

**Field-Based Testing of Tools to Assess Function Impairment and Psychosocial Problems
among GBV Survivors in South Kivu, Eastern DRC**

Conducted with support from VTF/USAID

by

International Rescue Committee

Democratic Republic of Congo

and

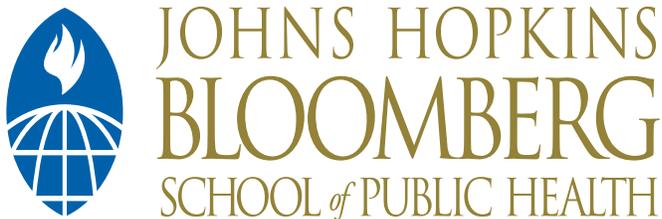
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Introduction

This report describes a pilot study of a quantitative instrument for the assessment of functional impairment and psychosocial problems among female survivors of sexual violence in South Kivu, Eastern Congo. The study was conducted by the International Rescue Committee and faculty from Johns Hopkins University, supported by the Victims of Torture Fund (VTF) through a subcontract with Boston University. The study was conducted in September-October 2007.

The intent of the pilot study was to develop an instrument and associated interview materials that are acceptable and understandable to local people; both the clients who would be interviewed using the instruments and the local counselors who will be conducting the interviews in the future as part of program assessments. The ultimate purpose of the instrument is to provide data to IRC to assess the effect of one component of their Gender-Based Violence GBV program in Eastern Congo (see Next Steps, below).

Background

IRC Gender-Based Violence Programming in DRC¹

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

The vulnerability of women and girls has significantly increased as a result of their taking on more responsibility for the care of children and families, especially as opportunities become scarcer and overall poverty increases. The burden of this responsibility requires women and girls to undertake further risks to provide for themselves and their families, sending them into the fields, forests, and markets to piece together the basic essentials for survival. It also exposes them to exploitation and abuse by those with more power, including humanitarian workers and peace-keepers. The vulnerability subsequent to this responsibility will continue as long as women and girls remain the primary providers, poverty persists or worsens, family members remain missing, and medical and other essential services remain inadequate.²

Should peace be achieved in eastern DRC, its fruits will take time to reach those who continue to be most affected by the long-standing conflict - women and girls.

¹ This section and the following section on IRC's GBV activities in DRC, and in eastern DRC in particular, are taken from IRC's original sector strategy proposal to USAID to address GBV issues.

² Marie Vlachová and Lea BIASON, eds., *Women in an Insecure World: Violence Against Women - Facts, Figures and Analysis* (Geneva Centre for the Democratic Control of Armed Forces, 2005).

IRC's Gender-Based Violence Program in eastern DRC

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

The program focuses on:

- Providing technical, material, and financial support to service providers to provide access to quality specialized health, psychosocial and legal services for survivors of sexual violence and torture;
- Supporting grassroots women's projects geared towards the psychosocial support, integration, and empowerment of survivors of sexual violence by increasing educational, socio-economic, and leadership opportunities for women and girls, and encouraging community mechanisms for psychosocial support;
- Strengthening inter-agency mechanisms to develop more comprehensive and effective service delivery and referral systems that respond to the security and protection needs of women and girls;
- Advocacy as a cross-cutting theme in all GBV programs, locally with Congolese ministries and institutions, United Nations (UN) agencies and international NGOs; internationally, through channels such as the IRC's advocacy department in Washington, D.C.; the Women's Commission for Refugee Women and Children; and contributions to international news media on the topic of violence against women and girls in the DRC.

Background to the Current Study

This study forms part of a wider ongoing collaboration between IRC and BU/JHU to assist in the monitoring and evaluation of IRC's current GBV programs in eastern DRC. The objectives of this collaboration were developed during an initial visit in December of 2005 between IRC, USAID and BU faculty. They are:

1. Assist IRC and local partners in identifying the major psychosocial problems of populations in Eastern DRC, and in understanding local conceptions of normal functioning in order to inform IRC programs.

2. Assist IRC and local partners to use this information to design the monitoring component of the GBV program and thereby monitor and evaluate the effect of programs to address these issues.

The first objective was the focus of a previous report, which described a qualitative assessment by IRC and BU/JHU exploring local concepts of psychosocial problems and functioning. With respect to objective 2, IRC incorporated data from the qualitative study into a logframe which revised the design for the GBV program's monitoring and evaluation. Plans for monitoring tools were later modified in revised terms of reference (See Appendix). This study forms a continuation of the M&E activities laid out in the revised TOR.

Under the revised TOR, data from the qualitative study were used to draft a draft instrument to assess both function and psychosocial problems from the local viewpoint. The intent was to produce an instrument that was truly locally appropriate while also reflecting issues that were being addressed by the GBV program. Because there are many languages used in South Kivu, it was decided to produce the instrument in Swahili, which is a common second language in the area and therefore the most widely spoken. In collaboration with external IRC staff, BU/JHU faculty drafted the first version of the instrument. This was then reviewed by local IRC staff as well as GBV counselors and their supervisors from local partners who worked with GBV survivors. Based on this feedback, the instrument went through a series of modifications. These continued until local and external IRC GBV staff, the counselors and supervisors from the local partners, and the BU/JHU faculty agreed that the resulting draft instrument reflected the qualitative data and the psychosocial objective of the IRC GBV program. This was the draft instrument that was used in the pilot study described here.

