A community-based intervention to improve mental health in female survivors of sexual and gender-based violence (SGBV) in a peri-urban community of Misisi in Lusaka, Zambia

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Abstract

Despite the high prevalence of domestic violence cases in Zambia's poor communities and the trauma associated with the survivors, most initiatives that seek to prevent sexual and gender-based violence (SGBV) remain small-scale and short-term. Using a longitudinal mixed-method design, this doctoral study sought to assess the extent and main forms of SGBV that women and girls are exposed to in Misisi compound, a peri-urban community in Zambia and then went on to evaluate the feasibility and preliminary effectiveness of a novel trauma-focused community-based intervention (CBI) supporting survivors. Paper 1 reviews and evaluates existing literature on the effectiveness of interventions designed to enhance mental health in female SGBV survivors from LMICs. The review finds that whilst CBIs are increasingly becoming popular in addressing SGBV, more research is needed to explore psychological interventions delivered by lay counsellors in LMICs, as there remains a significant gap in this research area. Paper 2 presents Stage 1 of the research, comprising the delivery of a co-developed TF-CBT training to a group of six wives of religious leaders (Amai Busas) with no mental health background and demonstrates its effectiveness in enhancing their confidence, knowledge, and skills in delivering TF-CBT to survivors. Paper 3 presents Stage 2 of the study, which demonstrates the feasibility, acceptability and effectiveness of a six-week TF-CBT intervention delivered by the trained Amai Busas in significantly improving mental health among female SGBV survivors and positively impacting the community.

My key finding and contribution to knowledge is that a co-developed, culturally adapted CBI delivered by trained and supervised members of a low-resource community was successful in enhancing the mental health of women affected by SGBV in a LMIC country with a shortage of mental health specialists. Additionally, a training co-developed in collaboration with lay community members had a positive outcome and impact on participants' knowledge, skills and perception of their ability to support female survivors of SGBV.

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List of Abbreviations

ANOVA	Analysis of Variance
ART	Antiretroviral Therapy
ASIST-GBV	Assessment Screen to Identify Survivors Toolkit for Gender-based Violence
BRS	Brief Resilience Scale
CBI	Community-based Intervention
CBT	Cognitive Behavioural Therapy
CPT	Cognitive Processing Therapy
CR	Co-researcher
DFV	Domestic and Family Violence
EU	European Union
EUC	Enhanced usual care
GBV	Gender-based Violence
HAM-A	Hamilton Anxiety Rating Scale
HAM-D	Hamilton Depression Rating Scale
HAP	Health Activation Program
HSCL-25	Hopkins Symptom Checklist
ImpACT	Improving AIDS care after Trauma
IPV	Intimate Partner Violence
IRC	International Rescue Committee
LHW	Lay health worker
LMIC	Low- and middle-income country
MMU	Manchester Metropolitan University
NHRA	National Health Research Authority
PCL-C	PTSD Checklist
PHZ	PsycHealth Zambia
PI	Principal investigator
PM+	Problem Management Plus
PPI	Patient and Public Involvement
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-analyses
PTG	Post-traumatic Growth
PTSD	Post-traumatic Stress Disorder
RA	Research Assistant

RAT	Relationship Assessment Tool
RCT	Randomised Controlled Trial
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-based Violence
SMZ	Strong Minds Zambia
TF-CBT	Trauma-focused Cognitive Behavioural Therapy
UN	United Nations
UNFPA	United Nations Fund for Population Activities
UNHCR	United Nations High Commission for Refugees
VSU	Victim Support Unit
WHO	World Health Organisation
ZP	Zambia Police

Dedication

Dedicated to my late father, Dr. Lumbwe Chiwele, who went to rest with the angels three months after I started my PhD. You will always be my biggest cheerleader, Dad. We did it.

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Chapter 1: Introduction

Sexual and gender-based violence (SGBV) is a global issue, but in Zambia, the prevalence is among the highest in the world. Being from Zambia and working with women who have suffered trauma and abuse, I wanted to provide a sustainable solution to help ease this issue and empower women to stand up against SGBV. This thesis shows how utilising a trauma-focused cognitive behavioural therapy (TF-CBT) programme tailored for the wives of local religious leaders known as Amai Busas can help women learn about, find support for, and escape abuse. This introductory chapter will focus on the context and perspectives that are and have been important in shaping my own understanding and epistemological stance.

The chapter sets the context for the papers presented in the thesis. I present a critical literature review of SGBV and its relationship with mental health. I then bring in SGBV in the Zambian context, followed by an introduction of community-based interventions (CBIs) in developing countries. Finally, I give an outline of the structure of this thesis, indicating how each chapter presented in this thesis contributes to this field, providing a more detailed rationale and overview of the aims of the thesis. I also outline the overall methodological approach of the study.

1.1 Sexual and Gender-based Violence

SGBV is defined as "any act of violence against an opposing gender that results in, or is likely to result in, physical, sexual or psychological harm or suffering, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life" (United Nations General Assembly, 1993). SGBV exists in every nation, community, and culture, irrespective of race, status, or wealth. However, its prevalence is higher in low- and middle-income countries, which face additional inequities (Sabri, 2023).

Due to the disproportionate impact on women, SGBV often becomes synonymous with violence against them (Sinko, 2019). According to the WHO, 35% of women globally have experienced SGBV at the hands of their partner or non-partner at some point in their lives (García-Moreno, 2013). SGBV is a violation of fundamental human rights and has been declared by the WHO as a major global public health problem found to have a lasting impact on women's physical and mental health (Gevers, 2014; Sinko, 2019; Stark, 2012). In severe cases, the resulting injuries of SGBV can be fatal (Stockl, 2013). In this study, I pay specific attention to the effects of SGBV on mental health, which are linked to psychopathology, including post-traumatic stress disorder, anxiety, depression, and suicide (Hossain, 2020).

To address SGBV efficiently, there is an imperative need to investigate the various factors that influence the phenomenon. Socio-ecological models frequently illustrate the interdependent relationships among individual, interpersonal, community, and societal

factors influencing SGBV (Heise, 1998; WHO, 2002). The United Nations (UN) recognises that this violence most often stems from gender inequality and is typically accepted or supported by laws, institutions, and cultural norms (UN, 1993). Research indicates that SGBV is often sustained and fuelled by firmly rooted cultural factors in societies, which comprise traditional gender norms and stereotypes that force rigid roles and expectations on individuals according to their gender (Chanda, 2024).

1.1.1 SGBV in Zambia

SGBV cases in Zambia are high. Key findings by the World Bank (2022) concerning women and girls indicate that 20.3% experience child sexual abuse by the age of 18, and 28.3% of girls who have ever had sex report that their first sexual encounter was unwanted. Furthermore, 39% of females are married by the age of 18, and 36% of all women aged between 15 and 49 have experienced physical violence since the age of 15. Additionally, 14% of all women aged 15 to 49 have experienced sexual violence, and 47% of ever-married women aged 15 to 49 have encountered physical, emotional, or sexual violence from a husband or partner (World Bank, 2022).

A total of 42,178 SGBV cases were reported in Zambia in 2024, with the gender breakdown of victims showing that 32,904 females (78%) and 9,274 males (22%) were impacted (Zambia Gender Division, 2025). However, it is known that many other SGBV cases go unreported (European Union [EU], 2017); therefore, these statistics

underestimate the actual magnitude of the problem. Moreover, there is a considerable lack of studies investigating survivors' experiences in Zambia, making it challenging to determine the true scope of the problem. Organisations have highlighted poverty, the power disadvantage faced by women in relationships, and societal acceptance of gender-based violence (GBV) as critical factors that render many women susceptible to abuse from spouses, coworkers, male relatives, and affluent individuals (Care, 2017; USAID, 2010).

1.1.2 Current SGBV Support in Zambia

Although Zambians identify SGBV as the top women's rights concern that needs addressing by their government and society, a slight majority also regard domestic violence as a family issue that should be resolved privately. Furthermore, many believe that a woman who reports SGBV to authorities will likely face criticism, harassment, or shame from her community (Chibwili, 2023). A study by Chibesa (2017) explored the effects of SGBV among couples in a Zambian shanty compound. Findings indicated that in addition to physical effects, psychological effects on victims included feelings of dehumanisation, reduced self-esteem, anxiety, fear of not knowing when the next attack will happen, and depression.

To protect women and girls in Zambia, the World Bank's (2023) Zambia Gender-Based Violence Assessment recognises a variety of GBV prevention and response

programmes in the country. These include counselling services, one-stop centres and shelters that are hospital-based and village-led, and fast-track courts. However, these efforts are usually under-funded, poorly coordinated, and geographically limited, unable to reach many SGBV survivors in the country (World Bank, 2023). Further, on some occasions, the mental health services provided have proved unsustainable (Kusantham et al., 2016). Victim Support Units (VSUs) have been set up by the government within the police department in each district. However, due to financial and capacity challenges, these units' abilities to effectively carry out criminal investigations, collect forensic evidence, and provide psychosocial support are affected. As a result, many survivors of SGBV are compelled to return to their perpetrators (EU, 2017). The situation is particularly worse in impoverished communities, where access to mental health services is limited due to the insufficient number of organisations supplementing government efforts in mental health awareness and treatment (Kusantham et al., 2016).

The mental well-being of survivors is often overlooked, even though it is crucial for them to receive appropriate treatment and support. Research indicates that, among other benefits, mental health interventions can lower the risk of further victimisation by addressing mental health issues in survivors of SGBV (Devries, 2013; Trevillion, 2012). Due to the lack of formal assistance and the influence of cultural norms in traditional African societies, many survivors of SGBV in Zambia and other African countries seek help from community representatives, such as traditional and religious leaders (Doucet & Denov, 2012; Stark, 2006). These leaders are often approached for guidance on preventing abuse and coping with mental health symptoms related to such trauma (WHO, 2001). However,

these leaders frequently lack formal training and knowledge about SGBV-related trauma and mental health issues. Therefore, it is essential to explore ways to collaborate with these community leaders and adapt support services to fit the African cultural and socio-economic context.

1.1.3 Community-based Interventions for SGBV

A community-based intervention is described as one that is provided by anyone in the community, whether healthcare professionals or regular individuals, and delivered locally within one's home, village, or specified community (Bhutta, 2010). Globally, numerous community-level interventions have been developed to address SGBV. These range from preventative interventions focusing on changing communities' attitudes and norms surrounding violence (Alangea, 2020), to those providing community-delivered care to overcome barriers preventing survivors from accessing support (Annan, 2017; Bass, 2013; Bryant, 2017; Dawson, 2016).

In the development of such interventions for specific low-resource communities, it has been increasingly recognised that there is a cardinal need for collaboration with community leaders who, for decades, have been providing support to local people, including women and girls who are survivors of SGBV. The WHO (2007) has identified the importance of capacity building among community leaders, specifically teaching them evidence-based treatments such as TF-CBT that have demonstrated therapeutic change

in controlled trials (Kazdin, 2008; Lancet Global Mental Health Group 2007, Collins et al., 2011). Although evidence-based therapies are widely used and reasonably accessible in high-income countries, there is limited access to them in low middle-income countries (LMICs) (Kazdin & Rabbitt 2013, Patel et al., 2011), including Zambia, where there exists a shortage of adequately trained mental health professionals and evidence-based, culturally adapted mental health interventions tailored specifically for at-risk populations (Fink et al., 2024). Additionally, in LMICs, many evidence-based therapies used in CBIs have been criticised for being 'West-centric' and not aligned with different cultures (Rathod, 2017). As a result, there is a demand for culturally relevant adaptations of interventions; however, this presents challenges due to the essential need to adhere to evidence-based methods (Rathod, 2014). To overcome barriers that prevent SGBV in LMICs from accessing evidence-based support, the WHO has recommended the development of CBIs designed with a model of workforce development, such as training community lay health workers (LHWs) such as local leaders to enhance access to these treatments (Collins et al., 2011, Kazdin & Rabbitt 2013, van Ginneken et al., 2013). By collaborating with community members in the delivery of interventions designed specifically for their communities, cultural relevance is enhanced.

1.2 Background and Context of Thesis

This project aims to expand the knowledge on SGBV in Zambia by piloting a novel CBI delivered by lay counsellors, with the aim of improving the psychological wellbeing of

underprivileged women who are survivors of SGBV in a poor urban community called Misisi, in Lusaka. In this study, the lay counsellors are wives of pastors in the community, who are locally known as 'Amai Busas'. I first met one of the Amai Busas eight years ago when my work in Misisi began as a volunteer psychotherapist. Two years prior, in 2014, I had co-founded PsycHealth Zambia – an indigenous youth-led Zambian organisation providing non-drug mental health services to individuals, couples, and families. In January 2016, I spearheaded a not-for-profit community-based project called 'Tilitonse' (We are Together), which we, as PsycHealth Zambia, piloted in Misisi compound. In this project, we went into Misisi on weekends to provide free psychotherapy and cognitive behavioural therapy (CBT) to women in the community who were facing various challenges, and it was during these sessions that I came to realise the magnitude of SGBV cases in Misisi, as a majority of the women we were seeing reported to have been experiencing SGBV at the hands of their partners. During one of our walks through the community, we came across Glory Baptist Church, where the lead pastor and his wife welcomed us and offered us some space to hold our sessions with the women every weekend. Further, they explained to us that many women in the community came to the pastor's wife (Amai Busa) to seek support after being abused by their husbands. The Amai Busa added that this was the case for all the Amai Busas in the other churches in the community. However, the Amai Busa emphasised that whilst she and her fellow Amai Busas were trying their best to counsel these women, the best they could do was encourage and strengthen the women based on Christian guidelines, although they knew that what was needed was therapy services from professional mental health workers as

many of the women were visibly suffering from what seemed like trauma and depression. From then on, Glory Baptist Church became our home, with the pastor and Amai Busa supporting our project with community mobilisation.

At the time, whilst I was privately practising as the managing director and principal psychologist at PsycHealth Zambia, I was also formally employed as a lecturer of psychology at Evelyn Hone College in Lusaka, under the Ministry of Higher Education. I was, therefore, able to enhance my experience in psychology both clinically and academically. However, as I gained more experience in community-based work with Tilitonse, I began to realise that whilst I was confident in my skills as a psychologist and lecturer, what I was lacking was the expertise I needed to effectively implement a public mental health project to a point where it could be scaled up to other poor communities. What had started out as a few visits to randomly provide free therapy to a few women in Misisi had now grown into a project that needed to be properly implemented, as we began to see how many women were benefiting from our program. By 2019, we had provided support to 1500 women. In the same year, I received a 'Commonwealth Points of Light' award in recognition of my impactful work by Her Majesty Queen Elizabeth II, and a World Bank 'SDGs and Her' award the following year, among other international awards. It was then that I decided it was time to pursue my PhD, with a focus on SGBV in this specific community, with the aim of creating an evidence-based intervention which could be scalable and replicated in other low-resource communities in the country.

The preparation phase of the intervention began in 2022. I collaborated with the Amai Busas to co-create a CBI based on their shared knowledge and the principles of TF-CBT. This preparation was achieved through a Patient and Public Involvement (PPI) consultation, during which we visited the Misisi community to hold in-depth interviews with two Amai Busas who acted as community key informants. The PPI consultation explored the extent and forms of SGBV in Misisi and carefully considered the Amai Busas' experiences and recommendations to develop the intervention. Subsequently, drawing from the data that was collected from this PPI exercise and an in-depth review of current evidence on SGBV interventions, a novel CBI was created.

This co-development process presented both challenges and valuable insights, because initially, I expected the Amai Busas' contributions to focus mainly on the prevalence and forms of SGBV in Misisi, which would allow me to tailor my intervention to those specific experiences. However, what I learnt from them went beyond this, revealing essential cultural factors that I later came to realise were the foundation of this intervention. The first impression I got from the Amai Busas was that the Misisi community had experienced the coming and going of numerous researchers and organisations before, but none of these ever involved them in the design and delivery of the projects. This sentiment reminded me that it was important for PPIs to be collaborative rather than merely informative, and this is precisely what I applied to this study. To implement this collaborative approach, I arranged the consultation to create a comfortable environment for the Amai Busas, fostering free dialogue between us, as opposed to a formal interview setting. As a result, the Amai Busas reported that the exercise made them, as community

members, feel appreciated and included in decisions being made for their community, and recognised for their role as community leaders who were already a source of support for female survivors of SGBV in Misisi.

The PPI was instrumental in informing two key stages of the project: the TF-CBT training for the Amai Busas, and the TF-CBT intervention. Designing the training for the Amai Busas was a huge learning curve for me, as I realised that the training offered an opportunity to adapt the intervention. The Amai Busas were women who were deeply involved in providing support for fellow women facing various challenges in the Misisi community, but had no formal clinical training. This recognition of their work in Misisi was very telling of how significant their impact already was within their community and influenced the first adjustment I made to the training structure. The adjustment involved a shift in our roles (the RA and myself as PI) from being expert trainers to co-learners and facilitators—because the Amai Busas brought with them a wealth of knowledge through their lived experiences as not only trusted faith-based supporters but also members of the Misisi community. The training sessions naturally evolved into mutual learning sessions, during which we collectively integrated formal TF-CBT elements with Zambian cultural wisdom.

The PPI consultation also highlighted the importance of paying careful attention to both content and context as I developed the training. The training adaptation process was therefore centred around making modifications to the content with specific attention to the language, structure, and delivery. Since the original training module is based on formal TF-CBT frameworks, language adjustments involved replacing clinical terminology

with simplified everyday words, and replacing role-play scenarios and examples (which were Western-based) with culturally relevant ones. To enhance understanding of foreign psychological concepts such as trauma, storytelling was employed, incorporating some faith-based references. Chapter 3 presents these processes in detail.

My experience with the intervention adaptation process was slightly different, as it primarily involved striking a balance between maintaining fidelity to the evidence-based TF-CBT framework, and allowing flexibility to make the intervention culturally relevant and meaningful to the women it aimed to support. In other words, the adaptation process allowed for the core elements of TF-CBT to be retained, but the way in which they were delivered to survivors in Misisi was significantly modified to adapt to the local context. For instance, similar to the adaptation of the training, language was modified by replacing clinical terms with simplified everyday words, and abstract psychological concepts were made easier to understand by the use of local examples and storytelling. Additional adaptations, which are detailed in Chapter 4 of this thesis, included the replacement of individual TF-CBT therapy with group therapy sessions, and the flexibility of session time limits to accommodate extra time for discussions, shared prayer, and storytelling. The most significant adaptation, however, was the appointment of the Amai Busas themselves to deliver the intervention rather than professional therapists. This was in line with the community's cultural setup, where women rely on female community leaders for counsel, guidance, and support.

Overall, the key challenge in applying changes informed by the PPI was balancing two aspects: respecting cultural values, and maintaining fidelity to the evidence-based framework of TF-CBT. However, instead of viewing the two as opposing factors, we collaborated with the Amai Busas to integrate them. Building on their insights, as the project progressed, I came to learn that the PPI was not a single consultation but an ongoing conversation that significantly shaped the project from development to delivery of the intervention. The adaptations made were not deviations from the original TF-CBT framework but essential cultural modifications that enhanced the acceptability and effectiveness of the intervention.

Following the successful adaptation process, the delivery of the training and that of the intervention are detailed in chapters three and four, respectively. The rest of this chapter gives an overview of this PhD thesis, beginning with the overall methodological approach of the project in its entirety, followed by an introduction to the papers that will be presented in the subsequent chapters. This detailed outline of the thesis is presented in section 1.4.

1.3 Methodological Approach

1.3.1 Theoretical Position

Theoretically, my study is based on the principles of CBT, with a specific reliance on Cohen's (2006) TF-CBT model. Defined as "a modern form of short-term psychotherapy based on the idea that the way an individual thinks and feels affects the

way they behave" (Misciagna, 2020, p. 3), research reports that the core tenets of CBT are applied across many SGBV interventions that have shown promising results (Lakin, 2022). Existing evidence points to TF-CBT being effective in improving mental health among survivors of traumatic events (Perry et al., 2022; Smith et al., 2022). Noticing numerous trauma symptoms among SGBV survivors in Misisi from my previous work in the community, I found the TF-CBT method appropriate for this study because it offers psychoeducation and helps clients in developing coping strategies for dealing with abuse-related memories and emotions. Further, it challenges maladaptive cognitions and develops healthier behaviour patterns that support psychological wellbeing, thereby reducing the anxiety associated with PTSD symptoms and depression (Neubauer et al., 2007). Additionally, therapists are encouraged to adapt the TF-CBT model to accommodate the needs of the survivors (Konanur, 2015). Therefore, I found the flexibility of the TF-CBT model to be convenient for my intervention, which was being designed to implement an evidence-based treatment in an environment for which it was not originally developed.

1.3.2 Epistemological Position

My epistemological position is both constructivist and pragmatic. Constructivism is a theory of knowledge that argues that the generation of knowledge and meaning stems from an interaction between humans' experiences and their ideas (Mogashoa, 2014). Specifically relevant to this study, is the social aspect of the theory, which,

according to Kim (2006, p. 27), emphasises the importance of culture and context in understanding what occurs in society and constructing knowledge based on this understanding. This theoretical approach was found suitable for this study as my aim was to understand the personal experiences and views of the survivors and the Amai Busas, as well as their interpretations of reality at a subjective, community, and socio-cultural level.

As a paradigm, pragmatism does not support the idea that the use of one analytic method can lead to objective truth (Frey, 2018), but rather, it argues that real-world problems should be investigated using the best methods, using multiple sources of information and knowledge to answer research questions (Andrew & Halcomb, 2007). A mixed methods approach was deemed appropriate for this study because methodological flexibility allows for the consideration of more information than can be captured through only quantitative research, such as participants' opinions, perspectives and experiences (Wisdom & Creswell, 2013). This study primarily relies on quantitative data serving to provide preliminary outcome measures to supplement the qualitative findings.

1.3.3 Study Procedures

Informed by the theoretical approach above, I began this study with a scoping review, which was chosen for this study because of the limitations of finding relevant research in rural regions in Africa. Therefore, taking the lead from the research papers I

had found, I did a forward and backward search, and used the keywords from these articles to help find more. The scoping review was important for gathering and evaluating existing evidence about trauma-focused community-based interventions with specific attention to their feasibility and acceptability in low and middle-income countries. After gaining an informed understanding of the nature of existing CBIs in the context of my research, the research aims and objectives presented in the following section (Section 1.3.4) were generated for the preliminary phase and the two main stages of the study.

1.3.4 Aims and Objectives

Preliminary Stage: Patient and Public Involvement (PPI)

Aim 1: To acquire an in-depth understanding of the specific needs of the community regarding a community mental health intervention for survivors of SGBV in Misisi.

Objectives

1. To acquire an informed understanding from key informants in the community of the specific needs of the SGBV survivors in Misisi.
2. To co-produce a community-based intervention aimed at supporting the mental health of SGBV survivors, stemming from the shared knowledge of the PI and the PPI representatives.

Training Delivery

Aim 2: To equip influential community members with skills and knowledge to enable them to provide mental health support to survivors of SGBV in Misisi compound, thereby contributing to a reduction in the mental health treatment gap in the community

Objectives:

1. To deliver trauma-informed training to representatives of the Misisi community (Amai Busas) to whom women often go to find support against SGBV.
2. To obtain feedback from the Amai Busas on the training proposed, in order to use this feedback to revise or integrate the training content (if needed) in the future.

Evaluation of Community Intervention

Aim 3: To deliver and evaluate the feasibility and preliminary effectiveness of a pilot community-based intervention supporting SGBV survivors in Misisi.

Objectives:

1. To deliver an intervention designed as a series of TF-CBT support group sessions to women who are survivors of SGBV in Misisi.
2. Using validated measures, conduct pre- and post-intervention evaluations to assess any changes that may occur in participants in connection with the intervention.

In line with the aims and objectives outlined above, Chapter Two, to follow, presents a scoping review that was conducted to synthesise existing evidence on the effectiveness and acceptability of CBIs for improving mental health in survivors of SGBV in LMICs. Chapter three presents the delivery of the brief adapted TF-CBT training to a group of six Amai Busas to equip them with skills and knowledge on trauma and mental health, thereby enabling them to provide mental health support to survivors of SGBV in Misisi compound. Chapter three also presents the findings of an evaluation of the training's effectiveness. Chapter four presents the third and final stage of this project, which was designed as a pilot study using mixed methods (qualitative and quantitative) to examine the feasibility and usefulness of the adapted CBI delivered by the trained Amai Busas. The final stage of this project was thus crucial, because it was to provide preliminary evidence about the feasibility of the CBI and its usefulness in improving the mental health of the survivors. Findings from this pilot study could offer useful insights on practices that are culturally relevant and relatively low-cost. If the present study produced encouraging results, the next step would be to consider a more rigorous investigation of the CBI's efficacy through a randomised controlled trial (RCT).

1.3.4 Study Design

This pilot study employed a mixed-methods longitudinal research design, combining qualitative and quantitative methods. Based on the above theoretical and

epistemological positions, the following study procedures were carried out to achieve the study's aims and objectives:

Preliminary Stage: Patient and Public Involvement (PPI)

Using audio-recorded semi-structured interviews, this study began with a PPI consultation with the wives of religious leaders, locally called '***Amai Busa'***, to whom survivors of SGBV often go to seek help, with the aim of acquiring an informed understanding of the specific needs of the community regarding mental health intervention for survivors of SGBV. The data collected from this consultation was thematically examined to gather the main themes emerging from the Amai Busa's interviews, and later used to inform the development of the intervention to follow.

Paper 2: Training Stage (Delivery and Evaluation of Training Proposed)

Following the PPI consultation, a TF-CBT training was delivered to a group of 6 Amai Busas, which was to allow them to later (in Paper 3) hold regular group meetings in which psychoeducation and TF- CBT would be used to support female SGBV survivors. A post-training evaluation was conducted, and the key points emerging from this stage were also used to inform the co-development of a community intervention model that would later, in Paper 3, be piloted on 30 female survivors of SGBV from the Misisi community.

Paper 3: Evaluation of Community Intervention

The final study involved the delivery of the intervention proposed above, which was designed as a series of 6 TF-CBT group sessions, and delivered in groups of 6 survivors once a week in local churches. An evaluation of the intervention was then carried out using validated measures for a pre, post and three-month follow-up assessment of participants' mental health, exposure to SGBV and psychological resilience.

1.3.5 Study Participants

Two participants were recruited for the preliminary stage using purposive sampling. The sample size was deemed sufficient to capture the Amai Busa's perspectives on SGBV in Misisi and to enable the co-production of the intervention for survivors that will be proposed in Stage 1 of the research (Paper 2) to follow. For Stage 1 (Paper 2), a total of six Amai Busas were recruited to undergo training in TF-CBT. Snowball and purposive sampling were used. The sample size was deemed sufficient to capture the Amai Busa's perspectives on SGBV in Misisi and to enable the co-production of the intervention for survivors. Finally, a total of 36 participants were recruited for Stage 2 (Paper 3). These were female survivors of SGBV residing in Misisi, who were identified and recruited by the Amai Busas, to whom survivors in the community usually go to seek support.

1.3.6 Data Analysis

The quantitative data collected was analysed with appropriate methods of statistical analysis, specifically Friedman's ANOVA tests to determine differences in scores, and Wilcoxon signed-rank tests to determine significance levels. The qualitative data was analysed using inductive reflective thematic analysis (Braun & Clark, 2021) and managed within NVivo to enhance transparency. NVivo is a software package which has been found to help improve the speed and accuracy of qualitative studies (Zamawe, 2015).

1.3.7 Ethical Considerations

Ethical approval to carry out the study was obtained from Manchester Metropolitan University (Ethos ID: 45296 for Stage 1 and Ethos ID:51497 for Stage 2), and from the Humanities and Social Sciences Research Ethics Committee in Zambia (Ref: HSSREC:2024-FEB-O54). The authority to conduct the research was then obtained from the National Health Research Authority (NHRA) of Zambia. Written informed consent was obtained from all participants at all three stages of the thesis, with participants being reimbursed for their transportation and lunch costs in accordance with local regulatory research and ethics bodies.

The PPI stage and training were considered as bearing low risk for participants, as these were key informants (Amai Busa) and not SBGV victims. Nevertheless, in the event that they may have had past direct experiences of SBGV and/or that they may have found

participation in the study distressing, appropriate risk management plans were put in place (as is detailed in appendices A and B).

Stage 2 was considered as bearing high psychological risk to participants. Therefore, in the event that participants may have found participation in the study distressing, a risk management plan was put in place based on the MMU distress protocol for qualitative data collection (Haigh & Witham, 2015). To minimise psychological harm to the PI and co-researcher, who are both trained psychologists, they kept notes in their journals and were in close contact with the PI's supervisors and kept them informed of any risk-related issues or incidents that occurred.

1.4 Thesis Format

The thesis presents three papers from one research project broken down into three studies, ordered based on the chronological order in which I began the projects, and written for academic publication. The outline of the rest of the chapters is therefore presented below.

Chapter 2: The effectiveness and acceptability of community- based interventions for improving mental health in survivors of trauma in low and middle-income countries: A Scoping Review

Prepared to be submitted to the following peer-reviewed journal: *Trauma, Violence, and Abuse: A Review Journal.*

The first paper presented was designed as a scoping review project. Herein, I synthesised existing evidence on the effectiveness and acceptability of CBIs for improving mental health in survivors of SGBV in LMICs. This project reviewed 10 studies using various forms of therapy to provide community-based support for female survivors of SGBV in LMICs and highlighted that brief CBIs can be effectively delivered by trained and supervised lay counsellors, especially when the interventions are culturally tailored specifically for each individual community.

Chapter 3: Experiences of training lay people to deliver a trauma-focused intervention for the improvement of mental health in female survivors of domestic violence in a peri-urban community in Zambia: An Empirical Study

Prepared to be submitted to the following peer-reviewed journal: *Journal of Interpersonal Violence.*

The second paper begins by presenting a PPI consultation conducted with the Amai Busas during the preparatory phase, and explains how the information gathered

from this consultation was applied to the design and cultural adaptation of the TF-CBT training. The paper then details the delivery and assessment of the effectiveness of the culturally adapted TF-CBT training provided to six Amai Busas for implementing a trauma-focused intervention aimed at supporting female survivors of SGBV in Misisi. The findings of the study are then presented, comprising the pre-post pilot outcome data showing improvements in participants' knowledge, skills, and confidence to provide support to SGBV survivors in their community. It also contains an evaluation of the training, and several recommendations for others designing brief training for LHWs delivering CBIs in low-resource communities.

Chapter 4: Effectiveness of a Community-Based Intervention to Tackle Domestic Violence and Improve Mental Health in Young Underprivileged Women in a Peri-Urban Community of Misisi in Lusaka, Zambia: An Empirical Study

Prepared to be submitted to the following peer-reviewed journal: *Journal of Family Violence.*

This empirical paper presents the findings of the third and final study of the project, which was a pilot study examining the feasibility and usefulness of the proposed CBI delivered by the six trained Amai Busas and designed as a series of TF-CBT group sessions. The study aimed to determine if the CBI could improve the mental health of female survivors of SGBV in the Misisi compound, improve the survivors' knowledge about SGBV

and its consequences, and explore the perceptions and opinions of the participants about the Amai Busa-delivered CBI. The paper provides preliminary evidence about the feasibility of the CBI and its usefulness in improving the mental health of SGBV survivors in Zambia.

Chapter 5: Discussion

This chapter presents an overview of the key findings of three studies, and goes into a critical and integrative account of the research implications and contributions of the papers of the thesis to knowledge and scholarship in the field of psychology. It then presents the study's practical implications, followed by a reflection on my experience of culturally adapting an evidence-based treatment model, with a specific focus on the challenges I faced, and the modifications that were necessary to tailor it to the Misisi context.

Chapter 6: Conclusion

The sixth and final chapter presents the thesis' strengths and limitations, and the final conclusion. I also describe my future research plans for the study, specifically the intention to expand the study into an RCT. Together, the three papers: a) identified, described and evaluated existing CBIs for the improvement of mental health in female SGBV survivors in LMICs, b) demonstrated that teaching lay counsellors supportive

counselling skills for SGBV survivors can be beneficial and effective in low-resource communities, and c) developed and piloted a new intervention bringing about improved mental health among female survivors of SGBV in a poor-urban community.

Chapter 2: Paper 1

The effectiveness and acceptability of community-based interventions for improving mental health in survivors of Sexual and Gender-based Violence (SGBV) in low and middle-income countries: A scoping review

2.1 Introduction

It is estimated that globally, around 736 million women have experienced Sexual and Gender-based Violence (SGBV) at least once in their life (UN, 2022). In east and southern Africa alone, 42% of women experience SGBV in their lifetime (World Bank, 2023). SGBV is defined as any harm inflicted against one's will on the basis of socially assigned differences between males and females (United Nations High Commissioner for Refugees [UNHCR], 2011). These acts can be physical, sexual, or mental, including threats of committing such acts and can occur publicly or privately. Globally, violence against women and girls is one of the most common violations of human rights, and it has no regard for social, economic, or national parameters (United Nations Fund for Population Activities [UNFPA] 2014). The World Health Organisation (WHO) reports that one in three women experience sexual or physical violence—most likely from their intimate partner (WHO, 2013). Such acts create behavioural trends that infringe the rights of women and girls, affect their ability to contribute positively to society, and can impair their health and

well-being. Some victims develop severe mental illness, experience both emotional and physical trauma, and some die as a result of the violence, which often has a serious impact (Alejo, 2014).

While SGBV affects people of all social statuses, people of low economic status have limited access to mental health support if they experience violence (Gevers et al, 2014). In many African countries, SGBV rates are high (Muluneh et al., 2020) and this form of violence may also be intertwined with others, such as human trafficking and modern slavery, often disproportionately affecting women (Kiss, 2022; The Borgen Project, 2020). A plethora of studies (Zuchowski, 2014; Rees et al., 2016) have highlighted a strong link between SGBV and mental illness. In particular, research (Karger et al., 2013 Umubyeyi, 2015) conducted in African countries such as Rwanda and South Africa suggest that SGBV has both short and long-term negative mental health effects. Survivors often have an increased risk of developing depression, anxiety, post-traumatic stress disorder (PTSD), and show higher rates of suicide attempts (Umubyeyi, 2015). Karger et al. (2013) found that young women in South Africa who had no mental health issues but experienced IPV had high chances of developing depression, alcohol abuse, or suicidal ideation over a two-year period of observation.

Due to the lack of 'formal support' from institutions and local organizations, most SGBV survivors in low resource communities seek support from community representatives, such as traditional and religious leaders to receive help regarding prevention of abuse and coping with abuse-related mental health symptoms. For instance,

in most local African cultural settings, women often seek help from wives of religious leaders in whom they confide, and the WHO has recognized that this is the case in traditional African societies (WHO, 2001). However, the said leaders lack formal training and information on SGBV-related trauma and mental health. There is a need to find ways to collaborate with such community leaders and to adapt services to the African socioeconomic setting. This has been emphasized for decades, dating as far back as 1961 at the First Pan African Psychiatric Conference in Nigeria (Lambo, 1961). The WHO supports the use of this approach in both developed and developing countries (WHO, 2020). This is exhibited through the organization's adoption of approaches such as 'Task Shifting', which is described as a process whereby specific tasks are moved, where appropriate, from specialists to health workers with shorter training and fewer qualifications (WHO, 2008). This approach may also involve the delegation of tasks to newly created health workers who have received specific competency-based training at the community level, such as lay counsellors or volunteers. The WHO suggests that reorganization and decentralization of healthcare services helps to address the existing shortages of human resources and provides evidence that access to health services can be extended to all people in a way that is effective and sustainable (WHO, 2008).

Nonetheless, very few studies (Freccero, 2011; Mirghani et al., 2017) have explored the influence and possible benefits of accessing community-based support for SGBV victims in developing nations. In most developing countries at present, there is no formal training available to members of the community that SGBV victims often seek support from, despite that this support could represent valuable help for women and girls

to end the abuse to which they are exposed. This is particularly the case for victims residing in poorer areas, who face significant barriers in accessing 'formal' channels of support for instance, from local and/or international organizations (European Union [EU], 2017). A few organisations have tried to supplement government efforts to deal with this by providing free psychotherapy services in these communities (StrongMinds, 2019). However, for this to be effective in the enhancement of well-being for SGBV survivors, research must play a part, as it is imperative for such support to be guided by evidence. There is a need to understand the extent to which SGBV affects mental wellbeing, the implications this has on young underprivileged women, and the effectiveness of community-based interventions (CBIs) aimed at improving their mental health. Evidently, most extant research and knowledge in this area is based on western populations and interpretations, therefore, it is imperative that more culturally sensitive research in other societies experiencing SGBV is conducted.

2.2 Method

2.2.1 Aims of Review

This scoping review aims to assess the feasibility and acceptability of community-based interventions for improving mental health in survivors of SGBV in low- and middle-income countries on the primary outcomes of anxiety, depression, and PTSD symptoms. The effectiveness of these interventions is also evaluated based on how they affect the

primary outcomes highlighted in the findings, specifically, in terms of whether there is a reduction in symptoms of anxiety, depression, and PTSD symptoms.

2.2.2 Search Process

The PRISMA checklist for Scoping Reviews (Page, 2021) was used as a guideline for this review. A literature search was conducted using two databases: PsycINFO and PubMed. A grey literature search was also conducted to seek evaluations of interventions, and a reference check of the studies included. The keywords used in the search were the following: “sexual and gender-based violence”, “gender-based violence”, “violence against women”, “intimate partner violence”, “domestic violence”, “family violence”, and “low-and-middle-income countries”, “developing countries” and “mental health”, “mental illness” and “interventions”, “treatments”, and “community-based interventions”, “community-based treatments”. Boolean operators (AND/OR) and truncation (*) were also used to capture variations of these terms.

2.2.3 Study Selection Criteria

Table 1 below illustrates the study inclusion and exclusion criteria. The filters applied to the database search were (1) studies published from 2013 to 2023; (2) English language peer-reviewed literature; (3) female participants; and (4) low-and-middle-income countries.

Table 1: Inclusion and Exclusion Criteria

	Inclusion Criteria	**Exclusion Criteria**
Population	- Women affected by SGBV in low-and-middle-income countries - Low-and-middle-income countries - Civilians - Women over 16 years of age	- Psychological trauma not associated with gender-based violence
Interventions	- Interventions developed specifically for women who are survivors of SGBV - Treatment interventions - Interventions aiming to improve any mental health outcome - Qualitative and quantitative measured outcomes - In-person interventions	- Screening interventions - Interventions aiming to improve only physical health outcomes - Digital interventions
Study Types	- Peer reviewed studies - RCTs - Case studies - Studies from 2013 to 2023 - English language	- Non-peer reviewed studies - Study protocols - Incomplete studies - Grey literature
Study Outcomes	- Anxiety - Depression - PTSD	- Studies not assessing any of the three outcomes (anxiety, depression or PTSD).

2.2.4 Search Strategy

The search strategy is outlined in Figure 1 below. Two independent reviewers assessed the full text of selected citations against the inclusion criteria for this review, and reasons for the exclusion of full-text studies that did not meet the inclusion criteria were recorded. Any disagreements that arose between the reviewers at each stage of the study selection process were resolved through discussion, or with a third reviewer.

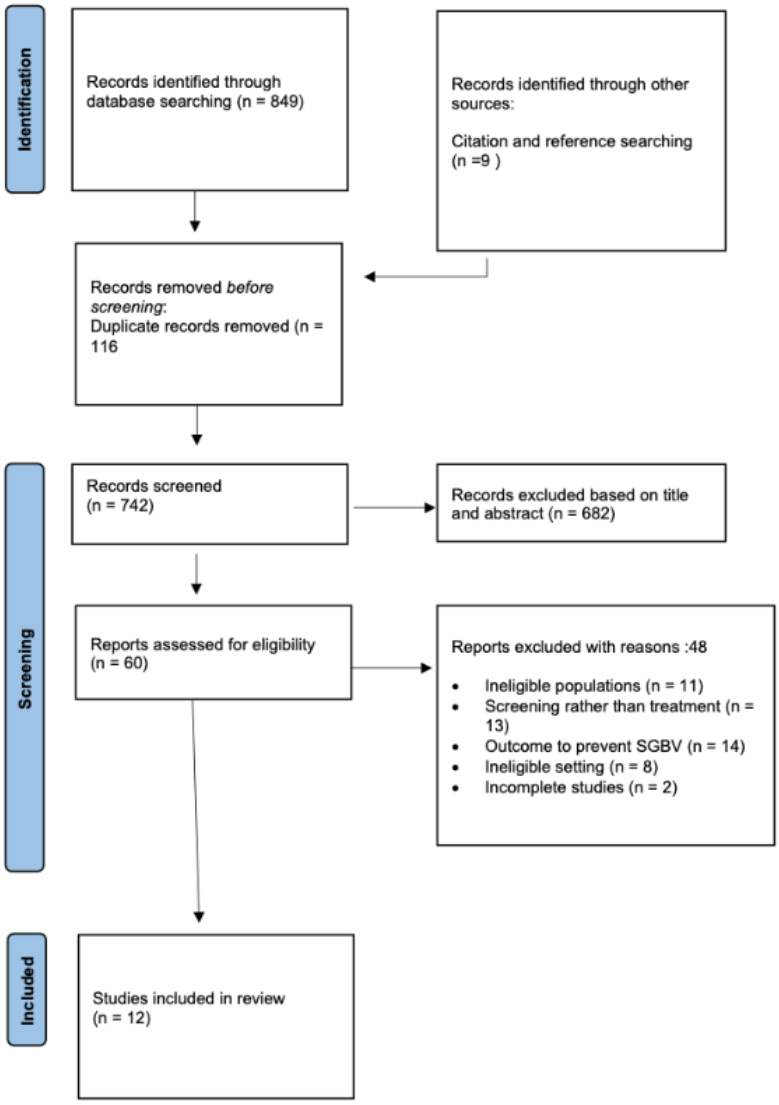

Figure 1: PRISMA Flow Diagram of Searches and Extraction of Studies

Study Types

For this review, all study types were considered, provided they were a primary study evaluating a manualised CBI for improving mental health in female survivors of SGBV in a low-and-middle-income country. As research in this area is still emerging, all types of randomised controlled trials (RCTs) were considered, as well as case studies.

2.2.5 Participants

2.2.5.1 Participant Characteristics

Participants included in this study were females aged 16 years and older. Trials where other participants with different and ineligible characteristics were also included if they had not less than 50% eligible participants.

2.2.5.2 Participant Conditions

Included in this review were women who self-reported recent or past experience of SGBV (i.e., any kind of violence against women), including violence perpetrated by a male intimate partner (IPV), family member, or any other male in their life. This also included women who experienced sexual violence, whether perpetrated by an intimate partner or not.

2.2.5.3 Study Settings

Only studies conducted in low or middle-income countries were included in this review. The World Bank (2016) criteria for categorizing a country as low- or middle-income was applied. Studies with populations during humanitarian crises were included, as well as those in periods after humanitarian crises. As a guideline for identification of study settings to include in this review, Rothman's (1995) typology was applied, which identifies four types of CBIs. These are: a) Community as a *setting* – referring to the location in which the intervention is being implemented; b) Community as a *target* of change; c) Community as an *agent* – emphasizing the need to work with naturally occurring units of solution as our units of practice; and d) Community as a *resource* – referring to the belief that community participation and ownership is required in order for population-level health outcomes to be achieved (McLeroy, 2003). Therefore, the studies included in this review were those that had participants recruited via community settings such as healthcare, church programs, and general community settings.

2.2.6 Types of Interventions

2.2.6.1 Experimental Interventions

This review considered psychological therapies that aimed at improving any mental health outcomes including anxiety, depression, and PTSD. The Cochrane Collaboration Depression, Anxiety and Neurosis Group (CCDAN, 2013) classification of

psychological interventions was used in the classification of interventions in this review. Included in this classification are the following: (1) Behavior Therapy/Behavior Modification (e.g., social skills training, behavior contracting, activity scheduling, exposure therapy and psychoeducation); (2) Cognitive Behavioral Therapy (e.g., problem-solving, rational emotive therapy, role play, restructuring); (3) Third-wave Cognitive Behavioral Therapies (e.g., acceptance and commitment therapy, mindfulness, meta-cognitive therapy, compassion-focused); (4) Psychodynamic therapies (e.g., insight-orientated therapy, countertransference, transference, object relations, psychoanalytic therapy); (5) Humanistic therapies (e.g., existential therapy, expressive therapy, supportive therapy, non-directive therapy); (6) Integrative therapies (e.g., motivational interviewing, interpersonal therapy, counselling, eclectic therapy, transtheoretical); (7) Systemic therapies (e.g., conjoint therapy, couples, marital or relationship therapy, family therapy); and (8) Other psychologically orientated interventions (e.g., art therapy, bibliotherapy, colour therapy, music therapy, psychodrama).

