friend (M=2.85, SD=0.908). The findings show that intentions of not seeking help were extremely unlikely (M=1.26, SD=0.601). In addition, the findings indicated that respondents with suicidal thoughts sought help from intimate partners (M=2.96, SD=1.023) and mental health professionals (M=2.91, SD=1.006). Conversely, the result demonstrated that intentions of not seeking help were extremely unlikely (M=1.35, SD=0.727).

A study done in Ethiopia to evaluate the perception of the participants who were Community Health workers with regard to mental illness, as well as their help-seeking behavior in March 2020. Results showed that in the event of a harrowing experience, the majority of the study participants (34.5%) would seek help or advice from their partner, moreover, one quarter, i.e. (25.2%) of the study participants indicated that they would seek help from psychologists. In addition, the general help-seeking behavior was that (38.8%) of the study participants had good help-seeking behavior; while the others (61.2%) had poor help-seeking behavior with regard to their mental health issues(Tesfaye et al., 2020).

The use of medicine was not preferred as a treatment for mental disorders though it was widely used by the majority (80.2%) of the study participants. In addition, (85.2%), and (61.0%) of the study participants indicated that the use of both medications as well as counseling could be effective in the treatment of mental disorders. On the other hand, (16.0%) of the study participants indicated that they had sought help from a healthcare professional for the treatment of psychological disorders, among them (47.8%) indicated that they had visited a healthcare facility and were attended by healthcare providers, (43.3%) of those who had gotten the services, most, i.e. (52.2%) narrated that their experience was very helpful.

Adamu, Yusuf, Inalegwu, Sufi, and Adamu (2018) delved into factors influencing the health-seeking behavior of health workers in a tertiary health institution in Nigeria. According to the findings of the study, the majority of respondents (99.3%) expressed the belief that having periodic medical checkups was crucial, with 65.8% having had one in the past. When feeling unwell, up to 75.2% of respondents frequently sought medical attention from a doctor. Self-medication was common among the majority of participants (75.2%), who typically used antimalarials, antibiotics,

and analgesics. Fear of test outcomes was the primary reason given for not seeking voluntary medical checkups (P = 0.012). Overall, respondents had a positive perception of periodic medical checkups, but self-medication was prevalent. Age, gender, profession, and duration of practice were identified as factors influencing both preventive and curative health-seeking behaviors.

2.5 Treating Trauma Survivors

There are various ways in which trauma survivors heal from their experiences. Trauma-informed services have become a hallmark for managing the consequences brought about by exposure to adverse events. The emergence of trauma-informed care services was spearheaded by the belief that harrowing experiences can extensively affect an individual's health as well as general well-being. Survivors of trauma often receive help from various health professionals. Empathy is one of the tools that professionals use with clients. It enables them to cope with painful emotions evoked (McNeillie, 2020). Empathic engagement with survivors of trauma involves listening to graphic descriptions of traumatic events and bearing witness to the human capacity for brutality and the pain and suffering caused by barbaric acts (Sui, 2016). This can lead to vicarious trauma and eventually burnout in the helper/mental health provider.

2.6 Trauma in Health Providers

Burnout occurs when an individual experiences frustration from a feeling of lack of control, and reduced interest when they cannot achieve their work-related goals and results (Valent, 2002). Burnout is usually experienced by professionals who work with survivors of horrifying experiences. It mainly occurs through exposure to a person's suffering, and the effects of traumatic experience (McNeillie, 2020). In addition, secondary traumatic stress occurs when an individual is unable to prevent impending danger, thus leading to a feeling of guilt (Valent, 2002). Another term often used with these is compassion fatigue. Compassion fatigue refers to strain arising from

the interaction with someone who is traumatized rather than going through a harrowing experience themselves (Cocker N. , 2016). It is often characterized by fatigue, moodiness, bad coping strategies such as drug and substance abuse, isolation, reduced performance at work, truancy, and indecision (Mathieu, 2007).

Studies have shown that there is a relationship between compassion fatigue, burnout, and secondary traumatic stress (Swain, 2014). Burnout and secondary traumatic stress both arise from separate failed survival strategies, which if not mediated by a third party lead to compassion fatigue (Valent, 2002).

2.6.1 Vicarious Traumatization

McCann & Pearlman, (1990) first used the term vicarious traumatization to describe general changes that occur within clinicians after interacting with clients who have been subjected to harrowing experiences (McCann, 1990). Pearlman and Saakvitne on the other hand, described it as, "a permanent change of the therapist's experience due to empathic engagement with the client's trauma material"(Pearlman, 1995). They suggested that the individual's cognitive schema is disrupted in five areas which include: "trust, intimacy, safety, control, and esteem". In addition, each represents a psychological need. Moreover, each schema is experienced with regard to self, others, and the world, and the individual needs to feel that the world is safe. Baird (2006) defined vicarious traumatization (VT) as the negative changes/emotions that occur in a healthcare provider. The negative emotions alter their beliefs about themselves and others (Baird, 2006).

Vicarious trauma (VT) develops over time due to continued exposure to horrifying experiences which bring about negative beliefs about power, independence, safety esteem, and intimacy (Baird, 2006). In addition, vicarious trauma (VT) can lead to decreased motivation and empathy. This manifests mentally while presenting as symptoms that align with post-traumatic stress disorder

(PTSD) such as intrusive re-experiencing of aspects of the client's trauma, alterations in cognition and affect, and physiological hyperarousal (Vrklevski, 2008). Other symptoms include depressed mood and discouragement, heightened levels of anxiety, limited desire for intimacy in close relationships, and self-esteem issues (Vrklevski, 2008).

The evidence seems to indicate that the development of VT can be moderated by various variables: age, gender, the amount of exposure to traumatized clients, length of time providing treatment for the abuse, and clinicians' history of abuse or maltreatment (Pearlman, 1995).

Mediating variables include access to support supervision, training for new as well as experienced clinicians, self-care strategies, and social support (Watkins et al., 2018). Research on vicarious trauma, although primarily focused on healthcare providers working with survivors of gender-based violence, has also looked at issues affecting other professional groups (McCann, 1990). Vicarious trauma in primary healthcare workers, particularly community health volunteers, has not been researched adequately.

2.7 Theoretical Framework

This study used a cognitive theory of psychopathology proposed by Aaron Beck in the early 1960s. Beck developed cognitive therapy with the belief that a person's experiences result in reasoning or beliefs. These perceptions relate to schemas, which are core beliefs developed from early life, to create our view of the world and determine our emotional states and behaviors. Beck believed disorders are maintained by negative attitudes and distorted thinking. The cognitive theory of psychopathology outlines the way people's perceptivity of, or beliefs about the situations that impact their emotional, behavioral, and physiological reactions. Moreover, individuals' perceptions are often perverted and flawed when they are perturbed (Beck, 2005). Different people have the potential to identify and measure their thought processes as well as to modify their

patterns of thinking. Studies have shown that when individuals gauge their thoughts, their distress usually decreases, and are able to function normally (Crosswell et al., 2020). Moreover, they also learn to recognize and modify their distorted thought patterns to understand themselves better and improve their interaction with other people. Distorted thoughts have been found to influence the way they process information. The cognitive model, therefore, describes individuals' emotional, physiological, and behavioral responses with regard to the way they perceive their experiences, which are affected by their perception as well as the way they interconnect with the world.

2.8 Conceptual Framework

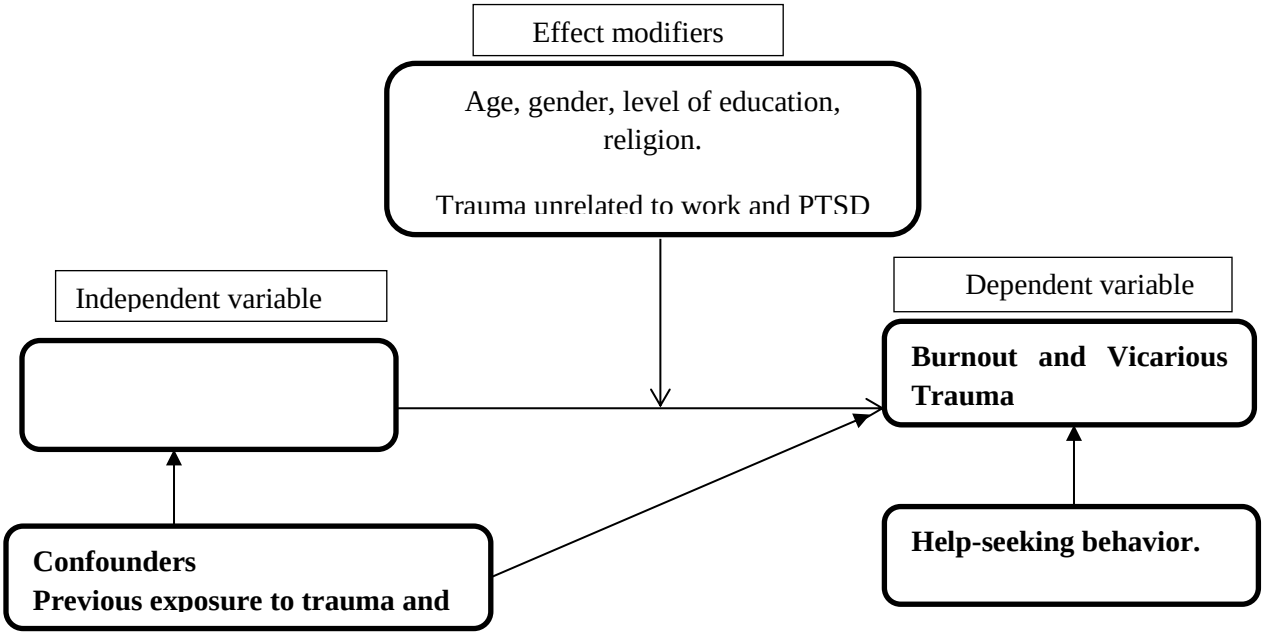

Figure 1: Conceptual Framework.

CHAPTER THREE: METHODOLOGY

3.0 Introduction

The chapter entails the research design that was used to carry out this research, the target population, sampling design and sample size, data collection, data management as well as analysis, and ethical considerations.

3.1 Study Design

The study used a cross-sectional mixed method design to determine the prevalence of burnout and vicarious trauma experienced by CHVs working with survivors of gender-based violence in informal settlements in Nairobi County and describe their help-seeking behavior. The independent variable of this study was secondary exposure to trauma while working as a CHV in the GBV services. The dependent variables were Burnout, Vicarious Trauma and help-seeking behavior. Structured questionnaires were used to collect quantitative data, while focused group discussion (FGD) and key informant interviews (KIIs) were used to collect qualitative data.

3.2 Study Site

The study was carried out in Mukuru – an informal settlement in the larger Embakasi Division in Nairobi County. It was established in 1958, and it covers an estimated 80 acres which sits on land that was once part of the farm owned by white settlers. Today Mukuru has 8 villages namely: Mukuru Kwa Njenga, Mukuru Kwa Reuben, Parasise, Sinai, Jamaica, Kingstone, Mariguni, and Fuata Nyayo. Moreover, it is estimated that more than 700,000 people occupy the informal settlement. As is characteristic of informal settlements in Kenya, Mukuru boasts an over-populated, cosmopolitan environment and comprises nearly all the major ethnic communities in Kenya. Mukuru is characterized by a high level of poverty, disease, congestion, insecurity, and

crime, making survival a daily battle for the residents. The choice of Mukuru as a study site was informed by the high number of cases of gender-based violence in Nairobi County and the presence of CHVs working with survivors of gender-based violence.

3.3 Study Population

The study targeted CHVs within Nairobi South Ward and Land Mawe in the Mukuru Fuata Nyayo area. Nairobi South Ward hosts 15 Community Health Units (CHU) with a total of 150 CHVs, 10 per CHU while Land Mawe Ward hosts 11 Community Health Units with 110 CHVs, 10 per CHU.

3.4 Sample Size Determination

According to Starehe sub–county Community Health Strategist there are 260 Community Health Volunteers within Nairobi South Ward and Land Mawe Ward.

Name of Ward	Number of CHUs	Name of CHU	No. of CHVs in every CHU	Informal settlement	Formal settlement
Nairobi South Ward	15	FuataNyayo A	10	✓	
		FuataNyayo B	10	✓	
		Mariguini	10	✓	
		Mariguini 1	10	✓	
		Mariguini 2	10	✓	
		Bakriview	10	✓	
		Barkrview A	10	✓	
		Barkrview B	10	✓	
		Hamaso	10	✓	
		Hamaso 1	10	✓	
		Hamaso 2	10	✓	

		Shimo la Tewa	10	✓	
		Sanaro	10	✓	
Land Mawe	11	Commercial	10	✓	
		Mandazi	10	✓	
		Crescent	10	✓	
		Kamongo	10	✓	
		Kingstone	10	✓	
Kariokor		Ziwani A	10		✓
		Ziwani B	10		✓
		Matopeni	10		✓
Ngara		Ngara	10		✓
CBD					✓
Pangani					✓

Table 1: CHVs in Starehe Sub-County.

Therefore, N = 260

Cochran's sample size formula was the most appropriate. Cochran's formula also considers an important risk element that the researcher wanted to accept at a 95% confidence interval. This confidence interval is within the true margin error also called type 1 error or an alpha level of .05 (Bartlett II, Kotrlik, & Higgins, 2001).

Using Cochran's formula for calculating sample size, this was the sample size: -

$$n_0 = \frac{t^2 \times p(1-p)}{d^2}$$

Where: -

t is the alpha level, which was set at .05. Therefore, each tail was .025 resulting in a value of 1.96, which corresponds with the 95% confidence level.

p is the prevalence of vicarious trauma and burnout among Community Health Volunteers in informal settlements. We haven't come across a study that reports on this prevalence so the study will assume a 50% estimate for both conditions. As a proportion, this was 0.50 with (1-p) = $0.50 n_o$ as the sample size

d is the acceptable margin of error or degree of accuracy, which was set at .05

Therefore: -

$$n_0 = \frac{1.96^2 \times 0.5(1 - 0.5)}{0.05^2} = 384.16$$

The calculated sample size however was more than the population (N=260). Cochran sample size correction formula indicated the right sample size (n_1) as: -

$$n_1 = \frac{n_0}{1 + \frac{n_0}{N}} = \frac{384.16}{1 + \frac{384.16}{260}} = 155$$

To account for the anticipated non-response rate, a 10% over-sample was applied adjusting the sample size (n_2) as follows.

$$n_2 = 155\ (110/100) = \underline{171}$$

Therefore, 86 CHVs from Nairobi South Ward (approximately 6 CHVs from each of the 15 Community Health Units in Nairobi South Ward) and 85 CHVs from Land Mawe Ward (approximately 7 CHVs from each of the 11 Community Health Units in Land Mawe Ward) i.e., a total of 171 CHVs were recruited in the study. The sample size was distributed proportionally in the two Wards.

3.4.1 Sample Size for Qualitative Data

CHVs were selected based on information-rich experiences. Factors to be considered included gender, age, level of education, and training in gender-based violence (GBV). Moreover, four focused group discussions were conducted.

3.4.1.1 FGD Group Composition

Each group had 8 participants – a heterogeneous sample, mixed males, and females- with at least 2 males in each group. In addition, each group had 2 representatives from the following age groups:

A. >30 to 40years.

B. 41 to 50 or < less than 50 years.

Levels of education- class 7 and below; secondary, post-secondary.

Training- at least 2 members in each group had undergone training.

3.4.2 Inclusion Criteria

- 18 years and older
- Attached to a Community Health Unit
- Working within the Nairobi South Ward and Land Mawe
- Consent to participate in the study

3.4.3 Exclusion Criteria

- Do not give consent.
- Not attached to any Community Health Unit
- Not working within the Nairobi South Ward and Land Mawe

3.5 Sampling Procedure

The selection of the 171 CHVs was undertaken using purposive, proportionate, and simple random sampling techniques. Community health units in Nairobi South Ward and Land Mawe in Mukuru Fuata Nyayo area were purposively selected because they are in informal settlements and CHVs were attached there. Proportionate sampling was used in the selection of a predetermined number of CHVs in each of the CHUs based on the sampling frame shown in Table 1 above. Finally, simple random sampling was used in the recruitment of CHVs in each of the CHUs in the two wards where a list of all the CHVs was used. Qualitative FGD participants were purposively selected from the 260 Community Health Volunteers or those who had done the quantitative interviews.

