



Division for the Advancement of Women



"Violence against women: a statistical overview, challenges and gaps in data collection and methodology and approaches for overcoming them"

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**Conducting population-based research on gender-based violence in
conflict-affected settings: An overview of a multi-country research
project**

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Background

There has been increasing concern in recent years among humanitarian aid organizations about the extent and effects of gender-based violence (GBV) in refugee, internally displaced and post-conflict settings. There has also been increasing recognition that GBV is an affront to public health, universally accepted human rights guarantees, and the restoration of refugee and internally displaced (IDP) families and communities. The list below illustrates women's and girls' vulnerability to violence during and following some of the more recent of the world's conflicts. While war may be understood as a contributing factor, all these manifestations of GBV are essentially based on long-standing attitudes and behaviors that sustain and reinforce GBV, whether in times of peace or of war.²

- 20,000 to 50,000 women were raped during the war in Bosnia and Herzegovina in the early 1990's
- the vast majority of Tutsi women in Rwanda's 1994 genocide were likely exposed to some form of GBV; of those, it is estimated that a quarter to a half million *survived* rape
- approximately 50,000 to 64,000 internally displaced women in Sierra Leone have histories of war-related assault
- in a 1995 survey of post-conflict Nicaragua, 50 percent of female respondents had been beaten by a husband, and 30 percent had been forced to have sex
- 76 percent of prostitutes surveyed in post-genocide Rwanda in 1998 who had undergone HIV testing were seropositive
- 66.7 percent of participants in a 1998 Sierra Leone survey on domestic violence had been beaten by an intimate partner
- according to a 1999 government survey, 37 percent of Sierra Leone's prostitutes were less than 15 years of age, and more than 80 percent were unaccompanied or displaced children
- an estimated forty thousand Burmese women are trafficked each year into Thailand's factories, brothels, and as domestic workers
- findings from a study of Palestinian refugee women indicated 29.6% of women were subjected to beating at least once during their marriage with the husband the main perpetrator and 67.9% of children had been beaten at least once almost entirely by their parents.
- 25 percent of Azeri women surveyed in 2000 by the Center's for Disease Control acknowledged being forced to have sex: those at greatest risk were among Azerbaijan's internally displaced, 23 percent of whom acknowledged being beaten by a husband.

Darfur is yet another setting where history repeats itself, and where, once again, the failure to stem the explosively high incidents of GBV will have far-reaching consequences to the survivors and their families, as well as to the communities in which it is occurring.

RHRC Consortium GBV Initiative

¹ This summary was published in abbreviated form in an article in *Forced Migration Review* 2004 19 (1)

² The statistics cited are taken from the RHRC Consortium's fact sheet on GBV, available at www.rhrc.org

From 2000-2004 the Reproductive Health Response in Conflict (RHRC) Consortium spearheaded a global “GBV Initiative.” The Initiative was jointly administered by the Women’s Commission for Refugee Women and Children and the International Rescue Committee, and funded by the U.S. State Department’s Bureau of Population, Refugees, and Migration (BPRM). The first major outcome of the Initiative was a qualitative assessment of GBV in conflict settings: *“If not now, when?: Addressing GBV in refugee, internally displaced, and post-conflict settings”* (2002). One of the primary findings of the global overview was that scant data are available about the prevalence of GBV or best practices for qualitatively or quantitatively describing the problem. Without sufficient quantitative, qualitative, or service delivery data, many humanitarian agencies lack the knowledge or the tools to comprehensively address GBV in the populations they serve.

In an effort to improve international capacity to measure, prevent, and respond to GBV among refugees, IDPs, and other conflict-affected populations, the GBV Initiative undertook the design of a *“Gender-based Violence Tools Manual for Assessment and Program Design, Monitoring, and Evaluation”* (2004). In addition to a series of qualitative assessment tools and techniques, the GBV Tools Manual contains a working draft of a standardized population-based survey designed to measure multiple forms of GBV in conflict-affected settings around the world. Field-tested in East Timor and Kosovo, the questionnaire was subsequently used to conduct a national survey in Rwanda as well as research among IDP women and girls in Colombia. The questionnaire is the first of its kind to have been applied in Africa, Asia, Europe, and Latin America. A primary objective of each of the four studies was to generate reliable prevalence data for locally-based programs to use in their GBV-related program planning and advocacy activities. A second objective of the research was to promote local capacity to conduct population-based research, so that local partners could obtain the tools (such as a validated questionnaire in the local language) and basic skills necessary to design follow-on research projects. An additional outcome will be the ability to use the data as part of a multi-country review of GBV in conflict-affected settings.

