THE LIFETIME PREVALENCE OF SEXUAL AND GENDER BASED VIOLENCE AMONG REFUGEE WOMEN ATTENDING OBSTETRICS AND GYNAECOLOGY CLINICS AT DADAAB REFUGEE CAMP HOSPITALS

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LIST OF ACRONYMS/ABREVIATIONS

ANC	ANTENATAL CLINIC
CBS	CENTRAL BUREAU OF STATISTICS
CCC	COMPREHENSIVE CARE CENTRE
FGC	FEMALE GENITAL CUTTING
FGM	FEMALE GENITAL MUTILATION
GBV	GENDER BASED VIOLENCE
GVRC	GENDER VIOLENCE RECOVERY CENTRE
HIV/AIDS	HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMUNODEFICIENCY SYNDROME
IDP	INTERNALLY DISPLACED PEOPLE
KDHS	KENYA DEMOGRAPHIC HEALTH SURVEY
MOH	MINISTRY OF HEALTH
NGO	NON GOVERNMENTAL ORGANIZATION
OAU	ORGANIZATION OF AFRICAN UNION
RHRC	REPRODUCTIVE HEALTH RESPONSE IN CONFLICT CONSORTIUM.
SGBV	SEXUAL AND GENDER VIOLENCE
STI	SEXUALLY TRANSMITTED INFECTIONS
UN	UNITED NATIONS
UNAIDS	UNITED NATIONS AIDS
UNHCR	UNITED NATION HIGH COMMISION FOR REFUGEE.
VCT	VOLUNTARY COUNSELLING AND TESTING
WHO	WORLD HEALTH ORGANIZATION.

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ABSTRACT

Background: Sexual violence occurs through out the world.Although in most countries there has been little research conducted on the problem, available data suggest that in some countries nearly one in four women may experience sexual violence by intimate partner and one-third of adolescent girls report their first sexual debut as being forced.

Sexual violence is a widespread international public health problem, and adequate, apropriate and comprehensive prevention and response are lacking in most countries world wide.

Objectives: To determine the lifetime prevalence of Sexual and Gender Based Violence among the refugee women attending obstetrics and gynaecology clinics at Dadaab refugee camp hospitals.

Methodology: This was a facility based cross sectional survey.The source of data for the study was face to face interview with the refugee women in Dadaab Refugee Camp aged above 18 years and willing to participate. The sample size of 310 was obtained using power analysis of population size.

Results: Three quarters of the respondents (75.9%) indicated they were married. Majority of the respondents (88.4%) were Muslims and 6.8% christians while the rest 5% were composed of traditional believers. Regarding formal education, 39.4% could read easily, 32.6% could read with difficulty and 28.1% could not read at all.

A total of 238 (76.8%) participants reported having undergone one form of sexual or gender based violence.Physical violence was reported by 76.1% and sexual violence by 45.5% in Dadaab refugee camp.

Concerning the distribution of the type of physical violence women experienced, 50.6% of them reported having been beaten and kicked and 35.5% threatened with a weapon of some kind while 31% had experienced physical disfigurement. Also 50.6% of the survivors reported that they had received threats of murder during the episode.Among those who had been sexually assaulted 29.7 % had been penetrated by force with an object in the vagina and 26.8% reported unwanted kissing.

The main perpetrators of sexual and gender based violence were from the disciplined forces accounting for 55.6%, with the least group comprising the medical fraternity at 2% and judges at 0.9%.

On the categories of injuries inflicted 49.6% reported deep wounds and cuts while 31.1% reported broken bones. Its vital to note that 49.2% of the clients experienced psychologicsl difficulties like nightmares and intrusive memories. Twelve percent (12.3%) of the refugee women in Dadaab camps conceived after the sexual assault.

Conclusion:

No significant difference in age was found between those subjected to violence and those who were violence free.

The high prevalence of Sexual and Gender Based Violence (SGBV) among the refugee women in Dadaab is appalling by any standards. What is more worrying is that over 50% of those who were subjected to SGBV also received threats of murder. This coupled with the findings that 33% of the survivors reportedly lost consciousness during the episode the situation looks grim. The disciplined forces who are integral part of the prevention and fight against SGBV are the main perpetrators.

Recomendations:.

Urgent and concerted effort to sensitize the uniformed forces not to perpetrate violence should be carried out and they should be trained in handling the victims/survivors of SGBV.

Training all the health workers serving the refugee women on handling survivors of SGBV will enhance the number of these women seeking help from the formal health institution and not traditional healers.

SGBV should be integrated in the regular outpatient services and SGBV prevention should be an integral part of the core function of NGOs including a mandatory induction course for all their employees .

Its important to explore the utilization of the religious sector to prevent these vice rather than grappling with its unmeasurable effects.

DEFINITION OF KEY WORDS AND TERMS

Sexual and Gender Based Violence(SGBV)

Any type of abuse that includes rape, sexual threats, exploitation, humiliation, assualts, molestation, domestic violence, incest, involuntary prostitution (sexual battering), torture, insertion of objects into the genital openings and attempted rape. (12)

Others include forced/child marriage and harmful traditional practices such as FGM/FGC, house killing and widow inheritance.

REFUGEE

Who is a refugee in Africa?: The OAU Convention (1969) defines a `refugee' as someone who: owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either or part or the whole of his/her country of origin or nationality is compelled to leave his/her place of habitual residence in order to seek refuge in another place outside his/her country of origin or nationality (p. 1) (13).

The following tables describe some of the more common forms of SGBV. The list is neither exhaustive nor exclusive. It is a practical tool developed primarily in a refugee context that can be applied to any context to identify the different forms of SGBV that exist.

Acts of SGBV have been grouped into five categories (14,15)

- Sexual violence
- Physical violence
- Emotional and psychological violence
- Harmful traditional practices
- Socio-economic violence (14)

DEFINATIONS OF SEXUAL VIOLENCE

TYPE OF ACT	DESCRIPTION/EXAMPLES	PERPETRATED BY
Rape and marital rape	The invasion of any part of the body of the victim or of the perpetrator with a sexual organ, or of the anal or genital opening of the victim with any object or any other part of the body by force, threat of force, coercion, taking advantage of a coercive environment, or against a person incapable of giving genuine consent (International Criminal Court)	Any person in a position of power, authority and control, including husband, intimate partner or caregiver.
Sexual abuse	Actual or threatened physical intrusion of a sexual nature, including inappropriate touching, by force or under unequal or coercive conditions.	Any person in a position of power, authority and control, family/community members, co-workers, including Supervisors, strangers.
Sexual exploitation	Any abuse of a position of vulnerability, different power, or trust for sexual purposes; this includes profiting momentarily, socially or politically from the sexual exploitation of another (ASC); sexual exploitation is one of the purposes of trafficking in persons (performing in a sexual manner, forced undressing and/or nakedness, coerced marriage, forced childbearing, engagement in pornography or prostitution, sexual extortion for the granting of goods, services, assistance benefits, sexual slavery).	Anyone in a position of power, influence, control, including humanitarian aid workers, soldiers/officials at checkpoints, teachers, smugglers, trafficking networks.
Sexual harassment	Any unwelcome, usually repeated and unreciprocated sexual advance, unsolicited sexual attention, demand for sexual access or favours, sexual innuendo or other verbal or physical conduct of a sexual nature, display of pornographic material, when it interferes with work, is made a condition of employment or creates an intimidating, hostile or offensive work environment.	Employers, supervisors or colleagues, any person in a position of power, authority, or control.

TYPE OF ACT	DESCRIPTION/EXAMPLES	PERPETRATED BY
Sexual violence is a weapon of war and torture	Crimes against humanity of a sexual nature, including rape, sexual slavery, forced abortion or sterilisation or any other forms to prevent birth, forced pregnancy, forced delivery, and forced child rearing, among others. Sexual violence as a form of torture is defined as any act or threat of a sexual nature by which severe mental or physical pain or suffering is caused to obtain information, confession or punishment from the victim or third person, intimidate her or a third person or to destroy, in which or in part, a national ethnic, racial or religious group.	Often committed, sanctioned and ordered by military, police, armed groups or other parties in conflict.

DEFINATIONS OF PHYSICAL VIOLENCE

TYPE OF ACT	DESCRIPTION/EXAMPLES	PERPETRATED BY
Physical assault	Beating, punching, kicking, biting, burning, maiming or killing, with or without weapons, often used in combination with other forms of sexual and gender-based violence.	Spouse, intimate partner, family member, friend, acquaintance, stranger, anyone in position of power, members of parties to a conflict.

DEFINATIONS OF EMOTIONAL & PSYCHOLOGICAL VIOLENCE

TYPE OF ACT	DESCRIPTION/EXAMPLES	PERPETRATED BY
Abuse/Humiliation	Non-sexual verbal abuse that is insulting, degrading, demeaning; compelling the victim/survivor to engage in humiliating acts, whether in public or private; denying basic expenses for family survival.	Anyone in a position of power and control; often perpetrated by spouses, intimate partners or family members in a position of authority.

DEFINATIONS OF HARMFUL TRADITIONAL PRACTICES

TYPE OF ACT	DESCRIPTION/EXAMPLES	PERPETRATED BY
Female genital mutilation (FGM)	Cutting of genital organs for non-medical reasons, usually done at a young age; ranges from partial to total cutting, removal of genitals, stitching whether for cultural or other non-therapeutic reasons; often undergone several times during life-time, i.e. after delivery or if a girl/woman has been victim of sexual assault.	Traditional practitioners, supported, condoned, and assisted by families, religious groups, entire communities and some States.
Early marriage	Arranged marriage under the age of legal consent (sexual intercourse in such relationships constitutes statutory rape, as the girls are not legally competent to agree to such unions).	Parents, community and State.
Forced marriage	Arranged marriage against the victim's/survivor's wishes; often a dowry is paid to the family; when refused, there are violent and /or abusive consequences.	Parent, family members.
Denial of Education for Girls or women	Removing girls from school, prohibiting or obstructing access of girls and women to basic, technical, professional or scientific knowledge.	Parents, other family members, community, some state.

DEFINATIONS OF SOCIAL – ECONOMIC VIOLENCE

TYPE OF ACT	DESCRIPTION/EXAMPLES	PERPETRATED BY
Discrimination and/or denial of Opportunities, services.	Exclusion, denial of access to education, health assistance or remunerated employment; denial or property rights.	Family members, society, institutions and organizations, government Actors.

1 INTRODUCTION AND LITERATURE REVIEW

The problem of SGBV in conflict situation is not a recent phenomenon. It dates as far back to the second world war where an estimated 100,000-200,000 Korean women were abducted by Japanesse army and forced into sexual slavery. An estimated 250,000-400,000 women were also raped during the Bangladeshi war for independence in 1971 and 39% of Vietnamese women aged between 11-40 fleeing their country by sea in 1985 were reported abducted and raped (16).

1.1 EXTENT OF SGBV

SGBV is still one of the most widespread human rights abuses and public health problems in the world today, affecting as many as one out of every three women.It is also an extreme manifestation of gender inequity,targetting women and girls because of their subordinate social status in society.The consequences of Gender Based Violence are often devastating and long term,affecting women's and girls' physical health and mental wellbeing.At the same time,its ripple effects compromise the social development of other children in the household,the family as a unit,the communities where the individuals live,and society as a whole.(17)

The true extent of sexual violence is unkown because in most countries there has been little research conducted on the problems (18) but available data suggest that nearly one in four women may experience sexual violence by an intimate partner in their lifetime and upto a third of adolescent girls report their first sexual debut to have been forced.