3.6 Recruitment Strategy

The study targeted CHVs working within Nairobi South Ward and Land Mawe Ward in Mukuru informal settlements. Appropriate ethical, Nairobi County Department of Health and community clearances were given. The researcher communicated with the Community Health Assistant (CHA) who supervises the CHVs and described the background and purpose of the study to them. The researcher with the help of CHA planned to meet all the CHVs together. The researcher approached them at their place of work on an agreed-upon date and described the background and purpose of the study to them. They were screened and only those who met the inclusion criteria were recruited. Those who gave written consent participated in the study.

The researcher provided self-administered questionnaires that the respondents filled them within the Community Health Units. FGDs were conducted at the community social hall next to the chief's camp Mariguini and at Nairobi South Health Center where some of the CHVs are attached.

3.7 Study Instruments

Measures that were used in this study included:

1) ***Social Demographic questionnaire***

   The respondents completed their information on the researcher-designed socio-demographic questionnaire which gathered participant information such as interview location, Name, age, gender, marital status, level of education, religion, and employment status, and captured a question in relation to vicarious trauma.

2) The Professional Quality of Life Scale

   The Professional Quality of Life Scale is a 30-item self-report measure of the positive and negative effects of working with people who have experienced extremely stressful events. It contains three subscales measuring Compassion Fatigue, Burnout, and Compassion Satisfaction. ProQOL is not a diagnostic tool. A score is calculated in each domain and cutoff scores are provided to interpret results (Table 2). Based on the recommendation from the PROQOL tool, for burnout, the researcher added scores in questions 1, 4, 8, 10, 15, 17, 19, 21, 26, 29, and for Traumatic Stress questions 2, 5, 7, 9, 11, 13, 14, 23, 25, 28. If the sum of Burnout and Secondary Traumatic Stress questions is 42 or more and the score is 57 or more it will indicate a high level of Burnout and Secondary Traumatic Stress. These scores were used to quantify who has burnout and Secondary Traumatic Stress and who doesn't and that is the dependent Variable.

Table 2: PROQOL Scores and Interpretation.

Summative scores	**Classification**

Compassion Satisfaction (Questions used: 3, 6, 12, 16, 18, 20, 22, 24, 27)	
22 or less	Low
Between 23-41	Average
42 or more	High
Burnout (Questions used: 1, 4, 8, 10, 15, 17, 19, 21, 26, 29)	
22 or less	Low
Between 23-41	Average
42 or more	High
Secondary Traumatic Stress (Questions used: 2, 5, 7, 9, 11, 13, 14, 23, 25)	
22 or less	Low
Between 23-41	Average
42 or more	High

A study done in Tanzania to assess the level of burnout for community health workers offering palliative care in low-income and middle-income countries, indicated that the reliability of the scales was analyzed using Cronbach's alpha. Moreover, factor loading of the questionnaire was made using the maximum likelihood analysis and varimax rotation (SPSS 22; SPSS, Inc., Chicago, IL) to examine the underlying constructs of the survey instrument. According to the factor analysis, some of the burnout items had weak loadings in the original scale but were slightly better on the other two scales. However, the original scales were used in this study. The researcher also used a translated Kiswahili version of ProQol of the same study for inclusivity, translated by Po¨yhia¨, R et al (2017).

3) General Help Seeking Questionnaire

The General Help-Seeking Questionnaire (GHSQ) was developed to formally assess two aspects of help-seeking: current intentions to seek help from different sources for different

problems; and the quantity or quality of previous professional psychological helping episodes. According to the study done on Adolescents in grades 7 to 12 years from NSW Australian public high schools. The General Help Seeking Questionnaire (GHSQ; Wilson et al. 2005) examined the intentions of the respondents to seek help from several sources. These sources range from informal sources (such as family and teaching staff) to professional sources such as the family doctor. It was the first study to focus on the reliability and validity of the measure. Research using the GHSQ demonstrated positive associations with aspects of emotional competence (Ciarrochi et al., 2002, 2003), in addition to retrospective help-seeking behavior (Ciarrochi& Deane, 2001) and prospective help-seeking behavior (Deane, Ciarrochi, Wilson, Richwood, & Anderson, 2001). The researcher also administered the Kiswahili version of the questionnaire to CHVs.

4) ***Qualitative- Interview Guide Questionnaire***

The researcher developed an interview schedule that was researcher administered. The schedule was used during the Focus Group Discussion to gather qualitative data information on protective factors that CHVS had adopted in dealing with burnout and vicarious trauma experienced when handling survivors of GBV. The interviews were audio recorded and transcribed verbatim. The audio was recorded after obtaining consent from the participants.

3.8 Reliability and Validity Check

3.8.1 Validity

To check on the validity of the questionnaire, the research instrument was subjected to pretesting among 17 CHVs. The sample of 17 CHVs is based on the scientific recommendation of using 10% of the sample size for pilot or exploratory studies. To ensure face, construct, and content validity,

the instrument was subjected to a thorough assessment to ensure that it captured and represented the constructed idea of the study, its relevance to the content being measured and to ensure it measured the indicators as expected. All sections of the tool were reviewed and rated for readability, clarity, and comprehensiveness in so far as the study is concerned. This assessment was done by the study supervisor and through an extensive literature search to ensure it met the criteria. The standard tools used like the Professional Quality of Life Scale (PROQOL) version 5 of 2009 were not changed and analysis of the data was also done as outlined in the tool.

3.8.2 Reliability

The reliability of the instruments used in the study was determined by means of a pilot study to establish that the way respondents answered questions was not influenced by the way they were ordered, including if the respondents comprehended the questions in a correct manner. Cronbach's Alpha (α) was used to measure the internal consistency of the questionnaire where the estimation was done with the aid of data analysis software. Taber (2018) described alpha values of 0.64-0.85 as adequate, therefore for this study alpha of >0.7 was acceptable.

3.9 Data Collection, Data Management, and Data Quality Control

Quantitative data were collected using KOBO collect and administered by trained interviewers. KOBO collect is an application used for the collection, analysis, and management of primary data. This was chosen because it is faster and improves data quality. CHVs who were eligible to participate in the study were asked the questions programmed on KOBO Collect electronic data capture platform and submitted to an online server in real-time. Data access to the online server was restricted to only the data management team of the study. Data were then extracted and subjected to data cleaning in preparation for analysis. Data cleaning involved ensuring no

duplicated entries, and that the data was accurate. Data validity and consistency checks were also done while programming the data collection tools into electronic format.

Data from key informant interviews and focus group discussions were collected using audio recorders with the consent of participants and transcribed verbatim by the members of the study. Key informant interviews and focus group discussions were facilitated by the researcher and another member of the team who helped with notetaking and ensuring the audio recorder was working. The transcripts were then exported into QSR NVivo 12 for analysis.

3.10 Flow Chart of the Data Collection Process

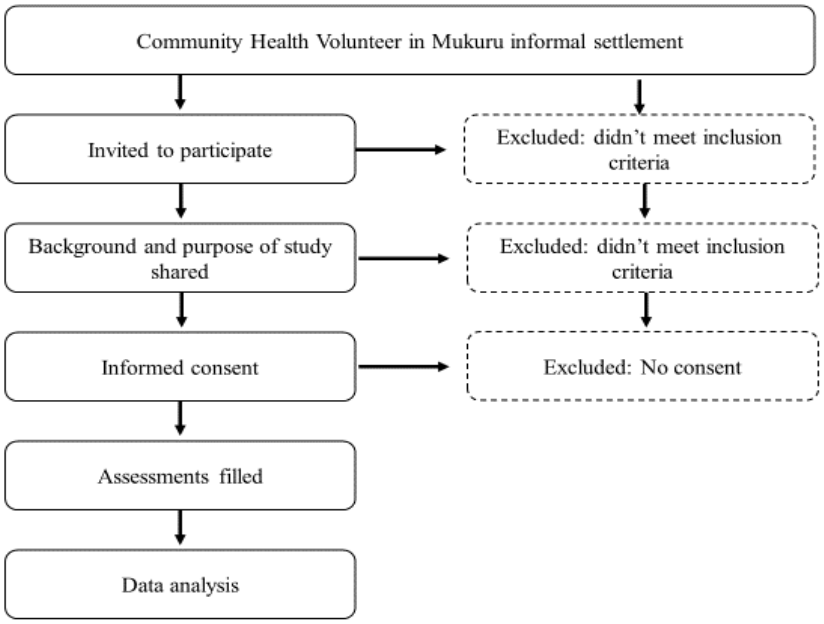

Figure 2: Flow Chart of Data Collection Process.

3.11 Data Analysis

Quantitative data were analyzed using both descriptive analysis techniques as well as inferential statistics. The descriptive analysis involved frequencies and proportions for categorical data and mean and standard deviations for continuous variables. Comparison between categorical variables

was done using Chi-Square tests and comparisons between continuous variables were done using t-tests. Karl Pearson's correlation coefficient was used to examine the strength of the correlation between burnout, secondary traumatic stress, and compassion satisfaction. The correlation coefficients were interpreted based on the interpretation provided by Hinkle et al. (2003).

To measure the professional quality of life assessed using the professional quality of life scale (PROQOL) version 5 of 2009 was used (Annex 5). The tool had 30 questions measuring compassion satisfaction, burnout, and secondary traumatic stress as low, average, or high. To model factors associated with these three issues, an ordinal logistic regression model was used with satisfaction, burnout, or secondary traumatic stress as outcome variables (dependent variables) and socio-demographic characteristics as independent variables. This was modeled both at the bivariate level where only two variables are examined at a time (one dependent variable and one independent variable) and at the multivariate level where more than two variables are examined (one dependent variable and two or more independent variables).

The ordered logistic regression model is in the class of generalized linear models (GLMs) and the equation is generally given as;

$$logit\left(\frac{p}{1-p}\right) = \beta_0 + \beta_1 X_1 + \cdots + \beta_k X_k$$

Where $\beta_0, \beta_1, \ldots, \beta_k$ are the model coefficients, $X_1, \ldots, X_k$ are the independent variables, $\frac{p}{1-p}$ is the odds of observing an event (success) compared to not observing an event (failure). All quantitative data were analyzed in STATA v17.

A thematic framework method was used to arrange data into key themes in QSR NVivo 12 for analysis. Emergent groups were identified during the analysis. An iterative process analysis was

also used to develop a coding framework and later a tentative thematic framework. Analysis charts were produced for each theme and category of participants. These charts were used to identify common themes across participants and sites.

Results from the quantitative data and qualitative data were triangulated as much as possible for context and for a more in-depth understanding of the findings.

3.12 Ethical Considerations

Institutional ethics review - The study was presented at the Department of Psychiatry before proceeding to the University of Nairobi/ Kenyatta National Hospital ethics research committee for approval to carry out the study. Once approval to carry out the study was granted by the ethical committee, the researcher sought written authority and clearance from the Ministry of Health County health offices, and thereafter the in-charge at the health centers.

Informed consent - Once all the approvals had been given, the researcher invited participants with the help of the sub-county community strategy coordinator. The researcher explained the study purpose and objectives to the participants, and they were given an opportunity to ask for clarification if need be. They were informed that participation was voluntary, and the information collected was for the study alone. They were also informed that the discussions would be audio-recorded and that only the researcher and her supervisors would have access to the recording and transcripts. Those who refuse to participate or withdraw at any stage would not be penalized and their withdrawal would in no way influence their role as a CHV in the community.

Participants who met the inclusion criteria and were willing to participate were included in the study once a proper explanation of the study process and the purpose of the study was given. They were offered a chance to participate without coercion. The study did not discriminate against any political affiliations, gender, race, sexual orientation, or physical disabilities.

Confidentiality - Participants were assured that the data would be kept confidential and would only be used for research purposes. There were no personal identifiers (only use of serial codes) on the transcripts; this ensured the anonymity of the participants. The transcripts were kept in a secure protected locked safe.

Compensation for participants - Participants did not receive any compensation for participating in the study.

Potential study risks - There was no physical harm expected from this study. However, the researcher had put measures in place to ensure that those who would present with any psychological distress, would review and refer for further follow-up at the Kenyatta National Hospital or Mathari Teaching and Referral Hospital.

Potential benefits to study participants -The data from the study will help the participants, Nairobi County mental health coordinator, and sub-county community strategy coordinator understand the nature and impact of vicarious trauma on its volunteers and how it impacts their well-being and ability to play their role in the community well. The findings of this study will help in placing structures and programs in place that take care of the well-being of the volunteers.

CHAPTER FOUR: RESULTS

4.0 Introduction

This chapter provides a discussion of the results of the study. It is organized based on the specific objectives of the study. First, reliability and validity analysis is conducted using Cronbach's alpha coefficient (Taber, 2018).

4.1 Response Rate

A total of 171 participants were targeted to be reached and 171 were reached, representing a response rate of 100%.

4.2 Reliability and Validity Analysis

The reliability test was conducted with 17 respondents from the study area to assess the instrument reliability and how the questions are asked practically in the field. Results from the pilot study indicated high reliability as indicated by Cronbach's alpha coefficient of 0.810. This was deemed acceptable according to Taber (2018).

Table 3: Reliability Statistics.

Variable	Items	Cronbach's Alpha	Remark
Help Seeking intentions	16	0.649	Adequate
Professional Quality of Life Scale	30	0.873	Acceptable
Overall Reliability Test (All questions)		0.810	Acceptable

Source: Pilot Test Data (2022)

4.3. Socio-Demographic Characteristics of the CHVs

Females were the majority in both wards; Land Mawe (males = 12 (12.1%), females = 87 (87.1%), and NSW; (males = 16 (23%), females = 55 (77%). The majority of CHVs were 40 years and above. With a representation of 41 to 50 years old at 35.7% and 50 years and above at 37.4% respectively. Overall, 72% of CHVs had some background training on introduction to GBV, causes, effects, and survivor-centered approach, this was relatively the same between the two wards (Land Mawe 72%, NSW 73.2%) and similarly, 159 (93%) of the CHVs have ever worked

with GBV victims (99% in Land Mawe, 89% in NSW). In terms of years of practice, half of the CHVs had been working as CHVs for between 10 – 19 years, with only 28 (16.4%) having worked less than 5 years and 18 (10.5%) having worked for twenty years and beyond. CHVs who had worked for between 10 -19 years were relatively more in NSW 48 (67.6%) compared to Land Mawe 40 (40%).

Christianity was the commonest religion practiced by the CHVs (88%) distributed as either Protestants (61%) or Catholics (27%). Islam was at 5% and 5% practiced other religions which included traditional. 1% reported not aligning themselves with any religion. There were slight differences in the two wards, especially for the Christians, with a proportion of those who aligned themselves to catholic being relatively higher in NSW (35%) compared to those in Land Mawe (21%) and for protestants, Land Mawe had a relatively higher proportion (70%) compared to NSW (49%). Most CHVs reported to align with their religion and belief system with most of the CHVs (94.7%) reporting to be regular church/mosque goers (almost every week).

About two-thirds (67%) of the CHVs from both wards reported having an intimate partner and slightly more than half (54%) reported living with a partner, 29% lived alone, 2% lived with their parents and 15% reported having other living arrangements like living with children as a single parent or living with grandchildren. There was no difference in these arrangements between the two wards as shown in table 5.

Over 50% of the CHVs reported to have attained lower secondary education (S1-S4) with 42% reporting to have primary education. Only 4% had some college education and 1% had obtained vocational/trade school or diploma. Less than 1% had completed a graduate or professional level of education. The proportion of those who had completed lower secondary education was slightly

higher in Land Mawe (53%) compared to NSW (47%) with no significant difference between the two wards in those who had attained primary education.