Included in this review were interventions using any treatment, provided it was psychological. No restrictions were applied to the frequency or duration of treatment sessions, as long as they met the criteria stated above. Although the focus of the review was on mental health treatments for female survivors of SGBV, interventions using couple-based therapies were also included, as this presented an opportunity to additionally assess the effectiveness of treatments when combined with their partners.

No restrictions were applied to the minimum training requirements for therapy treatment delivery in the interventions. This is due to the current lack of standardised definitions for training requirements. For instance, with CBT, the Beck Institute has outlined specific cardinal components of CBT in the Cognitive Therapy Scale, but the minimum training required to achieve these competencies is not specified (Young, 1980).

Similarly, in acknowledgement of the inconsistency amongst health professional regarding CBT training, the British Psychological Society (BPS) compiled a list of core competencies essential for the delivery of CBT training but did not specify the minimum training to achieve them (Roth, 2007). Therefore, interventions with both professional healthcare workers and lay people who have been trained were included in the review. Additionally, no restrictions were applied to the approach of intervention delivery. Both individual and group interventions were included.

2.2.6.2 Comparator Interventions

The selection criteria for comparator interventions consisted of inactive controls. These included no treatment at all, standard usual/normal care (e.g., regular counselling), waitlist, and physiological treatment (including medication).

2.2.7 Outcome Measures

Studies included in this review were selected based on three primary outcomes: PTSD symptoms, depressive symptoms, and anxiety symptoms, with a follow-up timeframe of 3 to 12 months. The focus of the review was on the effectiveness of interventions on these three symptoms (PTSD, depression and anxiety), as well as participant engagement data, such as enrolment, dropout and completion rates. All studies meeting the criteria were included regardless of whether the interventions were found to be effective or not.

2.2.8 Data Analysis

A narrative synthesis was conducted to synthesise the findings of the ten studies in this review. As a method, narrative synthesis has been recognised as an effective means of identifying the story underlying a body of diverse evidence through its flexibility in developing themes that provide organisation and consistency to that data (Briner & Denyer, 2012; Popay et al., 2006). Unlike a statistical approach, a narrative synthesis uses a textual method to analyse results and draw conclusions (Popay et al., 2006). This words-based approach was suitable for gathering and evaluating existing evidence about trauma-focused community interventions, focusing specifically on their feasibility and acceptability in low and middle-income countries.

To conduct the synthesis, Briner and Denyer's (2012) five steps were followed, which include: 1) planning; 2) structured search; 3) evaluating materials against agreed eligibility criteria; 4) analysis and thematic coding; and 5) reporting. Further, Briner and Denyer's (2012) narrative synthesis guidelines were adopted, adhering to the principles of organisation, transparency, replicability, quality, credibility, and relevance. In this review, the principle of organisation is demonstrated in the review's structure and focus on a specific research aim, providing clarity in a logical flow of information. Transferability is shown through the transparency of the study methods and processes applied, including the study inclusion, exclusion and selection criteria, as well as the data collection and analysis processes. Replicability is demonstrated through the detailed description of the review process, which enables other researchers to replicate or update it with new findings. Quality and relevance are ensured through the critical appraisal of the evidence included in the synthesis for its quality and relevance to the research aim. Finally, credibility is demonstrated through the application of narrative synthesis as an established research method (Briner & Denyer 2012; Popay et al., 2006). Additionally, peer scrutiny was applied as the study was reviewed by researchers who were not part of the project. Following the systematic collection of information described above, the findings were synthesised according to the effectiveness, feasibility and acceptability of CBIs; facilitators for implementation, challenges and barriers of implementation. Implications for future intervention development, delivery and evaluation were also identified. Table 2 summarises the studies included in this review, with the following specific data characteristics extracted from each study.

Table 2: Characteristics of Included Studies

Study (Author, Year)	Location	Trial Design	Intervention Therapy	CBI Type	Interventionists	Delivery	Min. Age	N Recruited	Primary Outcomes	Comparison Group	Acceptability Indicators	Key Findings
Annan et al., 2017	Côte d'Ivoire	2-arm Parallel RCT	Gender Dialogue Group	Community as a setting	IRC Field Agents	Group	18+	1110	PTSD	Savings-only sessions	46% attended >75% sessions	Reduced PTSD symptoms
Bryant et al., 2017	Kenya	Single-blind, Parallel RCT	PM+	Community as a setting & resource	Lay Community Members (8-day training)	Individual	18+	156	PTSD	Facility-based EAU care (nurses)	72.6% completion, 83% fidelity	Moderate reductions in distress
Bass et al., 2013	Congo (DRC)	2-arm Parallel RCT	Cognitive Processing Therapy	Community as a setting	Psychosocial Assistants (1–9 yrs exp.)	Group	18+	141	PTSD, Depression, Anxiety	Community-based individual support	65% intervention completion	Reduced PTSD, depression, anxiety; improved functioning
Dawson et al., 2016	Kenya	Feasibility RCT	PM+	Community as a setting	Community Health Workers	Individual	17+	30	Psychological distress, PTSD	Facility-based EAU care (nurses)	86% intervention completion	Reduced PTSD symptoms
Greene et al., 2019	Tanzania	Pilot Intervention	CPT + Advocacy Counselling	Community as a setting & resource	Lay Community Members	Individual + Group	18+	58	PTSD, Depression, Anxiety	Usual refugee camp services	Avg. 5.3 out of 8 sessions attended	Reduced psychological distress
Knettel et al., 2019	South Africa	Qualitative Study	ImpACT	Community as a setting & resource	Non-specialist, supervised by psychologist	Individual + Group	18+	31	PTSD, Depression	No comparison group	Safe, supportive environment reported	Reduced PTSD, improved ART adherence

Study (Author, Year)	Location	Trial Design	Intervention Therapy	CBI Type	Interventionists	Delivery	Min. Age	N Recruited	Primary Outcomes	Comparison Group	Acceptability Indicators	Key Findings
Latif et al., 2021	Pakistan	Feasibility RCT	Cognitive Behavioral Therapy (CatCBT GSH)	Community as a setting	Masters-level Psychologists	Group	18+	25	PTSD, Depression, Anxiety	Waitlist (no intervention)	92% completion rate	Reduced PTSD, depression, anxiety; improved functioning
Patel et al., 2019	India	RCT	Healthy Activity Program (HAP)	Community as a setting & resource	Lay Counselors (3-week training)	Individual	18+	100	Depression	Enhanced usual care with psychoeducation	Delivery success by lay counselors	Reduced depressive symptoms
Sapkota et al., 2022	Nepal	Pilot RCT	PM+	Community as a setting	Nurse trained as counselor	Individual	18+	51	Depression, Anxiety	Usual care + DFV support contacts	Positive participant experiences	Significant reductions in anxiety and depression
Sikkema et al., 2017	South Africa	Pilot RCT	ImpACT	Community as a setting	Non-specialist in HIV/AIDS setting	Individual + Group	18+	23	PTSD	Standard adherence counseling only	91% completion rate	Reduced PTSD at 3 months, but effects not sustained at 6-month follow-up

2.2.8 Studies Included

2.2.8.1 Study Design

A total of 10 studies were included in this review. Of these studies, there were: 2 randomized controlled trials (RCTs) (Knettel, 2019; Patel, 2019), 2 pilot randomized controlled trials (Sapkota, 2020; Sikkema, 2017), 2 feasibility randomized controlled trials (Dawson, 2016; Latif, 2021), 2 two-armed parallel randomized controlled trials (Anna, 2017; Bass, 2013), 1 single-blind parallel randomized controlled trial (Bryant, 2017), and 1 pilot intervention study design (Greene, 2019).

2.2.8.2 Sample Characteristics

A total of 1930 participants were recruited in the studies included. The number of participants recruited within the studies ranged between 25 (Latif, 2021) and 1198 (Annan, 2017). Of these, 164 dropped out of the studies, leaving 1725 participants analysed in this review. The minimum age of participants was 17 years old, with only one study (Dawson, 2016) having this age as the minimum, whilst the remaining nine studies had a minimum age of 18 years. No maximum age was reported. The mean age for all participants across the 10 studies was 32.79 years. A total of 942 (54.6%) participants were married.

2.2.8.3 Setting

In line with this scoping review's inclusion criteria, all of the included studies were conducted in low-and-middle-income countries (LMICs). Of these, two were conducted in Kenya (Bryant, 2017; Dawson, 2016), another two in South Africa (Knettel, 2019; Sikkema, 2017), with the rest being single studies in Cote D'Ivoire (Annan, 2017), Democratic Republic of the Congo (Congo DRC; Bass, 2013), Tanzania (Greene, 2019), Pakistan (Latif, 2021), India (Patel, 2019) and Nepal (Sapkota, 2020). These studies were published over a period of eight years (2013 to 2021).

2.3 Results

Interventions and Outcomes

In evaluating the effectiveness of interventions treating the three primary outcomes considered in the ten papers in this review, a total of six intervention therapies were identified: 1) Problem Management Plus (PM+); 2) Cognitive Processing Therapy (CPT); 3) Improving AIDS Care After Trauma (ImpACT); 4) Cognitive Behavioral Therapy; 5) Gender Dialogue; and 6) Health Activity Program (HAP).

The PM+ therapy is described as a brief psychological intervention developed by the WHO, using evidence-based strategies including behavioral activation, problem-solving, accessing social support, and stress reduction. Thirty percent (n = 3) of the studies reviewed employed the PM+ in their interventions. Bryant's (2017) CBI in urban Kenya

was conducted among a community sample of women with a history of SGBV. The brief, lay-administered intervention (PM+) was compared with Enhanced Usual Care (EUC), which in this case was a referral to a community nurse who would provide counselling for their problems. The PM+ intervention resulted in moderate reductions in psychological distress at the three-month follow-up. Another study conducted in Kenya (Dawson, 2016) found that women survivors' who had experienced adversity, including GBV, and who received PM+, displayed greater reductions in PTSD symptoms following treatment than those receiving EUC comprised of care and counselling from a community nurse. Similarly, Sapkota's (2020) antenatal-based intervention found significant decreases in anxiety and depression among pregnant women who were experiencing domestic and family violence in Nepal. These findings from all three studies suggest that PM+ is effective in reducing psychological distress and symptoms of anxiety, depression, and PTSD among female survivors of SGBV. Regarding acceptability, the findings from all three studies point to the high acceptability of PM+. Although acceptability was not directly measured, various indicators point to high engagement and PM+ being well-received by the community. Bryant's (2017) study reports a 72.6% completion rate and an 83% intervention protocol fidelity rate, and Dawson (2016) reports a completion rate of 86%. Although Sapkota's (2020) study does not specifically report a completion rate, the findings indicate that the intervention was acceptable among the target population, with participants reporting positive experiences.

The next most applied intervention therapy in this review (n = 2 studies; 20%) was CPT, which teaches skills to overcome negative thoughts and self-perceptions and gain control over the impact these have on survivors' lives. It helps survivors learn how to challenge and modify unhelpful beliefs related to their trauma. In Bass' (2013) study in Congo DRC, 16 villages were randomly assigned to either provide CPT (comprising one individual session and 11 group sessions) or individual support to female survivors of sexual violence who had high levels of PTSD and combined anxiety and depression. The study found that participants who received CPT reported a decrease in symptoms of PTSD and combined anxiety and depression. These participants also reported improvements in their functioning. In another study carried out in Tanzania (Greene, 2019), an intervention, termed *Nguvu* ('strength') was developed, incorporating brief CPT and another therapy called Advocacy Counselling, which was focused on increasing autonomy, empowerment and strengthening linkages to community support. The intervention was piloted among Congolese refugee women in Tanzania, and it was found that it was possible to implement an integrated health and protection intervention to address co-occurring psychological distress and IPV in a complex, dynamic refugee setting. Psychological distress in this study was measured as scoring an average of 1.75 or higher on the 25-item Hopkins Symptom Checklist (HSCL-25), which measures symptoms of anxiety and/or depression (Greene, 2019). These findings show that CPT has been found to be an effective treatment in improving mental health in women who have been affected by SGBV. Both studies also demonstrate the moderate acceptability of the intervention, with Bass (2019) reporting a 65% completion rate despite the challenging context of a low-resource, conflict-affected

setting. Greene (2019) does not report an explicit completion rate, but participants, on average, each attended approximately 5.3 sessions out of the 8 intervention sessions, indicating moderate engagement.

Another 20% (n = 2) of the studies reviewed (Knettel, 2020; Sikkema, 2017) employed the third intervention therapy identified, called ImpACT. ImpACT is designed to increase awareness of personal values, help survivors to understand the impact of sexual trauma, and encourage adaptive strategies for coping to promote long-term HIV care engagement. In a pilot trial conducted in Cape Town, South Africa, the intervention was delivered to 31 women living with HIV, many of whom reported improved symptoms of depression and PTSD, and that they felt better equipped to implement adaptive coping strategies (Knettel, 2020). A qualitative analysis of all the 31 women's perspectives on ImpACT found that by helping women to learn and adopt healthy coping strategies, ImpACT does have the potential to alleviate the combined challenge of HIV and sexual trauma in South Africa. Additionally, a qualitative case study of the same intervention (Knettel, 2020) was conducted on one of the participants, Xoliswa, a 34-year-old woman with complications of alcohol use and sexual trauma who had been diagnosed with HIV one year before being recruited into the ImpACT program. A unique aspect of this study was that it explored the interventionist's perspective and experience. The interventionist, who was a lay counsellor, tackled Xoliswa's concerns through the exploration of her personal values, teaching her active coping skills and addressing the barriers to accessing HIV care (Knettel, 2020). The findings of the study indicate reductions in Xoliswa's intake of alcohol, enhanced mental health, and a maintenance of strong HIV care engagement.

The interventionist, however, experienced emotional challenges and stress in the delivery of the intervention to Xoliswa and other women who were severely traumatised. Sikkemma's (2017) pilot RCT of the same intervention found reduced symptoms of PTSD and increased adherence to ART at a three-month follow-up post baseline in comparison to the control group. However, a six-month post-intervention follow-up found that there was poor adherence to ART and the reduction in PTSD symptoms did not differ significantly from that of the control group (Sikkema, 2017). This meant that although the treatment/intervention was effective in the short-term, its effects were not sustained long-term. However, the findings from both studies point to the acceptability of the intervention. While Knettel (2020) does not specify the exact completion rate in this particular study, participants report that it provided a safe and supportive environment, which they appreciated. Sikkema's (2017) research on the ImpACT intervention has reported notably high completion rates, at 91%, highlighting the acceptability of the ImpACT intervention among SGBV survivors living with HIV in South Africa.

The last three therapies were each employed by single studies (Annan, 2017; Latif, 2021; Patel, 2019) included in this review. CBT, which focuses on reforming maladjusted emotions, behaviours, and thoughts by challenging and removing negative beliefs, was employed by Latif et al. (2021) in a feasibility randomized controlled trial in Pakistan. In this intervention, they developed a self-help manual describing how to help oneself with symptoms of PTSD, depression and anxiety using CBT techniques. The self-help guide, dubbed *CatCBT GSH*, was culturally adapted and developed for female survivors of domestic violence in Pakistan. The trial was found to be feasible, and with a notably high

retention rate of 92%, the intervention was acceptable to Pakistani women who had experienced domestic violence. Additionally, it was found helpful in improving symptoms of PTSD, depression, anxiety and overall functioning in this population, demonstrating its effectiveness. It is important to distinguish the difference between CBT and CPT above, as they are quite similar. Although both are trauma-focused therapies, CPT focuses on identifying, challenging and changing unhelpful beliefs related to a particular trauma, while CBT focuses on identifying and changing harmful thoughts, behaviours, and feelings that contribute to mental health challenges (Resick et al., 2024).

Another therapy used by a single study was the Gender Dialogue intervention. In Annan's (2017) study in Cote D'Ivoire, a comparison was made between the impact of group savings only (control group) and groups that combined gender dialogue groups (GDG) with group savings (treatment groups) on PTSD symptoms in female survivors of SGBV. Of all the studies included in this review, this was the only one that included the women's partners in the intervention. In the GDGs, topics addressed included gender imbalances in the home, household finances and budgeting, the importance of non-violence in the home, communication and respect as partners, and acknowledgement of the contributions that women make to the wellbeing of the home. The findings at the conclusion of the trial indicated that women who were in the intervention group (VSLA+GDG) reported a reduction in PTSD symptoms, whereas the women in the control group (VSLA only) were found to have largely no changes to their levels of PTSD. The difference between the findings of the two groups were, however, non-significant (Annan, 2017). While acceptability was not explicitly measured in the study, participation rates

indicate that the intervention was moderately well-received, with 46% of couples attending more than 75% of the GDG sessions. Additionally, qualitative feedback from participants also points to the intervention being acceptable and beneficial.

Lastly, the HAP intervention is a culturally adapted form of Behavioral Activation (BA), which is an evidence-based psychological treatment for depression (Dimidjian et al., 2006). When BA is applied, the cycle of depression is broken by an activation of their behaviors to draw pleasure and mastery from their environment (Dimidjian et al., 2011). The HAP treatment was employed in an RCT by Patel (2019) in Goa, India, in which 112 female survivors of IPV were randomised to an intervention group. The core design of HAP was characterised by psychoeducation on activity and mood, behaviour monitoring, activity scheduling, social network activation, and problem solving (Patel, 2019). The study found that depressive symptoms were improved by training primary healthcare givers in the assessment and provision of safety planning for females experiencing IPV and depression (Murray et al., 2014), pointing to the effectiveness of HAP. While the intervention's effectiveness is clearly demonstrated, the study does not report specific data on the intervention completion rate. However, the lay counselors' successful delivery of HAP and the improvements in depressive symptoms among participants are indicators of the intervention's acceptability in this context.

2.4 Discussion

This scoping review synthesised evidence from 10 individual studies using various forms of therapy to provide community-based support for female survivors of SGBV in low- and middle-income countries. The key finding was that brief CBIs can be effectively delivered by trained and supervised lay counsellors, especially when the interventions are culturally tailored specifically for each individual community. All the interventions in the studies reviewed were found to be successful in improving the mental health of participants in their post-intervention evaluations, reinforcing existing evidence that brief psychological/behavioural interventions can be effective in the treatment of mental health effects of SGBV in women, without leading to adverse outcomes. However, some studies did report mixed and/or null findings. Broadly, these findings support the acceptability of such interventions in low-income communities.

The key characteristics identified in this review led to the discussion of three key aspects and concerns which influenced the effectiveness and acceptability of CBIs for women who have experienced SGBV: i) the impact of task-shifting on the effectiveness and acceptability of CBIs in low-resource communities, ii) the studies reviewed applied either individual or group-based therapies, or both in the delivery of interventions, and iii) the impact of women's concerns about their privacy and safety on the effectiveness and acceptability of CBIs.

A) Impact of Task-shifting on Effectiveness and Acceptability of Community-based Interventions

Most of the studies included in this review applied the task-shifting approach. Task shifting can be explained as the use of non-specialists or paraprofessionals (lay counselors) with little to no prior mental health training or experience to deliver care, under supervision (Dorsey, 2020). Sixty percent (n = 6) of the studies employed lay community health workers (CHWs) as interventionists following training in the therapies used (Bryant, 2017; Dawson, 2016; Greene, 2019; Knettel, 2019; Patel, 2019; Sikkema, 2017), making task shifting the most frequently used approach.

Some studies have suggested that the use of lay CHWs may have increased the effectiveness of the interventions they delivered, thereby resulting in their success (Stanford, 2013; Rahman, 2016). In Dawson's (2016) pilot of the PM+ intervention in Kenya, the training and supervision of CHWs sought to uphold a task-shifting approach. The intervention providers in this study were women engaged in community health work with the government, who underwent an eight-day training in PM+. A cardinal feature of the task-shifting approach is the supervision component. In this study, the CHWs were supervised weekly by local supervisors who were qualified clinical psychologists with experience in providing clinical supervision (Dawson, 2016). The local supervisors were also supervised weekly to bi-weekly for a maximum of two hours by the master trainer and a fourth local supervisor. The supervision structure was designed so that supervision flowed from an international intervention specialist based in another country to local

experts and onwards to CHWs (Dawson, 2016). The study found that the implementation of PM+ in peri-urban communities with non-specialized healthcare workers was successful, suggesting that Kenyan CHWs can competently deliver PM+ after brief training and under regular supervision. Similarly, Bryant's (2017) findings in the same country also suggest that lay health workers can be trained in PM+ and are capable of delivering this intervention in a way that can improve the mental health of female survivors of SGBV.

Apart from the evident challenge of the lack of qualified trainers being tackled, task shifting is also cost effective and thus tackles logistic barriers and compensates for multiple other barriers to the access of mental health services in low resource settings. For instance, by working with local community members as lay health workers, cultural adaptation is made possible and easily applicable, as they are in a place to recommend ways to improve the relevance and acceptability of the intervention content prior to initial implementation (Greene, 2019). Greene's (2019) feasibility study of the *Nguvu* intervention in Kenya found that it was feasible to train lay community members to deliver the intervention, and these findings were similar to those from other studies that have used paraprofessionals to deliver interventions (Tiwari, 2010; Bass, 2013). Cultural adaptations were made to the manual throughout the training of the lay community health workers, and these were based on recommendations from the facilitators regarding the improvement of language, comprehensibility, and the incorporation of locally salient examples in relation to gender norms and IPV (Greene, 2019).

It is important to take into consideration the wellbeing of interventionists in addition to those of the women who are receiving the interventions. Only one study in this review addressed the CBI from this angle. In Knettel's (2019) study, one of the ImpACT interventionists provided her perspective on her work with one of the participants. She had had no prior experience as an interventionist before, and received intense training coupled with supervision during the intervention. Initially, the interventionist reported having challenges with asking women about their trauma history. However, her confidence and comfort level increased after receiving her training. She also sought additional support from a therapist, which she reports greatly assisted in enabling her to manage her personal reactions to the difficult stories of the participants (Knettel, 2019). It can therefore be seen that the training, supervision, and additional support by a therapist collectively created a comprehensive and adequate package for the interventionist, as she reported to have confidently grown as a counselor by the time she was having actual sessions with the women.

From this review, incorporating task shifting within interventions where communities are given the opportunity to collaborate and provide their insight can make interventions more culturally acceptable and appropriate. In these circumstances, the community can further collaborate and contribute to the continued process by providing insight to further tailor the intervention to the needs of survivors (Joshi et.al., 2014). Across the ten studies reviewed, four interventions (PM+, ImpACT, HAP and CPT) were successfully delivered by lay counselors, resulting in significant improvements in participants' mental health. The findings of this review demonstrate that, in addition to

addressing the challenge of inadequate human resources in mental health, task shifting also fosters cultural competence and community trust, thereby contributing to high participation, engagement, and completion rates. Through the familiarity and relatability of lay counsellors, the approach increases intervention acceptability by communities. In some cases, this is also enhanced by the ability of lay counsellors to incorporate interventions into already existing community or healthcare structures, such as antenatal care, HIV clinics or church programmes, through the cultural relevance and perceived safety of the interventions.

B) Individual vs. group-based therapies in the delivery of community-based interventions

The second discussion point identified in this review is based on determining which delivery method, between individual and group interventions, is more effective and acceptable to survivors. Of the 10 studies, 40% (Bryant, 2017; Dawson, 2016; Patel, 2019; Sapkota, 2020) applied individual-based interventions, 20% (Annan, 2017; Latif, 2021) used group-based therapies, and another 40% (Bass, 2013; Greene, 2019; Knettel, 2019; Sikkema, 2017) used a combination of both individual and group-based therapies.

Bass and colleagues' (2013) RCT was conducted to investigate the effectiveness of group cognitive processing therapy (CPT) in comparison to individual support alone. This study found acceptability to be higher in group therapies than individual. An assessment

of the completion rate of all three assessments indicated a total of 65% of participants in the therapy group and 52% of participants in the individual-support group. Improvements in depression and anxiety were also significantly greater in the therapy group, and these findings were similar to those observed for PTSD and functional impairment. Overall findings of this study indicate that as compared to individual support alone, the combined use of group CPT plus individual support was significantly more effective in reducing symptoms of PTSD, depression, and anxiety in female survivors of SGBV in Congo DRC. The study also found that the benefits were large and were maintained six months after treatment ended (Bass, 2013).

Sikkema (2017) and Knettel (2019) both employed the ImpACT intervention, which is designed to use a combination of individual and group support. In Sikkema's (2017) study, the intervention comprised four 60-minute individual sessions (occurring weekly) and three 90-minute group sessions. The subsequent group sessions aimed to consolidate concepts from the individual sessions and were co-facilitated by an ImpACT lay provider and a community care worker from the study clinic (Sikkema, 2017).

In contrast to Bass's (2013) study, Sikkema et al (2017) found that attendance of the individual sessions was much higher than that of the group sessions. Overall, the attendance of individual sessions had a mean number of 3.10, with 65.6% of participants attending all four sessions, whereas attendance for group sessions was low, with only 25.0% attending any group sessions. It was highly notable that the individual sessions were found to have high feasibility and acceptability, while the group sessions were faced

with significant barriers and challenges in spite of the acceptability of group sessions in the study's formative research. The group sessions were found to be unsuccessful, and this was attributed to transport challenges, scheduling difficulties, and concerns of stigma and privacy (Sikkema, 2017). Similar results were found in Knettel's (2019) study, which showed that in addition to structural barriers, some women reported that privacy concerns made it hard for them to participate in the group sessions.

A few women in Knettel's (2019) study also reported facing challenges discussing their past trauma in group sessions. One woman noted, *"The sessions would irritate me when we talked about my rape; I hated to talk about it even though when I had talked about it, I would feel better. My heart would feel sore. Even talking about my HIV status irritated me because I still beat myself for infecting my child"* (p. 1393). This participant's experience brought to light the challenges that the women faced in contending with various complex stressors, which can be attributed to the decision of some women to not participate in the intervention, and for some to drop out. However, on a positive note, most group participants did report feeling less alone in their experiences after sharing and hearing from others, with some reporting that this was the first time they were ever opening up and disclosing their trauma, as they knew everything discussed was confidential and they would not be judged (Knettel, 2020).

Based on the studies reviewed in this paper, both individual and group therapy have been found to demonstrate effectiveness and acceptability in addressing mental health challenges among female survivors of SGBV in LMICs. However, in situations where

survivors have concerns about stigma, the findings suggest that individual therapy may be more acceptable, while on the other hand, group therapy may be more effective by fostering collective healing and social support among survivors. Incorporating both models, as used in the ImpACT intervention (Sikkema et al., 2017; Knettel et al., 2019), may offer an ideal balance by maximising therapeutic benefits while maintaining participant comfort and engagement.

C) Impact of Women's Privacy and Safety Concerns on Effectiveness and Acceptability of Community-Based Interventions

Finally, privacy and safety concerns were detected among participants in some of the studies reviewed (Greene, 2019; Knettel, 2020; Sikemma, 2017), as has already been implicated in the second discussion point above. This subject is cardinal, given the sensitivity of IPV and how important confidentiality is in ensuring that women's risk of ongoing violence is not increased. Knettel's (2020) study highlighted, in an analysis of the barriers to survivors' participation, concerns pertaining to privacy which made it difficult for women to be participative in group sessions. One participant is quoted explaining that she was *"afraid that I might be seen by a participant who knows me and who might go around discussing my problems"* (p. 1393). In Greene's (2019) study, one participant expressed the safety challenges that an acquaintance had experienced, sharing that she felt that if her husband found out she was participating in the intervention, it would be a problem and would complicate the matter even more (Greene, 2019). Suggestions made

by participants regarding this concern included an improvement in communication and organisation, suggesting that this would improve safety because the women would have advance knowledge of the precise time and date of each session, reducing their chances of being 'caught' by their partners or other people finding out. In contrast to Knettel's (2019) study, the concerns of participants in this study (Green, 2019) were in relation to their partners finding out about their involvement and participation, rather than other community members finding out. It is however important to note that these concerns were raised by low attenders of the intervention, whereas all the high attenders reported a feeling of safety in their participation in the *Nguvu* intervention.

In Dawson's (2016) pilot of PM+, the intervention did not appear to lead to an increased risk to participants' safety. Participants did not report any perceived stigma associated with being involved in the intervention. This may have been attributed to the approach of using a generic screening that did not directly target IPV survivors as the program was offered to all women impaired by psychological distress.

The findings of this review indicate that safety and privacy concerns directly impact both the effectiveness and acceptability of CBIs for female survivors of SGBV. Survivors' fears of stigma, community judgement, or retaliatory abuse from their partners affect enrollment and dropout rates, reducing participants' engagement during sessions. However, in some CBIs such as ImpACT (Sikkema et al., 2017; Knettel et al., 2019) where participants feel their privacy is respected, women have reported feeling safe, heard, and supported, which has been found to foster higher retention. Therefore, interventions that

thoughtfully address safety and confidentiality are not only more acceptable to survivors but also more effective, as they promote sustained engagement and deeper therapeutic outcomes.

2.4.1 Research Implications

From this review, it is clear that the evidence base around the effectiveness and acceptability of CBIs for mental health improvement in survivors of SGBV has grown in recent years. However, the mental health treatment gap remains wide among SGBV survivors in LMIC populations, and this review suggests that only a very limited number of studies have been conducted. Although the database search for this review initially returned over 800 articles, only 10 studies met the inclusion criteria, which were already quite broad. This highlights the dearth of evidence for CBIs for the improvement of mental health in female survivors of SGBV, especially in LMICs, in contrast to high-income countries (HICs) where evidence is more predominantly extant (Hoang, 2013; Sarnquist, 2021; WHO, 2005). This finding, however, is not surprising due to existing barriers such as inadequate trained healthcare providers, the difference in mental health systems in low-resource settings, as well as the diverse cultural and societal barriers in place (Tol et.al., 2019). The lack of research and knowledge in this area is a significant barrier to bridging the mental health treatment gap and enhancing population health and wellbeing (Tyrer & Fazel, 2014; Sabri, 2023).

The findings of this review show that all the studies that applied task shifting to their interventions were successful, supporting existing evidence that lay counsellors can successfully provide psychological interventions effectively if trained and appropriately supervised (Bolton, 2014; Bolton, 2003; Chibanda, 2015; McMullen, 2013). According to the WHO, task shifting, which is a relatively novel concept, was initially developed in response to the lack of adequately trained healthcare personnel in developing countries affected by the HIV pandemic (WHO, 2007). The theory behind the task shifting approach was that by shifting tasks of delivering interventions from highly educated professional health workers to less qualified but sufficiently trained members of the community, more efficient use of human resources can be carried out (WHO, 2007). One prominent advantage of this approach is the low costs associated with its delivery and implementation, and this has made it appealing in low resource settings (Joshi et al., 2014). However, there is still limited evidence of the feasibility and acceptability of the task shifting approach in LMICs, and therefore, this review contributes to the further studies that are needed to build and strengthen this evidence. Future investigation may also seek to highlight the potential long-term cost savings associated with task-shifting, as well as the effectiveness of different training models and supervision structures for task-shifting in CBIs, to provide valuable insight for intervention implementation and scalability.

Future research is also needed to show clear evidence of the acceptability and effectiveness of individual and/or group-based interventions in LMICs. Results from this review indicate mixed findings, with some studies showing more acceptability of

individual-based interventions compared to group-based (Sikkema, 2017; Knettel, 2019), and others reporting opposite findings (Bass, 2013). In this light, it is also vital to recognise the cultural aspects of the communities in which the CBIs are being implemented. For instance, generally, most Western countries are described as individualistic, whilst Asian or African societies are more collective in nature. These cultural differences have an influence on how CBIs are delivered and implemented (Karasz & KcKinley, 2007), as well as their acceptability in specific communities (Ying, 1990). Research has found that very few culturally specific interventions exist, especially in LMICs (Spangaro, 2007). Most CBIs in response to SGBV have been developed and evaluated for dominant culture populations in developed countries such as the United States. This has led to many interventions being used with populations outside of the group for which the intervention was developed and tested, thereby affecting the effectiveness of the intervention (Sundell et al., 2014). The findings of this study indicate that Cultural adaptation is therefore imperative in the delivery of effective interventions to new populations, and should be applied in the development of future interventions.

It is also worth considering that the design of adequate interventions is particularly challenging for communities that lack resources and are characterized by high levels of violence and trauma. The possibility of successful treatment is affected by numerous factors, including economic restrictions and insufficient structural conditions (Havenaar et.al., 2008). In LMIC, one's living conditions will have an effect on their mental health symptoms and therefore hinder their healing process after experiencing trauma (Harvey, 2007). It is thus imperative that contextual factors are taken into consideration

in the development of CBIs, to ensure that healing is made realistically possible within their specific living conditions (Campbell, 2005; De Arellano et.al., 2005). Therefore, future research is needed to understand the factors that contribute to barriers to engagement with such interventions (Kohrt et al., 2018; Burhansstipanov, 1998). Although such CBIs appear both rational and applicable, there is a need for research to be conducted to collate evidence on their effectiveness and to assess what mechanisms influence the ways in which they work, for whom, and under what conditions.

Although the review identified some promising results, three of these studies (Annan, 2017; Dawson, 2016; Sikkema, 2017) reported null findings. Sikkemma's (2017) pilot RCT of the ImpAct intervention reported reduced symptoms of PTSD at a three-month follow-up in comparison to the control group, but a six-month post-intervention follow-up found that the reduction in PTSD symptoms did not differ significantly from that of the control group, indicating that the intervention effects were not sustained long-term. In Annan's (2017) study, reductions in PTSD symptoms were reported, but these reductions had no significant difference in intervention group compared to control group. Dawson's (2016) study also reported reduced PTSD symptoms, and whilst these are not primary outcomes of this review, it is worth mentioning that in comparison with ETAU, no significant effect was observed on measures of functional impairment and general distress. One explanation may be that the concepts that these instruments evaluate, compared to the PTSD Checklist, are too diverse to detect effects in small sample sizes.

Lastly, this review found an existing notable gap in research including male perpetrators in CBIs aimed at improving mental health in female survivors of SGBV in LMICs. Existing evidence suggests that men who are psychologically distressed are likely to abuse alcohol, live in poverty, and perpetrate IPV (Greene, 2017; Spendelow, 2014). Research has found that by addressing men's mental health and the abuse of substances, IPV perpetration may be reduced (Murray, 2020). Although a number of studies (Keyte, 2019; Hossain, 2014) have found some promising results in the evaluation of CBIs focusing on masculinity and gender norms in relation to family violence, this evidence-base is mixed, and it is recommended that more research needs to be conducted in the future in order to have more evidence of successful interventions. Future research in this area may highlight possible interventions and strategies integrating female survivors and male perpetrators in the alleviation of IPV and its resultant mental health effects. There is, however, a need to keep in mind the concern regarding how best interventions for female survivors and those for men can be merged without threatening the women's safety and protection. For instance, as the two groups (female survivors and their perpetrators) need to be kept separate, an intervention can be developed and structured in such a way that the men are supported separately from the women, and the evidence developed from each group is used to inform the intervention of the other.

2.4.2 Practical Implications

Most interventions reviewed (Bryant, 2017; Dawson, 2016; Greene, 2019; Knettel, 2019; Patel, 2019; Sikkema, 2017) support extant evidence that brief interventions can be successfully delivered by supervised non-specialized lay workers following short training. However, a common factor across all the studies was the recommendation for modification and improvement in future versions of the interventions to be more culturally adaptive and sustainable. Studies have found that disparities in cultures (attitudes, beliefs and values) affect how CBIs are delivered, and how they are accepted by communities (Karasz & McKinley, 2007; Ying, 1990). For instance, an article by Doucet and Denov (2012) based on their study in Sierra Leone highlighted the importance of integrating culturally adapted practices into SGBV treatment models. Their study focused on the cultural significance of survivors receiving counsel and guidance from key community members, and found that SGBV survivors were comfortable and confident in receiving support from specific community members who bore high social status such as elders, religious leaders, traditional healers, and social workers. This study also found that the survivors who had received and concluded traditional interventions reported having the most favourable experiences when they received support and counsel from the village elders, and applied self-disclosure, which contributed to the normalisation of their experiences (Doucet and Denov, 2012). It is imperative to understand how people view and experience the world in order to understand the use and effectiveness of specific treatments and services (O'Brien, 2016).

In this review, recommendations included the up scaling of the trials in the future, with a greater intensity and/or duration, and more individual sessions replacing group sessions with additional booster sessions over time (Sikkema, 2017; Knettel, 2019; Greene, 2019). These improvements to the interventions may allow for, among other factors, enhanced skills development and the use of practice and application to new stressors among the women. Knettel (2019) further highlighted recommendations of an addition of six maintenance sessions focused on problem-focused coping and the practical application of the intervention skills (Satterfield, 2008), allowing for individually tailored content for clients, and the availability of support for participants with ongoing traumas possibly occurring during the course of treatment (Knettel, 2019). Additionally, an addition of maintenance sessions may also allow more time for the building of rapport, making it easier for participants to be comfortable with sharing their traumatic experiences to mitigate privacy and safety concerns (Schnyder et al., 2015).

Further highlighted in this review are several key factors that can influence the acceptability of group interventions for survivors of SGBV. These recommendations emphasise the importance of considering factors such as increased communication between intervention staff and participants, scheduling, incentives, session length, activities, and group composition in order to enhance participant retention and engagement (Greene, 2019; Knettel, 2019; Sikkema, 2017). By implementing these suggestions, intervention programs can better meet the needs of participants and improve the overall effectiveness of their treatments and/ or services. Additionally, there was an existing fear of judgment or lack of understanding due to generational differences,

as some women reported having elder relatives as members of their group, which made them uncomfortable to share information about their experiences of violence in their relationships. It was thus suggested that creating groups with similar age demographics could help create a safe and trusting environment for participants to share their experiences without fear of stigma or misunderstanding (Greene, 2019). By prioritising these considerations, CBIs can better support and empower survivors to seek help and heal from their experiences.

Lastly, although not among the top three themes found in this scoping review, it was noted that only one of the studies (Annan, 2017) incorporated the inclusion of survivors' male partners in their intervention. In the two-armed parallel pilot randomized controlled trial, the gender dialogue groups were structured so that the women's partners were also included in them and aimed to address household gender inequalities for the couples (Annan, 2017). The findings revealed a significant reduction in PTSD symptoms in the women and highlighted the social support that participants reported to have gained through the groups, which contributed to an increase in their attendance of meetings. The study further suggests that it may have also fostered increased social support in the household as it involved couples and not only women. Also shown were a decrease in economic abuse, lower use of violence, and improvements in gender dynamics in relationships. According to Doyle et al. (2018), gender transformative interventions that employ male and couple engagement approaches aimed at creating awareness among men and sensitizing them on more impartial norms can have positive outcomes in addressing perpetration of SGBV. A separate report that was also written on Annan's

(2017) study focused on the men alone and highlighted that increased social support among the male participants may have contributed to the positive findings of the study (Falb et al., 2014). It is therefore recommended that future CBIs are designed to promote gender equality and address SGBV by engaging both men and women in dialogue and support groups. By involving both partners in these interventions, not only are women able to receive support, but men are also able to benefit from increased social support and potentially change their behaviours towards their partners.

2.4.3 Strengths and Limitations

The findings of this review should be considered, taking into account several limitations. Firstly, the review was limited to studies carried out in English, thereby making it possible that a significant number of relevant studies exist that were conducted in LMIC countries in other languages and not included in this review. Additionally, the focus of this review was solely on LMICs, but there may have been literature from low resource settings in high-income countries that could have been relevant. Only studies published in peer-reviewed journals were considered, thereby possibly missing potentially relevant studies in non-peer reviewed documents and/or reports. Another limitation is that none of the studies reviewed conducted an analysis on the cost-effectiveness and overall financial aspects of their CBIs. For instance, although some studies suggested that task-shifting interventions may be a cost-effective method of treating psychological distress (Joshi et al., 2014), the evidence to support this is limited. Therefore, as these are studies

that were conducted in LMICs, financial barriers are highly evident in these populations and thus it is imperative to evaluate the nature of these financial barriers' effect on the implementation, feasibility, and sustainability of CBIs. Despite these limitations, this paper successfully contributes to the growing body of literature on the role that CBIs play among female survivors of SGBV in LMICs, a demographic that is often neglected in both practice and literature. It is vital to consider that there exists a significant literature gap pertaining to the acceptability, feasibility, and effectiveness of CBIs in LMICs.

2.5 Conclusion

CBIs can be effective in the improvement of mental health effects of SGBV in female survivors in LMICs. There is, however, an imperative need for the development of culturally adaptive interventions that are tailored specifically for each community. The implementation of existing and established mental health interventions for female survivors of SGBV in LMICs faces challenges such as longevity, increasing the costs of treatment delivery, and demands on participants, who usually are unable to commit to long programs due to economic and personal challenges. This presents the need for brief and effective interventions that do not have high costs. Overall, this review has highlighted that currently, there are limited interventions available for the improvement of mental health in female survivors of SGBV in low-and-middle-income countries. The need for the development of further interventions is therefore evident. However, from the few that were reviewed, it was found that CBIs can improve mental health in SGBV

survivors in LMICs, and future successes can be achieved through the application of innovative and culturally adaptive approaches such as task shifting to tackle challenges of manpower (which also improves cultural acceptability); an incorporation of both individual and group-based treatments; and enhanced communication and safety measures to ensure confidentiality.

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Chapter 3: Paper 2

Trainee Experiences of Community-Informed Trauma Training for Supporting Survivors of Sexual and Gender-Based Violence: An Empirical Paper

3.1 Introduction

Despite increasing evidence of the high prevalence of Sexual and Gender-based Violence (SGBV) cases in Zambia's poor communities and the trauma associated with SGBV among survivors, most initiatives that seek to achieve gender equality and prevent SGBV remain small-scale and short-term. Statistics from the Victim Support Unit (VSU) of the Zambia Police (2025) indicate that a total of 42,178 SGBV cases were reported in Zambia in 2024, with the gender breakdown of victims showing that 32,904 females (78%) and 9,274 males (22%) were impacted (Zambia Gender Division, 2025). These statistics show that Zambia has the highest incidences of SGBV against women in the Southern African Development Community (SADC) region (89%), despite having a law to reduce the incidence of this phenomenon.

By definition, SGBV is any harm inflicted against one's will on the basis of socially assigned differences between males and females (United Nations High Commissioner for Refugees [UNHCR], 2011). This includes acts that are physical, sexual, or mental, including threats of committing such acts and can occur publicly

or privately. Globally, violence against women and girls is one of the most common violations of human rights, and it has no regard for social, economic, or national parameters (United Nations Fund for Population Activities [UNFPA] 2014). This is in combination with a high level of societal tolerance of domestic violence (USAID, 2015). While there is some level of awareness about the support that is available for SGBV survivors, this is quite low, and the existing services are not comprehensive or systematic in nature

In Zambia, mental illness affects a broad spectrum of the population including children, adolescents, and youth (Mwape, et al., 2012). Most people often do not have adequate access to health services in general, and significantly, mental health services dedicated to SGBV victims are lacking. Further, on some occasions, the mental health services provided have proved unsustainable (Kusantham et al., 2016). The situation is made worse by the barriers Zambian SGBV survivors face when needing mental health support. Particularly in poor urban communities, one of the leading challenges is lack of access to mental health treatment as there are not enough organizations supplementing government efforts regarding mental health awareness and treatment (Kusantham et al., 2016). As a consequence, the psychological well-being of victims is often overlooked and has received less scholarly attention, and the situation of gender inequality appears to be pervasive. Receiving support appears to be essential not only to reduce the traumatic sequelae and the effects on mental health linked to SGBV, but also to reduce the situation of

discrimination and powerlessness many Zambian women face as a result of the combination of violence and systemic inequality.

3.1.1 Support for SGBV Survivors in Zambia

Due to the lack of 'formal support' from institutions and local organisations, most SGBV survivors in Zambia seek support from community representatives, such as traditional and religious leaders to receive help regarding prevention of abuse and coping with abuse-related mental health symptoms. In most local Zambian cultural settings, women often seek help from wives of religious leaders, in whom they confide. This is the case in Lusaka's Misisi compound, where wives of pastors (locally called *Amai Busa*) are usually approached by female survivors of SGBV in the community seeking counselling and support (PsycHealth Zambia, 2017). The World Health Organization (WHO) has recognized that most SGBV survivors living in low resource communities seek support from their local religious or traditional leaders, and this is especially the case in traditional African societies (WHO, 2001). However, often, the said leaders lack formal training and information on SGBV-related trauma and mental health. There is need to find ways to collaborate with such community leaders and adapt services to the African socioeconomic setting, and this has been emphasized for decades, dating as far back as 1961 at the First Pan African Psychiatric Conference in Nigeria (Lambo, 1961). The WHO supports the use of this approach in both developed and developing countries (WHO, 2020).