In terms of the revised TOR, phases I (qualitative assessment) and II (development of draft tools and piloting process) have now been completed as part of the lead up to the current study. This report describes activities that form parts of phase III (pilot testing).

Process

Trip Activities in the Context of the Revised TOR

In carrying out phase III in the revised TOR, some changes were made to the planned order and conduct of the component activities (activities 1-4). The original plan called for IRC and partners to conduct the pilot and field testing, with BU/JHU faculty advising from the USA. However, it was decided instead that BU/JHU faculty should travel to DRC for this phase and lead the process directly. This was due to concerns that the situation in DRC with respect to logistics, security, travel, and the capacity of local partners was more difficult than in other sites in which the faculty had worked, and that therefore a high degree of flexibility would be required which could best be achieved if the faculty were present. Because of these same concerns it was also decided that the additional field testing (instrument reliability and validity testing) which was to occur in addition to the pilot testing would not be feasible at this time.

On the other hand, since BU/JHU faculty would be in-country for the pilot study, it was decided to set up the data collection, collation, and analysis system during this visit (activity # 2), rather than waiting until later as per the revised TOR. Similarly, it was decided to conduct the training with counselors who would actually be using it to conduct assessments as part of the GBV

program. Hence their training would constitute the initial roll out of the interview process (Activity # 3).

Review of Interview Materials and Interview Training

The pilot study was preceded by two days of preliminary activities. The first day the staff of the IRC local partners who were to be the study interviewers reviewed the current Swahili version of the instrument, focusing on the language used. All sections of the draft version of the instrument – the instructions to the interviewees, the response categories, and the descriptions of each function item and psychosocial symptom – were scrutinized by the interviewers in order to select words and phrases that were most likely to be understandable to local women from the interior. Interviewers were able to reach consensus on numerous changes to the language. They were also introduced to an interview guide which BU/JHU faculty had drafted previously. This guide describes a step by step process to interviewing GBV survivors using the instrument, including a brief description of the purpose of the study. At the end of the interview guide were a series of questions to be asked of respondents after administering the instrument. These asked what was good about the interview, what they disliked, and what was difficult to understand or difficult to answer. Finally, interviewers were introduced to the nonverbal response card. This consists of a series of drawings that represent the response categories to the function section of the instrument. Its purpose is to assist interviewees (particularly illiterate respondents) to select a response category to each function question.

The following day the ten interviewers received training in how to use the instrument, interview guide, and nonverbal response card to conduct the interviews. This was followed by demonstrations and practice by the interviewers. The training and the study were led by BU/JHU faculty with assistance by IRC staff. All ten interviewers were staff of IRC local partner organizations, who had received training from IRC. Nine were counselors - 3 from ADIF (southern Kalehe), 3 from Anamad (northern Kalehe) and 3 from PSVS (Uvira). The remaining interviewer was a supervisor from ADIF.

Pilot Interviewing

The pilot study began immediately after the training. It was conducted over 3 days, from October 10-12, 2007. On each of the three days interviewers, BU/JHU faculty and IRC staff traveled to Katana and Kabimba districts which are approximately 1.5 hours travel north of Bukavu, the training site. Five interviewers went to each site and each interviewed two local women each day. All interviewees were GBV survivors who had already received services by one of IRC's local partners. From an ethical viewpoint it was felt that these women would be less likely to be upset by the interview process than GBV survivors who had not yet received services.

The study team (interviewers, BU/JHU faculty and IRC staff) met at the end of each day for review of the day's activities. Discussion included the interviewers' experiences, and interviewees' responses regarding what they liked and disliked about the interviews and what was difficult to answer and/or answer. The intent was to immediately revise the instrument and interview materials based on this daily feedback and to test the revised versions on the following

day. Three days of interviewing were set aside for this purpose, the expectation being that this would be long enough to identify and make any needed changes, and to test them in the field.

Pilot Data Analysis

Data from the pilot interviews were analyzed to explore the capacity of the instrument to provide accurate assessments. The first consideration was the frequency of missing data, particularly among the function questions. When asking questions about ability to do specific tasks, the expectation is that some respondents will be unable to answer questions that refer to tasks the respondent does not do. While there are procedures for handling missing data, if it happens too frequently for any one question it suggests that the question is not a useful assessment tool for a significant number of interviewees and should be removed or changed. Also important is the distribution of responses. Where responses are poorly distributed across the possible range, particularly if they cluster and the maximum or minimum levels, this suggests that they may be less effective in detecting change over time. There are exceptions to this principle, such as questions about suicide and self-harm. Responses to these questions cluster around the minimum response level but are retained in questionnaires because of their importance in detecting potentially fatal problems.

Establishment of Data Collection, Collation, and Analysis System.