Most of the CHVs indicated that they were self-employed (60.2%), with 15% reporting that they were unemployed (15.2%). About 6% were in part-time formal employment and 2% in full-time formal employment 4 (2.3%). A sizeable proportion (16%) reported to be in other forms of employment which included casual labor or informal employment. A slightly higher number of NSW CHVs were self-employed (63.4%) compared to their counterparts in Land Mawe (58%). The majority of the CHVs (93%) reported that they supported their families financially.

Table 4: Socio-Demographic Characteristics of CHVs in Nairobi South and Land Mawe Wards.

Socio-demographic characteristics		**Total (N=171)**		**Nairobi South Ward (N=71)**		**Land Mawe (N=100)**	
		N	%	n	%	n	%
Gender	Female	142	83.04	55	77.46	87	87.00
	Male	28	16.37	16	22.54	12	12.00
	Other	1	0.58	0	0.00	1	1.00
Age	<30years	12	7	3	4.2	9	9
	30-40years	34	19.9	9	12.7	25	25
	41-50years	61	35.7	30	42.3	31	31
	>50years	64	37.4	29	40.8	35	35
Training Experience	*Any background training on GBV?*	124	72.5	52	73.2	72	72.0
	Ever worked with victims of GBV before	159	93.0	70	98.6	89	89.0
	How long have you worked as a CHV?						

	<5y	28	16.4	2	2.8	26	26.0
	5-9y	37	21.6	10	14.1	27	27.0
	10-19y	88	51.6	48	67.6	40	40.0
	20y or more	18	10.5	11	15.5	7	7.0
	Religion						
Religion	Catholic	46	26.9	25	35.2	21	21.0
	Muslim	9	5.3	4	5.6	5	5.0
	None	2	1.2	1	1.4	1	1.0
	Other	9	5.3	6	8.5	3	3.0
	Protestant	105	61.4	35	49.3	70	70.0
	Frequency of going to church/Mosque?						
	Almost every week	162	94.7	70	98.6	92	92.0
	Almost never	2	1.2	1	1.4	1	1.0
	Just on holidays	1	0.6	0	0.0	1	1.0
Living Arrangement							
	Living alone	50	29.2	22	31.0	28	28.0
	Living with parent	3	1.7	0	0.0	3	3.0
	Living with partner	92	53.8	35	49.3	57	57.0
	Other	26	15.2	14	19.7	12	12.0
Education	Completed Graduate or Professional School	1	0.6	1	1.4	0	0.0
	Diploma	2	1.2	2	2.8	0	0.0
	Lower Secondary (S1-S4)	86	50.3	33	46.5	53	53.0

	Primary	72	42.1	30	42.3	42	42.0
	Some College/Certificate	7	4.1	3	4.2	4	4.0
	Upper Secondary (S5-S6)	1	0.6	1	1.4	0	0.0
	Vocational/Trade school	2	1.2	1	1.4	1	1.0
Employment Status							
	Formal employment (full-time)	4	2.3	3	4.2	1	1.0
	Formal employment (part-time)	10	5.8	7	9.9	3	3.0
	Others; casual, informal	28	16.4	7	9.9	21	21.0
	Self-employed	103	60.2	45	63.4	58	58.0
	Unemployed	26	15.2	9	12.7	17	17.0
	Financially support family	159	93.0	66	93.0	93	93.0

4.4 Prevalence of Burnout and Vicarious Trauma

The second objective of the study was to determine the prevalence of burnout and vicarious trauma in the study population. This was measured using a standardized Professional Quality of Life Scale (PROQOL) version 5 of 2009 (Annex 5) which had 30 questions aimed at measuring compassion satisfaction, burnout, and secondary traumatic stress.

Slightly over two-thirds of CHVS (71%) reported that they are highly satisfied with their work, with 29.2% reporting average satisfaction. None of the CHVs interviewed reported that they had low satisfaction with their work. The results of the study showed that there was no difference in satisfaction levels by sex, but the high satisfaction levels were higher among younger CHVs (75%

for <30 years old and 79% for the 30-40 years old) compared to the older CHVs (69% for 41-50 years old and 67% for the >50 years old).

None of the CHVs interviewed reported high burnout levels from their work. However, about a fifth (21%) reported average burnout, and close to 80% reported low burnout levels. Average burnout was relatively higher among the female (22%) compared to the male CHVs (11%). In relation to burnout by age, again, average burnout was higher among the older CHVs (21% for 41-50 years old and 25% for the >50 years old) compared to the younger CHVs (17% for <30 years old and 12% for the 30-40 years old).

A similar pattern to burnout was also observed for secondary traumatic stress. None of the CHVs interviewed reported having high levels of secondary traumatic stress. However, close to a third (31%) reported having an average level of secondary traumatic stress with 69% reporting having a low level of secondary traumatic stress. The average level of secondary traumatic stress was relatively higher among females (33%) compared to male CHVs (18%). It was also higher among the youngest (that is, <30 years old) and the oldest (>50 years old) at 33% and 34% respectively compared to the Middle Ages of 31-40 years and 41-50 years old at 24% and 31% respectively.

Table 5 presents results for compassion satisfaction among CHVs disaggregated by sex and age. For the purpose of table formatting, we present proportions in the table and provide the denominators at the column heading.

Table 5: Prevalence of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress among CHVs in Land Mawe and Nairobi South Wards.

	All **%**	**Wards %**	**Sex %**	**Age %**

		NSW (n=71)	Land Mawe (n=100)	Male (n=28)	Female (n=142)	<30y (n=12)	30-40y (n=34)	41-50y (n=61)	>50y (n=64)
Compassion Satisfaction									
Low	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Average	29.2	39.4	22.0	25.0	29.6	25.0	20.6	31.2	32.8
High	70.8	60.6	78.0	75.0	70.4	75.0	79.4	68.8	67.2
Burnout									
Low	79.5	80.3	79.0	89.3	78.2	83.3	88.2	78.7	75.0
Average	20.5	19.7	21.0	10.7	21.8	16.7	11.8	21.3	25.0
High	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Secondary traumatic stress									
Low	69.0	73.2	66.0	82.1	66.9	66.7	76.5	68.9	65.6
Average	31.0	26.8	34.0	17.9	33.1	33.3	23.5	31.1	34.4
High	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

4.4.1 Correlation between Burnout, Secondary Traumatic Stress, and Compassion Satisfaction

Karl Pearson's correlation coefficient was used to examine the strength of the correlation between burnout, secondary traumatic stress, and compassion satisfaction. There was a significant negative moderate correlation between compassion satisfaction score and burnout ($r=-0.52$, $p<0.001$). This means that the higher the satisfaction a CHV has with his/her work, the lower the chance that he/she would experience burnout. However, there was a significant positive moderate correlation between burnout and secondary traumatic stress ($r=0.54$, $p<0.001$). This means that the higher burnout CHV experiences, the higher secondary traumatic stress they also experience. There was

no significant correlation between compassion satisfaction and secondary traumatic stress. Table 6 presents the correlation coefficient and the p-values showing whether it is statistically significant or not.

Table 6: Karl Pearson Correlation Coefficients Showing Correlation between Compassion Satisfaction, Burnout, and Secondary Traumatic Stress.

	Compassion Satisfaction	**Burnout**	**Secondary traumatic stress**
Compassion Satisfaction	1	-	-
Burnout	**R=-0.522** **(p<0.001)**	1	-
Secondary traumatic stress	r=-0.102 (p=0.183)	**r=0.543** **(p<0.001)**	1

4.5 Help-Seeking Behavior in Addressing Burnout and Trauma

The third objective of this study was to assess help-seeking behavior for CHVs working with survivors of gender-based violence in informal settlements in Nairobi County.

4.5.1 Help-Seeking Intentions for Personal and Emotional Problems

Overall, findings show that in case of personal or emotional problems, CHVs were most likely to seek help from a mental health professional (mean = 6.3, sd = 0.1), followed by a doctor/GP (mean = 5.9, sd = 0.1) and religious leader or minister (mean=5.7, sd= 0.1). Another notable source of help mentioned was a colleague (mean = 4.8, sd=0.2). The other sources which CHVs would seek help from were a family member who is not a parent or intimate partner (mean 5.0, sd=0.2). With a mean of 4.7 (sd=0.2) CHVs reported that they would seek help also from a parent or a friend. The intimate partner score was relatively low with a mean of 4.0 (sd=0.2). The phone helpline was

also scored at a mean of 4.0 (sd=0.2) which was relatively lower compared to the other sources mentioned above.

However, there were interesting variations by sex and age in the mean scores for intimate partner, friend, and parent. Males were more likely to seek help from an intimate partner (mean=5.7, sd=0.3) compared to female CHVs (mean=3.7, sd=0.2). Additionally, the younger CHVs, that is, the <30 years old (mean=4.9, sd=0.6) and 30-40 years old (mean=4.6, mean=0.5) were more likely to seek help from an intimate partner compared to the older CHVs, that is, the 41-50 years old (mean=3.7, sd=0.4) and >50 years old (mean=3.8, sd=0.3). Again, the older CHVs, that is, >40 years old were more likely to seek help from a friend compared to the younger CHVs. For the parent, female CHVs were more likely to seek help from a parent (mean=4.9, sd=0.2) compared to the male (mean=3.8, sd=0.5). Interestingly, CHVs in all age categories indicated that they would seek some help from colleagues, phone helplines, and intimate partners. Mental health professionals' source of help was most preferred by land Mawe CHVs (mean = 6.6, sd = 0.1) compared to their counterparts in NSW (mean = 5.8, sd = 0.2). Similarly, Land Mawe CHVs were most willing to seek help from both a doctor/GP (mean = 6.0, sd = 0.2). 5 (3%) of the CHVs reported that they would not seek help from anyone when experiencing personal or emotional problems.

Table 7 presents a summary of the results for help-seeking intentions for personal and emotional problems.

Table 7: Help-Seeking Patterns among CHVs In Case Of Personal or Emotional Problems.

	All mean (sd)	Wards mean (sd)		Sex mean (sd)		Age mean (sd)			
	(n=166)	NSW (n=71)	Land Mawe (n=100)	Male (n=28)	Female (n=142)	<30y (n=12)	30-40y (n=34)	41-50y (n=61)	>50y (n=64)
Intimate partner	4.0 (0.2)	3.7 (0.3)	4.2 (0.3)	5.7 (0.3)	3.7 (0.2)	4.9 (0.6)	4.6 (0.5)	3.7 (0.4)	3.8 (0.3)
Friend	4.7 (0.2)	4.1 (0.2)	5.2 (0.2)	4.6 (0.4)	4.8 (0.2)	4.5 (0.7)	3.9 (0.4)	5.2 (0.2)	4.8 (0.3)
Parent	4.7 (0.2)	4.8 (0.3)	4.6 (0.3)	3.8 (0.5)	4.9 (0.2)	6.2 (0.5)	5.4 (0.5)	5.3 (0.3)	3.6 (0.3)
Another relative/family member	5.0 (0.2)	4.6 (0.2)	5.4 (0.2)	4.6 (0.4)	5.1 (0.2)	4.5 (0.7)	5.6 (0.3)	5.1 (0.2)	4.8 (0.3)
Mental health professional	6.3 (0.1)	5.8 (0.2)	6.6 (0.1)	6.5 (0.2)	6.2 (0.1)	6.0 (0.6)	6.6 (0.2)	6.0 (0.2)	6.4 (0.1)
Phone helpline	4.0 (0.2)	3.4 (0.3)	4.5 (0.2)	4.3 (0.4)	4.0 (0.2)	3.3 (0.6)	4.0 (0.4)	3.9 (0.3)	4.3 (0.3)
Doctor/GP	5.9 (0.1)	5.6 (0.2)	6.0 (0.2)	5.7 (0.3)	5.9 (0.1)	5.3 (0.5)	6.0 (0.3)	6.0 (0.2)	5.7 (0.2)
Religious leader/minister	5.7 (0.1)	5.1 (0.2)	6.2 (0.1)	5.7 (0.3)	5.7 (0.2)	6.1 (0.5)	5.8 (0.3)	5.6 (0.2)	5.8 (0.2)
Would seek help from another not listed	3.0 (0.2)	2.1 (0.2)	3.7 (0.3)	3.4 (0.5)	2.9 (0.2)	2.8 (0.8)	3.5 (0.5)	2.8 (0.3)	3.0 (0.3)
Colleague	4.8 (0.2)	4.5 (0.3)	5.0 (0.3)	4.5 (0.6)	4.9 (0.2)	5.0 (0.7)	4.9 (0.5)	4.9 (0.3)	4.6 (0.4)

4.5.2 Help-Seeking Intentions In Case Of Suicidal Thoughts

Overall, in the case of suicidal thoughts, CHVs would more likely seek help from a mental health professional (mean=6.0, sd=0.1) and from a religious leader (mean=6.0, sd=0.2). Another source

of help that had an overall high mean score was the parent (mean=5.4, sd=0.2). Intimate partner was one of the least sources of help with a low mean score of 3.7 (sd=0.2). Friend (mean=4.8, sd=0,2), other relative (mean=4.9, sd=0.2), doctor (mean=4.7, sd=0.2) and phone helpline (mean=4.5, sd=0.2) were also other potential sources. Intimate partner was the least preferred source across both sexes and wards scored at a low mean score of 3.7 (sd=0.2).

There were however notable variations by age in the scores with intimate partner scores reducing by age. The youngest, that is, <30 years old were more likely to seek help from an intimate partner mean=5.0, sd=0.8) compared to the older, that is 41-50 years old (mean=4.0, sd=0.4) and >50 years old (mean=3.2, sd=0.3). There was no difference by sex in help-seeking from an intimate partner. All the other sources had no huge differences by sex and age except a parent and mental health professional. The youngest (<30 years) were more likely to seek help from a parent (mean=5.6, sd=0.8) compared to the oldest (>50 years) (mean=5.0, sd=0.3). Similarly, the youngest (<30 years) were more likely to seek help from a mental health professional (mean=6.6, sd=0.3) compared to the oldest (>50 years) (mean=6.0, sd=0.2). 9 (5%) of the CHVs reported that they would not seek help from anyone in case they experience suicidal thoughts.

Table 8 presents a summary of the results for help-seeking intentions in case of suicidal thoughts.

Table 8: Help-Seeking Patterns among CHVs In Case Of Suicidal Thoughts.

	Mean (sd)	**By Division mean (sd)**		**By Sex mean (sd)**		**By Age (n=162) mean (sd)**			
	All (n=162)	Nairobi South Ward (n=67)	Land Mawe (n=95)	Male (n=26)	Female (n=135)	<30y (n=11)	30-40y (n=31)	41-50y (n=59)	>50y (n=61)

Intimate partner	3.7 (0.2)	3.6 (0.3)	3.7 (0.3)	3.8 (0.5)	3.6 (0.2)	5.0 (0.8)	3.6 (0.5)	4.0 (0.4)	3.2 (0.3)
Friend	4.8 (0.2)	4.2 (0.2)	5.2 (0.2)	4.5 (0.4)	4.9 (0.2)	4.9 (0.7)	4.7 (0.4)	4.7 (0.3)	4.9 (0.3)
Parent	5.4 (0.2)	5.3 (0.3)	5.4 (0.2)	5.5 (0.5)	5.4 (0.2)	5.6 (0.8)	5.7 (0.3)	5.5 (0.3)	5.0 (0.3)
Other relative/family member	4.9 (0.2)	4.3 (0.3)	5.3 (0.2)	4.6 (0.5)	5.0 (0.2)	4.3 (0.8)	5.2 (0.4)	4.9 (0.3)	4.8 (0.3)
Mental health professional	6.0 (0.1)	5.5 (0.2)	6.5 (0.1)	5.9 (0.3)	6.1 (0.1)	6.6 (0.3)	6.4 (0.3)	5.8 (0.2)	6.0 (0.2)
Phone helpline	4.5 (0.2)	3.9 (0.3)	4.9 (0.2)	4.8 (0.5)	4.4 (0.2)	3.8 (0.7)	4.6 (0.4)	4.3 (0.3)	4.7 (0.3)
Doctor/GP	4.7 (0.2)	4.2 (0.3)	5.1 (0.3)	5.0 (0.5)	4.6 (0.2)	4.8 (0.8)	4.9 (0.5)	5.1 (0.3)	4.2 (0.3)
Minister or religious leader	6.0 (0.2)	5.6 (0.3)	6.2 (0.2)	6.4 (0.3)	5.9 (0.2)	6.2 (0.4)	6.0 (0.4)	5.9 (0.3)	6.2 (0.3)
Would seek help from another not listed	3.6 (0.3)	1.9 (0.3)	4.4 (0.3)	2.9 (0.7)	3.7 (0.3)	3.8 (0.9)	3.4 (0.5)	3.6 (0.4)	3.7 (0.5)

4.6 Correlation between Help-Seeking Intentions and Compassion Satisfaction, Burnout, and Secondary Traumatic Stress

The correlation between compassion satisfaction, burnout, secondary traumatic stress, and help-seeking composite scores for help-seeking intentions in the case of personal or emotional problems and in the case of suicidal thoughts was also examined.