Nonetheless, very few studies (Freccero, 2011; Mirghani et al., 2017) have explored the influence and possible benefits of accessing community-based support for SGBV victims. In Zambia, at present, there is no formal training available to members of the community SGBV victims often seek support from, even though this support could represent valuable help for women and girls to end the abuse to which they are exposed. This is particularly the case for victims residing in poorer Zambian communities (locally called 'compounds'), who face significant barriers in accessing 'formal' channels of support for instance, from local and/or international organizations (EU, 2017). Among these compounds, Misisi appears to be deeply affected by SGBV and the related mental health issues described above. Misisi has an estimated population of 80,000, with the majority being women and girls. A recent study conducted by Strong Minds Zambia (2019) identified that out of a total of 1500 women that were screened for depression, 645 (43%) were found to be depressed, and 135 (9%) were suicidal. Misisi has no clinic, and no mental health facility to treat these issues. Two non-governmental organisations, PsycHealth Zambia (PHZ) and Strong Minds Zambia (SMZ), have tried to supplement government efforts to bridge this gap by providing free psychotherapy services in the community (PHZ, 2016; SMZ, 2017). However, for this to be effective, research must play a part, as it is imperative for such support to be guided by evidence. Recognising this gap, this study was developed as the PI became more aware of her own positionality—not only as a researcher with academic training, but also as someone who understood the community and its realities. This enabled the PI to

contribute a perspective grounded in both professional knowledge and community-rooted understanding.

3.1.2 Researcher Positionality and Motivation

The origin of this study is firmly rooted in my personal and professional journey of working in Misisi, a community largely affected by SGBV. It is essential to note that this thesis represents the latter stages of this journey, which in its entirety is much longer. Much of the groundwork, which involved engaging with the community, building relationships, and understanding the context, was undertaken well before the formal start of this doctoral work. The research presented in this thesis is the product of that foundation. In the same vein, most of the reflections I share in this section on my positionality stem from experiences before the PhD but have profoundly shaped how I have approached this research.

Having provided free outreach and psychotherapy services to women in the Misisi community for five years prior to the onset of this project, I identified critical gaps in the availability of mental health support for SGBV survivors. As a trained psychologist, cognitive-behavioural therapist and researcher, I initially began this project with a technical mindset, focused on the need to simply identify an existing intervention and apply it to this community. However, the more I became involved in the community, the more these assumptions began to be challenged. Through my

first-hand involvement and the relationships I formed with local community leaders, I became aware of the crucial need to develop a manualised CBI that could provide structured, evidence-based and transferable support for survivors. Importantly, this would be an intervention that would be culturally tailored explicitly for the Misisi community and relevant to ensure that it genuinely serves the needs of the women I aimed to support.

Consequently, the most significant turning point in my study's development was my collaboration with the Amai Busas, as their wisdom, influence and guidance proved invaluable. Gaining their trust, which was not initially planned, but rather occurred genuinely and naturally, was fostered by my respect, patience, humility, and willingness to learn from them as opposed to imposing my preconceived ideas. These discussions significantly shaped and laid the foundation for my research priorities, emphasising the crucial need for the Amai Busas' involvement in developing and delivering an intervention.

This collaborative process revealed that empowering trusted community members such as the Amai Busas to support survivors would be significantly more effective and sustainable than depending solely on external specialists. This insight prompted me to adopt a task-shifting approach within the study design, acknowledging the crucial contribution that trained non-specialists can make to addressing the mental health needs of survivors. By definition, task-shifting is the delegation or transfer of tasks from trained and specialised health professionals to paraprofessionals or

people with less qualifications in order to expand the coverage of service provision (Lewin, 2005). LHWs are individuals who complete such tasks related to healthcare delivery and they often have no formal tertiary education with certificates or degrees, but will have received some level of training in the context of the intervention (WHO, 2007). For my study, task shifting would meet the community's need for familiar, culturally relevant sources of support and enhance local capacity, thereby ensuring that the intervention remains relevant and sustainable in the long run. Ultimately, I worked with the Amai Busas to co-develop a training model that would not only equip them with the required skills and knowledge to support survivors of trauma in their community, but also honour the community's existing culture and knowledge.

The study reported in this paper forms part of a larger program of research into the feasibility, acceptability, and preliminary effectiveness of a community-based intervention (CBI) designed to tackle domestic violence and improve mental health in young underprivileged women in Misisi. The present study aims to contribute to the breadth of knowledge on SGBV in Zambia by developing a novel CBI to provide mental health support for SGBV victims/survivors in deprived environments. In the study, community-informed, trauma-focused training is designed and later delivered to representatives of the Misisi community (Amai Busas) to whom women often go to find support against SGBV in the second phase of the study to follow. Feedback is then obtained from the Amai Busas on the training, which can be used to revise or integrate the training content (if needed) in the future. The principal aim is to equip

influential community members (Amai Busas), through the training designed specifically for them, with skills and knowledge on trauma and mental health to enable them to provide mental health support to survivors of SGBV in Misisi. The study also aims to shed some light on the mental health issues that may be experienced by SGBV survivors, thus contributing to addressing the existing gap in research on mental health and its effects conducted in Misisi (Mayeya et al., 2004).

3.1.3 Task Shifting for the delivery of psychological interventions in LMICs

Globally, experts suggest that task-shifting strengthens and expands the workforce in the healthcare sector, and this can contribute to an increase in access to services (Selke, 2010). Various studies have found evidence to show that task-shifting is effective in the delivery of psychological interventions for numerous mental illnesses (Petersen, 2012; Van, 2013). A Cochrane review looking into the effect of LHW on people with psychological conditions found that between two and six months after treatment, interventions delivered by LHWs may enhance recovery in adults with depression and anxiety, compared to the control groups. (Chowdhary, 2014).

Numerous studies have used the task shifting approach to deliver mental health interventions in LMICs (Cooper, 2009; Rahman, 2008; Singla, 2014), and this has been done as a solution to the shortage of adequately trained mental health workers. These studies have engaged different levels of LHWs, ranging from nurses – who are paraprofessionals already working in the health sector, to lay volunteers from within

the community who usually have minimal formal education. Findings from such studies have shown that generally, participants prefer to have support delivered by LHWs as opposed to professional formal service providers, as they are more accessible (Mueller, 2010) and relatable (McClay, 2013). Formal mental health services are largely avoided due to the stigma attached to them.

3.2 Methods

3.2.1 Epistemological and Ontological Position

The epistemological position adopted for this study draws from the principles of constructivism. Constructivism is a theory of knowledge that argues that the generation of knowledge and meaning stems from an interaction between humans' experiences and their ideas (Mogashoa, 2014). Specifically relevant to this study is the social aspect of the theory, which, according to Kim (2006), emphasizes the importance of culture and context in understanding what occurs in society and constructing knowledge based on this understanding. This theoretical approach is suitable for this study as we aim to understand the personal experiences and views of the Amai Busas as representatives of the Misisi community, and their interpretations of reality at a subjective, community, and socio-cultural level. Further insight is provided by the Principal Investigator (PI) drawing from her network and prior experience as a community mental health worker and CBT specialist in Misisi.

3.2.2 Research Design and Procedure

A convergent mixed-methods design was employed in this study, based on the assumption that qualitative and quantitative data provide different types of information, and when combined, the two should yield the same results (Creswell, 2018). The research procedure was carried out in four phases. A similar framework is applied by Jennings (2018), who breaks down Patient and Public (PPI) involvement into three levels: "Low-level involvement, consisting of researchers asking for views which are then used to inform research decision making; Medium-level involvement, focusing on equity within the relationship between the researcher and the PPI participant, and comprising an ongoing partnership with shared decision making; and High-level involvement, which consists of people with experience of the health issue being researched having the dominant voice, delivering and managing research themselves" (Jennings, 2018, p. 2). For this study, low and middle level involvement are adopted during the PPI and TF-CBT training phases respectively, with high-level involvement applied in the final part of the larger study to follow. This framework was chosen for this study because it is an empirical, understandable, and measurable approach (Slade, 2014), which can be associated to mental health domains such as shared decision making and experience of care (Clark, 2015; Slade, 2019) and is extensively applied in health research.

Phase 1: Patient and Public Involvement (PPI) Exercise

Using audio-recorded semi-structured interviews, this study began with a PPI consultation with two community key informants who hold a pivotal role in helping SGBV survivors in Misisi. These are wives of religious leaders, locally called '*Amai Busa'*, to whom survivors of SGBV often go to seek help, with the aim of acquiring an informed understanding of the specific needs of the community regarding mental health intervention for survivors of SGBV. This consultation also explored the extent and forms of SGBV in the Misisi community. Subsequently, drawing from the data that was collected from the PPI exercise and an in-depth review of current evidence on SGBV interventions, a TF-CBT training was designed and would later be delivered to six Amai Busas in the second phase of the study to follow.

Phase 2: TF-CBT Training Delivery

A novel CBI was developed, taking into account the data collected in the PPI with the Amai Busas. This comprised a psychoeducation and Trauma-informed Cognitive Behavioural Therapy (TF-CBT) training being delivered to a group of six Amai Busas, which then allowed the Amai Busas to later hold regular group meetings in which psychoeducation and TF- CBT would be used to support female domestic violence survivors. These meetings were to be held in local churches and described as 'getting together' groups (with no reference to domestic violence or SGBV) to protect the participants.

Development of the training material was informed by information gained from the PPI consultation, and existing literature on SGBV and survivors' mental health needs.

Phase 3: Training Evaluation

Following the training's completion, an evaluation (in terms of useability and feasibility of the training protocol and contents) was performed using a set of video-recorded focus groups attended by the Amai Busas. The key points emerging from this stage were then used to inform the co-development of a community intervention model that was, in later stages of the study, to be piloted on 30 female survivors of SGBV from the Misisi community. The findings deriving from the transcripts obtained from the audio-recorded focus groups were analysed qualitatively, using thematic analysis (TA) methods following the steps suggested by Braun & Clarke (2022).

Phase 4: Post-training Assessment

A focus group discussion was held with the six Amai Busas after the training. Additionally, a post-training questionnaire developed by the PI for this study was administered in the form of a Qualtrics survey containing open-ended questions and a self-rating scale. These questions were aimed at exploring the Amai Busa's perceptions and views of the training, and their confidence in supporting SGBV Qualtrics survey link was sent out to the Amai

Busas via email. They were then invited to complete the survey at the end of the training (within one week after attending the last session).

3.2.2.1 Setting

This study was carried out in Misisi Compound, a poor urban community in Lusaka, Zambia. This particular community was selected because of the predominant evidence of inadequate access to mental healthcare services (Mayeya et.al, 2004), and because of the PI's encounter of many SGBV cases during her voluntary work as a community mental health worker in Misisi. The training was delivered at the Glory Baptist Church in Misisi, which was selected due to its central location, making it easily accessible for both participants and researchers. This was followed by the training evaluation, which comprised a focus group attended by the Amai Busas at the same location. Lastly, the post-training questionnaire containing open-ended questions was administered by the research assistant via Qualtrics to explore the Amai Busa's perceptions and views of the training, and their confidence in supporting domestic violence survivors using the TF-CBT approach. English was used as the language of instruction, as all six participants are fluent speakers of the language.

3.2.2.2 Participants

Using purposive sampling, two Amai Busas were recruited for the PPI stage (Phase 1) of this study, and for the training stage (Phase 2), four more Amai Busas were recruited in

addition to the previous two using snowball sampling. Collectively, the six Amai Busas were aged between 31 and 44 years old (see Participant Recruitment). This sample size was deemed sufficient to capture the Amai Busa's perspectives and insights on SGBV in Misisi and to enable the co-production of the intervention for survivors. Similar interventions have been conducted in African countries with small groups of community representatives, including 'The Friendship Bench' in Zimbabwe, where 10 female lay health workers were trained in CBT (Chibanda et al, 2007).

Of the six women recruited, three were unemployed, two were self-employed, and one was in formal employment. In accordance with the Zambian educational system comprising of primary school from years 1 to 7 (normally ages 6 to 12), and secondary school from years 8 to 12 (normally ages 13 to 17), one participant had completed her year 12 secondary education, one dropped out in year 11, one in year 9, another in year 8, and another in year 7. One participant had recently decided to go back to school as an adult and was currently enrolled as a year 7 pupil. Of the six participants, four had no prior training in any field, whilst two participants had received some brief training in basic counselling skills before.

Inclusion criteria for participants comprised women above the age of 18 who were wives of religious leaders in Misisi and were literate in the English language. Exclusion criteria included women who were unwilling to provide informed consent to participation, and women who would find it uncomfortable to discuss abuse with other women and/or in a group setting.

3.2.2.3 Participant Recruitment

Drawing from the PI's network in Misisi, participants for the training were identified and mobilized with the assistance of two Amai Busas who participated as community key informants in the PPI consultation and expressed interest in participating in the forthcoming TI-CBT training. The two Amai Busas already identified were asked to recruit further Amai Busas who could take part in the TF-CBT training. The Amai Busas were then asked to informally discuss the possibility of attending the training with other Amai Busas who might be interested and willing to take part in it. They were able to do so using their informal networks and the Pastors' Wives Association of Zambia, an organisation with which they were both affiliated. Moreover, the local research assistant (who had previously collaborated with the PI in a professional capacity) announced the study by informing the Amai Busas in local churches of the possibility to take part in the upcoming training sessions. Both the Amai Busas who took part in the PPI stage and the ones who were later recruited, as described above, were informed that attendance at the training was entirely voluntary and there was no obligation or pressure to participate.

3.2.2.4 Ethical Considerations

Ethical approval to carry out the study was obtained from Manchester Metropolitan University (Ethos ID: 45296), and from the Humanities and Social Sciences Research Ethics Committee in Zambia (Ref: HSSREC:2024-FEB-O54). Written informed consent was

obtained from all participants with participants being reimbursed for their transportation and lunch costs in accordance with local regulatory research and ethics bodies.

This study was considered as bearing low risk for participants, as initially, these were key informants (Amai Busa) and not considered SBGV victims. Nevertheless, in the event that they may have had past direct experiences of SBGV and/or that they may have found participation in the study distressing, a risk management plan was put in place based on the MMU distress protocol for qualitative data collection (Haigh & Witham, 2015). Throughout the study, participants were free to withdraw from any study-related activity at any point if they started to experience psychological distress. Additionally, participants who were to be found to need additional counselling would be referred to PsycHealth Zambia, an organisation with which the PI is affiliated as co-founder and psychologist. A psychologist from PsycHealth would be readily available to provide psychological first aid at no charge. Participants were also informed that the PI (a qualified Cognitive Behavioural Therapist) would be on hand to provide Psychological First Aid virtually in case of emergency, and referrals where needed.

One such incident is reported in this study. Of the six participants, one expressed the need for support during the last training session. This Amai Busa shared that she was experiencing SGBV from her husband, with the most recent episode occurring the previous night. Following this disclosure, the participant was immediately assigned a psychologist, and arrangements were made for her to begin receiving the support she needed as per the MMU distress protocol. The participant was reminded that she was

free to withdraw from the research at any time if needed, to which she confirmed her strong desire to continue, as she felt the skills she acquired from the training were helping her to deal with her challenges, and she also saw it as an opportunity for her to help other women in situations similar to hers. In addition to her therapy sessions with the assigned psychologist, the participant also continued to receive additional support from the PI who had bi-weekly virtual sessions with her. A similar case was reported in Jorm's (2004) study, where lay counsellors who participated in a brief counselling course reported improvements in their own mental health as a result of the training, even though they were not recruited based on mental health issues and no therapeutic benefits were promised to them.

3.2.3 The Role of PPI in Training Design and Content Development

The PI started working on designing a trauma-focused CBI for female survivors of SGBV in Misisi in 2022, a year into the start of this PhD. Although the importance of a strong collaboration with the community for the effectiveness and success of the intervention was understood, the PI genuinely had not anticipated how much her engagement with two Amai Busas would significantly influence and shape the intervention.

As previously mentioned, the Amai Busas are highly respected in the Misisi community. Though not formally trained as mental health professionals, they are trusted and regarded as reliable, primary sources of support for women in the community, including

survivors of SGBV. Therefore, a PPI consultation was carried out to gain an in-depth understanding of the mental health needs of SGBV survivors in Misisi, as well as the social and cultural dynamics that shape how trauma from SGBV is understood and addressed. The PPI consultation was also used to explore the forms and extent of SGBV in the community.

The PI was greatly amazed by the depth of the Amai Busas' knowledge, especially their understanding of trauma, resilience, and healing within their cultural context. In response, she began to revise the intervention that she had initially designed, which was originally intended to be delivered by herself with the support of other qualified therapists who were to be trained using a TF-CBT training she had designed. The goal was to culturally tailor the intervention to align with Misisi's culture, a process that began with the revision of the TF-CBT training content, which was adapted to include culturally relevant examples, materials translated into Chinyanja - a local language, and most significantly, training the Amai Busas themselves as lay facilitators in the next phase of the study. Their involvement was not a gesture of inclusion, but a recognition of their rightful role as central figures in supporting survivors in their community.

Grounded in the findings of the PPI, the cultural adaptation of the TF-CBT training was shaped in the following specific ways:

I. **Understanding Community-Specific Experiences of SGBV and Trauma**

The Amai Busas provided insights on the common types of SGBV in Misisi and the emotional and social challenges survivors consequently encounter. These insights also highlighted culturally specific expressions and descriptions of trauma, such as the attribution of flashbacks and bad dreams to spiritual/supernatural attacks, constant fear of when the next attack may occur, and somatic complaints – which, in the African context, is usually used to describe emotional distress due to the lack of psychological terminology in local languages.

II. Adaptation of Language

Based on the Amai Busas' feedback, the TF-CBT training manual and materials were adapted to include culturally relevant role plays and scenarios, and locally understood terms, replacing technical psychological terminology with accessible, everyday language with which survivors and community members could relate.

III. **Addressing Barriers to Community Engagement**

Barriers to community engagement such as fear of stigma, distrust of formal services, and concerns about confidentiality, were identified. In response, the training manual was revised to include a full module on participant recruitment, emphasising confidentiality practices to reassure survivors about trust and privacy. Additionally, meetings with Amai Busas were generally always known for their discreet nature. This aspect was also adapted to the TF-CBT intervention by

disguising the survivor meetings as regular church programs, thereby enhancing confidentiality and addressing the fear of stigma.

IV. **Incorporation of Storytelling**

To enhance understanding of foreign psychological concepts, such as trauma, storytelling was employed, incorporating some faith-based references. This was based on the idea that storytelling allows theory and science to become comprehensible and meaningful for general audiences (Krzywinski, 2013). In this study, storytelling was able to bridge the gap between the researchers as trainers and the Amai Busas as trainees by fostering a shared understanding of experiences.

V. **Adjusting the Delivery Method**

The most significant revision made to this intervention was the decision to train the Amai Busas themselves as lay facilitators in the final phase of the study – a delivery method that aligned with the community's culture and communication style, and rightfully recognised the Amai Busas as key sources of support for survivors in Misisi. The delivery method was further modified by including discussion-based approaches of TF-CBT into the training, rather than solely relying on strict, therapist-led sessions. This change was based on the strong suggestion from the Amai Busas that a flexible and friendly environment promoting communal support would help the women feel more comfortable, trust their peers, open up, and share their stories.

3.2.4 Training Content

The training comprised eight core modules conducted over five training days (30 hours in total) within a one-week period from 4th to 8th December 2023. Each day's training lasted six hours, with the morning session running from 9AM to 12AM, and the afternoon session from 1PM to 4PM. Once the Amai Busas had begun running the support groups, a programme of ongoing peer support and supervision (facilitated by the PI) was established to consolidate the core training, identify areas for further development, and to facilitate learning and the development of competence. This study investigated the impact of the eight core modules undertaken by trainees prior to engaging in support group facilitation. The key elements of the modules are outlined in Table 3 below.

Table 3: TF-CBT Training Module Contents

Module Number & Title	Description
1: Basic Skills in Counselling	The first module re-introduced participants to basic skills in counselling. As the Amai Busas were already involved in providing informal counselling in the community, this module also sought to review the participants' experience with basic helping counselling.
2: Introduction to Cognitive Behavioural Therapy (CBT)	This module introduced participants to CBT and the basic concepts it is based on. Participants were taught how to apply CBT to their counselling with the aid of stories/scenarios and group tasks.

3: Trauma and PTSD Psychoeducation	The third module introduced trauma and PTSD. Participants learnt how to identify the different signs of trauma, and how to help a traumatised person through counselling. This module also introduced the trauma-sensitive approach in counselling.
4: Trauma Focused Cognitive Behavioural Therapy (TF-CBT)	In Module 4, TF-CBT was introduced to participants, with a practical focus on the four phases of the therapeutic process. This was followed by a look at the various types of issues that can be treated with TF-CBT, and the limitations of TF-CBT.
5: Assessment and Screening Tools for TF-CBT	Module 5 presented an introduction to the various assessments and screening tools for TF-CBT. Participants practiced the administration of assessments, scoring, and interpretation of scores.
6: Understanding Sexual and Gender-based Violence (SGBV)	This module provided trainees with an understanding of what SGBV is, delving into the different forms of SGBV, the common causes, and its effects on survivors. The final part of this module focused on understanding child abuse.
7: Self-care and Stress Management for Mental Healthcare Providers	This module introduced trainees to stress, burnout, and the importance of self-care and stress management as mental healthcare providers. Trainees were guided on the different ways in which one can practice self-care and prevent burnout.
8: Participant Recruitment Skills	The final module aimed to introduce trainees to the recruitment of participants in research. Trainees were taught how to identify potential participants for a sensitive study, how to carry our recruitment safely and ethically, and how to obtain informed consent.

3.2.5 Data Analysis

Data analysis for this study was conducted qualitatively and quantitatively. The qualitative data was analysed thematically, using Braun and Clark's (2022) steps comprising: 1)

Familiarisation – during which initial findings of the study were reviewed; 2) Coding – which involved the setting out of common themes within the study and labelling them using highlighted colour coding; 3) Theme Construction – where labelled codes were combined into broader themes covering a wide range of recurring statements and opinions; 4) Reviewing of themes – and categorizing the findings; 5) Defining themes - This stage involved reviewing the category and theme names for clarity and accuracy; and 6) Writing a thematic analysis – providing a written summary explaining the procedures of data collection, methodology, and conclusions made.

Lincoln and Guba's (1986) 'Four Dimension Criteria' was applied to attain trustworthiness. According to Attride-Stirling (2001), in order to yield results that are meaningful and useful, it is essential that qualitative research is conducted methodically and with rigor. Morse et al. (2002) argue that without rigor, research loses its utility. Trustworthiness is equally imperative in qualitative research, and without it, research may have harmful consequences (Tierney & Clemens, 2010). Lincoln and Guba (1986) suggest that trustworthiness is crucial in the evaluation of a study's worth. They propose that by using the 'Four Dimensions Criteria', trustworthiness can be attained. These criteria comprise establishing credibility (confidence that the findings are true), transferability (demonstrating that the findings can be applied in other contexts), dependability (demonstrating the consistency of the findings and that they can be repeated), and confirmability (the degree to which respondents and researcher bias, motivation, or interest shape a study's findings).

The qualitative data collected in this study comprised data collected from the PPI consultation held before the training, and that collected from an audio-recorded focus group discussion attended by the Amai Busas after completion of the training. Thematic analysis was applied to the PPI data to derive themes from the Amai Busas' experiences as community key informants. Similarly, data from the focus group was analysed thematically to gather the main themes emerging from the Amai Busas' perceptions and views of the training.

The quantitative data comprised data collected from a pre/post-training questionnaire (administered via Qualtrics [Provo, UT]) containing a self-rating scale, which was used to assess any changes in participants' skills, knowledge, and confidence in supporting SGBV survivors using the TF-CBT approach. Data for this stage was analysed quantitatively.

A convergent mixed methods design was used (Creswell, 2018). This approach is based upon the assumption that both qualitative and quantitative data come up with different types of information, with qualitative data usually providing participants' detailed views and experiences, and quantitative data giving participants' scores on measures or tools. When combined, the two should yield the same results (Creswell, 2018). In this study, the qualitative and quantitative data were collected separately, with the qualitative data being collected at two time points - during the PPI stage, and during a post-training FGD. The quantitative data was equally collected at two time points - during the pre- and post-training assessment stages. The two sets of data (qualitative and quantitative) were

analysed separately, with the findings later being integrated as they complement one another. The qualitative data is the main focus, with the quantitative data supporting it.

3.3 Findings and Discussion

In accordance with the set research objectives, the data collected from this study is divided into three main parts. These are presented in Figure 2 below. Part 1 presents data collected from the PPI, comprising 'Community key Information and Insight on SGBV in Misisi'. Three themes were identified in part 1, and these included: 'Relationship between SGBV and poverty', 'cultural factors contributing to SGBV', and 'Unreported SGBV Cases —Barriers to seeking support and services for survivors in Misisi'. This data later informed the development of the training and the intervention in Study 3.

Part 2 presents data collected from the FGD held after the training, reporting the 'Effectiveness and Impact of the Training', with the following three themes identified: 'Personal Impact of Training on Amai Busas', 'Relevance and Applicability of Training Content', and 'Recommendations to Improve the Training'.

The final part of the study presents findings from the Training Evaluation – comprising the results of a pre- and post-training assessment.

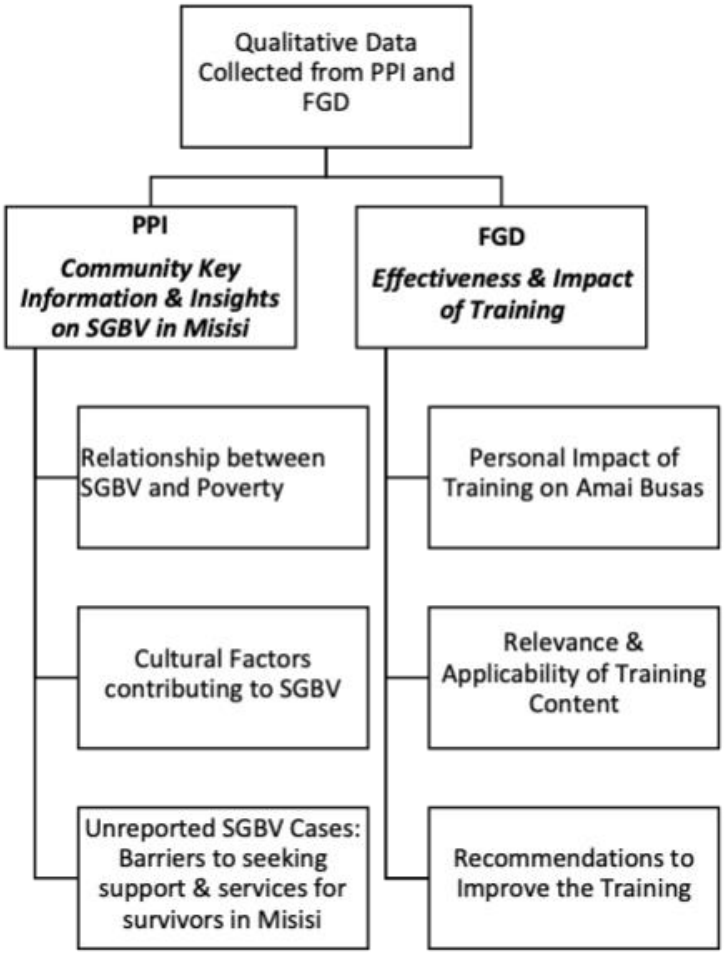

Figure 2: Emergent Themes and Subthemes from PPI Consultation and Post-training FGD

3.3.1 Findings from the Patient and Public Involvement (PPI) - Community

Key Information and Insights on SGBV in Misisi

Data collected at this stage presents an informed understanding of the specific needs of the Misisi community regarding mental health intervention for survivors of SGBV from the Amai Busas' points of view. The study sought to examine the Amai Busas' opinions on what they observed were the extent and most common forms of SGBV in their community. Generally, the results indicate that SGBV cases are high in Misisi, with the most common types being physical abuse, sexual abuse, early marriages, and child defilement. These findings are consistent with numerous studies that have investigated the prevalence of various forms of SGBV in Zambia (Phiri, 2023; Chanda, 2023). Various causes of SGBV in the community were reported, with the common ones being poverty/hunger in the home, lack of trust in one's partner, and alcohol abuse by both the men and the women.

A) ***Relationship between poverty and SGBV***

Poverty was found to have a strong link to SGBV in the Misisi community, as it was reported as one of the main catalysts of SGBV. Amai Busas shared:

"People are suffering in this komboni (community). For example, you find there is no money in the home, and this brings about stress, confusion and disagreement between husband and wife." [AB1]

"I don't know if it's (the violence) because they feel guilty because they can't provide. Or they are ashamed. But it's not good that they take out those frustrations on their wives." [AB2]

These participants highlighted that it was very common to find households in Misisi that could barely afford basic meals and necessities, bringing about conflict in the home. These findings are in line with global studies that have recognised that women are frequent victims of SGBV in contexts where there is anger and frustration over the lack of income, food and employment that leads to marital violence (Oduro, 2012).

The risk of conflict in the home is even higher when alcohol is involved. The findings from this study indicate a high presence of alcohol abuse in Misisi, and this is attributed largely to poverty. According to the Amai Busas, many men are unemployed and therefore unable to provide for their families:

"This issue of alcohol is a very big problem in Misisi. Something needs to be done. People here drink too much because they have no jobs, and they have too many problems. So they drink. But it's a big problem because when they drink, they go home and beat their wives." [AB2]

From this quote, the study suggests that there is a link between socio-economic challenges and alcohol and abusive behaviours, which is in line with many previous studies (Bryden, 2013; Collins, 2016; World Bank, 2022). Stress resulting from socio-economic challenges leads to the abuse of alcohol and other substances, which then

enhances men's abusive behaviour towards their spouse or partner. Research suggests that Zambia is among the nations with the highest levels of drinking alcohol in Africa (Kabuba et al., 2011). However, the problem of alcohol abuse exists among women also, thereby increasing the risk of conflict in the home especially if both partners are intoxicated. One Amai Busa shared:

"It's not only the men. Even the women drink too much. Some of them even more than men." [AB2)

This highlights that both men and women abuse alcohol in Misisi, supporting reports by the World Health Organisation (WHO) that have shown that Zambian women are among the heaviest drinkers in the world (WHO, 2014; 2018). A strong link has been found between alcoholism among women and the rise of SGBV cases in Zambia. This link has been cited by some studies (Likashi, 2019; Ngonga, 2016), who have asserted that high alcohol consumption among Zambian women increases their risk of being exposed to SGBV.

*B) **Cultural factors contributing to SGBV***

A second theme identified from the Amai Busas' consultation concerned cultural and societal norms related to SGBV, with subthemes of gender roles and religious beliefs. In Zambian societies, like in many African societies, cultural norms and beliefs have a significant relationship with SGBV, specifically through shaping attitudes towards gender

roles, power dynamics, and violence (Chanda, 2023). SGBV continues to persist because of ingrained cultural beliefs that fuel harmful norms and attitudes. Rigid gender roles and expectations which associate masculinity with aggression, control, and dominance – and femininity with obedience and submission – are significant contributors (Lewis, 2013). According to the Amai Busas, SGBV in marriages is largely attributed to such traditions as that of bride price (locally called '*lobola*') – a practice where the groom and/or his family make a payment to the bride's family. One Amai Busa shared:

"In fact, most women are even afraid to tell their own relatives that they are being abused, because they will just send them back saying, 'you belong to him now'." [AB1]

Another participant shared:

"You know because traditionally, when they have paid bride price, it is your duty as a wife to serve your husband." [AB2]

These quotes allude to the cultural expectation of a woman to take care of her husband and his family members. Scholars (Nichter & Goldman, 2019) argue that this practice has significant influence on gender roles, power dynamics, and attitudes towards violence in communities, as it symbolizes the transfer of ownership from the bride's family to that of the groom. This practice reinforces patriarchal structures where women are perceived as belonging to their husbands, thereby enhancing power imbalances in marriages, and ultimately contributing to instances of SGBV (Chanda, 2023; Nichter & Goldman, 2019).

Similarly, the Amai Busas highlighted that another common cultural practice that contributes to the list of risk factors of SGBV, is that of early/child marriage. Participants shared that child marriages are common in Misisi, coupled with underage pregnancies:

"A lot of girls get married too young because they get pregnant and their parents chase them away. You see, because in our culture, that's what they do. If a girl gets pregnant out of wedlock, it is the man's responsibility to take care of her and the baby. Not her parents. So, these girls drop out of school and are forced to go and live with the man who impregnated them." [AB2]

According to Phiri (2023), early marriage denies girls their right to an education, which in turn denies them economic independence, thereby making them vulnerable to different forms of abuse in marriage. Evidence from this and other studies (Canning, 2012; Cislaghi, 2020; Chanda, 2023; Raj, 2009) suggests that young girls who are forced into early marriage are at a higher risk of experiencing additional forms of SGBV (as child marriage is a form of SGBV) than those who are not.

Another significant cultural concept that came up was that of religion. According to the Amai Busas, some religious teachings are used to justify SGBV in marriages. The most dominant religion in Zambia is Christianity, and research suggests that some Bible teachings such as those on submission may be manipulated and used to justify gender inequality and control over women (Pertek & Le Roux, 2022). For instance, one Amai Busa commented:

"Most of us women suffer in silence, because we are taught by the church to submit to our husbands. That's why they don't do anything or report to anyone when they are abused. Because they think it's wrong to go against their husbands." [AB1]

"It's true. In fact, a lot of men even use this teaching as an excuse to control their wives." [AB2]

This shows that there exists a misunderstanding of the scripture by society, which may stem from the various ways in which it is taught, or the version of the Bible being used. Subsequently, this has led to a culture of acceptance of abuse. Studies have found that religious beliefs and practices also play an influential role in fueling gender-based violence (Carlson, 2005), and Zambian societies are not an exception (Chanda, 2023), particularly through the use of patriarchal religious interpretations to justify domestic abuse. Ghafournia (2017) argues that these patriarchal interpretations can lead survivors to isolation, self-blame, emotional abuse, coercion, intimidation and fear. According to Bates (2004), marriage-related norms and practices reinforce women's relative powerlessness, often exposing them to domestic violence.

C) *Unreported SGBV Cases: Barriers to seeking support and services for survivors in Misisi*

According to the Amai Busas, most SGBV cases in Misisi go unreported. Globally, many SGBV cases remain unreported, and this creates a challenge in establishing the actual

magnitude of SGBV (Chanda, 2023). Several issues came up on this subject in this study, with numerous barriers to seeking support being reported. Overall, survivors of SGBV in Misisi are hesitant to report and seek support, and this is largely due to various reasons, with the most common one being the financial dependence of women on their partners, who in most cases are their abusers. One of the Amai Busas commented:

"The women here, they say, if I report him and he gets arrested, who will look after us? How will I support my children? I have no job or money. I have no one else to help me." [AB2]

It can be construed, therefore, that when a victim of SGBV is unable to support herself and her children, it is very challenging for her to report her abuser to the judicial system. These findings are in line with some studies that have argued that poverty can increase women's vulnerability to domestic violence (Malgesini et al., 2019). In these cases, financial dependence is used to deter the woman from leaving.

Another issue that was revealed in this analysis was that of retaliatory violence. Most women fear reporting their abusers because they believe that if they reported them and they found out, it would make their partners' abuse even worse. According to the Amai Busas, this is made worse by the lack of faith that survivors have in the police system, as these women are scared to go to the police because they don't trust them. One Amai Busa shared:

"We have seen a lot of cases that have just disappeared because our police officers are corrupt. And this is just the truth. Abusers bribe them all the time." [AB1]

"Yes. That's why many women are scared to report them. Because they never get arrested, and they come back home even angrier and beat them." [AB2]

This describes that there is a common fear of the perpetrator, fear of a negative response by others, or the belief that the authorities will not take the case seriously, and such fears may discourage women and girls from reporting attacks to the relevant authorities, thereby hindering a timely, effective response (Palermo et al., 2014). Studies (Anguzu, 2023) suggest that these fears appear to be well-founded, as law enforcement and medical professions often disclose that women have reported abuse without being provided protection from retaliatory abuse.

Another barrier to the reporting of cases is shame and a fear of stigma and stereotyping from the community, which stems from the cultural expectations of women to stay in their marriages regardless of the hardships they face. Victims are scared to speak out or report incidents of violence because those who do are often shunned and blamed by the community (Chanda, 2023). The Amai Busa shared:

"... Yes, we call it 'shipikisha club'. As a woman, you have to be strong even if you are not happy in your marriage." [AB2]

"That's what adds fuel to the violence, you know. They are unhappy, but they are forced to stay together? Why? That's why many couples are killing each other." [AB1]

This concept of *'shipikisha club'* ('shipikisha' means to be strong) is widely known in Zambian culture, where a woman is considered the glue of her home and is expected to endure all kinds of pain she experiences in her marriage – including infidelity and abuse. It is an unwritten cultural norm taught to young women as they prepare for marriage. In instances where one decides to leave a bad marriage, she is considered to have failed as a woman, and is often stigmatised by her community. According to Chibwili (2023), domestic violence in Zambia is, by many people considered a private matter to be handled within the family, and it is very likely that a woman who reports GBV to the authorities will be criticised, harassed, or shamed by others in the community. Due to fear of being stigmatised and ostracised, many survivors do not seek help or report their abuse, and this reinforces impunity and silence as cultural norms (Lussier, 2016).

3.3.2 Findings from the Focus Group Discussion (FGD): Effectiveness and Impact of Training

The findings at this stage highlight participants' views of the impact of the training and yielded three themes, detailed below: 1) Personal impact of the training; 2) Relevance of training content; and 3) Recommendations to improve the training.

A) ***Personal Impact of the Training on the Amai Busas***

Generally, participants' feedback on the training was positive, with all of them reporting that the training went very well and they understood the content. *"The training was good. We were understanding and asking questions." [AB3].* Participants were able to ask questions for further clarification, and they were assisted accordingly by the trainer. When asked about how the training had impacted them, all six Amai Busas emphasised an improvement in their knowledge and skills, an increase in their confidence to help others, and increased knowledge of the types of abuse:

"I didn't know that bad language is also abuse. Abusive language can hurt others and after this training, I now know the language I can use." [AB4]

Previous work (Armstrong, 2003; Jorm, 2004; Naeem, 2004) has reported similar findings with an increase in participants' confidence to provide counselling and support to others, following brief training. These findings also show that the training impacted participants so that they have now developed new ways of thinking and apply what they learnt to their personal lives. Similar findings are also reported in other studies (Armstrong, 2003; Atif, 2016; Naeem, 2003; Wall, 2020). In Armstrong's (2003) study, paraprofessional counsellors who were offered a brief training reported to have learned more about themselves, and increased their personal effectiveness in their day-to-day lives. For instance, their newly acquired counselling skills could be used to resolve or better manage conflicts or relationships with family and friends (Armstrong, 2003). In the current study, participants reported the learning of various guidelines for providing support to survivors,

and the importance of non-verbal ques of communication in therapy. One Amai Busa shared, "*Through the training, I now know the steps to take: listen and then advise. You don't need to force." [AB2].* Another commented: *"I didn't know that in counselling, physically I need to show that I am paying attention." [AB5]*

Also evident was a positive review of the learning environment, which participants found safe and reassuring. One participant noted:

"I have learned so much. I didn't know a lot of things. Before this, you know, you keep doing certain things thinking you are doing a good job, but in reality, you don't know anything. Now I have learned something new, and it has impacted me." [AB1]

Being a part of a group with other like-minded women gave participants a sense of belonging, helped to build their confidence as they learned from others, and they felt free to open up about what they did not know. Some studies have published similar reports on participants appreciating the learning environment and being a part of a group (Armstrong, 2004), an indication that in the development of such training, the learning environment needs to be prioritised. Amai Busas also reported learning how to provide emotional support to survivors and prevent further psychological harm among them, the importance of assessing personal strengths or limitations when providing support, as well as when and how to provide referral to community resources.

B) ***Relevance and Applicability of Training Content***

Participants' responses suggest that what they learnt from the training was applicable to the target population in their community. The importance of developing relevant and culturally applicable training content is highlighted in various studies (Anakwenze, 2022; Chibanda, 2020; Naeem, 2010). In this study, the Amai Busas felt that women in their community, including their own family members, may be at risk of abuse or may be currently facing abuse, because abuse is normalized in the society and many women are experiencing it. Some of the Amai Busas briefly shared that they had already started applying what they had learnt from the training. One shared:

"I started (applying the skills learnt). I have a neighbour in church who learned about a girl child who was being abused. Nowadays, because of the economy, parents leave children at home with a brother or uncle while they go to look for food. The child was being abused by the father and her brother. This child was losing weight. The friends asked, "why are you looking like this?" and she said, "My father, as soon as my mother leaves early in the morning to go to Soweto market, before he goes to work, he abuses me. And when he goes, even my uncle does it to me". [AB2]

The Amai Busa shared that the child's friends told their mothers, who then called the Amai Busas for help. This situation describes and highlights one aspect of the relationship between socioeconomic challenges and SGBV. Certain home dynamics, such as child abuse and neglect, can be driven by poverty and increase the vulnerability of young girls and women to physical and sexual abuse, and violence (Bywatters & Skinner, 2022). In a

similar manner, another Amai Busa disclosed that she had begun applying her newly acquired skills just a few days prior to the focus group discussion. This Amai Busa shared a conversation she had had with an elderly woman from the church community:

"I was talking to an older person in church, who told me that what we are learning about, she thought it was normal. She told me, "Do you know that I was raped by my in-law when I went to the village in Choma? The houses in the village use only a curtain as a barrier between rooms and I was raped but I told myself maybe my sister's marriage will end, she'll be chased from her marriage." [AB6]

This statement illustrates the extent to which SGBV is normalized in the Zambian society, but also highlights the dynamics of existing gender imbalances. It also shows how women are seen as property of men, and that they are disposable, as men can use women as they please without consequences. Studies have shown that in many cases, family members are the perpetrators of rape in the home (Jones, 2004; Matthews, 2024). In Zambia, the extensive incident of sexual violence against women reflects extant power imbalances between the genders and often serves to perpetuate male power and control. Socioeconomic factors also come into effect, and the recurring connection between SGBV and poverty is seen. According to Tjaden & Thoenness (2000), a dependent individual can find herself being sexually abused for fear that those basic necessities that they depend on will be taken away. This fear is seen in the situation described above, where the victim feared that her sister would lose her marriage if she exposed her perpetrator – a possible

indication of her sister's dependence on her husband. This dependence can make one susceptible to sexual violence.

C) ***Recommendations to Improve the Training***

Participants were invited to suggest recommendations to improve the training. The most prominent recommendation, which was mentioned by all six Amai Busas, was for the project to be scaled up to reach more survivors across the country:

"This is a good program. We need more people. A lot of people at church were asking, 'is it just you being trained?' More women need to be trained." [AB2]

Participants also shared that as pastors' wives, their role in the church and community was already demanding and time-consuming, hence the need to train more Amai Busas in Misisi and other communities in order for more survivors to be reached and helped. Additionally, participants suggested that the training be extended to more community members, including survivors, to enable them to serve as role models to other survivors as they provide support to them:

"Some of us have not been abused but have seen with our eyes. Those who have experienced that situation, when you train them, will be 100 percent able to teach others because they have experienced it. So, when they tell someone else, they tell them with confidence because they themselves have passed through it." [AB1]

The idea of training survivors as LHW is supported by some scholars (Fuhr, 2014; Borkman, 1976; Davidson, 2012), who argue that during the selection of LHWs to train, it is a cardinal aspect to consider because survivors are able to offer support and guidance from their own past experiences, and act as role models in restoring hope for other survivors. Another participant added, *"It makes the victim feel better to know that someone has survived, even they will." [AB4].* This view is supported by Audet (2010), who suggests that when a therapist shares personal information or life experiences with their client (a concept called 'therapist self-disclosure'), it can help build rapport and enhance client comfort, thereby improving the therapeutic relationship. Additionally, these past experiences may also create motivation for helping others, as seen in this study where one of the Amai Busas disclosed her own experience of SGBV and chose to continue with the project as she had a strong desire to help other women who have been in similar situations.

The Amai Busas further recommended that the role of survivors in preventing violence should be looked into, with an aim to equip them with skills that would help them to sensitize others, and protect themselves from further abuse in the future. One participant stated, *"They (survivors) also need to be involved. Teach them how to help themselves and others to prevent SGBV." [AB5].* This view is supported by the United Nations (UN, 2022), who have adopted a survivor-centred approach in their framework of responding to sexual violence and recognise that instead of viewing survivors as just victims, it is important to consider and view them as leaders of change. According to the UN, there is a need to create supportive environments for survivors where they are empowered as

the key decision-makers and are able to freely express. what they need, as survivors understand better than anyone else what they need for healing and recovery (UN, 2022).

