Researching Violence Against Women

A PRACTICAL GUIDE
FOR RESEARCHERS AND ACTIVISTS

World Health Organization

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Introduction

Twenty years ago, violence against women was not considered an issue worthy of international attention or concern. Victims of violence suffered in silence, with little public recognition of their plight. This began to change in the 1980s as women's groups organized locally and internationally to demand attention to the physical, psychological, and economic abuse of women. Gradually, violence against women has come to be recognized as a legitimate human rights issue and as a significant threat to women's health and well-being.

Now that international attention is focused on gender-based violence, methodologically rigorous research is needed to guide the formulation and implementation of effective interventions, policies, and prevention strategies. Until fairly recently, the majority of research on violence consisted of anecdotal accounts or exploratory studies performed on nonrepresentative samples of women, such as those attending services for battered women. While this research has played a critical role in bringing to light the issues of wife abuse, rape, trafficking, incest, and other manifestations of gender-based violence, it is less useful for understanding the dimensions or characteristics of abuse among the broader population.

This manual has been developed in response to the growing need to improve the quality, quantity, and comparability of international data on physical and sexual abuse. It outlines some of the methodological and ethical challenges of conducting research on violence against women and describes a range of innovative techniques that have been used to address these challenges. We hope that the manual will be useful for those interested in pursuing research on violence, especially in developing countries and other resource-poor settings.

The manual draws on the collective experiences and insights of many individuals, most notably the members of the International Research Network on Violence Against Women (IRNVAW), an ad hoc group of researchers and activists that meets periodically to share experiences regarding research on violence. The Network arose out of a two-day meeting on methodology and research ethics organized in June 1995 by the Center for Health and Gender Equity. To date the IRNVAW has sponsored four international meetings and several members have collaborated with the World Health Organization (WHO) in the design and implementation of a multi-country study on women's health and domestic violence. Many of the examples and insights included in this manual come from the pioneering work of IRNVAW members, as well as the WHO Multi-country Study on Women's Health and Domestic Violence, a household survey of women that has been conducted in

at least ten countries to date. We have also drawn extensively from our own research experiences, primarily in Nicaragua, Indonesia, and Ethiopia.

Readership

This manual is written for anyone interested in the application of social science and public health research methods to the study of gender-based violence. The manual assumes a certain level of familiarity with the logic of research and is not a substitute for training in research or research methodologies.

It is designed for **researchers** who want to know more about adapting traditional research techniques to the special case of investigating physical and sexual abuse. And it is designed for **activists, community workers, and service providers** who want to become conversant in methodological issues. One of the goals of this manual is to facilitate collaborations between researchers and community-based workers and activists by providing practitioners with an introduction to the tools and language of research, and by giving researchers greater insight into the specific issues that accompany research on violence.

Focus of the manual

For the sake of brevity, this manual focuses primarily on the issue of **violence against women by their intimate partners**. Gender-based violence assumes many forms, including rape, sexual assault and coercion, stalking, incest, sexual harassment, female genital mutilation, and trafficking in women. Although many of the insights presented herein will apply to these other types of violence, no single manual could exhaustively address all forms of abuse. Additionally, we concentrate on **applied research**, as opposed to research designed to advance theory or to address questions of primarily academic relevance.

The manual is directed particularly to those researchers interested in the intersection of **violence and health in developing countries**, given the clear impact that gender violence has on women's health status. However, much of the information presented in the manual is applicable to violence research as it relates to other issues, such as human rights, the well-being of families and children, and economic development. Similarly, the lessons for developing countries may be relevant to some violence research undertaken in industrialized countries, particularly among economically marginalized and/or politically disenfranchised populations.

Finally, the manual advances an ethic of research that is action-oriented, accountable to the antiviolence movement, and responsive to the needs of women living with violence. It strongly encourages collaboration between researchers and those working directly on violence as activists and/or practitioners. Recent experiences in countries as diverse as Canada, Zimbabwe, Indonesia, South Africa, Nicaragua, and Cambodia have shown that powerful synergies can be achieved from partnerships between researchers and advocates. Whereas researchers help to ensure that the endeavor is grounded in the principles of scientific inquiry, the involvement of advocates and service providers helps ensure that the right questions are asked in the right way, and that the knowledge generated is used for social change.

This document was based on the contributions of thousands of women from around the world who shared their stories and personal experiences in the hopes that their voices would contribute to diminishing the suffering of future generations of women from violence. The publication is dedicated to them.

1

PHOTO BY HAFM JANSEN

Violence Against Women as a Health and Development Issue*

Topics covered in this chapter:

Definitions of violence against women
Prevalence of intimate partner violence
The patterning of intimate partner violence
Prevalence and characteristics of sexual coercion and abuse
The effects of violence on women's health
Explaining gender-based violence
How do women respond to abuse?
Challenges for international research on gender-based violence

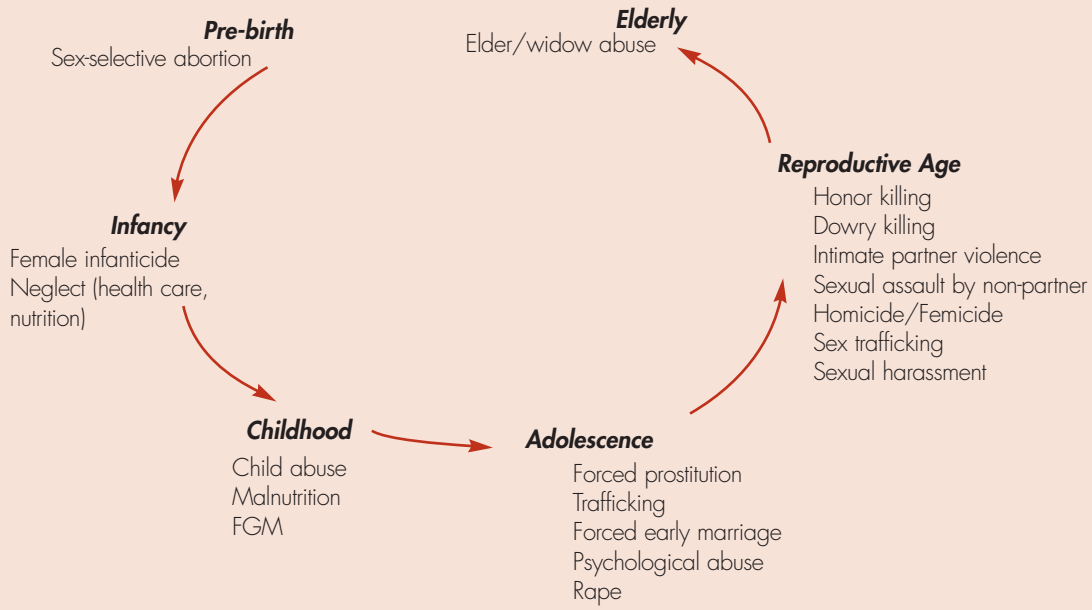
Violence against women is the most pervasive yet underrecognized human rights violation in the world. It is also a profound health problem that saps women's energy, compromises their physical and mental health, and erodes their self-esteem. In addition to causing injury, violence increases women's long-term risk of a number of other health problems, including chronic pain, physical disability, drug and alcohol abuse, and depression.[1, 2] Women with a history of physical or sexual abuse are also at increased risk for unintended pregnancy, sexually transmitted infections, and miscarriages.[3-5] Despite the high costs of violence against women, social institutions in almost every society in the world legitimize, obscure, and deny abuse. The same acts that would be punished if directed at an employer, a neighbor, or an acquaintance often go unchallenged when men direct them at women, especially within the family.

For over three decades, women's advocacy groups around the world have been working to draw more attention to the physical, psychological, and sexual abuse of women and to stimulate action. They have provided abused women with shelter, lobbied for legal reforms, and challenged the widespread attitudes and beliefs that support violence against women.[2]

Increasingly, these efforts are having

* Parts of this chapter are reprinted from Heise, Ellsberg and Gottemoeller, 1999[2] (available online at http://www.infoforhealth.org/pr/l11edsum.shtml).

FIGURE 1.1 THE LIFE CYCLE OF VIOLENCE AGAINST WOMEN



(Adapted from Watts and Zimmerman, 2002[6] and Shane and Ellsberg, 2002.[7])

results. Today, international institutions are speaking out against gender-based violence. Surveys and studies are collecting more information about the prevalence and nature of abuse. More organizations, service providers, and policy makers are recognizing that violence against women has serious adverse consequences for women's health and for society.

This chapter provides a brief overview of the issue of violence against women, including definitions, international prevalence, the documented health consequences of abuse, and evidence regarding causation and women's experiences of abuse. We include this information here for individuals who may be new to the topic and/or for those who are writing research proposals and may not have easy access to the international literature.

DEFINITIONS OF VIOLENCE AGAINST WOMEN

Although both men and women can be victims as well as perpetrators of violence, the characteristics of violence most commonly committed against women differ in critical respects from violence commonly committed against men. Men are more likely to be killed or injured in wars or youth- and gang-related violence than women, and they are more likely to be physically assaulted or killed on the street by a stranger. Men are also more likely to be the perpetrators of violence, regardless of the sex of the victim.[1] In contrast, women are more likely to be physically assaulted or murdered by someone they know, often a family member or intimate partner.[2] They are also at greater risk of being sexually assaulted or exploited, either in childhood, adolescence, or as adults. Women are vulnerable to different types of violence at different moments in their lives (see Figure 1.1).

There is still no universally agreed-upon terminology for referring to violence against women. Many of the most commonly used terms have different meanings in different regions, and are derived from diverse theoretical perspectives and disciplines.

One frequently used model for understanding intimate partner abuse and sexual abuse of girls is the "family violence" framework, which has been developed primarily from the fields of sociology and psychology.[8, 9] "Family violence" refers to all forms of abuse within the family regardless of the age or sex of the victim or the perpetrator. Although women are frequently victimized by a spouse, parent, or other family member, the concept of "family violence" does not encompass the many types of violence to which women are exposed outside the home, such as sexual assault and harassment in the workplace. Moreover, feminist researchers find the assumption of gender neutrality in the term "family violence" problematic because it fails to highlight that violence in the family is mostly perpetrated by men against women and children.

There is increasing international consensus that the abuse of women and girls, regardless of where it occurs, should be considered as "gender-based violence," as it largely stems from women's subordinate status in society with regard to men (Figure 1.2). The official United Nations definition of gender-based violence was first presented in 1993 when the General Assembly passed the Declaration on the Elimination of Violence against Women.[10] According to this definition, gender-based violence includes a host of harmful behaviors directed at women and girls because of their sex, including wife abuse, sexual assault, dowry-related murder, marital rape, selective malnourishment of female children, forced prostitution, female genital mutilation, and sexual abuse of female children (see Box 1.1 for the complete definition).[10]

Even when the abuse of women by male partners is conceptualized as gender-based violence, the terms used to describe this type of violence are not consistent. In many parts of the world, the term "domestic violence" refers to the abuse of women by current or former male intimate partners.[11, 12] However, in some regions, including Latin America, "domestic violence" refers to any violence that takes place in the home, including violence against children and the elderly.[13, 14] The term "battered women" emerged in the 1970s and is widely used in the United States and Europe to describe women who experience a pattern of systematic domination and physical assault by their male partners.[15] The terms "spouse abuse," "sexualized violence," "intimate partner violence," and "wife abuse" or "wife assault" are generally used interchangeably, although each term has weaknesses. "Spouse abuse" and "intimate partner violence" do not make explicit that the victims are generally women, whereas "wife abuse" and "wife assault" can be read to exclude common-law unions and dating violence.

For the purposes of this manual, we use the terms "violence against women" (VAW) and "gender-based violence" (GBV) interchangeably to refer to the full range of abuses recognized by the UN Declaration and other international agreements. We use

BOX 1.1 UNITED NATIONS DEFINITION OF VIOLENCE AGAINST WOMEN

The term "violence against women" means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. Accordingly, violence against women encompasses but is not limited to the following:

a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;

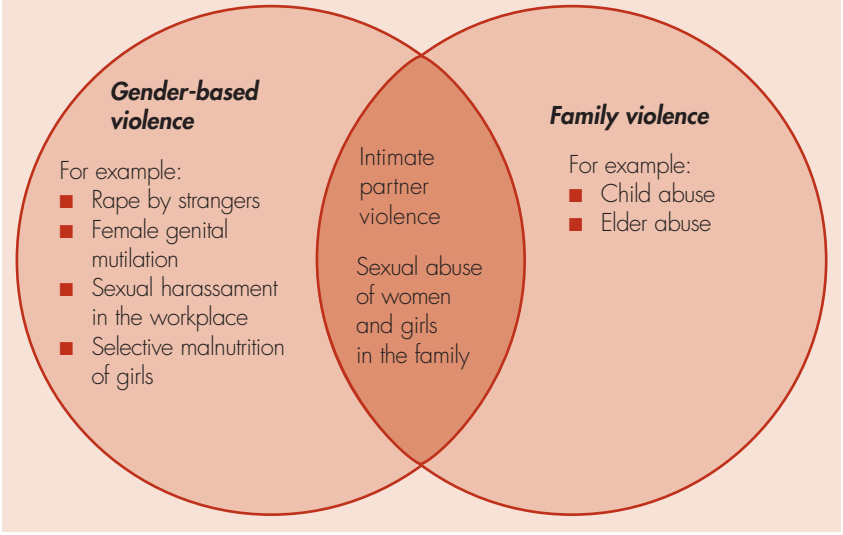
b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;

c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

Acts of violence against women also include forced sterilization and forced abortion, coercive/forced use of contraceptives, female infanticide and prenatal sex selection.