The methodology for conducting the research was primarily informed by standards promoted by the World Health Organization that seek to minimize harm and maximize benefits to GBV research participants and target communities. The field tests and subsequent surveys in Rwanda and Colombia resulted in a refinement of the questionnaire, as well as a refinement of the methodology for conducting GBV research in conflict-affected settings. A general overview of the questionnaire and research process is provided below.

Survey Questionnaire

The questionnaire was created for humanitarian settings by researchers at the University of Arizona College of Public Health, the Centers for Disease Control and Prevention (CDC), and the RHRC. It was designed to generate estimates of sexual and physical violence perpetrated by armed actors and other non-family members during time periods defined by historical markers including conflict, displacement, and post-conflict. It was also designed to investigate recent incidence of intimate partner violence and lifetime prevalence of injuries. Questions were incorporated to

elicit contextual information about the violence, including the types of injuries sustained, pregnancy outcomes, whether and what sources of help were consulted and their comparative value, and emotional health status. Other questions targeted exposure to family violence in childhood as well as forced abduction related to conflict.

To facilitate comparability with existing questionnaires and benefit from the efforts of previous investigators, questions were taken whenever possible from preexisting surveys, editing or adding response options to tailor them to conflict settings. However, it was generally not possible to use validated sexual violence questions, as this subject remains under-investigated globally. The survey consisted of items from the World Health Organization, Demographic and Health Survey (DHS), the CDC Reproductive Health Surveys, the International Rescue Committee (IRC), Physicians for Human Rights, the Impact of Events Scale, and the Hopkins Symptom Checklist.

The questionnaire was constructed so that it could be customized to each setting without undermining the reliability and comparability of standard measurement. It is divided into sections that focus on different time periods or types of violence; each can be removed in its entirety according to the objectives of the investigators. The questionnaire's response patterns can also be adjusted for each setting.

At the outset of research in each country, the questionnaire was reviewed by a team identified by local partners and revisions were made accordingly. The questionnaire was then translated to the local language, back-translated into English and checked for accuracy. It was reviewed and edited again by the local research team during the training. Further revisions were made to the questionnaire following its pilot test in each country.

Site Selection

Country sites were identified based on the following general criteria: 1) lack of preexisting data on the nature and scope of GBV related to conflict; 2) existence of local programs that could participate in and benefit from field research and provide referral services to participants; 3) geographic representation—with one country each chosen from Africa, Asia, Europe, and Latin America; 4) potential for local follow-up advocacy based on research findings. Specific geographic location in-country was determined by demographic representation of the population being surveyed, as well as accessibility to the research team and degree of security.

Sample Selection and Protocol Review

Women of reproductive age (18-49) were randomly selected to participate in the surveys for all countries except Colombia, which selected women 15-49 years of age. In East Timor, Kosovo, and Rwanda, population lists were obtained from local officials and population-proportional samples were selected. In Colombia, where no population lists were available, sample selection was based on a mapping of households. For all countries, only one woman from each selected household was asked to participate.

For the field tests in East Timor and Kosovo, as well as for the national research in Rwanda, a detailed research protocol was written by CDC and the RHRC and submitted for approval to CDC's internal review board. A summary of the Rwanda protocol was also submitted to national government partners. A local ethics committee convened by Profamilia reviewed and approved the protocol and questionnaire for Colombia.

Research Team

Locally-based organizations collaborated in planning and leading the research in all countries; in East Timor and Rwanda the primary collaborators were the International Rescue Committee (IRC) and their national and local partners; in Kosovo, the Women's Wellness Center; and in Colombia, Profamilia as the lead local partner, as well as La Liga de las Mujeres Desplazadas, La Red de Empoderamiento de Mujeres de Cartagena y Bolivar, Madres Comunitarios, and the University of Cartagena. The RHRC researcher provided field-based technical guidance in each country. Research experts from CDC and the University of Arizona College of Public Health provided remote consultation in preliminary planning and implementation, and representatives of the CDC oversaw fieldwork in East Timor and Rwanda.