There was a highly statistically significant strong positive correlation, between compassion satisfaction and help-seeking intentions score in the case of personal or emotional problems with a Karl Pearson correlation coefficient of 0.411 ($p<0.001$). Similarly, a strong significant positive correlation existed between compassion satisfaction and help-seeking intentions score in the case

of suicidal thoughts with a Karl Pearson correlation coefficient of 0.360 ($p<0.001$). This means that the higher the help-seeking score for emotional or personal problems and suicidal thoughts, the higher the compassion satisfaction scores. This implies that CHVs who are more likely to seek help in case of any mental health issue are also more likely to be satisfied with their work. There was no significant correlation between help-seeking intention scores and burnout and secondary traumatic stress. Table 9 summarizes the findings from this correlation analysis.

Table 9: Karl Pearson Correlation Coefficients Showing Correlation Between Help-Seeking Intentions And Compassion Satisfaction, Burnout, And Secondary Traumatic Stress.

	Compassion Satisfaction	**Burnout**	**Secondary traumatic stress**
Help Seeking score in case of personal or emotional problems	**r=0.411** (p<0.001)	r=-0.077 (p=0.328)	r=-0.084 (p=0.283)
Help Seeking score in case of suicidal thoughts	**r=0.360** (p<0.001)	r=-0.129 (p=0.101)	r=-0.065 (p=0.412)

4.7 Factors Associated with Compassion, Burnout, and Secondary Traumatic Stress

The fourth objective was to determine the association between socio-demographic factors, burnout, and trauma. This was analyzed using an ordinal logistic regression model to determine which socio-demographic factors are significantly associated with the three issues measured in the PROQOL scale. These are the outcome variables in the regression model. These are compassion satisfaction, burnout, and secondary traumatic stress. Table 10 presents odds ratios, 95% confidence intervals, and p-values for the three outcome variables for the bivariate model. Bivariate associations show that background training on GBV (OR 2.32; 95% CI: 1.14, 4.72; p = 0.020) and living with a parent/partner relative to living alone (OR 3.82; 95% CI: 1.83, 7.97; p<0.001) are significantly associated with satisfaction at work. None of the other socio-

demographic characteristics examined were significantly associated with burnout and secondary traumatic stress.

Table 10: Bivariate Ordered (Ordinal) Logistic Regression Model Examining the Association between Socio-Demographic Factors and Compassion Satisfaction, Burnout, and Secondary Traumatic Stress.

	Compassion Satisfaction		**Burnout**		**Secondary traumatic stress**	
	OR (95% CI)	p-value	OR (95% CI)	p-value	OR (95% CI)	p-value
Sex						
Female	0.79 (0.31, 2.01)	0.626	2.33 (0.66, 8.22)	0.190	2.28 (0.81, 6.36)	0.117
Age						
30-40y	1.29 (0.27, 6.05)	0.750	0.67 (0.11, 4.21)	0.666	0.62 (0.15. 2.59)	0.508
41-50y	0.74 (0.18, 3.03)	0.672	1.35 (0.26, 6.96)	0.717	0.90 (0.24, 3.38)	0.882
>50y	0.68 (0.17, 2.79)	0.595	1.67 (0.33, 8.42)	0.537	1.05 (0.28, 3.87)	0.944
Background training on GBV	2.32 (1.14, 4.72)	**0.020**	1.12 (0.48, 2.61)	0.792	1.08 (0.52, 2.25)	0.834
Ever worked with GBV victims before	0.79 (0.21, 3.07)	0.738	0.76 (0.19, 2.95)	0.687	0.61 (0.18, 2.00)	0.411
Duration worked as CHV						
5-9y	0.51 (0.16, 1.70)	0.276	2.68 (0.65, 11.01)	0.172	2.23 (0.73, 6.85)	0.160
10-19y	0.44 (0.15, 1.28)	0.133	2.78 (0.76, 10.1)	0.121	1.62 (0.59, 4.46)	0.347
20y or more	0.57 (0.14, 2.32)	0.429	0.49 (0.05, 5.12)	0.551	1.83 (0.48, 6.95)	0.373

Living arrangement						
With parent/partner	3.82 (1.83, 7.97)	**<0.001**	1.01 (0.45, 2.25)	0.978	2.13 (0.95, 4.79)	0.068
With other	8.31 (2.21, 31.24)	**0.002**	-	-	2.50 (0.87, 7.15)	0.087
Education						
Some Secondary	0.90 (0.46, 1.77)	0.753	1.64 (0.75, 3.60)	0.216	0.65 (0.34, 1.27)	0.205
Higher education	3.71 (0.44, 31.11)	0.228	0.56 (0.06, 4.80)	0.593	0.19 (0.02, 1.54)	0.119
Employment						
Employed	1.11 (0.27, 4.63)	0.885	1.15 (0.23, 5.71)	0.868	1.15 (0.23, 5.71)	0.868
Self or other	1.09 (0.44, 2.71)	0.857	1.09 (0.38, 3.16)	0.873	2.20 (0.78, 6.22)	0.138
Financial support to family	2.61 (0.80, 8.54)	0.112	0.76 (0.19, 2.95)	0.687	0.61 (0.18, 2.00)	0.411
Have intimate partner	0.81 (0.40, 1.64)	0.553	2.33 (0.95, 5.71)	0.066	1.23 (0.61, 2.48)	0.559

Notes: OR=Odds ratio, CI: Confidence Interval

Associations between socio-demographic factors, burnout, and trauma were also examined using a multivariate ordinal logistic regression model. All factors examined in the bivariate model were included. Table 11 presents odds ratios, 95% confidence intervals, and p-values for the three outcome variables for the multivariate model. Results from the multivariate model show that, holding other factors constant, background training on GBV (OR 2.46; 95% CI: 1.02, 5.91; p = 0.045), living with parent/partner compared to living alone (OR 11.32; 95% CI: 3.44, 37.24; p=<0.001), and other living arrangements compared to living alone (OR 7.88; 95% CI:1.89, 32.88, p= 0.005) were significantly positively associated with compassion satisfaction. Having an

intimate partner was significantly negatively associated with compassion satisfaction at work (OR 0.21; 95% CI: 0.06, 0.77, p=0.018). The multivariate model further revealed that females had higher odds of experiencing burnout compared to their male counterparts (OR 9.15, 95% CI: 1.81, 46.34, p=0.007). Apart from sex as noted in the previous paragraph, there were no other significant associations between the socio-demographic factors and burnout or secondary traumatic stress in both bivariate and multivariate models.

Table 11: Multivariate Ordinal Logistic Regression Model Examining Associations between Socio-Demographic Factors and Compassion Satisfaction, Burnout, and Secondary Traumatic Stress.

	Compassion Satisfaction		**Burnout**		**Secondary traumatic stress**	
	OR (95% CI)	p-value	OR (95% CI)	p-value	OR (95% CI)	p-value
Sex						
Female	0.44 (0.11, 1.73)	0.239	9.15 (1.81, 46.34)	**0.007**	3.23 (0.93, 11.24)	0.066
Age						
30-40y	1.67 (0.26, 10.65)	0.590	0.81 (0.1, 6.21)	0.836	0.74 (0.15, 3.72)	0.712
41-50y	0.83 (0.13, 5.15)	0.839	2.19 (0.32, 15.07)	0.424	1.06 (0.21, 5.22)	0.946
>50y	0.74 (0.11, 4.89)	0.756	4.31 (0.6, 30.86)	0.146	1.54 (0.3, 7.94)	0.608
Background training on GBV	2.46 (1.02, 5.91)	**0.045**	2.29 (0.82, 6.36)	0.112	1.78 (0.76, 4.15)	0.183
Ever worked with GBV victims before	0.74 (0.13, 4.30)	0.734	0.99 (0.17, 5.88)	0.990	0.69 (0.16, 3.02)	0.622
Duration worked as CHV						
5-9y	0.74 (0.18, 2.96)	0.669	1.82 (0.36, 9.18)	0.469	1.9 (0.53, 6.8)	0.321
10-19y	0.39 (0.11, 1.42)	0.154	2.54 (0.54, 11.89)	0.236	1.77 (0.52, 5.99)	0.356
20y or more	0.51 (0.09, 2.79)	0.438	0.19 (0.01, 2.64)	0.219	1.61 (0.32, 8.03)	0.559

Living arrangement						
With parent/partner	11.32 (3.44, 37.24)	**<0.001**	0.68 (0.2, 2.39)	0.550	3.08 (0.9, 10.54)	0.073
With other	7.88 (1.89, 32.88)	**0.005**	-	-	3.13 (0.95, 10.26)	0.060
Education						
Some Secondary	0.56 (0.25, 1.26)	0.162	2.57 (1.02, 6.5)	0.046	0.65 (0.31, 1.36)	0.253
Higher education	0.81 (0.07, 8.89)	0.864	2.81 (0.18, 43.69)	0.460	0.26 (0.03, 2.55)	0.245
Employment						
Employed	0.25 (0.03, 2.07)	0.198	4.18 (0.41, 42.5)	0.226	-	-
Self or other	0.4 (0.07, 2.12)	0.279	3.56 (0.59, 21.43)	0.166	-	-
Financial support to family	7.61 (0.86, 67.08)	0.068	0.14 (0.01, 1.43)	0.098	-	-
Have intimate partner	0.21 (0.06, 0.77)	**0.018**	3.15 (0.69, 14.34)	0.139	1.25 (0.33, 4.82)	0.743

Notes: OR=Odds ratio, CI: Confidence Interval

Where there is a dash (-) the confidence interval was too wide, which means the result may not be reliable so was suppressed

4.8 Qualitative Findings

Methodological triangulation was undertaken in this research work by means of complementing quantitative findings with qualitative data where the latter was generated from community health volunteers and their supervisors. Overall, the findings of the study revealed that CHVs experienced a myriad of challenges while working with the communities, which ultimately resulted in effects, such as fear, anxiety, and worry. It was further established that CHVs devised some coping mechanisms in response to the challenges they encountered, including their supervisors' actions to address their plight. Analysis of the data garnered from the interviews was carried out thematically.

From the qualitative data, most CHV's reported to be depending on their belief in God to cope better and manage diversities in terms of distress. Self-initiated mechanisms such as prayers, were hailed by the majority of the respondents who perceived them as one of the most effective mechanisms. This was reported in the qualitative report: -

> *When I pray and talk to my God it helps me to calm down and find time to reflect and solve problems, so it really helps me a lot.* ***(FDG CHVs- Land Mawe Ward).***
>
> *For me, it's through prayer. When I pray, I feel relieved. And it helps me to think about what I must do. And then secondly, sharing with colleagues* ***(FDG -CHVs Land Mawe Ward).***
>
> *For me, praying. Talking, especially praying loud. It helps me a lot. And it's the best for me because I feel released, and I feel relieved. For whatever reason that made me feel bad because when I pray mostly, I close my eyes and I cry, so through crying after that, I feel relieved.* ***(FGD- CHVs Nairobi South Ward).***
>
> *Going to church for me works very well. I know sometimes even when the church is closed, I go take the keys from the responsible person. And then I go to the church to pray and it's very effective for me because I feel relieved every time I pray. When I pray for myself and pray even for those whom I take care of* ***(FGD- CHVs Land Mawe Ward).***

4.8.1 Challenges Experienced by CHVs

4.8.1.1 Over Expectation by The Community

Seemingly CHVs have a personal informed sense of responsibility that is beyond their defined roles and the call for response is unpredictable, they could be called upon to respond even at night and sometimes the support can go beyond contributing their own money to ensure a referral has been done to the health facility, in most cases they may find themselves keeping the survivor in

hospital beyond normal working hours, therefore, interfering their family chaos resulting to Work-Life Conflict.

According to respondents, society has too much expectation of the role played by CHVs in GBV. Much as they are expected to support the community, by linking them to the relevant authorities or facilities, counseling, and offering credible support. Their support goes to having them offer financial help to ensure a continuum of care. They recalled providing transport to facilities, paying for legal fees, and standing in for the treatment cost among others. Interestingly to them, failure to offer necessary support by the CHVs would likely mean that the services offered had no impact, which may influence guilt and further affect their relationship with the community, as narrated by CHVs.

> *Sometimes, we visit some cases when someone is maybe sick, and they need it, but we don't have the ability to support so such a thing affects you so much because you want to help them, but you can't because you're not you are not able. So, we sometimes need support in terms of counselling* ***(FGD. 2, Nairobi South Ward).***

> *And sometimes in the community, we do interventions and especially in GBV cases, families hate us as CHVs our security is not guaranteed because families feel because of our involvement, we are breaking up their families.* ***FDG CHVs Land Mawe Ward).***

> *Sometimes gender-based violence has so many challenges, especially in the community, for example, you can get a victim who has been violated, and they don't have money to go to the hospital. As a CHV we are forced to contribute money so that we can take them to the hospital, and sometimes even the money that we contribute is never enough. (****FDG CHVs Land Mawe Ward).***
> *Another issue is when you push for a case, the process of care and justice requires so many things one of them is acquiring the p3 form for the survivor. So, when you*

go to the hospital in the past, a person didn't have to pay anything to get the p3 form, but nowadays, the survivor needs to pay between 1,100 to 1,200 shillings to get the p3 form. So, this one is a very big challenge because most of the victims do not have the money and this makes the case so hard because without the p3 form, the case will not move forward. So sometimes we must use our own money to support such cases. And considering we don't have support from the government, the CHVs get so challenged to help survivors push through their cases. ***FGD – Land Mawe Ward).***

Further the CHAs, in KIIs, articulated the fact that the community tends to forget they are CHVs are just ordinary members of the community perhaps just have additional responsibilities on a voluntary basis, they feel entitled to some of the support offered by the CHVs which was in good will. It was further revealed that they are sometimes made to provide them with safe spaces in the CHVs household; as narrated.

The challenge they face is mostly the survivors expect so much from the CHV, forgetting that they are just the same. People like them, but because they have come in to assist, they think they have gotten an angel from Heaven. So, I think most of the time they feel like we would have assisted more, but it is just because they don't have anything to assist those survivors with. Most of the time, like now, there are others who got physically the GBV for physical or domestic violence at home. Some of them are just like places to sleep. So, at some point, they take them to the household. But there is a limit in assistance for many people. For the CHC, we always tell them you can carry whatever you can, but don't tell them to expect so much from you because they have relatives." ***K.I.I – Land Mawe Ward).***

4.8.1.2 Lack of Support and Motivation in Their Line of Work

First CHVs pointed to empty promises by the government to offer them stipends, most of them claimed to have volunteered for years with no pay, yet they were given many responsibilities in the community and were supposed to cater to their own personal needs, they wondered whether the problem was on based on the fact that perhaps the government didn't really understand how burdening their roles were or whether it was just negligence.

> *To add on that, I am the CHVs chairperson, and we work as volunteers without pay which makes us most unmotivated in our work. This makes us lack morale at work.* ***(FDG CHV Land Mawe ward).***

4.8.1.3 Corruption, Lack of Accountability, and Transparency within the Legal System

To some great extent, the system was described as corrupt, sabotaged the CHVs efforts, and lacked transparency. Instead of offering justice with fairness the judiciary tended to plan with the perpetrators who got released and may either repeat the same crime or may endanger the lives of the person who reported them (CHVs).