The Amai Busas expressed their desire to continue learning and gaining more skills to provide better support for survivors of SGBV in their community. They recommended that the training time is increased to allow them to learn more, with one participant saying, *"We need more time added so we can ask more questions." [AB5]* Another participant shared the following:

"*This is a very good program, and we need more time added to the training. We also need more time to allow us to practice what we have learnt before we start the support groups." [AB3]*

It appears that while participants reported an increase in their confidence to provide support and counselling, they still felt that they needed more time and a few extra sessions to practice and strengthen their newly learnt skills. Similar recommendations are reported in Armstrong's (2003) study comprising a brief training for paraprofessional counsellors, where participants requested for the duration of the training time to be increased as they felt that not enough time was allocated to understanding and working with the different types of mental health challenges.

3.3.3 Pre- and Post- Training Assessment

This part of the study was carried out to assess any changes in participants' skills, knowledge, and confidence in supporting SGBV survivors using the TF-CBT approach, as a self-assessment scale on which they rated their own skills and knowledge before and after the training. Table 4 below presents the self-assessment scores before and after the training at the aggregate rather than individual level for the six Amai Busa's, as the small sample precluded further inferential analyses.

Table 4: Pre- and Post-training Evaluation Findings

Section A	**General Effectiveness of Training**				
Scale	**1** **Low**	**2**	**3** **Medium**	**4**	**5** **High**
Ability to counsel clients about the topics covered in the training					
Pre-evaluation	3	3			
Post-evaluation				3	3
Ability to manage clients regarding topics covered in the training					
Pre-evaluation	1	4	1		
Post-evaluation				2	4
Comfort level in providing services to clients in relation to the topics covered in the training					
Pre-evaluation	2	2	2		

Post-evaluation			1	2	3
Overall knowledge of the topics of the topics covered in the training					
Pre-evaluation	1	3	2		
Post-evaluation				3	3
Section B	**Specific Applicable Knowledge and Skills**				
Understanding of what Sexual and Gender-based Violence (SGBV) is?					
Pre-evaluation	1	3	2		
Post-evaluation				3	3
Understanding of what Trauma informed Cognitive Behavioural Therapy (TF-CBT) is?					
Pre-evaluation	3	2	1		
Post-evaluation			1		5
Ability to counsel and support survivors of SGBV using the TF-CBT model?					
Pre-evaluation	3	1	2		
Post-evaluation			1	2	3

The scale was divided into two sections – A and B. Section A assessed the general effectiveness of the training and comprised four items. The first item looked at their ability to counsel clients about the topics covered in the training. The Amai Busas rated themselves 'low' to 'just below medium' pre training, and 'just above medium' to 'high' post training, showing a marked improvement in their ability to counsel clients on topics covered in the training. A positive shift was also noted in the Amai Busa's ability to manage clients in the training topics covered with 67% of the participants rating themselves 'high' and 33% 'just below high' post training, compared to the 'low to moderate' participant ratings pre training. A moderate shift was noted in the Amai Busa's comfort level in providing counsel on the topics covered with 17% of the women rating themselves 'moderate', 33% between 'medium' and 'high', and 50% rating themselves 'high' post training evaluation, compared to 'low to moderate' participant ratings pre-evaluation. In general, participants' knowledge of the topics increased, with an even split in 'above medium to high' ratings post training from 'low to moderate' pre-training.

Section B, comprising three items, assessed specific applicable knowledge and skills. The cross tabulation above shows an improvement in the understanding of SGBV by Amai Busas, with initial ratings of 'low to medium' to all participants falling in the 'above medium to high' ratings. In the second item, Amai Busas understanding of TF-CBT showed the most improvement with 83% rating themselves as 'high' and 17% rating themselves as 'medium' post evaluation, compared to 'low' ratings pre-evaluation. Finally, 83% of the Amai Busas rated themselves 'above medium to high' and 17% 'medium' in their ability

to counsel and support SGBV survivors using the TF-CBT model post training, while all participants rated themselves 'low to medium' pre training.

Overall, there was a general increase in scores over the training, indicating that the training was successful in enhancing participants' confidence, knowledge, understanding, and skills. Results from this study, therefore, suggest that the training had a generally positive impact on participants' perception of their ability to counsel SGBV survivors effectively. Our findings support those of similar previous pilot studies (Armstrong, 2003: Chibanda, 2017; Naeem, 2003) that have demonstrated that brief training in counselling skills can have a positive impact on LHWs. Dewing (2015) agrees that in many resource-limited countries, LHWs are playing increasingly important roles in health service delivery and support. It is therefore necessary to understand the ability of this group of health workers to deliver good quality support and evidence-based practice. The findings of this study suggest that lay counsellors are capable of delivering counselling that is consistent with evidence-based approaches, provided they are trained sufficiently and supervised in a way that is focused on skills enhancement.

3.4 Research and Practical Implications

The findings of this study indicate that the Amai Busas had positive experiences of the TF-CBT training, and expressed a sense of being privileged to be involved, and having the potential to impact on the mental health of women who are survivors of SGBV in their community. However, there is an imperative need to find ways of developing counselling

courses and training based on evidence from research. Similar recommendations are made by Armstrong (2003), who suggests that after such training, it is important that there are clear structures of following up and understanding how lay counsellors implement the skills and knowledge gained, which, according to scholars (Cook, 2017; Barnett et. al, 2018) can ensure and enhance fidelity. Fidelity to an evidence-based treatment is vital because when components of the treatment are modified, the practice is no longer the same as the researched practice (Cook, 2017). Additionally, it may also be beneficial for further research in this area if other research includes the exploration and inclusion of trainer perspectives and experiences (Armstrong, 2003), which, in addition to participant experiences, would form a complete view of the whole training. Terry (2010) proposes that aspects of training delivery, such as teaching style and group facilitation, play an integral role in the participant's experience. Further, trainers are well positioned to share their views and recommendations, and if these are applied, training delivery may be more efficient.

The study also highlights that there is a cardinal need to address SGBV in Zambia with a multifaceted approach that recognises and challenges engraved cultural factors. Studies have pointed to poverty, women's power disadvantage in relationships, and social/cultural acceptance of GBV as key factors leaving many women vulnerable to abuse (Care, 2017; USAID, 2010; World Bank, 2022). In addition to challenging entrenched cultural norms (Chen, 2017), interventions aimed at addressing these issues need to also promote gender equitable attitudes and strengthen legal protections for women's rights (Salem, 2018). Future interventions need to incorporate efforts to advance gender

equality by collaborating with local communities, traditional leaders, religious leaders, and other community stakeholders to engage in relevant discourse with an aim to challenge harmful norms.

In the same vein, future mental health training designed for non-professional counsellors for SGBV survivors should include modules that promote women's empowerment and gender based on respect, equality, and non-violence. During the design and implementation of programmes, designers should target specific empowerment outcomes, and tailor the intervention components to the desired empowerment-related outcomes (Lwamba, 2022). In addition, to maximise the potential benefits of programmes, it is also important to target the restrictive gender norms and practices that may undermine intervention effectiveness. By addressing the cultural factors that enhance SGBV, a more inclusive and equitable society can be generated. In this study, local community leaders (Amai Busas) were successfully trained who are now sensitive to the experiences and needs of SGBV survivors in the community, and are therefore now better able to respond and provide the right support. The findings of the study also demonstrate a strong element of cultural sensitivity in the Amai Busas, which enables them to build trust with women in the community as they offer support.

This study also found that training participants sometimes may become affected and distressed by issues that arise. Future research may consider looking into the psychological effects of mental health training on participants who are lay counsellors. While it is generally likely that mental health-related courses attract those who are

interested in, or have experience with the topic, it is important to consider that the instructors' ability to manage this distress is very cardinal to the individual, as failure to do so may result in the individual's mental health declining (Jorm et al., 2007). In addition, failure to manage the distress also affects the rest of the participants in the group, as it may lead to reduced trust and confidence in the instructor's ability, skill and knowledge in managing mental distress. Some scholars (Wall, 2020) have recommended that future lay provider training and supervision have more formalised components that discuss potential challenges participants may encounter. For instance, forecasting and addressing expected challenges beforehand, normalizing expected negative emotions, and teaching coping strategies skills — including the skills that are included as part of the intervention itself (Wall, 2020). Another way in which this can be addressed is through the application of co-training methods, where more than one instructor facilitates/delivers the training. In case a participant experiences distress, this method allows one of the instructors to support them, while the other continues with the training delivery (Breslin & McCay, 2006). Some studies have shown concern for instructors delivering mental health courses alone, arguing that they may be at a disadvantage because they may be torn between the need to attend to the distressed participant, while being aware that the training delivery needs to continue.

3.5 Study Strengths and Limitations

This study is important and impactful, as it is addressing a gap in literature by undertaking TF-CBT work in a developing country. However, it is important to consider the limitations

of this explorative study. This was a pilot study among a small group of women in one setting, and the findings need to be expanded to other developing societies. Additionally, some participants' previous experiences as psychosocial counsellors may have shaped their reactions to the new intervention. Despite these limitations, the study successfully collected rich qualitative data which was strongly supported by the quantitative findings, and demonstrates that teaching women supportive counselling skills for SGBV survivors can be beneficial and effective in low-resource communities.

3.6 Conclusion

The findings from this study suggest that the training had a generally positive outcome and impact on participants' perception of their ability to support women who are survivors of SGBV. A culturally adapted brief course like this can produce appreciable gains in knowledge and skills required to handle women experiencing mental health challenges as a result of SGBV. From the training experience, participants learned more about themselves and their abilities as counsellors, and applied these learnings to their personal lives as well, thereby enhancing their effectiveness in not only their roles as helpers in the community, but also in their personal daily lives.

This study was carried out as part of a larger project into the development of a CBI to improve mental health in underprivileged female survivors of SGBV in Misisi. The next stage of the research will evaluate how well participants applied the knowledge and skills gained through this brief training, and the effectiveness of the TF-CBT intervention on female survivors of SGBV in the Misisi community.

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Chapter 4: Paper 3

A Community-Based Intervention to Improve Mental Health in Underprivileged Female Survivors of Domestic Violence in a Peri-Urban Community of Misisi in Lusaka, Zambia: An Empirical Study

4.1 Introduction

Sexual and gender-based violence (SGBV) is a global issue that exists in every culture (Rockowitz, 2023). It is a major public health issue that significantly impacts the physical and mental well-being of survivors (Lakin, 2022). SGBV is defined as 'violence inflicted upon a person based on their actual or perceived gender that results in – or is likely to result in – sexual, physical, mental or economic harm' (United Nations [UN], 2023). It encompasses acts that cause physical, mental, or sexual harm, threats of such acts, coercion, and other forms of deprivation of liberty, occurring in both public and private life (WHO, 2011). SGBV is one of the most common human rights violations worldwide (United Nations Fund for Population Activities, 2014), as reports indicate that one in three women experience sexual or physical violence- often from their intimate partner (WHO, 2013). Such acts violate the rights of women and girls, limit their contribution to society and harm their health and well-being.

SGBV levels in Zambia are high, with more than 36% of Zambian women having experienced SGBV since the age of 15 (Chibwili, 2023). According to Zambia Statistics Agency (2019), one in five women and girls (20%) experience sexual abuse before the age of 18, and 39% are married before the age of 18 (Zambia Statistics Agency, 2019; Bessa & Malasha, 2020). In 2024 alone, a total of 42,178 SGBV cases were reported in Zambia, with the gender breakdown of victims showing that 32,904 females (78%) and 9,274 males (22%) were impacted (Zambia Gender Division, 2025). However, it is known that many other SGBV cases go unreported (EU, 2017); therefore, these statistics underestimate the actual magnitude of the problem. Moreover, there is a considerable lack of qualitative studies investigating survivors' experiences in rural areas in low and middle-income countries (LMICs), making it challenging to determine the true scope of the problem.

To protect women and girls in Zambia, The World Bank's (2023) Zambia Gender-Based Violence Assessment recognises a variety of GBV prevention and response programmes in the country. These include counselling services, one-stop centres and shelters that are hospital-based and village-led, and fast-track courts. Nonetheless, these efforts are usually under-funded, poorly coordinated, and geographically limited, unable to reach many SGBV survivors in the country (World Bank, 2023).

A strong link has been found between SGBV and mental illness (Hossain, 2021). Research in African countries like Rwanda, South Africa, and Zambia (Chibesa, 2017; Karger et al., 2013; Umubyeyi, 2015) indicates that SGBV has both short- and long-term negative

effects on mental health. Victims and survivors often have an increased risk of depression, reduced self-esteem, anxiety and post-traumatic stress disorder, leading to higher rates of suicide attempts (Jewkes, 2017). For most survivors in Zambia, access to health services is inadequate, and mental health services dedicated to SGBV survivors are lacking. Further, on some occasions, the few mental health services provided have proved unsustainable (Kusantham et al., 2016) and have failed to evaluate the outcome/effectiveness of their support. For instance, Victim Support Units (VSUs) have been set up by the government within the police department in each district. However, financial and capacity challenges affect these units' abilities to effectively carry out criminal investigations, collect forensic evidence, and provide psychosocial support, leading to many SGBV survivors being forced to return home to the perpetrators (EU, 2017).

Due to this lack of 'formal support,' in most local Zambian cultural settings, women often seek help from community representatives, such as wives of religious leaders, in whom they confide. Such is the situation in Lusaka's Misisi compound, where female SGBV survivors from the neighbourhood frequently approach wives of pastors (known locally as "Amai Busa") in search of support and counselling (StrongMinds Zambia, 2019). These leaders often lack formal training on handling SGBV-related trauma and emotional distress. There is a need to find ways to collaborate with such community leaders and to adapt services to the African socioeconomic setting, and this has been emphasised for decades, dating as far back as 1961 at the First Pan African Psychiatric Conference in Nigeria (Lambo, 1961).

Nonetheless, very few studies (Freccero, 2011; Mirghani et al., 2017) have explored the influence and possible benefits of accessing community-based support for SGBV victims. In Zambia, at present, there is no formal training available to members of the community SGBV victims often seek support from, even though this support could represent valuable help for women and girls to end the abuse to which they are exposed. This is particularly the case for victims residing in poorer Zambian communities (locally called 'compounds'), who face significant barriers in accessing 'formal' channels of support for instance, from local and/or international organisations (EU, 2017). Two non-governmental organisations, PsycHealth Zambia (PHZ) and Strong Minds Zambia (SMZ) have tried to supplement government efforts to deal with by providing free psychotherapy services in the community (PHZ, 2016; SMZ, 2017). However, research must be involved for this to be successful because it is essential for such support to be based on facts. This study therefore aimed to contribute to the breadth of knowledge on SGBV in Zambia by piloting a novel community-based intervention (CBI) delivered by Amai Busas, aimed at improving the psychological wellbeing of underprivileged women who are survivors of SGBV.

4.1.1 Task Shifting

Considering the treatment gap noted earlier, it is important to investigate and consider other methods of delivering mental health support and interventions to survivors of SGBV in low-resource communities like Misisi. One potential solution is to implement task-shifting to LHWs. The World Health Organization (WHO) defines task-shifting as "a process

in which specific tasks are delegated to less-skilled healthcare workers, when suitable, to optimise the use of existing health resources and quickly enhance capacity while developing training and retention programs" (2007). The aim of this approach is to expand healthcare access in low-resource communities and improve the utilisation of resources (Lewin, 2005).

Globally, experts suggest that task-shifting strengthens and expands the healthcare sector workforce, which can contribute to increased access to services (Selke, 2010). Various studies have found evidence to show that task-shifting is effective in the delivery of psychological interventions for numerous mental illnesses (Petersen, 2012; Van, 2013). A Cochrane review investigated the impact of LHWs on people living with mental health conditions. The findings indicated that, in comparison to control groups, interventions provided by lay health workers may lead to an increase in the number of adults recovering from depression or anxiety within two to six months after treatment (Chowdhary, 2014).

Numerous studies have used the task-shifting approach to deliver mental health interventions in LMICs (Cooper, 2009; Rahman, 2008; Singla, 2014) as a solution to the shortage of adequately trained mental health workers. These studies have engaged different levels of LHWs, ranging from nurses – who are paraprofessionals already working in the health sector, to lay volunteers from within the community who usually have minimal formal education. According to the findings of these studies, participants typically prefer LHWs to formal, professional service providers because they are more approachable (Mueller, 2010) and relatable (McClay, 2013). In many settings, formal

mental health services are avoided mainly due to the associative stigma attached to them (Zartaloudi, 2009), where mental health professionals are judged with similar stigmatising stereotypes as their patients (Gunasekaran, 2022; Picco, 2019).

This study explored the feasibility, effectiveness, and acceptability of a CBI to tackle domestic violence and improve mental health in underprivileged women in Misisi. The study aims to contribute to the breadth of knowledge on SGBV in Zambia by developing a novel CBI to provide mental health support for SGBV victims/survivors. The principal aim is to equip influential community members (Amai Busas) to whom SGBV survivors usually go for support with skills and knowledge on trauma and mental health to enable them to provide mental health support to survivors of SGBV in the Misisi compound. The study also addresses the current research gap on mental health and its effects in Misisi (Mayeya et al., 2004) by shedding some light on the potential mental health issues that SGBV survivors may experience. Designed as a pilot longitudinal study employing mixed methods (qualitative and quantitative), the study also contributes to filling the existing gap of mixed-method data on the effectiveness and feasibility of CBIs addressing the mental health effects of SGBV in survivors in peri-urban communities in Zambia. A mixed methods approach was suitable for this study because it was important to gain an in-depth understanding of participants' individual views and experiences related to SGBV and the intervention. Additionally, it would provide clear insight into quantitative information, including descriptive data and pre-post assessments of participants' mental health. Findings from this pilot could offer valuable insights into culturally relevant and

relatively low-cost practices to enhance the wellbeing of women who are burdened by SGBV.

4.2 Methods

4.2.1 Study Setting

This study was carried out in Misisi Compound, a poor urban community in Lusaka, Zambia. This community was selected because of the predominant evidence of inadequate access to mental healthcare services (Mayeya et.al, 2004), and because of the PI's encounter of many SGBV cases during her voluntary work as a community mental health worker in Misisi. The intervention was delivered by the six previously trained Amai Busas between 17th February 2024 and 23rd March 2024 at the Glory Baptist Church in Misisi, which was selected due to its central location, making it easily accessible for both participants and researchers. English and Nyanja were used as languages of instruction, as English is the official language of the country, and Nyanja is the most spoken local language in Lusaka.

4.2.2 Amai Busas' Preparatory TF-CBT Training

In preparation for this study, six Amai Busas received five days of TF-CBT training by a team comprising the Principal Investigator (PI) and a research assistant (RA). Content included teaching on trauma, training in counselling skills, and role plays. Amai Busas

were encouraged to practice these new skills via role plays amongst each other and were directly supported by the PI and RA, who provided ongoing supervision, mentorship and support. The RA, working full-time on the study, provided in-person supportive supervision by sitting in on sessions or practising role plays ahead of a session, while the PI attended these supervision sessions virtually.

4.2.3 Study Participants

Participants were female survivors of SGBV residing in Misisi compound. As this was a pilot study, a small number of participants was recruited for the quantitative part of the study (n = 36) using Snowball sampling. For the qualitative part of the study, a subset of them (n = 12-15) were invited to participate in one-to-one interviews with the PI one week after the last TF-CBT group session.

Inclusion criteria comprised women who self-identified as having experienced SGBV in the three years prior to the time of study, resided in Misisi, were able to give verbal consent, and were aged above 18. No maximum age limit was applied. Exclusion criteria comprised: i) Women who may have been at risk of further SGBV if they took part in the evaluation (e.g., if survivors felt that their participation could not be kept confidential); and ii) Women who at the time of study were experiencing severe psychological distress, as reflecting and sharing their experiences of SGBV in a group-setting may have had detrimental effects on their psychological wellbeing.

4.2.4 Participant Enrolment

Due to the sensitivity of the study topic and the high levels of stigma surrounding SGBV, it was expected that there may have been reluctance in individuals to come forward and participate in the study. Potential participants were identified by the Amai Busas, to whom such groups usually go to seek help. The Amai Busas approached potential participants individually on a case-by-case basis, as they already had some SGBV survivors who had reached out to them for support. To avoid the possibility of coercion on the part of the Amai Busas, during the training stage, the Amai Busas were trained on how to approach potential participants without forcing them – by making it clear that participation was completely voluntary, and the usual emotional support they received from the Amai Busas was not conditional upon their participation in the study.

Women who were interested in participating in the study declared their interest to the Amai Busa (either in person or by phone call) who then arranged a meeting with them and gave them basic information about the study (i.e., information about the aims of the study and the group sessions, but no additional information about data management etc). Interested participants were then invited to meet the RA who held group information sessions in which she fully informed them about the study, verbally going over all parts of the study's Participant Information Sheet (PIS). The RA answered any questions asked by women who were interested in participating and ensured that participants were clear on the details of the project. Due to the anticipated issue of illiteracy among some participants, consent was obtained verbally. Audio-consent was also be obtained by the

Amai Busa before beginning the TF-CBT sessions, clarifying that participants agreed to take part in the study and to be audio-recorded.

4.3 Research Design

This was a pilot longitudinal study employing a mixed-methods research design, combining qualitative and quantitative methods. Quantitative data (comprising a series of mental health assessments) was collected at three time points: baseline, endline, and follow-up. Qualitative data was also collected at three time points and included recorded TF-CBT sessions during the intervention (to assess fidelity), one-on-one interviews at endline, and a focus group discussion at follow-up. Quantitative data was analysed using appropriate statistical methods, while qualitative data was analysed using thematic analysis (Braun & Clarke, 2021). Table 5 below presents a mapping of the key stages of the project, outlining the primary outcomes of focus and their corresponding specific indicators at each stage.

Table 5: Project Mapping, Primary Outcomes, and Key Indicators

Study Stage	Key Activities	Indicators	Primary Outcome Focus
1. Eligibility Screening	• Participant recruitment • Informed consent • Inclusion/exclusion criteria application	• No. of participants screened and enrolled • Demographic match with target group • Eligibility based on screening	Feasibility
2. Baseline Assessments	• Pre-intervention measures of mental health and emotional wellbeing • Administration of HAM-A, HAM-D, PCL, BRS	• Baseline scores on outcome measures • Readiness to proceed with intervention	Feasibility & Effectiveness
3. Intervention Delivery	• Weekly TF-CBT sessions • Supervision & fidelity monitoring • Delivery of adapted intervention material	• Completion rate of sessions • Fidelity scores from evaluation sheets • Implementation challenges or adaptations • Participant responsiveness	Feasibility, Fidelity & Effectiveness
4. Endline Assessments	• Immediate post-intervention measures of mental health and emotional wellbeing • Administration of HAM-A, HAM-D, PCL, BRS • Qualitative feedback from participants (One-to-one interviews and FGD) • Session quality evaluation	• Change in scores from baseline • Participant-reported impact • Amai Busas' feedback on delivery experience • Observed improvement in delivery	Effectiveness & Acceptability
5. Follow-up Assessments	• Re-administration of HAM-A, HAM-D, PCL, BRS • Follow-up FGD • Dropout and retention tracking	• Retention and dropout rates • Sustainability of outcomes • Continued acceptability of intervention content and structure	Acceptability & Effectiveness

4.3.1 Epistemological Position

The epistemological position in this study was pragmatism. Pragmatism, as a paradigm, does not support the idea that the use of one analytic method can lead to objective truth (Frey, 2018), but rather, it argues that real-world problems should be investigated using the best methods, using multiple sources of information and knowledge to answer research questions. A mixed methods approach was deemed appropriate for this study because methodological flexibility allows for the consideration of more information than can be captured through only quantitative research, such as participants' opinions, perspectives and experiences (Wisdom & Creswell, 2013). This theoretical approach was suitable for this study as the aim was to understand the personal experiences and views of the survivors and the Amai Busa, as well as their interpretations of reality at a subjective, community, and socio-cultural level. In addition to providing an in-depth understanding of participants' individual views and experiences in relation to SGBV and the intervention, the qualitative data also contextualised and added further insight into the quantitative data collected, as part of a mixed-methods process known as profoundisation (Wisdom & Creswell, 2013). Once participants consented to participating, the following six steps were taken:

Step 1 - Brief Eligibility Screening

The primary outcome of focus at this stage was feasibility. Assessments evaluated the severity of SGBV, severity of related mental health difficulties and risk of participation. Those who screened highly on the Hamilton Anxiety Scale, Hamilton Depression Scale and Participant Risk Assessment Tool (devised specifically for this study) were not included in the study but received support as usual (separately – not as part of the study) from the Amai Busa, who further made a referral to a local organisation called PsycHealth Zambia with the client's consent.

Step 2 - Baseline (pre-intervention) Assessment

At baseline, feasibility and preliminary effectiveness were the primary outcomes of focus. Assessments included the Brief Resilience Scale (BRS; Smith et.al., 2008), Relationship Assessment Tool (RAT; Smith et al., 1995), and the PTSD Checklist (PCL-C; Weathers et al., 2013). Each participant was attended to in a private/confidential room, and the items of the three psychometric instruments mentioned above (see Table 1 below) were read out one by one, as it was unlikely that some participants would be able to read or write. Participants' responses to each questionnaire item were then directly entered on Qualtrics (Provo, UT), using numbers for each participant as a pseudonym.

Step 3 – CBI delivered by Amai Busa

At the intervention delivery stage, the primary outcomes of focus were feasibility, fidelity, and effectiveness. Six Amai Busa (already trained by the PI) delivered a series of six weekly TF-CBT group sessions, each conducted in groups of six survivors. The 36 participants recruited were divided into these groups of six using random allocation, and each group was facilitated by an Amai Busa. These sessions ran concurrently for six weeks, with one session taking place every week for each group.

The meetings were held in a local church and described as 'getting together' groups (with no reference to domestic violence) to protect the participants and ensure that confidentiality was maintained. Each group met for about an hour, and the Amai Busa followed an intervention protocol to discuss specific topics in each session. These sessions were audio-recorded; with a recording device placed on the Amai Busa who delivers the session, and an additional recording device placed closer to the participants. At the end of the data collection phase, the integrity of the CBI and the adherence of the Amai Busa to the protocol was evaluated by the PI and an experienced CBT-therapist (who was independent of this project), who evaluated a subset of the recorded sessions.

Step 4 – Post Intervention Assessment

The endline assessments focused on effectiveness. After each participant completed their last group session, the PI assessed them using the Hamilton Anxiety Scale, Hamilton

Depression Scale, Brief Resilience Scale, and PTSD Checklist as indicated in Figure 1 below. This was done virtually with the same arrangements as the pre-assessments.

Step 5 – Post-intervention Interviews

This stage of the study focused on acceptability and effectiveness. Following completion of the CBI sessions, the RA, on behalf of the PI, contacted participants who consented to being contacted after the CBI, and asked them if they still wished to participate in a one-to-one interview with the aim of acquiring an in-depth understanding of their individual views and experiences in relation to SGBV and the intervention. These interviews were then carried out virtually by the PI herself via a Teams video call with participants in a private room set up by the RA. Depending on participant preference, interviews were recorded in either English or Chinyanja, and in some cases both languages. The PI then transcribed (and translated where needed) the interviews in English.

Step 6 – Follow-up Assessment

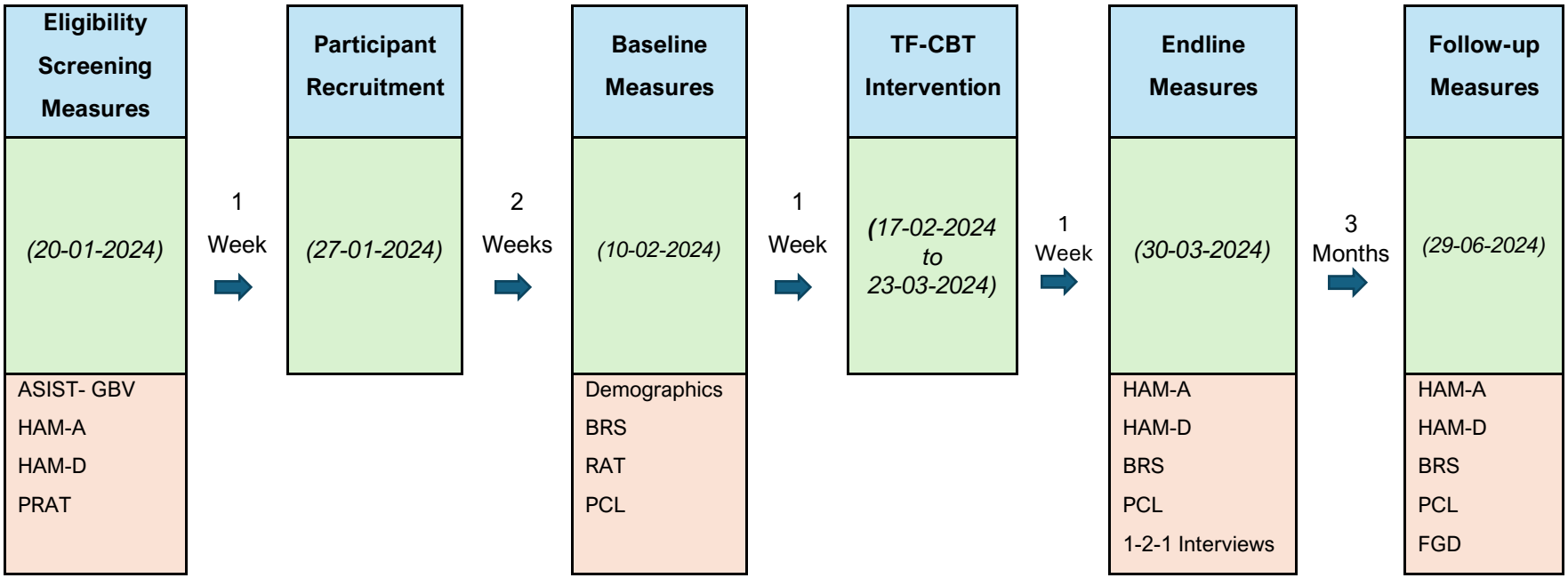
Focusing on intervention acceptability and effectiveness, the PI conducted a final assessment three months after the intervention, virtually with all participants. This was to assess the effectiveness of the CBI over time, as participants may not have shown significant change immediately after the intervention. In arrangements similar to the pre-

and post-intervention assessments, the RA set up a private room where participants were interviewed by the PI via a Teams video call.

4.3.2 Measures and Assessments

Most of the questionnaires that were found to be relevant to this study have not been standardised and validated in Zambia. In addition, we expected most of the participants to be illiterate. For these reasons, the study relied on well-known questionnaires that are easy to deliver, and each of the items / questions / statements on these instruments were read out to participants by the RA, who then directly entered the participants' responses into Qualtrics. Figure 3 below presents the flow of the study and the questionnaires that were used at each stage.

Figure 3: Study Flow Diagram



Note: *ASIST-GBV = Assessment Screen to Identify Survivors of Gender-based Violence; HAM-A = Hamilton Anxiety Scale; HAM-D = Hamilton Depression Scale; PRAT = Participant Risk Assessment Questionnaire; BRS = Brief Resilience Scale; RAT = Relationship Assessed Risk Tool; PCL = PTSD Checklist; FGD = Focus Group Discussion; TF-CBT = Trauma-Focused Cognitive Behavioural Therapy.*

4.3.2.1 Quantitative Measures

SGBV Screening. The seven-item *Assessment Screen to Identify Survivors of Gender Based Violence* (ASIST-GBV; Vu et.al., 2013) is a brief seven-item screening tool with strong psychometric properties and high validity, designed to confidentially identify for referral a range of GBV, including threats of violence, physical violence, sexual violence and exploitation, forced pregnancy, forced abortion, and forced marriage in the last 12 months. An example item is, "*In the past 12 months, have you been threatened with physical or sexual violence by someone in your home or outside of your home?* If the participant responded 'yes' to experiencing any of the violence in questions from 1.1 to 1.7, she screened positive for GBV.

Anxiety. The 14-item *Hamilton Anxiety Scale* (HAM-A; Hamilton, 1959) is a valid and reliable scale developed to assess the severity of a patient's anxiety, based on 14 parameters, including anxious mood, tension, fears, insomnia, somatic complaints and behaviour at the interview. An example item is, "*Anxious mood - Worries, anticipation of the worst, fearful anticipation, irritability."* Each item is scored on a scale of 0 (not present) to 4 (severe), with a total score range of 0–56, where <17 indicates mild severity, 18–24 mild to moderate severity and 25–30 moderate to severe.

Depression. The *Hamilton Depression Rating Scale* (HAM-D17; Hamilton, 1960) a widely used measuring instrument to assess the severity of depression in dynamics and the effectiveness of treatment of patients. The most used versions in research are either a 17- or a 21-item scale. The 17-item scale was used in this study. The scoring of the severity

of the depressive symptoms is based on these 17 items. An example item is, "*Depressed Mood – Feels life is not worth living."* Scoring is done between 0 (not present) and 4 (severe), using either a three-point or a five-point scale and summed up to obtain the total score.

Risk Assessment. The four-item *Participant Risk Assessment Questionnaire* (2023) developed specifically for this study, assesses participant's safety from harm by others and themselves if they participate in the study. An example item is, "*Do you feel your participation in this study will put you at risk of harm when you return home?"* If the participant indicates YES to any of the questions, and/or indicates recent thoughts and/or attempts to end their life, they are considered high risk.

Resilience. The six-item *Brief Resilience Scale* (BRS; Smith et.al., 2008) is a scale that was created to assess resilience as the ability to bounce back or recover from stress. The scale has high psychometric properties and was developed to assess a unitary construct of resilience, including both positively and negatively worded items. An example item is, *"I tend to take a long time to get over setbacks in my life."* The possible score range on the scale is from 1 (low resilience) to 5 (high resilience), with higher scores representing greater perceived resilience.

Relationship Assessment. The 10-item *Relationship Assessment Tool* (Smith et al., 1995) is a screening tool for intimate partner violence (IPV). As opposed to focusing on physical abuse, the Relationship Assessment Tool assesses for emotional abuse by measuring a woman's perceptions of her vulnerability to physical danger and loss of power and control

in her relationship. A series of 10 statements ask a woman how safe she feels physically and emotionally in her relationship on a scale of 1 to 6, ranging from disagree strongly (1) to agree strongly (6). An example item is, "*He makes me feel like I have no control over my life, no power, no protection."* The numbers associated with her responses to the 10 statements are summed to create a score. A score of 20 points or higher on this tool is considered positive for IPV.

PTSD symptoms. The 17-item *PTSD Checklist* (PCL-C; Weathers et al., 2015) is a standardised self-report rating scale for PTSD comprising 17 items that correspond to the key symptoms of posttraumatic stress disorder in the last month, using a scale from 0 (not at all) to 4 (extremely). An example item is, "*Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?"* Higher scores indicate greater PTSD symptoms.

One-to-One Interview Guide. The *One-to-One Interview Guide* (Coulibaly et al., 2023) comprises seven main open-ended questions which guide the conversation towards survivors' detailed experiences of SGBV. These items further consist of follow-up questions aimed at exploring the psychosocial consequences of the abuse. An example of the questions asked is, "*What impact did these experiences have on your life?"* The questions were developed from previous literature (Coulibaly et al., 2023) and adapted for this study in English. They were also translated into Chinyanja.

Demographics. Demographic information such as age, marital status, educational level and occupation was also collected to report on the general characteristics of the sample.

4.3.2.2 Intervention Integrity Assessment

A randomly selected sample of the audio-recorded TF-CBT sessions (16% of them)[1] was assessed by an experienced CBT therapist (who was unrelated to the study) for adherence to the intervention protocol. Similar rates have been checked for integrity in other studies (15%, David et al., 2008; 17%, Marks et al., 1998).

The session quality was evaluated according to the contents of an Intervention Evaluation Sheet (see Appendix X) devised specifically for this study, containing a set of standardised items that allowed the assessors to evaluate the training delivered, referring to the same aspects (e.g., adherence to the session worksheet, accessibility of language used, quality of interaction with the group).

4.3.3 Ethical Approvals

Ethical approval to carry out the study was obtained from Manchester Metropolitan University (Ethos ID: 45296), and from the Humanities and Social Sciences Research Ethics Committee in Zambia (Ref: HSSREC:2024-FEB-O54). Authority to conduct the research was then obtained from the National Health Research Authority (NHRA) of Zambia. Written informed consent was obtained from all participants with participants being reimbursed for their transportation and lunch costs in accordance with local regulatory research and ethics bodies.

This study was considered as bearing high psychological risk to participants. Therefore, if participants found participation in the study distressing, a risk management plan was put in place based on the MMU distress protocol for qualitative data collection (Haigh & Witham, 2015). Throughout the study, participants were free to withdraw from any study-related activity at any point if they started to experience psychological distress. Additionally, participants who were to be found to need additional counselling would be referred to PsycHealth Zambia, an organization with which the PI is affiliated as co-founder and psychologist. A psychologist from PsycHealth was available to provide psychological first aid at no charge. Participants were also informed that the PI (a qualified Cognitive Behavioural Therapist) would be on hand to provide Psychological First Aid virtually in case of emergency, and referrals where needed.

To minimise psychological harm to the PI and the volunteer co-researcher, who are both trained practitioners and have worked as clinicians in Zambia, they kept notes in their journals and were in close contact with the PI's supervisors (one of whom was also a practitioner psychologist, experienced in working with survivors of trauma). In all stages of this project, the PI informed her supervisors of any risk-related issues or incidents that occurred.

4.4 Data Analysis

4.4.1 Sample Size

Quantitative Study. As this was a pilot study, 36 participants were recruited through convenience sampling. This was as recommended by Browne (1995), who suggests a minimum of 30 participants for pilot studies, as their primary purpose is not hypothesis testing, and therefore sample size is not usually calculated. However, one way is to determine sample size through power analysis. Similar research using TF-CBT for 25 female survivors of domestic abuse has observed large effect sizes (e.g., Latif et al., 2021). A power analysis with 80% power and alpha of .05 indicates that a minimum of 24 participants is required to detect a large effect size (f = .35) with four outcomes (depression, anxiety, resilience, and trauma symptoms) across three time points.

Qualitative Study. A total of 12 participants were recruited for the one-to-one interviews at endline and a focus-group discussion at follow-up. Malterud et al. (2016) recommend using information criteria to guide the sample size – so the sample is not set in advance – but guided by (a) the aim of the study, (b) sample specificity, (c) use of established theory, (d) quality of dialogue, and (e) analysis strategy. Generally, studies with narrower aims, more specific participant combinations, stronger theoretical support, higher quality interview dialogue, and deeper analysis can be conducted with fewer participants. Studies with broader aims, less specific participant combinations, weaker theoretical support,

lower quality interview dialogue, and shallower analysis require more participants (Malterud at al., 2016).

4.4.2 Quantitative and Qualitative Data Analyses

Quantitative. Data included outcome data from the intervention, for which the independent variable was the three-time point assessment (pre-intervention, post-intervention and three-month long-term follow-up assessment), with the dependent variables comprising four related mental health outcomes likely to be experienced by survivors: depression, anxiety, resilience, and trauma symptoms. Participants' characteristics were explored with descriptive statistics, and the effect of the intervention was examined with pre-post intervention comparisons (specifically Friedman's ANOVAs) of the participants' scores in the questionnaires. A non-parametric test was deemed suitable for this study, as it had a small clinical sample; therefore, data was likely to violate normality assumptions (Nahm, 2016). The collected data was first entered into Qualtrics, then exported to and analysed with the Statistical Package for Social Sciences (SPSS version 29).

Qualitative. Data comprised data collected through the semi-structured interviews, which were analysed thematically, guided by Braun and Clark's steps (2021). The first step was 'Familiarisation', where the initial findings of the study were reviewed. Step 2 was 'Coding', which involved the setting out of common themes within the study and labelling

them using highlighted colour coding. The third step was 'Constructing themes', which involved the combination of labelled codes into broader themes covering a wide range of recurring statements and opinions. The fourth step was 'Reviewing themes', where the researcher reviewed the themes and categorised their findings. Step 5 was 'Defining themes', which involved the review of the category and theme names for purposes of clarity and accuracy, and the final step was 'Writing a thematic analysis', which comprised a written summary explaining the procedures of data collection, methodology, and conclusions made. NVivo was used to improve the speed and accuracy of the analytic process (Zamawe, 2015).

4.4.3 Adherence to Protocol and Intervention Integrity

A subset of the audio-recordings (16% of them) was evaluated by a CBT specialist, who analysed the audio-recorded TF-CBT sessions in order to assess the quality of the intervention delivery. This data was analysed with descriptive statistics.

4.4.4 Amai Busas' Support and Supervision

A structured support and supervision system was put in place to ensure that the Amai Busas were well-equipped and confident in delivering the intervention. This included weekly group supervision sessions facilitated by the PI, where the Amai Busas could debrief and reflect on their experiences, discuss any challenges, and receive guidance on

cases that they felt were difficult for them. Additionally, the RA carried out routine session observations to provide real-time feedback and encouragement.

4.5 Results

4.5.1 Quantitative Study Results

4.5.1.1 Demographic Data

Thirty-six participants were recruited for this study. Their ages ranged from 19 to 60, and the mean age was 38.70 years (*SD* = 9.30). Of these, 3 (8%) were employed, 16 (44%) were small business owners, and 17 (47%) were unemployed/had no source of income. Regarding marital status, 15 (42%) participants were married, 9 (25%) were divorced, 8 (22%) were widowed, 3 (8%) were single, and 1 (3%) participant was separated. Data on participants' educational levels showed that 5 (14%) had completed their year 12 secondary education (high school), 16 (44%) had dropped out in primary school, and 13 (36%) had dropped out in high school.

4.5.1.2 Participant Engagement and Retention

The study achieved a completion rate of 72%. Of the 36 participants who started the intervention, three participants exited before the endline assessment, and a further seven

dropped out before the three-month follow-up, resulting in a total of 26 participants available for the final assessment. It is important to note that of the 10 who dropped out, 1 dropped out for unknown reasons, 2 due to logistical challenges, and on a positive note, 7 dropped out due to reasons of relocation, after having gained the courage to leave their abusive partners and return to their own families.

4.5.1.3 Findings from Fidelity and Integrity Assessment

The fidelity and integrity assessment yielded positive results, as presented in Table 6 below. The Amai Busas demonstrated high levels of adherence to the structured worksheets and confidently covered the content. Language use was also positively rated as clear and locally relevant, enabling participants to understand the material. Most notably, the quality of interaction between Amai Busas and participants was rated as particularly strong, with the results showing strong empathy, responsiveness, and group cohesion among the women. These results indicate that, in addition to delivering the technical elements of the intervention with fidelity, the Amai Busas were also able to establish relational conditions that may strengthen effective trauma-informed care. These positive results not only demonstrate high fidelity among the Amai Busas, but also further support the feasibility and acceptability of the intervention.

Table 6: Fidelity and Integrity Findings

Amai Busa	Integrity Score /40	Fidelity Score /20	Overall Rating
A	36	18	Strong
B	35	18	Strong
C	38	19	Strong
D	37	19	Strong
E	39	20	Excellent
F	35	17	Strong

4.5.1.4 Supervision Report Findings

Key to maintaining fidelity and integrity among the Amai Busas was the supervision and support program that had been established. A total of 10 weekly group supervision sessions were held over the course of the project (from eligibility screening to endline), complemented by routine session observations by the RA, and consistent communication via a WhatsApp group facilitated by the PI and RA. These sessions allowed the Amai Busas to discuss any challenges, reflect on their experiences, and seek guidance on complex cases.

Findings from session observation reports and supervision logs showed that the Amai Busas' competence and confidence improved over time, with earlier sessions often

reporting questions about how to manage latecomers and group disagreements, while later sessions reported more profound discussions, such as adapting examples to real-life situations and avoiding countertransference. Overall, this layered support system not only contributed to the strong fidelity scores and high session completion rates of the intervention but also prioritised the emotional well-being of the Amai Busas.

4.5.1.5 Outcome Data from Intervention

Friedman's ANOVA tests were conducted to determine differences in participants' scores for depression, anxiety, PTSD, and resilience at three time points (baseline, endline and three-month follow-up). Post hoc analyses with Wilcoxon signed-rank tests were also conducted to determine the significance levels. Table 7 below shows a summary of the descriptive statistics for the key study variables, while Table 8 shows the summary findings of the non-parametric tests—Friedman's ANOVA and Wilcoxon signed-rank test. These findings, presented in the tables, are thereafter explained.