Efforts were made to recruit the all-female research teams from local women's organizations, and to include representatives from the target research population. The research teams were comprised of supervisors, interviewers, house locaters and, if necessary, translators. In Rwanda and Colombia, "psychosocial assistants" were added to the teams to address any issues that might arise for interviewers or participants during the interview process. (Supervisors had this responsibility in East Timor and Kosovo.) The house locaters, who were generally women well-known and respected within the target population, were responsible for randomly selecting one woman at the household level, and the interviewers, who were *not* known to the participants, were responsible for conducting a face-to-face interview with the selected participants. Each interview lasted approximately one hour, with each interviewer completing an average of four interviews a day. The supervisors were responsible for monitoring the activities of the locaters, reviewing the questionnaire for mistakes immediately following the interview, and ensuring safety and security protocols. Supervisors were also responsible for making sure that data collection forms were stored and locked each day and that any identifiers were removed from research materials to preserve anonymity of participants.

Training

The research teams in East Timor and Kosovo received one and half weeks of full-time training; this was expanded to two weeks in Rwanda and Colombia. While many of the team members had previous experience working on GBV issues, the training nonetheless began with a basic introduction to GBV, focusing on GBV within the team members' community, as well as team members' attitudes related to GBV. The introduction included information on the effects of GBV, an overview of common reactions to traumatic experiences, and of vicarious trauma and self-care. When available, representatives from local organizations expert in GBV and/or psychosocial issues were invited to present on these issues to the research team.

The research team also received information on safety and security protocols, with an emphasis on confidentiality as a critical component of reducing risk to research team members and participants. Team members were asked to sign a confidentiality agreement that committed them to never disclosing specific information about a participant to anyone outside the research team, and to not discussing the research with people outside the research team while the survey was underway. Team members were, however, encouraged to share the questionnaire and training materials with their respective organizations once the research was completed.

The translated questionnaire was presented to team members for feedback on its contents. After a question-by-question review, which in Rwanda and Colombia was expanded to include a rationale for each question's content and structure, the interviewers practiced administering the questionnaire first in a large group and later in pairs. The supervisors checked the questionnaires and reviewed mistakes with the interviewers after each practice interview. Interviewers then conducted pilot tests among a convenience sample of women. The pilot test gave the supervisors an opportunity to assess the skills of the interviewers and to make a final selection of the interview teams. Based on the pilot tests, final revisions were made to the questionnaire.

While the interviewers practiced administering the questionnaire, the house locaters were trained in approaching a household and, in cases where complete household lists were unavailable, in randomly selecting a participant at the household level. House locaters were provided scenarios to assist them in identifying and managing potential challenges to random selection, scheduling appointments, and ensuring confidentiality at the community and household levels.

The locally-based data entry and analysis experts participated in the training in Rwanda and Colombia. In Rwanda, the data experts sat in on the initial overview of concepts and review of the questionnaire, and then worked with a trainer from CDC on creating a data entry program while the interviewers practiced administering the questionnaire and the house locaters practiced using the locator forms. In Colombia, the data entry and analysis expert was also a trainer of the locaters and supervisor of the research process.

Data Collection

Because of the sensitive nature of the questions and the difficulty in obtaining privacy at the participant's home, women who were willing to participate were interviewed at a central location outside the participant's home, where the questionnaire was administered in a private area. After the participant was first selected by the house locator and had given initial verbal consent to participate in a survey on women's health and welfare, she was scheduled for an appointment time at the designated location. When the participant arrived for the interview, the contents of a comprehensive verbal consent form were read to her by the interviewer, informing her that any information she provided would be anonymous, that her decision to participate was completely voluntary, and that participation would have no bearing on her access to food, water, health care, or relief services for herself or her family. Participants were also told that if they chose to be interviewed, information about

family life and exposure to various forms of GBV would be recorded. Informed verbal consent was obtained from each woman after the consent form was read.

Where local health and psychosocial services existed for participants, as was the case in East Timor, Kosovo, and Colombia, participants were informed that referrals were available and a list of organizations providing support services to survivors would be provided to participants upon request. In Rwanda, participants were advised to access local women's representatives who had been apprised of the research and had agreed to provide follow-up support if necessary. At the recommendation of the research teams in each country, participants were also given small gifts for their participation. However, participants were not informed of the gifts prior to completing the interview in order to avoid influencing participation.

In East Timor and Kosovo the research teams concluded that the number of women agreeing to participate in the research was inversely related to the degree of visibility of the research project. The higher the visibility of the research, the less likely women were to consent to participation when asked by a locator or, after initially consenting, to show up for the interview at the designated location. The research design was adjusted with positive outcomes in Rwanda so that the researchers were only working in a village for an average of one day. In Colombia, as an additional security precaution, the interviews were conducted outside the barrios; however, this presented its own challenges as fewer women were willing to travel the distance required to be interviewed.