(From United Nations, 1993.[10])

FIGURE 1.2 THE OVERLAP BETWEEN GENDER-BASED VIOLENCE AND FAMILY/DOMESTIC VIOLENCE



the terms "intimate partner violence," "wife abuse" and "domestic violence" interchangeably to refer to the range of sexually, psychologically, and physically coercive acts used against adult and adolescent women by current or former male intimate partners.

PREVALENCE OF INTIMATE PARTNER VIOLENCE

International research consistently demonstrates that a woman is more likely to be assaulted, injured, raped, or killed by a current or former partner than by any other person. Table 1.1 presents findings from nearly 80 population-based studies carried out in more than 50 countries. These studies indicate that between 10 percent and 60 percent of women who have ever been married or partnered have experienced at least one incident of physical violence from a current or former intimate partner. Most studies estimate a lifetime prevalence of partner violence between 20 percent and 50 percent. Although women can also be violent, and abuse exists in some same-sex relationships, the vast majority of partner abuse is perpetrated by men against their female partners.

Researchers find considerable variation in the prevalence of partner violence from country to country, and among studies within a country. Unfortunately, lack of consistency in study methods, study design, and presentation of results makes it difficult to explore the causes and consequences of violence. As a result, it is often difficult to compare results even between studies performed in the same country.

Partly to address this shortcoming, the World Health Organization worked with collaborating institutions in 15 sites in ten countries between 1998 and 2004 to implement a multi-country study of domestic violence and women's health. The *WHO Multi-country Study on Women's Health and Domestic Violence Against Women*—also referred to here as the WHO VAW Study—was the first ever to produce truly comparable data on physical and sexual abuse across settings.[16] This research project sought to minimize differences related to methods by employing standardized questionnaires and procedures, as well as a common approach to interviewer training.

We will return to the WHO VAW Study many times throughout the manual to highlight some of the challenges posed by this project and how they were resolved.

THE PATTERNING OF INTIMATE PARTNER VIOLENCE

The WHO VAW Study also provided a rare opportunity to examine the "patterning" of violence across settings. Does physical violence occur together with other types of violence? Do violent acts tend to escalate over time? Are women most at risk from partners or from others in their lives?

The WHO VAW Study findings confirm that most women who suffer physical or sexual abuse by a partner generally experience multiple acts over time. Likewise, physical and sexual abuse tend to co-occur in

TABLE 1.1 PHYSICAL ASSAULTS ON WOMEN BY AN INTIMATE MALE PARTNER, SELECTED POPULATION-BASED STUDIES, 1982–2004

Country		Ref	Year of study	Coverage	Sample size	Study* population*	Age (years)	Proportion of women physically assaulted by a partner (%) last 12 mo	Ever
Africa									
Ethiopia	◆	17	2002	Meskanena Woreda	2261	III	15–49	29	49
Kenya		18	1984–87	Kisii District	612	V	>15		42[d]
	■	19	2003	National	3856	III	15–49	24	40
Namibia	◆	20	2002	Winhoek	1367	III	15–49	16	31
South Africa		21	1998	Eastern Cape	396	III	18–49	11	27
			1998	Mpumalanga	419	III	18–49	12	28
			1998	Northern Province	464	III	18–49	5	19
	■	22	1998	National	10,190	II	15–49	6	13
Tanzania	◆	20	2002	Dar es Salaam	1442	III	15–49	15	33
	◆	20	2002	Mbeya	1256	III	15–49	19	47
Uganda		23	1995–1996	Lira & Masaka	1660	II	20–44		41[d]
Zambia	■	24	2001–2002	National	3792	III	15–49	27	49
Zimbabwe		25	1996	Midlands Province	966	I	>18		17[b]
Latin America and the Caribbean									
Barbados		26	1990	National	264	I	20–45		30[a,c]
Brazil	◆	20	2001	Sao Paulo	940	III	15–49	8	27
	◆	20	2001	Pernambuco	1188	III	15–49	13	34
Chile		27	1993	Santiago Province	1000	II	22–55		26[d]
		28	1997	Santiago	310	II	15–49	23	
	●	29	2004[p]	Santa Rosa	422	IV	15–49	4	25
Colombia	■	30	1995	National	6097	II	15–49		19[d]
	■	31	2000	National	7602	III	15–49	3	44
Dominican Republic	■	24	2002	National	6807	III	15–49	11	22
Ecuador	▲	32	1995	National	11,657	II	15–49	12	
El Salvador	▲	33	2002	National	10,689	III	15–49	6	20[d]
Guatemala	▲	34	2002	National	6595[f]	VI	15–49	9	
Honduras	▲	35	2001	National	6827	VI	15–49	6	10
Haiti	■	24	2000	National	2347	III	15–49	21	29
Mexico		36	1996	Guadalajara	650	III	>15		27
		37	1996[p]	Monterrey	1064	III	>15		17
		38	2003	National	34,184	II	>15	9	
Nicaragua		39	1995	Leon	360	III	15–49	27	52
		40	1997	Managua	378	III	15–49	33	69
	■	41	1998	National	8507	III	15–49	13	30
Paraguay	▲	42	1995–1996	National	5940	III	15–49		10
	▲	43	2004	National	5070	III	15–44	7	19
Peru	■	24	2000	National	17,369	III	15–49	2	42

TABLE 1.1 PHYSICAL ASSAULTS ON WOMEN BY AN INTIMATE MALE PARTNER, SELECTED POPULATION-BASED STUDIES, 1982–2004

Country		Ref	Year of study	Coverage	Sample size	Study* population*	Age (years)	Proportion of women physically assaulted by a partner (%) last 12 mo	Ever
Latin America and the Caribbean (continued)									
Peru (continued)	◆	[20]	2001	Lima	1019	III	15–49	17	50
	◆	[20]	2001	Cusco	1497	III	15–49	25	62
Puerto Rico	▲	[44]	1995–1996	National	4755	III	15–49		13[e]
Uruguay		[45]	1997	National	545	II[k]	22–55	10[c]	
North America									
Canada		[46]	1993	National	12,300	I	>18	3[b,c]	29[b,c]
		[47]	1999	National	8356	III	>15	3	8[g]
United States		[48]	1995–1996	National	8000	I	>18	1[a]	22[a]
Asia and Western Pacific									
Australia	*	[49]	1996	National	6300	I		3[b]	8[b,d]
		[50]	2002–2003	National	6438	III	18–69	3	31
Bangladesh		[51]	1992	National (villages)	1225	II	<50	19	47
		[52]	1993	Two rural regions	10,368	II	15–49		42[d]
	◆	[20]	2003	Dhaka	1373	III	15–49	19	40
	◆	[20]	2003	Matlab	1329	III	15–49	16	42
Cambodia		[53]	1996	Six regions	1374	III	15–49		16
	■	[24]	2000	National	2403	III	15–49	15	18
China		[54]	1999–2000	National	1665	II	20–64		15
India	■	[24]	1998–1999	National	90,303	III	15–49	10	19
		[53]	1999	Six states	9938	III	15–49	14	40
	●	[29]	2004[p]	Lucknow	506	IV	15–49	25	35
	●	[29]	2004[p]	Trivandrum	700	IV	15–49	20	43
	●	[29]	2004[p]	Vellore	716	IV	15–49	16	31
Indonesia		[55]	2000	Central Java	765	IV	15–49	2	11
Japan	◆	[20]	2001	Yokohama	1276	III	18–49	3	13
New Zealand	◆	[56]	2002	Auckland	1309	III	18–64	5	30
	◆	[56]	2002	North Waikato	1360	III	18–64		34
Papua New Guinea		[57]	1982	National, rural villages	628	III[k]			67
Philippines	■	[58]	1993	National	8481	IV	15–49		10
		[59]	1998	Cagayan de Oro City & Bukidnon	1660	II	15–49		26
	●	[29]	2004[p]	Paco	1000	IV	15–49	6	21
Republic of Korea		[60]	1989	National	707	II	>20	38	
Samoa	◆	[20]	2000	National	1204	III	15–49	18	41
Thailand	◆	[20]	2002	Bangkok	1048	III	15–49	8	23
		[20]	2002	Nakonsawan	1024	III	15–49	13	34
Vietnam		[61]	2004	Ha Tay province	1090	III	15–60	14	25

TABLE 1.1 PHYSICAL ASSAULTS ON WOMEN BY AN INTIMATE MALE PARTNER, SELECTED POPULATION-BASED STUDIES, 1982–2004

Country		*Ref*	*Year of study*	*Coverage*	*Sample size*	*Study* population**	*Age (years)*	*Proportion of women physically assaulted by a partner (%) last 12 mo*	*Ever*
Europe									
Albania	▲	62	2002	National	4049	III	15–44	5	8
Azerbaijan	▲	63	2001	National	5533	III	15–44	8	20
Finland	*	64	1997	National	4955	I	18–74		30
France	*	65	2002	National	5908	II	>18	3	9[i]
Georgia	▲	66	1999	National	5694	III	15–44	2	5
Germany	*	67	2003	National	10,264	III	16–85		23[b]
Lithuania	*	68	1999	National	1010	II	18–74		42[b,d,h]
Netherlands		69	1986	National	989	I	20–60		21[a]
Norway		70	1989	Trondheim	111	III	20–49		18
	*	71	2003	National	2143	III	20–56	6	27
Republic of Moldova	▲	72	1997	National	4790	III	15–44	8	15
Romania	▲	73	1999	National	5322	III	15–44	10	29
Russia	▲	74	2000	Three provinces	5482	III	15–44	7	22
Serbia/Montenegro	◆	20	2003	Belgrade	1189	III	15–49	3	23
Sweden	*	75	2000	National	5868	III	18–64	4[e]	18[e]
Switzerland		76	1994–1996	National	1500	II	20–60	6[c]	21[c]
	*	77	2003	National	1882	III	>18		10
Turkey		78	1998	E & SE Anatolia	599	I	14–75		58[a]
Ukraine	▲	79	1999	National	5596	III	15–44	7	19
United Kingdom		80	1993[p]	North London	430	I	>16	12[a]	30[a]
		81	2001	National	12,226	I	16–59	3	19[i]
Eastern Mediterranean									
Egypt	■	82	1995–1996	National	7123	III	15–49	13	34
	●	29	2004[p]	El–Sheik Zayed	631	IV	15–49	11	11
Israel		83	1997	Arab population	1826	II	19–67	32	
West Bank and Gaza Strip		84	1994	Palestinian population	2410	II	17–65	52	

Key ■ DHS survey data[24] ● INCLEN data[85] ▲ CDC study ◆ WHO study[20] * International Violence Against Women (IVAWS) Study

* Study population: I = all women; II = currently married/partnered women; III = ever–married/partnered women; IV = women with a pregnancy outcome; V = married women – half with pregnancy outcome, half without; VI women who had a partner within the last 12 months.

[a] Sample group included women who had never been in a relationship and therefore were not in exposed group.

[b] Although sample included all women, rate of abuse is shown for ever–married/partnered women (number not given).

[c] Physical or sexual assault.

[d] During current relationship.

[e] Rate of partner abuse among ever–married/partnered women recalculated from authors' data.

[f] Weighted for national representativity.

[g] Within the last five years.

[h] Includes threats.

[i] Since the age of 18.

