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### Assessing the Effectiveness of the Survivor Support Programs in Addressing Child Sexual Abuse: Case Study

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#### Abstract

This thesis presents a comprehensive assessment of the effectiveness of survivor support programs for child sexual abuse (CSA) at the Young Women's Christian Association (YWCA) in Zambia. Anchored within an integrated conceptual framework combining principles of Trauma-Informed Care and Ecological Systems Theory, the study investigated the types of services provided, their accessibility and quality, and the resulting outcomes for child survivors. A convergent mixed-methods research design was employed, gathering data from 60 caregivers of survivors and key program staff through questionnaires, semistructured interviews, and focus group discussions. The analysis revealed that YWCA Zambia provides a crucial range of services, with trauma-informed counselling forming the core intervention, and that these services are delivered with high regard for confidentiality, staff attitude, and a child-friendly environment. Consequently, caregivers reported significant positive outcomes, including improved child well-being, enhanced school performance, and better family understanding, with these domains showing strong intercorrelation. However, the study identified critical

systemic barriers that moderate overall effectiveness. Severe geographic inaccessibility disproportionately affects peri-urban and rural clients due to centralized service locations, and long wait times indicate capacity constraints. A stark gender disparity was also uncovered, with male survivors nearly absent from counselling and holistic support, highlighting a major gap in equitable engagement. The study concludes that while YWCA Zambia's programs are effective in fostering recovery for those who can access them, their population-level impact is limited by structural inequities in access and inclusivity. Recommendations are directed at YWCA Zambia to decentralize services and develop male-engagement strategies; at policymakers to integrate psychosocial support into public health and justice systems; and at future researchers to conduct longitudinal studies and explore the direct perspectives of survivors. The findings underscore the necessity of adapting survivor support models to navigate the complex ecological realities of the Zambian context to achieve broader and more equitable effectiveness.

**Keywords:** Child Sexual Abuse, Survivor Support Programs, Effectiveness, YWCA Zambia, Trauma-Informed Care, Accessibility, Service Outcomes, Mixed-Methods Research, Zambia

#### 1. Introduction

##### 1.1 Overview

This chapter presents the foundation of the research study. It outlines the background and context of child sexual abuse (CSA) and the imperative for survivor support programs, specifically in Zambia. It introduces YWCA Zambia as the case study and establishes the problem statement, objectives, research questions, and the overall significance and scope of the investigation into the effectiveness of its support services for child survivors.

##### 1.2 Background

Child sexual abuse (CSA) is a profound violation of children's rights and a critical public health concern with devastating immediate and long-term consequences, including psychological trauma, social stigma, and increased vulnerability to further exploitation (Wangamati *et al.*, 2019). In Zambia, CSA remains a significant challenge, exacerbated by socio-economic factors, cultural silence, and often under-resourced response systems. Effective survivor support programs are essential for mitigation, healing, and justice. These programs typically encompass medical care, psychosocial counselling, legal aid, and

social reintegration services (Brown *et al.*, 2022).

The Young Women's Christian Association (YWCA) Zambia is a prominent non-governmental organization that has been at the forefront of addressing gender-based violence, including CSA. It offers a range of support services aimed at aiding survivors through their recovery journey. However, the mere existence of such programs does not guarantee their effectiveness. The complex needs of child survivors require services that are not only available but also accessible, culturally appropriate, trauma-informed, and capable of fostering tangible improvements in well-being (Muridzo & Chikadzi, 2020) [11]. This study, therefore, aims to critically evaluate the effectiveness of YWCA Zambia's survivor support programs in addressing these multifaceted needs.

Clearer understanding of their strengths and potential limitations.

### 1.3 General Objective

To assess the effectiveness of YWCA Zambia's survivor support programs in addressing the needs of child sexual abuse survivors.

### 1.4 Specific Objectives

1. To examine the types of survivor support services provided by YWCA Zambia.
2. To evaluate the accessibility and quality of these services for child survivors.
3. To assess the outcomes of support programs on the psychosocial, legal, and social wellbeing of survivors.