Analysis and Dissemination of the Findings

The data from the field-tests in East Timor and Kosovo was entered and analyzed in the United States by collaborators at the CDC. Partnering organizations in Rwanda and Colombia have entered and are analyzing their data in-country using data analysis standards developed during the field-tests by the CDC that will facilitate comprehensive analysis as well as comparability of findings. Research findings were disseminated by IRC and local partners in East Timor through focus groups and the national media. The Women's Wellness Center in Kosovo will be responsible for disseminating their research. Similarly, partnering organizations in Rwanda and Colombia will assume responsibility for dissemination of the data generated by their studies.

Overview of Findings: East Timor

Of the 288 women who participated in the East Timor pilot study, an average of one in four reported exposure to psychological and physical violence perpetrated by someone outside their family directly following East Timor's 1999 vote for independence from Indonesia (a period of pervasive and systematic political violence commonly referred to as "the crisis"). The majority of women who experienced crisis-related violence reported being threatened with a weapon (92%) and being subjected to "improper sexual comments" (95.8%). In over two-thirds of the incidents reported for the crisis period, women were threatened to be killed. The primary perpetrators were identified as militia, Indonesian military, or Indonesian police.

Levels of reported violence were significantly lower for the post-crisis period, with a 75.8% decrease in physical violence and a 57.1% decrease in sexual violence, though types of violence most commonly reported stayed relatively constant. Displacement to a camp in West Timor was significantly associated with reported rates of sexual violence post-crisis. Perpetrators within East Timor following the crisis were primarily identified as neighbors and other community members.

Levels of intimate partner violence were investigated for two periods: the year before the crisis and the 12 months prior to administering the interview. 46.8% of all women in relationships reported some form of intimidation and control, verbal abuse, physical assault, or sexual coercion by their partner in the year before the crisis, and 43.2% in the past year. Among women in relationships, 23.8% reported physical assault in the year before the crisis and 24.8% in the past year. Types of physical violence included “slapped or twisted arm”; “threatened with a machete, knife or gun”; “choked”; or “hit with a fist or something else.” Of the women who had ever experienced domestic violence, 41.5% sustained physical injuries, but only a third of those women sought medical treatment for their injuries. Findings on help-seeking behavior suggest that East Timorese women most often seek assistance from family members. For crisis and post-crisis outsider violence respectively, 6.9% and 13.3% of women who experienced violence reported it to the authorities. Of those who did not tell anyone about their experience, 38.7% (during crisis) and 50% (post-crisis) did not tell because they believed nothing could be done. Domestic violence survivors were even less likely to seek assistance than survivors of violence perpetrated by someone outside the family.

Conclusion

In the case of East Timor, the research methodology informed subsequent national research on GBV and the findings of the pilot test and succeeding survey were used to facilitate parliamentary discussions on national policies to address GBV. This illustrates the influence that representative data can often have on policy reform—an advantage not fully shared by anecdotal evidence and qualitative research. It is hoped that similar positive outcomes will follow in Kosovo, Rwanda, and Colombia.

Conducting GBV prevalence research in conflict-affected settings presents many scientific, ethical, and methodological challenges. However, as the overview above suggests, it is possible to design a survey questionnaire and conduct population-based research using methodologies that meet international standards for reliable data collection while supporting local partnerships and local ownership of the data. Each field study offered the opportunity to further refine and expand the training of research teams, especially in terms of educating local researchers about the purpose and design of the questionnaire and the research methodology, and providing the researchers sufficient time to practice the questionnaire prior to undertaking the research. Though research teams in all countries were initially hesitant to administer the questionnaire in settings where GBV was generally perceived as a private issue, debriefings with interviewers following the research were universally positive. Many felt that the interview provided an unprecedented opportunity for the participant to receive validation and support. Security, a primary concern in all countries, was prioritized through risk reduction strategies designed according to international standards and in collaboration with local partners; no security incidents occurred.

during the research in any countries. At minimum, the field-tests in East Timor and Kosovo, as well as the surveys in Rwanda and Colombia, affirmed the feasibility of the study design, demonstrated the safety of the methodology, and provide a basis from which to improve future research efforts.

For more information on the process and outcomes of the multi-country GBV prevalence studies or the RHRC GBV Initiative, contact Jeanne Ward, Jeanne@theIRC.org