A 1994 survey of 204 Liberian refugee women showed that 49% had experienced SGBV (19) · A suvey in sierraleone conducted 2002 revealed 9% war related SGBV among women and girls.(20)

In the balkans between 10,000-30,000 kossovo albanian women and girls reported having been raped or suffered other forms of sexual vilence during 1999 refugee exodus.(19)
A study conducted in East Timor in 2003 found that 39% of respondents have been tortured with 5% reporting rape and other forms of sexual violence. (21)

At Kenyatta National Hospital, 41.4% of women attending gynaecology clinic had ever experienced at least one form of domestic violence,the most common type being physical(27%). (22) An earlier study conducted among women attending family planning clinic had determined a prevalence of domestic violence of 56.4%.(23)

1.2 THE CONSEQUENCES OF SEXUAL VIOLENCE

The injuries that refugee women sustain from SGBV persist long after the crime. Refugee victims of SGBV in different parts of the world have reported ongoing medical problems, including miscarriages by women raped when pregnant, hemorrhaging for long periods, inability to control urination, sleeplessness, nightmares, chest and back pains, and painful menstruation.(24) They have also reported such medical problems as unwanted pregnancy, unsafe abortion, HIV and other sexually transmitted diseases, sexual dysfunction, trauma to the reproductive tract, and chronic infections leading to pelvic inflammatory disease and infertility. Survivors of SGBV in refugee situations have often experienced depression, guilt, terror, shame, and loss of self-esteem. They may also be rejected by spouses and families, ostracized, and subjected to further exploitation or to punishment (25). These physical, psychological, and social consequences of SGBV only add to the pain of uprooting and forced migration.

In terms of the reproductive health of refugee women, it is obvious that several Characteristics of refugee life would logically increase exposure to STDs including HIV/AIDS. Several assessments of the point prevalence of HIV and other STDs have been conducted in refuge settings (26) For example; a 1989 prospective study of 179 pregnant Vietnamese refugees in Hong Kong found 3% prevalence of syphilis and no gonorrhea (27). The International Rescue Committee (28) in 1999 reported similar syphilis rates in a 1998 survey of 876 Sudanese and Somali refugees attending an antenatal clinic at the Kakuma Refugee Camp in Kenya.

SGBV can profoundly affect the physical, emotional, mental and social wellbeing of the survivors. It is associated with a number of health consequences including unwanted pregnancy, gynecological complications (per vaginal bleeding, chronic pelvic pain, VVF), STI including HIV/AIDS, depression, post traumatic stress disorder, suicidal thoughts and behavior at times, death of partner. Socially the survivor may face ostracism from family, friends and the community (29).

Among the more common consequences of sexual violence are those related to reproductive, mental health and social well-being. Pregnancy may result from rape though the rate varies between settings and depends particularly on the extent to which non barrier contraceptives are being used. A study of adolescent in Ethiopia found that among those who reported having being raped ,17% conceived after the rape(30),a figure similar to the 15-18% reported by rape crises centres in Mexico(31,32). In India, a study of married men revealed that men who admitted forcing sex on their wives were 2.6 times more likely to have caused an intended pregnancy than those who admit to such behaviour (33)

Gynaecological complications have been consistently found to be related to forced sex. These include vaginal bleeding or infection, decreased sexual desire, genital irritation, pain during intercourse, chronic pelvic pain and urinary tract infection. (33-41)

HIV infection and other sexually transmitted diseases are recognized consequences of rape (42).Research on women in shelters has shown that women who experience both sexual physical abuse from intimate partners are significantly more likely to have had sexually transmitted diseases (43).

Sexual violence has been associated with a number of mental health and behavioral problems in adolescence and childhood. (44-47) In one population based study, the prevalence of symptoms or signs suggestive of a psychiatric disorder was 33% in women with a history of sexual abuse as adults,15% in women with a history of physical violence by an intimate partner and 6% in non-abused women(48).

Women who experience sexual assault in childhood are more likely to attempt or commit suicide than other women (49). The association remains, even after controlling for sex, age, education, symptoms of post-traumatic stress disorder and the presence of psychiatric disorders. (50, 51). In Ethiopia, 6% of raped school girls reported having attempted suicide (30).

A study conducted to determine the immediate gynaecological morbidity in women and female children presenting with sexual assault at the Gender Violence Recovery Centre (GVRC) at Nairobi Women's Hospital found that extragenital injuries were noted in 25.3% of the victims.

Most genital injuries were bruises 52.9% of the vulva, vagina, cervix and anus followed by tears 46.7% of the perineum, hymen, and vagina. Among the severe injuries were those that resulted in vesico vaginal fistula (0.8%), rectovaginal fistula (0.8%) and abdominal hematoma (0.4%). (52)

Violence is also a risk factor during pregnancy that leads to adverse pregnancy outcome. At Kenyatta National Hospital,The prevalence of violence among women attending antenatal clinic was 9%. (53)

1.3 SGBV IN CONFLICT AND REFUGEE POPULATION:

SGBV especially against women is increasingly documented in Internally Displaced Persons and refugee population yet still remains a silent affliction.Although it is women who are often the victims of SGBV, both women and men may be victims and subject to rape ,defilement,damage to physical,emotional and psychological health,disruption of life and loss of self confidence and esteem. (54)

In a population of 106,000 refugees in Dadaab, Kenya, 106 cases of rape were reported in the first nine months of 1998, more than the preceeding 12 months.(55) Researchers established that the refugees attributed increased sexual violence (including rape and sexual coercion) to worsening camp security and the lack of economic opportunity for women.

Economic security would allow women to buy firewood rather than collect it in unsafe areas outside the camp, where more than 90% of rapes were said to occur, and also would allow them to resist demands for sex from other refugees and authorities within the camp.

Studies of domestic violence among refugees are less common than studies of rape. In community-based surveys of men and women in Kakuma Refugee Camp, Kenya, conducted in 1998, researchers found that 57% of women and 76% of men believed husbands had the right to beat their wives.(56) There were striking differences in these attitudes by nationality, however. A greater proportion of Sudanese approved of wife-beating (70% of women and 87% of men) than did Somalis.
SGBV is a widespread international public health problem but adequate, appropriate and comprehensive prevention and response are lacking in most countries worldwide (7,8,9)

Since the early 1990's the humanitarian communities has increased its attention to the problem of sexual violence.In 2001 WHO and UNHCR jointly produced guide lines to enable the development of clinical mangement protocol for post rape care in displaced settings.

In 2003 UNHCR, issued sexual and gender based violence against refugees,returnees and internally displaced person guide lines for prevention and response(UNHCR MAY 2003) (54). This includes minimum standards for prevention and response action, roles and responsibilities of specific staff and organisations in displaced settings.

Despite the availability of these guideines many humanitarian organizations are not aware of their specific responsibilties, many have not been trained and there are many who view SGBV interventions as "luxury" or fashionable rather than essential life saving humanitarian intervention.(57).

The impact of AIDS on regional and global stability has become significant with many more people dying of AIDS than as a result of conflict.Recognizing the securitty implications of HIV/AIDS, the UN security council adapted resolution 1308 in july 2000 which stressed that HIV pandemic if unchecked may pose a risk to stabilty and security.The councills action laid down the groundwork for the prominence given to AIDS as a security issue including a gender component in the declaration of commitment to HIV/AIDS adapted by the UN Geneva assembly in june 2001.(57,58).

Recent conflicts has seen an increase in the use of rape and sexual violence increasing the risk of contracting HIV/AIDS.For example in early 1993 between 250.000-500,000 women were raped during the Rwanda genocide resulting in 17% of them testing HIV postive as compared to a prevalence of 11% among nonraped women. (59)

1.4 SEXUAL VIOLENCE BY INTIMATE PARTNERS

In many countries a substantial proportion of women experiencing physical violence also experience sexual abuse.In Mexico and United States, studies estimate that 40-52% of women experiencing physical violence by an intimate partner have also been sexually coerced by that partner (60,61). Findings from studies show that sexual assault by an intimate partner is neither rare nor unique to any particular region of the world.(62-74).

1.5 ETHICAL AND SAFETY ISSUES IN RESEARCHING GBV

The WHO ethical and safety recommendations for GBV research highlight the following key issues. (86)

(a) Safety of respondent and research team is vital

(b) Prevalence study need to be methodologically sound and build upon current research experience on how to minimize the under reporting of violence.

(c) Protecting confidentiality is essential to ensure both woman's safety and data quality.

(d) All research team members must be carefully selected and receive special training and on going support.

(e) Study design must include actions aimed at reducing any possible distress caused to the participant by the research.

(f) Field workers should be trained to refer women requesting assistance to available local services and source of support.

(g) Researchers have an ethical obligation to help ensure that their findings are properly interpreted and used to advance policy and intervention development.

(h) Violence questions should only be incorporated into surveys designed for other purposes when ethical and methodological reqirements can be met.

Heise and Ellsberg make the following suggestions on how to minimize harm to both the respondents and research staff. (86)

(i). Interveiw only one woman per house hold

(ii). Don't inform the wider community that the survey includes questions on violence

(iii). Don't interview men about violence in the same household or clusters where women have been asked about violence.

(iv). Interviews should be conducted in complete privacy.

(v). Dummy questionnaires should be used if others enter the room during the interview

(vi). Use of self response questionnaires in some portions of the interveiw may be useful for literate populations.

(vii). Train interviewers to recognize and deal with a respondent's distress during the interveiw

(viii). End the interview with a positve note that emphasizes on a woman's strengths.

1.6 PROMOTING DISCLOSURE

Many women are willing to talk about their experiences on GBV- Studies on painful subjects such as violence face challenges on how to convince people to speak openly about intimate aspects of their lives.

The degree of openness depends on the study design, issues such as clearly worded and understood questions,how many times the respondent is asked about violence and the context of the interview and how comfortable the women are with the interviewer which depends on several factors such as the sex of the interviewer,length of the interview,presence of other people and whether the interviewer is interested in her story.

The following key strategies have been proposed to enhance disclosure of violence. (8)

(a) Give the respondent several opportunities to dislose violence.

(b) Use of behaviorally specific questions rather than asking general subjective questions such as have you been ever abused.

(c) Selection and training of interveiwers who are skilled at developing rapport with respondents.

(d) The interveiwer to be fluent with the respondents mother tongue and avoid using translator as far as possible.

1.7 STUDY JUSTIFICATION

Gendeer Based Violence is a common problem with serious reproductive and social consequences.

A determination of prevalence is important. Despite the fact that these camps have been in existence since 1991/1992 ,no prevalence study has been done among these population who are vulnerable by virtue of their socio-political status.

The KDHS 2003 found that 28.9% of married, divorced or separated women in North Eastern province reported physical or sexual violence ever and 18.9% reported violence in the year preceeding the survey in 2002 (75).

Prevalence estimates have been found to be higher in more focused studies than multipurpose surveys (76). The recent post-election violence in Kenya revealed alot of global human rights abuse top on the list being sexual and gender based violence and a subsequent increase in the HIV new infection rate (87).

A report published in a local daily states that Nairobi Women's Hospital has released a report detailing 443 cases of sexual abuses during post-election violence. Of these 149 were minors mainly girls and 7 of the survivors are already HIV positve. Most of the perpetrators were gangs of unknown young men and some of the victims were raped by up to 11 youths (87). This threatens the gains made in reducing the incidence of the pandemic which is not only public health issue but touches on every aspect of life in the country.

This scenario of the Internally Displaced People (IDPs) in Kenya can be compared to the refugees who have at one time experienced the consequences of lawlessness in their country of origin during civil crises which are generaly as a result of political turmoil. Note that most of these violence especially SGBV go unreported and the victims suffer in silence. Thus its prudent upon us to put an elaborate mechanism in place to prevent these abuses and protect the survivors.