## Theoretical/Conceptual Framework

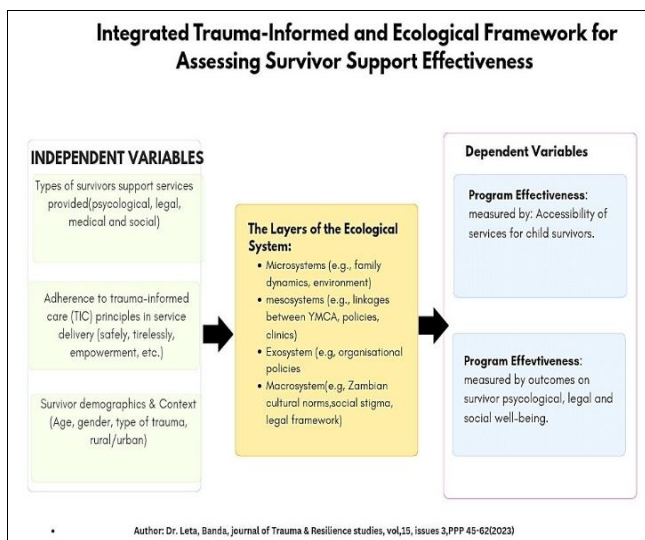


Figure 1 presents the study's integrated conceptual framework, which positions the effectiveness of YWCA Zambia's support programs as the central outcome to be explained. The framework posits that program effectiveness—defined by the accessibility of services and their positive impact on survivors' psychosocial, legal, and social well-being—is directly influenced by two core independent variables: the specific types of services provided (e.g., counselling, legal aid) and the degree to which these services are delivered according to Trauma-Informed Care (TIC) principles, such as safety, trust, and empowerment. This direct relationship forms the foundation

of the assessment, suggesting that comprehensive, trauma-sensitive services are fundamental prerequisites for successful outcomes.

However, this relationship is not isolated; it is critically moderated by the multifaceted context in which both the survivor and the program exist, represented by the Ecological Systems model. As illustrated, the influence of service types and TIC adherence on ultimate effectiveness is filtered through and shaped by interacting systemic layers. These include the survivor's immediate microsystem (family), the inter-agency connections of the mesosystem, the organizational setting of the exosystem, and the broader cultural-legal macrosystem of Zambia. Consequently, the framework visually and logically demonstrates that a program's success is contingent not only on its internal design but also on how well it navigates and functions within this complex ecological reality surrounding each child survivor.

## 2. Literature Review

### 2.1 Overview

This chapter provides a comprehensive review of scholarly literature on the effectiveness of survivor support programs for child sexual abuse (CSA). The review adopts a tripartite structure, examining services from global, African, and Zambian perspectives to understand universal best practices, regional adaptations, and local realities. This approach facilitates identification of research gaps that warrant further investigation.

### 2.2 Thematic Area: Types of Survivor Support Services

#### 2.2.1 Global Context: High-Income Countries

Survivor support services for child sexual abuse have evolved significantly in high-income nations, focusing on trauma-informed, accessible, and multi-disciplinary care. This evolution directly responds to research documenting severe and long-term mental health consequences of abuse. Papalia *et al.* (2017) established substantial long-term co-prevalence of psychiatric illness and behavioral problems following CSA, necessitating robust, specialized interventions.

#### Canada

Canadian specialized treatment centers, exemplified by Little Warriors, provide comprehensive episodic therapy emphasizing strong healing alliances and trauma-informed care. These facilities demonstrated adaptability during the COVID-19 pandemic by incorporating hybrid models, including webinars and digital awareness groups, maintaining engagement with caregivers and survivors. This adaptation underscores the need for flexible and scalable support structures, addressing challenges in recruitment and retention within mental health services (Liu *et al.*, 2018) [9].

#### United Kingdom

Service provision for CSA survivors in the UK is complex and fragmented, spanning statutory and non-profit sectors. Peer support has emerged as a valuable component, delivered through diverse models including face-to-face groups, online forums, and creative activities. However, effectiveness depends critically on timing, survivor readiness, and cultural appropriateness. Funding constraints and lack of uniform quality standards remain significant

obstacles, underscoring the need for integrated and well-resourced services (Green & Skeates, 2018).

### Evidence Base for Peer Support Programs

Peer-to-peer support programs are implemented with increasing frequency across organizations to help people cope with problems ranging from severe mental illness, substance abuse, to traumatic loss and bereavement. While peer support has gained acceptance as an effective adjunct to traditional treatment for serious mental illness and addictions (Davidson *et al.*, 2004; Dumont & Jones, 2002; Repper & Carter, 2011), evidence remains more limited for other populations.