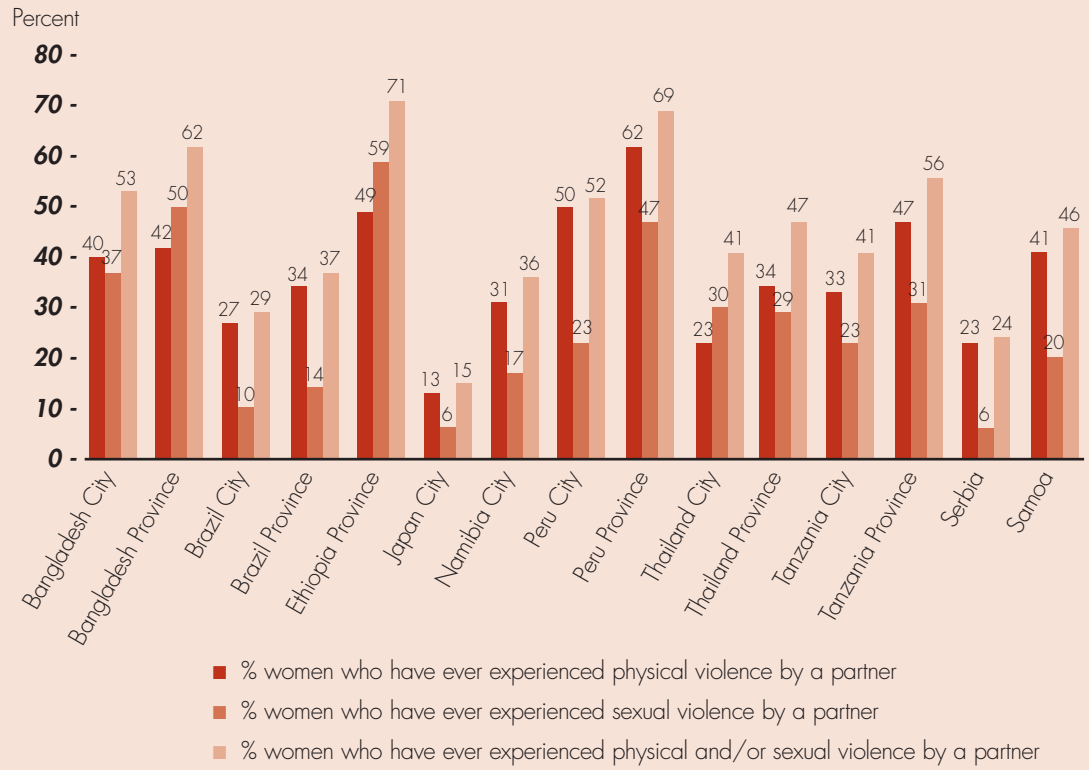
[j] Since the age of 16.

[k] Nonrandom sampling methods used.

[p] Publication date (field work dates not reported).

(Updated from Heise et al, 1999.[2])

FIGURE 1.3 PREVALENCE OF PHYSICAL VIOLENCE AND/OR SEXUAL PARTNER VIOLENCE IN TEN COUNTRIES



(From WHO, 2005.[20])

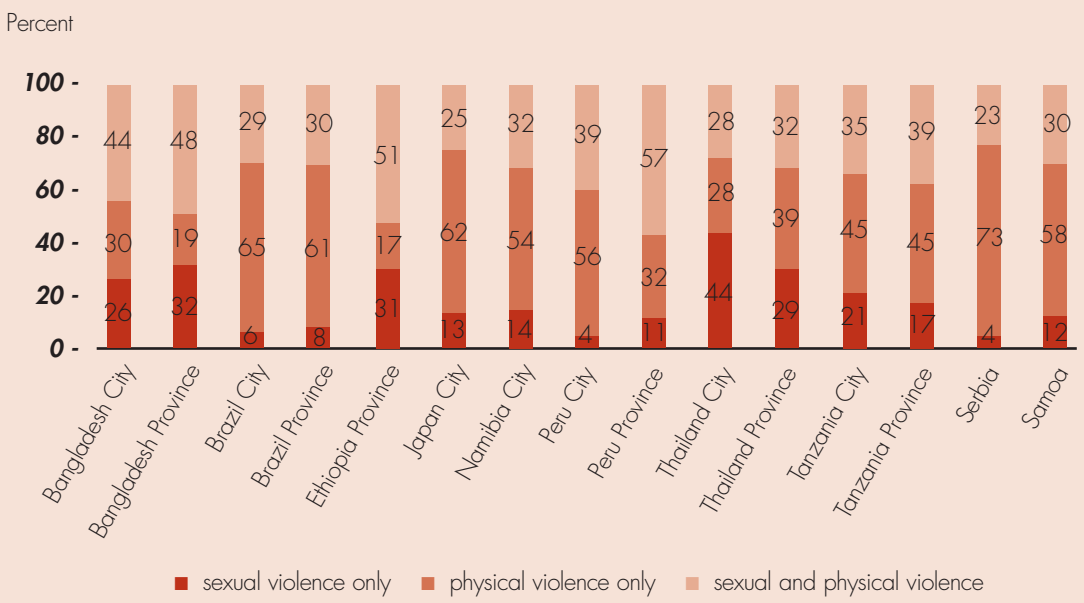
many relationships. Figure 1.3 summarizes the proportion of women who have experienced violence by an intimate partner among ever-partnered women aged 15 to 49 in the various sites included in the study. The first bar portrays the percentage of women in each setting who have experienced physical violence by a partner; the second bar portrays sexual violence by a partner; and the third bar represents the percentage of ever-partnered women who have experienced either physical and/or sexual violence by a partner in their lifetime.

Until recently, it was believed that few women exclusively experienced sexual violence by an intimate partner. Available studies from North and Central America had indicated that sexual violence was generally accompanied by physical abuse and by emotional violence and controlling behaviors.[2]

The findings from the WHO VAW Study suggest that, although this pattern is maintained in many countries, a few sites demonstrate a significant departure. In both the capital and province of Thailand, a substantial portion of women who experience partner violence, experience sexual violence only (Figure 1.4). In Bangkok, 44 percent of all cases of lifetime partner violence have experienced only sexual violence. The corresponding statistic in the Thai province is 29 percent of cases. A similarly high percentage of cases of violence in Bangladesh province (32 percent) and Ethiopia province (31 percent) involve sexual violence only.

These results speak to the importance of developing a broader international research base on violence against women. Insights derived exclusively from the North American literature may not reflect the reality of women's experiences in other settings.

FIGURE 1.4 INTIMATE PARTNER VIOLENCE ACCORDING TO TYPES OF VIOLENCE (AMONG EVER-ABUSED WOMEN)



(From WHO, 2005.[20])

PREVALENCE AND CHARACTERISTICS OF SEXUAL COERCION AND ABUSE

For many women and girls, sexual coercion and abuse are defining features of their lives. Forced sexual contact can take place at any time in a woman's life and includes a range of behaviors, from forcible rape to nonphysical forms of pressure that compel girls and women to engage in sex against their will. The touchstone of coercion is that a woman lacks choice and faces severe physical, social, or economic consequences if she resists sexual advances.

Studies indicate that the majority of nonconsensual sex takes place among individuals who know each other—spouses, family members, dating partners, or acquaintances.[86, 87] In fact, much nonconsensual sex takes place within consensual unions and includes a woman being compelled to have sex when she does not want it, or to engage in types of sexual activity that she finds degrading or humiliating.[1, 88, 89]

Much sexual coercion also takes place against children and adolescents in both industrial and developing countries. Between one-third and two-thirds of known sexual assault victims are age 15 or younger, according to justice system statistics and information from rape crisis centers in Chile, Peru, Malaysia, Mexico, Panama, Papua New Guinea, and the United States.[2]

Sexual exploitation of children is widespread in virtually all societies. Child sexual abuse refers to any sexual act that occurs between an adult or older adolescent and a child, and any nonconsensual sexual contact between a child and a peer. Laws generally consider the issue of consent to be irrelevant in cases of sexual contact by an adult with a child, defined variously as someone under 13, 14, 15, or 16 years of age.

Because of the taboo nature of the topic, it is difficult to collect reliable figures on the prevalence of sexual abuse in childhood. Nonetheless, the few representative sample surveys provide cause for concern.

A review of 25 studies worldwide indicates that 0 to 32 percent of women report that they experienced sexual abuse in childhood (see Table 1.2). Although both girls and boys can be victims of sexual abuse, most studies report that the prevalence of abuse among girls is at least 1.5 to 3 times higher than among boys.[90] Abuse among boys may be underreported compared with abuse among girls, however.

Further data reveal that coercion may be an element in many young girls' initiation into sexual life. An increasing number of studies have begun to document that a substantial number of young women's first sexual experiences are forced or unwanted, especially among younger adolescents. Table 1.3 summarizes data from a number of population-based surveys on the prevalence of forced first sex, including data emerging from the WHO VAW Study. A plethora of studies now confirm that the younger a girl is when she first has sex, the more likely she is to report her sexual debut as forced.[91]

Trafficking in women and girls for forced labor and sexual exploitation is another type of gender-based violence that has grown rapidly during the past decade, largely as a result of war, displacement, and economic and social inequities between and within countries. Although reliable statistics on the number of women and children who are trafficked are lacking, rough estimates suggest that from 700,000 to 2 million women and girls are trafficked across international borders every year.[6, 92, 93] These women face many risks, including physical violence and rape, both in their work and when trying to negotiate safer-sex practices.

Another aspect of gender-based violence that has been largely overlooked until recently is violence against women in situations of armed conflict. Recent reports have documented systematic rape in many conflicts, including the former Yugoslavia, Rwanda, Liberia, Sierra Leone, and Uganda.[94-96] These reports have highlighted the extent to which rape has been used as a deliberate strategy to "destabilize population, advance ethnic cleansing, express hatred for the enemy or supply combatants with sexual services."[96] In 2002, the International Criminal Tribunal in The Hague recognized the seriousness of sexual offences in war as a crime against humanity. International relief agencies are also calling attention to the precarious situation of women in refugee settings where rape, child sexual abuse, intimate partner violence, and other forms of sexual exploitation are widespread.

THE EFFECTS OF VIOLENCE ON WOMEN'S HEALTH

Gender-based violence is associated with serious health problems affecting both women and children, including injuries, gynecological disorders, mental health disorders, adverse pregnancy outcomes, and sexually transmitted infections (STIs) (Figure 1.5). Violence can have *direct* consequences for women's health, and it can increase women's risk of *future* ill health. Therefore, victimization, like tobacco or alcohol use, can best be conceptualized as a risk factor for a variety of diseases and conditions, rather than primarily as a health problem in and of itself.[2, 4]

Both population-based research and studies of emergency room visits in the United States indicate that physical abuse is an important cause of injury among women.[97] Documented injuries sustained from such physical abuse include contusions, concussions, lacerations, fractures, and gunshot wounds. Population-based studies indicate that 40 to 75 percent of women who are physically abused by a partner report injuries due to violence at some point in their life.[2]

Nevertheless, injury is not the most

TABLE 1.2 PREVALENCE OF CHILD SEXUAL ABUSE: SELECTED STUDIES, 1990–2003

Country & Year (Ref. No.)	*Study Method & Sample*	*Definition of Child Sexual Abuse*	*Prevalence*
Australia 1997 [98]	■ Retrospective study of 710 women	■ Sexual contact before the age of 12 with perpetrator 5+ years older; or unwanted sexual activity at ages 12-16	■ 20% of women report abuse
Bangladesh 2002 [20]	■ Population-based survey of women ages 15–49 (Dhaka 1602, Matlab 1527)	■ Unwanted sexual activity, contact and noncontact before the age of 15	■ In Dhaka 7% of women; in Matlab 1% of women report abuse
Barbados 1993 [99]	■ National random sample of 264 women	■ Sexual contact that is unwanted or with a biological relative; or before the age of 16 with perpetrator 5+ years older	■ 30% of women report abuse
Brazil 2002 [20]	■ Population-based survey of women ages 15–49 (Sao Paulo 1172, Pernambuco 1473)	■ Unwanted sexual activity, contact and noncontact before the age of 15	■ In Sao Paulo 8% of women; in Pernambuco 6% of women report abuse
Canada 1990 [100]	■ Population survey of 9953 men and women age 15+	■ Unwanted sexual activity, contact and noncontact, while growing up	■ 13% of women, 4% of men report abuse
Costa Rica 1992 [101]	■ Retrospective survey of university students	■ Unwanted sexual activity, contact and noncontact; no ages specified	■ 32% of women, 13% of men report abuse
Ethiopia 2002 [20]	■ Population-based survey of 3014 women ages 15–49	■ Unwanted sexual activity, contact and noncontact before the age of 15	■ 0.2% of women report abuse
Germany 1992 [102]	■ Multiple-screen questionnaire answered by 2,151 students in Würzburg and Leipzig	■ Distressing sexual activity, contact and noncontact, before the age of 14; or with perpetrator 5+ years older	■ In Würzburg 16% of girls, 6% boys; in Leipzig 10% of girls, 6% of boys report abuse
Japan 2002 [20]	■ Population-based survey of 1361 women ages 15–49	■ Unwanted sexual activity, contact and noncontact before the age of 15	■ 10% of women report abuse
Malaysia 1996 [103]	■ Retrospective self-administered questionnaire answered by 616 paramedical students	■ Vaginal or anal penetration, or unsolicited sexual contact, or witnessing exhibitionism before the age of 18	■ 8% of women, 2% of men report abuse
Namibia 2002 [20]	■ Population-based survey of 1492 women ages 15–49	■ Unwanted sexual activity, contact and noncontact before the age of 15	■ 5% of women report abuse
New Zealand 1997 [104]	■ Birth cohort of 520 girls, studied from birth to age 18	■ Unwanted sexual activity, contact and noncontact, before the age of 16	■ 14% of girls report contact abuse; 17% report any abuse
Nicaragua 1997 [105]	■ Anonymous self-administered questionnaire answered by 134 men and 202 women ages 25–44 drawn from population-based sample	■ Sexual contact, including attempted penetration, before the age of 13 with perpetrator 5+ years older; or nonconsensual activity over the age of 12	■ 26% of women, 20% of men report abuse
Norway (Oslo) 1996 [106]	■ Population-based sample of 465 adolescents, ages 13–19, followed for 6 years	■ Sexual contact, including "intercourse after pressure," occurring between a child before the age of 13 and an adult over the age of 17; or involving force	■ 17% of girls, 1% of boys report abuse