Kenya being the hub of peace and stability in a region wrecked by political and civil instabilty/unrest harbours the highest number of refugees in subsaharan Africa.This therefore implies that the number of refugees in our country and their unique health needs affect our planning in the health sector.

1.8 OBJECTIVE

The broad objective of this study was to determine the life time prevalence of SGBV among refugee women attending obstetrics and gynaecology clinics at dadaab refugee camp hospitals.

The specific objectives of the study was to;

(i) Determine the socio-demographic pattern of the women experiencing SGBV;
(ii) Determine the common types of violence experienced by women in Dadaab Refugee Camp;
(iii) Determine the main perpetrators of the SGBV in refugee situations;
(iv) Determine the type of injuries sustained by the women during the episode of violence.

2 METHODOLOGY

Study Design:

Facility based cross-sectional survey.

Study populations:
All refugee women above 18 years attending dadaab refugee camp obstetrics and gynaecology clinics were included in the study.

Study location: (84)

Dadaab Refugee camps refers to a group of three camps-Ifo, Dagahaley and Hagardeer in Kenya's remote eastern zone near the somali border. The camps were set up around the town of Dadaab beginning in 1991 when civil war erupted on a grandscale in Somalia.
The wars coupled with prolonged drought forced more than 900,000 Somalis to flee to neighbouring countries.

Once the immediate needs of the hungry and the exhausted people who came in 1991 were met camp life began to settle down into a pattern that continues up to this day.

The camps now house approximately 160,000 with majority from Somali (97%) although there are also refugees from Uganda, Sudan, Ethiopia and Congo. The camps are in a remote mainly unoccupied land that is hard to police. This coupled with their proximity to the Somali border where arms can easily be imported makes them prime target for bandits.

Women bear much of the responsibilities of maintaining the camp life. They collect water from the well, care for the children, gather firewood, wacth out for poisonous snakes and prepare meals. The life of women is very hard.Young women do much the same work as their mothers and many teen- agers are married often to older men. FGM is still rampant. Women are especially vulnerable when they venture outside the camp in search of firewood to cook for their families.

As the years have gone by, areas closer to the camps have become deforested forcing women to venture further and further away to gather wood (up to 20 Km). When they are so far away from the camps they are in danger of being assaulted by bandits. However assaults do also take place in the camps but at night violence often stalks the camp itself.

The UNHCR has strengthened the police forces by purchasing more vehicle to patrol the land. It has also initiated a programme that delivers firewood to the women in the camp relieving most of the obligation to aforage far while a German relief organization (GTZ) has suported a programm to increase planting of "live fencing" for protection (live plants used to fence the compound).

The Kenyan government has also been encouraged to set up a mobile court to try and punish offenders. All these efforts are proofing invaluable in providing some security for the refugees.

In recent years hopes of repatriation have declined and people have began to get involved in community development activities.
Strong anti rape groups are also at work in the camps. A pilot project of prevention of sexual violence against refugee women was launched in May 1999. The programme focuses on social counselling as well as physical security. It seems that womens' role is changing in this isolated society.

Inclusion criteria:
Refugee women 18 years and over attending dadaab refugee camp obstetrics and gynaecology clinics who consented to participate in the study.

Exclusion criteria:
Those who are too ill to participate in the study.

Duration of the Study:

Four months from May - August 2008.

Sample size:

Using Cohen 1988 power annalysis (85).

The KDHS 2003 found that 28.9% of married divorced or separated women in North Eastern province reported physical or sexual violence ever and 18.9% reported violence in the year preceeding the survey (2002) (75)

$$n = \frac{z^2 \times p(1-p)}{d^2} = 310$$

n= minimum sample size.

p= estimated prevalence (28%)

z= standard normal deviation for desired level of error when α= 0.05,=(1.96)

d= Absolute precision(level of significance) 95%

2.1 DATA COLLECTION

The principal investigator recruited eight (8) female interviewers. The interviewers' were selected from among the nurses in the facilities. The interviewer selection criteria besides gender and educational level includeed language to reduce language barrier during the face to face interviews. This ensured that whenever possible all respondents being interviewed in a language she is fluent in.

They underwent training for two (2) days using interviewers training manual from the GBV tool manual of RHRC(see appendix iv). The training covered the overview of the research, interview logistics, security issues, ethics of conducting research, interviewer responsibilty, interviewer skills, stress management and interviewer confidentiality contract.

Patients are ussually given appointment dates to the clinic. On arrival they are given serial numbers on a first come first number basis. The interviewer called the number of every third patient to the interview room, the language of the patient determined and allocated the most appropriate interviewer and the interview then proceeded.

The interviewer determined wether the patient fulfilled inclusion and exclusion criteria by asking age and refugee status. The interviewer also excluded patients who have been interviewed previously by asking the client. The respondent is also informed that she does not participate in the interview incase she happens to fall into the sampling process in her subsequent visits during the study period.

The interviewer then administered a written consent and responded to any questions or concerns that may have been raised. For those who consented, face to face interview was conducted using a structured pre-coded questionnairre in strict confidence with due regard to the guidelines.

After completion of the interview the patient was then allowed to resume the normal outpatient clinic as was routine. The completed questionnaire was then kept under lock by the principal investigator for data analysis. Data validation was carried out immediately after the interview sessions in the evening.

2.2 OVERVIEW OF QUESTIONNAIRE

The SGBV measures were borrowed from the RHRC 2003 SGBV tool mannual for studying prevalence of SGBV. (78-83). The interview was conducted using questionnaire created from the SGBV tool manual for studying prevalence of SGBV.

The survey questionnaire included in this study has been piloted in both East Timor and Kosovo.It was also used to conduct national research in Rwanda as well as research among Internally Displaced Persons women in colombia.The questionnaire was created for humanitarian setting by researchers at the university of Arizona college of puplic health,the CDC and RHRC consortium so that it could be applied cross culturally to collect the prevalence data relevant to the country under investigation as well as allow for international comparisons and contrasts.

It consist of items taken from the WHO multicountry studies on domestic violence, DHS (demographic health surveys), CDC and prevention, a physicians for human rights survey and the impact of events scale and hopkins symptom check list. (78-83)
The main parts of the questionnaire were as follows;

(i) Personal information.
(ii) Availability and accessibilty of basic services to the respondent.
(iii) Marrital history of respondent.
(iv) Experience of partner violence.
(v) Personal information of partner.
(vi) Types of violence experienced.
(vii) Perpetrators of violence.
(viii) Experience of violence during pregnancy.
(ix) Types of injuries sustained.
(x) Where respondents sought help.
(xi) Response to violence.

2.3 ETHICAL CONSIDERATIONS:

Ethical approval to carry out the study was sought from the ethical committee of Kenyatta National Hospital as well as the managemnet of Dadaab refugee camp health sector through GTZ.

Written consent to participate in the study was obtained from the participant after explaining the purpose and reassuring them of upholding confidentiality by conducting the interviews in absolute privacy with the respondent(except with children under 2yrs). The respondent was warned that if any one enters the room the topic will be changed. The participants' responses will be confidential.

Interviewers were carefully selected and trained on minimizing participant distress as well as on issues of referals for care and support. The study instrument included questions that minimize distress to the participant.

Incase of any distress caused by the research to the participants that the interviewer was not able to handle they were adviced to refer the clients to the DROP IN centres which are available in all the three camps. These centres are manned by trained counsellors with the support of CARE (NGO).

2.3.1 INFORMED CONSENT

The consent form(Appendix A) was read to the patient/respondent in the language she understands by a translator/interviewer during the interview. A written consent was then obtained from the paticipant(thump print). (9)

2.4 DATA MANAGEMENT AND ANALYSIS;

Data from questionnaires was entered into a computer using SPSS for windows version 12. Data cleaning was then done before analysis. Analysis was carried out using SPSS for windows involving descriptive statistics like means and standard deviation for continuous data and frequency distribution.

2.5 STUDY CONSTRAINTS

a) The self report measures may have been influenced by social desirabilty. This was minimized by informing the respondent at the onset of the interview that there were no direct benefits (e.g. Resettlement in the developed countries) for those interviewed.

b) Response bias, or inaccurate recall is a major constraint of the study

c) Errors in translation could have an effect on the psychometric properties of the measure.

d) The cross-cultural adaptability of the questionnaire had not been validated. This however was minimized by ensuring that all refugees from different cultural backgrounds participated in the research to compare their responses.

3 RESULTS

The following tables and charts explain the output from the various responses obtained from the administered questionnaires.

Three hundred and ten women participated in the study. Their age ranged from 18 to 53 years with a mean age of 29.27 years and a standard deviation of 8.5 years.. Throughout this study data or information the investigator is unable to obtain is marked as missing.

Table 1: Age and Marital status of Women in Dadaab Refugee camp

		Marital Status		Percentage	
Age	**Frequency**	**Unmarried**	**Married**	**Unmarried %**	**Married %**
18 - 20	36	25	10	8.1	3.2
21 – 25	105	22	81	7.1	26.1
26 – 30	43	9	34	2.9	11.0
31 – 35	52	7	45	2.3	14.5
36 – 40	39	5	34	1.6	11.0
41 – 45	13	2	11	0.6	3.5
46 – 50	7	0	7	0.0	2.3
51 - 55	5	0	5	0.0	1.6
Missing	10	10	3	3.2	1.0
Total	**310**	**80**	**230**	**25.8**	**74.2**

Table 1 above shows the cross tabulation of results of age with marital status. Over 74.2% of the respondents were married women while 1% did not indicate their marital status and 3% of the respondents were not willing to disclose their age and therefore indicated as missing data

Religion

Table 2: Religious affiliation of the respondents.

Religion	**Frequency**	**Percent (%)**
Muslim	274	88.4
Christianity	21	6.8
Orthodox	10	3.2
Traditional	01	0.3
Waqefata	01	0.3
Unknown	03	1.0
Total	310	100.0

The majority of the respondents 88.4% were of the Islamic faith as shown in table 2 above. A smaller percentage of 1% did not ascribe to any known faith.

Distribution of Nationality

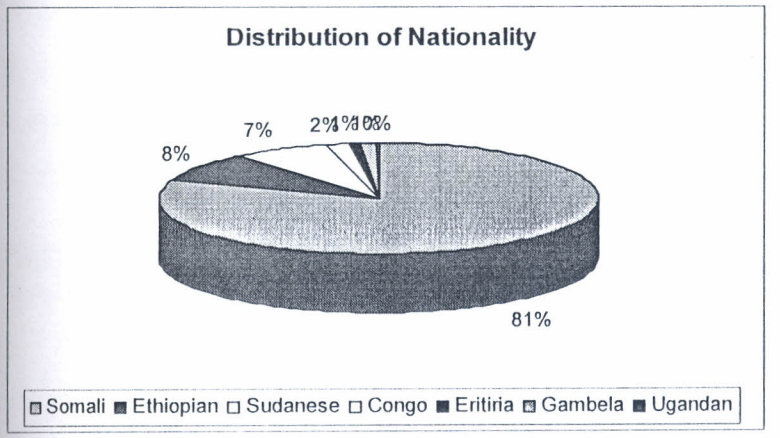
The nationalities of the respondents are given in the table 3 below.

Table 3: Distribution of Nationality of the respondents

Nationality	Frequency	Percent (%)
Somali	250	80.6
Ethiopian	26	8.4
Sudanese	22	7.1
Congo	5	1.6
Eritiria	3	1.0
Gambela	3	1.0
Ugandan	1	0.3
Total	310	100.0

The majority of the respondents are from Somalia which accounted for 80.6% . Other nationals were Ethiopians 8.4% and Sudanese constituting 7.1% as shown in table 3 above and depicted in chart1 below.