The period since 1990 witnessed dramatic increases in peer support utilization. By 2005, over 10,000 peer providers worked in U.S. mental health settings alone (Goldstrom *et al.*, 2006). Peer support is defined as a system of giving and receiving help founded on respect, shared responsibility, and mutual agreement (Mead, Hilton, & Curtis, 2001). These programs consistently involve people with similar backgrounds providing emotional, social, or practical support to each other (Solomon, 2004).

A key assumption underlying peer support is that shared experiences and life circumstances enable peers to establish stronger connections of trust and support with those in need (Castellano, 2012). Peer support services aim to promote hope, recovery from trauma, improved life skills, psychological well-being, and social integration (Landers & Zhou, 2011).

### Theoretical Foundations

A central process underlying peer support effectiveness is social support—the belief that people are available and willing to provide emotional and practical help (Solomon, 2004). Social support encompasses emotional support, advice and information, practical assistance, and help understanding events (House, 1981). Research consistently associates social support with positive health outcomes, especially during stressful situations (Reblin & Uchino, 2008).

Evidence suggests peer social support is particularly beneficial. Studies of Vietnam veterans found those experiencing greater peer social support showed less post-traumatic stress disorder (PTSD) than isolated peers (Stretch, 1991). Similarly, Gulf War veterans with perceived peer social support and personality hardiness experienced reduced ill effects from combat exposure (Bartone, 2000). These benefits likely stem from the social support mechanism, potentially enhanced by rapid trust establishment in peer relationships (Castellano, 2012).

### Mental Health Applications

Solomon's (2004) early review of peer support in mental health programs concluded there was "very high level of support" for peer provider effectiveness. Studies by Christensen and Jacobson (1994) and Gould and Clum (1993) found peer or paraprofessional self-help therapy equally effective, sometimes superior, to professional therapy for improving life skills and reducing depression.

Reviews examining peer support for severe mental health problems (schizophrenia, major affective disorder) found positive evidence, though studies varied in methods and rigor (Davidson *et al.*, 1999; Solomon & Draine, 2001). Davidson *et al.* (1999) reported self-help peer-run groups

reduced symptoms (anxiety, confused thinking, suicidal thoughts) while increasing social connections and quality of life. Additional benefits included fewer and shorter hospitalizations (Kennedy, 1989), improved coping skills, and health satisfaction (Raiff, 1984).

Simpson and House's (2002) systematic review identified five randomized controlled studies and seven comparative studies examining peer/consumer impacts in mental health services. No studies showed detrimental effects; several demonstrated positive effects including greater patient satisfaction and reduced hospitalization. Other studies reported lower hospitalization rates, improved self-esteem, and enhanced quality of life when peers participated in treatment (Chinman, Weingarten, Stayner, & Davidson, 2001; Clarke *et al.*, 2000; Felton *et al.*, 1995).

Repper and Carter (2011) examined studies on peer support integration into mental health services, confirming earlier findings that peer support programs showed equivalent or improved outcomes compared to programs without peers. Documented improvements included fewer hospitalizations, longer community living (Min, Whitecraft, Rothband, & Salzer, 2007), increased control and independence, improved self-esteem and confidence (Davidson *et al.*, 1999; Dumont & Jones, 2002; Ochocka, Nelson, Janzen, & Trainor, 2006), more extensive social support networks and community engagement (Ochocka *et al.*, 2006; Yanos, Primavera, & Knight, 2001), and enhanced social skills (Forchuk, Martin, Chan, & Jensen, 2005).

This review also found peer support programs increased hope and belief in better futures (Davidson, Chinman, Sells, & Rowe, 2006), reduced stigma (Ochocka *et al.*, 2006), and fostered greater acceptance, empathy, and understanding (Davidson *et al.*, 1999; Sells, Davidson, Jewell, Falzer, & Rowe, 2006).

Davidson, Bellamy, Guy, and Miller (2012) identified three main advantages of peer support over traditional approaches: (a) increased hope through positive self-disclosure; (b) use of experiential knowledge to facilitate positive role modeling; and (c) greater trust, understanding, and empathy between peer supporter and recipient. Their described RCT showed peer support group participants increased in sense of control and ability to make life changes, became more hopeful and engaged in managing care, and were more socially connected and involved in communities (Tondora *et al.*, 2010).