> *Most of the time it is because of corruption. The case will not be solved, because they get money to pay the chief pay the police. So, the case we'll just go like that and go unsolved* ***(FDG – CHV Land Mawe Ward).***

4.8.1.4 Lack of Safe Spaces for the Survivors of GBV

CHVs reported that victims lack safe spaces within the community, and therefore this becomes challenging to manage them after being saved from the perpetrators. CHVs discussed the needs of survivors of domestic violence, highlighting the importance of shelters or safe spaces for them. They noted that at the sub-county level did not have such resources available. However, they

mentioned that they work closely with children and sometimes receive support from police officers in providing safe spaces for survivors.

> *Some of them require shelters or safe places for the survivors where they can shelter. that is something that we do not have. We usually network with children's officers sometimes they give us support when it comes to safe spaces and sometimes when we report at the police station. But we lack shelter for these survivors within our community, at least if we can have one shelter or safe space per sub county, it will really help those survivors* ***(FGD. 8 – Nairobi South****).*

4.8.2 Effects of Challenges Experienced by CHVs

4.8.2.1 Fear, Anxiety, and Worry

CHVs explained that they experienced fear worry and anxiety, which generally deprived them of sleep, with visions of what transpired during the day in handling GBV cases while others experienced negative health effects such as ulcers due to disappointment experienced.

> *It does affect us so much and sometimes we lose sleep at night because of the cases we handle during the day.* ***(FDG CHVs- Land Mawe).***

> *It affects me in a way that I feel like I can't sleep sometimes at night. It makes me feel anxious thus the thoughts keep coming back to me at night. Like in terms of visions.* ***(FDG CHVs- Nairobi South).***

Some further narrated that they lost their appetite as a result of anxiety and fear.

Sometimes we also worry about the safety of our clients, especially when there are web quest cases in the community. Sometimes after serving a case, that night or daytime, you live asking yourself, Is my client safe? And our children safe for example, if you will, sometimes find a case whereby a mother doesn't have access to the kid. And after solving the case you ask yourself has this mother been given the kid back so sometimes you worry a lot and when you get even to your house, you can't eat your appetite is affected and your sleep is also affected. ***(FDG CHVs- Land Mawe)****.*

While others experienced negative health effects such as ulcers due to disappointment experienced.

> *It hurts me inside my heart, and it makes me feel so disappointed when I think of that survivor, it to hurts me, the stress makes me think about it repeatedly and it makes me get ulcers.* ***(FDG CHVs- Nairobi South)***

a) Negative effect on CHVs' social and personal development

First, CHVs expressed fear that their negative energy as a result of work strained their relationship in their marriage; the feeling of hopelessness was expressed to their families also the whole ordeal of witnessing GBV made them to lack the desire to getting married.

> *Sometimes it also affects our marriages, our family relationships. Sometimes you're told by your husband now that you are so concerned about the community, just go away, and let the community marry you. So, it affects the relationship between our spouses and even among our children.* ***(FDG CHVs -Land Mawe)***

> *Sometimes such things when they happen to you, you lose hope, even in marriage because if you're told like that, you're told that you can't help, it makes you lose morale to also have a family and get married." (****FDG CHVs- Nairobi South)***

> *Sometimes when you go through such events, sometimes you wake up in the morning and you are so hopeless and you don't feel like waking up, you feel so weak. You feel that your body doesn't have the energy to wake up and sometimes it also affects our families at home.* ***(FDG CHVs -Land Mawe).***

Similarly, one waking up to uncertainty coupled with huge demand in their work makes them draw back their economic wellbeing.

> *Sometimes our work affects our personal work or our own business because you will wake up in the morning and our CHA or our supervisor may call in that morning when you have already planned for your own things, and this affects our own businesses and affects even our income so it would have been better if the government provides some things for us so*

that we are paid for the work that we are doing in the community. **(*FDG CHVs Land Mawe).***

4.8.2.2 Helplessness, Self-Doubt, and Uncertainty

CHVs reported that it takes a lot of sacrifice to offer support to GBV survivors, however, perceived helplessness, and lack of control in offering support frustrated and angered the CHVs. They further explained that when they encounter discouragement from the same people they are trying to assist. They reported that they were demoralized and generally felt less appreciated, and this resulted in some giving up.

> *I feel angry sometimes when I'm told like that. I feel like I'm helpless because I'm able to help but the people that I want to help feel like I don't have the capacity to help **(FDG. 4. CHVs Land mawe).***
>
> *Sometimes you find a client who has been violated by the husband. And when you help such a client, you take the client to administration or the government people to help them after some time you go and find that the survivor has gone back to the person who is the perpetrator. So that makes you feel bad because you really try to help so much but at the end of the day, the survivor goes back so even though the community views it as if what you're working in the community is not helping, it really demoralizes your work and makes you feel like what you're doing is not appreciated. **(FDG CHVs Land Mawe Unit).***
>
> *It's saddening to see a case not going through and at some point, it has caused me to get stomach ulcers, which affects me a lot. When I see things are not working for me, for example, when I refer a client and they don't get the services. I feel like giving up because I lack morale to continue with my work **(FGD – Nairobi South Unit).***

My work sometimes affects me psychologically, especially when I offer myself to help. And some people see that I'm not offering the relevant help they want. It's just that it's like, the person didn't want us to help them. And it helped it hurts me psychologically in so many ways. And when I offer myself to help and I get some limitations on the way it hurts inside my way, my heart a lot. And mostly when you do a referral, and you reach a point, when you start seeing objections on the way it really affects me a lot. Especially in the legal process, where you find that maybe the police do not understand what is supposed to be done, or corruption happens between the perpetrator and the police, not all police are bad. Some of them are good, like the best one we have worked with, during a certain training and who say that he has really tried to train other policemen on GBV cases. So, for that one, I feel like if I get such a person or it will be helpful, and it will help me have morale. ***(FGD – CHV Nairobi South Unit).***

Sometimes when I see the community fighting us or the person, we want to help fighting you, I feel so disappointed. And sometimes I feel like giving up. Because inside my heart, I feel so hurt that the people that I'm trying to help, are not seeing my help to be of any great purpose. So, I feel so hot. And sometimes I feel like leaving them alone and let the case go." ***(FGD – CHV Nairobi South Unit).***

4.8.3 Manifestation of stress among CHVs

a) Ill health

The majority of the CHVs stated that their initial indicator of stress was when they felt sick. While some pointed to intense headaches, others narrated that they experienced stomachache, and increased heartbeat perhaps due to anxiety as well as joint pains.

*When I get headaches on one side of my head, it shows that I'm stressed, and when I get stomach pains, especially on the upper side of my stomach" (**FGD CHVs Land Mawe).***

*When I stand, I feel like I'm weak in my body and my joints. **Respondent 5:** When there is an increase in heartbeat. **Respondent 6:** When I feel my head is paining me and heavy" **(FGD – Nairobi South Ward).***

b) Loss of appetite

Loss of appetite was another pointer to stress, to some it led to loss of weight while others stated that it resulted in ulcers, as recounted.

"Respondent 6:** When I feel I'm losing weight I know that affected and I am stressed up" (**FGD CHVs Land Mawe).

"Respondent 4:** When I lose appetite and before that I feel like a pain in the stomach, one of the effects of ulcers" **(FGD - Nairobi South Ward).

"Respondent 2:** When I feel like I am losing appetite. My eating patterns change and that indicates that I'm stressed. And sometimes I also feel like I'm empty inside my stomach or feel the pain inside my stomach. When I feel like that, I know that there is something wrong and there's something that is bothering me psychologically." (**FGD- Nairobi South Ward)

c) Lack of motivation to express disinterest

Some CHVs stated that they expressed that their stress pointer was based on disinterest in work as well as general life, this was demonstrated in the form of fatigue, feeling of hopelessness, loss of morale, inability to meet the target at work,

"Respondent 1: *By getting tired, when I feel tired and hopeless that tells me that I am being affected by my work thus I feel fatigued" (**FDG CHVs Land Mawe).***

"Respondent 1: *I usually know I am stressed when I fail to meet my targets." (**FDG CHVs Land Mawe).***

"Respondent 2: *I feel sad. I feel like there is no hope and it really demotivates me. And when I find another case, I won't feel like helping again because I feel like I will fail again. And sometimes also the survivor will also tell others that this person won't help you. I had a problem, and they didn't help me, so it demotivates me." (**FGD – Nairobi South).***

The issue of performance as a pointer to stressors was further emphasized by the CHA.

*One CHV cannot perform as usual, maybe the way she used to perform…A CHV also the way they talk in their tone shows that this CHV is undergoing burnout. The way she or he relates with the other CHVs, you can find that most of them when they are undergoing burnout or stress, she or he tends to shy away from other CHVs, **(K.I.I - CHA Police band clinic- Land Mawe)***

a) Expression of uncontrollable anger and easily irritable

Both CHVs and CHEWs demonstrated that anger was another key pointer to stress, this was demonstrated through easily irritable, cry, use of harsh tone and poor body language, to some this was further extrapolated to their family members who underwent harassment in the process.

"Respondent 5: *For me when I get harsh on small issues, that shows that I'm not okay. I have some anger issues that I am experiencing when dealing with situations"* ***(FDG CHVs Land Mawe).***

"Respondent 8: *When I cry- crying shows that I'm stressed, and I get emotional so easily"* ***(FDG CHVs Land Mawe).***

"A lot of crying. I pick stress, I pick depression. What else do you pick when they share that you can relate to burnout in relation to the precarious trauma?" ***(K.I.I Nairobi South Ward CHA 2).***

"Respondent 1*: For me, when I get angry, and when I'm at home, shout at my children. I wake them up or beat them up. That's when I know my work is affecting"* ***(FGD – Nairobi South Ward).***

Key respondents were also keen to point to anger as a pointer to stress when dealing with the CHVs as explained.

Respondent: *Sometimes talking harshly. You can tell this person has a problem, a serious psychological issue. So, the tone, sometimes the expression on body language, this person is undergoing trouble."* ***(K.I.I - CHA Police band clinic - Land Mawe).***

"Respondent: *There are some who come with you can just see when they explain the case, you feel that person is so overwhelmed, and it has really touched. And then you can see when they go until they also feel like they are too overwhelmed. Some even cry in terms of when they are explaining the problem. So, you can imagine when somebody cries, you can feel the pain. You can see even from the height; it shows that the chu is so overwhelmed and he also needs the assistance to*

*come out of it so that it will not be affected." (**K.I.I - CHA Police band clinic - Land Mawe).***

"Respondent:** And sometimes they shout. Why is this happening? I wish I did not witness it happening. I wish I was not caught to solve that problem." **K.I.I Nairobi South Ward CHA 2

e) Recurrent thoughts of work-related visions

Recurrent thoughts/ visions of what transpired at work was illustrated by more than half of the respondents stating that the thoughts led to headaches, sometimes led to lack of sleep at night as well as loss of appetite.

Respondent 2:** For me recurring thoughts when I keep thinking of something repeatedly. I know that I'm affected" **(FDG CHVs prisons).

"Respondent 5:** When you are going to do something else apart from what you are doing your mind keeps shifting back to the previous occasion, you have recurring thoughts about something I usually know that I am affected" (**FDG CHVs prisons)

"Respondent 3:** Sometimes when I feel absent-minded, sometimes you feel like your mind is not with you and you're just hanging somewhere without being present within yourself,"(**FGD – Nairobi South).

4.8.4 Copying Mechanism Based on the Challenges Experienced by CHVs

4.8.4.1 Access to Counselling in the Community for CHVs

The qualitative report indicated that most CHVs would reach out for help in times of distress because of their work. Counseling support from the community was described as taking place within community spaces, such as churches or hospitals. The respondents emphasized the

importance of these services in providing support to individuals who may be facing difficult situations. While they did not provide further details about the type of counseling services offered, their words suggest that they value the availability of such resources. Below are some of the quotes from FGD's respondents.

> *I seek counselling services at the hospital, and when I'm done with that therapy, I feel relieved. And when I share with the counsellor, they give me a hint on how to cope, and I feel redeemed.* **(FGD- Nairobi South Ward)**

> *So, for me, I look for a friend, I talk to them, I share what is going on in my life. And then after that, I feel relieved, and I feel like everything is fine. So, I usually look for a colleague or workmate maybe there's a challenge that I'm going through and they may have also gone through the same, so I find it easy to understand my situation and find a solution.* ***(*FDG CHVs -Land Mawe).**

Respondents were also asked where counsellors are found. From the findings, counsellors are mainly found in churches, hospitals, and in public schools. Different CHVs had different ways of coping but one approach that emerged common to most CHVs was through prayer and seeking help from a religious leader. Below are some quotes narrated by some respondents in an FGD.

> *We have like the Pefa church, we have the Catholic Church, we have St. Bakhita primary school and at Mater Hospital. (**FDG CHVs -Nairobi South).***

> *There are some churches that have counselling services like PEFA church even the Catholic Church has counselling services as well as at Mater Hospital. They also provide online counselling services which support us so much." **(FGD – Nairobi South)***

> *Going to church for me works very well. I know sometimes even when the church is closed, I go take the keys from the responsible person. And then I go to the church to pray and it's very effective for me because I feel relieved every time I pray. When I pray for myself and pray even for those whom I take care of **(FDG CHVs- Land Mawe).***

From the qualitative data, peer counseling was demonstrated as the most effective coping

mechanism that helped the CHVs since they could all relate to the challenges. The efforts made by CHVs towards enhancing their well-being through seeking help protect them from exposure to further psychological distress that may lead to mental illnesses. Prevention mechanisms borrowed and practiced by individual CHVs minimize the level of distressed cases reported by CHVs which enables them to cope better and prevents burnout and vicarious trauma because of their work.

Another source of help that was notably stated by CHVs was seeking help from religious leaders and through prayers. Spirituality and religion often provide a safe space, a sense of security, and social structure those beliefs are often a powerful way of coping during difficult times. Being a frequent member of an active religious community can provide structure, support, and a sense of acceptance, all of which are beneficial to mental health.

4.8.4.2 Training

Training obtained was reported by some CHVs who stated that they had been trained on how to manage stressors in society. An interviewee posited that they were taught relaxation techniques during their training, which has been helpful in managing their stress.

> *We have been trained in problem management. So, we try and solve the issues on our own, we always try our best to solve it in the community.* ***(FDG. 8- CHV Land Mawe).***

4.8.4.3 Counseling Services from Health Facilities

From the focus group discussions, a respondent noted that they benefited from counseling services offered by health facilities. The interviewees posited that the therapy services they received from counselors in hospitals equipped them with the necessary hints on how to cope with stressful events in life.

I seek counselling services at the hospital, and when I'm done with that therapy, I feel relieved. And when I share with the counsellor, they give me a hint on how to cope, and I feel redeemed. ***(FGD. 2 CHV, Nairobi South).***

4.8.4.4 Prayer as a Self-Initiated Mechanism

Self-initiated mechanisms, such as prayers, were hailed by the majority of the respondents who perceived them as one of the most effective mechanisms. A respondent explained that they found relief through prayer when they faced difficult situations. Despite their personal preference for prayer, the respondents acknowledged the importance of seeking out social support as well.

When I pray and talk to my God, it helps me to calm down and find time to reflect and solve problems, it really helps me a lot. ***(FDG. 4, CHVs Land Mawe Ward).***

4.8.4.5 Peer Counseling

Peer counselling was reported as the most effective coping mechanism that helped the CHVs since they could all relate to the challenges. They noted that sharing their thoughts and feelings with others not only made them feel better but also allowed for potential solutions to be offered. By working together with others to find solutions, an interviewee explained that the weight of the stress they faced was reduced substantially.