Chart 1: Distribution of Nationality of the respondents.



Education Level & Employment

Table 4: Education level and employment

		Frequency	Percentage (%)	Employment		
				Unemployed	Working for trade	Working for money (Wages)
Education Level	Never attended school	104	33.5	75	6	23
	Primary	102	32.9	62	2	38
	Secondary	76	24.5	38	3	35
	High school	1	0.3	0	0	1
	University	5	1.6	0	0	5
	Madrasa	9	2.9	9	0	0
	Unknown	13	4.2	8	5	0
Total		**310**	**100.0**	**192**	**16**	**102**

Table 4 above shows a combined tabulation of educational level and employment status was done. It showed majority of the respondents were illiterate at 33.5% followed by 32.9% being primary schools leavers as shown in table 4, 1.6% of the respondents were graduates. Out of the 104 who never attended school, 75 were unemployed, 6 are self employed and 23 are wage earners.

Table 5: Source of income

Source of income	Frequency	Percent (%)
No Stable income	113	36.5
Support from husband	66	21.3
Support from relatives	5	1.6
Money from own work	111	35.8
Social services/welfare	12	3.9
Casual/Ration	3	1.0
Total	310	100.0

Table 5 above shows the various source of income for the respondents. Majority, 36.5% of the respondents had no stable source of income while 35.8% depended on trade and various forms of employment.

Ease of access to service utilization

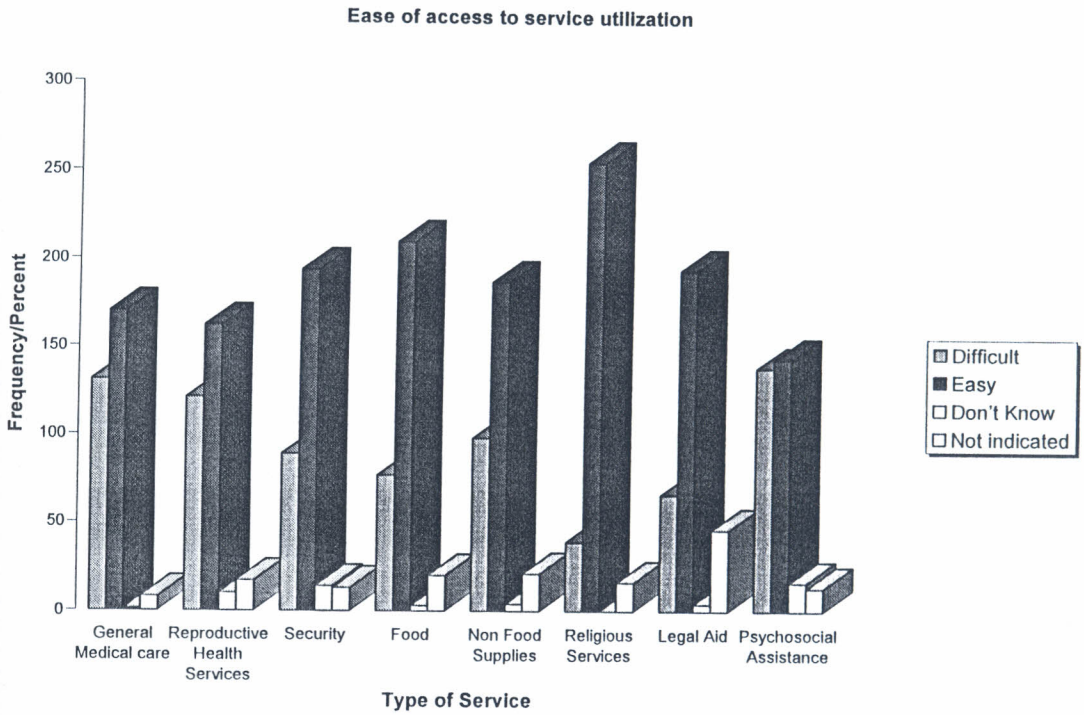


Chart 2: Ease of utilizing services in the village

Chart 2 above sumarizes the ease of utilization and access to general medical care, reproductive health, security, food and non food supplies among others. The chart shows that religious services was the most easily accessible service with 82% while reproductive health services was the lowest at 52.3%.

Sexual and gender based violence

Table 6: Combined sexual, gender and physical violence

Type of violence	Yes		No		Total	
	Freq	%	Freq	%	Freq	%
Sexual & gender based violence	238	76.8	72	23.2	310	100
Physical violence	74	23.9	236	76.1	310	100
Sexual violence	169	54.5	141	45.5	310	100

Table 6 above show the various types of violence and their distribution. A total of 238 (76.8%) participants were subjected to one form or the other or a combination of sexual and gender based violence.

Table 7: **Distribution of type of physical/sexual violence**

Type of physical/sexual violence	Frequency	Percent (%)
Physical Violence		
Slapped or hit	89	28.7
Choked	58	18.7
Beaten or kicked	157	50.6
Tied up or blind folded	76	24.5
Threatened with weapon of any kind	110	35.5
Shot or stabbed	70	22.6
Deprived of food, water or sleep	87	28.1
Experienced physical disfigurement of body	96	31.0
Detained against own will	78	25.2
Forced to watch someone being physically assaulted	60	19.4
Sexual Violence		
Subjected to improper sexual comments	69	22.3
Forced to remove or stripped own clothing	55	17.7
Given internal body cavity searches	34	11.0
Subjected to unwanted kissing	83	26.8
Touched on sexual parts of one's body	73	23.5
Beaten on sexual parts of own body	80	25.8
Forced or threatened with harm to make one receive oral, vaginal or anal sex	63	20.3
Penetrated by force with an object in the vagina or anus	92	29.7
Compelled to engage in sex for provision of basic needs in return	52	16.8
Forced to watch someone being sexually assaulted	48	15.5

Table 7 above shows the distribution of the type of violence experienced by the survivors.The most common form of physical violence being beating and kicking reported by 50.6% of the respondents and 35.5% reported being threatened with a weapon.The most common form of sexual violence reported is forceful penetration of the vagina or anus with an objective at 29.7%.

Table 8: Perpetrators of physical/sexual violence

	Frequency	Percent (%)
Military	93	39.1
Civil defence forces	70	29.4
Don't know	56	23.5
Police officer/Interrogator	41	17.2
Unknown to respondent	39	16.4
Jail/Prison guard	30	12.6
Neighbour/Community member	26	10.9
Religious worker	21	8.8
Others	18	7.6
Paramilitary	17	7.1
Humanitarian relief worker	16	6.7
Teacher	11	4.6
Doctor/Medical person	9	3.8
Prosecutor/Judge	4	1.7

The table 8 above and chart 3 below show the perpetrators of physical and sexual violence majority being from the disciplined forces led by the military at 39.1%. Among the lowest reported perpetrators are the medical personnel, humanitarian relief workers and legal practitioners.

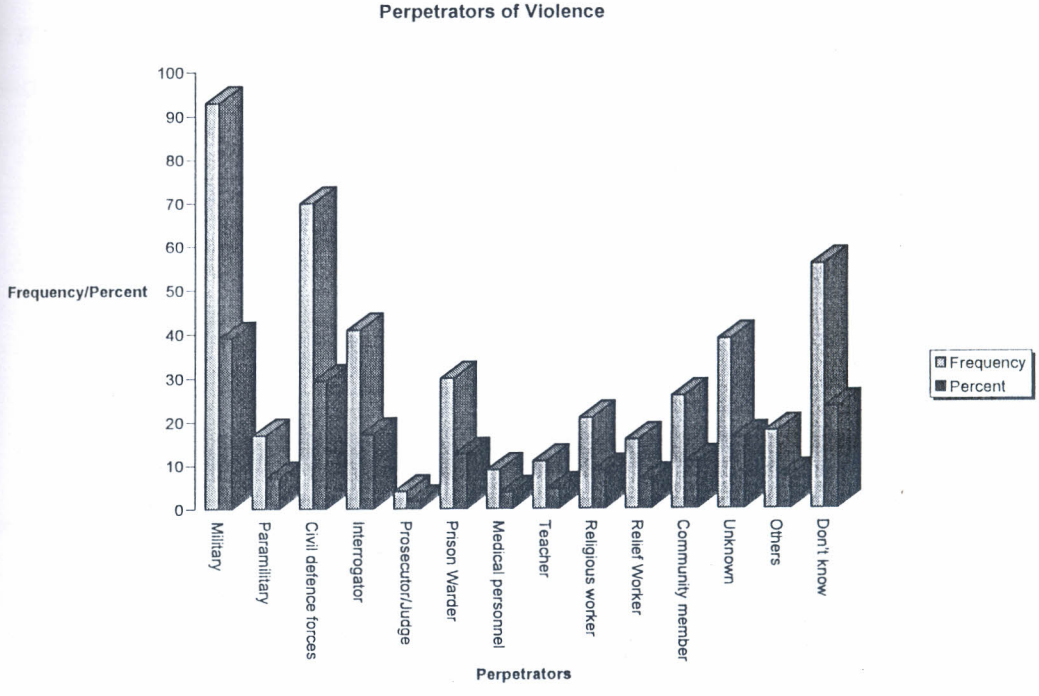


Chart 3: Perpetrators of violence

Table 9: Threats of murder during the episode

Threats of murder during the episode	Frequency	Percent (%)
No	67	21.6
Yes	157	50.6
Don't know	68	21.9
Refused/no response	4	1.3

Table 9 indicates that there is a high proportion of respondents reporting threats of murder during the episode at 50.6%.

Injuries experienced as a result of mistreatment

Table 10: Injuries experienced as a result of mistreatment

	Frequency	Percent (%)
Bruises, scrapes, welts	68	28.6
Loss of consciousness	80	33.6
Dislocations	76	31.9
Broken bone or bones	74	31.1
Deep wounds or cuts	118	49.6
Psychological difficulties(nightmares, intrusive memories)	117	49.2

The most commonly reported form of injury is deep wounds and cuts at 49.6% and it is sad to note that 33.6% of the respondents reported having lost consciousness as shown in table 10 above and chart 4 below.

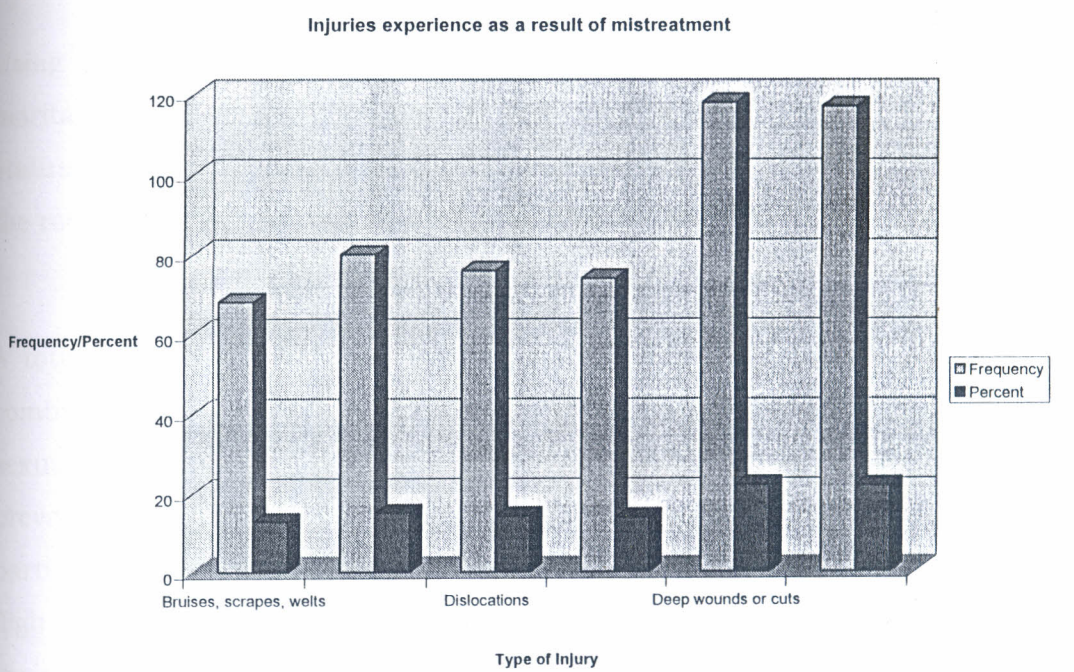


Chart 4: Type of injury

4 DISCUSSION

This was a facilty based cross sectional survey carried out at the Dadaab refugee camp hospitals specifically in the obstetrics and gynaecology clinics.