Another longitudinal RCT compared traditional care with peer provider mentorship over nine months (Sledge *et al.*, 2011). The peer recovery mentor group showed multiple benefits: fewer and shorter hospitalizations, less substance abuse, lowered depression, and increased hope, well-being, and autonomy.

Chinman *et al.* (2014) identified 20 studies (1995-2012) addressing peer support effectiveness for mentally ill patients, including 11 randomized controlled trials, six quasi-experimental, and three correlational/descriptive designs. Most demonstrated moderate effectiveness, with improved outcomes when peers supplemented traditional clinical services or served in teaching roles. Peers proved more effective than professional staff alone in facilitating recovery and reducing inpatient service use. Notable RCTs showed outpatient peer-based recovery program participants exhibited reduced depression and anxiety symptoms with improved hopefulness and quality of life at 6-month and 8-

month follow-up (Cook, Copeland, *et al.*, 2012; Jonikas *et al.*, 2013).

### Applications Beyond Mental Health

Peer support effectiveness extends to other health domains. Parry and Watt-Watson (2010) summarized six RCTs with heart disease patients, finding peer support associated with improved health, self-efficacy, and well-being. Peers for Progress (2014) documented benefits across global health problems, with 21 of 22 reviewed studies showing significant health improvements following peer support interventions for diabetic patients, including lowered plasma glucose levels (Dale, Caramlau, Sturt, Friede, & Walker, 2009; Heisler, Vijan, Makki, & Piette, 2010). Evidence also indicates peer supporter involvement often reduces healthcare costs (Campbell, 2014; Sledge *et al.*, 2011).

### Limitations and Risks

Not all evidence is uniformly positive. Fuhr *et al.* (2014) reviewed 14 RCTs finding peer-delivered interventions alone provided only small positive effects (quality of life and hope) compared to normal psychiatric treatment for severe mental illness patients. Lloyd-Evans *et al.* (2014) found modest positive effects on hope and recovery but no benefits regarding hospitalizations or symptoms. Embuldeniya *et al.* (2013) reviewed peer support for chronic illness patients, finding generally positive results in reducing isolation and loneliness but identifying risks. Isolation increased when patients found little in common with peer mentors. Peer mentors becoming overly emotionally engaged experienced diminished wellbeing. These findings underscore the need for careful training, monitoring, and appropriate matching between peer supporters and recipients.

### Bereavement Applications

Peer support programs increasingly help survivors grieving family member or friend deaths, including programs for police and emergency responders (Grauwiler *et al.*, 2008), parents who lost children to suicide, drugs, or illness (Feigelman, Jordan, McIntosh, & Feigelman, 2012), and military death survivors (Harrington-LaMorie & Ruocco, 2011). Despite potential for aiding grief recovery, no systematic assessment of peer support effectiveness in this domain existed prior to recent evaluations.

### United States and Australia

The United States and Australia implemented multidisciplinary Child Advocacy Centers (CACs) offering coordinated medical, criminal, and psychosocial support under one roof. These facilities reduce system-induced trauma by minimizing investigative interviews while ensuring survivors receive comprehensive care. Campbell *et al.* (2019) argue this coordinated, trauma-informed approach to system navigation is essential for ethical and effective service delivery. The CAC model associates with increased prosecution rates and improved mental health outcomes for survivors, demonstrating integrated service delivery value (Reeson *et al.*, 2022).

### Scandinavian Countries

Scandinavian nations embed survivor support services within public health systems, ensuring universal access to medical, mental, and legal assistance. These countries

emphasize early intervention, family involvement, and long-term follow-up, with services tailored to children's developmental needs. Integrating support services within mainstream healthcare reduces stigma and promotes holistic healing, aligning with World Health Organization (2022) public health models for addressing violence.

### Japan and South Korea

Japan and South Korea developed specialized hotlines and crisis intervention services for CSA survivors, providing immediate access to counseling, legal advice, and hospital treatment referrals. These services operate 24/7, supported by public awareness campaigns encouraging reporting and reducing stigma. Technology use, including mobile apps and online chat services, expanded support program reach, particularly for children. This approach addresses known disclosure and help-seeking barriers, which Alaggia *et al.* (2019) identify as complex and multifaceted.