Sharing works for me, especially with colleagues. Because when it comes to issues with GBV you do not share with just anyone. I feel at least relieved, that when you give up or leave the job that we are doing in the community, you feel there is that self-part that asks, who are you going to live this work to? So, it's hard to leave because sometimes the community depends on us. ***(FGD. 4, Nairobi South).***

4.8.5 Perceived Support Offered to CHVs

4.8.5.1 Strategies for Support Supervision

Generally, the CHEWs offered support supervision to CHVs. When asked about the strategies used to offer support supervision, they pointed out the use of phones or physical meetings. On frequency, they supervise CHVs, on a monthly basis during monthly meetings while others stated that it is done one on a daily basis.

*"**Respondent**: They normally share whenever we have follow-up monthly meeting"* (***K.I.I - CHA Police band clinic-Land Mawe)***

"Respondent:** It happens sometimes daily on a weekly basis. it can also be monthly."* ***(K.I.I Nairobi South Ward CHA 2).

On general roles and experiences of the CHVs. CHAs acknowledged that CHVs experience challenges in their day-to-day roles and are usually overwhelmed, which warrants support such as counselling. Although previously they had been managing stress on their own, they had been challenged on the importance of opening up and sharing.

***"Respondent:** Mostly when you encounter many cases of GBV, you also learn how to live with those issues because you can see the cases reported this time, next week, last week it was the same. So, what it means is that people are just becoming used to the same issues happening or reported at some point, but we usually tell them to report and get assistance because they might get affected. Now, most of the time they cope by talking, as CHVs we tell them to speak up about whatever they face. That is why we are just close to them so that we get much information in the community concerning their lives and we are close to support. They don't hide anything they are free to talk, we get to learn a lot from them and even whatever they face. When they are talking about it, the*

*issue becomes lighter. And mostly we tell them to reach out and talk we can assist." **(K.I.I – CHA-Prison band Land Mawe).***

According to CHAs there exist several facilities with counselling services perhaps little known to CHVs. However, their availability was termed as limited as well as their expertise since the majority were nurses and not counsellors.

Respondent:** Sometimes they go to the facilities. Sometimes they go to where they can be offered counselling by a counsellor who comes at the facility level occasionally. And sometimes they share amongst themselves as peers, especially as the GBV champions. At the facility level, the counsellor from Starehe Sub-County meets the CHVs when they want to whenever he is around. However, at the facility level, there are nurses even if they're not trained counselors who have the knowledge and skills to offer a listening year and support to many issues presented to them**." (K.I.I Nairobi South Ward CHA 2).

Much as the CHVs had been trained to handle overwhelming circumstances as well as seek peer counselling, and in circumstances where they felt the issues were beyond them at the household level they were encouraged to forward them to the relevant authorities.

Respondent:** It is not regularly; it depends on the issue and mostly when the case is so tedious to them and maybe they are overwhelmed so that we can seek help or services like counseling but there are many cases that are considered, and we have trained them on GBV so they're just part of them when they get the case. Seeking help from even their colleagues is emphasized, they share amongst themselves, and they report feeling relieved. But there are those cases that are so severe that they just feel overwhelmed. In such cases, we recommend they seek support through counselling. **(K.I.I – Police band -Land Mawe).

"Respondent:** So according to them, it's like, those cases are supposed to be handled at the household level. Even the relevant authorities are not supposed to be informed. So, they're accused that you informed the CHA, informed that chief informed the Police." (**K.I.I Nairobi South Ward CHA 2).

They further narrated there exist counselling centers, such as NPC Nuru Promotion Center, Child Fund, Kenya Cross, Mater Hospital and St. Catherine Center,

"Respondent:** We have MPC, Mukuru Promotion Center, counselling from Child Fund, Mater Hospital, St. Catherine Center, and Kenya Red Cross Society. Another one is called Nilinde. We have another new partner; I must have forgotten the name. But there are many partners in the community, even in Churches." **(K.I.I –Police Band-CHA).

CHAPTER FIVE: DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

5.1 Discussion

5.1.1 Socio-Demographic Characteristics of CHVs

The majority of CHVs were females while in age distribution, most of them were 40 years and above. The results indicate that most CHVs engaged in the Community Health strategy system are women. This is due to most men in the informal settlements being the breadwinners who depend on wages to support their families. Several existing studies have generated similar findings to those of this study. For instance, a study on the impact of the COVID-19 pandemic on posttraumatic stress, grief, burnout, and secondary trauma of social workers in the United States, which was carried out by Holmes, Rent rope, Korsch-Williams, and King (2021) established that most of the social workers were primary female with a mean age of 39.76 years. Similarly, the findings concur with those of Kokonyaet al. (2014) whose study established that there were more females (72.2%)

than males among medical workers. However, the study revealed that the mean age of the medical workers was 35 years.

5.1.2 Prevalence of Burnout and Vicarious Trauma

About a fifth (21%) of CHVs were found to have average burnout and close to 80% reported low burnout levels. None of the CHVs interviewed reported having high levels of secondary traumatic stress. However, close to a third (31%) reported having an average level of secondary traumatic stress with 69% reporting having a low level of secondary traumatic stress. From the above results, it's evident that most CHVs are satisfied with their work, thus low levels of burnout and secondary traumatic stress. This implies that most CHVs are passionate and despite the challenges faced in the course of their work, they have zeal and strong coping strategies which are also enhanced by the training and supervision provided at the community level. This result of the study is comparable to that of Dass-Brailsford and Thomley (2012) whose findings revealed that mental health volunteers were not affected by secondary trauma since they felt that their experiences were very enriching and that they had played a major role in speeding up the healing process of the residents who had benefited from their services.

The findings of this study seem to contradict those of a study by Kokonya et al. (2014) who found that burnout syndrome was highly prevalent among medical workers, with a crude prevalence rate of 95.4% where the major contributors included self-factors, patients' relatives, and work environment. In addition, findings from a study by Ndetei et al. (2008) showed that 99% of the staff at the Mathari Psychiatric Hospital reported low to high emotional exhaustion whereas 87.8% reported depersonalization because of low morale and heavy workload. A study undertaken in Brazil by Saude Colet et al. (2014) established that 29.3% of community health agents had characteristics of burnout syndrome, which is relatively higher than that of this study.

5.1.3 Help-Seeking Behavior

While the results indicated average or low levels of burnout and trauma, it is still necessary to explore possible factors that could have led to high levels of trauma and what would be the help-seeking behavior for CHVs. Any level of trauma if it is not zero needs to be addressed because it can lead to negative health and social outcomes. The study examined personal and emotional problems as well as help-seeking intentions in case a CHV experiences suicidal thoughts. On a scale of 1 (lowest) to 7 (highest) CHVs were asked to rate their likelihood of seeking help from different groups listed in case they experienced personal and emotional problems or suicidal thoughts.

Overall, findings show that in case of personal or emotional problems, CHVs were most likely to seek help from a mental health professional followed by a doctor/GP and religious leader or minister. The other sources which CHVs would seek help from were a family member who is not an intimate partner. CHVs reported that they would seek help from a parent or a friend. Another notable source of help mentioned was a colleague, the intimate partner score was relatively low with a mean of 4.0 (sd=0.2). The result of the study on seeking help from a friend mirrors with of Deane et al. (2001) whose study reported that intentions to seek help from friends and intentions to seek help from a teacher/school advisor were reliable predictors of future help-seeking behavior.

The willingness of CHVs to seek help from mental health professionals shows their level of knowledge as well as being an indication that they have acquired information through GBV training, which acts as a prevention factor in psychological distress from the nature of their work and enables them to cope better in adversities. This also indicates a high level of trust CHVs have in mental health professionals. From the report both male and female CHVs were willing to seek help from a mental health professional, however, most men would seek help from their spouses

while Females may prefer seeking help from religious leaders. Similarly, the qualitative report indicated that most CHVs would reach out for help in times of distress because of their work. First counselling from the community was narrated to have been acquired from the community spaces such as the churches, hospitals, neighbors within the community as well as relatives. It demonstrated the most effective coping mechanism that helped the CHVs since they could all relate to the challenges. The efforts made by CHVs towards enhancing their well-being through seeking help protect them from exposure to further psychological distress that may lead to mental illnesses. Prevention mechanisms borrowed and practiced by individual CHVs minimize the level of distressed cases reported by CHVs which enables them to cope better and prevents burnout and vicarious trauma because of their work. The result of this study mirrors those of Adamu et al. (2018) whose study established that up to 75.2% of health workers in a tertiary health institution in Nigeria frequently sought medical attention from doctors. Another source of help that was notably stated by CHVs was seeking help from religious leaders and through prayers. Spirituality and religion often provide a safe space, a sense of security, and social structure those beliefs are often a powerful way of coping during difficult times. Being a frequent member of an active religious community can provide structure, support, and a sense of acceptance, all of which are beneficial to mental health.

5.1.4 Association between Socio-Demographic Factors, Burnout, and Vicarious Trauma

Findings from the study showed that there was a statistically significant positive correlation though low, between compassion satisfaction and help-seeking intentions score in the case of personal or emotional problems with a Karl Pearson correlation coefficient of 0.411 ($p<0.001$). Similarly, though low, a significant positive correlation existed between compassion satisfaction and help-seeking intentions score in the case of suicidal thoughts with a Karl Pearson correlation coefficient

of 0.360 ($p<0.001$). This means that the higher the help-seeking score for emotional or personal problems and suicidal thoughts, the higher the compassion satisfaction score. However, there was no significant correlation between help-seeking intention scores and burnout and secondary traumatic stress. Moreover, there is a significant positive correlation between socio-demographic factors, burnout, and vicarious trauma. From the study findings, average burnout was relatively higher among the female (22%) compared to the male CHVs (11%). The findings of this study concur with several studies conducted in various settings. For example, a study by Norlund et al. (2010) established a high prevalence of burnout in the general working population in Sweden (Shirom Melamed Burnout Questionnaire >4.0) was 13%. Females experienced a greater degree of burnout compared to males, with the largest difference being observed in the age range of 35 to 44 years. As individuals aged, burnout levels decreased for both genders. Factors such as job demands, control, and insecurity were associated with the occurrence of burnout.

Having an intimate partner was significantly negatively associated with compassion satisfaction at work (OR 0.21; 95% CI: 0.06, 0.77, $p=0.018$). This could be attributed to the nature of work in the identification, response, and referral in helping GBV survivors. CHVs had unpredictable working hours, and they could be called upon to respond even at night sometimes the support required of them can go as far as contributing their own money to ensure a referral has been done to the health facility, in most cases they may find themselves keeping the survivor in hospital beyond normal working hours, therefore, interfering with their family life and resulting in Work/Life Conflict. In contrast, living with a parent/partner compared to living alone (OR 11.32; $p=<0.001$), and other living arrangements compared to living alone (OR 7.88; $p= 0.005$) were significantly positively associated with compassion satisfaction. This result of the study compares favorably with that of Wang et al. (2020) whose outcome established that being married/member

of an unmarried couple, including other factors like regular exercise, good quality sleep, and higher job satisfaction was positively associated with compassion satisfaction.

In the multivariate model, females had higher odds of experiencing burnout compared to their male counterparts (OR 9.15, 95% CI: 1.81, 46.34, p=0.007). According to the research ages 35 to 54 years are the most productive ages in a life span, women at this age are likely to be juggling many roles including mothering, caring for elderly parents, housework, and sometimes being the breadwinner and thereby experiencing significantly higher stress than men. The area of study is a low social economic environment meaning most people depend on wages, and small businesses to survive. From the social demographic report, data showed that the majority of the CHVs were self-employed, followed by part-time employment meaning that besides volunteer work, CHVs are also engaged in other income generation which would contribute to women being overwhelmed due to the social structure with multiple tasks and expectations from the society.

5.2 Conclusion

The findings of this study suggest that CHVs are more likely to seek help from mental health professionals, regardless of their social demographic profiles. This highlights the importance of building the capacity of mental health professionals so that they can respond appropriately when called upon to support CHVs and other groups interacting with survivors of gender-based violence. The study also revealed gender differences in help-seeking behavior, with male CHVs more likely to seek help from their spouses and female CHVs more likely to seek help from religious leaders. In addition, the qualitative report indicated that CHVs are more likely to reach out for help in times of distress related to their work. Addressing these gender and occupational differences in help-seeking behavior, community health organizations can better support the mental health needs of

their CHVs and improve the quality of care for survivors of gender-based violence. Overall, this study also found that most CHVs are satisfied with their work, thus low levels of burnout and secondary traumatic stress. This implies that most CHVs are well-equipped with coping strategies.

5.3 Recommendations

The first objective was to determine the socio-demographic characteristics of CHVs working with survivors of gender-based violence in an informal settlement in Nairobi County. Most CHVs engaged in response of GBV at the informal settlement of Mukuru Fuata Nyayo were ages 40 years and above and had minimal attainment in high school level certification in their education, meaning more efforts in providing training and mentorship in community health approaches.

From the qualitative report, CHVs highlighted the need for capacity building on GBV as follows; It's important for key stakeholders to take charge in their role in creating awareness. First, train the CHVs and CHEWs and provide resources for the CHVs to intensify creating awareness at the community level. From the qualitative report, the following recommendations on the need for capacity building were stated as below.

Respondent** 1: What I can say is that it'll be good if the government can organize for us refresher training on how to deal with our issues and those related to the work we are doing because things keep changing, for example, today, after this session, the discussion we have had it has helped, us to reduce the stress of our work. So, refresher training will help us to understand how to help others and how to deal with this issue.* ***(FGD – Nairobi South)

"Respondent:** Sometimes we meet when we take reports and we do some activities like action days and when we come together, we merge some units and then we do some action days talking about issues on GBV and we have seen it has helped in many communities that many people have just opened. Yeah."* ***(K.I.I – Land Mawe)

"Respondent: *We also need to be trained on how to handle GBV cases because some of us are not trained. And I understand when they train, they will know how to handle and even themselves out too, so training is key and it's because we don't have so many partners year-round. We just pray maybe one day we will have partners to assist us because even the training they did, there were very few trained and it was a long time ago."* ***(K.I.I – Land Mawe).***

CHVs are instrumental/ resourceful and can be a source of change at the community level, however there is a need to focus on their well-being by ensuring their physical safety through the provision of protective gear since they lack equipment such as gloves, raincoats, torches, gumboots etc., lack of proper identification documents, and lack of support/motivation financially demotivate them and may put them to risk, while the government may have minimal efforts in compensation in case of harm in course of their work. The majority of the CHVs reported that they use their own resources and are not reimbursed, there is a need to address the financial remuneration of the CHVs in the County.

The second objective was to determine the prevalence of Burnout and Vicarious Trauma in the study population. Efforts in enhancing community mental health approaches should be prioritized and more mental health professionals based at primary health care facility outlets, health care workers continuously trained and sensitized on mental health and psychosocial support as frontline responders and avail tele services to enable CHVs access to mental health professional services. Integration of mental health and psychosocial support services should be a priority at every service delivery point to enable CHVs to seek help anytime. Routine screening for depression and anxiety (psychological distress) and trauma should be availed to all community health volunteers (CHVs) and community health workers (CHWs) and psychological support systems established and as

recommended by the Key Informants frequent support supervision for all CHVs. The supervisors (CHAs) should also be trained to provide psychological intervention through debriefing during their monthly sessions and refer appropriately in case of any psychological need and psychiatry review.

The third objective was to identify the protective factors in addressing burnout and vicarious trauma among CHVs working with survivors of gender-based violence in informal settlements. Efforts should be put in place to enable CHVs to seek help. As discussed on KII's it was recommended to have frequent support supervision for all CHVs this can be intensified on a monthly basis. CHVs, viewed these platforms as an avenue for sharing, encouraging each other, and providing feedback to CHAs who should also offer potential solutions and enhance communication across cadres based on experience which may offer relief to CHVs. Through the community mental health approach institutions such as religious institutions should have professional counsellors and trained religious leaders to offer basic counselling and enable access to affordable to no-cost related counselling services**.**

Community mental health approaches to be emphasized, key community gatekeepers, and institutions play a key role in the prevention and promotion of mental health. Religious institutions where the community congregates should create safe spaces and a mental health professional to provide psychological help to the members. It was evident that religion was one of the protective factors in CHV's psychological health. More so sensitization through awareness creation during services and trainings to religious leaders should be prioritized. Referral mechanisms can be instituted between religious institutions and health facilities offering mental health. This is because the data showed that patients seek help from religious leaders who may not have professional training in mental health.