Three quarters (75.9%) indicated they were married. Majority (88.4%) were Muslims and 6.8% Christians while the rest 5% were composed of traditional beliefs. On education, 39.4% could read easily, 32.6% could read with difficulty and 28.1% could not read at all. The highest level of education attained primary school and never attended school combined is 66.4% and 61.9% of the respondents are not employed at all. Majority of the respondents reported that they were either primary school leavers or never attended school at all these two combined accounts for two thirds of the respondents (66.4%) and 61.9% of the respondents are not employed at all.

No significant difference in age was found between those subjected to violence and those who were violence free using unpaired students t-test (mean age of 29.65 ± 8.1 years Versus mean age of 28.0 ± 9.6 years; p = 0.19). see table below.

Group	Mean age in yrs	SD	P- value
Violence free	28.0	9.6	0.19
Experienced Violence	29.65	8.1	0.19

Using chi-square no association was found between being subjected to violence and marital status, religion, education and employment . Therefore the socio-demographic status of the respondent in the refugee camps doese not influence the propensity of the respondents to suffer sexual and gender based violence.

A total of 238 (76.8%) participants were subjected to one form or the other or a combination of sexual and gender based violence.Physical violence is 76.1% and sexual violence is 45.5% in dadaab refugee camp.A study on determining the prevalence of SGBV in Dukwi refugee camp in Botswana found that about 75% of participants had experienced some form of SGBV either in their home country, during flight/transit, or in the host country. More than half (56.4%) had experienced SGBV in their home countries, 39.3% reported experiencing SGBV during flight/transit, and about 37% of the participants reported having experienced SGBV while in Botswana (89).

The percentages of the women having experienced SGBV in both refugee camps a almost the same echoeing a message that these people require extra preventi protection .

The Pabbo refuge camp research revealed that 6 out of 10 women in Pabbo camp Uganda are physically and sexually assaulted, threatened, and humiliated by men whom they enjoy the greatest trust. Most men do this under the influence alcohol(15).

A multipurpose inter-agency survey done in 1999 indicated that 28% of women in t Dadaab camps had been sexually assaulted since becoming refugee.[58] Prevalen estimates have been found to be higher in more focused studies than multipurpo surveys (17)

World Health Organization multicountry study on womens health and domes violence against women initial results 2005, on prevalence ,health outcomes a women responses conducted in ten countries reported that in Ethiopia which is p of the WHO multicountry study 49% of ever partnered women experienced physi violence by a partner at some point and 29% during the last 12 months.Fifty ni percent (59%) of ever partnered women experienced sexual violence at some point their lives and 44% during the last 12 months. Combining the data for physical a sexual violence 71% of ever partnered women experienced one or other form violence or both over their life time(84).

This is very close to the findings in Dadaab refugee camp(76.8%) where ethiopian a somali refugees make the majority of the sample (91.7%). Being neighbour countries they share common socio-cultural setting.

At Kenyatta Nationl Hospital, 41.4% of women attending gynaecology clinic had e experienced at least one form of domestic violence,the most common type be physical(27%)(22). An earlier study conducted among women attending fa planning clinic had determined a prevalence of domestic violence of 56.4%(23).

It is important to note that wether in a refugee set up or a settled population i developing country half of the women are at risk of SGBV in their lifetime.

Concerning the distribution of the type of physical violence women experienced 50.6% of them were beaten and kicked and 35.5% were threatened with a weapon of some kind while 31% experienced physical disfigurement of the body.Also 50.6% of the survivors reported that they received threats of murder during the episode and this demonstrates the magnitude of the offence to be grave with more than half the population risking death.

A study of GBV conducted among East Timor refugees noted that the majority of women who experienced violence reported being threatened with a weapon (92%) and being subjected to improper sexual comments (95.8%). Notably in over two thirds (68.8%) of the incidents ,women reported that the perpetrators threatened to kill them. In another study on GBV in liberia 55% of the participants reported being kicked and beaten while 71% of them report being threatened with a weapon.(21)

Of those sexually assaulted among the women in this study, 29.7 % had been penetrated by force with an object in the vagina and 26.8% suggested unwanted kissing.

In the Liberian study of 2004 twenty six percent of the respondents reported being penetrated by force with an object and 34.2% suggested unwanted kissing (11). These findings therefore indicate that irrespective of the location and time Refugee women portray similar percentages and types of SGBV.

The main perpetrators of sexual and gender based violence are from the disciplined forces at 55.6%. with the least group of proffessionals being the medical fraternity at 2% and judges at 0.9%. Compared with the Liberian study 52.2% of rape was done by members of fighting forces and one judge (0.5%) was reported to have committed rape(11).

Injuries inflicted on the survivors were classified and 49.6% reported deep wounds and cuts while 31.1% reported broken bones.Its vital to note that 49.2% of the clients experienced psychological difficulties like nightmares and intrusive memories. It is sad to note that 33.6% of the subjects reported having lost consciousness during the episode.

During the study in liberia 100% of the respondent admitted suffering from one or more psychological problems with 91.5% (feeling of humiliation),72.8% (insomnia) and 70.6% confussion and embarrassment. These psychological injuries are often under estimated and ignored living the survivor to suffer in silence.

This big disparity between the Dadaab and Liberian study could be because the latter study was conducted immediately after the war when the victims had fresh memories while the Dadaab one has been conducted eighteen years after the fall of the government.

Comparing this with the findings of the WHO multicountry study in Ethiopia, of the women who experinced physical violence by a partner 19% had been injured at least once. Among the injuries were bruises(39%), sprains and dislocations (22%)fractures (18%) (88)

A study conducted to determine the immediate gynaecological morbidity in women and female children presenting with sexual assault at the Gender Violence Recovery Centre(GVRC) at Nairobi Women's Hospital found that extragenital injuries were noted in 25.3% of the victims.Most genital injuries were bruises 52.9% of the vulva, vagina, cervix and anus followed by tears 46.7% of the perineum,hymen and vagina. Among the severe injuries were those that resulted in vesico vaginal fistula(0.8%), rectovaginal fistula(0.8%)and abdominal haematoma(0.4%) (52).

4.1 CONCLUSION:

The high prevalence of Sexual and Gender Based Violence (SGBV) among the refugee women in Dadaab is appalling by any standards. What is more worrying is that over 50% of those who were subjected to SGBV also received threats of murder. This coupled with the findings that 33% of the survivors reportedly lost consciousness during the episode the situation looks grim. The disciplined forces who are integral part of the prevention and fight against SGBV are the main perpetrators.

4.2 RECOMMENDATIONS

(i) Promote gender equality and women human rights by improving women's legal and socio-economic status.This is likely to be in the long term, a key intervention in reducing women's vulnerabilty to violence.This includes awareness of their rights, access to education and economic independence.

(ii) Put elaborate reproductive and mental health mechanisms in place for these women to access services easily without stigmatization.This therefore demands to train the health workers to be compassionate, empathic and confidential in their dealings with SGBV survivors

(iii) Lobby for policy formulation in the host government to enact laws that equate SGBV to attempted murder and inculcate SGBV in our education curricullar.

(iv) An urgent and concerted effort should be undertaken to first of all to sensitize all the disciplined forces not to perpetrate violence and secondly they should be trained in handling the victims/survivors of SGBV.

(v) Integrate SGBV in the regular outpatient services so that it becomes routine for the clients to express their experiences without much barriers because alot of them are suffering in silence. This will increase the reporting rate and hence timely intervention.

(vi) NGO's in the refugee camps must have gender friendly policies and make SGBV prevention as an integral part of their core function including a mandatory induction course for all their employees to sensitize them to the plight of the survivors.

(vii) Religious services is the most easily accessible service in Dadaab refugee camp and since religions especially the islamic religion is against SGBV we need to integrate these group of leaders into the prevention of SGBV in the refugee camps.

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APENDIX I – Consent Form

Participant study number:

I am Dr Bashir Mohamud Issak from the University of Nairobi.
I am interested in learning about some of the issues that women have to deal with here specifically the levels of SGBV among refugee women in Dadaab. I hope that your answers to my questions will help improve services for women, girls and families in this community and help the health professionals, and others to be more responsive to women in their daily lives.

If you choose to participate I will ask you a short set of questions about yourself some of which may be personal.Your decision not to participate will not lead to victimization or denial of care from the camp staff.You will not be paid for participating in the study though the information provided will help women who may be subjected to SGBV.

It is not a test so there are no right and wrong answers. Your own opinion and answers are very important to me. Please feel free to tell me what you really think or know. I offer you a guarantee of confidentiality. The information I am getting from you won't in any circumstances be publicly disclosed in a way that would identify you. At any point during the interview you may ask me to skip a question you cannot or do not want to answer. Your participation is completely voluntary and you may chose to leave at anytime during the interview or discussion.

Do you have any question before we proceed?

Do you want to participate? Yes/No

If yes,
Participants signature/left thumb print_____

Now, I would like to ask you some questions about what happened to you if any. I know it may be difficult to acknowledge that any of these things happened to you, but please remember that what you tell me is completely confidential and your answers will help me get a sense of the needs of women in your community.

APPENDIX II – Somali Translation of Consent

SOMALI TRANSLATION OF CONSENT
Qoraalka ogolanaashaha

Nambarka kaqeybqaate:
Isbarasho:

Anigu waxaa liiyiraahdaa Dr Bashir Mohamud Issak kasocdo jaamacadda Nairobi. Waxaan rabaa inaan ogaado dhibaatooyinka dumarka aay lakulmaan.gaar ahaan xadgudubka jinsiyada kusaleeysan xarooyinka qahootiga ee Dadaab.

Waxaan rajeeynayaa in jawaabahaadi ay waxkabedeli doonaan atheegaha ay kahelaan dumarka, gabdhaha iyo qoosaska bulshadan.Iyo shaaqaalaha caafimaadka ay noqdaaan kuwa ujilicsan baahitha dumarka.

Hadaad dooratto inaad kaqeeb qaadato suaallo gaagaaban kukhuseyo oo qaarkoodina suaalo shaqsi ah ayaan kuweeydinayaa.Hadaad goaansatid inaadan kaqeybqaadanin wax midibtakoor ah kaaga imanayaa xaga shaqaalaha caafimaadka majirto.Hadaad kaqeybqaadatidnah wax ajuura ah malahan balse jawaabahaagi ayaa lagayaabaa inaykalmeeyaan dumarka laguxadgudbey.

Suaalahani imtixaan maaha wayo jawab sax ah ama khalad ah majirto.
Fikradahaadi iyo jawaabahaadi add ayay muhiimad iiguleeyihiin.Fadlan athoo xur ah fikradahaadi iyo aqoontaadi ilaqeybso.Anne waxaa ballan iga ah in waxaad ilaqeybsato dhan ay sir yihiin.Jawaabahagi inne si shaqsiyadaadi usoo bandhigeyso looma daabacaayo.Wakhti waliba xur baad utahay in aad suaal aadan jawabi rabin aad kaboodo.