### Adaptation and Continuum of Care

Case studies from Canada and the UK illustrate the importance of adapting support services to survivor and family needs. Little Warriors in Canada scaled up post-treatment support resources and advocated for school counselor inclusion to facilitate reintegration. UK stakeholder interviews highlight the need for a continuum of care, positioning peer support as one step in broader recovery journeys rather than standalone interventions (Konya *et al.*, 2020) <sup>[4]</sup>. This continuum must actively overcome barriers like stigma, which Kennedy and Prock (2018) identified as a core issue affecting female survivors' sense of self and service engagement.

### 2.2.2 African Context

Across Africa, the typology of support services for child sexual abuse survivors is shaped by significant resource constraints, pluralistic legal structures, and socio-cultural norms profoundly influencing disclosure and help-seeking behaviors.

### Formal Service Pathways

Research from Kenya suggests formal service pathways typically include post-rape medical treatment, often focused on HIV post-exposure prophylaxis (PEP) and forensic evidence collection, followed by police engagement and, theoretically, psychosocial support and legal proceedings (Kilonzo, Taegtmeier, *et al.*, 2008; Ellis, Ahmad, & Molyneux, 2005). However, service delivery faces frequent systemic barriers.

Ajema, Mukoma, Kilonzo, Bwire, and Otjombe (2011) documented significant challenges faced by Kenyan service providers, including inadequate resources, lack of inter-sectoral coordination, and insufficient training, compromising medico-legal service quality.

### Policy-Implementation Gap

A relevant theme in African literature is the critical gap between policy frameworks and implementation. Despite progressive legislation like Kenya's Sexual Offences Act (2006), research reveals survivors frequently encounter fragmented, under-resourced systems. Christofides *et al.* (2005), assessing South African services, found rape survivors, including children, were regularly deprioritized in overburdened public health facilities, with caregivers

sometimes displaying negative attitudes. This is compounded by healthcare sector corruption, identified as a major barrier to accessing vital care and medical supplies in countries like Uganda (Bouchard, Kohler, Orbinski, & Howard, 2012; Vian, 2008).

Furthermore, extensive court delays, documented in Kenya's judiciary reports, severely undermine legal outcomes and prolong survivor distress.

### **Psychosocial Support Gaps**

Psychosocial support remains an especially underdeveloped service continuum aspect. While medical and legal responses receive priority, often due to donor funding streams related to HIV and justice, dedicated long-term therapeutic services for children are scarce. Wangamati, Gele, and Sundby (2020) found Kenyan health providers often had limited knowledge and training in child survivors' specialized psychosocial needs, highlighting a critical service gap. Literature indicates available counseling is often short-term and may not be trauma-focused, contrasting starkly with evidence-based models standard in high-income countries (Murray & Nguyen, 2014).

### **Community and Family Dynamics**

Community and family play dual roles, acting as both potential facilitators and barriers to service access. Kisanga, Nyström, Hogan, and Emmelin (2013) explored parents' experiences reporting CSA in urban Tanzania, finding fear of stigma, family shame, and community gossip were powerful deterrents to engaging formal systems. This suggests effective support services must actively work to engage and educate families and communities, creating enabling environments for disclosure and healing rather than operating in isolation.

### **Integrated Service Models**

Integrated, one-stop models have been piloted in Africa with promising results but face sustainability challenges. The Refentse intervention study in South Africa demonstrated that a comprehensive care model integrating medical treatment, HIV PEP, counseling, and legal assistance could be effectively implemented in rural settings, improving service uptake (Kim, Askew, *et al.*, 2009). Similarly, Kenya developed integrated post-rape care services, but Kilonzo, Theobald, *et al.* (2009) noted maintaining such models required continuous advocacy, training, and systemic commitment regularly threatened by funding instability.

### **Cultural Adaptation and Ethical Considerations**

Case studies from the continent underscore the need for culturally attuned, context-specific adaptations. Wangamati, Combs Thorsen, Gele, and Sundby (2016) raised important ethical questions about whether certain post-rape care procedures in Kenya were inadvertently hurting minors, pointing to the need for services to be child-friendly and trauma-informed, not just clinically procedural.