During and after the pilot study, BU/JHU faculty met with local IRC staff who will be responsible for the study data. Faculty provided orientation in the use of Epi-info, a software product for data entry, management and analysis developed and supported by the CDC. Two versions were installed on the staff's computer – the smaller MS DOS-based version and the larger (and most recent) Windows based version. IRC staff were also provided with data files for both pilot versions of the questionnaire into which they could enter the interview results and practice using the software. Both versions were provided because each has advantages and disadvantages, which IRC first explored before deciding which version to use. Staff chose to use the Windows-based version. Before leaving DRC, BU/JHU faculty then worked with IRC staff to develop a data entry file in the Windows version of Epi-info which reflected the pilot version of the questionnaire.

Results

Interviewing Process

Sixty local GBV survivors were interviewed over the three days of the pilot study – two per interviewer per day. Most interviewees reported feeling positive about the interview process and none reported disliking it. Many interviewees reported being pleased at being asked questions which no-one (or few people) had asked them before. This included some of the function questions, such as pounding cassava, cultivation, and attending church. Others appreciated being asked about the psychosocial problems, including being rejected, badly treated, suicide, thinking about what happened to them in the past, and feeling shame. Several other respondents stated they did not like being asked about suicide or remembering what happened, because these

questions reminded them of how they felt soon after the GBV occurred. When asked which questions were difficult to answer, some respondents referred to the function questions asking about difficulty in raising animals, trade and caring for children. In each case, the problem was that these were not activities for which the respondent was responsible.

Despite concerns prior to the study, few respondents became upset during the interview as a result of the interview process. On two occasions interviewees became tearful because the questions reminded them of negative events and emotions. In both cases, the interviewers, as instructed, offered to take a break and the interviewees were able to complete the interview without further distress. In one case the nonverbal card was distressing to the respondent; the picture of a woman forced to the ground under the weight of a stone reminded the respondent of her own situation. This woman was able to complete the interview but could not bring herself to look at the response card.

Initially, the nonverbal response card was used only with the function questions. Over the course of the three days it was decided to modify the nonverbal response card for use with the psychosocial symptoms, but removing the last picture. All interviewers agreed that this worked well and so the change was continued.

This was the only substantial change to the interview materials over the course of the study. The instrument itself was not changed, since none of the concerns described above for any of the questions referred to more than one or two respondents. Hence, all 60 interviews were conducted with essentially the same interview materials.

Data Analysis

As expected, some respondents were unable to answer some of the function questions, on the basis that the questions refer to specific tasks that they do not do. This occurred for 11 of the 21 function questions but for 9 of them the numbers were small (5 or less) which is acceptable. However, for two questions – on trading/making money and raising animals – 13 and 14 respondents respectively (22 and 23%) were unable to answer. This high rate of non-response suggests that these questions should be removed.

As expected, missing data on the symptom questions was rare and limited to three questions. For each of these questions only one respondent failed to answer.

Response distributions generally showed acceptable variation. Among the function items, activities involving interacting with others tend to cluster around minimal difficulty whereas more physical tasks tended to be skewed more towards increased difficulty. Overall, responses on the symptom questions tended towards greater severity than the function questions.

Nine respondents reported feeling bothered by wanting to kill themselves either moderately or a lot over the prior 2 weeks. Six of these also reported similar feelings of wanting to harm themselves, and an additional four respondents also reported wanting to harm themselves but did not report a significant desire to kill themselves. The staff of the local partner NGO caring for

the respondents was informed of these findings and asked to follow up with them to further assess their needs and, if warranted, refer them for further assessment and care.

Establishment of Data Collection, Collation, and Analysis System.

In the spirit of building capacity at IRC, we attempted to develop procedures which would enable IRC staff to do as many as possible of the data collection and analysis tasks.

IRC staff should be able to use epi info to generate descriptive statistics, do simple comparisons (such as t tests), and tests of association (such as regression). We were unable to automate replacement of function item missing data within either the dos or windows versions of epi info. The procedure requires that each missing data point is identified and replaced with the respondent's mean score on the remaining function items. This is simple to program in commercial statistical packages but very difficult in epi info. Because of the level of difficulty the idea was abandoned for the time being and BU/JHU faculty did the missing data replacement on the pilot interviews using a commercial program: SPSS. However, IRC staff can do this 'by hand': for those interviews in which data is missing, the data analyst can calculate the mean of the other function responses on a hand calculator and use the results to replace the missing data. Although this takes some time it is a simple process and therefore easily done.

Discussion

The purpose of the pilot study was to produce an instrument that would be acceptable and understandable to both interviewers and interviewees (GBV survivors) and which the latter would be able to answer. The reports by the interviewers of both their own reactions and those of the interviewees, and the data analysis exploring missing data and response distributions, suggest that the final pilot versions of the instrument and the nonverbal response card meet these requirements, but with one change: the removal of two function questions due to excessive missing data. The final versions of the instrument and nonverbal response cards are included as separate files to this report. The pilot study interview guide is also in a separate file. Future use of the instrument in the context of GBV program participation (see below) will not require the pilot study interview guide since it will be used in the context of assessment.

With the removal of the two function questions we are confident that the resulting version of the instrument and associated materials are:

- understood by both interviewers and interviewees
- acceptable to interviewers and interviewees
- that most interviewees can answer the questions
- that the interviewee answers will provide an adequate response range for detecting changes in both symptoms and function.

We are also confident that IRC can collect and enter the data into the epi info database, and perform basic frequency analyses.

Recommendations/Next Steps.