The Fourth objective was to determine the association between socio-demographic factors, Burnout, and vicarious trauma. Proper structures for the identification and response of GBV survivors at the community level should be established example community-based hotlines to report GBV cases and proper response mechanisms to prevent CHVs from responding to survivors at night which worries' their safety and well-being. The local administrative should be sensitized, empowered, and avail necessary resources required to enable prompt and effective referral and linkages from the community to the facility and legal arm.

It's recommended to have CHVs get motivated on a monthly basis in terms of allowances/ stipends by the Government to enable them to have a source of income. Most of the CHVs have dedicated their time as volunteers but never get remunerated, they have therefore taken other strategies for upkeep and even when called upon to support they are demotivated or unavailable, thus the need for motivation is highly emphasized.

More research on Burnout and Vicarious Trauma among CHVs working with survivors of gender-based violence is recommended to unearth experiences, needs, and support required to minimize psychological distress.

Research Time Schedule

Activity	**January-Oct 2021**	**Oct-Dec 2021**	**Jan 2022-May 2022**	**May 2022-Jul 2022**	**Aug 2022-Dec 2022**	**May 2023**	**June 2023**
Development of proposal							
Approval of proposal							
Ethics committee							
Data collection							
Data analysis and reporting							
Presentation							
Completion of work and binding							

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APPENDICES

APPENDIX 1: CONSENT FORM

Study Title: **Health Seeking Behaviour Of Community Health Volunteers Working With Survivors Of Gender Based Violence In Relation To Burnout And Vicarious Trauma In Informal Settlements.**

Investigator: Nancy Gathi- 0720093440

RESEARCHERS' STATEMENT

1. Introduction

We are requesting you to take part in this research. This consent form gives you pertinent information that will help you decide whether you will be interested in this study or not. It provides you with important information pertaining what you would be required to do during the study, about the risks and benefits of the study, and about your rights and responsibilities as a study participant. Being in the study is voluntary. Kindly read this carefully. Again you may ask any questions about the study, then you can decide whether you'd like to participate or not.

2. Purpose and Benefits

We are requesting you to participate in this study because you are a community health volunteerworking with survivors of gender based violence in Mukuru informal settlement in Nairobi County. The purpose of this interview is to learn about your experiences as a CHV. Moreover, we would like to understand whether you experience burnout or vicarious trauma as well as your coping mechanism.

3. Procedures

If you agree to take part in the study, we will ask you to participate in an interview that will be led by a member of the study team, in a private room. Before we start the discussion, we will ask you to answer a few questions including your age, level of education among others. We will thereafter start the discussion and ask you to tell us about your experiences while working as a community health volunteer.

If you agree to participate today, you will sign or make your mark on this consent form. We will give you a copy of this consent form for your records. We will then arrange a time for you to participate in interview with our research assistant. The discussion will take about 35 minutes. Audio recording will also be done during the focus group discussions (FGDs). Each FGD will take approximately 25 Minutes. We will also take notes during the discussion. Moreover, we will not use your name during the interview. Again, you do not have to answer every question if you do not want to. The only people who will hear your answers are those involved in the study.

4. Risks and Discomfort

Although we will do our best to protect your privacy, it is possible that someone not involved with the study could find out what you say during the interview. However, we will ensure that we protect your privacy. We will not record your full name during the interview and will not share your words with any other person.

5. Benefits

You may not directly benefit from the study. However, your answers to questions will help to support the Ministry of Health as well as policy makers in identifying the best treatment approaches.

6. Other information

i. You do not have to be in this study if you don't want to.
ii. You may withdraw from the study at any time without necessarily giving any reason for your withdrawal.

Will being in this study cost you anything?

There will be no financial cost to you.

Use of information in future studies

The information we obtain from you for this study might be used for future studies if need be. We will remove anything that might identify you from the information. That information may then be used for future research studies or given to another investigator without getting additional permission from you. However, a review board will decide whether or not we need to get additional permission from you.

7. Confidentiality of Research Information

Confidentiality

The information you provide will be kept secret by the study staff. We will not publish or discuss in public anything that could identify you. We will use a number code to identify your responses and will only link the number code to your name in a storage device/book. The storage device/book will be stored in a room/cabinet under lock and key, and that only the research team will be aware of.

Government and university staffs sometimes review similar studies to make sure they are being conducted safely and legally. If this study is subjected to such review, your records may be examined. However, the study records will not be used to put you at any risk or harm. The records of this discussion may be reviewed by assessment staff and representatives of University of Nairobi School of Medicine, as well as the Kenyatta National Hospital and University of Nairobi Ethics and Research Committee.

What if you have questions in future?

If you have further questions or concerns regarding your participation in this study, please call or send a text message to Nancy Gathi 0720093440.

If you have questions regarding your rights as a research participant, or personal injury, you should contact the Secretary/Chairperson- Kenyatta National Hospital Ethics and Research Committee, at 2726300-Extension 44102.

STUDY PARTICIPANT'S STATEMENT

I have read this consent form or had the information read to me. I have had the chance to discuss this research study with the researcher. I have had my questions answered in a language that I understand. The risks and benefits have been explained to me. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this study.
I understand that all efforts will be made to keep information regarding my personal identity confidential.
By signing this consent form, I have not given up any of the legal rights that I have as a participant of this research study.

I agree to participate in this research study: Yes_____ No_____

I agree to have the questionnaire preserved for later study: Yes _____No_____

_____	_____	_____
Participant's Name	Signature/Thumbprint	Date
_____	_____	_____
Witness name	Signature/Thumbprint	Date

(if unable to sign)

_____	_____	_____
Researcher's name	Signature	Date

Copies to: Researcher

Participant

APPENDIX 2: CONSENT FORM (SWAHILI VERSION)

FOMU YA IDHINI

Kichwa chaUtafiti: **Utaftaji wa Msaada wa Afya kwa Wawezeshaji wa Afya ya Jamii Wanaofanya Kazi na Waathiriwa wa Unyanyasaji wa Kijinsia Kuhusiana na Uchovu na Kiwewe Kikubwa Katika Makazi Yasiyo Rasmi.**

Mtafiti:Nancy Gathi- 0720093440

TAARIFA YA ATAFITI

1. Utangulizi

Tunakuomba ushiriki katika utafiti huu. Fomu hii ya idhini inakupa habari muhimu ambayo itakusaidia kuamua kama utapendezwa na utafiti huu au la. Inakupa habari muhimu kuhusu kile ungehitajika kufanya wakati wa utafiti, kuhusu hatari na faida za utafiti, na kuhusu haki na majukumu yako kama mshiriki wa utafiti. Kuwa katika utafiti ni kwa hiari. Kwa ukarimu soma jambo hili kwa makini. Tena unaweza kuuliza maswali yoyote kuhusu utafiti, kisha unaweza kuamua kama ungependa kushiriki au la.

2. Kusudi na Faida

Tunakuomba ushiriki katika utafiti huu kwa sababu wewe ni mfanyakazi wa afya ya jamii anayefanya kazi na manusura wa unyanyasajiwa kijinsia katika makazi yasiyo rasmi ya Mukuru katika Kaunti ya Nairobi. Madhumuni ya mahojiano haya ni kujifunza kuhusu uzoefu wako kama CHV. Aidha, tungependa kuelewa kama unapata uchovu aukiwewekibaya pamoja na utaratibu wako wa kukabiliana.

3. Taratibu

Ikiwa unakubali kushiriki katika utafiti, tutakuomba ushiriki katika mahojiano ambayo yataongozwa na mwanachama wa timu ya utafiti, katika chumba cha faragha. Kabla ya kuanza majadiliano, tutakuomba ujibu maswali machache ikiwa ni pamoja na umri wako, kiwango cha elimu kati ya mengine. Baada ya hapo tutaanza majadiliano na kukuuliza utuambie kuhusu uzoefu wako wakati unafanya kazi kama mfanyakazi wa kujitolea wa afya ya jamii.

Ikiwa unakubali kushiriki leo, utatia sahihi au kueka alama yako kwenye fomu hii ya idhini. Tutakupa nakala ya fomu hii ya idhini kwa rekodi zako. Kisha tutapanga muda wa kushiriki kwako katika mahojiano na msaidizi wetu wa utafiti. Majadiliano yatachukua takribani dakika 35.Tutarekodi pia majadiliano ya kikundi. Majadiliano ya kikundi yatachukua takribani dakika 25. Pia tutachukua maelezo wakati wa majadiliano. Aidha, hatutatumia jina lako wakati wa mahojiano.

Tena, huna haja ya kujibu kila swali kama hutaki. Watu pekee ambao watasikia majibu yako ni wale wanaohusika katika utafiti.

4. Hatari na Usumbufu

Ingawa tutafanya bidii yetu kulinda faragha yako, inawezekana kwamba mtu ambaye hahusiki na utafiti anaweza kujua unachosema wakati wa mahojiano. Walakini, tutahakikisha kwamba tunalinda faragha yako. Hatutarekodi jina lako kamili wakati wa mahojiano na hatutashiriki maneno yako na mtu mwingine yeyote.

5. Faida

Huwezi kufaidika moja kwa moja na utafiti. Hata hivyo, majibu yako ya maswali yatasaidia kusaidia Wizara ya Afya pamoja na watunga sera katika kutambua mbinu bora za matibabu.

6. Maelezo mengine

i. Huna haja ya kuwa katika utafiti huu kama hutaki.
ii. Unaweza kujiondoa kwenye utafiti wakati wowote bila kutoa sababu yoyote ya kujiondoa kwako.

Je, kuwa katika utafiti huu utakugharimu chochote?

Hakutakuwa na gharama za kifedha kwako.

Matumizi ya habari katika masomo ya baadaye

Maelezo tunayopata kutoka kwako kwa utafiti huu yanaweza kutumika kwa masomo ya baadae ikiwa inahitajika. Tutaondoa chochote ambacho kinaweza kukutambua kutoka kwa habari. Habari hiyo inaweza kutumika kwa masomo ya utafiti wa baadaye au kupewa mpelelezi mwingine bila kupata ruhusa ya ziada kutoka kwako. Walakini, bodi ya ukaguzi itaamua ikiwa tunahitaji kupata ruhusa ya ziada kutoka kwako.

7. Usiri wa Habari za Utafiti

Usiri

Maelezo unayotoa yatahifadhiwa siri na wafanyakazi wa utafiti. Hatutachapisha au kujadili kwa umma chochote ambacho kinaweza kukutambua. Tutatumia msimbo wa nambari kutambua majibu yako na tutaunganisha tu msimbo wa nambari kwa jina lako katika kifaa cha kuhifadhi / kitabu. Kifaa cha kuhifadhi / kitabu kitahifadhiwa katika chumba / sefu lililo na kufuli na ufunguo, na kwamba ni timu ya utafiti tu itakuwa na ufahamu.
Wafanyakazi wa serikali na chuo kikuu wakati mwingine hupitia tafiti zinazofanana ili kuhakikisha kuwa zinaendeshwa kwa usalama na kisheria. Ikiwa utafiti huu unakabiliwa na ukaguzi kama huo, rekodi zako zinaweza kuchunguzwa. Hata hivyo, rekodi za utafiti hazitatumika

kukuweka katika hatari yoyote au madhara. Rekodi za majadiliano haya zinaweza kupitiwa upya na wafanyakazi wa tathmini na wawakilishi wa Chuo Kikuu cha Nairobi, Kitengo Cha Afya, pamoja na Hospitali ya Taifa ya Kenyatta na Kamati ya Maadili na Utafiti ya Chuo Kikuu cha Nairobi.

Vipi kama una maswali katika siku zijazo?

Ikiwa una maswali zaidi au wasiwasi kuhusu ushiriki wako katika utafiti huu, tafadhali piga simu au tuma ujumbe mfupi wa maandishi kwa Nancy Gathi 0720093440.

Ikiwa una maswali kuhusu haki zako kama mshiriki wa utafiti, au jeraha la kibinafsi, unapaswa kuwasiliana na Katibu / Mwenyekiti- Kamati ya Maadili na Utafiti wa Hospitali ya Kitaifa ya Kenyatta, kwa 2726300-Ugani 44102.

TAARIFA YA MSHIRIKI WA UTAFITI

Nimesoma fomu hii ya idhini au nimepata habari iliyosomwa kwangu. Nimepata nafasi ya kujadili utafiti huu na mtafiti. Maswali yangu yamejibiwa kwa lugha ambayo ninaelewa. Hatari na faida zimefafanuliwa kwangu. Ninaelewa kwamba ushiriki wangu katika utafiti huu ni wa hiari na kwamba ninaweza kuchagua kujiondoa wakati wowote. Ninakubali kwa uhuru kushiriki katika utafiti huu.

Ninaelewa kwamba juhudi zote zitafanywa ili kuweka habari kuhusuutambulisho wanguwa kibinafsisiri.

Kwa kutia sahihi fomu hii ya idhini, sijaacha haki zozote za kisheria ambazo ninazo kama mshiriki wa utafiti huu.

Nakubali kushiriki katika utafiti huu: Ndio_____ Hapana _____

Ninakubali maswali kuhifadhiwa kwa ajili ya masomo ya baadaye: Ndio _____Hapana _____

Jina la Mshiriki	Sahihi/Alamayakidole	Tarehe
Jina la Shahidi	Sahihi/Alamayakidole	Tarehe

(Ikiwahawezikutiasahihi)

Jina la Mtafiti	Sahihi	Tarehe

Nakala kwa: Mtafiti
Mshiriki

APPENDIX 3: GENERAL HELP SEEKING QUESTIONNAIRE

GENERAL HELP SEEKING QUESTIONNAIRE- Original Version (GHSQ)

Question 1= Personal or emotional problems

Question 2= Suicidal ideation

Note: In all questions, items a-j measure **help-seeking intentions**. Help sources should be modified to match the target population.

1. If you were having a personal or emotional problem, how likely is it that you would seek help from the following people?
Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

1= Extremely Unlikely 3= Unlikely 5= Likely 7= Extremely Likely

a. Intimate partner(e.g. Girlfriend ,boyfriend,husband,wife)	1	2	3	4	5	6	7
b.Friend(not related to you)	1	2	3	4	5	6	7
c.Parent	1	2	3	4	5	6	7
d. Other relative/family member	1	2	3	4	5	6	7
e. Mental health professional(e.g. psychologist,socialworker,counsellor)	1	2	3	4	5	6	7
f. Phone helpline (e.g. Lifeline)	1	2	3	4	5	6	7
G. Doctor/GP	1	2	3	4	5	6	7
h. Minister or religious leader(e.g. Priest, Rabbi,Chaplain)	1	2	3	4	5	6	7
i.I would not seek help from anyone	1	2	3	4	5	6	7
j.I would seek help from another notlistedabove(pleaselistinthespaceprovided, (e.g.,workcolleague.Ifno,leaveblank)_____	1	2	3	4	5	6	7

2. If you were experiencing suicidal thoughts, how likely is it that you would seek help from the following people? Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

1= Extremely Unlikely 3= Unlikely 5= Likely 7= Extremely Likely

a.Intimatepartner(e.g.,girlfriend,boyfriend,husband,wife,de'facto)	1	2	3	4	5	6	7
b.Friend(notrelatedtoyou)	1	2	3	4	5	6	7
c.Parent	1	2	3	4	5	6	7
d.Other relative/familymember	1	2	3	4	5	6	7
e.Mental healthprofessional(e.g.psychologist, socialworker,counselor)	1	2	3	4	5	6	7
f.Phonehelpline(e.g.Lifeline)	1	2	3	4	5	6	7
g.Doctor/GP	1	2	3	4	5	6	7
h.Ministerorreligiousleader(e.g.Priest, Rabbi,Chaplain)	1	2	3	4	5	6	7
i.Iwouldnotseekhelpfromanyone	1	2	3	4	5	6	7
j.Iwouldseekhelpfromanothernotlistedabove(pleaselistinthespaceprovided, e.g.,workcolleague.Ifno,leaveblank)_____	1	2	3	4	5	6	7

APPENDIX 4: GENERAL HELP SEEKING QUESTIONNAIRE (SWAHILI VERSION) ;

by Simeon Kintu (2022)

DODOSO LA KUTAFUTA MSAADA WA JUMLA - TOLEO LA AWALI (GHSQ)

Swali la 1= Matatizo ya kibinafsi au ya kihisia

Swali la 2= Wazo la kujiua

Kumbuka: Katika maswali yote,a-jni**nia ya kutafuta msaada**. Vyanzo vya msaada vinapaswa kurekebishwa ili kuoana na walengwa.