Ultimately, the African service landscape is characterized by innovation in the face of adversity, but also by persistent disconnect between expected multi-sectoral responses and the lived reality of survivors navigating underfunded, poorly coordinated, and sometimes stigmatizing systems.

### **2.2.3 Zambian Context**

Within Zambia, the landscape of support services for child

sexual abuse survivors is characterized by reliance on civil society organizations and international partners, operating alongside frequently under-resourced government systems. Despite existing legal frameworks, including the Anti-Gender-Based Violence Act (2011), specialized trauma-informed care delivery remains inconsistent and geographically uneven.

### **Geographic Distribution**

Lalor's (2018) <sup>[7]</sup> assessment of child sexual abuse in sub-Saharan Africa highlights that, like many neighbors, Zambia faces extensive challenges implementing comprehensive national responses, with services regularly concentrated in urban centers like Lusaka and the Copperbelt, leaving rural populations with minimal access.

### **Medical Response**

The medical response often serves as the first point of contact, mainly focused on forensic examinations and Post-Exposure Prophylaxis (PEP) for HIV—a critical component given the region's high incidence rates (Lema, 2023) <sup>[8]</sup>. However, this medical response may not always integrate with psychosocial care. Murray, Nguyen, and Cohen (2020) <sup>[12]</sup> emphasize that effective CSA care requires shifting beyond the biomedical to address complex psychological sequelae of trauma, an integration not systematically practiced across Zambian health facilities.

### **Psychosocial Support Delivery**

Existing psychosocial support is often delivered by NGOs and community-based organizations, which may employ group therapy or art-based modalities. The effectiveness of such creative therapies has been noted in similar contexts. Pretorius and Pfeifer (2020) documented positive results with group art therapy for sexually abused girls in South Africa, suggesting a potential model for culturally resonant interventions in Zambia.

### **Legal and Judicial Barriers**

Legal and judicial processes present a major barrier to holistic support. While police Victim Support Units (VSUs) are mandated to handle cases, they are often hampered by inadequate training, high caseloads, and limited collaboration with social services. This mirrors challenges documented in Ghana, where Morhe and Morhe (2020) identified tremendous obstacles in implementing defilement laws due to systemic and resourcing problems in the justice sector. In Zambia, case attrition is common, and lengthy, often re-traumatizing court processes can undermine a child's healing, failing to provide the sense of justice or closure that is a key component of healing outcomes (Diehl & Prout, 2020) <sup>[1]</sup>.

### **School-Based Initiatives**

School-based initiatives are increasingly recognized as a vital frontline for identification and initial support. Feldman and Crespi (2020) argue schools are pivotal settings for prevention programs and for creating safe environments facilitating disclosure. In Zambia, some NGOs partner with schools to offer life-skills training and teacher training on recognizing abuse signs. However, these programs are not nationally standardized or scaled, and their reach is limited. The potential for schools to act as links to more specialized services remains largely untapped in a coordinated way.

### Evidence Gaps

A vast gap in the Zambian context is the shortage of robust, localized data and outcomes evaluations for survivor support programs. While the global evidence base strongly advocates for trauma-focused cognitive behavioral therapy (TF-CBT) (Foa *et al.*, 2017; van der Kolk, 2020), there is limited published research on the adaptation, fidelity, and effectiveness of such specific therapeutic models within Zambia. Most documentation consists of NGO project reports rather than peer-reviewed research, making it difficult to assess the authentic impact and quality of services. This evidence gap impedes evidence-based policymaking and sustainable resource allocation.

### Traditional and Community Systems

Finally, the role of traditional and community systems cannot be neglected. As in much of sub-Saharan Africa, many Zambian families first seek resolution through community leaders or traditional justice systems. The interaction—and sometimes conflict—between these informal structures and formal legal and support services adds a layer of complexity. An effective Zambian model must therefore engage with these community systems to ensure survivor protection and promote referral pathways to professional care, rather than allowing parallel structures to function in contradiction. Therefore, the overall picture is one of fragmented efforts by committed actors within a system that lacks the integration, sustainable funding, and rigorous evaluation needed to ensure consistent, quality support for all child survivors. The review reveals a persistent disconnect between policy frameworks and implementation, particularly in resource-limited settings, with insufficient evidence on adapting evidence-based interventions to African contexts and limited integration between formal services and community support systems.