Kaqeyqaadashadaadi waa akhtiyaarkaadi markaad doontana waad kabixi karta.

Intaan hori usoconin suaal maqabtaa?

Madooneysaa inaad kaqeyb qaadato? Haa/Maya

Saxiixa kaqeyb qaataha:_____

Hadaba waxaan suaalo kaaweydinaayaa dhacdooyin kuheley hadaay jiraan.Waan ogahay inay a adaktahay dhacdooyinkan qof aad laqeybsatid lakin waxaan kuxasuusinayaa in waxaad iisheegtid dhan ay sir ahaanayaan.Jawaabahaagi waxaay fikrad igasiinayaan baahitha dumarka kunool bulshadan.

APPENDIX III – Kiswahili Translation of Consent

Fomu ya makubaliano ya kujiunga na utafiti.

Nambari ya muhusika:_____

Mimi naitwa Dr Bashir Mohamud Issak kutoka chuo kikuu cha Nairobi. Niingependa kujifunza baadhi ya mambo ambayo yanahusu akina mama haswa kiwango ya dhulma ya kijinsiya katika kambi za wakimbizi za Dadaab. Ninatarajia ya kwamba majibu yako itasaaidia kuboresha huduma ya akina mama,wasichana na familia katika jamii hii.Pia kusaidia wafanya kazi wa idara ya afya na wengine kuelewa mahitaji ya akina mama katika maisha yao ya kila siku.

Ukikubali kujiunga na utafiti huu nitakuuliza maswali mafupi maswali mengine ni kuhusu vitu vya binafsi.Maamuzi wako wa kutojiunga na utafiti huu haitakukuletea ubaguzi wala kunyimwa matibabu na wafanya kazi wa afta hapa.Hautalipwa kwa kujiunga na utafiti huu walakin habari utakopeana itawasaidia akina mama ambao wanadhulumiwa kijinsia.

Hii si mtihani kwa hivyo hakuna jawabu sawa au lisilosawa.Maoni yako na majibu yako ni muhimu sana kwangu.Tafadhali ujisikiye huru kuniambia yale ambaye unafikiria au unayajua nakupa uhakika ya kuwa hayo mambo utaniambia yatakuwa ya siri.Matokeyo ya utafiti yanayochapishwa hayatakutambulisha kamwe na yatabaki siri.Uko huru wakati wowote katika mazungumzo yetu kuruka swali ambayo hutaki kujibu.Kujiunga kwako ni kwa hiyari yako na una haki ya kujiondoa wakati wowote.

Je uko na swali lolote kabla hatujaendelea?

Je unataka kujiunga na utafiti huu?

Sahihi ya muhusika----------

Sasa ningependa kukuuliza maswali kuhusu yaliyokupata.Ninajua inaweza kwa ngumu ku amini ya kwamba hayo mambo yame kupata lakini tafadhali ukumbuke ya kwamba chochote utakachonieleza itabaki kwa siri na majibu yako yatanisaidia kufahamu mahitajiau matakwa ya akina mama katika jamii hii.

APPENDIX IV - SGBV Prevalence Questionnaire

SECTION 1: BACKGROUND

*(Indicate **DK** if the respondent does not know the answer to the question and indicate **REFUSE** if she does not want to answer)*

1) How old were you on your last birthday? _____ Years

2) Where were you born? (Village/country) _____/_____

3) What is your nationality?

□ Somali □ Ethiopian □ Sudanese □ other (specify)

_____What is your ethnicity *(specify tribe/clan)* _____

4) What is your religion?

□ Islam □ Christianity □ other (specify) _____

5) Can you read/write easily, with difficulty, or not all?

□ Easily □ with difficulty □ not at all □ DK

6) Have you ever attended school and if so, what is the highest level of school you attended?

□ Never attended school □ Primary school □ Secondary □ High school □ University □ Other (specify) □ DK

7) Are you the head of your household (the person responsible for making all the primary decisions for the household)?

□ No □ Yes □ DK □ Refuse

8) Are you currently working for money (wages), working for trade, or are you unemployed? (Circle all mentioned)

□ Unemployed □ working for trade□ working for money (wages)

□ DK □ Refuse

9) What is your main source of income?

□ No income □ Support from husband/partner

□ Support from other relatives □ Money from own work

□ Social services/welfare □ other □ DK □ Refuse

10) Please tell me if it is difficult or easy for you to utilize the following services in the village:

		Difficult	Easy	DK	Refuse
A	General medical care				
B	Reproductive Health services and supplies like birth control and sanitary supplies				
C	Police				
D	Food				
E	Supplies other than food				
F	Religious services				
G	Legal aid				
H	Psychosocial assistance				

SECTION 2: MARRIAGE HISTORY

11) Have you ever been married or lived with a man with whom you were having a serious (intimate, sexual) relationship?

□ No □ Yes □ *Refuse*

12) How many different times have you ever been married or lived with men with whom you were having a serious (intimate, sexual) relationship?

□ Total times married and/or lived with men □ DK □ Refuse

13) How old were you when you first married/lived with a man with whom you had a serious (intimate, sexual) relationship?

□ Years □ DK □ Refuse

14) Are you currently married or living with a man?

□ No

□ yes currently married

□ Yes currently living with a man

□ DK

□ refuse

15) How did your most recent relationship end?

□ Divorced □ Separated □ Widowed

□ Partner/husband abandon respondent

□ Partner/husband left for other reasons (describe)

_____

□ Respondent abandoned her partner/husband

□ Respondent left her partner/husband for other reasons (describe)

_____

□Other (specify) _____

□ DK

□ Refuse

a) **If the respondent currently has a husband/partner with whom she lives, go to Q18**

b) **If respondent does not currently have a husband/partner with whom she lives, but has ever had a husband/partner with whom she has lived, go to Q 19**

c) **If respondent has never had a husband/partner with whom she has lived, but currently has partner (a boyfriend) who she does not live with go to Q 23**

d) **If respondent has never been in a serious (intimate, sexual) relationship with a man, go to Q27**

5) Did you yourself choose your husband/partner, did someone else choose him for you, or did he choose you?

□ both chose □ Partner chose

□ Partners family chose □ Respondent chose

□ Respondents family chose

□ Other_____

□ DK □ Refuse

7) Before marrying/living with your husband/partner, were you asked whether you wanted to marry/live with him or Not?

□ Yes □ No □ DK □ Refuse

8) Did your marriage involve dowry/bride price payment?

□ Yes dowry □ Yes bride price □ No □ NA (never married) □ DK

□ Refuse

9) Has the entire dowry/bride price been paid for, or does some part still remain to be paid?

□ All paid □ partially paid □ None paid □ DK □ Refuse

0) Overall, do you think the amount of dowry/bride price payment has had a positive impact on how you are treated by your husband and/or his family, a negative impact, or no particular impact?

□ Positive impact □ Negative impact □ No impact

□ DK □ Refuse

IF RESPONDENT IS NOT CURRENTLY INVOLVED IN A SERIOUS (INTIMATE, SEXUAL) RELATIONSHIP WITH A MAN SKIP TO Q 25.

Now I would like to focus specifically on your current relationship. The following questions are about the husband/ partner (boyfriend) you have right now. I am asking you these questions to get general background information, but will not ask any questions that might specifically identify your husband/partner (boyfriend). Just like these questions are anonymous for you, they are also anonymous for your husband/ partner (boyfriend).

21) How old was your **current** husband/partner (boyfriend) on his last birthday?

□ Years □ NA (respondent's husband dead, no current partner) □ DK

22) Can he read/write easily, with difficulty, or not at all?

□ Not at all □ with difficulty □ Easily read □ DK

23) Has he ever attended school and if so, what is the highest level of school he attended?

□ Did not attend school □ Primary school □ Secondary School

□ High School □ University □ Other □ DK □ Refuse

24) Is he currently working for money, working for trade, or is he unemployed? (Circle all that apply)

□ Unemployed

□ Working for money

□ DK

□ Refuse

25) Now I am going to ask you to think about the one experience of mistreatment during the occupation and the war in [home country] that you consider the most serious for the following questions. I am asking you to only think of one experience when you respond to the questions below. This will help us get a sense of which experiences were most difficult for people.

In the one experience that you feel was the most severe, which of the following were done to you? Were you:

		No	Yes	DK	Refuse
A	Slapped or hit				
B	Choked				
C	Beaten or kicked				
D	Tied up or blind folded				
E	Threatened with weapon of any kind				
F	Shot or stabbed				
G	Deprived of food water or sleep				
H	Experienced physical disfigurement of your body				
I	Detained against your will				
J	Subjected to improper sexual comments				
K	Forced to remove or stripped of your clothing				
L	Given internal body cavity searches				
M	Subjected to unwanted kissing				
N	Touched on sexual parts of your body				
O	Beaten on sexual parts of your body				
P	Forced or threatened with harm to make you give or receive oral sex or have vaginal or anal sex				
Q	Penetrated by force with an object in your vagina or anus				
R	Compelled to engage in sex in order to receive something such as food, water, or other(describe)				
S	Forced to watch someone being physically assaulted				
T	Forced to watch someone being sexually assaulted				
U	Anything else(describe)				

26) Who did these things? (Circle all mentioned)

□ Military □Paramilitary

□Civil defense forces □Police officer or interrogator

□Prosecutor or judge □Jail or prison guard

□Doctor/Medical person □Teacher

□Religious worker □Humanitarian relief worker

□Neighbor/Community member □Unknown to respondent □Other

□DK □Refuse

27) Where were you when the episode took place?

□In your house □At work □ Elsewhere in your village

□Elsewhere in your country □ Other (describe)

□DK □ Refuse

28) Did one person or a group of people mistreat you? □ One person

□A group of people □DK □ Refuse

29) Did the assailant(s) threaten to kill you at any time during the episode?

□ No □ Yes □ DK □ Refuse

30) Who was with you at the time of the episode? (Circle all mentioned)?

□ Respondent was alone □ Husband/partner □ Children

□ Other woman □ Other family □ someone else

□ DK □Refuse

31) Were you already pregnant at the time of the episode and if so what happened to the pregnancy?

□Not pregnant □Miscarriage □Premature delivery □Still birth

□Pregnant and delivered healthy child □Abortion □Other

□DK □Refuse

32) Did you become pregnant as a result of the episode and if so what happened to the pregnancy?

□Not pregnant □Miscarriage □Premature delivery □Still birth

□Pregnant and delivered healthy child □Abortion □Other

□ NA (no sexual assault) □DK □Refuse

33) At the time of the incident, did you know the person/ people who mistreated you?

□No □Yes □DK □Refuse

34) Did you experience any of the following injuries as a result of the mistreatment? (Read choices and circle response)

	No	Yes	DK	Refuse
A. Bruises, scrapes, welts				
B. Loss of consciousness (black out)				
C. Dislocations				
D. Broken bone or bones				
F. Deep wounds or cuts				
G. Psychological difficulties, such as nightmares, intrusive memories, significant changes in sleep patterns				
H. Other injury				

35) Did you seek medical care for your injuries? If you sought medical care for your injuries, whom did you consult for medical assistance? (Circle all mentioned)

□Did not seek treatment □Traditional healer □Neighbor/friend

□Hospital □Health centre
□Respondents family □Self treated □Other □DK □Refuse

36) What was the main reason you did not seek medical care for your injuries? (Circle all mentioned)

□Did seek treatment □Did not need medical care □Did not know where to go □Medical care not available □No use/would not do any good □Embarrassed □Respondent afraid of further violence

□Would not be believed or taken seriously

□Respondent thought she would be blamed

□Bring bad name to the respondent's family

□Bring bad name to the husband's family

□Had no money □No transport □Other □DK □Refuse

37) Did you tell anyone about what happened during the episode? If you told anyone (other than the people who were with you during the episode), whom did you tell? (Circle all mentioned)

□Did not tell any one □Husband □Male family member □Female family member □Friend □Medical practitioner □NGO worker

□UN staff member

□Police or local Authorities □ Religious authority □Women's group

□Someone else

□Other □DK □Refuse **(SKIP TO Q 63)**

38) What was the major reason you did not tell anyone about what happened?