TABLE 1.2 PREVALENCE OF CHILD SEXUAL ABUSE: SELECTED STUDIES, 1990–2003

Country & Year (Ref. No.)	*Study Method & Sample*	*Definition of Child Sexual Abuse*	*Prevalence*
Peru 2002 [20]	■ Population-based survey of women ages 15–49 (Lima 1414, Cusco 1837)	■ Unwanted sexual activity, contact and noncontact before the age of 15.	■ In Lima 20% of women; in Cusco 8% of women report abuse
Samoa 2000 [20]	■ Population-based survey of 1640 women ages 15–49	■ Unwanted sexual activity, contact and noncontact before the age of 15.	■ 2% of women report abuse
Serbia & Montenegro 2003 [20]	■ Population-based survey of 1453 women ages 15–49	■ Unwanted sexual activity, contact and noncontact before the age of 15.	■ 2% of women report abuse
Spain 1995 [107]	■ Face-to-face interviews and self-administered questionnaires answered by 895 adults ages 18–60	■ Unwanted sexual activity, contact and noncontact before the age of 17.	■ 22% of women and 15% of men report abuse
Switzerland (Geneva) 1996 [108]	■ Self-administered questionnaire answered by 1193 9th grade students	■ Unwanted sexual activity, contact and noncontact.	■ 20% of girls, 3% of boys report contact abuse; 34% of girls, 11% of boys report any abuse
Switzerland (National) 1998 [109]	■ National survey of 3993 girls, ages 15–20, enrolled in schools or professional training programs	■ "Sexual victimization," defined as "when someone in your family, or someone else, touches you in a place you didn't want to be touched, or does something to you sexually which they shouldn't have done."	■ 19% of girls report abuse
Thailand 2002 [20]	■ Population-based survey of women ages 15–49 (Bangkok 1534, Nakhonsawan 1280)	■ Unwanted sexual activity, contact and noncontact before the age of 15.	■ In Bangkok 7.6% of women; in Nakhonsawan 4.7% of women report abuse
Tanzania 2002 [20]	■ Population-based survey of women ages 15–49 (Dar es Salaam 1816, Mbeya 1443)	■ Unwanted sexual activity, contact and noncontact before the age of 15.	■ In Dar es Salaam 4% of women; in Mbeya 4% of women report abuse
United States 1997 [110]	■ National 10-year longitudinal study of women's drinking that included questions about sexual abuse, answered by 1099 women	■ Unwanted sexual activity, contact and noncontact, before the age of 18; or before the age of 13 with perpetrator 5+ years older.	■ 21% of women report abuse
United States (Midwest) 1997 [111]	■ Self-administered questionnaire answered by 42,568 students in grades 7–12	■ "Sexual abuse," defined as "when someone in your family or another person does sexual things to you or makes you do sexual things to them that you don't want to do."	■ 12% of girls, 4% of boys report abuse
United States (Washington State) 1997 [112]	■ Multiple-choice survey of 3128 girls in grades 8,10 and 12	■ "Sexual abuse," defined as "when someone in your family or someone else touches you in a sexual way in a place you didn't want to be touched, or does something to you sexually which they shouldn't have done."	■ 23% of all girls; 18% of 8th graders, 24% of 10th graders, 28% of 12th graders report abuse

(Updated and adapted from Heise et al, 1999[2] and WHO, 2002.[1])

TABLE 1.3 PERCENTAGE OF MEN AND WOMEN REPORTING FORCED SEXUAL INITIATION: SELECTED POPULATION-BASED SURVEYS, 1993—2003

Country or Area	*Study Population*	*Year*	*Sample Size*	*Age Group (years)*	*Percentage reporting first sexual intercourse as forced*	
					Females	*Males*
Bangladesh	Dhaka	2002	1369	15–49	24	
Bangladesh	Matlab	2002	1326	15–49	30	
Brazil	Sao Paulo	2002	1051	15–49	3	
Brazil	Pernambuco	2002	1234	15–49	4	
Cameroon	Bamenda	1995	646	12–25	37	30
Caribbean	Nine countries	1997–1998	15,695	10–18	48	32
Ethiopia	Gurage	2002	2238	15–49	17	
Ghana	Three urban towns	1996	750	12–24	21	5
Japan	Yokohama	2002	1116	15–49	0	
Mozambique	Maputo	1999	1659	13–18	19	7
Namibia	Windhoek	2002	1357	15–49	2	
New Zealand	Dunedin	1993–1994	935	Birth cohort	7	0
Peru	Lima	1995	611	16–17	40	11
Peru	Lima	2002	1103	15–49	7	
Peru	Cusco	2002	1557	15–49	24	
Samoa	National	2002	1317	15–49	8	
Serbia & Montenegro	Belgrade	2002	1310	15–49	1	
South Africa	Transkei	1994–1995	1975	15–18	28	6
Tanzania	Dar es Salaam	2002	1556	15–49	14	
Tanzania	Mbeya	2002	1287	15–49	17	
Tanzania	Mwanza	1996	892	12–19	29	7
Thailand	Bangkok	2002	1051	15–49	4	
Thailand	Nakhonsawan	2002	1028	15–49	5	
United States	National	1995	2042	15–24	9	—

(From World Health Organization, 2002[1], 2005.[20])

common physical health outcome of gender-based abuse. More common are "functional disorders"—ailments that frequently have no identifiable cause, such as irritable bowel syndrome; gastrointestinal disorders; and various chronic pain syndromes, including chronic pelvic pain. Studies consistently link such disorders with a history of physical or sexual abuse. Women who have been abused also tend to experience poorer physical functioning, more physical symptoms, and more days in bed than do women who have not been abused.[113-116]

For many women, the psychological consequences of abuse are even more serious than its physical effects. The experience of abuse often erodes women's self-esteem and puts them at greater risk of a variety of mental health problems, including depression, anxiety, phobias, post-traumatic stress disorder, and alcohol and drug abuse.[2]

Violence and sexual abuse also lie behind some of the most intractable

reproductive health issues of our times—unwanted pregnancies, HIV and other STIs, and complications of pregnancy. Physical violence and sexual abuse can put women at risk of infection and unwanted pregnancies *directly*, if women are forced to have sex, for example, or if they fear using contraception or condoms because of their partner's reaction. A history of sexual abuse in childhood also can lead to unwanted pregnancies and STIs *indirectly* by increasing sexual risk-taking in adolescence and adulthood. There is a growing body of research indicating that violence may increase women's susceptibility to HIV infection.[117-120] Studies carried out in Tanzania and South Africa found that seropositive women were more likely than their seronegative peers to report physical partner abuse. The results indicate that women with violent or controlling male partners are at increased risk of HIV infection. There is little information as yet to indicate how violence increases women's risk for HIV. Dunkle and colleagues suggest that abusive men are more likely to have HIV and impose risky sexual practices on their partners. There are also indications that disclosure of HIV status may put women at risk for violence.[118]

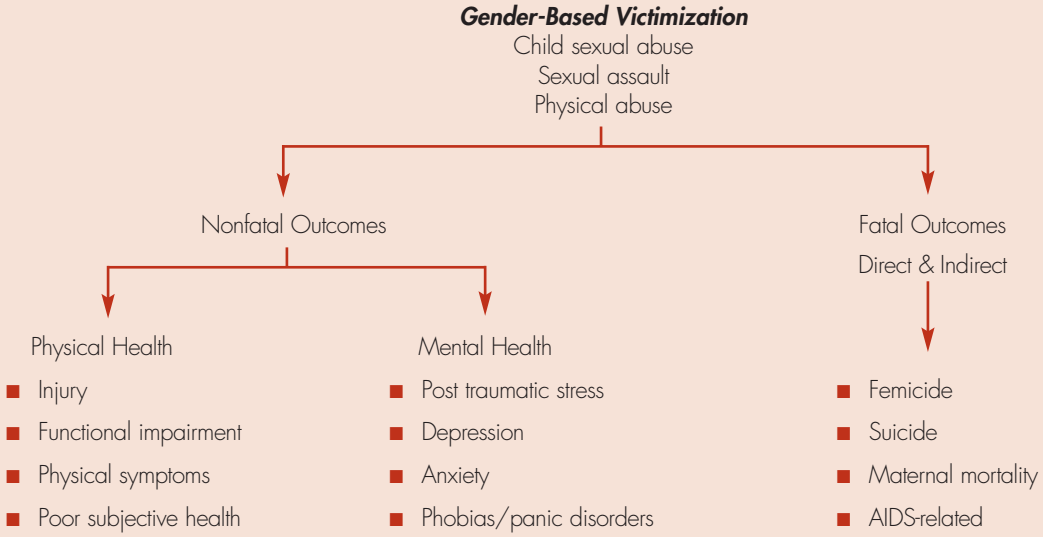
Violence can also be a risk factor during pregnancy. Studies from around the world demonstrate that violence during pregnancy is not a rare phenomenon. Within the United States, for example, between 1 percent and 20 percent of currently pregnant women report physical violence, with the majority of findings between 4 percent and 8 percent.[5] The differences are due partly to differences in the way women were asked about violence.[3, 5, 121, 122] A recent review found that the prevalence of abuse during pregnancy is 3 to 11 percent in industrialized countries outside of North America and between 4 and 32 percent in developing countries, including studies from China, Egypt, Ethiopia, Mexico, India, Nicaragua, Pakistan, Saudi Arabia, and South Africa.[3]

Violence during pregnancy can have serious health consequences for women and their children.[2] Documented effects include delayed prenatal care, inadequate weight gain, increased smoking and substance abuse, STIs, vaginal and cervical infections, kidney infections, miscarriages and abortions, premature labor, fetal distress, and bleeding during pregnancy.[4]

Recent research has focused on the relationship between violence in pregnancy and low birth weight, a leading cause of infant deaths in the developing world. Although research is still emerging, findings of six different studies performed in the United States, Mexico, and Nicaragua suggest that violence during pregnancy contributes to low birth weight, pre-term delivery, and to fetal growth retardation, at least in some settings.[121, 123] A recent meta analysis of existing studies confirms that intimate partner violence during pregnancy is indeed associated with a significant, albeit small, reduction in birth weight.[124]

In its most extreme form, violence kills women. Worldwide, an estimated 40 to more than 70 percent of homicides of women are perpetrated by intimate partners, frequently in the context of an abusive relationship.[125] By contrast, only a small percentage of men who are murdered are killed by their female partners, and in many such cases, the women are defending themselves or retaliating against abusive men.[126] A study of female homicide in South Africa found that intimate femicide (female murder by an intimate partner) accounted for 41 percent of all female homicides. This study estimated that a woman is killed by her intimate partner in South Africa every six hours.[127] Violence is also a significant risk factor for suicide. Studies in numerous countries have found that women who have suffered domestic

FIGURE 1.5 HEALTH OUTCOMES OF VIOLENCE AGAINST WOMEN



Injurious Health Behaviors

- Smoking
- Alcohol and drug use
- Sexual risk-taking
- Physical inactivity
- Overeating

Functional Disorders

- Chronic pain syndromes
- Irritable bowel syndrome
- Gastrointestinal disorders
- Somatic complaints
- Fibromyalgia

Reproductive Health

- Unwanted pregnancy
- STIs/HIV
- Gynecological disorders
- Unsafe abortion
- Pregnancy complications
- Miscarriage/low birth weight
- Pelvic inflammatory disease

(From Heise et al, 1999.[2])

violence or sexual assault are much more likely to have had suicidal thoughts, or to have attempted to kill themselves.[19]

EXPLAINING GENDER-BASED VIOLENCE

Violence against women is widespread, but it is not universal. Anthropologists have documented small-scale societies—such as the Wape of Papua New Guinea—where domestic violence is virtually absent.[128, 129] This reality stands as testament to the fact that social relations can be organized to minimize abuse.