Table 7: Descriptives for Key Study Variables

	N	*M*	*SD*	Median	Range	α
Depression Baseline	36	34.94	6.63	35.0	20 – 48	.65
Depression Endline	33	4.45	3.39	3.0	0-14	.75
Depression Follow Up	27	8.62	5.31	8.0	0-21	.71
Anxiety Baseline	36	30.55	10.26	30.5	9-54	.86
Anxiety Endline	33	3.75	5.14	1.0	0-19	.87
Anxiety Follow Up	27	11.59	8.24	12.0	0-29	.80
PTSD Baseline	36	67.36	12.54	66.0	37-85	.82
PTSD Endline	33	19.15	3.81	17.0	15-32	.86
PTSD Follow Up	26	33.88	10.93	34.5	9-59	.73
Resilience Baseline	36	13.47	3.77	13.5	0-22	.44
Resilience Endline	33	27.48	4.91	30.0	6-30	.83
Resilience Follow Up	26	19.19	4.67	19.5	10-27	.68

Note. M = mean, *SD* = standard deviation, α = Cronbach's alpha internal reliability.

Table 8: Non-Parametric Test Findings

Measure	Friedman's ANOVA (χ^2)	Baseline-Endline (Z)	Baseline-Follow-up (Z)	Endline-Follow-up (Z)
Hamilton Depression	42.70, $p < .001$	-5.01, $p < .001$	-4.54, $p < .001$	-3.22, $p = .001$
Hamilton Anxiety	44.42, $p < .001$	-5.01, $p < .001$	-4.46, $p < .001$	-3.56, $p < .001$
PTSD Checklist	45.53, $p < .001$	-5.01, $p < .001$	-4.35, $p < .001$	-4.02, $p < .001$
Resilience Scale	39.91, $p < .001$	-4.83, $p < .001$	-4.01, $p < .001$	-4.16, $p < .001$

Depression

The test revealed a significant difference in depression scores at the three time points. The scores were found to have significantly decreased from baseline (*Mdn* = 35) to endline (*Mdn* = 3), and then significantly increased from endline (*Mdn* = 3) to follow-up (*Mdn* = 8). Despite this slight increase, depression scores were still found to have decreased significantly between baseline (*Mdn* = 35) and follow-up (*Mdn* = 8).

Anxiety

Findings indicate that there was a statistically significant difference in anxiety scores across the three time points. Wilcoxon signed-rank tests found that anxiety scores decreased significantly from baseline (*Mdn* = 30.5) to endline (*Mdn* = 1), then increased

significantly between endline (*Mdn* = 1) and follow-up (*Mdn* = 12). However, there was a significant decrease in follow-up scores from baseline to follow-up, with median scores of 30.5 and 12, respectively.

PTSD Symptoms

PTSD scores were also found to be significantly different at the three time points. Wilcoxon signed-rank tests showed that PTSD decreased significantly from baseline (*Mdn* = 66) to endline (*Mdn* = 17). A significant increase in PTSD scores is reported between endline and follow-up, with median scores at 17 and 34 respectively. In a similar pattern to depression and anxiety scores reported above, PTSD scores are still reported to have a significant overall decrease between baseline (*Mdn* = 66) and follow-up (*Mdn* = 34.50) four months later.

Resilience

Lastly, a Friedman's analysis of participants' scores on the Brief Resilience Scale found that there was a statistically significant difference at the three time points. A Wilcoxon signed-rank test found that resilience increased significantly from baseline (*Mdn* = 13.5) to endline (*Mdn* = 30). However, resilience scores significantly decreased between endline (*Mdn* =30) and follow-up (*Mdn* =19). Resilience scores increased from baseline (*Mdn* =13.5) to follow-up (*Mdn* =19).

4.5.2 Qualitative Study Results

Following a thematic analysis of the data collected in this study across the three time points (baseline, endline and follow-up), the following three key themes were generated in relation to the women's personal experiences with SGBV and the intervention: 1) *Ku Mangusuka:* Manifestation of Mental Distress and Pathways to Liberation; 2) *Tilitonse*: Empowerment of Women by Women; and 3) *Nkani za Ndalama*: Financial Illiteracy and Economic Control. These themes are described below, considering the changes in participants' moods and attitudes as they shared their experiences throughout the duration of the intervention at the three main time points.

A) Ku Mangusuka: Manifestation of Mental Health Distress Symptoms and Pathways to Liberation

The first theme that stood out among the women was the manifestation of mental health distress as a result of the abuse. This theme was chosen because of its frequency and relevance across all qualitative aspects of the study, as well as its role in shaping the intervention. The theme arose from repeated survivor accounts describing emotional, psychological and physiological changes, and was present in over 80% of interviews. Participants usually described these manifestations in culturally specific ways that were often different from standard Western psychiatric descriptions. This stood out quite significantly, as the women did not use clinical terms such as 'depressed' or 'anxious' to describe their feelings. They instead used words that reflected a very personal and cultural understanding of suffering, through both emotional and somatic symptoms such

as “very bad pain in my heart”, “overthinking”, "a heavy feeling", “struggling to swallow”, and “failing to sleep”. Some participants shared the following;

“I still can’t sleep at night. I am always thinking and thinking. It’s like my head is just always busy and I can’t control it” [P11, baseline].

"...I wasn't eating, I wasn't drinking water... I was failing. It’s like I had a big lump in my throat.” [P03, baseline]

“For me to bathe, put powder, to apply lotion, I was failing. I was holding onto something inside” [P03, baseline].

These quotes were selected because they highlight how mental distress manifests in ways that can be understood differently across cultures and may not always match traditional psychiatric definitions. The quotes also emphasise the importance of understanding local expressions in shaping the development of the intervention, as relying solely on Western symptom checklists risks alienating survivors or invalidating their lived experiences. These findings validate the importance of co-designing the intervention with the Amai Busas, whose input informed the integration of common local expressions into examples, case vignettes, and role-plays used in the training, ensuring that the content felt familiar and relatable.

The findings of this study reveal a pattern in which survivors’ psychological distress gradually decreased as the intervention progressed, resulting in experiences of mental liberation. This concept of liberation, locally known as ‘*ku mangusuka*’, can be described as a person mentally releasing all negative thoughts and emotions about an aspect of

their life they have been suppressing for a prolonged period. Participants referred to this experience as being ‘set free’ after finally opening up about their abuse and seeking help for it. At baseline, women harboured negative feelings such as fear and anger and because of their SGBV experience. By the endline, participants demonstrated notable progress, with reports of improved mental wellbeing. A participant shared the following during a one-to-one interview at endline;

“I’m feeling good, I'm free. Because wherever I go, I can bathe, I eat, I do what I want. I don't feel lost. I feel like I'm a person. I can feel my body weight, I'm a new human being” [P03, endline].

The quote above reflects the positive effect of the TF-CBT sessions on mental health, demonstrating both psychological and physiological healing. The quotes below go on to show how, at endline, following the TF-CBT sessions, the women described strong feelings of mentally releasing negative emotions and pain that they had been holding on to. One word that was consistently recurring was the word ‘free.’ Some participants shared:

"No, I'm feeling good. I feel good in my body, my thoughts. Now I am free. I am free now. Even my thoughts, it's a free mind. My body is going back (to normal). I'm feeling good” [P12, endline].

“I learned from the sessions, and I am now free. I was feeling shame because people were laughing at me saying 'look at how she is finished'. But now, I feel proud because I feel good, I even look good now because I found help” [P09, endline]

This recurring reference to the feeling of freedom among survivors demonstrates their newly acquired confidence and empowerment to take control of their bodies, minds, and lives, as opposed to feeling as if they had no control previously. These quotes illustrate the recurrence of the concept of 'freedom' among participants, with the participants portrayed as having the weight of shame, self-blame and judgment lifted off them, giving them the courage to make their own choices. The concept of freedom was also used as a reference to the women's newly acquired sense of safety, specifically for those who had removed themselves from their abusive situations.

At follow-up, data collected shows that three months after the intervention had ended, participants were still reporting improved mental health. Participants shared the following;

"Ever since the programme, I can feel a big change in me. I am doing far much better now. You know, all those bad things I went through? I have let them go. For my spirit to feel at peace, I had to let them go. So now I feel free." [P18, follow-up].

"Because of the way I was counselled in this group, it came out. Even today, I am still healed. The sickness I had, it came out. Yes, it's true this program can help. The way I have been helped, through learning... it has helped me." [P12, follow-up].

The quotes above were selected because they illustrate that three months after the intervention, the women were able to let go of their negative thoughts, ultimately resulting in an emotional release. This gave them a sense of relief and a new life to look forward to, whereas before the intervention, they believed they would never feel this

way. The quotes demonstrate that through the intervention, survivors developed a sense of healing and moving on from the abuse. The co-development and cultural adaptation of the intervention with the Amai Busas was crucial in facilitating this transformation. The Amai Busas, sharing the same cultural, religious and social background, were able to provide culturally appropriate support to survivors in an environment and setting where they felt safe, comfortable and at home. Incorporating local idioms and faith-based values (e.g., every session opening and closing with a prayer) into the training and intervention allowed survivors to process their trauma in a way that felt familiar and respectful.

B) 'Tilitonse': Empowerment of women by women

The second theme generated was the empowerment of women by women, a concept of unity and mutual support. This theme was selected because it illustrates a significant outcome of the co-development and cultural adaptation of the intervention, and is titled 'Tilitonse,' a popular Nyanja term directly translated as 'we are together.' Following the TF-CBT sessions, participants reported numerous positive developments as a result of what they had learned about their mental health, their human rights and their new knowledge and skills. Overall, the study reported improvements in participants' resilience, confidence, independence, and courage to open up in comparison to before they received support from the TF-CBT intervention.

At baseline, participants did not seem to be conscious of the gravity of other women experiencing similar abuse, as none of them spoke about what other women may be going through. However, at endline, when participants expressed the importance of the

sessions, they shared how they felt that they could transfer what they had learnt to other women, as they had developed an enhanced awareness of the suffering of many other women and survivors in their community. This motivation was not introduced by the Amai Busas, but emerged organically as survivors started to change their narratives and turn their pain into purpose. *"You know, after the sessions, I have realised that so many women are suffering in Misisi" [P01, endline].* One participant expressed that she had learned a lot from the sessions, but more importantly, she shared, *"I now understand how much women are abused without even knowing it and how we are supposed to live" [P07, endline].* With this understanding, participants consequently expressed a strong desire to contribute to community sensitisation on domestic violence, disrupt the culture of silence, and raise awareness on SGBV support services available for women, with another participant quoted saying, *"The way I have learnt, I know I can teach others going through the same thing also so that they know" [P13, endline].*

Another participant shared,

"I want to help my fellow women. I can help them by showing them where to go and letting them know that if they tell them the situation they're going through, they can be helped with what is hurting in the heart so they can be happy" [P01, endline].

From these quotes, a strong sense of altruism is apparent in the participants. Their desire to help other women experiencing abuse like them is evident. Based on their own traumatic experiences, they felt they had special insight into other women's pain. In the same vein, it was clear that their experiences with receiving support and healing provided

them special insight into what these other women's futures could look like if they, too, received the same support. Several participants also spoke about helping others because they felt they were best suited to do so based on their personal experiences with SGBV:

"If I find another woman who is going through the same thing, I can help them nicely. I can also give good advice now because of what I experienced and what I have learnt." [P11, endline].

Also revealed from the quotes was that participants also developed an understanding that to help other women, there was a need to raise community awareness on SGBV and educate the men as well. A participant shared, "*I really want men and women in my community to know about domestic violence, to show them insights" [P11, endline].* Another participant shared, *"We also need to teach the men. That is the only way things will change." [P09, endline].* Participants strongly suggested the inclusion of men in future interventions, as they believed *"...they are the root cause" [P04, endline]* of the problem and the best way of resolving it would be to change the way they think.

These quotes demonstrate a collective shift among survivors, from focusing on individual healing to a shared responsibility for others. From the onset of the project, the Amai Busas' involvement as trusted community leaders framed the intervention within a community care model, emphasising that healing was not only for survivors as individuals, but also for the community. The survivors' wish to help others reflects this model and confirms the intervention's cultural basis.

Overall, this theme highlights that through TF-CBT, the women gained knowledge and transformed their perceptions of gender roles and women's rights, instilling in them the courage to act for change and help other women. Participants expressed belief in the idea that knowing other women had also suffered in the same way would help some women overcome their own trauma. However, the quotes above also demonstrate that while the women themselves felt empowered to make a difference, they understood that it was not possible for them to solely achieve this without the engagement of men.

C) 'Nkani za Ndalama': Financial illiteracy and economic control

The third theme generated from this study was the issue of financial illiteracy among women. This theme was established due to its recurring appearance in the interviews and focus group discussions, as well as the important role it played in shaping the narrative of participants' recovery. The phrase '*Nkani za ndalama*' simply refers to finances. Most participants shared that their partners controlled them economically, using the women's lack of financial literacy as an excuse. Economic control is described as a type of economic abuse that includes preventing, limiting, or controlling a victim's finances and related decision-making (Adams, 2008).

The following quotes were selected because they not only provide a clear picture of the women's experiences of this type of abuse and the different ways in which it can present itself, but also the intervention's impact on participants in terms of financial independence awareness. At baseline, participants' accounts seemed to stem from a

place of feeling trapped and hopeless. One participant shared, *"He doesn't give me money. Everything is just restricted" [P21, baseline].* Other participants added:

"... he counts every coin for me. 'How much is a tomato? 2 Kwacha.' And that's what he'll give me exactly." [P02, baseline]

"He says look at you, you don't even know how to handle money. Simple budgeting, you don't know. How can I even rely on you when you can't even run the house?" [P11, baseline].

"For me, I've been told I'm useless. That I don't know how to make calculations and stretch money until the month end. So, he doesn't give me money... even for my own upkeep. To buy lotion, sanitary pads, nothing." [P19, baseline]

These quotes illustrate how the abuse was characterised by the abusers' full control of their households' finances, and restriction of the victims' access to financial resources. Additionally, abusers controlled any spending in the home, with some survivors describing being followed to the market or local shop to make sure they had control over what was being bought. Generally, participants describe having no involvement in, or awareness of, the financial matters in the household. The quotes above also show how the women were not only controlled and abused financially by their partners but also taunted and belittled based on their financial illiteracy.

At endline, participants demonstrate an increased awareness and understanding of economic control as a form of abuse. Women identified their own experiences of this abuse, elaborating and sharing additional accounts that they previously did not recognise

as abusive. One woman shared, *"I didn't even know that this was also abuse. I now know my rights. He shouldn't be treating me like this" [P20, endline].* This participant expressed that through the intervention, she realised many of her experiences in her marriage, which she thought were insignificant and could be ignored, were forms of abuse. Her quote above also illustrates a profound realisation of her human rights and that she did not have to continue tolerating any form of abuse. Another participant shared the following:

"I'm used to living like this because it's our tradition. You must listen to your husband and let him run the house. So even money, you must let him be in control. But now I know that some of our traditions are not very good for us women. I see now that this is abuse. Because I can't even buy myself lotion or do my hair. Nothing" [P03, endline].

The above quote also brings to light the relationship between economic abuse and unhealthy cultural practices. Participants' newly acquired knowledge and awareness of this link fostered a strong desire for change in their respective lives. This desire for change is observed to have continued into the follow-up stage, where participants expressed a desire to identify new methods to assist themselves and other women in achieving financial independence. Participants shared the following:

"I think your project should introduce a lot of activities in the community so that the survivors can be kept busy doing the same activities and making some money. For me, I thank God I have found some part-time work as a cleaner. It's not much, but it's something " [P07, follow-up].

"I received the counselling, and now I am okay. But I still can't support myself and my children. I left my husband because of the abuse. We are on separation. What will I do now?" [P20, follow-up].

"For me, I think all of us learnt so much from the program and we really benefitted. Personally, I am doing fine mentally and emotionally. My only worry now is where to start from again... I don't know how I will take care of myself and the children. I need to find something soon. If I can be helped with even just a simple job, it can be a start" [P25, follow-up].

Overall, the quotes show a transformation from economic illiteracy and vulnerability, to an awareness of the need for financial independence. Additionally, the quotes show that the intervention was successful in instilling healing, healthy coping strategies, and knowledge in the women about the different forms of abuse, thereby enabling them to identify these in their own lives and those of other women. However, the study also found that women who were able to leave their abusive situations, having previously depended on their abusive partners, needed further support, specifically in establishing new ways of gaining financial independence.

The identification of this theme directly reflected the intervention's co-development process, as early Patient and Public Involvement (PPI) consultations with the Amai Busas revealed that although emotional healing was the main goal, there was a need to address the issue of financial abuse. Some of the participants were previously unaware that the financial mistreatment they experienced from their partners, was, in fact a form of abuse.

This discovery resulted in the incorporation of a culturally relevant element of 'Understanding Financial Abuse' into the adapted trauma-focused cognitive behavioural therapy (TF-CBT) training. An additional reason why this theme was selected was that it challenged existing SGBV interventions that focus only on emotional or psychological symptoms. In the Misisi context, financial control was not only a sign of gender inequality, but also a root cause of mental distress as demonstrated in survivors' accounts of their experiences. This, therefore, called for a need to address the abuse directly to allow survivors to gain practical knowledge.

4.6 Discussion

This is the first study to demonstrate that a brief TF-CBT intervention had a transformative effect on the mental health of female survivors of SGBV in a peri-urban community in the Zambian context. The findings indicate that the TF-CBT sessions were found to be impactful to the women in numerous ways, including significant improvements in their mental health, learning healthy coping skills, minimising shame in help-seeking behaviours, and citing interpersonal interaction as one of the highlights of the sessions. The quantitative data collected at three time points (baseline, endline, and follow-up) indicate that the overall effect on participants' anxiety, depression, PTSD and resilience scores suggested a statistically significant improvement in mental health. Although a decline in mental health was noted between endline and follow-up, it remained smaller than the overall improvement from baseline to follow-up. These findings suggest that

future versions of the intervention may require improvements, such as ongoing support beyond the TF-CBT sessions and the inclusion of empowerment elements to encourage independence in the women.

4.6.1 Reflection on Themes

A thematic analysis of the qualitative data identified three main themes: i) manifestation of mental distress and pathways to mental liberation, ii) empowerment of women by women, and iii) financial illiteracy and economic control by abusers.

Reflecting on the first theme (manifestation of mental distress and pathways to liberation), as a researcher, I came to recognise the importance of genuinely listening to the way survivors describe their distress in their own words, as opposed to imposing and labelling their symptoms with clinical terms. Their expressions of experiences, from pain to healing, taught me that respecting cultural context is essential for interventions to be meaningful and successful.

My reflection on the second theme (empowerment of women by women) was prompted by a profound realisation. While my initial focus was on the clinical outcomes of my study (reduced anxiety, depression, and PTSD scores), hearing survivors express their desire to help other women in their community and become agents of change led me to think more broadly about the true meaning of healing in this specific context. I learnt that to survivors, recovery was not only based on their own healing but also on their ability to help others.

Regarding the third theme (financial illiteracy and economic abuse), listening to the women share their personal experiences helped me realise that financial abuse was not separate from their trauma - it was a significant part of it. Their stories revealed how their abusers used financial dependence to control them, and how gaining financial literacy and independence was essential for recovery. To address this problem of financial illiteracy and economic abuse, rather than imposing generic financial education, I collaborated with the Amai Busas to embed lessons in different financial abuse scenarios, contextualised by gender expectations, family roles, and the different cultural norms around money in the traditional Zambian context. For instance, discussions about healthy household financial decision-making were framed within the local idioms of respect and negotiation, making the content more relatable and understandable.

Overall, the three themes presented in this paper stood out not only because of their frequent recurrence throughout the study, but also because they strongly reflect how well the qualitative and quantitative findings complement one another and tell the same story.

4.6.2 Effectiveness, Acceptability, and Feasibility of the Intervention

Scholars have suggested that the effectiveness of psychological interventions should be evaluated through outcomes, mediators, and mechanisms of change (Kazdin, 2007). This study's findings offer preliminary evidence of the effectiveness of an intervention, with

reports of significant reductions in anxiety, depression, and PTSD symptoms, as well as improved resilience. In line with other similar work (Murray, 2013; van Ginekken, 2013), these outcomes suggest that evidence-based treatments can be delivered in low-resource settings and yield meaningful change.

The acceptability of the intervention is evidenced by the high attendance and completion rates (91% at endline and 72% at follow-up), along with participant satisfaction reflected in their positive feedback on both the content and delivery. Studies conducted in similar contexts and settings have reported strong acceptability based on participants' high attendance and completion rates (Murray, 2014; Patel, 2011). Additionally, scholars (Sekhon et al., 2017; Kohrt et al., 2018) suggest that the acceptability of treatments and interventions is not determined solely by participant satisfaction alone, but by various factors, including how confident and competent non-specialists feel when delivering support. This is demonstrated in this study by the Amai Busas' strong performances in the previous study's assessment of their knowledge, skills, and confidence post-training.

Feasibility in this study is reflected in the successful delivery of the co-developed intervention by lay counsellors, supported by a culturally adapted manual, along with structured supervision. According to Peters et al. (2013), feasibility is determined by assessing whether an intervention can be implemented as intended in a real-world setting, as well as its scalability and sustainability. Collectively, the preliminary results of this study (the qualitative results and quantitative findings supporting them) demonstrate

meaningful psychological impacts on survivors in Misisi and show practical potential for real-world use and scaling.

4.6.3 Study Implications

Key findings of this study highlight that despite being a pilot test of an intervention rather than a large-scale effectiveness RCT, this study has contributed a novel, co-developed, feasible, and promising intervention ready for more robust efficacy testing. The study successfully developed a culturally relevant intervention that has had a significant impact on the Misisi community, and effectively equipped six community leaders with the skills to deliver support to survivors using evidence-based methods. Following the new evidence from the successful training and delivery of the pilot, the Amai Busas have expressed their commitment to continue and expand the project in collaboration with the PI as it scales up into a formally registered community programme.

The key findings described above support those of other similar studies (Bass, 2013; Bryant, 2017; Dawson, 2016) that have contributed to existing evidence that brief CBIs tailored for SGBV survivors can be effectively delivered by trained and supervised lay counsellors in LMICs. As is demonstrated by the quantitative findings, this study highlights significant positive changes in women's emotional and mental wellbeing following the TF-CBT sessions, with specific improvements in their assessment scores for anxiety, depression, PTSD, and resilience. The qualitative findings additionally show specific reports of participants experiencing healing and growth from their abuse after learning

how to apply healthy coping skills, followed by strong desires to help other women in similar situations. These changes can also be described as posttraumatic growth, which is defined as positive psychological growth in the aftermath of traumatic events (Machinga-Asaoul, 2024; Sinko, 2019; Tedeschi & Calhoun, 2004). Scholars suggest that posttraumatic growth does not invalidate survivors' pain and suffering but rather recognises and accepts both the negative and positive outcomes of the traumatic experience (Machinga-Asaoul, 2024). Currently, there is no published evidence of research on posttraumatic growth in survivors of trauma in Zambia. The findings of this study, therefore, contribute towards filling this gap in research.

This study found a strong theme of women empowerment, with survivors expressing their desire to help other women in situations similar to theirs. These findings are supported by a number of studies (Drauker 2003; Grossman, 2006) that have reported that when survivors of SGBV support other survivors, these 'helping behaviours' can contribute to their own healing and help them to understand their own journey. Other studies have also found that these 'helping behaviours' contribute to the improvement of survivors' mental health (Frazier, 2001; Martsolf & Drauker, 2008; McMillen et al., 1995; Wright et al., 2007). Despite these findings, there is still a dearth of research data on the specific ways in which these helping behaviours affect specific aspects of survivors' mental health. Future research is needed to examine this, in order for evidence-based CBIs to be developed with the possibility of involving survivors as lay counsellors for fellow survivors.

Although many factors contribute to the victimisation of women who experience SGBV, economic instability may explain why women are vulnerable and unable to leave abusive relationships. Financial abuse has been found to contribute to the challenges that victims face when they attempt to leave their abusers. However, it is still one of the least studied forms of abuse (Sanders, 2014). Scholars (Meller, 2024; Stylianou, 2018) describe economic and financial abuse as a situation where an abuser controls a victim's ability to obtain, use, or maintain any financial resources, preventing economic security and financial independence. In this study, women have reported numerous experiences of financial/economic abuse, resulting in many of them failing to leave their abusive partners and the few who have, being left in situations where they are unable to support themselves and/or their kids. These findings support scholars (Adams, 2008; Meller, 2024; Postmus, 2018) who have argued that due to financial dependency, many women fail to leave economically abusive relationships because their standard of living is threatened immediately after leaving, and this can affect their long-term economic options. The findings also support the feminist theory, which suggests that among other methods of control, abusers use financial control to have dominance over women. To address this problem, one increasingly popular response is financial literacy (Eggers del Campo, 2022). There is a need for further research to investigate the feasibility of future CBIs increasingly developing programs that include a significant component aimed at teaching women about traditional finance and raising awareness on financial abuse as a form of SGBV (Stylianou, 2018).

One aspect that is also important to consider is that of cultural factors in relation to economic abuse. A few studies have called attention to the effect that cultural norms have on economic abuse, with reference to norms such as gendered attitudes around finances, religion and family dynamics (Singh, 2020). For instance, in many African cultures, women are traditionally expected to take care of the home, the children, and cater to their husbands, whilst the husbands are financially responsible for the family. Additionally, some traditions such as bride price, a payment made by a groom to the bride's family before he is permitted to marry her (Chen, 2023), may also contribute to the vulnerability of women to economic control (Chowbey, 2017). There is therefore a need for future research to investigate the different ways in which unhealthy cultural practices or norms influencing financial abuse can be addressed and challenged.

4.6.4 Practical Implications

The study has several implications for future CBIs that might consider utilising lay counsellors for mental health support for survivors of SGBV. The first key area is the need to include economic empowerment components in designing future CBIs for survivors in LMICs. For instance, some economic empowerment interventions include elements such as financial literacy training and/or skills training. According to Ditter (2014), empowering survivors economically is necessary for them to escape the cycle of violence and establish a new life, as it contributes towards creating a fairer and more secure environment for healing. For survivors, financial independence also boosts self-esteem and instils a feeling of accomplishment (Showalter, 2016).

To be effectively addressed, SGBV in low-resource communities in LMICs needs to be tackled with interventions that have a comprehensive and holistic approach, from preventive measures challenging unhealthy cultural norms, to mental health support and economic empowerment measures. Researchers (Weissman, 2012; Ragavan, 2020) argue that effectively tackling SGBV requires a well-rounded community response focused on the needs of survivors. This includes establishing job training programs, ensuring affordable housing accessibility, promoting economic development efforts, and fostering collaborations among service providers, community organisations, and various stakeholders to enhance access to counselling, healthcare, and legal support. The current results additionally reveal that at the three-month follow-up, many women experienced a decline in mental health, indicating a need for additional mental health support.

As this and other studies have demonstrated the effectiveness of CBIs delivered by lay counsellors in low-resource communities, it is also imperative that in the development of future CBIs, there is a consideration for the development and validation of screening tools that are lay counsellor user-friendly. Similar recommendations are made by Chibanda et al. (2014), who proposed the development of screening tools that could be easily used by LHW with minimal supervision, and further went on to validate such tools through a cluster randomised controlled trial showing the effectiveness of the Friendship Bench intervention in Zimbabwe (Chibanda, 2016).

4.6.5 Strengths and Limitations

This study successfully developed and tested a novel intervention, effectively delivered by trained and supervised lay counsellors in a peri-urban community where such services, tailored specifically for female survivors of SGBV, are highly lacking. The study's longitudinal structure facilitated the identification of changes in survivors before and after the intervention. Furthermore, the mixed methods approach allowed for the qualitative and quantitative data to corroborate each other, thus providing greater depth to the women's journey through the programme.

However, the study had a few limitations, with the primary one being that it is a pilot study among a small group of women in one setting and centred around the use of local community leaders who have lived in the Misisi community for over 10 years, as lay counsellors. There is a need for the findings to be expanded to other developing societies. Additionally, the intervention requires that the lay counsellors are literate, making it challenging to replicate in remote rural areas where access to education is highly limited.

Furthermore, the intervention's immediate positive mental health outcomes were observed, but the long-term effects have not been determined due to the study's follow-up period being only three months. However, while some might consider three months to be relatively short, it is longer than the follow-up periods of other similar studies (Sabri, 2022; Tiwari, 2005). In future studies, the intervention's follow-up period should be increased to provide evidence that the intervention has lasting effects, and also to

establish whether it is possible to maintain these effects, especially among high-risk populations such as SGBV survivors who continue being at risk of experiencing issues with their abusers, as well as socioeconomic challenges. The study findings also indicate poor reliability of the resilience measure, which may be due to the lack of cultural validation. Future versions of the interventions should therefore consider the use of a different measure to assess resilience in SGBV survivors in Zambian communities.

4.7 Conclusion

This study presents the development, effectiveness, and acceptability of a novel culturally tailored programme that can be embedded into communities to help them learn from each other and support one another to understand, escape from, and recover from abuse. The intervention was effective in significantly reducing anxiety, depression and PTSD symptoms, as well as increasing resilience in participants. Although the treatment effects were found to have slightly decreased three months post-intervention, the reasons for this decline can inform better implementation and scaling of the intervention in other low-resource settings. Overall, the preliminary positive outcomes reported in participants' mental health, along with growing evidence, suggest that a culturally adapted TF-CBT approach can be feasible, acceptable, and potentially effective in addressing mental health problems among SGBV survivors in LMICs.

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Chapter 5: Discussion

This chapter presents a critical and integrative account of the research implications and contribution of the papers of this thesis to knowledge and scholarship in the field of psychology.

5.1 Summary of Key Findings

My unique contribution to knowledge is that culturally adapted community-based interventions delivered by trained and supervised lay health workers can be effective in the improvement of mental health effects of SGBV in female survivors in LMICs. Nonetheless, it is crucial to develop culturally adaptive interventions tailored to each community. My scoping review presented in Paper 1 highlights that currently, there are limited interventions aimed at enhancing mental health for female survivors of SGBV in LMICs. This clearly illustrates the necessity for developing more interventions. Nonetheless, among the limited options (10 studies) reviewed, it was discovered that CBIs can positively influence the mental health of SGBV survivors in these regions. Future advancements may result from adopting innovative and culturally relevant methods, such as task shifting to address workforce shortages (which also boosts cultural acceptance), incorporating both individual and group treatments, and improving communication and safety protocols to safeguard confidentiality.

The second key finding, from Paper 2, suggests that the co-developed and culturally adapted training had a generally positive outcome and impact on participants' perception of their ability to support women who are survivors of SGBV. A brief course like this can produce appreciable gains in knowledge and skills required to handle women experiencing mental health challenges as a result of SGBV. From the training experience, participants learned more about themselves and their abilities as counsellors, and applied these learnings to their personal lives as well, thereby enhancing their effectiveness in not only their roles as helpers in the community, but also in their personal daily lives.

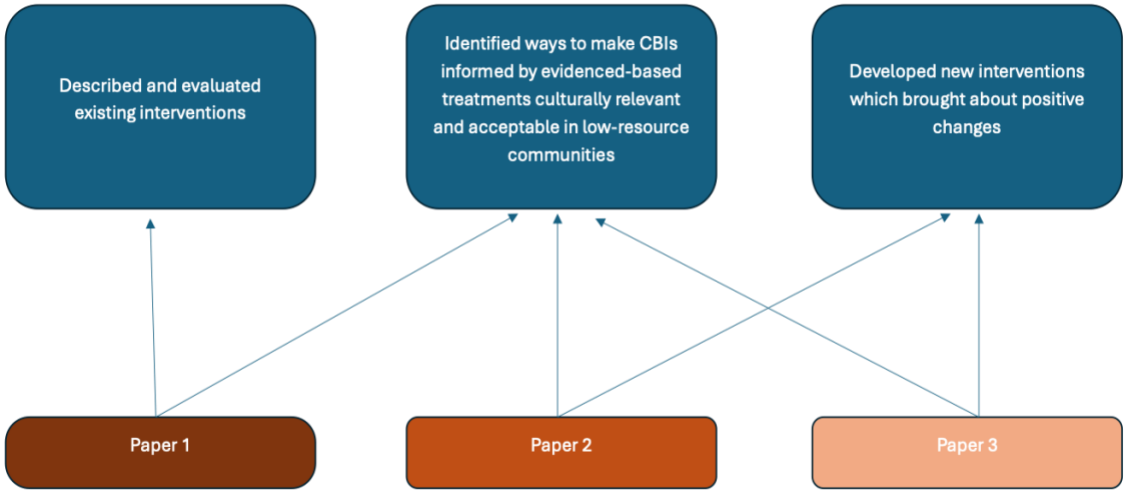
Finally, Paper 3 shows how this study found that a co-developed CBI delivered by trained and supervised members of a low-resource community was successful in enhancing the mental health of women affected by SGBV in a country with a shortage of mental health specialists. With an initial target of recruiting 30 participants, the study ended up recruiting 36, presumably due to high interest rates in participating from the community. The statistical data shows retention rates of 91% at endline and 72% at follow-up, reflecting the feasibility and acceptability of the culturally adapted intervention. It is important to note that out of the 10 participants who dropped out, 7 did so due to reasons of relocation after gaining the courage to leave their abusive partners – reflecting the effectiveness of the intervention. Findings from the pre-post assessments also suggest a statistically significant improvement in participants' mental health from baseline to follow-up. Qualitatively, the study found that following the intervention, survivors experienced a sense of mental liberation, and an enhanced sense of unity and mutual support for fellow women. Participants also learned healthy coping

skills and reported increased confidence in their ability to remove themselves from abusive situations. An additional key finding that was unexpected was that of altruism and PTG among survivors. These findings demonstrate the effective application of this intervention in a peri-urban community, showing that trained and supervised Zambian lay health workers can competently provide evidence-based treatments within their own communities. The study, therefore, presents promising results and justifies the need for a follow-up study to establish feasibility before intervention validation with a fully powered RCT.

5.2 Research Contributions and Implications

The three papers presented in this thesis address a number of research aims and objectives pertaining to the development of CBIs to improve mental health in female survivors of SGBV in LMICs. The studies used mixed research designs, which allowed for the flexible application of methods to suit respective research aims. The specific study contexts, aims, methodologies and findings of each study are presented in each paper separately. This chapter offers a critical, comprehensive account of the contribution of the three papers of the thesis to knowledge and scholarship in the field of psychology, which has been summarised into three contribution themes. Figure 4 below shows how each of the three papers are linked to the contribution themes, with each being described in more detail in the sections that follow.

Figure 1: Contribution Domains



Note. The arrows indicate the domains to which each paper contributes.

5.2.1 Contribution theme 1: Described and evaluated existing evidence-based interventions

Paper 1 presents a scoping review that evaluates existing interventions and contributes knowledge about their key features and characteristics, as well as recommendations for their improvement. The paper summarises existing literature on the effectiveness of SGBV interventions designed to enhance mental health in female survivors from LMICs. The review highlights that whilst CBIs are increasingly becoming popular in addressing SGBV, there is a dearth of evidence of such interventions focused on improving mental health in female survivors in LMICs in comparison to high-income

countries. Numerous scholars underline this research gap (Keynejad, 2023; Murray, 2020). Therefore, despite the very broad inclusion criteria applied, only ten publications met these criteria and were included. An analysis of these ten studies identified a total of five intervention therapies: 1) Problem Management Plus (PM+); 2) Cognitive Processing Therapy (CPT); 3) Improving AIDS Care After Trauma (ImpACT); 4) Cognitive Behavioural Therapy; 5) Gender Dialogue; and 6) Health Activity Programme (HAP).

The review concentrated specifically on three key outcomes: anxiety, depression, and PTSD. The analysis aimed to examine and identify which of the ten interventions proved effective in reducing symptoms of the three outcomes, with findings indicating that all ten were effective. Furthermore, also explored were the components present in these interventions to identify common elements, highlighting what has been most frequently included in successful strategies for improving the mental health of SGBV survivors. The paper contributes to this domain by presenting the key finding of the review: CBIs can improve mental health in SGBV survivors in LMIC, and future successes can be achieved through innovative and culturally adaptive approaches, such as a) task shifting to address manpower challenges (which also improves cultural acceptability), b) incorporating both individual and group-based treatments, and c) enhancing communication and safety measures to ensure confidentiality.

Previous research (Murray, 2020; Spangarow, 2007) has shown that there are very few psychosocial interventions that have been developed and evaluated for survivors of SGBV. However, scholars such as O'Brien (2016) recognise that, globally, providers and

researchers are building a body of research focused on recommended intervention strategies to engage female survivors of SGBV and tackle their psychological symptoms. Similar reviews have been carried out by scholars such as Lakin (2022), who reviewed psychological interventions for survivors of intimate partner violence in humanitarian settings in LMICs. The findings noted that, generally, contemporary research is moving towards a less medicalised approach to mental health and more towards integrating mental health interventions into broader social intervention programmes, such as violence prevention initiatives. Lakin (2022) further suggests that the adaptation of specialised mental health treatments to make them more scalable and easier to implement as community and family support methods should be the focus of future programming. This supports the recommendations made in my scoping review, where there is an emphasis on the importance of adapting and tailoring treatments to the specific needs of the communities in which they are delivered. To achieve this, one contribution of my review points to the effectiveness of the task-shifting approach in delivering CBIs, having found that 60% of the studies reviewed employed this approach. A similar review (Keith, 2023) of GBV interventions in Sub-Saharan Africa reports similar results of psychological interventions using non-professional counsellors being effective in the management of GBV-induced mental disorders. Out of the eight studies they reviewed, six employed the use of lay counsellors and reported improvement in symptoms of depression, anxiety, PTSD, alcohol misuse or dysfunction (Keith, 2023). However, my review highlights the significant relationship between cultural norms and task-shifting, pointing to the effect that cultural norms have on the implementation of

task-shifting and vice-versa. Yankam (2023) agrees with this argument, suggesting that cultural norms can substantially hinder task-shifting interventions in terms of access, involvement, and delivery. My review sets the tone for the rest of this thesis regarding the importance of the relationship between task-shifting and cultural adaptation in the development of psychological interventions for survivors of SGBV in LMICs, and contributes to this theme by demonstrating how numerous successful CBIs have attributed their effectiveness to, among other elements, the task-shifting approach, which was reported to have also enhanced cultural adaptation in their interventions.

Like other reviews (Keith, 2023; Lakin, 2022; Morrison, 2007; O'Brien, 2016), my scoping review calls for more rigorous and enhanced research exploring psychological interventions delivered by lay counsellors and directed toward addressing SGBV, as there remains a significant gap in this research area especially in LMICs. While there continues to be a growing body of research on SGBV interventions globally, the review identifies gaps in specific areas, such as insufficient evidence of interventions that have included men. In light of this, the review points out the cardinal need for the inclusion of men in SGBV interventions – including those designed for the improvement of mental health in survivors. Keith (2023) also reports identifying this gap, and recommends that the engagement of men is key to the effective reduction of GBV in Sub-Saharan Africa, where social norms are patriarchal in nature and relationship power dynamics are favourable to men, who are the primary SGBV perpetrators (Keith, 2023). Additionally, their review found that interventions that involved both men and women were most effective in reducing SGBV, and that these were found to have employed gender-separate sessions.

The employment of gender-separate sessions further reiterates another key issue identified by my scoping review, regarding the safety of female survivors and basically the importance of ensuring that interventions that aim to include men are designed in such a way that there is no risk to the women's safety.

Overall, the findings of my scoping review contribute to this theme by adding to the existing body of evidence on the applicability of CBIs using evidence-based treatments to provide support for SGBV survivors in LMICs. The findings of this and other similar reviews call for future research to prioritise the identification of factors that hinder or facilitate cultural adaptation in interventions, especially from the perspectives of lay counsellors – who should be allowed to play a crucial role in the development and execution of the programs. Morrison (2007) argues that it is not possible for a single intervention to address all risk factors for SGBV or reduce it quickly. Instead, various interventions across different levels of the ecological model (individual, community, institutional, legal, and policy) are needed. My review, presented in Paper 1, therefore contributes to existing data at the community level by showcasing the identification, evaluation and summary of CBIs that have been assessed in peer-reviewed literature, the outcome of which will benefit researchers and practitioners in LMICs.

5.2.2 Contribution theme 2: Identified ways to make CBIs informed by evidence-based treatments culturally relevant and acceptable in low-resource communities

Research suggests that cultural adaptation of interventions is important to ensure effectiveness, feasibility and acceptability by service users and the wider community (Fendt-Newlin, 2019; Kumpfer, 2017). All three papers presented in this thesis contribute to this theme by demonstrating that evidence-based interventions can be adapted to fit the local contexts of specific communities. They highlight critical reflections on how culturally relevant and acceptable interventions are when implemented in settings that they were not originally developed for.

According to Sekhon (2017), treatment acceptability is determined by several factors, including behavioural measures such as participants' total completion rates, attitudes toward the intervention, its appropriateness, suitability, convenience, perceived effectiveness, and reasons for discontinuation. In the empirical study presented in Paper 3, the high completion rates (91% at endline and 72% at follow-up) and participant satisfaction may be indicators of high intervention acceptability. These results are complemented by the notable reduction in mental health distress and the qualitative data, which shows the positive impact the intervention had on participants, including mental liberation and healing, learning to apply healthy coping skills, and gaining a strong sense of mutual support for fellow women. Similar findings are reported by Dawson (2016), who attributes the high completion rates in his CBI to high acceptability.

Paper 1 highlights that there is a gap in mental health interventions for SGBV survivors in LMICs (O'Brien, 2016; Spangaro, 2007). The paper thus contributes to this theme by identifying the few existing interventions in the specific context of this thesis and highlighting their strengths and limitations regarding cultural adaptation. All ten studies reviewed emphasised the critical need for improvements in future versions of the interventions to make them more culturally adaptive and sustainable. The paper further provides supporting studies that argue inconsistencies in cultures (attitudes, beliefs, and values) influence the delivery of community-based interventions (CBIs) and their acceptability in the specific contexts where they are implemented (Doucet & Denov, 2012; Karasz & McKinley, 2007; Ying, 1990). The findings of my scoping review align with those of a similar review which was carried out on the cultural adaptation of psychological interventions delivered by lay health workers in Africa, where Mabunda (2022) identifies six methods of cultural adaptation employed by CBIs. These include the cultural competency of the lay therapists, the incorporation of language translation and local practices into treatment, the incorporation of religious concepts, the incorporation of community engagement, the adaptation of methods and training to match LHW experiences, the incorporation of local symbols, and finally, the incorporation of client-derived goals. The interventions identified in Mabunda's review were first developed in the United States of America (Interpersonal therapy, Trauma-focused therapy), the United Kingdom (Problem-solving therapy), and Australia (Narrative exposure therapy) (Mabunda, 2022). The findings of my scoping review therefore support such existing

evidence, as the cultural adaptation methods described by Mabunda are identified in the various interventions reviewed.

In most of the studies reviewed in Paper 1 of this thesis, cultural adaptation is achieved through the application of Task Shifting, as proposed by Doucet and Denov (2012), who emphasise the importance of integrating culturally competent practices into SGBV treatment models. Doucet and Denov demonstrate this in their study, which focused on the cultural significance of survivors receiving advice and counsel from key community members. They found that SGBV survivors who underwent traditional interventions had the most positive experiences when village elders offered support and advice. These findings are supported by scholars such as Lakin (2022), who emphasises that transdiagnostic treatments, which can be delivered by paraprofessionals or trained lay providers, have the capacity to benefit numerous survivors in need. These treatments have demonstrated effectiveness in reducing mental health symptoms and improving overall psychological well-being. Despite studies showing evidence of LHWs being crucial for delivering complex psychological interventions to individuals with mental illnesses in LMICs, research on how these interventions are applied, culturally adapted, and incorporated into health systems is limited (Joshi, 2014; Schnieder, 2016). The findings of Paper 1 are significant in contributing to a wider understanding of the bi-directional relationship between cultural factors and the delivery of CBIs in low-resource communities. Further research is required to fully appreciate the success of the interventions reviewed after the application of the recommended cultural adaptation components.