□ Feelings of shame □Fear of being stigmatized □ Fear of rejection by family or friends □Did not trust anyone □Thought nothing could be done □Other

□DK □Refuse

39) What has been most helpful to you so far in coping with your experience? (Circle all that apply)

□Support group for women □Talking it over with friends

□Talking it over with family □Assistance from NGO workers □Legal advice/Traditional justice

□Religious counseling □Mental health counseling

□Medical assistance □Trying to forget about experience □Other

□DK □Refuse

40) Are there other things that you think might be helpful to you in coping with your experience? (Circle all that apply)

□Support group for women

□Talking it over with friends

□Talking it over with family

□Assistance from NGO workers

□Legal advice/Traditional justice

□Religious counseling

□Mental health counseling

□Medical assistance

□Trying to forget about experience

□Other □DK □Refuse

APPENDIX V - Sample Interviewer Training Handbook

INTRODUCTION

This sample training handbook identifies some of the major points that should be part of any training of interviewers. The handbook is divided into two primary sections. The first section outlines basic research concepts and the responsibilities of the interviewer. The second section reviews the items in the questionnaire and provides clarification on specific questions.

A handbook is a valuable reference tool that interviewers can personalize with notes and commentary on some of the more specific information introduced during the training, and then use as a reference while in the field conducting interviews. Some important components highlighted in this handbook include ethics of conducting research, safety and security concerns while in the field and engagement skills for interviewers. In its explication of the research questions, the handbook also presents a basic rationale for the design of the survey instrument. Interviewers should fully understand the rationale and language for each question prior to conducting the research. Considerable time should be given during the training for the interviewers to repeatedly practice administering the questionnaire.

This sample training handbook is not definitive and should be adjusted for each research effort. Most importantly, the handbook does not address a very important component of interviewer training: examining attitudes and beliefs of interviewers regarding GBV. Even so, it offers those considering prevalence research a sense of what is involved in preparing for and mounting a population-based survey.

SECTION I: RESEARCH OVERVIEW

A. BASIC RESEARCH TERMINOLOGY

Quantitative Research involves collecting and analyzing data. A questionnaire is used to collect data from a sample of the population so that the results can give information about the whole population.

Qualitative Research involves using interviews and observations to describe situations. It usually does not involve statistical analysis. One example of qualitative research is a **focus group,** that is, a group of people who are gathered together to discuss specific issues. The group you want to learn about is called the **population**. Often the group of people you want to study is too large to be tested. The **sample** is the group of people you select to be in your study who will give you information about the whole population.

Random sampling is when every person in the population has an equal chance of being selected to be in the sample. This is an effective way to make sure that the sample reflects the population as a whole.

Example: You wish to know some information about a village of 100 people but you don't have time to talk to everyone who lives in the village. You have a list of everyone who lives in a village numbered from 1 to 100. You decide that you need a sample of 30 people to find out the information you need. You have a computer pick 30 numbers randomly between 1 and 100. You then pick the people on the list with these selected numbers for your sample. These selected people are the only ones who will be asked whether they want to participate in the research.

The question of how large a sample size should be can be a difficult one. If the sample is too small, you will not be able to make valid conclusions from your sample. If the sample is too large, you can waste time and money. Usually the kind of analysis you use with the information will determine how large the sample ought to be. In general, the more information you want, the larger your sample will have to be.

Reliability refers to how consistent a questionnaire is. A questionnaire is considered reliable if it gives us the same result over and over again.

Validity refers to how well the questionnaire measures what it is supposed to be measuring. Will other similar tests give similar results?

Action-based Research focuses on practical, not theoretical significance. The goal is to gain knowledge to apply to the local situation.

IF YOU FIND YOURSELF IN AN EMERGENCY SITUATION:

1. If you are in a *dangerous situation*, leave immediately. Go immediately to the site supervisor to report the situation.
2. If, as in the case of the locater or driver, you cannot immediately reach the site supervisor by cell phone, return immediately to the site to report the incident to the supervisor. If the emergency is a medical one in which there is absolutely no danger to the driver or the locater, transport the participant to the hospital and then immediately return to the site to report the incident to the supervisor. If the situation is one of risk to a potential participant by a family member and the participant wishes to leave the household, immediately assist the participant in leaving the household and return with the participant to the site

B. GENERAL LOGISTICS

Purpose of study

This survey has been designed to improve understanding of the extent and effects of violence women may experience in their lives. The survey will involve interviewing women between the ages of [ ]. We are conducting this survey with the goal of trying to increase resources for women's programs, increase sensitivity to women's issues, and improve the lives of women affected by violence. All information obtained and received in the process of conducting research will be held in the strictest confidence.

Interview Teams

Following a minimum of ten days in training, teams of interviewers will be selected to work at field sites, Monday-Friday, for a minimum of [days/weeks]. Each team will receive on-site supervision by a research coordinator. Each interviewer within each team will submit their questionnaires for review by the supervisor at the close of each interview. Women from the community will be recruited to participate in the survey by locaters.

Locaters

One locater for each village under investigation will be identified and asked to participate in a minimum of five days of training: two days in which the basic research concepts and the research plan will be reviewed, a third day in which the locaters will work separately with a supervisor in reviewing their specific responsibilities, and two additional days in which the locaters will join with the interviewers for a practice field test. During the survey, two locaters will each be working in a village each day to identify women willing to participate in the survey. The locaters will go to pre-selected houses in each village to invite women to participate in the survey.

The locaters will explain the basic components of the survey to the potential participant. If the woman agrees to participate, she will be guided, and where necessary, transported, to the survey site, where interviewers will be waiting to conduct the survey.

Drivers

Drivers are responsible for transporting the interview teams from [a central location] to the selected field sites each day. Departure time will be [hour/minute]. After dropping off the interviewers at the interview site, each driver will transport the locaters to pre-selected houses where the locaters will invite women to participate in the surveys. The drivers should be accessible by cell phone or walkie-talkie at all times. At the end of the day, the drivers will be responsible for returning the interviewers back to [a central location]. Departure from the villages to the [central location] will be no later than [hour/minute] each day.

Supervisors

There will be one supervisor based at each interview site every day. Each supervisor will be responsible for overseeing their interview team. They will also be responsible for ensuring data is collected properly, that security and safety precautions are reinforced, and that all aspects of survey implementation to proceed smoothly. Supervisors will be working with the locaters to assist selection of survey participants

C. Security Issues

The safety and security of the interviewers, locaters, drivers, and survey participants are very important. Security issues generally override any other rules or obligations related to the research. Supervisors at each site will be equipped with cell phones or walkie-talkies, as will both drivers. Each person with the cell phone should be responsible for ensuring that the phones are in good working order and equipped with sufficient card minutes each day.

As you know, this study asks the participants about some very painful experiences they might have had. The questions may stir up strong feelings in both the participant and the interviewer. This manual will provide some basic information about dealing with these feelings as they come up. This manual will also provide some basic information on how to address emergency situations, including who you can call for help in dealing with the participant's or your own reactions to the interview.

You are not expected nor is it your responsibility to provide mental health treatment to participants. However, you should be prepared to provide a list of people with whom the participant and her family may consult. We have asked helpers in the community to consent to have their names placed on a resource list. This list can be handed out to participants at the time of the interview, and will be provided to you during training.

You must ensure, however, that you will not put the participant at risk by providing written referrals for assistance that may later be discovered by a partner or other family member. If the participant does not feel safe taking written materials but does request further assistance, the interviewer should assist the participant in developing a strategy for seeking out services subsequent to the interview.

D. Emergency Procedures

We have established procedures that will assist staff to know how to respond to an emergency and what to expect at that time. We do not anticipate that emergencies will happen often, if at all, but it is important for all research staff to read the following carefully. Also please use common sense in dangerous situations: get out of danger, leave immediately, and get assistance.

EXAMPLES OF POSSIBLE EMERGENCY SITUATIONS:

1. **A medical emergency**. For example, a participant has a heart attack and needs medical treatment. Hospitalization may be needed or a situation may arise that requires police intervention.
2. **A participant is having flashbacks.** For example, the person who has experienced significant trauma, such as a rape survivor, starts to feel as though she is back in the traumatic setting. You try to talk to her but she just keeps staring at you. She could be hearing or seeing ("reliving") the traumatic event.
3. **A participant seems suicidal.** For example, she tells you that she has attempted suicide within the last six months or she says that she is planning on killing herself in the near future. The attempt seems particularly imminent; she reports a suicide plan or describes how she is planning to kill herself.
4. **A participant has threatened to hurt or kill someone.** A participant expresses intent to harm a specific person, such as a husband or neighbor. This participant may also be more likely to become dangerous or violent within the interview situation.
5. **Someone at the household (for example, a husband) becomes abusive to the locater and/or driver.** This situation may be a potential risk if a member of the household determines the nature of the survey, and becomes angry about a potential disclosure by the participant.
6. **The interviewer suspects current child abuse.** The information revealed suggests that a child has been abused or mistreated by the participant or someone known to the participant.

E. Ethics of Conducting Research

RIGHTS OF RESEARCH PARTICIPANTS:

Even though we want as many of the selected individuals to participate as possible, there are ethical guidelines to protect the rights of the research participants. All research follows these strict ethical guidelines. The rules listed below must be adopted by all interviewers and locaters to ensure participants' rights and to minimize any potential for harm.

1. People have the right to refuse to participate in the study.
2. People have the right to withdraw from the study at any time.

3. Participants must be informed about the general purpose of the study. Each participant needs to be given information explaining the purpose of the study.

4. Participants must be informed about what they will be asked to do if they agree to participate in this study. This study asks participants about their experiences with violence and trauma, demographic information, health, and several other issues.
5. Participants must be informed of the potential risks associated with participation in the study. These risks may include psychological discomfort related to discussion of topics that may be painful. Participating in the study may involve some inconvenience by requiring up to one hour of their time.
6. Participants must be informed of potential benefits associated with participation in the study. Information that is collected from this study will be used to help generate awareness about the impact of violence on women's lives. However, women will not receive any compensation personally for their participation other than referral to services should they request them.

7. Participants must be informed about confidentiality. All information shared by the participants will be kept confidential. Participants will remain anonymous, which means that code numbers will be on the materials instead of names. The site supervisors will take precautions for safe-guarding all materials.
8. Participants must be informed about who they can contact if they have any questions about the study.
9. Participants must complete a PARTICIPANT CONSENT FORM to indicate that they have been informed of their rights as research participants. Participants may complete the form by giving verbal consent or by marking an 'x' on the consent form.

F. Responsibilities of the Interviewer

Interviewing is very different from the ways we talk to other people. You are conducting a research interview that is very structured. Before research studies can be completed successfully and before the investigators can be confident that the data collected are accurate, there are certain procedures and rules to be followed.

1. **Attend and complete all training sessions and practice interviews.**
2. **Agree to the rules of confidentiality and sign confidentiality contract.**

Confidentiality is a crucial part of data collection. If people feel that the information given will be told to others at a later date, their responses may not be totally accurate. Moreover, failing to preserve confidentiality may directly or indirectly cause harm to participants and researchers. However, there may be exceptions to breaking confidentiality, such as when a participant tells you that they may hurt themselves or others. In these cases, immediately seek assistance from your site supervisor.