Why is violence more widespread in some places than in others? Increasingly, researchers are using an "ecological framework" to understand the interplay of personal, situational, and socio-cultural factors that combine to cause abuse.[21, 130-133] In this framework, violence against women results from the interaction of factors at different levels of the social environment (Figure 1.6).

The framework can best be visualized as four concentric circles. The innermost circle represents the biological and personal history that each individual brings to his or her behavior in relationships. The second circle represents the immediate context in which abuse takes place: frequently the family or other intimate or acquaintance relationship. The third circle represents the institutions and social structures, both formal and informal, in which relationships are embedded, such as neighborhoods, the workplace, social networks, and peer groups. The fourth, outermost circle is the economic and social environment, including cultural norms.

A wide range of studies shows that several factors at each of these levels increase the likelihood that a man will abuse his partner:

- **At the individual level**, the male was abused as a child or witnessed marital violence in the home, had an absent or rejecting father, or frequently uses alcohol. A recent review of nationally representative surveys in nine countries found that for women, low educational attainment, being under 25 years of age, having witnessed her father's violence against her mother, living in an urban area, and low socio-economic status were consistently associated with an increased risk of abuse.[24]

- **At the level of the family and relationship**, the male controls wealth and decision making within the family and marital conflict is frequent.

- **At the community level**, women are isolated with reduced mobility and lack of social support. Male peer groups condone and legitimize men's violence.

- **At the societal level**, gender roles are rigidly defined and enforced and the concept of masculinity is linked to toughness, male honor, or dominance. The prevailing culture tolerates physical punishment of women and children, accepts violence as a means to settle interpersonal disputes, and perpetuates the notion that men "own" women.

The ecological framework combines individual level risk factors with family, community, and society level factors identified through cross cultural studies, and helps explain why some societies and some individuals are more violent than others, and why women, especially wives, are so much more likely to be the victims of violence within the family. Other factors combine to protect some women. For example, women who have authority and power outside the family tend to experience lower levels of abuse in intimate partnerships. Likewise, when family members and friends intervene promptly, they

appear to reduce the likelihood of domestic violence. In contrast, wives are more frequently abused in cultures where family affairs are considered "private" and outside public scrutiny.

Justifications for violence frequently evolve from gender norms, that is, social norms about the proper roles and responsibilities of men and women. Many cultures hold that a man has the right to control his wife's behavior and that women who challenge that right—even by asking for household money or by expressing the needs of the children—may be punished. In countries as different as Bangladesh, Cambodia, India, Mexico, Nigeria, Pakistan, Papua New Guinea, Nicaragua, Tanzania, and Zimbabwe, studies find that violence is frequently viewed as physical chastisement—the husband's right to "correct" an erring wife.[2] As one husband said in a focus group discussion in Tamil Nadu, India, "If it is a great mistake, then the husband is justified in beating his wife. Why not? A cow will not be obedient without beatings."[134]

Worldwide, studies identify a consistent list of events that are said to "trigger" violence.[130] These include: not obeying the husband, talking back, not having food ready on time, failing to care adequately for the children or home, questioning him about money or girlfriends, going somewhere without his permission, refusing him sex, or expressing suspicions of infidelity. All of these represent transgressions of dominant gender norms in many societies.

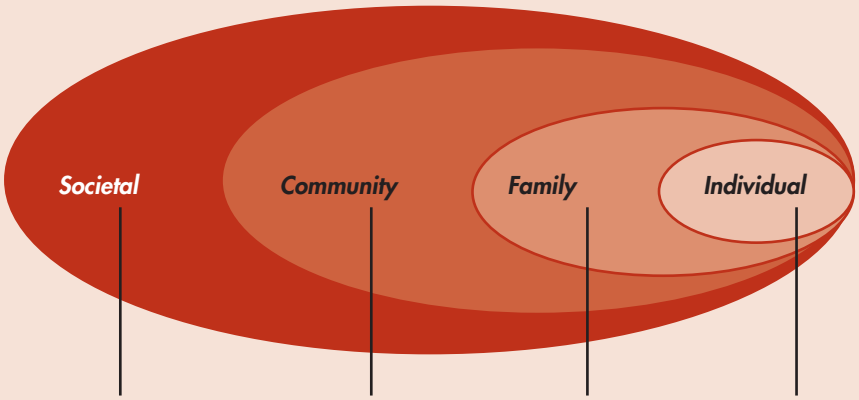
Although the ecological framework has gained broad acceptance for conceptualizing violence, there have been few attempts to explore how individual and community level risk factors relate to each other and ultimately influence women's vulnerability to violence. One study performed in the United States found that the socio-economic status of the neighborhood had a greater impact on the risk of violence than individual household income levels.[135] A study in Bangladesh found that some aspects of women's status could either increase or decrease a woman's risk of being beaten, depending on the socio-cultural conditions of the community she lives in. In one site, characterized by more conservative norms regarding women's roles and status, women with greater personal autonomy and those who participated for a short time in savings and credit groups experienced more violence than women with less autonomy. Community-level measures of women's status had no effect on the risk of violence.

The opposite was true in the less conservative setting where women had better overall status. In this site, individual measures of autonomy and participation in credit schemes had no impact on the risk of violence, whereas living in a community where more women participated in credit groups and where women had a higher status overall had a protective effect. These findings suggest that the same condition (mobility or participating in a credit group) may have completely different effects on a woman's risk of violence, according to whether the activity is seen as acceptable by community norms. These findings underscore the complexity of these issues and the dangers in applying knowledge gained from one site to another without understanding of the broader cultural context.[136]

HOW DO WOMEN RESPOND TO ABUSE?

Most abused women are not passive victims, but use active strategies to maximize their safety and that of their children. Some women resist, others flee, and still others attempt to keep the peace by capitulating to their husband's demands. What may seem to an observer to be lack of response to living with violence may in fact be a woman's strategic assessment of

FIGURE 1.6. AN ECOLOGICAL FRAMEWORK FOR EXPLAINING GENDER-BASED VIOLENCE



- Norms and laws granting men control over female behavior
- Violence accepted for resolving conflict
- Masculinity linked to dominance, honor or agression

- Isolation of women and family
- Delinquent peer groups
- Low socio - economic status

- Marital conflict
- Male control of wealth and decision making in the family
- Poverty
- Unemployment

- Being male
- Witnessing marital conflict as a child
- Absent or rejecting father
- Being abused as a child
- Alcohol use

(From Heise, 1998.[130])

what it takes to survive and to protect herself and her children.

A woman's response to abuse is often limited by the options available to her. Women consistently cite similar reasons for remaining in abusive relationships: fear of retribution, lack of other means of economic support, concern for the children, emotional dependence, lack of support from family and friends, and an abiding hope that "he will change." In some countries, women say that the social unacceptability of being single or divorced poses an additional barrier that keeps them from leaving destructive marriages.[2]

At the same time, denial and fear of social stigma often prevent women from reaching out for help. In numerous surveys, for example, from 22 to almost 70 percent of abused women say that until the interview they never told anyone about their abuse. Those who reach out do so primarily to family members and friends. Few have ever contacted the police.[1, 20]

Despite the obstacles, many women eventually do leave violent partners—even if after many years. In a study in León, Nicaragua, for example, 70 percent of abused women eventually left their abusers. The median time that women spent in a violent relationship was six years. Younger women were likely to leave sooner than older women.[137]

Studies suggest a consistent set of factors that propel a woman to leave an abusive relationship: The violence gets more severe and triggers a realization that her partner is not going to change, or the violence begins to take a toll on the children. Women also cite emotional and logistical support from family or friends as pivotal in their decision to leave.[2]

Leaving an abusive relationship is a multistage process. The process often includes periods of denial, self-blame, and endurance before women recognize the abuse as a pattern and identify with other women in the same situation, thereby beginning to

disengage and recover. Most women leave and return several times before they finally leave once and for all.[138] Leaving does not necessarily guarantee a woman's safety, however, because violence may continue even after a woman leaves. In fact, a woman's risk of being murdered by her abuser is often greatest immediately after separation.[139]

CHALLENGES FOR INTERNATIONAL RESEARCH ON GENDER-BASED VIOLENCE

Nearly 30 years of groundbreaking research in the field of gender-based violence has greatly expanded international awareness of the dimensions and dynamics of violence. However, there are still many gaps in our current state of knowledge. Researchers interested in gender-based violence from a public health perspective face a number of important challenges.

- **The scarcity of population-based data limits our understanding of how violence affects different groups of women.** Until very recently, the majority of research was been carried out with nonrepresentative samples of women, often those who have attended shelters or other services for victims. Although these studies are useful for understanding the dynamics of abuse, they do not tell us how many women overall are affected, nor provide information about individuals who do not seek services. According to most estimates, these women greatly outnumber those who seek help.

- **Most international prevalence figures on violence are not comparable.** This is due mainly to inconsistencies in the way that violence is conceptualized and measured. Researchers need to develop consensus around violence research methods that allow us to make meaningful comparisons between studies. Methodological consistency refers not only to defining violence using similar criteria, but also the use of measures to minimize underreporting of violence, such as ensuring privacy during the interview and providing interviewers with special training on violence.[139]

- **Research on violence may put women at risk.** Many researchers point out that research on violence involves a number of inherent risks to both respondents and interviewers.[140] The World Health Organization has developed a set of guidelines to minimize the risk of harm to researchers and participants.[141] However, these guidelines are just now being incorporated more widely into international research practice.

- **More public health research is needed to understand how violence affects the health of women and children in different settings.** Studies of battered women consistently demonstrate the negative impact of abuse on women's psychological status and reproductive health, and emerging epidemiological studies indicate that violence towards mothers may even affect infant birth weight and survival. However, more research is needed to determine what proportion of women's overall mental and physical health problems is associated with violence and to investigate the mechanisms through which violence affects health.

- **More cross-cultural research is needed to reveal how societal norms and institutions promote or discourage violent behavior.** Most researchers agree that cultural norms can greatly affect the extent and characteristics of

violence, as well as the way that specific acts are interpreted in different societies. Nonetheless, there have been few systematic attempts to compare these issues in different settings. Most theories about the dynamics of abuse have been based on the experiences of US and European women, and it is unclear how relevant these are to women from other cultures.

- **Research evaluating different approaches to violence prevention is scarce.** Although there has been an enormous increase in both community and clinic-based programs to prevent violence and to support abused women and girls, few programs have been systematically documented or evaluated. For example, many activists and professional associations in the United States currently encourage health providers to ask each woman at every visit whether she has been abused. However, there is little information about what happens to women after disclosing violence, or whether asking women is an effective tool for enhancing women's safety. In particular, we need to develop criteria for assessing whether practices that are effective in one setting are likely to be relevant or feasible in another, very different setting.

The greatest challenge facing researchers in the field of violence is to learn from past mistakes, to identify "best practices," and to find out what makes them successful so that we can channel resources and efforts where they are most likely to make a difference.

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Ethical Considerations for Researching Violence Against Women*

Topics covered in this chapter:

Respect for persons at all stages of the research process
Minimizing harm to respondents and research staff
Maximizing benefits to participants and communities (beneficence)
Justice: Balancing risks and benefits of research on violence against women

[The experience] that most affected me was with a girl my age, maybe 22 years old...She told me all about how her husband beat her while she was washing clothes in the back patio. Her mother-in-law would spy on her and tell her son things so that he would punish her. She was very afraid, and her voice trembled as she spoke, but she really wanted to tell me about her tragedy. She kept looking over to where her mother-in-law was watching us. She asked me for help and I told her about the Women's Police Station. When her mother-in-law got up to go to the latrine, I quickly gave her a copy of the pamphlet and she hid it. She thanked me when I left and I ended up crying in the street because I couldn't stand to see such a young girl being so mistreated… Nicaraguan interviewer. (Ellsberg et al, 2001.[19])

In many ways, researching violence against women is similar to researching other sensitive topics. There are issues of confidentiality, problems of disclosure, and the need to ensure adequate and informed consent. As the previous quote from an interviewer illustrates, however, there are aspects of gender-based violence research that transcend those in other areas because of the potentially threatening and traumatic nature of the subject matter. In the case of violence, the safety and even the lives of women respondents and interviewers may be at risk.[1]

In 1991, the Council for International Organization of Medical Sciences (CIOMS)

* This chapter was adapted from Ellsberg and Heise, 2002.[1]

presented a set of International Guidelines for Ethical Review of Epidemiological Studies.[3] These guidelines apply the basic ethical principles of biomedical research involving human subjects to the field of epidemiology: respect for persons, non-maleficence (minimizing harm), beneficence (maximizing benefits), and justice. In 1999, the World Health Organization (WHO) published guidelines for addressing ethical and safety issues in gender-based violence research.[4] The guidelines were based on the experiences of the International Research Network on Violence Against Women (IRNVAW) and were designed to inform the *WHO Multi-country Study on Women's Health and Domestic Violence Against Women*. (See Box 2.1 for a description of the main points.) The authors argue that these ethical guidelines are critical, not only to protecting the safety of respondents and researchers, but also to ensuring data quality.