## 3. Research Methodology

### 3.1 Overview

This chapter outlined the methodology employed to investigate the effectiveness of YWCA Zambia's survivor support programs. It detailed the research design, target population, sampling strategy, data collection procedures, methods of analysis, and the ethical considerations that guided the entire study.

### 3.2 Research Design

A convergent mixed-methods research design was utilized to provide a comprehensive assessment of program effectiveness. This approach integrated qualitative and quantitative data collection and analysis, allowing for the triangulation of findings. As Brown *et al.* (2022) advocate in similar assessments of survivor care, a mixed-methods approach was essential for capturing both the nuanced, lived experiences of survivors and the measurable patterns of service provision and outcomes. The qualitative component explored in-depth perspectives on service accessibility, quality, and impact, while the quantitative component provided descriptive and inferential statistics on program reach and key outcome indicators.

### 3.3 Target Population

The study targeted three distinct groups to gain a holistic understanding of the support programs. The primary group comprised child sexual abuse survivors, aged 13-17, who

had accessed YWCA Zambia's services within the preceding 24 months. The second group consisted of their non-offending caregivers or guardians. The third group included service providers directly involved in program delivery at YWCA Zambia, such as counsellors, social workers, legal officers, and program managers.

### 3.4 Sampling Design

A purposive sampling strategy was employed to select information-rich participants who had direct and relevant experience with the phenomena under study. For survivor and caregiver participants, initial sampling was facilitated through YWCA Zambia's anonymized client records, with further snowball sampling used where appropriate and ethical. Service providers were selected purposively based on their role and tenure within the organization. Jin *et al.* (2023) note the importance of purposive sampling in case study research to ensure participants can provide deep insights into specific processes and outcomes.

### 3.5 Sample Size Determination

The final sample comprised a total of 60 participants. For the qualitative component, which included in-depth interviews and focus group discussions, sample size was guided by the principle of data saturation, where no new themes or insights emerged from subsequent interviews. This approach aligns with established qualitative research practices. For the quantitative component, a target of 60 completed surveys was set to allow for meaningful descriptive analysis and to provide a foundation for understanding service demographics and patterns.

### 3.6 Data Collection Methods

Primary data was collected using three main instruments. Semi-structured interview guides were used for in-depth interviews with caregivers and service providers, exploring themes of service quality, barriers, and perceived outcomes. A separate, age-appropriate, and trauma-informed interview protocol was used for individual sessions with child survivors, prioritizing their safety and comfort. Two focus group discussions were conducted with service providers to explore inter-departmental coordination and organizational challenges. Finally, a structured questionnaire was administered to collect quantifiable data on service utilization, demographics, and scaled responses on satisfaction and perceived effectiveness from caregivers.

### 3.7 Data Analysis

Qualitative data from interviews and focus groups were transcribed and analyzed using thematic analysis, following the structured process outlined by Braun and Clarke (2006). This involved familiarization with the data, generating initial codes, searching for themes, reviewing themes, and defining and naming themes. Quantitative data from the questionnaires were cleaned and analyzed using Statistical Package for the Social Sciences (SPSS) software. Descriptive statistics (frequencies, percentages, means) were generated, and inferential statistics, such as chi-square tests, were used to explore relationships between variables like service type and reported satisfaction.

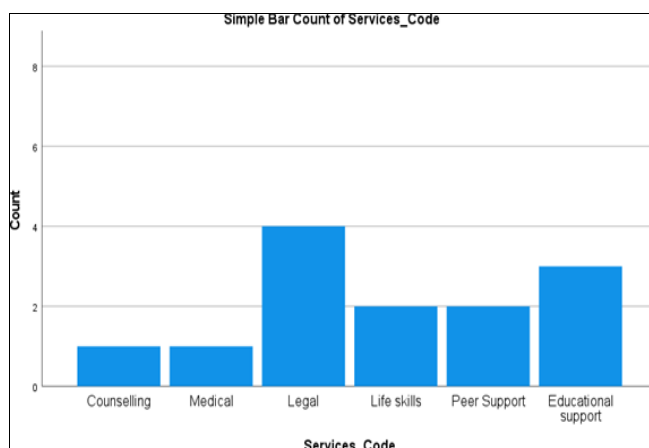
This study set out to assess the effectiveness of survivor support programs at YWCA Zambia in addressing the needs of child sexual abuse survivors. Based on a convergent mixedmethods analysis of data from caregivers, the research