- IRC and local partners should begin using the instrument and nonverbal response card in their initial assessments of new clients of the GBV program. This should initially be done by those counselors who were trained to use the instrument for the pilot testing and are therefore already skilled in the use of these materials. Meanwhile, IRC should train other counselors in other sites in the use of these materials whenever possible, followed by their use in their own initial client assessments. BU/JHU faculty will provide materials and distance technical assistance for these trainings and implementation.
- As described in the Section: Trip Activities in the Context of the Revised TOR, the field testing anticipated in the revised TOR was not conducted at this time. Such testing of the reliability and validity of the instrument is important to developing and confirming the instrument's accuracy. In discussions with IRC it was decided that, rather than doing this testing prior to the instrument rollout, that BU/JHU faculty would conduct these tests by data analysis on the interviews conducted after rollout (both the initial and follow-up interviews). Any changes to the instrument that are suggested by these tests will be implemented in a final version of the instrument that will then continue to be used by the program.
- IRC staff are equipped with the capacity to enter the data into the epi info program, and to perform basic data analysis. Data collected to date should also be regularly shared with BU/JHU faculty to conduct additional analysis. This includes the substitution of missing data with interpolation data based on an individual's other function responses (as a check on hand calculations by IRC staff). BU/JHU should otherwise continue to take responsibility for data analysis and interpretation.
- IRC and BU/JHU will determine when repeat assessments will take place. These should happen either at the end of an individual's program participation, or after a long enough period in the program that effect is expected, or both.

Acknowledgements

This study was co-facilitated by Karin Wachter of IRC New York and Sarah Mosely of IRC Bukavu, with assistance from Isabelle Chan and the rest of the team at IRC/Bukavu. Their detailed preparation and skillful management both before and during the study made this the most smoothly run study of this type that this author has ever done. I wish to express my great appreciation, particularly given the many challenges associated with field work in eastern DRC.

Appendix A: Updated Terms of Reference for IRC and BU/JHU Collaboration.

Revised TOR for BU/JHU engagement with IRC

March 29, 2007

Projected Dates for future activities added in October, 2007.

The monitoring and evaluation challenges associated with GBV in conflict settings are well known among those who intervene in such contexts. With that in mind, the IRC is looking forward to JHU/BU's³ assistance with developing functional indicators and related effect evaluation⁴ tools for IRC's program in DR Congo. More specifically, the IRC sees the goal of this collaboration as the development of simple, usable and meaningful effect evaluation tools for IRC and partner programs in DRC, so that the IRC and its partners can better assess the effect of their respective service delivery program interventions⁵. The majority of GBV survivors assisted by IRC are through local partners who provide psychosocial support and referral services, using a case management approach.

These revised Terms of Reference are intended to narrow down prior proposals so that it is linked directly and clearly to the goal of developing effect evaluation tools specifically for the effect of the IRC DRC GBV program service delivery component, focusing primarily on psychosocial and referral services provided by, or through the reference of, the psychosocial partners.

Purpose

The purpose of JHU/BU's travel and involvement with IRC will be to help IRC staff to develop functional (and as necessary other) tools to evaluate the effect of the service delivery component of its GBV program, with attribution. This will include 3 basic components:

- A qualitative assessment conceived to elicit from people their notion of functionality, well-being and factors associated with resiliency; (completed).
- Subsequent analysis of the assessment findings and identification of gender-specific "functional indicators" that accurately represent local value and meaning; (completed).
- Development of data collection tools and protocols based on these (and as necessary other) indicators that can evaluate the success of IRC's programs at the "effect" level of its service delivery component and attribute changes in "function" or well-being to IRC partners' services.(completed but await final results and revisions)

³ BU/JHU have been selected for a broader partnership by USAID VTF.

⁴ The language "effect evaluation" is cognizant of the fact that the process and tools foreseen as outputs of the collaboration will (a) capture changes in the level of indicators assessing change in symptoms and function; and (b) be applied at specific intervals with beneficiaries of the program, to provide information on the overall change enabled by the program overtime. The instrument will be capable of monitoring change in the group of program recipients but has not been validated for accurately assessing change among individual beneficiaries.

⁵ This therefore relates specifically to the Effect 2 of the IRC DRC GBV program's log frame.

Deliverables

Primary:

- Effect evaluation protocols – including any tools and forms necessary to implement them – that include “functional indicators” that appropriately serve as proxy effect indicators for well-being of survivors of gender-based violence and are attributable to the services provided by IRC partners; (completed. Currently being used and will be revised at end of the effect assessment, based on lessons learned during the assessment)
- A final report detailing how these effect evaluation tools can be used to assess both need and program effects (including data collection, collation and analysis) and which also explains any potential complications during the pilot testing of the tools;
- Training materials for IRC staff and partners on the use of the designed data collection tools and protocols and materials to be able to continue these trainings independently; (completed, and has since been used by IRC to train their partners).

Secondary:

- (As necessary), development of data collection tools, and related final report and training, on other indicators related to the existing GBV program at the “effect” or “output” levels.

Proposed Methodology

This chart is provided mostly with the aim for JHU/BU to review and provide feedback/complete based on the methodology that JHU/BU will define to address the above brief.