3. **Make every effort to protect the welfare of the participants at all times.**

(a) In all studies it is important to conduct the interview in private, only with the participant. If there is someone else present while you are conducting the interview, ask for assistance from the site supervisor in moving to a private area.

(b) Build rapport with the participant. Rapport is the relationship that the interviewer and participant will create so there is the trust and willingness to share the personal information in the survey questions. Establishing rapport can usually be done by being friendly, and taking a somewhat leisurely attitude toward the interview. Do not proceed with the interview until you are sure the participant is relatively comfortable with the interviewer and the surroundings.

(c) **DO NOT** write any confidential information concerning the respondent on the questionnaire (e.g., person's name or where she lives). d) Do not force participant to answer questions she is not comfortable answering. e) Be aware of your voice. Do not give the impression that you are being critical, you are surprised, or you approve or disapprove of the answers. f) Notify the site supervisor immediately of any difficulties that are encountered during or as a result of the procedure. g) Follow standard procedure for dealing with participants upset by the interview.

4. **Follow established interviewing procedures, so that all interviews are conducted in the same way, with every participant.**

(a) Obtain interview material in advance and review material packets for completeness.

(b) Never copy questionnaires and never change questionnaire numbers

(c) Follow procedures and mark off each activity when it is completed.

(d) Clearly ask the participant questions and record answers with participant's consent.

(e) In all cases where questions involve written responses, neatly print responses.

(f) If a respondent answers "don't know" to any question or refuses to answer any question, an effort at recall should be encouraged with a probe such as "Could you give me your best guess?"

(g) If probing to obtain an answer fails, circle the "DK" or "REF" response for that question.

(h) If you are unsure which answer choice to circle based on the participant's response, excuse yourself, and ask for help from the site supervisor.

5. Follow standard methods for correcting data during the interview and after the interview is completed.

(a) If you circle the wrong answer or make an error in a write-in entry during the interview, neatly and completely erase the mistake and circle the correct answer or write in the correct entry.

(b) Edit questionnaire at the close of each interview, while the participant is still sitting with you.

(c) In the case of missing data, complete with participant.

(d) Invite participant to have coffee or cookies while you submit the questionnaire to the site supervisor.

(e) Review the questionnaire with the site supervisor.

(f) If there is still missing data, return to the participant, bring her back to the confidential interviewing area, and complete the missing data.

(g) Request answers for missing data questions and/or request clarification on ambiguous responses. **Never guess at the answer to a question.**

(h) Be sure all questions that should have been answered by the participant have a response marked or written in.

(i) Be sure that all write-in responses are legible.

(j) Be sure that all stray marks have been removed from the areas designated for response categories.

(k) Transcribe messy or hard to read pages onto blank questionnaire pages.

G. Interviewer Skills

The **Interviewer** takes on a role as a person who will ask important questions when she begins to interact with the participant. The interviewer conveys to the participant that this interview is valuable. The interviewer must present herself in a way that indicates that she is trustworthy; she can be counted on to keep confidentiality, and will not make judgments about the person.

1) When Meeting the Participant:

The interviewer introduces herself and identifies the organization she is working with or representing. She informs the participant what kind of information she will be asking about and obtains her consent to participate.

2) During the Interview:

There may be times when you become very uncomfortable. You may not understand what is going on with the participant. You may be uncertain about the wisdom of proceeding with the interview, especially if you feel that you are in danger. Take the time to consider options and decide what to do: stop, take a break, and seek assistance from your site supervisor.

Trust your gut reactions and don't just keep moving on automatically. ***Be alert to the participant's responses and offer breaks if necessary.***

If a participant is clearly upset, ask "Would you like to take a break?" or "Can I get you some water?" Whether or not a participant is upset, if the interview goes over one hour, take time for a brief break. Remember; only leave when the person is calm, not when he or she is very upset!

3) At the End the Interview:

Thank the respondent for taking part in this survey, reassuring them that all information they have submitted will be held in the **strictest confidence**. Inform them that this information will be put into a report and will be used to help alleviate existing problems of safety and violence against women, for planning future services, and in trying to establish an educational prevention program, thus making their community a safer place to live in.

4) General Tips on Interviewing Behavior:

In this type of survey, there are times when you want to say or do something that is comforting. Remember that you are not a mental health clinician and your main objective is to complete the survey. For the purposes of this study, your role does not involve probing about feelings or providing counseling. You are neither a therapist nor a close friend of the family and must behave accordingly. Your demeanor toward the study participants should be friendly, polite and empathetic, while at the same time maintaining a professional distance. The following are some suggested guidelines for appropriate interviewer behavior.

a) Avoid excessive socializing

You should not allow the interview to become an occasion for socializing. You should chat with the participants for a few moments on arriving and leaving and answer all their questions about the study. Avoid getting involved in lengthy conversation, before, during, or after the interview.

b) Maintain a neutral and accepting attitude

You must not react with shock or disapproval to anything the participant tells you in the interview. Sometimes participants will report behavior that you may find disturbing. It is very important not to show your reaction if you feel this way; otherwise, you may not only upset the participant, but potentially discourage her from being honest in answering the questions. Your attitude should be matter-of-fact and accepting. If certain questions in the interview make you uncomfortable, give them extra practice, until you feel at ease reading them. If you are relaxed, it will help the participant to relax.

c) Be responsive to the participant

If the participant tells you about a sad event or becomes upset during the interview, you should not ignore her feelings; be responsive and sympathetic and allow her to talk a little about the event before continuing. If the situation seems to be leading to a lengthy discussion, you may suggest that the discussion be continued after the interview is completed. If a participant becomes very upset during the interview, suggest a break; do not wait for the participant to ask. Without being rude, try to avoid getting into personal discussions about yourself. You may have to answer a few questions to be polite, but be as general and noncommittal as possible and change the focus to the participant as soon as you can.

You should try to answer all questions as completely as you can. You may also encounter participants who are hostile or defensive. Please try to maintain as neutral a manner as possible in these situations and, if necessary, ask the site supervisor for assistance.

e) Avoid giving clinical opinions

Because the study has some questions about physical and mental health issues, participants may ask your opinion about problems. You should not give your opinion about any aspect of physical or emotional well-being. You should explain that you are not a trained health worker, and you are not in a position to give an opinion. If the participant is very concerned, you may suggest that she may want to talk to someone, and provide her with a list of resources.

f) Respond to participant's concerns

The participants may become concerned when they say "yes" to a number of symptom questions. They may ask: "Does that mean there is something wrong with me?" In general, it's best to be noncommittal in your response, since there may indeed be something wrong and you don't want to give false reassurance. You can say: "Saying 'yes' doesn't always mean there's something wrong; a lot of people say 'yes' to these questions." If the participants seem worried, suggest they talk their concerns over with a health care provider.

MORE HELPFUL HINTS

- Slow, clear speech.
- Repeat instructions and/or question when needed.
- Use the guidelines within the handbook for each question if clarification is needed for the participant beyond repetition.
- If pressured by the participant to give examples of responses where it is not indicated that you should list responses (many times participants want to know what we want to hear - they are trying to avoid the shame of a wrong answer), gently say "I need YOU to tell me" or "I can only read the question" or "Whatever you say is the right answer."
- All of the participant's answers are correct.
- Encourage breaks, breaths.

- Allow breaks at any time. Even if you are halfway through a page you can always finish the page after the break.
- Stress to the participant that it is okay to cry.
- Encouragement such as "we're moving along fine" can be helpful.

THINGS YOU NEVER WANT TO DO:

- Yawn during the interview.
- Refuse a break when asked.
- Use judgmental language - "You had a BAD month?" "Now that's a GOOD answer."
- Ask questions that are not in the study.
- Tell the participant not to cry. Tell the participant not to feel the way they feel.
- Be funny or sarcastic.
- Sound irritated.
- Act bored, try to hurry the participant.

H. Stress Management for Interviewers

Continually talking about and working with the issue of personal experiences can be stressful. At the close of each day, a time for group discussion will be set aside so that interviewers can talk about any issues they have related to their own emotional strains. If there are concerns that are not addressed during the group discussions, please seek out the site supervisor. You are not expected to do this work alone!

Here are some basic ways to manage stress:

1. Take care of your **Emotional Self:**
   Get support for yourself by talking with someone. If you need to talk right away, you may want to speak to your site supervisor. If you do not wish to speak to your site supervisor, names on the resource list are available Call Someone or talk with someone after a particularly troublesome contact.
2. Take care of your **Physical Self:** Get enough rest, exercise, and eat properly.
3. Take care of your **Intellectual Self:** Make attempts to think about what your goals are in this work.
4. Take care of your **Spiritual Self:** Seek spiritual help according to your beliefs.

INTERVIEWER CONTRACT

(To be signed by interviewer and given to supervisor on first day of interviewer training)

Confidentiality means that information is not shared outside the setting where it was obtained; it is kept private. There are several types of confidentiality involved with this study.

1. Employee confidentiality means that personal information that Interviewer, Site Coordinators, and other Participants in the training share about themselves during the training and afterwards will not be shared outside the training group or Study staff.
2. Participant confidentiality means that we will not reveal the names of women who participated in the study. When we share the results of the study with others, no individual's responses will be identified. For Site Coordinators and Interviewers, this means that we will not discuss or reveal names of Participants to anyone except to other Study staff. It also means that we will not discuss any information that we learn during the course of any interview with anyone except for other Study staff.
3. Questionnaire confidentiality means that the interview materials that we will be using are not to be shared with anyone except during the course of an interview. It is important to let Participants in the study know what the study is about and the nature of the questions we will be asking (see Rights of Research Participants). However, we will not show interview materials to people outside of the study. These interview materials are tools for research that are only to be used by people who have been trained to administer them. Always keep the completed interviews in a private, secure place.

As an interviewer, I agree to abide by these rules of confidentiality. I understand that if I do not abide by these rules of confidentiality, I will be subject to dismissal.

Name: ----------

Date: ----------

UNHCR
e UN Refugee Agency

Dagahaley Refugee Camp

As of January 2007

Regional Spatial Analysis
Nairobi, K

Printed: 22 January 2007

Sources: UNHCR

UNHCR
The UN Refugee Agency

As of January 2007

The boundaries shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

Sources UNHCR

The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

Sources: UNHCR, IRD

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Ref: KNH-ERC/ 01/ 429

22nd May, 2008

Dr. Bashir M. Issak
Dept. of Obs. & Gynae
School of Medicine
UNIVERSITY OF NAIROBI

Dear Dr. Bashir

RESEARCH PROPOSAL: "THE LIFETIME PREVALENCE OF SEXUAL AND GENDER BASED VIOLENC AMONG REFUGEE WOMEN ATTENDING OBSTETRIC AND GYNAECOLOGY CLINICS AT DADA/ REFUGEE CAMP HOSPITALS" (P326/11/2007)

This is to inform you that the Kenyatta National Hospital Ethics and Research Committee has review and **approved** your above revised research proposal for the period 22nd May, 2008 – 21st May, 2009.

You will be required to request for a renewal of the approval if you intend to continue with the stu beyond the deadline given. Clearance for export of biological specimen must also be obtained fr KNH-ERC for each batch.

On behalf of the Committee, I wish you fruitful research and look forward to receiving a summary of research findings upon completion of the study.

This information will form part of database that will be consulted in future when processing rela research study so as to minimize chances of study duplication.

Yours sincerely

PROF A N GUANTAI
SECRETARY, KNH-ERC

c.c. Prof. K.M. Bhatt, Chairperson, KNH-ERC
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