Papers 2 and 3 contribute to this domain in numerous ways, as collectively, they present the development and delivery of a TF-CBT-informed intervention culturally tailored for a high-risk population in a specific community. Paper 2 presents evidence of training laypeople in specific knowledge and skills required for providing culturally relevant mental health support for SGBV survivors in Misisi and, in doing so, contributes to supporting the development of competence. Fink (2024) supports this approach, as he underscores that the training of local community health workers is an important component of adapting mental health interventions for local contexts. In their review of Fink's study, which evaluated the implementation of Problem Management for Moms (PM+) in Zambia, Dalal et al. (2024) emphasise that it is important to deeply understand local cultural norms and values, as well as how mental health is perceived in order for a psychological intervention to be implemented effectively. The current study demonstrates this, as it began with a preparatory stage consisting of a PPI consultation with two key community informants (Amai Busas) who play a crucial role in assisting SGBV survivors in Misisi. From this consultation, the study gained a clear understanding of the community's specific mental health needs for SGBV survivors and the extent and forms of SGBV in Misisi. Subsequently, using the data collected from the PPI exercise and existing literature, a TF-CBT training comprising culturally relevant content and methods was successfully designed and later delivered to six Amai Busas, thereby equipping them to support survivors in their community. In this way, this study complements numerous studies that support this approach and highlight the significance of creating training content that is both relevant and culturally appropriate (Anakwenze, 2022; Chibanda,

2020; Naeem, 2010). Mabunda (2022) also supports the experience and participation of LHW from the development of mental health interventions to their delivery and suggests that an understanding of this participation and experience can then inform the future development and cultural adaptation of mental health interventions.

In Paper 2, cultural adaptation is further demonstrated in the TF-CBT training content, where role-plays and scenario examples are tailored to the Zambian cultural context using Zambian names and relatable situations. For instance, in Module 2 (Introduction to Cognitive Behavioural Therapy), activity 2.3 is a group task designed for trainees to learn and practice 'Case Conceptualization,' a key aspect of CBT. Participants receive a handout titled 'Mumba's Story,' which they must read thoroughly and conceptualise the case. They are informed that this study was based on a real case encountered by the Principal Investigator at Kalingalinga Police Post in Lusaka in 2008. Similar studies (Bass, 2013, Bolton, 2007, Chibanda, 2016) have successfully applied this approach in their intervention training, where the use of stories and local examples with local symbols/idioms was effective in the cultural adaptation process.

In addition to the above, training Amai Busas as lay counsellors for this intervention was, in itself, culturally influenced. As highlighted in Paper 2, Zambian culture typically encourages women to seek support from older women or those they regard as community leaders. This is also typically the case in many traditional African societies (Doucet & Denov, 2012). Therefore, Paper 2 further contributes to this domain by providing evidence that collaborating with community leaders in developing training

programs tailored specifically for their communities can be beneficial and effective in maintaining cultural relevance and acceptability. The Amai Busas' post-training assessment results show a marked improvement in their confidence to support women in their community, and this can be attributed, partly, to their playing a role in developing the intervention for these women.

Paper 3 contributes to this theme by presenting the delivery and impact of the pilot intervention delivered by the Amai Busas, adding to existing evidence that a novel, brief, culturally tailored TF-CBT intervention delivered by LHWs can have a transformative effect on the mental health of female survivors of SGBV in a low-resource community (Lakin, 2022; Mabunda, 2022; Yankam, 2023). The paper brings to light the numerous cultural factors in the Zambian context that contribute to SGBV, including those leading to economic abuse of women by their partners. This is illustrated with shared accounts of survivors' lived experiences. The paper also discusses how the intervention targets and successfully challenges these unhealthy cultural norms and beliefs, with participants expressing a shift in their mindset after learning that what they had always accepted as normal tradition in every marriage was, in fact, a form of abuse. This approach is supported by Sabri (2019), who argues that successful SGBV interventions require more than just addressing the needs of individual survivors, but need to include aspects aimed at transforming relations and addressing discriminatory social norms and systems that promote gender inequality and SGBV. It goes without saying that these transformational elements need to be culturally tailored to each target society. This study contributes to this theme by complementing existing studies that have found social empowerment

interventions to be effective in challenging harmful cultural norms (Doyle, 2018; Quattrochi, 2019) and changing survivors' beliefs, thereby increasing their awareness, self-worth, and confidence to actively participate in their communities and support other women.

5.2.3 Contribution theme 3: Developed new interventions that resulted in enhanced skills, knowledge, mental health and wellbeing

Papers 2 and 3 contribute to this domain as they collectively present the development, delivery and evaluation of a pilot intervention. The evaluations from the pre-post design in both studies indicate positive changes in participants, with respective reports of enhanced skills and knowledge in Paper 2, and improved mental health and well-being in Paper 3.

Paper 2 focused on the development of a TF-CBT intervention for female survivors of SGBV. Development began with a PPI consultation with two community representatives (Amai Busas), followed by the capacity building of six Amai Busas in order to equip them with skills and knowledge on trauma and mental health, thereby enabling them to provide mental health support to survivors of SGBV in Misisi. Here, information collected from the Amai Busas' previous PPI consultation was used to enhance and adapt an existing TF-CBT training intervention. Barnett (2019) supports this community-partnered approach, emphasising that such partnerships are important for ensuring that the intervention meets the local culture and context. In the current study, a pre-post

evaluation of the training delivered to the six Amai Busas in Misisi suggested high participation and engagement in the interactive activities. The findings suggested that the training successfully enhanced participants' confidence, knowledge, understanding, and skills. Results from this study suggest that the training had a generally positive impact on participants' confidence in their ability to effectively support SGBV survivors. Other studies (Armstrong, 2003; Chibanda, 2015) report similar findings, indicating that short periods of training positively influenced LHWs' confidence in being able to effectively counsel in actual situations and promoted self-reflection and personal growth. In this study, further positive changes were reported in the six Amai Busas' well-being, including accounts of personal healing from applying the skills they acquired in the TF-CBT training to their own lives. The Amai Busas reported being able to foster improvements in their own relationships and those of their loved ones.

One particular account that stood out was the case of one of the Amai Busas, who, at the end of the training program, revealed that she had been experiencing abuse at the hands of her husband (a respected pastor and leader in the community). This participant reported having applied the TF-CBT skills on herself and expressed an enormous amount of gratitude to the program, sharing that she would not have managed to cope if she had not learnt how to do so in a healthy way. The participant also insisted on carrying on with the program as a lay counsellor, firmly confident that giving her an opportunity to help other women would contribute to her own healing. This account demonstrates the positive impact of the intervention on not only the survivors but the LHWs as well. This is the first time aspects of post-traumatic growth (PTG) and altruism are identified in the

study within a Zambian context. The Amai Busa's traumatic experience gained a whole new meaning through her desire and efforts to help others who were experiencing similar events (Staub, 2005). This finding aligns with those of previous studies that have found that the involvement of women in programs designed to support other women usually affects their health and wellbeing positively (Gower et al. 2022; Page et al. 2021; Shim et al. 2011). Also demonstrated is prosocial behaviour, referred to by Staub (2005) as 'altruism born of suffering', a concept that women engage in kindness and helping behaviours such as giving back to their communities or helping other survivors, despite the trauma they experienced themselves. According to Shillington (2024), research on altruism in relation to IPV is scarce. This is also the case in Zambia, where there is currently no published evidence of research on PTG. Therefore, although participants in this study were not specifically asked about altruism or assessed for PTG, the study found that they did engage in altruistic behaviours, and contributes to literature by being the first study to demonstrate that a novel culturally sensitive SGBV intervention was effective in not only improving mental health in survivors in Zambia, but also promoting altruism and PTG.

Paper 3 focused on the piloting of the TF-CBT intervention developed in Paper 2. This six-week group programme was delivered to 36 female SGBV survivors in Misisi by the six trained Amai Busas. A pre-post evaluation found that the women's mental health improved significantly over the course of the intervention. For instance, pre-post results for PTSD indicate a significant decrease from baseline to the three-month post-intervention follow-up. This programme has been highly impactful in the community by providing a crucially needed support structure that is accessible, relatable, and effective

in enhancing the wellbeing of SGBV survivors, and the Amai Busas are committed to scaling up, with the aim of formally registering it as a not-for-profit project in the future to enable them to apply for the support they need to continue and expand the project. Fraser (2010) describes the process of designing an intervention as both evaluative and creative, and suggests that in order for it to be effective, there is a need to combine existing research and theory with other knowledge, such as knowledge of the environment. This is to be followed by the development of principles and action strategies for the intervention, and once the design is complete, an intervention is to be developed and improved overtime through a series of pilot studies that then lead to larger studies to assess efficacy and effectiveness (Fraser, 2010). Fixsen (2005) also adds that full and faithful implementation of an intervention requires continuous support, supervision and training. Therefore, despite being a small pilot test of an intervention rather than a large-scale effectiveness RCT, this study has contributed a novel, co-developed, feasible, and promising intervention ready to be upscaled into a larger and more vigorous study to test efficacy.

5.3 Practical Implications

Overall, this study contributes to existing evidence that adapting evidence-based treatments for local contexts is feasible while considering key factors like effectiveness and cultural relevance in settings different from where they were originally developed.

5.3.1 Confronting Harmful Cultural Norms

The research highlights the critical need for culturally aware interventions targeting the underlying causes of SGBV in Zambia. Through community dialogue and confronting damaging cultural norms, sustainable solutions can be developed that foster gender equality and ensure safer environments for all individuals. O'Brien (2016) notes that cultural context plays a role in a woman's vulnerability to SGBV, as well as her ability to survive it. In many cultures globally, gender norms are unequally applied. The current study emphasises that in Zambia, culturally ingrained gender roles significantly contribute to the reinforcement of SGBV. For instance, the patriarchal system in Zambian society typically gives men power and authority over women, creating significant power imbalances that enable violence and foster a culture of impunity regarding SGBV (Chanda, 2024). By identifying cultural beliefs and practices that reinforce SGBV, this study lays the foundation for future interventions to address the root causes. Additionally, the findings inform the design and implementation of SGBV prevention and intervention programs in Zambia. By appreciating the cultural settings where SGBV manifests, policymakers and practitioners can develop strategies that are both culturally sensitive and more effective in addressing this issue. Such strategies may include community-based initiatives that involve local leaders and stakeholders in confronting harmful norms and fostering gender equality.

Existing interventions that have challenged harmful cultural norms have reported promising results in the prevention of SGBV perpetration (Keith, 2023; Perez-Martinez,

2023). An example is educational interventions that challenge toxic masculinity, specifically concerning gender roles, patriarchal societal norms and gender-biased attitudes on IPV, among others. Casey et al. (2016) highlight the gender-transformative approach, which reinforces gender-equality and aims to empower both genders in order to develop nonviolent and equal relationships. Research has shown that this approach may effectively prevent gender-based violence perpetration among adolescent boys and men (Casey et al., 2016; Dworkin et al., 2013; Levy et al., 2019; Lourenço et al., 2019; O'Neill, 2008).

5.3.2 Women Empowerment Interventions

Studies (Dahal, 2022; O'Mullan, 2024) have highlighted that SGBV not only reflects but also reinforces existing gender inequalities. To address this, we must create effective interventions aimed at transforming gender norms and relationships. This approach should combine women's economic and social empowerment. Women's empowerment generally refers to the process of removing constraints that hinder the ability of women and girls to determine and realise their goals (World Bank, 2023). Studies have shown that mental well-being in SGBV survivors experiencing anxiety and depression can be improved through social support and empowerment training (Jose, 2016; Quattrochi, 2019). There is also a rigorous body of evidence showing how women's experience of SGBV can be reduced through economic and social empowerment interventions (Ellsberg et al., 2015; Keith, 2023). For instance, research (Dunbar et al., 2010; Proynk, 2006)

highlights how the integration of microfinance programs into gender empowerment programs found that women involved in the interventions experienced a reduction in IPV compared to those who did not participate. In the present study, survivors, after gaining awareness and knowledge about economic abuse, expressed the need for support to acquire financial literacy and independence. In this way, this study reinforces the crucial need and relevance of the integration of economic and social empowerment interventions, and will therefore inform the development of future interventions for SGBV survivors in the Zambian context and other LMICs.

Essentially, to enhance the effectiveness of future versions of CBIs for SGBV survivors, it is important that a multifaceted approach is employed, combining social and economic empowerment components. However, the safety of the women should be prioritised in order to avoid the risk of male backlash. Del Campo (2020) brings to light the existing debate between the Marital Dependency Theory and the Resource Theory. The Marital Dependency Theory suggests that financial dependency on a male partner increases women's vulnerability to abuse, as it makes them less likely or able to leave the relationship (Vyas & Watts, 2009). Consequently, women with greater financial resources possess more bargaining power and are better positioned to leave abusive relationships. On the other hand, the Resource Theory argues that an increase in women's financial independence may challenge traditional gender dynamics, leading their partners to try to reassert dominance through violent behaviour (Cools, 2017). Other scholars refer to it as the 'male backlash theory', proposing that as women's empowerment increases, there can be a corresponding rise in intimate partner violence, indicating a potential backlash

effect (Bulte & Lensink, 2020; Kilgallen et al., 2021). It is, therefore, essential to prioritise the safety of women when designing future interventions for SGBV survivors that include economic empowerment programs, and to monitor closely for potential enhancements of conflict and violence within their households.

5.3.3 Altruism and Posttraumatic Growth in Survivors

One of the themes that was identified in Paper 3 of this thesis strong desire of the women to help others in similar situations – a concept referred to as altruism. Behaviour is usually described as altruistic when it is motivated by a desire to help others without any self-interest (Kraut, 2020). In Zambia, there is no local word for altruism, or any concept related to it. Therefore, like many other technical or scientific concepts, the meaning must be explained to locals using culturally relevant scenarios and examples. Research has shown a strong link between altruistic behaviour and aspects of wellbeing, health and happiness (Xu, 2024). Staub and Vollhardt (2008) introduced the idea of altruism born of suffering (ABS), suggesting that individuals who have experienced trauma often redefine their sense of life's purpose and become more compassionate and helpful. Although studies provide evidence of the importance of support groups and psychotherapy in improving mental health symptoms in survivors of GBV, survivors are often looking for more than symptom relief in their healing experiences (Sinko et al., 2022). Empirical studies support this phenomenon, indicating that experiencing trauma can enhance prosocial behaviours like donating money, giving blood, participating in

rescue efforts, and volunteering (Xu, 2018). In Zambia, there is currently no evidence of trauma-focused interventions that have highlighted altruism and PTG, especially in SGBV survivors. The findings of this study will, therefore, inform the future development and implementation of such interventions in the Zambian context. In this study, survivors strongly expressed their desire to help other women experiencing abuse in their community, sharing that in the same way in which they were helped, they would also like to help someone else in need. When asked how they would like to help, the women listed raising awareness of SGBV and the various types that exist, counselling fellow women, and referring them to the appropriate places for support.

Although there is limited literature on the connection between altruism and SGBV specifically, some broader trauma recovery models, such as Tedeschi & Calhoun's (2004) Post-Traumatic Growth model, have documented processes of trauma survivors shifting their focus to advocacy and helping others as empathy increases. Herman (1992) also highlights the process of survivors turning to advocacy in his phasic model of trauma recovery, where he proposes that survivors of trauma, as part of their healing process, desire to help other women, as this reflects them taking back control of their identity and incorporating their trauma into a renewed sense of self. The findings of my study support these theoretical perspectives, as shown in the accounts of survivors describing their desire to help other women experiencing abuse. Scholars (Staub & Vollhardt, 2008; Xu, 2024) also argue that altruism promotes posttraumatic growth (PTG), a phenomenon observed in SGBV survivors during their healing process journey. It is, therefore, worth considering in the future development of CBIs that a survivor-centred approach is

adopted, in which survivors can be trained, engaged, and supervised in providing support to other survivors in their community, especially in LMICs, where evidence of existing interventions exploring this approach is scarce. The study also demonstrated that service providers (LHWs) can also be survivors, and therefore future interventions need to cater for their wellbeing in order to allow them to undergo their own treatment and healing from trauma before they can facilitate the treatment of others. The findings of this study contribute to existing evidence that altruism in survivors of abuse provides healing, improves mental health, and promotes PTG (Lekskes, 2007; Stidham et al., 2012; Xu, 2024), and can therefore be used to inform future SGBV interventions in Zambia and other developing countries.

5.4 Cultural Adaptation Within Evidence-Based Practice: Challenges and Necessary Modifications

Reflecting on the most impactful lessons from this project, one that stood out to me was learning that in low-resource communities like Misisi, it is essential to exercise caution when implementing structured, evidence-based treatment models. In this setting and context, the primary focus was to understand and reflect on the experiences of the people of Misisi, then adapt the support accordingly. Therefore, despite the strong framework that TF-CBT offered, it could not be applied to this context directly without any modifications. Bernal et al. (2009) argue that cultural adaptation of evidence-based

treatments requires careful modifications not only to language, but also across numerous areas including delivery style, metaphors, and community norms. In line with similar studies (Rahman et al., 2008; Kohrt et al., 2015), this intervention successfully maintained fidelity to the TF-CBT model while incorporating culturally rooted adaptations to language, structure, and relational dynamics.

As is presented in Paper 2, the most significant adaptation made to this intervention was the decision to train the Amai Busas themselves as lay facilitators in line with the community's culture and communication style, rightfully recognising the Amai Busas as key sources of support for survivors in Misisi. In addition, several barriers to community engagement and participation were identified, including fear of community stigma, distrust of formal services, and concerns about confidentiality. Paper 2 demonstrates how these factors were effectively addressed by incorporating a whole module on participant recruitment into the Amai Busas' TF-CBT training, with an emphasis on confidentiality practices. Confidentiality was further enhanced by adopting a locally discreet nature of the meetings with Amai Busas to the intervention, which was applied by disguising the survivors' meetings as regular church meetings.

Modifications were also successfully made to the language in the manual. Some terms were too technical to be understood by local community members and were therefore replaced with simpler terms or locally used phrases. The original role-play scenarios and examples were also replaced with culturally relevant and relatable ones. Furthermore, it was also important to incorporate some traditional and religious healing practices into

the intervention, such as prayer and singing of hymns at the beginning and end of every session. These are practices that are deeply rooted in the community, and while they are not included in the original TF-CBT model, they are an essential part of the women's faith and belief in healing. Therefore, instead of discarding these practices, this intervention embraced them.

The main finding in this area was that all the necessary cultural modifications made to this intervention did not take away from its integrity. They enhanced its relatability, relevance, and effectiveness. With a goal of maintaining both fidelity and flexibility, the core principles of TF-CBT were preserved, but adjustments and shifts were allowed where needed. Survivors' session completions, high engagements, and improved mental health demonstrate that these adaptations did not dilute or compromise the evidence-based practice but strengthened it.

Chapter 6: Conclusion

My original contribution to research is that a novel culturally adapted intervention that was co-developed with and delivered by local members of a community was effective in improving mental health in female survivors of SGBV in a LMIC. In a peri-urban community where access to mental health services is limited and there are many barriers to support for SGBV survivors, the program successfully trained six local women in the delivery of TF-CBT and equipped them with evidence-based skills and knowledge to help women in their community. Pre- and post-assessment results of the study indicate significant positive effects on the mental health of survivors, demonstrating not only the feasibility, effectiveness, and acceptability of the intervention, but the trainability of local LHW in evidence-based treatment methods, and their capability of delivering successfully as well. As is highlighted in my scoping review, there is a need for more research exploring psychological interventions delivered by lay counsellors and directed toward addressing SGBV, as there remains a significant gap in this research area especially in LMICs. Therefore, in addition to contributing to the existing body of research identifying this gap through my scoping review, my main study then contributes to knowledge, an effective, culturally relevant and promising intervention. To the best of my knowledge, no other intervention has been published that has engaged wives of pastors in the delivery of TF-CBT support to survivors of SGBV in Zambia or other LMICs. My study provides evidence that the faith-based sector can collaborate with the mental health sector in co-developing and delivering specifically tailored support for peri-urban communities in LMICs.

6.1 Meeting the Research Objectives

This chapter presents the overall conclusion of the study findings. It provides a summary of the results arranged in subtitles corresponding to the study aims and objectives, followed by the study's strengths and limitations, future research directions, and an overall summary statement. The main aims of this study were 1) to acquire an informed understanding of the specific needs of the community regarding a community mental health intervention for survivors of SGBV in Misisi; 2) to equip influential community members with skills and knowledge to enable them to provide mental health support to survivors of SGBV in Misisi compound, thereby contributing to a reduction in the mental health treatment gap in the community; and 3) to deliver and evaluate the feasibility and preliminary effectiveness of a community-based intervention supporting SGBV survivors in Misisi. To demonstrate how I arrived at my key findings, I will address the specific research objectives set out under the above three aims at the beginning of the thesis, which were as follows:

- To acquire an informed understanding from key informants in the community of the specific needs of the SGBV survivors in Misisi.
- To co-produce a CBI aimed at supporting the mental health of SGBV survivors, stemming from the shared knowledge of the PI and the PPI representatives.
- To deliver trauma-informed training to representatives of the Misisi community (Amai Busas) to whom women often go to find support against SGBV.

- To obtain feedback from the Amai Busas on the training proposed, in order to use this feedback to revise or integrate the training content (if needed) in the future.
- To deliver an intervention designed as a series of TF-CBT support group sessions to women who are survivors of SGBV in Misisi.
- Using validated measures, assess any changes that may occur in participants in connection with the intervention.

6.1.1 To acquire an informed understanding from key informants in the community of the specific needs of the SGBV survivors in Misisi

The study found that the most common types of SGBV in Misisi are physical abuse, sexual abuse, financial abuse, early marriages, and child defilement, supporting findings of similar studies that have investigated the prevalence and forms of SGBV in Zambia (Phiri, 2023; Chanda, 2023). The most common causes of SGBV in Misisi were reported to include poverty/socioeconomic challenges, lack of trust in one's partner, and alcohol abuse by both the men and the women. In addition to the above, cultural norms and beliefs were found to have a significant relationship with SGBV, specifically through shaping attitudes towards gender roles, power dynamics, and violence (Chanda, 2023). Practices such as bride price, forced early marriages as a result of underage pregnancy, and some religious beliefs were found to contribute to SGBV. A look into who women turn to for help when they experience abuse, and the current available support for SGBV

survivors in Misisi revealed that women will mostly seek help from elders in their family, and female religious leaders, who in most cases are wives of pastors.

Based on these insights and the review of relevant literature, the study successfully identified that there was a need for the development of an intervention that would be tailored specifically to the Misisi community and delivered by a group of people who they have trust and confidence in. It was also important for the intervention to not only provide mental health support for survivors of SGBV but also address and challenge the specific harmful cultural norms recognised by members of the community.

6.1.2 To co-produce a community-based intervention aimed at supporting the mental health of SGBV survivors, stemming from the shared knowledge of the PI and the PPI representatives

In collaboration with the Amai Busas, the study successfully co-developed a CBI informed by TF-CBT methods. This was designed as a support group program for female survivors of SGBV in Misisi, and it was to be delivered by the Amai Busas – whom women in the community usually go to for support. Drawing from the insights gained from the Amai Busas, the intervention began with a TF-CBT training designed specifically to enable them to provide support for women who are survivors of abuse in their community. The intention was to create a solution 'with' them, rather than 'for' them. The Amai Busas' involvement in the co-development of the CBI was found to be very instrumental in the

successful process of cultural adaptation, which included the incorporation of elements such as translation of TF-CBT material in local languages and role plays with localised scenarios.

6.1.3 To deliver trauma-informed training to representatives of the Misisi community (Amai Busas) to whom women often go to find support against SGBV

The study found that it was feasible to deliver a TF-CBT training to a group of six Amai Busas who had no background in mental health. Comprising eight core modules, the training was conducted over five training days (30 hours in total) within a one-week period. Each day's training lasted six hours, with the morning session running from 9AM to 12AM, and the afternoon session from 1PM to 4PM. Once the Amai Busas had begun running the support groups, a program was put in place comprising peer support among the Amai Busas and supervision by the PI and CR in order to reinforce the training received and identify areas that needed improvement. This study investigated the impact of the eight core TF-CBT modules undertaken by trainees before they actively engaged in the facilitation of support groups.

6.1.4 To obtain feedback from the Amai Busas on the training proposed, in order to use this feedback to revise or integrate the training content (if needed) in the future

The study was successful in achieving this objective and found that the training was effective in enhancing participants' confidence, knowledge, understanding, and skills in the delivery of TF-CBT. Results show that the training had a generally positive impact on the Amai Busas' perceptions of their ability to counsel SGBV survivors effectively, and also apply them to their own personal lives. My findings support those of similar previous pilot studies (Armstrong, 2003; Chibanda, 2017; Naeem, 2003) that have determined the positive impact of brief training in counselling skills on lay counsellors. As LHWs are increasingly becoming involved in the delivery of health services in many resource-limited countries (Dewing, 2015), studies such as this are important in contributing to the understanding of the ability of this group of health workers to effectively deliver support that is evidence-based and of good quality. My findings suggest that lay counsellors are capable of delivering therapy informed by evidence-based approaches when they are trained sufficiently and supervised in a way that is aimed at enhancing their skills.

6.1.5 To deliver an intervention designed as a series of TF-CBT support group sessions to women who are survivors of SGBV in Misisi

My study successfully delivered a novel, culturally adapted CBI through six trained Amai Busas, in a series of six weekly TF-CBT group sessions, which were conducted in groups of six survivors, with each being facilitated by one Amai Busa. The meetings were held in a local church which offered to host our program to support their community. Each group met for about an hour and the Amai Busa followed an intervention protocol to discuss specific topics in each session. These sessions were audio-recorded; with a recording device placed on the Amai Busa who delivered the sessions, and an additional recording device placed closer to the participants. In addition to the RA who was efficient in coordinating all the administrative and logistic processes, the Amai Busas were also active in coordinating the women in each of their groups. There were no reports of the daily lunch and transport allowance being insufficient for participants, indicating that the budget was allocated to them was adequate. However, the Amai Busas did raise some concerns about their own allowances, recommending that in the future, it is increased so as to give them the flexibility of using hail rides/ taxis, as sometimes sessions would start late, and they would consequently leave the church late because they usually stayed behind to have debriefs as counsellors. However, overall, with a higher recruitment rate than initially targeted, and completion rates of 91% at endline, and 72% at follow-up, the study found that the delivery of the intervention was achievable, and both groups of

participants (Amai Busas and survivors) reported an appreciation of the interpersonal interaction element of the programme, having created new relationships with other women who they felt safe to open up to and confide in.

6.1.6 To assess any changes that may occur in participants in connection with the intervention using validated measures.

This is the first SGBV study to demonstrate that a brief TF-CBT intervention can have a transformative effect on the mental health of female survivors in a peri-urban community in the Zambian context. The findings point to a significant impact on both the Amai Busas and survivors, with survivors reporting significant improvements in their mental health, learning healthy coping skills, and minimising shame in help-seeking behaviours. From the TF-CBT sessions, survivors learned to effectively cope and deal with their trauma, and grew confident in their approach towards life and its challenges. An unexpected key finding was the PTG among participants, which makes my study the first to highlight prosocial behaviour, altruism and PTG in survivors of SGBV within the Zambian context.

The quantitative data collected at three time points (baseline, endline, and follow-up) indicate that the overall effect on all four primary outcomes (anxiety, depression, PTSD, and resilience) suggested a statistically significant improvement in mental health. Despite a decline in mental health being noted between endline and follow-up, it remained comparatively smaller than the overall improvement from baseline to follow-

up. These results suggest that future versions of the intervention may require improvements, such as ongoing support beyond the TF-CBT program and the inclusion of empowerment elements to encourage independence in the women. Overall, using validated measures, this found that a six-week TF-CBT intervention delivered by LHWs was successful in significantly improving mental health among female SGBV survivors in Misisi compound, a community where access to mental health services and support for survivors is limited.

6.2 Strengths and Limitations

This study holds significant strengths in its theoretical and practical implications. Theoretically, it demonstrates the development and testing of an innovative CBI, showing that lay community leaders can be trained to effectively deliver evidence-based treatments that enhance mental health among survivors of SGBV in peri-urban settings. Practically, to my knowledge, this represents the first study in Zambia to evaluate a co-developed, culturally tailored intervention for SGBV survivors in collaboration with religious leaders. The intervention was effective in reducing anxiety, depression, and PTSD, while promoting resilience. Additionally, it fostered the reconstruction of meaning and PTG among survivors. These findings offer fresh insights into integrating cultural sensitisation, empowering women, and challenging harmful cultural norms into intervention programs, thereby assisting survivors in coping with trauma and transforming suffering into strength.

It is essential to acknowledge the study's limitations. Firstly, while Paper 1 used a standardised method to identify interventions in the literature and assess their feasibility, effectiveness, and acceptability in low- and middle-income countries (LMIC), it was not a systematic review, and therefore, did not offer a thorough evaluation of the field's overall standing or the broader therapeutic effectiveness in these contexts. A scoping review was deemed more suitable because the study context is still an emerging research area, and the findings can inform future deeper research in the form of systematic reviews. Nonetheless, it yielded meaningful insights into how these interventions can be specifically tailored for survivors of SGBV in respective LMIC environments and highlighted the crucial modifications needed for their effective implementation. Secondly, this was a pilot study conducted with a small number of women in a single location, and the results must be further explored in societies in other developing regions. Thirdly, follow-up assessments over longer periods would have been more beneficial, as treatment effects may diminish with time. It has not been established whether the intervention results have been maintained long-term and, therefore, need to be interpreted carefully. Future versions of this intervention need to assess participants over longer time periods in order to evaluate the sustainability of the treatment effects.

Finally, the PPI consultation only engaged two Amai Busas. Future versions of the intervention need to include other stakeholders such as existing SGBV non-governmental organisations working in Misisi, the Zambia Police VSU, and men from the community, as they would provide additional valuable insights from their perspectives and experiences that could inform future intervention development.

6.3 Future Directions of Research

The findings of the study presented in this thesis provide a foundation for further research and discussion in the context of effectively addressing mental health problems in survivors of SGBV in LMICs such as Zambia. Given the promising findings pointing to the effectiveness and acceptability of this intervention, it could be scaled up into a full RCT with a larger sample size and apply the recommended modifications outlined in this thesis, including an increment to the duration of treatment and follow-up period. To begin with, one important aspect I intend to prioritise is the identification of barriers and facilitators to cultural adaptation of interventions from the perspectives of lay counsellors. In the current study, the Amai Busas shared their views on the cultural factors influencing SGBV in Zambia, and their insights and experiences as lay counsellors need to be explored in more detail in future publications about cultural adaptation and intervention acceptability in this context. A comprehensive understanding of their experiences from the conception to implementation of such a comprehensive mental health intervention will enhance future efforts to develop and adapt these interventions culturally in Zambia.

Secondly, considering the themes of altruism and PTG identified in this study, and in light of the lack of empirical evidence in the Zambian context, I am eager to explore the feasibility and effectiveness of involving survivors of SGBV in delivering the intervention. Xu (2023) supports this approach, highlighting the significance of integrating prosocial behaviours into intervention programs to assist victims in coping with trauma and transforming their pain into resilience. Stidham et al. (2012) also support this approach,

pointing out that their study found that participants had experienced some healing from their trauma before they were able to actively help others effectively. Therefore, my future research in this context would seek to generate evidence that would later provide guidance to clinicians and researchers intending to work with survivors of sexual violence in the delivery of interventions, regarding the need to be mindful of the various healing stages that survivors go through and the diverse ways they engage in altruistic behaviour.

Lastly and of equal importance, this study underscored a crucial need for effective interventions aimed at transforming gender norms and relationships and identified that empowerment interventions had been found to be effective in this regard. Therefore, I intend to further examine the feasibility of incorporating women empowerment programmes into the intervention, including components such as financial literacy training, skills development, and gender awareness. The findings of this future research can be used to inform the development of manuals to be used in clinical trials and further empirical studies, including RCTs.

6.4 Summary

Currently, there is limited evidence of interventions aimed at enhancing mental health for female survivors of SGBV in LMICs, illustrating the need for developing more interventions. This study contributes to filling this gap in knowledge by demonstrating that a co-developed, culturally adapted CBI delivered by trained and supervised members

of a low-resource community was successful in enhancing the mental health of women affected by SGBV in a LMIC country with a shortage of mental health specialists. The study also contributes evidence that a training co-developed in collaboration with lay community members had a positive outcome and impact on participants' knowledge, skills and perception of their ability to support women who are survivors of SGBV. These study findings demonstrate the effective application of this intervention in a peri-urban community and provide valuable insights into how to adapt and implement mental health interventions aimed at addressing SGBV in Zambia and comparable low-resource environments. The intervention, guided by TF-CBT demonstrates promise for community-based mental health initiatives to enhance outcomes for survivors. Nevertheless, it underscores the necessity for more comprehensive long-term research, greater cultural involvement, and a readiness to question established norms. By tackling these areas, future initiatives can significantly enhance mental health care delivery and outcomes for underserved communities globally.

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Appendices

Appendix A. Study 1 Participant Information Sheet

A Community-Based Intervention to Tackle Domestic Violence and Improve Mental Health in Young Underprivileged Women in a Peri-Urban Community of Misisi in Lusaka, Zambia

1. Invitation to research

I would like to invite you to take part in a training in Trauma-focused Cognitive Behavioural

Therapy (TF-CBT), as part of our study. My name is Kayumba Chiwele, and I am the Principal Investigator (PI). Our research project seeks to assess the extent and main forms of SGBV that women and girls are exposed to in your community - Misisi, and will then go on to evaluate the feasibility and preliminary effectiveness of a community-based intervention supporting SGBV survivors.

This study is being completed in fulfilment of the completion of a PhD in Psychology with the Manchester Metropolitan University, and is sponsored by the Commonwealth Scholarship Commission in the United Kingdom.

1. **Why have I been invited?**

You have been invited to participate in this study because of your influential position in this community as a respected Amai Busa to whom women come for counsel – including survivors of SGBV.

2. **Do I have to take part?**

It is up to you to decide. We will describe the study in this information sheet that has been shared with you. We will then ask you to sign a consent form to show you agreed

to take part. You are free to withdraw at any time, without giving a reason. However, kindly note that the time at which a withdrawal request is submitted will affect the type of action we are able to take to honour the request. This is explained in detail in section 5 below.

3. **What will I be asked to do?**

In this stage of the study, you will be asked to take part in a training along with 5 other Amai Busas from different churches within the Misisi community. The training will be informed by

Trauma-Informed Cognitive Behavioral Therapy (TI-CBT) and will allow for you to hold regular group meetings in which psychoeducation and TI-CBT will be used to support female domestic violence survivors in your community. These meetings will be held in local churches and will be advertised as 'getting together' groups (with no reference to domestic violence) to protect the participants and ensure that confidentiality is maintained.

The training will be delivered virtually by the PI over a 5-day period, but the RA will be there with you in person to handle all administrative tasks such as setting up at the venue, and ensuring that everything is in place. Each day's training will last for a duration of 6 hours, with the morning session from 9AM to 12AM, and the afternoon session from 1PM to 4PM. At the end of the training, you will be asked to take part in video-recorded Focus Group Discussions. We will need your consent to record you.

This information sheet will give you information on the training you will attend if you agree to take part in the study. Within seven days from the day you receive this PIS, you can respond to the PI (via the email address that was used to share this PIS with you) to confirm your interest in participating. Following this, you can then use the link that was sent to you in the same email for the Consent Form which you can read and sign (by adding your name) online, on a platform called Qualtrics.

4. **Are there any risks if I participate?**

This stage of the study (Study 1) is considered as bearing low-risk for you as participants. Nevertheless, in the event that you have past direct experiences of SBGV and/or that you may find participation in this stage distressing, the following Risk Management actions will be taken.

You can withdraw from participation at any point, without having to provide an explanation. You can do so by notifying the PI (via email or during training sessions). However, as stated above, kindly note that the time at which a withdrawal request is submitted will affect the type of action we are able to take to honour the request.

If you submit your withdrawal request whilst data collection is in progress, you can expect that any data collected from you will be withdrawn and will not be used in the rest of the study, including data analysis and any outcomes of the research such as publications.

If you submit your withdrawal request once data analysis has begun or been completed (i.e., two weeks from participation), it might not be possible to remove your data. In this case, the Principal Investigator will discuss with you which data we are capable of removing, and the reasons why any remaining data cannot be withdrawn from the project. Therefore, for this particular stage of the study, you can withdraw your consent to the use of the data provided by contacting the PI via email, within 2 weeks from the date of the last training session. If you do so within this timeframe, all data collected will be deleted. However, any data that includes you in the form of video or audio recordings of focus group discussions will not be deleted as it includes data from other participants, but your responses, contributions and information will be excluded from being used in the study.

You will not be asked to reimburse any of the money given to you for lunch and transport during your participation in the study.

In the event that you feel you may need psychological support, please inform the PI. The following organisation will be contacted and a psychologist will be assigned to you at no cost.

Organization	**Contact Information**
PsycHealth Zambia	Mutandwa Road, Roma Lusaka, Zambia

	Phone: +260 955 264975 **Email:** info@psychzambia.com **Website:** www.psychzambia.com

- **Are there any advantages if I participate?**

We cannot guarantee that you will receive any other direct benefits from this study, though you will have an opportunity to contribute to delivering an innovative intervention that we hope will be highly beneficial to your community by participating in this study.

For your transportation costs, you will receive a compensation of K50.00, and an additional K50.00 for lunch per day.

- **Informed consent**

After you are done reading through this Participant Information Sheet today and you maintain your willingness to participate in the study, you can respond to the PI (via the email address that was used to share this PIS with you) within seven days to confirm your interest in participating. Following this, you can then use the URL of the link that was sent to you in the same email for the Consent Form which you can read and sign (by adding your name) online, on a platform called Qualtrics.

- **What information about me will you collect and why?**

When you agree to participate in this research, we will collect from you personally identifiable information such as your name, age and contact details as we gather consent. Additionally, on the last day of the training, we will invite you to participate in a Focus Group Discussion where we will ask you to share your experiences, opinions and recommendations regarding support for SGBV survivors in your community. This session will be video-recorded.

- **How will my information be stored and how will you look after it?**

When you agree to participate in this research, we will collect from you personally identifiable information. The Manchester Metropolitan University ('the University') is the Data Controller in respect of this research and any personal data that you provide as a research participant and the supervisor, Dr. Daniela Di Basilio is the Data Custodian. The University is registered with the Information Commissioner's Office (ICO), and manages personal data in accordance with the General Data Protection Regulation (GDPR) and the University's Data Protection

Policy.

We will collect personal data as part of this research (such as your name, age, and contact details). As a public authority acting in the public interest, we rely upon the 'public task' lawful basis. When we collect special category data (such as medical information or ethnicity) we rely upon the research and archiving purposes in the public interest lawful basis. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, your data will be handled in line with the procedure specified in Section 5 above.

The PI will handle all your personal data. Other Co-researchers involved in this study who will have access to the rest of the data which will be pseudonymised are;

I. Dr. Maria Livanou -Co-Supervisor
II. Dr. Kim Heyes – Co-Supervisor
III. Mr. Kaluso Masuwa – Cognitive Behavioural Therapist
IV. Mr. Joshua Swali Nkazi – Research Assistant

a. **How will you use my information?**

The data collected from you as part of this study (i.e., FGD video recordings and dataset deriving from Qualtrics – including consent forms) will be stored on the PI's MMU OneDrive. No other copies will be saved on portable devices. The PI will also store any notes from the study including her journal on OneDrive. Data entry, transcription and data analysis will be carried out by the PI.

All this data, once analysed, will then be used to inform the development of a mental health intervention which will be tailored specifically to support female SGBV survivors in your community.

b. **Will my data be sent anywhere else, or shared with other people or organisations?** We will not share your personal data collected in this form with any third parties.

If your data is shared, this will be under the terms of a Research Collaboration Agreement which defines use, and agrees confidentiality and information security provisions. It is the University's policy to only publish anonymized data unless you have given your explicit written consent to be identified in the research. **The University never sells personal data to third parties.** We will only retain your personal data for as long as is necessary to achieve the research purpose.

For further information about use of your personal data and your data protection rights please see the *University's Data Protection Pages*.

c. **When will you destroy my information?**

All the raw (unprocessed) data collected as part of this study, which includes your personal data (such as your name, age, and contact details) will be kept for up to 10 years after the end of the study. This is in line with MMU's standard operating procedures. Equally, your Consent Form will be retained for a period of up to 10 years.

However, FGD video recordings will be transcribed by the PI onto an encrypted computer within 5 days of the original FGD, and once fully transcribed, the original video recordings will be disposed of by the PI, following MMU's data disposal regulations.

d. **Data Protection Law**

Data protection legislation requires that we state the 'legal basis' for processing information about you. In the case of research, this is 'a task in the public interest.' If we use more sensitive information about you, such as information about your health, religion, or ethnicity (called 'special category' information), our basis lies in research in the public interest. Manchester Metropolitan is the Controller for this information and is responsible for looking after your data and using it in line with the requirements of the data protection legislation applicable in the UK.

You have the right to make choices about your information under the data protection legislation, such as the right of access and the right to object, although in some circumstances these rights are not absolute. If you have any questions, or would like to exercise these rights, please contact the researcher or the University Data Protection Officer using the details below.

You can stop being a part of the study at any time, without giving a reason. You can ask us to delete your data at any time, but it might not always be possible. If you ask us to delete information within the first 2 weeks of beginning data collection, we will make sure this is done. If you ask us to delete data after this point, we might not be able to. If your data is anonymised, we will not be able to withdraw it, because we will not know which data is yours.

e. **What will happen to the results of the research study?**

The results of this research study will be presented in international conferences and will be shared via publications in peer-reviewed journals, to benefit different types of audience. Your identity will not be revealed in any of these dissemination methods. You can also request for a summary of the research results by contacting the PI after the end of the study in December, 2023.

There are five key audiences for this research, these are:

III. Commissioning organizations (such as The Psychology Association of Zambia and The Ministry of Health)
IV. Community mental health provider staff
V. Patients and the public
VI. Academia

a. **Who has reviewed this research project?**

This research project has been reviewed by the PI's supervisory team, the MMU Research Ethics and Governance Committee, and the National Health Research Authority of Zambia.

b. **Who do I contact if I have concerns about this study or I wish to complain?**

For general questions about the research project, the PI and the Supervisor can be contacted using the following details;

Principal Investigator

Ms. Kayumba Chiwele

Psychology Department

Manchester Metropolitan University

M15 6BH

United Kingdom

Email: *kayumba.chiwele@stu.mmu.ac.uk*

Supervisor

Dr. Daniela Di Basilio

Department of Psychology

Manchester Metropolitan University

M15 6BH

United Kingdom

Email: *d.di-basilio@mmu.ac.uk*

If you have any concerns regarding the study, you can also contact the Chair of the Faculty of Health and Education, Ethics Committee (Dr Claire Fox) via Email: *FOHE-Ethics@mmu.ac.uk*

If you have any concerns regarding the study or the personal data collected from you, our Data Protection Officer and Commissioner's office can be contacted using the following details respectively:

Manchester Metropolitan Data Protection Officer dataprotection@mmu.ac.uk

Tel: 0161 247 3331 Legal Services, All Saints Building, Manchester Metropolitan University, Manchester, M15 6BH

UK Information Commissioner's Office

You have the right to complain directly to the Information Commissioner's Office if you would like to complain about how we process your personal data:
https://ico.org.uk/global/contact-us/

THANK YOU FOR CONSIDERING PARTICIPATING IN THIS PROJECT

Appendix B. Study 2 Participant Information Sheet (English)

A Community-Based Intervention to Tackle Domestic Violence and Improve Mental Health in Young Underprivileged Women in a Peri-Urban Community of Misisi in Lusaka, Zambia

1. Invitation to research

My name is Kayumba Chiwele, and I am the Principal Investigator (PI) in a project that aims to help Zambian women and girls who experience Sexual and gender-based Violence (SGBV) at home. To do so, I have trained a group of Amai Busas to deliver groups that will support women and girls experiencing abuse. I will then evaluate if these groups have been helpful for female victims of abuse.

I am conducting this study as part of my PhD in Psychology with the Manchester Metropolitan University, sponsored by the Commonwealth Scholarship Commission in the United Kingdom.

2. Why have I been invited?

You have been invited to participate in this study because you may have experienced SGBV at home. Domestic abuse is defined as any form of violence (including hitting, shouting or forcing another person to do something) that is done by a partner or a family member against another person in their family. Men can be victims of SGBV too, but in this study, we are only interested in hearing about women' experiences of the abuse.

3. Do I have to take part?

No, it is up to you to decide. This sheet will help you to understand what will happen if you decide to take part in this study. If you agree to take part, a week from now, my Co-researcher (CR), Ms. Chalwe Ilunga will ask you to express your consent verbally by reading out loud the items on a document called a 'Consent Form'. You will be given the option to answer either 'YES' or 'NO' to each of these statements, and this procedure will be audio recorded. This is called audio or verbal consent. Once your audio consent has been recorded, the recording will then be sent to me, and I will keep it safe and confidential (meaning that I will not show it to anyone except my supervisor).

You are free to withdraw at any time, without giving a reason. However, kindly note that the time at which a withdrawal request is submitted will affect the type of action we are able to take to honour the request. This is explained in detail in **section 5** below.