Tasks	Level of Effort	Timing/Status
Phase I: <i>Qualitative Assessment</i>		
1. Conduct qualitative field work to assess issues and function	1 US-based faculty for 2 weeks (prep time) 2 faculty in Congo for 2-3 weeks <i>IRC provides: ; 10-14 local interviewers for 2 weeks</i> <i>2 translators</i>	Completed in February and March 2006
2. Completion of qualitative analysis and write-up	2 US-based faculty BU for 3 days each	Finalized in October 2006

Phase II: <i>Develop draft tools</i>		
<p>1. JHU/BU to develop draft version of the functionality instrument (based on the qualitative data already collected) targeting the psychosocial well-being of GBV survivors; IRC to review the draft and propose any additions that are considered useful or that are thoughts to reflect the likely effect of the program on function that are not included</p>	<p>1 US-based faculty for 1 week. <i>IRC: GBV Technical Advisor + DRC GBV Coordinator + staff time for 2 days</i></p>	<p>Aug 2007</p>
<p>2. Advise IRC on a straightforward process to pilot the tool: JHU/BU to develop the process and necessary materials for the piloting and plan the implementation of this phase with IRC field staff</p>	<p>1 US-based faculty for 1 week <i>IRC: GBV Technical Advisor + DRC GBV Coordinator. In the absence of the latter, IRC will avail 1 international staff from the DRC Grants Unit to look at the logistical and organizational aspects of the process.</i></p>	<p>Aug 2007</p>

Phase III: Pilot Testing Tool		
1. Work with local partners to pilot and field-test the function instrument; <i>this process should be particularly cognizant of the need to appropriately train and supervise the interviewers to avoid bias noted in previous usage of such tools, and to facilitate attribution</i>	<i>IRC: DRC GBV Coordinator and partners – in the absence of the former, the IRC DRC Grants Unit staff mentioned above will lead the process in DRC. GBV Technical Advisor to follow up the process. (2 weeks)</i> JHU/BU will communicate with field staff during testing to monitor progress and provide feedback and advice as needed.	October 2007 and beyond
2. Finalize the instrument and methodology for its subsequent implementation and data collection; create necessary systems/tools for collecting, collating and analyzing the data.	1 JHU/BU faculty at BU for 2 weeks. Faculty will review the procedures with the relevant IRC staff so that they are familiar with them. <i>IRC: GBV Technical Advisor + DRC GBV Coordinator if recruited. DRC Grants Unit staff will continue to look at look at the logistical and organizational aspects.</i>	Nov-dec 2007
3. Develop and conduct training in rolling out full implementation of the tool;	Faculty will travel to DRC to directly provide training and orientation. 1 faculty for 2 weeks. <i>IRC: Key IRC and partner staff – DRC GBV Coordinator or Grants Unit staff will ensure logistical preparation and implementation.</i>	Feb, 2008
4. Collect and analyze data to inform programming;	<i>IRC with JHU/BU technical support (on-going). 1 US-based faculty for 1 week.</i>	April 2008 and beyond

Appendix B: Addendum to original report: Summary of Baseline data collected on IRC GBV program participants.

A Overview

- Function data show high levels of difficulty functioning for most items: unusually high percentages of respondents reported a lot of difficulty or inability to complete most tasks. Levels were much higher than we normally see in other trauma-affected populations recruited into interventions, including others in sub-Saharan Africa. Among these other populations the percentages of those reporting a lot of difficulty or being unable to complete a particular task are less than 10% of the sample, whereas here 20-50% or more report such difficulty across most tasks.
- There is not clear pattern regarding which types of tasks are most difficult, although the data does suggest that physical tasks and those requiring both mental and physical activity are more difficult than mental tasks alone.
- The data does not describe the causes of these difficulties. Dysfunction is likely to be due to a combination of factors including lack of resources, physical and mental problems, and community attitudes. Also, we have no comparison data. Therefore, while it is highly likely that these women have higher levels of dysfunction and symptom severity compared with other women in the same communities, we have no idea how much higher these levels are
- Symptom severity also tends to be high for most symptoms. As with the function data, the frequency of severe symptoms is higher than for other populations we have recruited into programs. For individual symptoms the percentage of persons reporting significant severity (being bothered a moderate amount or a lot by a symptom) tend to range from 40-70% or even higher. In most other comparable (trauma-affected persons recruited into programs) , the rates are around 30-40%
- The bottom line is that these data suggest a group of women struggling with high levels of dysfunction and troubling symptoms. These appear to be the results of their past experiences and their current difficult situation with respect to family and community.