This chapter examines each of the basic principles mentioned in the CIOMS guidelines in turn and explores the challenges of applying them to the special case of conducting research on domestic and sexual violence.

BOX 2.1 ETHICAL AND SAFETY RECOMMENDATIONS FOR DOMESTIC VIOLENCE RESEARCH

- The safety of respondents and the research team is paramount and should infuse all project decisions.
- Prevalence studies need to be methodologically sound and to build upon current research experience about how to minimize the underreporting of abuse.
- Protecting confidentiality is essential to ensure both women's safety and data quality.
- All research team members should be carefully selected and receive specialized training and ongoing support.
- The study design must include a number of actions aimed at reducing any possible distress caused to the participants by the research.
- Fieldworkers should be trained to refer women requesting assistance to available sources of support. Where few resources exist, it may be necessary for the study to create short-term support mechanisms.
- Researchers and donors have an ethical obligation to help ensure that their findings are properly interpreted and used to advance policy and intervention development.
- Violence questions should be incorporated into surveys designed for other purposes only when ethical and methodological requirements can be met.

(From WHO, 1999.[4])

RESPECT FOR PERSONS AT ALL STAGES OF THE RESEARCH PROCESS

Informed consent for respondents

The principle of respect for persons incorporates two fundamental ethical principles: respect for autonomy and protection of vulnerable persons. These are commonly addressed by individual informed consent procedures that ensure that respondents understand the purpose of the research and that their participation is voluntary.

There is still no consensus on whether the informed consent process for VAW studies should explicitly acknowledge that the study will include questions on violence or whether it is sufficient to warn participants that sensitive topics will be raised. The WHO VAW study used an oral consent process that referred to the survey as a study on women's health and life experiences.[5] Women were advised that, "Some of the topics discussed may be personal and difficult to talk about, but many women have found it useful to have the opportunity to talk." Women were told that they could end the interview at any time or skip any question they did not want to answer. (See Box 2.3 for an example of the informed consent form used in the WHO VAW study.) A more detailed explanation of the nature of the questions on violence was provided directly before the violence questions, and respondents were asked whether they wanted to continue and were again reminded of their option not to answer. It is a good idea to prepare a list of responses for questions that a woman might ask about the study, such as how she was selected for the study, what will the study be used for, and how her responses will be kept secret.

BOX 2.2 ADAPTING ETHICAL GUIDELINES TO LOCAL SETTINGS

Researchers involved in the *WHO Multi-country Study on Women's Health and Domestic Violence Against Women* debated at length the value of mentioning violence directly in the initial consent process versus adding a second-order consent process immediately before the questions on abuse. Some researchers argued that it was important to alert women up front as to the true nature of the questions whereas others felt it was preferable to postpone introducing the notion of violence until immediately prior to the actual abuse-related questions. This would allow some rapport to develop, but still give a woman an opportunity to opt out of the violence-related questions.

The consent process was well received by respondents in all countries except Japan. During pilot testing, several Japanese respondents expressed a sense of betrayal because they had not been informed that the interview contained questions about violence.[6] As a result, the Japan team modified its consent language to explicitly acknowledge violence up front. This is an excellent example of how ethical principles and actual experience can combine to guide practice.

BOX 2.3 INDIVIDUAL CONSENT FORM

Used in the *WHO Multi-country Study on Women's Health and Domestic Violence Against Women*

Hello, my name is [*]. I work for [*]. We are conducting a survey in [study location] to learn about women's health and life experiences. You have been chosen by chance (as in a lottery/raffle) to participate in the study.

I want to assure you that all of your answers will be kept strictly secret. I will not keep a record of your name or address. You have the right to stop the interview at any time, or to skip any questions that you don't want to answer. There are no right or wrong answers. Some of the topics may be difficult to discuss, but many women have found it useful to have the opportunity to talk.

Your participation is completely voluntary but your experiences could be very helpful to other women in [country].

Do you have any questions?

(The interview takes approximately [*] minutes to complete). Do you agree to be interviewed?

NOTE WHETHER RESPONDENT AGREES TO INTERVIEW.

[ ] DOES NOT AGREE TO BE INTERVIEWED

THANK PARTICIPANT FOR HER TIME AND END INTERACTION.

[ ] AGREES TO BE INTERVIEWED.

Is now a good time to talk?

It's very important that we talk in private. Is this a good place to hold the interview, or is there somewhere else that you would like to go?

TO BE COMPLETED BY INTERVIEWER

I CERTIFY THAT I HAVE READ THE ABOVE CONSENT PROCEDURE TO THE PARTICIPANT.

SIGNED: _____

(From WHO, 2004.[5])

Mandatory reporting of abuse

Some countries have laws that require certain kinds of professionals to report cases of suspected abuse to authorities or social service agencies. Such laws raise difficult issues for researchers because they throw into conflict several key ethical principles: respect for confidentiality, the need to protect vulnerable populations, and respect for autonomy. In the case of adult women, there is consensus among most researchers that the principles of autonomy and confidentiality should prevail and that researchers should do everything within their power to avoid usurping a woman's right to make autonomous decisions about her life. (Of course if a woman seeks support in reporting her abuse, researchers should oblige.)

The dilemma of whether to comply with legal reporting requirements is particularly problematic when dealing with child abuse. There is no consensus internationally about how to handle cases of child abuse because children are generally considered more vulnerable and less able to act on their own behalf. The dilemma is particularly acute in settings where there are no effective services to assist troubled families, or where reporting is likely to trigger a cascade of events that might put the child at even greater risk (such as being removed from his/her home and placed in an institution). The WHO VAW study specifically excluded questions about child abuse, but required teams to develop local protocols

for handling cases of child abuse that interviewers might nonetheless come to know about. The guiding principle of these protocols was to act in "the best interests of the child," a standard that each team operationalized locally, based on advice from key agencies about prevailing conditions.

Community agreement

In many countries, it is also important to obtain community support for research, as well as individual consent. (Community consent, however, should never replace individual consent.) This is often sought by meeting with community leaders to explain the overall objectives of the research. For safety reasons, when obtaining community support for VAW research, it is important to frame the study in general terms—such as a study on women's health or life experiences rather than mention violence or abuse directly. If it becomes well known in the community that women are being questioned about violence, men may prohibit their partners from participating or may retaliate against them for their participation. In addition to potentially jeopardizing the safety of respondents, this could also undermine the study objectives and data accuracy.

MINIMIZING HARM TO RESPONDENTS AND RESEARCH STAFF

Ensuring participant safety

The primary ethical concern related to researching VAW is the potential for inflicting harm to respondents through their participation in the study. A respondent may suffer physical harm if a partner finds out that she has been talking to others about her relationship with him. Because many violent partners control the actions of their spouses closely, even the act of speaking to another person without his permission may trigger a beating.

No systematic studies have been performed to determine how often women suffer negative consequences from participating in research on violence. However, several VAW researchers have recorded chilling examples of experiences where women have been placed at risk as a result of inadequate attention to safety issues.[8] For example, researchers from Chiapas, Mexico, describe how, when they first began researching domestic violence, they were not fully aware of the risks involved. They included a small set of questions on domestic violence within a larger study on reproductive health without taking any special precautions regarding safety of respondents. They were shocked to learn later that three respondents were beaten by their partners because they had participated in the survey.[9]

The WHO guidelines provide a number of suggestions about how to minimize risks to respondents, including:

- Interviewing only one woman per household (to avoid alerting other women who may communicate the nature of the study back to potential abusers).
- Not informing the wider community that the survey includes questions on violence.
- Not conducting any research on violence with men in the same clusters where women have been interviewed.[4]

Protecting privacy and confidentiality

His mother and sisters kept passing by, and would peek in the doorway to see what we were talking about, so we would have to speak really softly…and the girl said to me, "Ay, don't ask me anything in front of them." (Nicaraguan interviewer) [2]

Protecting privacy is important in its own right and is also an essential element in ensuring women's safety. In addition to

interviewing only one woman per household, the WHO recommendations advise researchers to conduct violence-related interviews in complete privacy, with the exception of children under the age of two. In cases where privacy cannot be ensured, interviewers should be encouraged to reschedule the interview for a different time or place. Achieving this level of privacy is difficult and may require more resources than might be needed for research on less sensitive topics.

Researchers have developed a variety of creative methods for ensuring privacy. Interviewers in Zimbabwe and Nicaragua often held interviews outside or accompanied women to the river as they washed clothes. Many studies have successfully used "dummy" questionnaires, containing unthreatening questions on issues such as breastfeeding or reproductive health. Respondents are forewarned that if someone enters the room, the interviewer will change the topic of conversation by switching to a dummy questionnaire. Other members of the research team such as supervisors and even drivers can also play a role in distracting household members who are intent on listening to the interview. In one instance in Zimbabwe, fieldworkers entered into lengthy negotiations to purchase a chicken from the husband of a respondent so that she could be interviewed in private.[10] Other researchers have carried candy and coloring books to keep children busy during interviews.

BOX 2.4 SUGGESTIONS FOR MINIMIZING HARM TO WOMEN PARTICIPATING IN RESEARCH

- Interview only one woman per household.
- Don't inform the wider community that the survey includes questions on violence.
- Don't interview men about violence in the same households or clusters where women have been asked about violence.
- Interviews should be conducted in complete privacy.
- Dummy questionnaires may be used if others enter the room during the interview.
- Candy and games may be used to distract children during interviews.
- Use of self-response questionnaires for some portions of the interview may be useful for literate populations.
- Train interviewers to recognize and deal with a respondent's distress during the interview.
- End the interview on a positive note that emphasizes a woman's strengths.

PHOTO BY HAFM JANSEN

Interview in Thailand

Indeed, the Japanese team for the WHO VAW study found it so difficult to achieve privacy in Japan's crowded apartments that they had to depart from the protocol and use self-response booklets for especially sensitive questions. In this highly literate population, women were able to read and record their answers without the questions having to be read aloud.[6]

Ensuring privacy may be even more problematic in telephone surveys. Interviewers for the VAW survey in Canada were trained to detect whether anyone else was in the room or listening on another line, and to ask whether they should call back at another time. They provided respondents with a toll free number to call back if they wanted to verify

PHOTO BY HAFM JANSEN

Respondent in Tanzania tells children to go play before starting her interview

that the interview was legitimate, or in case they needed to hang up quickly. About 1,000 out of a sample of 12,000 women called back, and 15 percent of the calls were to finish interrupted interviews.[11]

Minimizing participant distress

Interviews on sensitive topics can provoke powerful emotional responses in some participants. The interview may cause a woman to relive painful and frightening events, and this in itself can be distressing if she does not have a supportive social environment.[12] Interviewers therefore need to be trained to be aware of the effects that the questions may have on informants and how best to respond, based on a woman's level of distress.

Most women who become emotional during an interview actively choose to proceed, after being given a moment to collect themselves. Interviewer training should include practice sessions on how to identify and respond appropriately to symptoms of distress as well as how to terminate an interview if the impact of the questions becomes too negative.

Interviewer training should also include explicit exercises to help field staff examine their own attitudes and beliefs around rape and other forms of violence. Interviewers frequently share many of the same stereotypes and biases about victims that are dominant in the society at large. Left unchallenged, these beliefs can lead to victim-blaming and other destructive attitudes that can undermine both the respondent's self esteem and the interviewer's ability to obtain quality data.

Referrals for care and support

At a minimum, the WHO guidelines suggest that researchers have an ethical obligation to provide a respondent with information or services that can help her situation. In areas where specific violence-related services are available, research teams have developed detailed directories that interviewers can use to make referrals. In Canada's VAW survey, for example, the computer program used by telephone interviewers had a pop-up screen that listed resources near the respondent, based on her mail code. In Zimbabwe, Brazil, Peru, and South Africa, researchers developed small pamphlets for respondents that listed resources for victims along with a host of other health and social service agencies.[10] All women were offered the pamphlet after being asked if it would be safe for them to receive it (cases have been reported where women have been beaten when a partner found informational material addressing violence). In Zimbabwe, interviewers carried a referral directory and wrote out addresses on physician referral pads so that the referral would not attract suspicion if discovered. Ideally, contact should be made in advance with the services so that they are prepared to receive referrals from the study.

In settings where resources are scarce or nonexistent, researchers have developed interim support measures. For example, a study on violence against women performed in rural Indonesia brought in a

counselor to the field once a week to meet with respondents.[13] In Ethiopia, the study hired mental health nurses to work in the closest health center for the duration of the fieldwork.[14] The number of women who actually make use of such services is often quite low, but subsequent interviews with women indicate that they appreciate knowing that services are available if needed.[11] In Peru and in Bangladesh, the WHO VAW team has used the study as an opportunity to train local health promoters in basic counseling and support skills. In this way, the team will leave behind a permanent resource for the community.