1.Kama ungekuwa na tatizo la kibinafsi au kihisia, kuna uwezekano gani kwamba ungetafuta msaada kutoka kwa watu wafuatao?
Tafadhali onyesha majibu yako kwa kuweka mstari kupitia nambari ambayo inaelezea vyema nia yako ya kutafuta msaada kutoka kwa kila chanzo cha msaada ambacho kimeorodheshwa.

1 = Hamna uwezekano wowote 3 =Haiwezekani 5 = Kuna uwezekano 7 = Uwezekano mkubwa sana

a.Mpenzi wakaribu (kwamfano, mpenzi, mume,mke)	1	2	3	4	5	6	7
b.Rafiki (hahusianinawewe)	1	2	3	4	5	6	7
c.Mzazi	1	2	3	4	5	6	7
d.Jamaa/ mwanafamilia	1	2	3	4	5	6	7
e.Mtaalamu wa afya ya akili (kwa mfano mwanasaikolojia,mfanyakaziwa kijamii,mshauri)	1	2	3	4	5	6	7
f.Msaadawa simu (kwa mfano Lifeline)	1	2	3	4	5	6	7
g.Daktari / GP	1	2	3	4	5	6	7
h.Waziriaukiongozi wa kidini (kwamfano Kuhani, Rabi,Chaplain)	1	2	3	4	5	6	7
i.Sitatafutamsaadakutoka kwa mtu yeyote	1	2	3	4	5	6	7
j.Ningetafutamsaadakutokakwamwingine ambaye hajaorodheshwa hapo juu (tafadhaliorodheshakatikanafasiiliyotolewa, (kwa mfano,mwenzake wa kazi. Kamahapana,acha wazi)_____	1	2	3	4	5	6	7

2. Kama ungekuwa unakabiliwa na mawazo ya kujiua, kuna uwezekano gani kwamba ungetafuta msaada kutoka kwa watu wafuatao?
Tafadhali onyesha majibu yako kwa kuweka mstari kupitia nambari ambayo inaelezea vyema nia yako ya kutafuta msaada kutoka kwa kila chanzo cha msaada ambacho kimeorodheshwa.

1 = Hamna uwezekano wowote 3 = Haiwezekani 5 = Kuna uwezekano 7 = Kuna uwezekano mkubwa sana

a.Mpenzi wakaribu (kwamfano, mpenzi, mume,mke)	1	2	3	4	5	6	7
b.Rafiki (hahusianinawewe)	1	2	3	4	5	6	7
c.Mzazi	1	2	3	4	5	6	7
d.Jamaa/ mwanafamilia	1	2	3	4	5	6	7
e.Mtaalamu wa afya ya akili (kwa mfano mwanasaikolojia,mfanyakaziwa kijamii,mshauri)	1	2	3	4	5	6	7
f.Msaadawa simu (kwa mfano Lifeline)	1	2	3	4	5	6	7
g.Daktari / GP	1	2	3	4	5	6	7
h.Waziriaukiongozi wa kidini (kwamfano Kuhani, Rabi,Chaplain)	1	2	3	4	5	6	7
i.Sitatafutamsaadakutoka kwa mtu yeyote	1	2	3	4	5	6	7
j.Ningetafutamsaadakutokakwamwingine ambaye hajaorodheshwa hapo juu (tafadhaliorodheshakatikanafasiiliyotolewa, kwa mfano,mwenzake wa kazi. Kamahapana,acha wazi)_____	1	2	3	4	5	6	7

APPENDIX 5: PROFESSIONAL QUALITY OF LIFE SCALE (ProQOL)

Compassion Satisfaction and Fatigue (ProQOL) Version 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never **2=Rarely** **3=Sometimes** **4=Often** **5=Very Often**

1. I am happy.
2. I am preoccupied with more than one person I *[help]*.
3. I get satisfaction from being able to *[help]* people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I *[help]*.
7. I find it difficult to separate my personal life from my life as a *[helper]*.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
9. I think that I might have been affected by the traumatic stress of those I *[help]*.
10. I feel trapped by my job as a *[helper]*.
11. Because of my *[helping]*, I have felt "on edge" about various things.
12. I like my work as a *[helper]*.
13. I feel depressed because of the traumatic experiences of the people I *[help]*.
14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a *[helper]*.
20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
21. I feel overwhelmed because my case [work] load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
24. I am proud of what I can do to *[help]*.
25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a *[helper]*.
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

APPENDIX 6: PROFESSIONAL QUALITY OF LIFE SCALE (SWAHILI VERSION)

PROFESSIONAL QUALITY OF LIFE SCALE (ProQOL)

Compassion Satisfaction and Fatigue (ProQOL) Version 5 (2009)

KISWAHILI VERSION; by Po¨yhia¨, R et al (2017)

UkiwasaidiawengineutahusiananaMaishayaomojakwamoja. Yamkiniulivyokwishaona, hurumayakokwaunaosaidiainakipelengeechanya (mazuri) nahasi (mabaya). Tungependakukuulizamaswalikuhusuuzoefukwapandezoteyachanyanahasiuliyokumbananayoka mamsaidizi. Fikiriakilaswalikatikaorodhaifuatayomintarafuyahaliulipokwasasa.

Katikanafasimbeleyaswalitianambaunayoonanikwelizaidikuhusuhaliyakokatika siku 30 zilizopita.

0= HataKamwe	**1= Mara Chache Sana**	**2= Mara Chache**
3= Mara Kwa Mara	**4= Mara Nyingi**	**5= Mara Nyingi Sana.**

_____1. Ninaonafuraha.

_____ 2. Ninaafikishwana Zaidi yamtummojaninayemsaidia.

_____ 3. Mimi hupatakuridhikanikiwezakuwasaidiawatu.

_____ 4. Nahisinimehusianishwanawatuwengine.

_____ 5. Sauti za ghafulananisizotarajiahunishtua.

_____ 6. Mimi huwananguvu Zaidi baadayakufanyakazina wale ninaosaidia.

_____ 7. Ni vigumukwangukutenganishamaishayangubinafsinamaishakamamsaidiziwa watu.

_____8. Nakosarahayausingizikwaajiliyataabukubwayakisaikolojia au yakimwili inayotokanananinaowasaidia.

_____ 9. Nafikirinimeambukizwanafadhaayaoninaowasaidia.

_____10. Najisikianimenaswanakaziyanguyakuwasaidiawatu.

_____11. Kwa sababuyakuwasidiawatu, nimehisinimefikaukingonikwa mambo mengi.

_____12. Napendakaziyakuwasaidiawatu.

_____13. Nina huzuniitokanayonakuwasaidiawatu.

_____14. Nahisi Kama napitiamaumivuyafadhaayamtuniliyesaidia.

_____15. Ninayoimaniinayonistahimilisha.

_____16. Nina radhinajinsinimewezakuendelezambinunaitifakizangu za kutoamsaada.

_____17. Nimekuwamtu Yule Yuleambayedaimanimetamaniniwe.

_____18. Kazi yangu (yakuwasaidiawatu) yaniridhisha/ furahisha.

_____19. Nasikiauchovu Sana kwasababuyakaziyakuwasaidiawatu.

_____20. Ninayomawazonahisia za furahakwa wale nisaidiaonajinsininavyoweza kuwasaidia.

_____21. Nahisikuzidiwanakiasi cha kazi au ukubwa (wingi) wa mambo ninayoshughulikia.

_____22. Naaminikwambanawezakubadilishamaishayaninaowasaidia.

_____23.Najaribukuyaepuka mambo au matukioyanayolingananafadhaa za watuninaowasaidia.

____ 24. Nina mpangowakuwamsaidizikwamudamrefu.

____ 25. Kama matokeo ya kuwasaidiawatu, Napata mawazoyaghafulayanayonitisha.

____ 26. Najiskianimedhoofishwanamfumowakuwasaidiawatu.

____ 27. Najisikianimepatamafanikiokamamsaidizi (Nimekuwahodarikamamsaidizi).

____ 28. Siwezikukumbukasehemumuhimuyakaziyangunawalioathiriwanauwewe.

____ 29. Mimi nimtumwepesi Sana kwajambololote.

____ 30. Nina furahakwambaniliamuakufanyakazihiiyausaidiziwawatu.

APPENDIX 7: INTERVIEW GUIDE

HEALTH SEEKING BEHAVIOUR OF COMMUNITY HEALTH VOLUNTEERS WORKING WITH SURVIVORS OF GENDER BASED VIOLENCE IN RELATION TO BURNOUT AND VICARIOUS TRAUMA IN INFORMAL SETTLEMENTS.

Date: _____ Interview Location: _____

Interviewer pseudonym: _____ Age_____ Gender_____

Community Health Unit Name: _____

1. What are some of the challenges you face in course of your work?

2. How do the challenges affect you? (psychologically, emotionally, physically)

3. How do you manage and cope with the mentioned challenges?

4. If you have ways of coping which is the most effective? And why do this effective coping skills work for you?

5. What are some of the indicators that show you have been affected by your work?

APPENDIX 8: INTERVIEW GUIDE (SWAHILI VERSION)

UTAFTAJI WA MSAADA WA AFYA KWA WAWEZESHAJI WA AFYA YA JAMII WANAOFANYA KAZI NA WAATHIRIKA WA UNYANYASAJI WA KIJINSIA KUHUSIANA NA UCHOVU NA KIWEWE KIKUBWA KATIKA MAKAZI YASIYO RASMI.

Tarehe: _____ Eneo la Mahojiano: _____

Mhojiwa pseudonym: _____ Age_____ Gender_____

Jina la Kitengo cha Afya ya Jamii: _____

1. Ni baadhi ya changamoto gani unazokabiliana nazo wakati wa kazi yako?

2. Changamoto zinakuathiri vipi? (kisaikolojia, kihisia, kimwili)

3. Mnakabiliana vipi na changamoto mlizotaja?

4. Ikiwa una njia za kukabiliana ambazo ni bora zaidi? Na kwa nini ujuzi huu mzuri wa kukabiliana hufanya kazi kwako?

5. Ni baadhi ya viashiria gani vinavyoonyesha kuwa umeathiriwa na kazi yako?

APPENDIX 9: SOCIO-DEMOGRAPHIC QUESTIONNAIRE

What is your gender?	a. Male b. Female c. Other
How old are you?	a. Less than 30 years b. Btwn 30-40 years c. Btwn 41- 50 years d. Above 50 years
Any background training on GBV?	a. Yes b. No
Any experience working with survivors of GBV?	a. Yes b. No
What is your religion?	a. Catholic b. Protestant c. Muslim d. None e. Other (Specify)
How often do you go to church/Mosque?	a. Almost every week b. Less than once a week, but more than just on holidays (eg. Christmas, Easter) c. Just on holidays d. Almost never
Which one of the statements below best describes your living arrangements?	a. Living alone □ b. Living with a partner □ c. Living with a parent/s □ d. Other □ e. If "other", please specify:
What is the highest level of education you have attained?	a. Primary b. Lower Secondary (S1-S4) c. Upper Secondary (S5-S6) d. Some College/Certificate e. Diploma f. Vocational/Trade school g. Bachelor's Degree h. Some Graduate or Professional School i. Completed Graduate or Professional School
What is your employment status?	a. Formal employment (full-time) b. Formal employment (part time) c. Self-employed d. Student e. Retired f. Unemployed g. Other-
Do you financially support your family?	a. Yes b. No

APPENDIX 10: SOCIO-DEMOGRAPHIC QUESTIONNAIRE (SWAHILI VERSION)

Jinsia yako ni gani?	a.Mwanaume b.Mwanamke c.Nyingine
Una umri gani?	a. Chiniyamiaka 30 b. Kati yamiaka 30-40 c. Kati yamiaka 41- 50 d. Zaidi yamiaka50
Dini yako ni gani?	a.Katoliki b.Kiprotestanti c.Muislamu d.Hakuna e.Nyingine (Taja)
Ni mara ngapi unakwenda kanisani/Msikiti?	a.Karibu kila wiki b.Chini ya mara moja kwa wiki, lakini zaidi ya likizo (kwa mfano. Krismasi, Pasaka) c.Wakati wa likizo d.Karibu kamwe
Ni ipi kati ya kauli zilizo chini zinaelezea vyema mipango yako ya kuishi?	a.Kuishi peke yako ☐ b.Kuishi na mpenzi ☐ c.Kuishi na mzazi/wazazi ☐ d.Nyingine ☐ e.Ikiwa "nyingine", tafadhali taja:
Je, kiwango cha juu cha elimu umefikia wapi?	a.Msingi b.Sekondari ya Chini (S1-S4) c.Sekondari ya Juu (S5-S6) d.Baadhi ya Chuo / Cheti e.Diploma f.Shule ya Ufundi/Biashara g.Shahada ya Kwanza h.Baada ya kuhitimu au Shule ya Kitaaluma i.Mhitimu aliyemaliza au shule ya kitaaluma
Hali yako ya ajira ni gani?	a.Ajira rasmi (wakati wote) b.Ajira rasmi (sehemu ya muda) c.Kujiajiri d.Mwanafunzi e.Mstaafu f.Kutokuwa na rasimu g.Nyingine-
Je, unaisaidia familia yako kifedha?	a.Ndiyo b.Hapana

APPENDIX 11: KEY INFORMANT INTERVIEW SCHEDULE

KEY INFORMANT INTERVIEW SCHEDULE

Introduction:

Good morning/afternoon, my name is Nancy Gathi, MSc. Student of the University of Nairobi (KNH campus). Thank you for taking your time to talk to me today. I am conducting a research/survey on Health Seeking Behavior of Community Health Volunteers Working with Survivors of Gender Based Violence in relation to Burnout and Vicarious Trauma in Informal Settlementsas part of my studies.

Based on your knowledge, expertise, and interaction with the subject of this research as a health care provider, I have selected you as an informant in this study, and that is why I am sharing this questionnaire with you. Some questions demand you to divulge some information about the CHVs that may be confidential, but I assure you that your answers will be used for this research only and will not be shared with anyone else other than the researcher. Remember, there is no right or wrong answer. However, your honest responses to these questions would be crucial in understanding theprevalence of burnout and vicarious trauma as well as help-seeking behaviors of CHVs working with survivors of gender-based violence in an informal settlement in Nairobi County. This interview will take about 25 minutes to complete. Would you be willing to participate?

1. **Yes_____ 2. No_____**

QUESTIONNAIRE IDENTIFICATION INFORMATION

QUESTIONAIRRE CODE: [_____|____ |____]

001 INTERVIEWER: _____

002 DATE OF INTERVIEW: _____ \ ____ _2022.

003 INTERVIEWEE TITLE:_____

004 LENGTH OF TIME IN POSITION _____

(Kindly respond to the questions below)

1). Do CHVs share their experiences while interacting with survivors of gender based violence?

(Probe: a).whether they attend support supervision regularly

b). whether they seek help whenever they encounter a challenging situation

2). What are some of the challenges that CHVs face while interacting with survivors of gender-based violence?

(Probe: may have presented with burnout and vicarious trauma)

3). What are some of the coping strategies that CHVs working with survivors of gender based violence use?

4). In your opinion, should CHVs working with survivors of gender-based violence be provided with psychosocial support services?

a). If yes, what kind of psychosocial support services should they be provided with?

(Probe: whether counseling, psychotherapy, moral support etc.)

We have come to the end of the interview. Thank you for your time and cooperation. Before we finish, is there anything else you would like to add to what we have discussed?