B. Responses to Individual Questions

Age of interviewee

Age of interviewee	Frequency	Percent	Cum Percent	
15	3	5.1%	5.1%	■
16	1	1.7%	6.8%	■
17	1	1.7%	8.5%	■
18	1	1.7%	10.2%	■
19	2	3.4%	13.6%	■
22	1	1.7%	15.3%	■
25	2	3.4%	18.6%	■
26	4	6.8%	25.4%	■
30	1	1.7%	27.1%	■
32	1	1.7%	28.8%	■
33	1	1.7%	30.5%	■
34	1	1.7%	32.2%	■
35	1	1.7%	33.9%	■
36	5	8.5%	42.4%	■
37	5	8.5%	50.8%	■
38	1	1.7%	52.5%	■
39	4	6.8%	59.3%	■
40	2	3.4%	62.7%	■
42	3	5.1%	67.8%	■
43	1	1.7%	69.5%	■
45	6	10.2%	79.7%	■
46	1	1.7%	81.4%	■
47	1	1.7%	83.1%	■
49	1	1.7%	84.7%	■
50	3	5.1%	89.8%	■
52	1	1.7%	91.5%	■
60	3	5.1%	96.6%	■
62	1	1.7%	98.3%	■
68	1	1.7%	100.0%	■
Total	59	100.0%	100.0%	■

Site

Site	Frequency	Percent	Cum Percent	
Bushushu-Muhongoza	10	11.6%	11.6%	
Kabamba	15	17.4%	29.1%	
Kalehe-Buhobera	7	8.1%	37.2%	
Katana	10	11.6%	48.8%	
Minova	30	34.9%	83.7%	
Nyabibwe	10	11.6%	95.3%	
Sange	4	4.7%	100.0%	
Total	86	100.0%	100.0%	

Interviewer

Interviewer	Frequency	Percent	Cum Percent	
Annie Mbujibunyi	30	34.9%	34.9%	
Cibalonza Cinesha	15	17.4%	52.3%	
Germaine Riziki Nfizi	14	16.3%	68.6%	
Jeannette M'Lwahimbwa	10	11.6%	80.2%	
Kashindi Cishesha	4	4.7%	84.9%	
Manimani Baleke	3	3.5%	88.4%	
Nabushako L.	10	11.6%	100.0%	
Total	86	100.0%	100.0%	

Partner

Partner	Frequency	Percent	Cum Percent	
ADIF	40	46.5%	46.5%	
ANAMAD	42	48.8%	95.3%	
PSVS	4	4.7%	100.0%	
Total	86	100.0%	100.0%	

FUNCTION (A01-A21)

Response categories:

0=no difficulty with that task.

1=a little difficulty

2=a moderate amount of difficulty

3=a lot of difficulty

4=often cannot do the task

9=respondent did not answer question.

A01 cultivating

A01 cultivating	Frequency	Percent	Cum Percent	
0	5	6.0%	6.0%	
1	21	25.3%	31.3%	
2	19	22.9%	54.2%	
3	31	37.3%	91.6%	
4	6	7.2%	98.8%	
9	1	1.2%	100.0%	
Total	83	100.0%	100.0%	

A02 trading/making money

A02 trading/money	Frequency	Percent	Cum Percent	
0	3	3.6%	3.6%	
1	10	11.9%	15.5%	
2	21	25.0%	40.5%	
3	30	35.7%	76.2%	
4	8	9.5%	85.7%	
9	12	14.3%	100.0%	
Total	84	100.0%	100.0%	

A03 cooking

A03 cooking	Frequency	Percent	Cum Percent	
0	16	19.0%	19.0%	
1	22	26.2%	45.2%	
2	12	14.3%	59.5%	
3	30	35.7%	95.2%	
4	4	4.8%	100.0%	
Total	84	100.0%	100.0%	

A04 caring for children

A04 care kids	Frequency	Percent	Cum Percent	
0	7	8.4%	8.4%	
1	15	18.1%	26.5%	
2	20	24.1%	50.6%	
3	36	43.4%	94.0%	
4	4	4.8%	98.8%	
9	1	1.2%	100.0%	
Total	83	100.0%	100.0%	

A05 advising family members

A05 advise family	Frequency	Percent	Cum Percent	
0	29	34.9%	34.9%	
1	8	9.6%	44.6%	
2	26	31.3%	75.9%	
3	10	12.0%	88.0%	
4	7	8.4%	96.4%	
9	3	3.6%	100.0%	
Total	83	100.0%	100.0%	

A06 Advising people in the community

A06 Advise community	Frequency	Percent	Cum Percent	
0	26	31.0%	31.0%	
1	12	14.3%	45.2%	
2	24	28.6%	73.8%	
3	5	6.0%	79.8%	
4	9	10.7%	90.5%	
9	8	9.5%	100.0%	
Total	84	100.0%	100.0%	

A07 exchanging ideas with others

A07 exchanging ideas	Frequency	Percent	Cum Percent	
0	35	42.2%	42.2%	
1	17	20.5%	62.7%	
2	14	16.9%	79.5%	
3	14	16.9%	96.4%	
4	2	2.4%	98.8%	
9	1	1.2%	100.0%	
Total	83	100.0%	100.0%	

A08 pounding cassava

A08 poundcasava	Frequency	Percent	Cum Percent	
0	3	3.7%	3.7%	
1	24	29.3%	32.9%	
2	14	17.1%	50.0%	
3	38	46.3%	96.3%	
4	3	3.7%	100.0%	
Total	82	100.0%	100.0%	

A09 raising animals

A09 raiseanimals	Frequency	Percent	Cum Percent	
0	7	8.3%	8.3%	
1	14	16.7%	25.0%	
2	12	14.3%	39.3%	
3	20	23.8%	63.1%	
4	9	10.7%	73.8%	
9	22	26.2%	100.0%	
Total	84	100.0%	100.0%	