leads to a nuanced conclusion: YWCA Zambia’s programs demonstrate significant strengths in service quality and generate positive psychosocial, academic, and familial outcomes for children who access them, yet their overall effectiveness is substantially constrained by systemic barriers to accessibility and engagement. The findings confirm that the organization provides a crucial range of services, with trauma-informed counselling forming the cornerstone of its intervention model. The high ratings for confidentiality, staff attitude, and child-friendly environments indicate successful implementation of core principles of care, which correlates strongly with caregiver-reported improvements in their child’s overall well-being, school performance, and family understanding. These positive outcomes affirm that the programs are achieving their intended impact in fostering healing and functional recovery when services are received.

However, the study reveals critical limitations that moderate this success. Severe geographic inaccessibility centralizes services in urban areas, imposing prohibitive travel burdens on peri-urban and rural populations. Long wait times further restrict timely access. Furthermore, a stark gender disparity in service utilization—with male survivors almost entirely absent from counselling and holistic support—points to a major gap in equitable engagement, likely driven by socio-cultural stigma and non-inclusive outreach. These challenges highlight the powerful influence of the ecological context, where exosystemic (organizational location, capacity) and macrosystemic (gender norms, rural-urban divides) factors act as significant barriers.

Therefore, it is concluded that while YWCA Zambia’s support programs are effective in process and outcome for those who can access them, their overall effectiveness at a population level is limited by inequitable access and inclusive engagement. The programs operate with quality within their immediate sphere but are not yet fully adapted to overcome the broader systemic and cultural barriers within the Zambian ecological landscape. This gap between the quality of provision and the breadth of access represents the central challenge to maximizing the organization’s impact on addressing child sexual abuse.

*Frequency of Support Services Accessed by Clients*

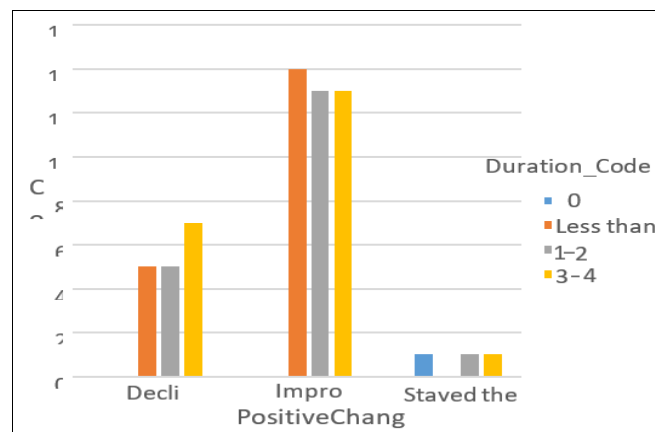


Source: 2025 Primary data

*Relationship Between Service Duration and Client-Reported Positive Life Change*

According to the findings on the distribution of accessed support services, the data reveals a clear hierarchy of

demand among the available options. Counselling is by far the most frequently utilized service, significantly outpacing all others. Medical and Legal services form a secondary tier of common needs, with similar but substantially lower frequencies than Counselling. Life skills, Peer Support, and Educational support services are accessed the least, with Peer Support being the least utilized of all. This pattern suggests that while clients present with a range of needs, immediate mental health (Counselling) and basic health/rights (Medical/Legal) supports are the most critical entry points, whereas more developmental or community-based services (Life skills, Peer Support, Educational) represent secondary or specialized tiers of intervention in this client population.



According to the findings on the association between the length of service engagement and client-reported outcomes, the data reveals a clear trend where longer service duration correlates with a higher likelihood of reporting life improvement. The most significant pattern is that among clients who reported an Improved positive change, the majority had engaged #], the "Less than 1 week" duration category contains the highest count of clients who reported their lives had Declined. The category for clients who felt their life Stayed the same is distributed across durations but shows a smaller peak among midlength engagements. This pattern suggests that sustained intervention is a critical factor in achieving positive client outcomes, as brief engagements may be insufficient to effect meaningful change and could even correlate with negative experiences. The findings imply that program structures encouraging and facilitating longer-term engagement are essential for maximizing the intervention’s positive impact.

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