4. What will I be asked to do?

You will be asked to take part in a group that will be delivered by an Amai Busa. In the group, the Amai Busa will talk about domestic abuse and will explain some of the principles of a theory called "Trauma-focused Cognitive Behavioural Therapy (TF-CBT)", which is used to best understand the types of trauma that can derive from abuse at home and most importantly, how women can learn to cope with the abuse and to better protect themselves from it.

The group will be delivered to 5-6 survivors (including you), once a week, in your local church, and this will be for a duration of 1 hour. These sessions will be audio-recorded. Before and after taking part in the group, you will fill in an online questionnaire. You will do this before the start of the first group session and at the end of the last session. This will help us to understand if the group has been helpful to you. Ms. Chalwe, the CR will administer these questionnaires to you and enter your answers online.

You may also be asked to have an individual one-to-one interview with me as PI, where I will ask you about your personal experiences of SGBV, and your opinion about the TF-CBT groups you participated in. You may answer all the questionnaires administered to you in the assessments mentioned, but you are not obliged to take part in this interview even if you have completed the assessments. The one-to-one is completely voluntary. You can either choose to participate, or not participate in it. Your choice will not affect your participation in the rest of the study or the support you will be receiving. After this one-

to-one interview, I will then evaluate if these groups have been helpful to you and the other women in your group.

Finally, three months after the intervention has ended, we will contact you again to ask you some questions about your welfare. This is so we can assess whether the support you will have received from the TF-CBT was helpful and effective.

5. Are there any risks if I participate?

As someone who might experience trauma from Sexual and Gender-based Violence, it is possible that you may feel psychologically distressed because of the sensitive topics that will be discussed. in the event that you find participation in this stage distressing, the following Risk Management actions will be taken.

You can withdraw from participation at any point, without having to provide an explanation. You can do so by notifying the Amai Busa or the CR (during the TF-CBT sessions). However, kindly note that the time at which a withdrawal request is submitted will affect the type of action we are able to take to honour the request.

If you submit your withdrawal request whilst data collection is in progress, you can expect that any data collected from you will be withdrawn and will not be used in the rest of the study, including data analysis and any outcomes of the research such as publications.

If you submit your withdrawal request once data analysis has begun or been completed (i.e., two weeks from participation), it might not be possible to remove your data. In this case, the Principal Investigator will discuss with you which data we are capable of removing, and the reasons why any remaining data cannot be withdrawn from the project. Therefore, for this particular stage of the study, you can withdraw your consent to the use of the data provided by informing the CR (who will contact me) within 2 weeks from the date of the last training session. If you do so within this timeframe, all data collected will be deleted. However, any data that includes you in the form of video or audio recordings of focus group discussions will not be deleted as it includes data from other participants, but your responses, contributions and information will be excluded from being used in the study.

You will not be asked to reimburse any of the money given to you for lunch and transport during your participation in the study.

If it so happens that you feel you may need psychological support at any point, inform the Amai Busa or the CR, and we will arrange for you to receive the support you need. The following organization will be contacted on your behalf and a psychologist will be assigned to you.

The PI is affiliated with PsycHealth Zambia as Co-founder. You are also free to contact the organization personally.

PsycHealth Zambia

Mutandwa Road, Roma

Lusaka, Zambia

Phone: +260 955 264975

Email: info@psychzambia.com

Website: www.psychzambia.com

You are also encouraged to inform an Amai Busa if you feel that your participation in the group may put you in any danger and in such a case, you will be supported in finding appropriate support against the abuse.

As researchers, we do **not** have the duty to report criminal activity (including domestic abuse) to the authorities. What you will tell us will be kept confidential, unless we (as researchers) and the Amai Busas think that you or your children might be at serious and immediate risk of harm. In that case, we will help you by alerting the authorities. You can also ask the Amai Busas to call the authorities on your behalf, if you wish to do so. If we need to look for support for you and your children from the local authorities, we will always tell you first.

6. Are there any advantages if I participate?

We cannot guarantee that you will receive any other direct benefits from this study, though in the groups, you will be able to learn more about domestic abuse and how to defend yourself against it. Also, by taking part in the one-to-one interview, you will help the study team (me and my supervisors) to understand how we can develop groups and other forms of support for Zambian women suffering from SGBV.

For your transportation costs, you will receive an amount of K50.00.

7. Informed Consent

After you are done going over all parts of this Participant Information Sheet, the CR will answer any questions you may have and ensure that you are clear on the details of the project. We will then allow a period of one week to give you time to think about participation and not make any decisions in haste. One week from now (7 days), if you decide you want to take part in our study, we will have a second meeting, which aims at obtaining your consent to participate. The CR will ensure a space with privacy (in the churches premises) to go over all parts of the PIS again (including the parts that clarify that participation is voluntary and the parts that explain your withdrawal rights and how your data will be managed). The CR will ask you again if you have any additional questions. The CR will then read out each of the consent form items to you and ensure that your consent is clear and audible. The process will be audio-recorded (and audio-consent files will be uploaded directly by the CR onto the PI's MMU OneDrive where the PI will safely store them).

Audio-consent will also be obtained by the Amai Busa, before you begin your sessions, clarifying that you agree to take part in this study and to be audio-recorded.

8. What information about me will you collect and why?

When you agree to participate in this research, we will collect from you personally identifiable information such as your name, age and contact details as we gather consent. Additionally, you will be asked to take part in 3 assessments at different time points:

I) Before the intervention;

II) Immediately after the intervention; and

III) Three months after the end of the intervention.

During these assessments, you will be asked questions about your wellbeing, such as whether you have been experiencing feelings of sadness, anxiousness, fear, and how you have been coping.

Finally, on the last day of your TF-CBT sessions, we may invite you to participate in a one-to-one interview with the PI. You are free to agree or disagree to take part in this interview. This will not affect your participation in the rest of the study in any way. In this interview, we will ask you to share your personal experiences, opinions and recommendations regarding support for SGBV survivors in your community. This session will be audio-recorded.

9. What will happen with the data I provide?

When you agree to participate in this research, we will collect from you personally identifiable information. The Manchester Metropolitan University ('the University') is the Data Controller in respect of this research and any personal data that you provide as a research participant and my supervisor, Dr. Matt Brooks is the Data Custodian. The University is registered with the Information Commissioner's Office (ICO),and manages personal data in accordance with the General Data Protection Regulation (GDPR) and the University's Data Protection Policy.

We will collect personal data as part of this research (such as your name, age, and contact details). As a public authority acting in the public interest, we rely upon the 'public task' lawful basis. When we collect special category data (such as medical information or ethnicity) we rely upon the research and archiving purposes in the public interest lawful basis. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, your data will be handled in line with the procedure specified in **Section 5** above.

The PI will handle all your personal data. Other co-researchers involved in this study who will have access to the rest of the data which will be pseudonymised are;

- Dr. Kim Heyes - Co-supervisor
- Mr. Kaluso Masuwa - Cognitive Behavioural Therapist
- Ms. Chalwe Ilunga – Voluntary Co-researcher (CR)

10. How will you use my information?

The data collected from you as part of this study (i.e., audio recordings and dataset deriving from Qualtrics – including consent forms) will be stored on the PI's MMU OneDrive. No other copies will be saved on portable devices. The PI will also store any notes from the study including her journal in OneDrive. Data entry, transcription and data analysis will be carried out by the PI.

Once all this data has been analysed, the results of this study will be used in a write up for a PhD thesis. Additionally, the findings will be shared with other researchers and I will write them up in scientific articles that will be sent to journals to be published. I will also talk about them in conferences, and we hope they will contribute to creating helpful interventions for women suffering from domestic abuse. You will not be identifiable from any of the study results or publications, which means that your identity will remain secret both during and after the study, so that you will not be put at risk by taking part in this study.

11. Will my data be sent anywhere else, or shared with other people or organisations?

We will not share your personal data collected in this study with any third parties. If your data is shared, this will be under the terms of a Research Collaboration Agreement which defines use, and agrees confidentiality and information security provisions. It is the University's policy to only publish anonymized data unless you have given your explicit written consent to be identified in the research. **The University never sells personal data to third parties.** We will only retain your personal data for as long as is necessary to achieve the research purpose. For further information about use of your personal data and your data protection rights please see the *University's Data Protection Pages.*

12. When will you destroy my information?

Your personal data (name and contact details) will be kept for the purpose of recontacting you if you consent to participate in the one-to-one interviews, and also for the long-term follow-up assessment which will be done three months after the end of the TF-CBT sessions. Additionally, this data will also be used to contact you if you consent to receiving the findings of the study upon completion. Therefore, your personal identifiable data will be kept until the end of the study in December, 2024. However, the anonymized study data (including anonymized interview transcripts and questionnaire

data) will be kept for a period of up to 10 years. This is in line with MMU's standard operating procedures.

For the session recordings, these will be transcribed by the PI onto an encrypted computer within five days of the original session, and once fully transcribed, the original audio recordings will be disposed of by the PI, following MMU's data disposal regulations.

13. Data Protection Law

Data protection legislation requires that we state the 'legal basis' for processing information about you. In the case of research, this is 'a task in the public interest.' If we use more sensitive information about you, such as information about your health, religion, or ethnicity (called 'special category' information), our basis lies in research in the public interest. Manchester Metropolitan is the Controller for this information and is responsible for looking after your data and using it in line with the requirements of the data protection legislation applicable in the UK.

You have the right to make choices about your information under the data protection legislation, such as the right of access and the right to object, although in some circumstances these rights are not absolute. If you have any questions, or would like to exercise these rights, please contact the researcher or the University Data Protection Officer using the details below.

You can stop being a part of the study at any time, without giving a reason. You can ask us to delete your data at any time, but it might not always be possible. If you ask us to delete information within the first two weeks of beginning data collection, we will make sure this is done. If you ask us to delete data after this point, we might not be able to. If your data is anonymised, we will not be able to withdraw it, because we will not know which data is yours.

14. What will happen to the results of the research study?

The results of this research study will be presented in international conferences and will be shared via publications in peer-reviewed journals, to benefit different types of audience. Your identity will not be revealed in any of these dissemination methods. You can also let us know if you would like us to share these findings with you by saying so during the consent process. If you confirm this, the PI will contact you and share the study findings with you after the end of the study in December, 2024.

There are four key audiences for this research, these are:

5. Commissioning organizations (such as The Psychology Association of Zambia and The Ministry of Health)
6. Community mental health provider staff
7. Patients and the public
8. Academia

15. Who has reviewed this research project?

This research project has been reviewed by the PI's supervisory team, the MMU Research Ethics and Governance Committee, and the National Health Research Authority of Zambia.

16. Who do I contact if I have concerns about this study or I wish to complain?

For general questions about the research project, the PI and the Supervisor can be contacted using the following details;

Principal Investigator	**Supervisor**
Ms. Kayumba Chiwele	Dr. Matt Brooks
Psychology Department	Department of Psychology
Manchester Metropolitan	Manchester Metropolitan University
University	
M15 6BH	M15 6BH
United Kingdom	United Kingdom
Email: kayumba.chiwele@stu.mmu.ac.uk	Email: m.brooks@mmu.ac.uk

If you have any concerns regarding the study, you can also contact the Chair of the Faculty of Health and Education, Ethics Committee (Dr Claire Fox) via Email: *FOHE-Ethics@mmu.ac.uk*

If you have any concerns regarding the study or the personal data collected from you, our Data Protection Officer and Commissioner's office can be contacted using the following details respectively:

Manchester Metropolitan Data Protection Officer dataprotection@mmu.ac.uk

Tel: 0161 247 3331 Legal Services, All Saints Building, Manchester Metropolitan University, Manchester, M15 6BH

UK Information Commissioner's Office

You have the right to complain directly to the Information Commissioner's Office if you would like to complain about how we process your personal data:

https://ico.org.uk/global/contact-us/

THANK YOU FOR CONSIDERING PARTICIPATING IN THIS PROJECT

Appendix C. Study 2 Participant Information Sheet (Chinyanja)

Pepala Laciziwitso

Bungwe lomwe ilikuchitapo kanthu pothana ndi nkhanza zapabanja ndikusogolela thanzi la azimayi achichepere omwe ali ndi vuto lalikulu m'tawuni la Misisi mu Lusaka, mu ziko la Zambia.

- **Kuitaniwa kuti tifufuze**

Ndikufuna kukupemphani kuti mutenge nawo mbali mugulu yotandizirira azimai omwe azakumana ka magulu 6 monga gawo la phunziro lathu. Dzina langa ndine Kayumba Chiwele, ndipo ndine Principal Investigator (PI). Ntchito yathu yofufuza ikufuna kuwunika, kuthese ndi kugwira ntchito koyambirira kwa kulowerera kwa anthu omwe akuthandizira opulumuka ku SGBV kwa Misisi compound.

Phunziro iyi iza zakwanisika mukulingana ndi ma phunziro yo maliza ya PhD mu Psychology pa Manchester Metropolitan University, ndipo athandizidwa ndi Commonwealth Scholarship Commission ku United Kingdom.

2. N'chifukwa chiyani mwaitanidwa?

Mwaitanidwa kuti mutengeko mbali mu phunzi iyi chifukwa mwatidziwitsa za nkanza zapakhomo zamene munakumananazo pa umoyo wanu.

3. Kodi muvomela kutengako nawo mbali?

Cili kwa inu kusankha. Tidzafotokoza phunziro mu pepala ili la chidziwitso lomwe lagawidwa nanu. Kenaka tidzakupemphani kuti musaine fomu yovomerezeka kuti musonyeze kuti mwavomera kutenga nawo mbali. Muli ndi ufulu oleka kutenga mbali nthawi iliyonse, popanda kupereka

chifukwa. Komabe, dziwani mokoma mtima kuti nthawi yomwe pempho loleka likuperekedwa lidzakhudza mtundu wa zochita zomwe tikhoza kuchita kuti tilemekeze pempholo. Izi zafotokozedwa mwatsatanetsatane mu gawo 5 pansipa.

4. Nichani chamene muzafunsidwa kuchita?

Mu gawo iyi ya Phunziro, mudzapemphedwa kuti mutenge nawo mbali la thandizo ya gulu la 6, pamodzi ndi azimayi ena 6 omwe, mofanana ndi inuyo, olo opulumuka kuchiwawa cha pakhomo ndipo amakhala mkati mwa komboni la Misisi. Misonkhano ya thandizoyi idzadziwitsidwa ndi zomwe timati Trauma-Informed Cognitive Behavioral Therapy (TI-CBT) ndipo zidzachitika m'matchalitchi am'komboni ino. Adzafotokozedwa ngati magulu a 'kugwirizana' (popanda kutchula zachiwawa zapakhomo) kuti akutetezeni ngati otenga nawo mbali ndikuonetsetsa kuti chinsinsi chikusungidwa.

Chithandizo cha gulu chidzaperekedwa ndi Wansembe Wamkazi (Mai Busa) pa magawo yali 6, ndipo mudzakumana kawiri pa sabata. Gawo la tsiku lililonse lidzakhala kwa nthawi ya ola limodzi. Pa tsiku la gawo lomaliza, mungapemphedwe kuti mutenge nawo gawo pa zokambirana zakuya za munthu aliyense zojambulidwa ndi PI. Tidzafunikira chilolezo chanu kuti tikulembeni.

Pepala lachidziwitso ili lidzakupatsani chidziwitso pa misonkhano wa thandizo ya gulu lomwe mudzapezekapo ngati mukuvomereza kutenga nawo mbali pa phunziroli. Pasanathe masiku asanu ndi awiri kuchokera tsiku lomwe munalandira PIS iyi, muzayankha PI kuti mutsimikizire chidwi chanu chotenga nawo mbali.

5. Pangang’ale zoopsa zilizonse muli phunziro iyi, ngati mwapeza chonvesa kuyipa pamene mutenga mbali tikoza kuchitapo zochita mu ku chosapo zoopsa.

Pangakhale zoopsa zina mu phunziroli, popeza tidzakhala tikuthana ndi nkhani zovuta zokhudzana ndi zomwe mwakumana nazo za SGBV. Chifukwa chake, ngati mwakhumudwitsika mu stage iyi, zochita zotsatirazi za Risk Management zidzatengedwa. .

Mukhoza kutuluka pa gulu otenga nawo mbali pa nthawi iliyonse, popanda kupereka zifukwa. Mukhoza kutero mwa kudziwitsa PI mukakumana kwa magawo. Komabe, monga tafotokozera pamwambapa, dziwani mokoma mtima kuti nthawi yomwe pempho lochoka likuperekedwa lidzakhudza mtundu wa zochita zomwe tikhoza kuchita kuti tilemekeze pempholo.

Ngati mupereka pempho lanu lotulukila pamene kusonkhanitsa deta kukuchitika, mungayembekezere kuti deta iliyonse yosonkhanitsidwa kuchokera kwa inu idzachotsedwa ndipo

sidzagwiritsidwa ntchito mu phunziro lonse, kuphatikizapo kusanthula deta ndi zotsatira zilizonse za Phunziro monga zofalitsa. .

Ngati mutapereka pempho lanu lotulukila pamene kusebenzelapo kwa deta kwayamba kapena kwatha (ie, masabata awiri kuchokera pakutenga nawo mbali), sizingatheke kuchotsa deta yanu. Pankhaniyi, Wofufuza Wamkulu adzakambirana nanu deta yomwe tikhoza kuchotsa, ndi zifukwa zomwe deta iliyonse yotsala singachotsedwe mu polojekitiyi. .

Chifukwa chake, pa ntawi lapadera ya maphunziro, mukhoza kuchotsa chilolezo chanu chogwiritsira ntchito deta yomwe yaperekedwa podziwitsa PI, mkati mwa masabata awiri (2) kuyambira tsiku lomaliza la maphunziro. Ngati muchita zimenezo mkati mwa nthawiyi, deta yonse yosonkhanitsidwa idzachotsedwa. Komabe, deta iliyonse yomwe ikuphatikizapo inu mu mawonekedwe a kanema kapena zojambula zomvetsera za zokambirana zamagulu pa misonkhano sizidzachotsedwa popeza zikuphatikizapo deta kuchokera kwa ophunzira ena, koma mayankho anu, zopereka ndi chidziwitso zidzachotsedwa kuti zisagwiritsidwe ntchito mu phunziroli.

Simudzapemphedwa kuti mubwezere ndalama iliyonse yomwe mwapatsidwa pa chakudya chamasana ndi mayendedwe panthawi yomwe mukuchita nawo phunziroli.

Ngati mukuona kuti mungafunike thandizo la mumaganizo, chonde dziwitsani PI. Mabungwe otsatira awa adzalandiridwa ndipo katswiri wa zamaganizo adzapatsidwa kwa inu popanda kulipila.

PI ikugwirizana ndi PsycHealth Zambia monga Co-founder. Mulinso ndi ufulu wolumikizana ndi aliyense wa mabungwe awiriwa payekha.

Mabungwe	**Okambilana Nao**
PsycHealth Zambia	64/C Mutandwa Road, Roma Lusaka, Zambia **Phone:** +260 955 264975 **Email:** info@psychzambia.com **Website:** www.psychzambia.com

6. Kodi pali zabwino zilizonse mungateko nawo mbali?

Sitingathe kutsimikizira kuti mudzalandira phindu lina lililonse kuchokera ku Phunziro, kupatula kuti mudzalandira yothandizila ndi kulimbana / kuthana ndi zotsatira za nkhanza zomwe mwakumana nazo. Kuphatikiza apo, mudzakhala ndi mwayi wothandizira pa chitukuko cha kulowerera kwatsopano komwe tikuyembekeza kuti kudzapindulitsa kwambiri komboni lanu mu kutengako nawo mbali pa phunziroli iyi.

Pa ndalama zanu zoyendera, mudzalandira malipiro a K50.00, ndi K50.00 yowonjezera pa chakudya chamasana patsiku.

7. Chilolezo chodziwitsidwa

Mukamaliza kuwerenga kudzera mu Pepala la Chidziwitso cha Ophunzira lero ndipo mukusunga kufunitsitsa kwanu kutenga nawo mbali pa phunziroli, mutha kuyankha PI mkati mwa masiku asanu ndi awiri kuti mutsimikizire chidwi chanu chotenga nawo mbali. Potsatira izi, mukamapereka lipoti la gawo loyamba, PI akhoza kukutsogolerani kudzera mu kusaina kwa Fomu Yovomerezeka.

8. Kodi ndi mfundo ziti zokhudza inu ine zimene tidzasonkhanitsa ndipo n'chifukwa chiyani?

Mukavomereza kutenga nawo mbali mu Phunziro, tidzasonkhanitsa kuchokera kwa inu nokha chidziwitso chodziwika monga dzina lanu, zaka ndi mauthenga pamene tikusonkhanitsa chilolezo. Kuphatikiza apo, pa tsiku la gawo lomaliza, tikhoza kukupemphani kuti mutenge nawo mbali pa kuyankhulana kwakuya kwa munthu ndi PI, komwe adzakufunsani mafunso okhudzana ndi zomwe mwa kumana nazo za SGBV.

9. Kodi zidziwitso zanu zidzasungidwa bwanji ndipo tizisamalira bwanji?

Mukavomereza kutenga nawo mbali mu Phunziro, tidzasonkhanitsa kuchokera kwa inu nokha chidziwitso chodziwika. The Manchester Metropolitan University ('the University') ndi Data Controller polemekeza Phunziro ndi deta iliyonse yaumwini yomwe mumapereka monga wochita nawo Phunziro ndi woyang'anira, Dr. Maria Livanou ndi Data Custodian. Yunivesiteyi yalembetsedwa ndi Information Commissioner's Office (ICO), ndipo imayang'anira deta yaumwini malinga ndi General Data Protection Regulation (GDPR) ndi University's Data Protection Policy.

Tidzasonkhanitsa deta yaumwini monga gawo la Phunziro (monga dzina lanu). Monga ulamuliro wa boma wochita census, timadalira maziko ovomerezeka a 'ntchito yaboma'. Tikasonkhanitsa deta yapadera ya gulu (monga chidziwitso chachipatala kapena fuko) timadalira ofufuza ndi zolinga zosungirako mu chidwi cha anthu mwalamulo. Ufulu wanu wopeza, kusintha kapena kusuntha chidziwitso chanu ndi wochepa, popeza tiyenera kuyang'anira chidziwitso chanu m'njira zapadera kuti ofufuza akhale wodalirika komanso wolondola. Ngati mutachoka pa phunziroli, deta yanu idzasamalidwa monga mogwirizana ndi ndondomeko yomwe yatchulidwa mu Gawo 5 pamwambapa.

Ofufuza ena omwe akukhudzidwa ndi phunziroli omwe adzakhala ndi mwayi wopeza deta ndi;

6. Dokota. Matt Brooks – Wina Oyang’ anira
7. Dokota. Kim Heyes - Wina Oyang’ anira
8. Kaluso Masuwa – Ozindikara Machitidwe Othandizira
9. Chalwe Ilunga– Othandizira Wafufuza

10. Kodi tidzagwiritsa ntchito bwanji chidziwitso chanu?

Deta yosonkhanitsidwa kuchokera kwa inu monga gawo la phunziroli (ie, gawo ndi zojambula zoyankhulana ndi mafomu ovomerezeka) zidzasungidwa pa MMU OneDrive ya PI. Palibe makope ena omwe adzasungidwa pa zipangizo zonyamula. PI adzasungiranso zolemba zilizonse kuchokera ku phunziroli kuphatikizapo magazini yake mu OneDrive. Kulowa kwa deta ndi kulemba kudzasamalidwa ndi PI ndi Wothandizira ofufuza, pomwe kusebenzelapo deta kudzachitidwa ndi PI.

Deta yonseyi, ikangosanthula, idzagwiritsidwa ntchito pofufuza ndi kuwunika kuthekera kwa kulowerera kumeneku.

11. Kodi deta yanga yanu idzatumizidwa kwina kulikonse, kapena kugawana ndi anthu ena kapena mabungwe?

Sitidzagawana deta yanu yaumwini yosonkhanitsidwa mu mawonekedwe awa ndi aliyense wachitatu.

Ngati deta yanu yagawidwa, izi zidzakhala pansi pa malamulo a Research Collaboration Agreement yomwe imafotokoza kugwiritsa ntchito, ndikuvomereza chinsinsi ndi chitetezo cha chidziwitso. Ndi ndondomeko ya University kokha kufalitsa deta anonymized pokhapokha inu anapereka chilolezo chanu cholembedwa momveka kudziwika mu Phunziro. The University konse kugulitsa deta munthu kwa anthu ena. Tidzangosunga deta yanu kwa nthawi yaitali yomwe ili yofunikira kuti tikwaniritse cholinga cha Phunziro.

Kuti mudziwe zambiri zokhudza kugwiritsa ntchito ya deta yanu ndi ufulu wanu woteteza deta chonde onani Masamba Oteteza Deta a University.

12. Kodi tidzawononga liti chidziwitso chanu?

Deta yaumwini yosonkhanitsidwa monga gawo la kafukufukuyu idzasungidwa kwa chaka chimodzi chokha pambuyo pa mapeto a phunziro palokha ndikuwonongedwa pambuyo pake ndi PI, potsatira malamulo otaya deta a MMU. Deta ya kafukufuku (pseudonymised) idzasungidwa mpaka zaka 10 (mogwirizana ndi njira zogwirira ntchito za MMU) pambuyo pa mapeto a phunziroli. Mofananamo, Mafomu Ovomerezeka adzasungidwa kwa nthawi yo mpaka zaka 10.

13. Lamulo la Chitetezo cha Deta

Malamulo oteteza deta amafuna kuti tifotokoze 'maziko alamulo' pokonza chidziwitso chokhudza inu. Pankhani ya kafukufuku, imeneyi ndi 'ntchito yothandiza anthu.' Ngati timagwiritsa ntchito zambiri zokhudza inu, monga chidziwitso chokhudza thanzi lanu, chipembedzo, kapena fuko (lotchedwa 'gulu lapadera' chidziwitso), maziko athu ali mu kafukufuku mu chidwi cha anthu. Manchester Metropolitan ndi Mtsogoleri wa chidziwitsochi ndipo ali ndi udindo woyang'anira deta yanu ndikugwiritsa ntchito mogwirizana ndi zofunikira za malamulo oteteza deta omwe amagwira ntchito ku UK.

Muli ndi ufulu wosankha za chidziwitso chanu pansi pa malamulo oteteza deta, monga ufulu wopezeka komanso ufulu wotsutsa, ngakhale kuti nthawi zina ufulu umenewu suli weniweni. Ngati muli ndi mafunso alionse, kapena mukufuna kugwiritsa ntchito ufulu umenewu, chonde funsani wofufuza kapena University Data Protection Officer pogwiritsa ntchito tsatanetsatane pansipa.

Mukhoza kusiya kukhala mbali ya phunziro nthawi iliyonse, popanda kupereka chifukwa. Mukhoza kutipempha kuti tichotse deta yanu nthawi iliyonse, koma sizingatheke nthawi zonse. Mukatipempha kuti tichotse chidziwitso mkati mwa masabata oyambirira a 2 kuyambira kusonkhanitsa deta, tidzaonetsetsa kuti izi zachitika. Ngati mutipempha kuti tichotse deta pambuyo pa mfundoyi, mwina sitingathe. Ngati deta yanu ndi anonymized, sitidzatha kuchotsa izo, chifukwa sitidzadziwa kuti ndi deta iti yomwe ili yanu.

14. Kodi n'chiyani chidzachitikire zotsatira za Phunziro iyi?

Zotsatira za Phunziro iyi zidzaperekedwa pamisonkhano yapadziko lonse lapansi ndipo zidzagawidwa kudzera m'mabuku m'magazini owunikira ndi anzawo, kuti apindule ndi mitundu

yosiyanasiyana ya omvera. Chizindikiritso chanu sichidzaululidwa m'njira iliyonse yofalitsa imeneyi. Mukhozanso kupempha chidule cha zotsatira za Phunziro mwa kulumikizana ndi PI pambuyo pa mapeto a phunziro mu December, 2024.

Pali omvera asanu ofunika kwambiri pa kufufuza, awa ndi awa:

A. Mabungwe otumiza (monga The Psychology Association of Zambia ndi The Ministry of Health)

B. Ogwira ntchito zaumoyo wamaganizo a Community

C. Odwala ndi anthu onse

D. Academia

15. Kodi ndani wavomeleza ntchito yofufuzayi?

Ntchito yofufuzayi yawunikiridwa ndi gulu loyang'anira la PI, MMU Research Ethics and Governance Committee, ndi National Health Research Authority of Zambia.

16. Kodi mungalankhule ndi ndani ngati muli ndi nkhawa ndi phunziroli kapena mukufuna kudandaula?

Kwa mafunso ambiri okhudza polojekiti yofufuza, PI ndi Woyang'anira angapezeke pogwiritsa ntchito mfundo zotsatirazi;

Wafufuza wamkulu

Ms. Kayumba Chiwele

Psychology Department

Manchester Metropolitan University

M15 6BH

United Kingdom

Email: kayumba.chiwele@stu.mmu.ac.uk

Oyang'anira

Dr. Matt Brooks

Department of Psychology

Manchester Metropolitan University

M15 6BH

United Kingdom

Email: m.brooks@mmu.ac.uk

Ngati muli ndi nkhawa iliyonse yokhudza Phunziro, mutha kulumikizananso ndi Wapampando wa Faculty of Health and Education, Ethics Committee (Dr Claire Fox) kudzera pa Email: FOHE-Ethics@mmu.ac.uk

Ngati muli ndi nkhawa iliyonse yokhudza phunziroli kapena deta yaumwini yomwe yasonkhanitsidwa kuchokera kwa inu, Woyang'anira Chitetezo cha Deta ndi ofesi ya Commissioner angapezeke pogwiritsa ntchito mfundo zotsatirazi:

Woyang'anira Chitetezo cha Deta ya Manchester Metropolitan dataprotection@mmu.ac.uk.

Tel: 0161 247 3331 Ntchito Zamalamulo, Nyumba ya Oyera Mtima Onse, Manchester Metropolitan University, Manchester, M15 6BH

UK Information Commissioner's Office

Muli ndi ufulu wodandaula mwachindunji ku Ofesi ya Information Commissioner ngati mukufuna kudandaula za momwe timakonzera deta yanu:

https://ico.org.uk/global/contact-us/

ZIKOMO CHIFUKWA CHOGANIZIRA KUTENGA NAWO MBALI PA NTCHITOYI!

Appendix D. Study 1 Consent Form

A Community-Based Intervention to Tackle Domestic Violence and Improve Mental Health in Young Underprivileged Women in a Peri-Urban Community of Misisi in Lusaka, Zambia

Participant Identification Number:

	Please tick your chosen answer	YES	NO
1	I confirm that I have read the participant information sheet version 1.4, dated 10/10/2022 for the above study.	☐	☐
2	I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐	☐
3	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected, and without having to reimburse any money given to me for lunch and/or transport during my participation in the study.	☐	☐
4	I understand that If I submit my withdrawal request once data analysis has begun or been completed (i.e., two weeks from participation), it might not be possible to remove my data. In this case, the Principal Investigator, Ms. Kayumba Chiwele will discuss with me which data is capable of being removed, and the reasons why any remaining data cannot be withdrawn from the project.	☐	☐
5	I understand that if I submit a withdrawal request within 2 weeks after participation, all data collected from me will be deleted. However, any data that includes me in the form of video or audio recordings of focus group discussions will not be deleted as it includes data from other participants, but my responses,	☐	☐

	contributions and information will be excluded from being used in the study.		
6	I agree to participate in the project to the extent of the activities described to me in the above participant information sheet, including audio and/or video recordings of some of the sessions I participate in, and . a post-training assessment	☐	☐
7	I understand and agree that the personal information I provide will be transferred to the UK for research purposes.	☐	☐
8	I understand that if I want to know about the study findings, I can contact Kayumba via email after December, 2023.	☐	☐

…… ……..

Name of participant Date

Appendix E. Study 2 Consent Form (English)

A Community-Based Intervention to Tackle Domestic Violence and Improve Mental Health in Underprivileged Women in a Peri-Urban Community of Misisi in Lusaka, Zambia

Participant Identification Number:

	Please clearly state your chosen answer	YES	NO
1.	I confirm that I have read the participant information sheet version **1.2** dated 09**/08/2023** for the above study.	☐	☐
2	I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐	☐
3	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected, and without having to reimburse any money given to me for lunch and/ or transport during my participation in the study.	☐	☐
4	I understand that If I submit my withdrawal request once data analysis has begun or been completed (i.e., two weeks from participation), it might not be possible to remove my data. In this case, the Principal Investigator, Ms. Kayumba Chiwele will discuss with me which data is capable of being removed, and the reasons why any remaining data cannot be withdrawn from the project.	☐	☐
5	I understand that if I submit a withdrawal request within 2 weeks after participation, all data collected from me will be deleted. However, any data that includes me in the form of audio recordings of group therapy sessions will not be deleted as it includes data from other participants, but my responses, contributions and information will be excluded from being used in the study.	☐	☐

6	I agree to participate in the project to the extent of the activities described to me in the above participant information sheet, including a pre- and post-assessment, and a follow-up assessment 3 months after receiving the TF-CBT support.	☐	☐
7	I agree to my participation being audio recorded for analysis. No audio clips will be published without my express consent (additional media release form).	☐	☐
8	I understand that my personal data collected in this study will not be shared with any third parties. If it is shared, this will be under the terms of a Research Collaboration Agreement which defines use, and agrees confidentiality and information security provisions. It is the University's policy to only publish anonymized data unless I have given my explicit written consent to be identified in the research.	☐	☐
9	I understand and agree that the personal information I provide will be transferred to the UK for research purposes.	☐	☐
10	I understand that the following co-researchers will also have access to my personal information: • Ms. Chalwe Ilunga (Volunteer Co-researcher) • Mr. Kaluso Masuwa (Cognitive Behavioural Specialist)		
	The following items are OPTIONAL. This means that you can choose to reject any of them, and you will still be able to participate in the study.		
11	I agree to participate in a one-to-one interview with the Principal Investigator after the last session of the TF-CBT support.	☐	☐
12	I understand and agree that my words may be quoted anonymously in research outputs.	☐	☐
13	I give permission for a fully anonymised version of the data I provide to be deposited in an Open Access repository so that it can be used for future ***research*** and ***learning***.	☐	☐
14	I confirm that I would like to be contacted and have the results of the study shared with me at the end of the project.	☐	☐

Appendix F. Study 2 Consent Form (Chinyanja)

Pepala Yovomereza: Phunziro 2

Vamene tingachite po chingiliza lufyengo wamene umachitika mumanyumba nakuchinja kukaganiza kwa bwino kuli azamai upondelezedwa mu komboni ya Misisi Mu Lusaka muziko la Zambia.

	Namba yotengelako mbila: **Sakani yanko yaku mutima kwanu**	Nivomela	Nikana
1	Nivomela kuti ninabelenga pa pepa yotengako mbali nambala 1.2 inalembedwa pa siku la 09 mwezi wa August mwaka 2023 pali iyi phunzilo.	☐	☐
2	Bananipasa nthawi yo ganizapo pali mau, nakufunsa mafunso nakuyankidwa mokutila.	☐	☐
3	Niziba kuti kutenga mbali kwanga ni kozi peleka ndipo ninga lekeze kutenga mbali kulibe chifukwa, kulibe kupondelezedwe ufulu wanga, naku sabweza ndalama yachakudwa olo yokwelela paku ntanga mbala muli phunziro iyi.	☐	☐
4	Niziba kuti ngati napempa kuti nilekeze kutengako mbali pamene bayamba kusebenzelapo pa mau, kapena pamene basiliza (pamboyo yama weeks yabili) chizankala chosa kwanilisika kulekeza mau yanga. Mwaicho Bakulu ba iyi phunziro Mai Kayumba Chiwele banga kambilane ine pali mau yanga kulekelezedwa naku pasa vifukwa chosa kwanilisika kuleleze mau muli iyi nchito.	☐	☐
5	Niziba kuti ngati napele pempo yo lekeze kutenga mbali muli ma weeks yabili mau yanga yonse yaza chosedwa. Komanso, mau ena yangankale muma video kapena mu liu pakati pa gulu yothandizana siyaza chosedwa kulingana ku yaphatikizana na mau yabo tengako mbali ena, koma ma yanko, mau na zoikilapo zanga ziza chosedwa po sebenzesa mau muli iyi Phunziro.	☐	☐

6	Nivomela kutengako mbali muli iyi nchito kulingana nazo funika kuchitika monga pa pepa ya mau yotengelako mbali, mafunso yakuya ya ine ndeka kuikilapo mafunso yapo yamba na posiliza kufufuza, kuikilapo na mafunso paka pita ma months yatatu	☐	☐
7	Nivomela kuti mau yanga banga chite record ku lingana na kufunikila kwa phunzilo iyi. Kuka funika kuti mau yanga ba yasebenzese kuli vinangu, niyenekela kuba pasa chi vomeleso kuti bapitilize.	☐	☐
8	Nivomela kuti mau yanga yonizibisa monga zina yanga siyaza ka pasiwa kuli bantu bailibonse. Kuka funika kuti mau aya yapasiwe kuli bantu, kufunika kuti yapasiwe, tiza ka funika ku saina ma pepala yakuti ni vomelese. Namvela kuti university iyi siyinga pase mau yanga kuli bantu bali bonse mpaka na vomelesa.	☐	☐
9	Niziba komanso nivomela kuti ngati mau yanga nizapeleka yaza pelekedwa ku dziko ya UK kulingana na zo phunzisana chabe.	☐	☐
10	Nivomelesa kuti aba ba pa nchito banga belenge ma pepala ya deta yanga: 7. Ba Chalwe Ilunga 8. Ba Kaluso Masuwa	☐	☐
	Aya mafunso yaza konkapo, munga sanke ku vomelesa olo kukana. Olo kuti mukane, muza pitiliza ku nkala mo mu ma phunzilo aya.		
11	Nivomela kuti tinga nkale pansi te babili naba mai Kayumba kuyanka mafunso yamene baza nkala nayo.	☐	☐
12	Nivomela kuti mau yanga banga ya sebenzese mu ma buku yolemba, koma zina yanga ziyiza zibika.	☐	☐
13	Nivomelesa kuti mau yanga yonse yamene napasa mu punzhilo iyi, yanga sebenzedwe ku punzisa bantu bambili kusogoro.	☐	☐
14	Nivomela kuti ninga kondwere kuni tumila ma results ya phunziro iyi ikasila.	☐	☐

Appendix G. Study 2 Simplified Participant Information Sheet

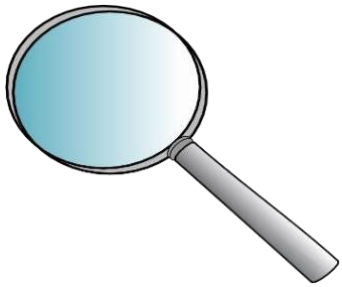
(English)

A Community-Based Intervention to Tackle Domestic Violence and Improve Mental Health in Young Underprivileged Women in a Peri-Urban Community of Misisi in Lusaka, Zambia.

- Invitation to participate in study:

	8. Hi, my name is Kayumba Chiwele. 9. I am a student at The Manchester Metropolitan University in the UK. 10. I am learning how to be a Doctor in Psychology (PhD). 11. Psychologists help people learn to cope with stressful situations.

	• I am trying to learn more about Domestic Violence. • Domestic Violence is defined as any form of violence (such as hitting, shouting or forcing another person to do something) that is done by a partner or a family member against another person in their family.

	• I want to collect information called research. • I am working on a project where we would like to help Zambian women and girls who experience violence at home. To do so, I have trained a group of Amai Busas to deliver some groups that will support women and girls experiencing abuse. • We will then later try and see if these groups have been helpful for female victims of abuse.
	• I would like to invite you to take part.

- Why have I been invited?

	• You have been invited because you may have experienced domestic abuse at home. 9. I want to learn about people who have experienced domestic abuse so that we can try and find ways to help them cope.

- Do I have to take part?

	1. You do not have to take part. 2. If you say '**NO**' then that is OK. 3. It is your choice.
	4. If you say '**YES**', a week from now, my Co-researcher, Ms. Chalwe Ilunga will meet with you and ask you some questions to confirm that you would like to take part in the study. 5. This is called '***Consent***'. She will ask you to answer either 'YES' or 'NO' to each of these questions, and this will be audio-recorded. 6. She will chat to you again about my research and you can ask her questions if you wish.
	• If you change your mind and don't want to take part at any time, that is OK too. • You don't have to tell us why. • You will not be asked to give back any money given to you for transport.

- What will happen to me if I take part?

	• You will be asked to take part in a group with 5 other women that will be delivered by an Amai Busa. In the group, the Amai Busa will talk about; • Domestic abuse and how it can affect those who go through it, • How women can learn to cope with the abuse and to better protect themselves from it. • You will meet once a week, in your local church for 1 hour.
	• The Amai Busa will use a recorder machine so that we can remember what you discuss in the groups. Later, we will write down important information from your discussions and then we will delete the recordings.
	• You will also be asked to fill in some online questionnaires at three time-points. for us to assess whether the support you received was helpful. • ***Before the start of the first group session*** • ***At the end of the last group session*** • ***Three months after the end of the last group session.*** • Ms. Chalwe will help you with these questionnaires.

	• You may also be asked to have a one-to-one interview with me. • You do not **HAVE** to take part. • You are free to say 'YES' or 'NO'. • If you say 'YES', I will ask you about your personal experiences of domestic violence, and how you feel about the groups you participated in.

- What are the benefits of taking part?

	• You will not receive any other direct benefits from this study, but in the groups, you will learn more about domestic violence and how to defend yourself against it. • For your transportation costs, you will receive an amount of K50.00 for each day.

- Are there any possible risks?

	3. It is possible that you may feel distressed because of the sensitive topics that will be discussed. 4. If you feel you may need psychological support at any point, inform the Amai Busa or Ms. Chalwe, and we will

	arrange for you to receive help from the following organization; **PsycHealth Zambia** Mutandwa Road, Roma Lusaka, Zambia **Phone:** +260 955 264975 **Email:** info@psychzambia.com **Website:** www.psychzambia.com

- Will my taking part be kept confidential?

	• Yes. We will not use your real name in our work. • We will lock the information away. • This is to keep your information safe so that others can't take it or know that you took part.

- What will happen to the results?

	The results of this study will be: • Used in a write up for my studies • Shared with other researchers by writing them up in scientific articles and presenting in conferences

	4. If you would like us to, we will send you information on what we learnt from you. 5. Ms. Chalwe will ask you about this during the Consent stage.

8. Who has reviewed this study?

	• People from The Manchester Metropolitan University in the UK, and the National Health Research Authority in Zambia have reviewed it to make sure it is safe for me to gather this information.

- Who do I contact if I have concerns about this study or I wish to complain?

You can contact me at the address below:	You can also contact my Supervisor at the address below:

Principal Investigator	**Supervisor**
Ms. Kayumba Chiwele Psychology Department Manchester Metropolitan University M15 6BH United Kingdom Email: kayumba.chiwele@stu.mmu.ac.uk	Dr. Matt Brooks Department of Psychology Manchester Metropolitan University M15 6BH United Kingdom Email: m.brooks@mmu.ac.uk

If you have any concerns regarding the study, you can also contact the Chair of the Faculty of Health and Education, Ethics Committee (Dr Claire Fox) via Email:

FOHE- Ethics@mmu.ac.uk

THANK YOU FOR CONSIDERING PARTICIPATING IN THIS STUDY!

Appendix H. Study 2 Simplified Participant Information Sheet

(Chinyanja)

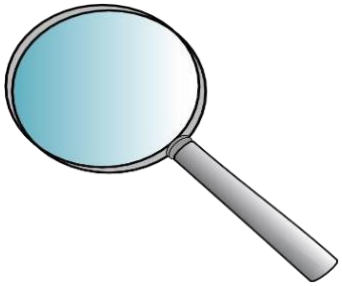
Pepala Laciziwitso

Vamene tingachite po chingiliza lufyengo wamene umachitika mumanyumba nakuchinja kukaganiza kwa bwino kuli azamai upondelezedwa mu komboni ya Misisi Mu Lusaka muziko la Zambia.

1. Kuitaniwa kuti tifufuze

	• Mwachoma bwanji, zina yanga ndine Kayumba Chiwele. • Ndine student ku Manchester Metropolitan University, ku UK. • Ndi punzila kunkala dokota wo tandiza bantu kuli matenda ya maganizo. • Ba dokota bo tandiza bantu na matenda ya maganizo baitaniwa kuti ni ba Psychologist.
	I. Apa, nifuna kuziba maningi ma nkani yomenyena panyumba. II. Aya ma nkani, yamene tikamba kuti Domestic Violence olo SGBV (Sexual and Gender-based Violence), nima nkani yakuti muntu akumenya, aku shouta na kuku tukwana, olo kuku patikiza kuchita chintu chamene siufuna). Uyu muntu

	kwambili chima pezeka kuti ni mwamuna wako olo bululu wako.