A10 other types of labor

A10 otherlabor	Frequency	Percent	Cum Percent	
0	20	24.4%	24.4%	
1	17	20.7%	45.1%	
2	9	11.0%	56.1%	
3	16	19.5%	75.6%	
4	9	11.0%	86.6%	
9	11	13.4%	100.0%	
Total	82	100.0%	100.0%	

A11 Working with others on tasks to assist the community

A11 Communitytasks	Frequency	Percent	Cum Percent	
0	28	33.7%	33.7%	
1	18	21.7%	55.4%	
2	17	20.5%	75.9%	
3	13	15.7%	91.6%	
4	4	4.8%	96.4%	
9	3	3.6%	100.0%	
Total	83	100.0%	100.0%	

A12 Working with family members on tasks to assist the family

A12 familytasks	Frequency	Percent	Cum Percent	
0	28	33.7%	33.7%	
1	15	18.1%	51.8%	
2	21	25.3%	77.1%	
3	17	20.5%	97.6%	
4	2	2.4%	100.0%	
Total	83	100.0%	100.0%	

A13 socializing

A13 socialize	Frequency	Percent	Cum Percent	
0	37	45.1%	45.1%	
1	13	15.9%	61.0%	
2	11	13.4%	74.4%	
3	17	20.7%	95.1%	
4	2	2.4%	97.6%	
9	2	2.4%	100.0%	
Total	82	100.0%	100.0%	

A14 getting help when you need it

A14 gettinghelp	Frequency	Percent	Cum Percent	
0	24	28.6%	28.6%	
1	11	13.1%	41.7%	
2	22	26.2%	67.9%	
3	15	17.9%	85.7%	
4	5	6.0%	91.7%	
9	7	8.3%	100.0%	
Total	84	100.0%	100.0%	

A15 making decisions

A15 makedecisions	Frequency	Percent	Cum Percent	
0	27	33.3%	33.3%	
1	19	23.5%	56.8%	
2	15	18.5%	75.3%	
3	18	22.2%	97.5%	
4	2	2.5%	100.0%	
Total	81	100.0%	100.0%	

A16 taking part in family activities

A16 familyactivities	Frequency	Percent	Cum Percent	
0	36	42.9%	42.9%	
1	10	11.9%	54.8%	
2	20	23.8%	78.6%	
3	16	19.0%	97.6%	
4	1	1.2%	98.8%	
9	1	1.2%	100.0%	
Total	84	100.0%	100.0%	

A17 taking part in community activities

A17 comm activities	Frequency	Percent	Cum Percent	
0	33	39.3%	39.3%	
1	18	21.4%	60.7%	
2	17	20.2%	81.0%	
3	13	15.5%	96.4%	
4	1	1.2%	97.6%	
9	2	2.4%	100.0%	
Total	84	100.0%	100.0%	

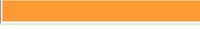
A18 learning new skills or acquiring new knowledge

A18 new skills+know	Frequency	Percent	Cum Percent	
0	34	40.5%	40.5%	
1	15	17.9%	58.3%	
2	11	13.1%	71.4%	
3	13	15.5%	86.9%	
4	5	6.0%	92.9%	
9	6	7.1%	100.0%	
Total	84	100.0%	100.0%	

A19 concentrating on your tasks and responsibilities

A19 concentrating	Frequency	Percent	Cum Percent	
0	31	36.9%	36.9%	
1	19	22.6%	59.5%	
2	15	17.9%	77.4%	
3	16	19.0%	96.4%	
4	3	3.6%	100.0%	
Total	84	100.0%	100.0%	

A20 dealing with strangers

A20 dealingstrangers	Frequency	Percent	Cum Percent	
0	47	56.6%	56.6%	
1	16	19.3%	75.9%	
2	12	14.5%	90.4%	
3	6	7.2%	97.6%	
9	2	2.4%	100.0%	
Total	83	100.0%	100.0%	

A21 attending church

A21 attendchurch	Frequency	Percent	Cum Percent	
0	35	41.7%	41.7%	
1	10	11.9%	53.6%	
2	16	19.0%	72.6%	
3	12	14.3%	86.9%	
4	9	10.7%	97.6%	
9	2	2.4%	100.0%	
Total	84	100.0%	100.0%	

SYMPTOMS (B01-B21)

Response categories:

0=not at all bothered by this symptom.

1=bothered a little bit

2=bothered a moderate amount

3=bothered a lot

9=respondent did not answer question.

B01 loss of appetite

B01 lossappetite	Frequency	Percent	Cum Percent	
0	4	5.0%	5.0%	
1	30	37.5%	42.5%	
2	30	37.5%	80.0%	
3	16	20.0%	100.0%	
Total	80	100.0%	100.0%	

B02 insomnia

B02 insomnia	Frequency	Percent	Cum Percent	
0	2	2.5%	2.5%	
1	27	33.8%	36.3%	
2	19	23.8%	60.0%	
3	32	40.0%	100.0%	
Total	80	100.0%	100.0%	

B03 fearful

B03 fearful	Frequency	Percent	Cum Percent	
0	5	6.2%	6.2%	
1	15	18.5%	24.7%	
2	29	35.8%	60.5%	
3	32	39.5%	100.0%	
Total	81	100.0%	100.0%	

B04 afraid of becoming infected with diseases

B04 afraid of diseases	Frequency	Percent	Cum Percent	
0	4	5.0%	5.0%	
1	1	1.3%	6.3%	
2	30	37.5%	43.8%	
3	45	56.3%	100.0%	
Total	80	100.0%	100.0%	

B05 remember terrible event when you don't want to.