Bearing witness to violence

The image of these stories affects you, to see how these women suffer, and especially the feeling that no one supports them. These are experiences that you never forget… (Nicaraguan interviewer)[2]

Although preventing harm to respondents is of primary importance, researchers also have an ethical obligation to minimize possible risks to field staff and researchers. Sources of risk include threats to physical safety either as a result of having to travel in dangerous neighborhoods or from unplanned encounters with abusive individuals who object to the study. Some strategies to reduce the first source of risk include removing extremely dangerous neighborhoods from the sampling frame before drawing the sample (for example those controlled by narco-traffickers); outfitting teams with cell phones; and having male drivers accompany female interviewers into dangerous areas.

PHOTO BY HAFM JANSEN

Interview in Bangladesh

Abusive partners have also been known to threaten interviewers with physical harm. In a South African study, for example, a man came home from a bar in the middle of his partner's interview and pulled a gun on the fieldworker, demanding to see the questionnaire. Because of prior training, the interviewer had the presence of mind to give the man an English version of the questionnaire, which he was unable to read.[10] "Dummy" questionnaires would also have been helpful in this situation.

The most common risk for fieldworkers, however, is the emotional toll of listening to women's repeated stories of despair, physical pain, and degradation. It is hard to overestimate the emotional impact that research on violence may have on field-

BOX 2.5 PROTECTING RESPONDENT SAFETY IN CAMBODIA

Researchers in a study performed in Cambodia found a young woman who was held prisoner in her own home by her husband. When the research team arrived to interview her, they found the woman locked in her house, with only a peephole where a chain was threaded through a crudely cut hole in the door. The woman conducted the interview through the peephole. During the interview, the husband appeared and was suspicious about their activity. The team gave him a false explanation for their visit and then left the home.

The next day, the team sought help from the Ministry of Women's Affairs, which co-sponsored the study. Secretariat staff informed the researchers that the woman's husband had stormed into their office the preceding afternoon, dragging his wife by the arm. He demanded to know who had been at his door. He told the Secretariat personnel that if they couldn't confirm her explanation, then his wife would suffer. They readily confirmed her story. She was safe for the moment, but the researchers realized that it would be too dangerous to ever approach this woman again.

The team made several overtures with different government officials and the police to help get the woman freed, but everyone was afraid to intervene because the woman's husband had an important position. Researchers described the frustration that the team felt at not being able to free the woman and the guilt they felt at having put the woman in greater danger.

(From Zimmerman, 1995.[8])

workers and researchers. As the narrative from a Nicaraguan fieldworker presented at the beginning of this chapter illustrates, a study on violence often becomes an intensely personal and emotional journey for which many researchers are not prepared. Particularly when field staff have had personal experiences of abuse, the experience can be overwhelming. Judith Herman, in her work on psychological trauma in survivors of political and domestic violence, describes this as a common experience for those who study violence:

To study psychological trauma is to come face to face both with human vulnerability in the natural world and with the capacity for evil in human nature. To study psychological trauma means bearing witness to horrible events.[15]

Including discussions of violence in interviewer training is crucial for reducing distress during fieldwork. During fieldwork, another important measure is to provide interviewers and research staff with regular opportunities for emotional debriefing, or when necessary, individual counseling. Researchers have used a variety of creative strategies for protecting the emotional health of their staff. In Peru, for example, the WHO multi-country team employed a professional counselor to lead weekly support sessions that incorporated guided imagery and relaxation techniques. Experience has repeatedly demonstrated that emotional support for fieldworkers is essential. Not only does it help interviewers withstand the demands of the fieldwork, but it also improves their ability to gather quality data.

Transcripts of debriefing sessions with interviewers who participated in studies without adequate support illustrate this point:

…When I heard stories about women being beaten and tied up, I would leave there feeling desperate… I would be a wreck, and my supervisor would tell me "get a hold of yourself, you cry for every little thing." But how could I control myself? I couldn't stand it… I would try, but sometimes it was impossible, and I would burst into tears during the next interview… (Nicaraguan interviewer) [2]

Other interviewers commented that they felt extremely drained and distracted by the interviews where women reported violence. One woman reported that she had stopped working for the study because she could not bear to listen to women's stories of abuse. [2]

Experience has shown that trauma-related stress is not confined to field staff who are directly involved with respondents. Field supervisors, transcribers, drivers, and even data entry personnel may be affected. In one study in Belize, a transcriber broke down after hours of listening to in-depth qualitative interviews with survivors of abuse.[16]

It is particularly important to provide opportunities during training for interviewers to address their own experiences of abuse. Given the high prevalence of gender-based violence globally, it is likely that a substantial proportion of interviewers will have experienced gender-based violence themselves at some point. These experiences need to be taken into consideration. Most people learn to cope with painful past experiences, and usually do not dwell on them in their everyday lives. However, when trainees are confronted with the subject matter the information may awaken disturbing images and or emotions. For many trainees, simply acknowledging the fact that these reactions are normal and providing timely opportunities to discuss them will be sufficient to help them complete the training and participate successfully in fieldwork. In those rare cases where feelings become too overwhelming, trainees should be supported in their decision to withdraw from the study.

MAXIMIZING BENEFITS TO PARTICIPANTS AND COMMUNITIES (BENEFICENCE)

The principle of beneficence refers to the ethical obligation to maximize possible benefits to study participants and the group of individuals to which they belong. This principle gives rise to norms requiring that the risks of research be reasonable in light of the expected benefits, that the research design be sound, and that the investigators be competent both to conduct the research and to ensure the well-being of participants.

The interview as an intervention

Asking women to reveal stories of trauma can be a transforming experience for both researchers and respondents. Indeed, there is ample evidence that most women welcome the opportunity to tell their stories if they are asked in a sympathetic, nonjudgmental way. In our experience, women rarely refuse to answer questions on violence.

Many women who disclose violence in surveys have never told anyone about their situations.[17] Many studies find that participants find the experience to be so helpful that they ask fieldworkers to "interview" a friend or relative who has a story to tell. As Herman notes, "remembering and telling the truth about terrible events are prerequisites both for the restoration of the social order and for the healing of individual victims."[15]

Even the act of telling her story can offer a woman some small way of transforming her personal ordeal into a way to help others. Indeed, researchers sensitive to this issue encourage interviewers and field staff to take hope and satisfaction from their participation in the process of giving a voice to women's suffering.

A qualitative study of survivors of abuse who had visited a women's crisis center in Nicaragua found that a central part of women's process of recovery and personal as well as collective empowerment came not only from increased knowledge of their rights, but also from the opportunity to share their experiences and to help other women in similar situations.[18] In this sense, asking women about experiences of violence may be seen as an intervention in itself. At the very least, asking conveys the message that violence is a topic worthy of study, and not a shameful or unimportant issue.

In this same vein, many fieldworkers in the León, Nicaragua, research described the experience of listening to women's stories, as well as the opportunity to tell their own stories in the debriefing sessions, as a profoundly healing experience. One interviewer who had never before discussed her experiences said,

[when I joined this study] I felt that I had finally found someone I could tell everything to, someone with whom I could share my burden, because it's horrible to feel so alone. Now I feel that a weight has been taken off me…I feel relieved…[19]

Remembering and telling the truth about terrible events are prerequisites both for the restoration of the social order and for the healing of individual victims. (Herman, 1992.[15])

The interview is also an opportunity to provide women with information on gender-based violence. Many studies have issued small cards that can be easily hidden in a shoe or inside a blouse with information about local resources for abused women and messages such as, "If you are being abused, there are ways out" or "Violence is never justified." Such messages may enable women to see experiences in a new light or to identify violence in others close to them.

Researchers also stress the importance of ending the interview on a note that emphasizes women's strengths and tries to minimize distress, particularly as a respondent may have revealed information that

made her feel vulnerable.[20] A number of studies have carefully scripted such endings to ensure that the interview finishes with clear statements that explicitly acknowledge the abuse, highlight the unacceptability of the violence, and emphasise the respondent's strengths in enduring and/or ending the violence. The WHO study ends each interview with the words, *"From what you have told me, I can tell that you have had some very difficult times in your life. No one has the right to treat someone else in that way. However, from what you have told me I can also see that you are strong and have survived through some difficult circumstances."*[7]

One indication of how women have viewed the interview process can be obtained by assessing respondents' satisfaction with the interview. At the end of the WHO interview, respondents were asked the following question: "I have asked about many difficult things. How has talking about these things made you feel?" The answers were written down verbatim and coded by the interviewer into the following three categories: good/better, bad/worse, and same/no difference. The majority (between 60 and 95 percent in seven sites) of women who had experienced physical or sexual partner violence reported that they felt good/better at the end of the interview. In most countries, the range was similar between women who had or had not experienced partner violence. Very few women reported feeling worse after being interviewed. Between 0.5 and 8.4 percent of women reporting partner violence ever (highest in Peru) and between zero and 3.2 percent of women with no history of partner violence felt worse.[17]

Looking for households in Samoa

PHOTO BY HAFM JANSEN

Assuring scientific soundness

The CIOMS guidelines note: "A study that is scientifically unsound is unethical in that it exposes subjects to risk or inconvenience while achieving no benefit in knowledge."[3] This principle is particularly important in the area of gender-based violence where women are asked to disclose difficult and painful experiences and where the act of research itself may put women at further risk of abuse. Thus the WHO guidelines note that violence researchers have an ethical responsibility to ensure the soundness of their work by selecting a large enough sample size to permit conclusions to be drawn, and by building upon current knowledge about how to minimize underreporting of violence. (See Chapter 7 for more discussion of sampling techniques.) Underreporting of violence will dilute associations between potential risk factors and health outcomes, leading to falsely negative results. Underestimating the dimensions of violence may also prevent violence intervention programs from receiving the priority they deserve in the allocation of resources.

Research demonstrates that disclosure rates of violence are highly influenced by the design and wording of questions, the training of interviewers, and the implementation of the study.[2] In Chapter 6, we discuss this issue in much greater depth and outline the variety of measures that have been developed to enhance disclosure of violence.

Using study results for social change

It is important to feed research findings into ongoing advocacy, policy making, and intervention activities. Too often critical research findings never reach the attention of the policy makers and advocates best positioned to use them. The enormous personal, social, and health-related costs of violence against women place a moral obligation on researchers and donors to try to ensure that study findings are applied in the real world. It is also important that the study community receives early feedback on the results of the research in which it has participated. Chapter 14 addresses this issue in more detail and describes several successful examples of how research findings have been used to contribute to changing laws and policies on domestic violence.

One way to improve the relevance of research projects is, from the outset, to involve organizations that carry out advocacy and direct support for survivors of violence, either as full partners in the research or as members of an advisory committee. Such committees can play an important role in helping guide the study design, advise on the wording of questions, assist with interviewer training, and give guidance on possible forms of analysis and the interpretation of results. These groups also have a central role to play in publicizing and applying the project's findings.

JUSTICE: BALANCING RISKS AND BENEFITS OF RESEARCH ON VIOLENCE AGAINST WOMEN

Research, like any endeavor that touches people's lives, involves inherent risks. The principle of distributive justice demands that the class of individuals bearing the burden of research should receive an appropriate benefit, and those who stand to benefit most should bear a fair proportion of the risks and burdens of the study.

In the case of gender-based violence research, the risks are potentially large, but so too are the risks of ignorance, silence, and inaction. Researchers and ethical review boards must constantly balance this reality. Lisa Fontes cites the case of a colleague from India who wanted to study wives who were hospitalized after having been burned by their husbands in disputes over dowry. She ultimately decided not to conduct the research for fear that the research would put women at further risk. As Fontes observes, "Her decision eliminated the research-related risk to the participants, but also eliminated the potential benefit of reducing the terrible isolation and vulnerability of these victims."[21]

Women would ask me what this survey was for, and how it would help them. I would tell them that we won't see the solution tomorrow or the next year. Our daughters and granddaughters will see the fruits of this work, maybe things will be better by then. Nicaraguan fieldworker. (From Ellsberg, et al, 2000.[19])

It is possible to conduct research on violence with full respect for ethical and safety considerations if proper care and resources are devoted to this end. We must remember that women living with violence are already at risk. Researchers cannot eliminate this reality, just as they cannot fully eliminate the possibility that further harm will be caused by their study. The obligation of researchers is to carefully weigh the risks and benefits of any study and to take every measure possible to limit possible harm and to maximize possible benefit. At the very least, we must ensure that when women take risks to share their stories, we honor that risk by using the findings for social change.