	II. Pali ino ntawi, nipempako kukambisana naimwe kuti nitengeko mawi kuli imwe. III. Nisebenzera pali nchito yamene ifuna kuti titandize azimai na asikana bamene bamapita muli nkani iyi yo menyewa pa nyumba. Kuti ti batandize, tina punzisa ko amai busa bali 6 mo tandizila asikana na azimai mu nkani iyi. Kuza ka nkala ku ma meeting na amai busa aba, pamodzi na amuzimai benangu. IV. Po siliza, tizaka pima kuti aya ma meeting bushe yana kutandizani bwanji.
	• Pali ino ntawi, nipempa kuti imwe mutitandizeko muli iyi nchito.

2. N'chifukwa chani mwaitanidwa?

	• Mwaitanidwa kuti mutengeko mbali mu phunzi iyi chifukwa mwatidziwitsa za nkanza zapakhomo zamene munakumananazo pa umoyo wanu. • Tifuna kuti titandize azimai na asikana bamene bamapita muli nkani izi zamene muna pitamo.

3. Kodi muyenekela kuvomela kutengako nawo mbali?

	5. Cili kwa inu kusankha. 6. Kenaka tidzakupemphani kuti musaine fomu yovomerezeka kuti musonyeze kuti mwavomera kutenga nawo mbali. 7. Muli ndi ufulu oleka kutenga mbali nthawi iliyonse, popanda kupereka chifukwa.
	8. Kodi muka vomera kutenga mbali, amai Chalwe Ilunga azakabwela kukamba naimwe futi kuku funsisisani kuti mwavomera kutenga mbali. 9. Iyi, iyitaniwa kuti 'Consent'. Baza kufunsani kuti muyanke ati 'Ehe' olo 'iyayi'. Elo bazaka ku chitani record naka limba. 10. Bazaka ku kumbusani nafuti pali iyi punzhilo, elo munga bafunse mafunso yonse yamene munga nkale nayo.
	• Muka chinja nzeru kuti simufuna kutenga mbali, kulibe vuti ili yonse, munga chokemo mu punziro. • Simu yenekera kutiuza chifukwa chamene mwa chokelamo. • Simuza yenekera kubweza ndalama zili zonse yayi.

4. Nichani chamene muzafunsidwa kuchita?

	• Mu gawo iyi ya Phunziro, mudzapemphedwa kuti mutenge nawo mbali la thandizo ya gulu la 6, pamodzi ndi azimayi ena 6 omwe, mofanana ndi inuyo, olo opulumuka kuchiwawa cha pakhomo ndipo amakhala mkati mwa komboni la Misisi. 6. Mu gulu iyi, muza kambisana pali nkani yo menyewa panyumba 7. Elo nafuti muzambisana pa njila zo zitandizilamo • Muza kumana kamodzi mu week imodzi, elo ma meeting aya yazankala ya 1 hour.
	• Amai Busa aza sebenzesa ka recorder machine pakuti tika sunge bwino mawi yamene muzati uza muma gulu yanu.
	• Tiza kupempani kuti muyankeko mafunso ya pa internet pa ntawi zitatu; • ***Poyamba gulu yo yambirira*** • ***Po siliza gulu yo silizisa*** • ***Paka pita ma months yatatu.*** • Amai Chalwe azaka kutandizani kuyanka aya mafunso pa computer.

	• Tizaka ku pempani ku nkala pansi tebabili imwe naine kuti nika kufunseni koni ma funso pa mweka chabe. • Simu yenekela kuvomela iyayi. • Ngati simufuna, munga kane, elo ngati mufuna, munga vomele • Muka vomela, niza kufunsani mafunso pali vonse vamene muna pitamo kuli bamuna banu. Cho silizisa, niza kufunsani ngati ma gulu yanu yana kutandizani olo iyayi.

5. Kodi pali zabwino zilizonse mungateko nawo mbali?

	• Kulibe chilichonse chamene tinga kupaseni iyayi. Koma, muma gulu yanu na azimai, muza punzila pali iyi nkani ya SGBV, elo na njila yo zitandizilamo. • Tiza kupasani ma K50 per day ya transport.

6. Kodi, muli zoipa zili zonse mu phunziro iyi?

	8. Pangakhale zoipa zina mu phunziroli, popeza tidzakhala tikuthana ndi nkhani zovuta zokhudzana ndi zomwe mwakumana nazo za SGBV.

	9. Chifukwa chake, ngati mwakhumudwitsika mu stage iyi, muyenekela ku udza amai Chalwe olo amai busa. Azakutandizani kutumila ba Psychologist ku: **PsycHealth Zambia** Mutandwa Road, Roma Lusaka, Zambia **Phone:** +260 955 264975 **Email:** info@psychzambia.com **Website:** www.psychzambia.com

7. Kodi, bantu bonse bazaziba kuti nina tenga mbali muli phunziro iyi?

	• Yayi. Sitiza sebenzensa zina yanu mu nchito iyi. • Deta yonse izatengewa kuli imwe, tizaka ikomela. • Tika ikomela, kulibe angaitenge, olo anga zibe kuti ndimwe munati tandiza kuyanka mafunso yatu.

8. Kodi n'chiyani chidzachitikire zotsatira za Phunziro iyi?

	Zotsatira za Phunziro iyi zidzaperekedwa pamisonkhano yapadziko lonse lapansi ndipo zidzagawidwa Kudzera m'mabuku m'magazini owunikira ndi anzawo, kuti apindule ndi mitundu yosiyanasiyana ya omvera.

	• Muka tivomelesa, tika siliza nchito mu December, 2024, tinga kutumineni deta yonse yamene tiza pezamo mu punziro iyi. • Amai Chalwe azaku funsisisani pa stage yotenga consent.

8. Kodi ndani wavomeleza nchito yofufuzayi?

	9. Nchito yofufuzayi yawunikiridwa ndi gulu loyang'anira la PI, MMU Research Ethics and Governance Committee, ndi National Health Research Authority of Zambia.

9. Kodi mungalankhule ndi ndani ngati muli ndi nkhawa ndi phunziroli kapena mukufuna kudandaula?

Wafufuza Wamkulu	Oyanga’nira
Principal Investigator Ms. Kayumba Chiwele Psychology Department Manchester Metropolitan University	**Supervisor** Dr. Matt Brooks Department of Psychology Manchester Metropolitan University M15 6BH

M15 6BH United Kingdom Email: kayumba.chiwele@stu.mmu.ac.uk	United Kingdom Email: m.brooks@mmu.ac.uk

Ngati muli ndi nkhawa iliyonse yokhudza Phunziro, mutha kulumikizananso ndi Wapampando wa Faculty of Health and Education, Ethics Committee (Dr Claire Fox) kudzera pa Email: FOHE-Ethics@mmu.ac.uk

ZIKOMO CHIFUKWA CHOGANIZIRA KUTENGA NAWO MBALI PA NTCHITOYI!

Appendix I. Study 1 Participant Debrief Sheet

A Community-Based Intervention to Tackle Domestic Violence and Improve Mental Health in Young Underprivileged Women in a Peri-Urban Community of Misisi in Lusaka, Zambia.

Study 1 Participant Debrief Sheet

Thank you for participating in our study. We hope that you have found it interesting and have not been upset by any of the topics discussed. However, if you have found any part of this experience to be distressing and you wish to speak to one of the researchers, please contact:

Kayumba Chiwele – Principal Investigator

Email address: KAYUMBACHIWELE@stu.mmu.ac.uk

There is also an organisation below that you can either contact yourself, or ask the Principal Investigator to arrange a session for you. The PI is affiliated with PsycHealth Zambia as Co-founder.

Organisations	Contact Information
PsycHealth Zambia	Mutandwa Road, Roma Lusaka, Zambia **Phone:** +260 955 264975 **Email:** info@psychzambia.com **Website:** www.psychzambia.com

THANKS AGAIN FOR TAKING PART IN OUR STUDY!

If you'd like to know the main findings of this study, please contact the principal investigator (Kayumba Chiwele) after the end of the study (November, 2023). Please note that the data will be analysed collectively, so we will not be able to give any information on *your* answers.

Appendix J. Study 2 Participant Debrief Sheet

A Community-Based Intervention to Tackle Domestic Violence and Improve Mental Health in Young Underprivileged Women in a Peri-Urban Community of Misisi in Lusaka, Zambia.

Thank you for participating in our study. The data you contributed will help me to complete my dissertation project, which is focussed on helping Zambian women and girls who experience violence at home and aimed to evaluate the feasibility and preliminary effectiveness of a community-based intervention delivered by Amai Busas to SGBV survivors in Misisi.

What happens now?

I will now start analysing the data from all participants. Transcripts of our TF-CBT sessions and one-to-one interviews will be typed up in the weeks following our last meeting. If for any reason you would like to withdraw your data from being used in the study, please remember that the time at which a withdrawal request is submitted will affect the type of action we are able to take to honour the request.

If you submit your withdrawal request within the next 2 weeks, you can expect that any data collected from you will be withdrawn and will not be used in the rest of the study, including data analysis and any outcomes of the research such as publications.

If you submit your withdrawal request once data analysis has begun or been completed (I.e., two weeks from participation), it might not be possible to remove your data. In this case, the Principal Investigator will discuss with you which data we are capable of removing, and the reasons why any remaining data cannot be withdrawn from the project.

What if I would like to remove my data from the study?

In order to withdraw your data from my database which is anonymised I will need your unique, anonymous personal code that you created at the start of the study.

Please quote this code if you contact me to withdraw your data from the study.

What if I need to speak with someone following the interview?

We hope that you have found it interesting and have not been upset by any of the topics discussed. However, if you have found any part of this experience to be distressing and you wish to speak to one of the researchers, please contact:

1. Kayumba Chiwele – Principal Investigator

   Email address: kayumba.chiwele@stu.mmu.ac.uk

2. Dr. Matt Brooks – Principal Supervisor

   Email address: m.brooks@mmu.ac.uk

You can also contact the organisation below for assistance.

Organisations	**Contact Information**
PsycHealth Zambia	Mutandwa Road, Roma Lusaka, Zambia **Phone:** +260 955 264975 **Email:** info@psychzambia.com **Website:** www.psychzambia.com

THANKS AGAIN FOR TAKING PART IN OUR STUDY!

If you'd like to know the main findings of this study, the principal investigator (Kayumba Chiwele) will contact you after the end of the study (December, 2024) to share these with you. Please note that the data will be analysed collectively, so we will not be able to give any information on *your* answers.

Appendix K. Study 1 Participant Withdrawal Form

A Community-Based Intervention to Tackle Domestic Violence and Improve Mental Health in Young Underprivileged Women in a Peri- Urban Community of Misisi in Lusaka, Zambia

Introduction

If you would like to withdraw as a participant in this research project, please complete this form and return it to the Principal Investigator. However, kindly note that the time at which a withdrawal request is submitted will affect the type of action we are able to take to honour the request.

If you submit your withdrawal request whilst data collection is in progress, you can expect that any data collected from you will be withdrawn and will not be used in the rest of the study, including data analysis and any outcomes of the research such as publications.

If you submit your withdrawal request once data analysis has begun or been completed (I.e., two weeks from participation), it might not be possible to remove your data. In this case, the Principal Investigator will discuss with you which data we are capable of removing, and the reasons why any remaining data cannot be withdrawn from the project. Therefore, for this particular stage of the study, you can withdraw your consent to the use of the data provided by contacting the PI via email, within 2 weeks from the date of the last training session. If you do so within this timeframe, all data collected will be deleted.

However, it is important for you to understand that any data that includes you in the form of video or audio recordings of focus group discussions will not be deleted as it includes data from other participants, but your responses, contributions and information will be excluded from being used in the study.

If you withdraw, you will not be asked to reimburse any of the money given to you for lunch and/or transport during your participation in the study.

Participant name or Study ID Number:

Participant to complete this section. Please initial one of the following boxes:

I confirm that I wish to withdraw from the study before data collection has been completed and that none of my data will be included in the study.	
I confirm that I wish to withdraw all of my data from the study before data analysis has been completed and that none of my data will be included in the study.	
Signature of participant:	Date:
Signature of person who will ensure that the stated data has been deleted:	Date:

Please return this form to the Principal Investigator via email (kayumba.chiwele@stu.mmu.ac.uk)

Appendix L: Study 1 Training Evaluation Form

A Community-Based Intervention to Tackle Domestic Violence and Improve Mental Health in Young Underprivileged Women in a Peri-Urban Community of Misisi in Lusaka, Zambia.

On a scale of 1 – 5, with 1 being 'low', 3 being 'medium', and 5 being 'high', how would you rate yourself on the following? Circle your choice.

Part A: General Effectiveness of Training

1. **Ability to counsel clients about the topics covered in this training**

Before Training: 1 2 3 4 5

After Training: 1 2 3 4 5

2. **Ability to manage clients regarding topics covered in this training**

Before Training: 1 2 3 4 5

After Training: 1 2 3 4 5

3. **Comfort level in providing services to clients in relation to the topics covered in this training**

Before Training: 1 2 3 4 5

After Training: 1 2 3 4 5

4. Overall knowledge of the topics covered in this training

Before Training: 1 2 3 4 5

After Training: 1 2 3 4 5

Part B: Specific Applicable Knowledge and Skills

5. **Understanding of what Sexual and Gender-based Violence (SGBV) is?**

Before Training: 1 2 3 4 5

After Training: 1 2 3 4 5

6. **Understanding of what Trauma-informed Cognitive Behavioral Therapy (TF-CBT) is?**

Before Training: 1 2 3 4 5

After Training: 1 2 3 4 5

7. **Ability to counsel and support survivors of SGBV using the TF-CBT model?**

Before Training: 1 2 3 4 5

After Training: 1 2 3 4 5

Appendix M: Study 2 Participants Risk Assessment

Questionnaire

1. Will you feel safe when you return home today?

   YES NO

   If No, what are your reasons for not feeling safe?

2. Are you fearful that your partner or someone else will cause you harm when you return home today?

   YES NO

3. Do you feel your participation in this study will put you at risk of harm when you return home?

   YES NO

   If YES, how?

4. Have you had any thoughts of killing yourself because of the violence that you have experienced?

   YES NO

   If yes, when was the last time you had these thoughts?

5. Have you ever acted on these thoughts and tried to kill yourself?

   YES NO

   If yes, when?

Instructions:

From the information attained above, do you feel the client is in immediate danger?

YES *- If the client seems to be in immediate danger;*

1. *Exclude from the study and offer referrals*
2. *Create a Safety Plan with the client, and escort them to support services (e.g., police station, safe shelter, hospital).*

NO *- If you believe the client is not in immediate danger, proceed with study recruitment procedure.*

Appendix N. ASIST-GBV Screening Tool for Women

***Introduction**:* Violence is a traumatic experience for both men and women. When we ask women about "gender-based violence", we are asking about different types of violence that women/girls may experience. This could include physical violence (hitting, punching, kicked, slapped, choked, hurt with a weapon, or otherwise physically hurt), sexual violence, psychological harm (threats, insults, talk down to you), including threats of violence and/or coercion by members of their own family, acquaintances, and/or strangers in the home, community and/or during armed conflict. Gender based violence can also lead to health problems (physical and mental) for some women. The purpose of these questions is to assess your experiences of gender-based violence. Your responses can help us identify with you the most appropriate health and protection services. We are asking all clients who come to IRC health facilities these same questions. Your responses to these questions are confidential and will not be shared with anyone without your permission.

Is it okay for us to ask you questions on gender-based violence? Yes _____ No _____

IF no, ask if she would like additional resources for health or safety.

Screening questions:
1.1 In the past 12 month, have you been threatened with physical or sexual violence by someone in your home or outside of your home?
1.2 In the past 12 month, have you been hit, punched, kicked, slapped, choked, hurt with a weapon, or otherwise physically hurt by someone in your house or outside of your house?
1.3 In the past 12 month, have you been forced to have sex against your will?
1.4 In the past 12 month, were you ever forced to have sex to be able to eat, have shelter, or have sex for essential services [such as protection or school] because you or someone in your family would be in physical danger if you refused?
1.5 In the past 12 month, were you ever physically forced or made to feel that you had to become pregnant against your will?

1.5a If yes, are you currently pregnant because of that?
1.6 In the past 12 month, has anyone ever forced you to lose a pregnancy? By this, I mean forced you to take a medication, go to a clinic, or physically hurt you to end your pregnancy.
1.7 In the past 12 month, were you coerced or forced into marriage (or to partner with someone)?
END OF SCREENING: If the participant responded 'yes' to experiencing any of the violence in questions from 1.1 to 1.7, she has screened positive for GBV.

Screening questions:
1.8 REFERRAL: [*Interviewer: Ask all who screen positive]* Would you like to be referred to service for your experience of gender-based violence? **These could include health, psychosocial, and protection services.**

Appendix O. Relationship Assessment Tool

RELATIONSHIP ASSESSMENT TOOL

The Relationship Assessment Tool is a screening tool for intimate partner violence (IPV). The tool, developed by Dr. Paige Hall and colleagues in the 1990's, was originally named the WEB (Women's Experiences with Battering). Terminology has since evolved in the field and the unique characteristic of this assessment tool which measures women's experiences in abusive relationships is more accurately reflected by using the name, Relationship Assessment Tool.

References in the literature and publications use the original name, the WEB. The Relationship Assessment Tool and the WEB are the same tool and therefore supported by the same validation studies and research.

As opposed to focusing on physical abuse, the Relationship Assessment Tool (WEB) assesses for emotional abuse by measuring a woman's perceptions of her vulnerability to physical danger and loss of power and control in her relationship. Research has shown that the tool is a more sensitive and comprehensive screening tool for identifying IPV compared to other validated tools that focus primarily on physical assault. Evaluation studies of the Tool have demonstrated its effectiveness in identifying IPV among African-American and Caucasian women. The Relationship Assessment Tool (WEB) has not been validated with same sex partners; it can be adapted for use with same sex couples by changing "he" to "my partner" in the screening tool.

This tool can be self-administered or used during face-to-face assessment by a provider. A series of 10 statements ask a woman how safe she feels, physically and emotionally, in her relationship. The respondent is asked to rate how much she agrees or disagrees with each of the statements on a scale of 1 to 6 ranging from disagree strongly (1) to agree strongly (6). The numbers associated with her responses to the 10 statements are summed to create a score. A score of 20 points or higher on this tool is considered positive for IPV.

PUBLICATIONS ABOUT THE WEB:

Coker AL, Pope BO, Smith PH, Sanderson M, Hussey JR. Assessment of clinical partner violence screening tools. Journal of the American Medical Women's Association. 2001(winter):19-23.

Smith PH, Thorton GE, DeVellis R, Earp JL, Coker AL. A population-based study of the prevalence and distinctness of battering, physical assault, and sexual assault in intimate relationships. Violence Against Women. 2002;8(10):1208-1232.

Smith PH, Earp JL, DeVellis R. Measuring battering: Development of the Women's Experience with Battering (WEB) scale. Women's Health: Research on Gender, Behavior, and Policy. 1995;1(4):273-288.

RELATIONSHIP ASSESSMENT TOOL

Date:

This is a self-administered tool for clients to fill out. If the client was unable to complete this tool today, was it because other people were present in the home? Circle one: Yes/No

Other reason for not using tool today: _____

_____

(Note to home visitor: Please modify this script based on your state laws. This is just a sample script.)

"Everything you share with me is confidential. This means what you share with me is not reportable to child welfare, INS (Homeland Security) or law enforcement. There are just two things that I would have to report- if you are suicidal, or your children are being harmed. The rest stays between us and helps me better understand how I can help you and the baby."

We ask all our clients to complete this form. For every question below, please look at the scale and select the number (1-6) that best reflects how you feel.

1 Strongly Disagree

2 Disagree

3 Somewhat Disagree

4 Somewhat Agree

5 Agree

6 Strongly Agree

1) He makes me feel unsafe even in my own home .....
_____
2) I feel ashamed of the things he does to me .....
_____
3) I try not to rock the boat because I am afraid of what he might do .....
_____
4) I feel like I am programmed to react a certain way to him .....
_____
5) I feel like he keeps me prisoner .....
_____
6) He makes me feel like I have no control over my life, no power, no protection .....
_____
7) I hide the truth from others because I am afraid not to .....
_____
8) I feel owned and controlled by him .....
_____
9) He can scare me without laying a hand on me .....
_____
10) He has a look that goes straight through me and terrifies me.....
_____

Thank you for completing this survey.

Appendix P. Hamilton Anxiety Rating Scale (HAM-A)

HAMILTON ANXIETY RATING SCALE (HAM-A)

Below is a list of phrases that describe certain feelings that people have. Rate the patients by finding the answer that best describes the extent to which he/she has these conditions. Select one of the five responses for each of the 14 questions.

	0 = Not present	1 = Mild	2 = Moderate	3 = Severe	4 = Very severe
1. Anxious mood Worries, anticipation of the worst, fearful anticipation, irritability.	☐	☐	☐	☐	☐
2. Tension Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax.	☐	☐	☐	☐	☐
3. Fears Of dark, of strangers, of being left alone, of animals, of traffic, of crowds.	☐	☐	☐	☐	☐
4. Insomnia Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors.	☐	☐	☐	☐	☐
5. Intellectual Difficulty in concentration, poor memory.	☐	☐	☐	☐	☐
6. Depressed mood Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing.	☐	☐	☐	☐	☐
7. Somatic (muscular) Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone.	☐	☐	☐	☐	☐
8. Somatic (sensory) Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, pricking sensation.	☐	☐	☐	☐	☐
9. Cardiovascular symptoms Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat.	☐	☐	☐	☐	☐
10. Respiratory symptoms Pressure or constriction in chest, choking feelings, sighing, dyspnea.	☐	☐	☐	☐	☐
11. Gastrointestinal symptoms Difficulty in swallowing, wind abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation.	☐	☐	☐	☐	☐
12. Genitourinary symptoms Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence.	☐	☐	☐	☐	☐
13. Autonomic symptoms Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair.	☐	☐	☐	☐	☐
14. Behaviour at interview Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, etc.	☐	☐	☐	☐	☐

Scoring: Each item is scored on a scale of 0 (not present) to 4 (very severe), with a total score range of 0–56, where <17 indicates mild severity, 18–24 mild to moderate severity, 25–30 moderate to severe and 31-56 severe to very severe.

References: 1. Hamilton M.The assessment of anxiety states by rating. *Br J Med Psychol* 1959;32:50-5. **2.** Maier W, Buller R, Philipp M, Heuser I. The Hamilton Anxiety Scale: reliability, validity and sensitivity to change in anxiety and depressive disorders. *J Affect Disord* 1988;14(1):61-8. **3.** Borkovec T and Costello E. Efficacy of applied relaxation and cognitive behavioral therapy in the treatment of generalized anxiety disorder. *J Clin Consult Psychol* 1993;61(4):611-9.

Appendix Q. Hamilton Depression Rating Scale

HAMILTON DEPRESSION RATING SCALE (HAM-D17)

1 DEPRESSED MOOD *(sadness, hopeless, helpless, worthless)*
- 0 |__| Absent.
- 1 |__| These feeling states indicated only on questioning.
- 2 |__| These feeling states spontaneously reported verbally.
- 3 |__| Communicates feeling states non-verbally, i.e. through facial expression, posture, voice and tendency to weep.
- 4 |__| Patient reports virtually only these feeling states in his/her spontaneous verbal and non-verbal communication.

2 FEELINGS OF GUILT
- 0 |__| Absent.
- 1 |__| Self reproach, feels he/she has let people down.
- 2 |__| Ideas of guilt or rumination over past errors or sinful deeds.
- 3 |__| Present illness is a punishment. Delusions of guilt.
- 4 |__| Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations.

3 SUICIDE
- 0 |__| Absent.
- 1 |__| Feels life is not worth living.
- 2 |__| Wishes he/she were dead or any thoughts of possible death to self.
- 3 |__| Ideas or gestures of suicide.
- 4 |__| Attempts at suicide (any serious attempt rate 4).

4 INSOMNIA: EARLY IN THE NIGHT
- 0 |__| No difficulty falling asleep.
- 1 |__| Complains of occasional difficulty falling asleep, i.e. more than ½ hour.
- 2 |__| Complains of nightly difficulty falling asleep.

5 INSOMNIA: MIDDLE OF THE NIGHT
- 0 |__| No difficulty.
- 1 |__| Patient complains of being restless and disturbed during the night.
- 2 |__| Waking during the night – any getting out of bed rates 2 (except for purposes of voiding).

6 INSOMNIA: EARLY HOURS OF THE MORNING
- 0 |__| No difficulty.
- 1 |__| Waking in early hours of the morning but goes back to sleep.
- 2 |__| Unable to fall asleep again if he/she gets out of bed.

7 WORK AND ACTIVITIES
- 0 |__| No difficulty.
- 1 |__| Thoughts and feelings of incapacity, fatigue or weakness related to activities, work or hobbies.
- 2 |__| Loss of interest in activity, hobbies or work – either directly reported by the patient or indirect in listlessness, indecision and vacillation (feels he/she has to push self to work or activities).
- 3 |__| Decrease in actual time spent in activities or decrease in productivity. Rate 3 if the patient does not spend at least three hours a day in activities (job or hobbies) excluding routine chores.
- 4 |__| Stopped working because of present illness. Rate 4 if patient engages in no activities except routine chores, or if patient fails to perform routine chores unassisted.

8 RETARDATION (slowness of thought and speech, impaired ability to concentrate, decreased motor activity)
- 0 |__| Normal speech and thought.
- 1 |__| Slight retardation during the interview.
- 2 |__| Obvious retardation during the interview.
- 3 |__| Interview difficult.
- 4 |__| Complete stupor.

9 AGITATION
- 0 |__| None.
- 1 |__| Fidgetiness.
- 2 |__| Playing with hands, hair, etc.
- 3 |__| Moving about, can't sit still.
- 4 |__| Hand wringing, nail biting, hair-pulling, biting of lips.

10 ANXIETY PSYCHIC
- 0 |__| No difficulty.
- 1 |__| Subjective tension and irritability.
- 2 |__| Worrying about minor matters.
- 3 |__| Apprehensive attitude apparent in face or speech.
- 4 |__| Fears expressed without questioning.

11 ANXIETY SOMATIC (physiological concomitants of anxiety) such as:
gastro-intestinal – dry mouth, wind, indigestion, diarrhea, cramps, belching
cardio-vascular – palpitations, headaches
respiratory – hyperventilation, sighing
urinary frequency
sweating
- 0 |__| Absent.
- 1 |__| Mild.
- 2 |__| Moderate.
- 3 |__| Severe.
- 4 |__| Incapacitating.

12 SOMATIC SYMPTOMS GASTRO-INTESTINAL
- 0 |__| None.
- 1 |__| Loss of appetite but eating without staff encouragement. Heavy feelings in abdomen.
- 2 |__| Difficulty eating without staff urging. Requests or requires laxatives or medication for bowels or medication for gastro-intestinal symptoms.

13 GENERAL SOMATIC SYMPTOMS
- 0 |__| None.
- 1 |__| Heaviness in limbs, back or head. Backaches, headaches, muscle aches. Loss of energy and fatigability.
- 2 |__| Any clear-cut symptom rates 2.

14 GENITAL SYMPTOMS (symptoms such as loss of libido, menstrual disturbances)
- 0 |__| Absent.
- 1 |__| Mild.
- 2 |__| Severe.

15 HYPOCHONDRIASIS
- 0 |__| Not present.
- 1 |__| Self-absorption (bodily).
- 2 |__| Preoccupation with health.
- 3 |__| Frequent complaints, requests for help, etc.
- 4 |__| Hypochondriacal delusions.

16 LOSS OF WEIGHT ***(RATE EITHER a OR b)***

a) According to the patient:	b) According to weekly measurements:
0 |__| No weight loss.	0 |__| Less than 1 lb weight loss in week.
1 |__| Probable weight loss associated with present illness.	1 |__| Greater than 1 lb weight loss in week.
2 |__| Definite (according to patient) weight loss.	2 |__| Greater than 2 lb weight loss in week.

17 INSIGHT
- 0 |__| Acknowledges being depressed and ill.
- 1 |__| Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
- 2 |__| Denies being ill at all.

Total score: |__|__|

Ratings should be based upon symptoms over the past one week.
Ratings should be based on a clinical interview, supplemented, where necessary, by collateral history from caregivers.

Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery, and Psychiatry*, *23*(1), 56–62. https://doi.org/10.1136/jnnp.23.1.56

Appendix R. Brief Resilience Scale (BRS)

Please respond to each item by marking <u>one box</u> per row		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
BRS 1	I tend to bounce back quickly after hard times	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
BRS 2	I have a hard time making it through stressful events.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
BRS 3	It does not take me long to recover from a stressful event.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
BRS 4	It is hard for me to snap back when something bad happens.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
BRS 5	I usually come through difficult times with little trouble.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
BRS 6	I tend to take a long time to get over set-backs in my life.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Scoring: Add the responses varying from 1-5 for all six items giving a range from 6-30. Divide the total sum by the total number of questions answered.

My score: _____ item average / 6

Appendix S. PTSD Checklist – Civilian Version

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, pick the answer that indicates how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					

10.	Feeling *distant* or *cut* off from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD-Behavioral Science Div.

How is the PCL Scored?

1) Add up all items from each of the 17 items for a total severity score (range = 17-85)
17-29 This cut off shows little to no severity.

28-29 Some PTSD symptoms - If you are seeing or will be seeing a therapist, print the results of this Quiz and take to your therapist for further evaluation.

30–44 Moderate to Moderately High severity of PTSD symptoms - If you are seeing or will be seeing a therapist, print the results of this Quiz and take to your therapist for further evaluation.

45-85 High Severity of PTSD symptoms - If you are seeing or will be seeing a therapist, print the results of this Quiz and take to your therapist for further evaluation.

Appendix T. Brief Resilience Scale

Brief Resilience Scale (BRS)

Please respond to each item by marking one box per row		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
BRS 1	I tend to bounce back quickly after hard times	1	2	3	4	5
BRS 2	I have a hard time making it through stressful events.	5	4	3	2	1
BRS 3	It does not take me long to recover from a stressful event.	1	2	3	4	5
BRS 4	It is hard for me to snap back when something bad happens.	5	4	3	2	1
BRS 5	I usually come through difficult times with little trouble.	1	2	3	4	5
BRS 6	I tend to take a long time to get over set-backs in my life.	5	4	3	2	1

Scoring: Add the responses varying from 1-5 for all six items giving a range from 6-30. Divide the total sum by the total number of questions answered.

My score: _____ item average / 6

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: assessing the ability to bounce back. *International journal of behavioral medicine*, *15*(3), 194-200.

Appendix U. One-to-one Interview Guide

Thank you for being here to talk to me today, and for your participation in our study so far. Our chat today will last for about 1 hour. We will talk about domestic violence. If you recall from your talks with Ms. Chalwe and the Amai Busa, Domestic Abuse is defined as any form of violence (such as hitting, shouting or forcing another person to do something) that is done by a partner or a family member against another person in their family.

In this interview, we will discuss what you think about domestic violence, and your own personal experiences. We will also talk about your experience and opinion on the just ended TF-CBT support group sessions you attended. I would like you to relax and speak freely and openly. But more importantly, please only share what you're comfortable with and don't feel obliged to discuss anything that you're not comfortable sharing with me.

If you feel uncomfortable or overwhelmed at any point, please let me know and we can pause or end the interview if needed.

- As I have mentioned, I am here to talk to you about domestic violence. Do you believe that it occurs frequently in your community?

*If **'NO',** skip to question 2.*

*If **'YES',***

- What are the common forms in which this violence takes place?

1. Who do you think is most affected by domestic violence?

- Why do you think this violence happens?

- What was your experience of domestic abuse? Please only share what you are comfortable sharing.

    - How long did it last?

    1. How did you feel at the time?

A. Were you aware of any help or support that you could access?

*If **'NO',** skip to question 4.*

*If '**YES',***

- Did you approach any support services? If so, which ones? If not, why not?

    A. What was your experience of using these services?

    1. How easy or difficult was it to access and use these services?

    - Did you experience any stigma when seeking or using these services? In other words, did people exclude, insult, or otherwise disapprove of you because you sought or used services?

    6. What would make it easier for you to access and use these services?

2. Some survivors of domestic violence don't feel able to report the person who has caused them harm. Did you report the person who caused you harm?

*If **'NO',*** why not?

*If **'YES',***

1. Why did you decide to report them?

7. Can you describe this process?

6. Did you receive any support or guidance during this process from family, friends or local services?

5. What made this process easy or difficult for you? Please explain.

4. Did you experience any stigma during the process of reporting the person who caused you harm? In other words, did people exclude, insult, or otherwise disapprove of you because you reported this person? If 'Yes', please explain further.

3. How did you feel at the time?

2. What would have made it easier for you to report this violence?

1. Were you able to escape the abusive situation?

*If **'NO'**, skip to question 6.*

*If **'YES'**;*

1. How did you go about that?

1. What difficulties did you face when trying to escape the situation? Please explain.

1. Did you receive any support or guidance during this process from family, friends, or local services? If 'Yes', please explain further.

1. Did you experience any stigma because of your decision to separate yourself from the person who caused you harm? In other words, did people exclude, insult, or otherwise disapprove of you because you did so? If 'Yes', please explain further.

1. How are you doing now following this experience, mentally, physically and emotionally?

(a) What impact did these experiences have on your life?

1. If you have children, how have they been affected?

(a) What are you doing in your life now to continue to heal from your experiences?

1. What do you want men and women in your community to know about domestic violence?

a. What do you want men and women in your community to know about supporting and respecting survivors of domestic violence?

b. What would you tell other women who are going through a similar situation in their lives right now?

c. What do you feel needs to be done in your community to reduce and eliminate domestic violence and to support survivors?

2. Tell me about the TF-CBT group sessions you just finished attending.

a. Did you find them helpful? (If **YES**, why? If **NO**, why not?)

b. What specifically can you say stood out for you in these sessions?

3. Do you think this is a program that can be beneficial for other women who are survivors of SGBV in your community? Why/why not?

a. Is there anything you think should be changed about the program to make it better?

b. What words of encouragement/ empowerment would you give to other women experiencing domestic abuse?

c. Is there anything else you would like to add that you feel we have not discussed today?

We have come to the end of our interview. Thank you for taking the time to participate.

Appendix V. One-to-one Interview Guide (Chinyanja)

Zikomo popezeka pano kukambisana ndiine lelo, ndiku tengako mbali mukukambisana kwatu kufika apa. Kukambisana kwatu lelo kuzankala kwa ola limozi. Tizakambisana pali nkondo zamumanyumba. Mukakumbukila kuchoka mukulankuzana kwanu ndi Amulongo. Chalwe ndi Amai Busa, Nkondo yamuma nyumba (kuchitawina choipa) izindikilidwa munga nkondo iliyonse (munga kumenya, kunyoza olo kukakamiza muntu wina kuchita chinachache) yomwe ichitidwa ndi bwenzi muchikwati olo wachibululu mubanja kwamuntu wina mubanja yao.

Mukulankuzana, Tizakambisana zomwe inu muganizapo pali nkondo zamuma nyumba, ndi zomwe inu munapyolamo. Tizakambisananso pa zopyolamo zanu ndi maganizo yanu pali mapunzilo yanasila posachedwa apa ya TF-CBT gulu la tandizo mapuzilo munatengako mbali. Nifuna inu munkale omasuka, mulankule momasuka ndi ufulu. Koma mofunikila kwakukulu, inu mugawane ndi ife izo muli nazo ndichitotozo musazinve kukakamiziwa kukamba zilizose zomwe mulibe chitotozo kugawana ndi ine.

Ngati Mwazinva kusowa chitotozo kapena kukakamiziwa pa nyengo iliyose, inu mundiziwise ndipo tinga imilile olo kutesa kulankuzana kwatu ngatinikofunikila.

1. Monga nalakulila, nilipanu kulakuzana ndi inu Kamba kazinkondo zamuma nyumba. Kondi mukulupilila kuti zimachitika kambili mumadela mwanu?

   Mukati “YAYI” pitani ku funso yachibili (2)

   Mukati “INDE;

2. Kodi ndinjila zotani zomwe nkondo zimachitikilamo?
3. Kodi ndiyani omwe munganiza amaletedwa kuipa Kamba kazi nkondo za muma nyumba?
4. Muganiza nichani zinkondo izi zimachitika?

   b. Nikotani kupyolamo kwanu kwazinkondo mumanyumba (kuchitidwa zoipa) ? Inu mugawane izo muli ndi chitotozo kugawanako.

c. Inankalako kwa nthawi itali motani?

d. Munazinva motani pa nthawi ija?

e. Kodi munali kuziwa tandizo iliyose olo kutandiziwa kulikose munga peze?

Mukati “YAYI” pitani ku funso yachinayi (4).

Mukati ‘INDE;

5. Kodi munasakilako tandizo iliyose? Ngatiso, munasakila yabwanji? Ngatisiso, nichani simunasakile?
6. Kodi munankala ndiku pyolamokotani kotani kusewezesa matandizo aya?
7. Kodi zinali zosavuta kapena zovuta motani kupeza ndiku sewezesa matandizo aya?
8. Kodi munapyolamo muma nyazi (kusebanyika) kulikose pamene munali kusakila olo kusebenzesa matandizo aya? Mumau yena kodi banthu anakupatulani, ku nyoza olo kosalola inu chifukwa munasakila kapena munasewezesa matandizo?
9. Kodi nichani chingapepuse zintu kwainu kuyenda ndi kusewezesa matandizo?
10. Ena opyola muzinkondo zamuma nyumba samava kukwanisa kuvumbulusa muntu anawaletela nachita ngozi. Kodi inu munavumbulusa muntui omwe anakuchitilani ngozi?

Mukati ‘YAYI’; nichifukwa chani?

Mukati ’INDE’;

11. Kodi nichani munagamula kumuvumbulusa iwo?
12. Inu masulilani njila iyi yovumbulusa?
13. Kodi munalandilako tandizo iliyose olo kusogololedwa kulikonse kupyolamo uku kuchoka kubanja, abwenzi kapena matandizo yaliyonse?
14. Nichani chinalenga kuti njila iyi ipepuke kapena yovutisa kwaiwe? Masulila
15. Kodi unapita mukunyozedwa (kusebanyika kulikose) mu nthawi ya kuvumbulusa muntu anakuchitani ngozi? Mumau yena, kodi bantu anakuchosani, ku nyoza olo kapena kukaniza inu Kamba munavumbulusa muntu uyu? Ngati ‘Inde; inu masulilani mwakuya.
16. Kodi Munaziva motani pa nthawi iyi?
17. Kodi ndichani chinapepusa zintu kwa inu kuvumbulusa (lipoti) nkondo iyi?
18. Kodi inu munakwanisa kutawa munkalidwe wankondo uyu?

Mukati ‘YAYI; pitani ku funso yachisanu ndi kamonzi (6)

Mukati ‘INDE;

19. Kodi munakwanisa motani?
20. Kodi munapeza mavuto bwanji potawa munkalidwe wankondo uyu? Inu masulilani
21. Kodi munalandilako tandizo iliyose kapena kusogololedwa popyolamo munjila iyi ku choka ku banja, abwenzi, olo matandizo yaliyonse? Ngati ‘Inde; inu masulilani mwakuya.

22. Kodi munapita muma nyozo (kusebanyika) kulikose kamba kaku gamula kwanu kuzipatula ku muntu omwe anakuctilani ngozi? Mumau yena kodi bantu anakuchosapo, ku nyoza olo kulesa iwe Kamba unachita izo? Ngati 'Inde; inu masulila mwakuya.
23. Kodi iwe uzinva bwanji apa manje kukonka kupitamo uku, mu maganizilo, kutupi ndi kumanvedwa?
24. Kodi ndi zotulukamo zotani zomwe unapitamo zinaleta paumoyo wako?
25. Ngati ulindi bana, kodi ndi zotani zachitika kwa beve?
26. Kodi uchita chani mu umoyo wako apa kupitiliza kuchila (kupola) kuzomwe unapitamo mu umoyo wako?
27. Kodi ufuna azibambo ndi azimai mudela lako aziwe chani pali nkondo zamumanyumba?
28. Kodi ufuna azibambo ndi azimai mudela lako aziwe chani pali kutandiza ndi kulemekeza awo anapita (anapulumuka) muzi nkondo zamumanyumba?

    a. Kodi ungawauze chani azimai bena omwe apyolamo mumunkalidwe wazi nkondo pali pano mu umoyo wao?

    b. Kodi mukunva nichani chomwe chinachitidwe mudela mwanu kuchepesako ndi kusiliza nkondo zamumanyumba ndi kutandiza awo anapyolamo (anapulumuka)?

29. Ndiuzeni koni pali TF- CBT gulu lamapuzilo yomwe munatengako mbali nakusiliza posachedwa apa?

a. Kodi munazipeza zatandizo? (Ngati 'Inde; motani? Ngati 'Iyayi, Sizina tandize motani?)

b. Kodi nivichani vomwe mungalakule vinachoka mwatandizo mumapunzilo aya?

c. Kodi muganiza kuti uyu ndi mundandanda omwe ungankale wapindu kubena azimai omwe anapyolamo (anapulumuka) ku SGBV (kukakamizidwa ndiwina wa mphavu kuchila inu) mudela lanu? Kodi zingankale zapindu motani/ kapena osati zapindu motani?

c. Kodi kulizili zonse zomwe muganizila kuti zisintidwe mumundandanda kuti unkale bwino kuposapo?
d. Kodi ndi mau otani achilimbiso/ olimbisa omwe mungapase ku azimai bena omwe apita munkondo zamu manyumba (kuchitidwa zoipa)?
e. Kodi kulizina zache zomwe mufuna kuikilapo zomwe mukunva sitina lankuzana musiku yalelo?

Tafika kumapeto yakulankuzana kwatu. Zikomo popezako nthawi kutengako mbali.

Appendix W. TF-CBT Training Content

TRAUMA-FOCUSED COGNITIVE BEHAVIOURAL THERAPY

FOR SGBV SURVIVORS

TRAINING CONTENT

MODULE 0: INTRODUCTIONS

LEARNING OBJECTIVES

CORE MATERIALS

PREPARATION

ACTIVITY 0.1: WORKSHOP REGISTRATION AND PRE-TEST

ACTIVITY 0.2: WORKSHOP INTRODUCTION

ACTIVITY 0.3: GETTING TO KNOW EACH OTHER

ACTIVITY 0.4 INTRODUCTION OF THE AGENDA AND OVERVIEW OF COURSE OBJECTIVES

MODULE 1: BASIC SKILLS IN COUNSELLING

ACTIVITY 1.1: REVIEWING OUR EXPERIENCES WITH BASIC HELPING COUNSELLING

ACTIVITY 1.2: "WHAT DO I GET OUT OF IT?" BECOMING AWARE OF WHAT MOTIVATES ME, AND WHAT MIGHT MAKE IT HARDER FOR ME TO HELP PEOPLE

ACTIVITY 1.3: WHEN WE NEED MORE THAN BASIC HELPING SKILLS

Appendix X. Intervention Delivery Evaluation Sheet

Study Title: A Community-Based Intervention to Tackle Domestic Violence and Improve Mental Health in Young Underprivileged Women in a Peri-Urban Community of Misisi in Lusaka, Zambia

Participant Identification Number:

….....

Skills **Score (1 – 5)**

SN	**Basic Counselling Skills (Integrity)**		
1.	Quality of interaction with the group		
2.	Listens carefully and communicates understanding to clients		
3.	Is genuine and warm with participants		
4.	Is respectful of and validates the participants		
5.	Appropriate use of paraphrases, content reflections and summaries including appropriate delivery and accuracy		
6.	Appropriate use of questions, probes, and accents including appropriate timing, concreteness, accuracy and brevity		
7.	Appropriate use of silences		
8.	Avoidance of advice-giving and inappropriate problem-solving		
	Professional Skills (Fidelity)		
12.	Session theme clearly explained to participants		
13.	Adherence to session worksheet		

14.	Accessibility of language used		
15.	Intervenes appropriately in cases of need to alert authorities		

ADDITIONAL COMMENTS:

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ASSESSED BY:

…..... …..

NAME SIGNATURE

….....

DATE

Appendix Y. The Amai Busas

Permission was obtained from the Amai Busas to have their pictures shared.

The Amai Busas, after completion of their TF-CBT Training.

Top Left to bottom right: *Bernadette, Ruth, Sarah, Dorcas, Rose and Victoria*

A site visit and courtesy call by the PI, Co-researcher and volunteer Psychotherapist six months after the intervention.

Left to right: *Victoria, Rose, Sarah, Ruth, Chalwe (Co-researcher), Kayumba (PI), Bernadette, Dorcas and Serah (Volunteer Psychotherapist)*