B05 remember event	Frequency	Percent	Cum Percent	
1	6	7.5%	7.5%	
2	17	21.3%	28.8%	
3	57	71.3%	100.0%	
Total	80	100.0%	100.0%	

B06 feeling badly treated by husband

B06 treated by husb	Frequency	Percent	Cum Percent	
0	26	32.9%	32.9%	
1	17	21.5%	54.4%	
2	24	30.4%	84.8%	
3	12	15.2%	100.0%	
Total	79	100.0%	100.0%	

B07 feeling badly treated by other family members

B07 treated by other fam	Frequency	Percent	Cum Percent	
0	28	34.6%	34.6%	
1	22	27.2%	61.7%	
2	21	25.9%	87.7%	
3	10	12.3%	100.0%	
Total	81	100.0%	100.0%	

B08 feeling badly treated by community members

B08 treated by comm	Frequency	Percent	Cum Percent	
0	46	56.8%	56.8%	
1	13	16.0%	72.8%	
2	12	14.8%	87.7%	
3	10	12.3%	100.0%	
Total	81	100.0%	100.0%	

B09 feeling shame

B09 feeling shame	Frequency	Percent	Cum Percent	
0	22	26.8%	26.8%	
1	14	17.1%	43.9%	
2	26	31.7%	75.6%	
3	20	24.4%	100.0%	
Total	82	100.0%	100.0%	

B10 feeling rejected by husband or fiance

B10 reject by husb	Frequency	Percent	Cum Percent	
0	27	32.5%	32.5%	
1	16	19.3%	51.8%	
2	25	30.1%	81.9%	
3	15	18.1%	100.0%	
Total	83	100.0%	100.0%	

B11 feeling rejected by everybody

B11 reject by all	Frequency	Percent	Cum Percent	
0	39	46.4%	46.4%	
1	17	20.2%	66.7%	
2	15	17.9%	84.5%	
3	13	15.5%	100.0%	
Total	84	100.0%	100.0%	

B12 feeling stigmatized

B12 stigma	Frequency	Percent	Cum Percent	
0	33	39.8%	39.8%	
1	15	18.1%	57.8%	
2	21	25.3%	83.1%	
3	14	16.9%	100.0%	
Total	83	100.0%	100.0%	

B13 think too much about what happened to you (the terrible event)

B13 think too much event	Frequency	Percent	Cum Percent	
0	1	1.2%	1.2%	
1	7	8.3%	9.5%	
2	34	40.5%	50.0%	
3	42	50.0%	100.0%	
Total	84	100.0%	100.0%	

B14 think too much about other things that upset you

B14 think too much other	Frequency	Percent	Cum Percent	
0	1	1.2%	1.2%	
1	24	28.6%	29.8%	
2	40	47.6%	77.4%	
3	19	22.6%	100.0%	
Total	84	100.0%	100.0%	

B15 withdrawing into yourself

B15 withdraw	Frequency	Percent	Cum Percent	
0	33	39.3%	39.3%	
1	12	14.3%	53.6%	
2	22	26.2%	79.8%	
3	17	20.2%	100.0%	
Total	84	100.0%	100.0%	

B16 feeling hopeless

B16 hopeless	Frequency	Percent	Cum Percent	
0	21	25.6%	25.6%	
1	28	34.1%	59.8%	
2	19	23.2%	82.9%	
3	14	17.1%	100.0%	
Total	82	100.0%	100.0%	

B17 thinking about killing yourself

B17 suicide	Frequency	Percent	Cum Percent	
0	41	49.4%	49.4%	
1	21	25.3%	74.7%	
2	10	12.0%	86.7%	
3	11	13.3%	100.0%	
Total	83	100.0%	100.0%	

B18 feeling guilty

B18 guilty	Frequency	Percent	Cum Percent	
0	50	59.5%	59.5%	
1	19	22.6%	82.1%	
2	5	6.0%	88.1%	
3	10	11.9%	100.0%	
Total	84	100.0%	100.0%	

B19 thinking about hurting yourself

B19 hurt self	Frequency	Percent	Cum Percent	
0	37	44.0%	44.0%	
1	25	29.8%	73.8%	
2	9	10.7%	84.5%	
3	13	15.5%	100.0%	
Total	84	100.0%	100.0%	

B20 wanting to avoid other people

B20 avoid others	Frequency	Percent	Cum Percent	
0	31	37.3%	37.3%	
1	16	19.3%	56.6%	
2	19	22.9%	79.5%	
3	17	20.5%	100.0%	
Total	83	100.0%	100.0%	

B21 loss of interest in activities and things that used to interest you.

B21 loss interest	Frequency	Percent	Cum Percent	
0	28	33.3%	33.3%	
1	15	17.9%	51.2%	
2	19	22.6%	73.8%	
3	22	26.2%	100.0%	
Total	84	100.0%	100.0%	