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3

PHOTO BY HAFM JANSEN

Developing a Research Strategy

Topics covered in this chapter:

Different types of research
The research process
Choosing a research topic and objectives
Formulating your research questions
Choosing a research design
Quantitative or qualitative methods?
Population- or service-based research?
Collaboration between researchers and activists
Drafting the protocol

Developing a research strategy may be the most crucial task in any research project. The entire project can be derailed by errors in this phase. Common errors include research questions that are not well conceptualized or articulated, a research design that is not well suited to the task, or methods that do not match the needs of the project or the skills and resources at hand. With proper planning, however, these pitfalls can be avoided.

Which elements are most critical to developing an effective **research proposal protocol**? This chapter begins with a brief overview of the different types of research and the roles they can play in strengthening the global response to violence against women. It continues with a discussion of the early steps in the research process—namely, formulating the research question and objectives—and gives examples that show how these concepts can be applied to issues of violence.

Next it describes some of the more common research designs used in social science and public health research and discusses the advantages and disadvantages of each. Box 3.1 provides a study checklist of the tasks that researchers need to address throughout the research process. Asterisks denote elements most relevant for researchers using a quantitative approach (e.g., a community survey).

DIFFERENT TYPES OF RESEARCH

There are many different types of research and the language of research can be daunting. For the purposes of this manual, we

TABLE 3.1 DIFFERENT KINDS OF RESEARCH

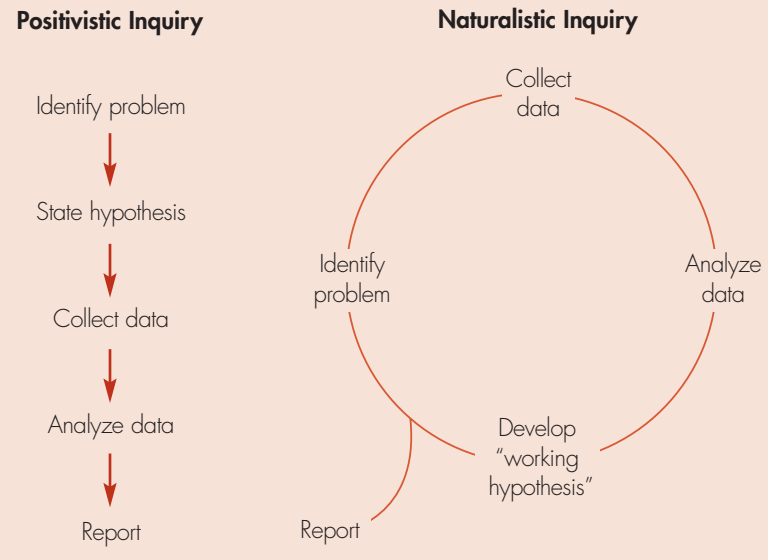
Type of Research	Purpose
Basic	To increase knowledge and advance theory as an end in itself
Applied	To understand the magnitude, nature and/or origins of social problems in order to identify solutions
Formative	To facilitate the development of an intervention (e.g., a program or policy) or help develop quantitative instruments
Operations	To monitor and improve ongoing interventions
Evaluation	To evaluate the impact/effectiveness of completed interventions

have adopted the following typology to describe the many different types of research (see Table 3.1).

Basic research is dedicated to advancing theory and may not necessarily answer questions that have obvious program or policy implications. **Applied research** uses many of the same techniques but concentrates on asking questions of more immediate, practical relevance. **Formative or exploratory research** tends to be less in-depth and is geared toward generating the background insights and knowledge necessary to pursue further research or to design an actual intervention. **Operations research** concentrates on improving the process of ongoing interventions. **Evaluation research** helps evaluate the impact or success of interventions.

This manual concentrates primarily on the logic and tools of formative and applied research. All types of research are important and can make substantial contributions to knowledge in the field of gender violence. Theory building, evaluation, and operations research are complex fields in their own right, however, and are beyond the scope of this book.

FIGURE 3.1 THE RESEARCH PROCESS IN QUANTITATIVE AND QUALITATIVE RESEARCH



(From Dahlgren et al, 2003.[1])

THE RESEARCH PROCESS

Four basic steps are common to virtually all research projects:

- Identify a problem to study
- Collect data
- Analyze the data
- Report the results

Box 3.1 presents a more detailed list of the steps that are commonly taken to achieve the goals of the study. The order in which these steps are performed and the techniques used to achieve them may vary widely from study to study depending on the researcher's theoretical framework—the underlying assumptions about how knowledge is produced.

The two main traditions within research—positivistic and naturalistic inquiry—approach the enterprise in distinctly different ways. **Positivistic inquiry**, also known as science-based or deductive inquiry, generally starts with a hypothesis and proceeds to test it in a systematic and linear way (see Figure 3.1). In contrast, **naturalistic inquiry** (also known as **interpretive inquiry**) concentrates on studying the natural environment without manipulation or predetermined constraints on the outcome. The research process in naturalistic inquiry tends to follow a circular path. A

general theme may be identified for study, and the research question becomes more focused as additional data are collected and analyzed. This is referred to as an **emergent design** because the actual focus of the study and even the methods used for data collection and analysis may emerge as the study progresses. Naturalistic studies tend to use qualitative research methods and positivistic studies tend to use quantitative methods. Both traditions can be either descriptive or analytic and both can play an important role in the study of violence against women. This manual presents examples from both approaches.

CHOOSING A RESEARCH TOPIC AND OBJECTIVES

The first step in any research endeavor is to identify a problem or area that could benefit from further investigation. In the field of violence there are hundreds of topics worthy of further study. One simply needs to determine what kind of information is most needed in a specific context.

The next step in the process is to narrow the focus of inquiry to a topic amenable to investigation. Guiding questions here are: What do you want to know and what is worth knowing? Researchers generally begin to narrow their topic by gathering and reading all the relevant articles and books on the subject (also known as a "literature review"). It is very important to identify what is already known about an issue before deciding on a research topic. Otherwise, you risk either "reinventing the wheel" or investigating questions that do not contribute to advancing knowledge or improving people's quality of life.

When the research impulse emerges from the need of a service provider, an NGO, or an activist group, it may be relatively easy to define a research objective. For example, you may be a family planning provider who wants to know the degree to which coercion

BOX 3.1 STUDY CHECKLIST

Following are some of the most important steps that will need to be taken in the course of most studies. There may be some differences according to whether the research is based primarily on quantitative or qualitative methods.

Problem formulation

- Explore the research problem through contacts with community representatives, health workers, local women's groups, and through a review of the published and unpublished literature.
- Formulate the research problem; discuss within the research team and with others concerned to get suggestions and identify a conceptual framework.
- Formulate and decide on research objectives, study design, study area, study population, and study methods.
- Operationalize the variables under study.*
- Design an appropriate sampling plan or strategy.
- Prepare draft questionnaire.*
- Plan for initial data analysis.
- Translate materials, questionnaires, forms.
- Plan for study personnel, equipment to be used, transport, accommodation, finance, and other logistics.
- Write a preliminary study protocol.

Organization

- Obtain consent from the participating communities (individually or via representatives).
- Obtain consent from other local, district, or national authorities concerned.
- Obtain financial support.
- Obtain ethical clearance from ethical review committee.
- Develop manual or instructions for fieldworkers.
- Organize support network for women participants and fieldworkers.
- Obtain educational materials on violence for use by study participants.
- Recruit fieldworkers.
- Train fieldworkers.
- Pilot study of organization, questionnaire, equipment, standardize measurement procedures.*
- Revise questionnaire, instructions to fieldworkers, study protocol.*

Fieldwork

- Supervise fieldwork.
- Edit interviews to identify errors.*
- Maintain contact with the local community to ensure a good participation in and support for the study.
- Hold "debriefing" sessions with fieldworkers to avoid "burnout."

Analysis and reporting

- Control data entry to minimize errors.*
- Discuss quality of data, difficulties with certain questions, and routines with fieldworkers.*
- Inspect the data matrix together, collaborate with fieldworkers in the control and clearing of data.*
- Perform preliminary analysis, discuss with the research team and with community representatives and relevant authorities.
- Complete final analysis and interpretation.
- Report back to community, health authorities, and political authorities. Discuss consequences and possible actions.
- Present results in reports and publications both for local and broader audiences, where relevant.
- Plan for intervention and evaluation.

** These steps are particularly relevant for quantitative studies.*
(Adapted from Persson and Wall, 2003.[2])

and abuse affects your clients' interest in and ability to use different methods of contraception. Or you may be the director of a women's shelter who wants to know what happens to women once they leave your care. Even here it is important to investigate what may already be known about the topic, either in the research literature or by others in the community.

The best way to build trust and long-term allies is to include individuals and organizations in the process of establishing research topics and questions.

When the motivation for research comes from outside the local community, perhaps from a university or government agency, it is especially important to to involve others—preferably service providers and activists—in the process of refining your research topic. One way to do this is to consult with local **stakeholders** or individuals who, by virtue of their work and/or life experience, may have insights into questions that need to be asked, and answered. This can take the form of consultation with a local advisory board, or individual meetings with women's groups and others who may have opinions on what research would be useful to pursue. Consulting with potential stakeholders early in the process can help ensure that the research is both relevant and doable, and it can help build trust and alliances with the very groups that will probably be in a position to use and disseminate the findings. Too often researchers only seek out local women's groups or other nongovernmental organizations when they want access to a research population (e.g., approaching a local shelter in order to find "abused women" to interview). Not surprisingly, this can breed resentment and distrust.

Decide on a research design or on data collection methods after you decide what you want to know.

FORMULATING YOUR RESEARCH QUESTIONS

The next task is to express your research interests in simply worded, direct questions, preferably one question for each topic. The research questions should support your research objectives. Table 3.2 gives several examples of how you might go about developing research questions. You may start out with many more questions than can be resolved in a single study. If you do, trim the list to a manageable number. This can be a sensitive process, particularly if you are balancing the needs of different actors. For example, the kind of information that a governmental women's institute would like to collect on violence may be quite different from the data that women activists need for advocacy purposes, or what a researcher might consider important from a theoretical perspective. Although reaching a consensus regarding the research questions can be time-consuming, including the perspectives of stakeholders at this stage is likely to greatly increase the potential impact of the study results.

Remember that as a rule, research questions in qualitative research can be initially more general, because they will be refined as data are collected and analyzed. However, in quantitative research, when conducting surveys, for example, you need to determine the research questions before data collection begins because they form the basis for establishing the hypotheses to be tested. (See Table 3.2.)

CHOOSING A RESEARCH DESIGN

Many organizations interested in using research to improve the quality of their programs or services make the same mistake: They choose a study design before clarifying exactly what information is needed. We recommend that you carefully consider alternative study designs, and choose one that best addresses the research objectives and is most likely to answer the research questions you have

developed. This decision must, of course, take into account what is feasible given a project's material and human resources. If you cannot implement the most appropriate design for a given research question, it is better to change the focus of the research or to modify the design. A poorly designed study may actually do more harm than good. For example, a survey carried out with a sample size that is too small to yield significant results may underestimate the prevalence of violence or its impact on a given population, which could in turn negatively affect policies or program funding.

While there is a wide range of different research designs available to address different research questions, this manual will

TABLE 3.2 SELECTING A RESEARCH DESIGN

Examples of different methods that might be used for different research questions. Descriptions of the specific methods are provided in later chapters.

Research Objective	Research Question	Possible Study Design
A Cambodian woman's advocacy organization wanted to determine how widespread violence was in Cambodia and how women responded to domestic violence. They also wanted understand how community members viewed victims and perpetrators of abuse. The purpose of the research was to bolster lobbying efforts and to produce a public awareness campaign.[4, 5]	How common is abuse by an intimate partner in Cambodia? How common is forced sex? Who are the perpetrators? Where does the violence take place? In the home? On the street? At work? Other places? To whom do women turn after they have been victimized? What services do they think are important? How commonly do community members subscribe to common rape myths?	Population-based survey of men and women Focus group discussions with community leaders In-depth interviews with survivors of violence
An international organization working with Somali refugees in Kenya was interested in finding out more about sexual violence in the refugee camps. Aid workers had heard rumors that a number of women in the camp were raped when they left the camp to get firewood and feared that some pregnancies may have been the product of forced sex by guards or bandits.[6, 7]	Do women in the camps feel at risk of rape? What are the most common circumstances of forced sex? Who are the perpetrators? What do women and men think could be done to improve women's safety?	Survey of women in the camp In-depth interviews Participatory appraisal
The International Planned Parenthood Federation, Western Hemisphere Division (IPPF/WHD) initiated a program to integrate screening and care for survivors of gender-based violence within reproductive health programs in Venezuela, Peru, and the Dominican Republic. The program managers wanted to evaluate how the program had succeeded in changing the attitudes and practices of health providers and whether women felt satisfied with the care they were receiving.[8]	What did the health promoters know about domestic violence prior to the training? What did they learn during the training course about the identification, assessment, and referral of abused women and children? Was there a positive change in providers' attitudes towards victims of violence? How many women attending family planning and sexually transmitted infection clinics were asked about violence? How many were appropriately referred according to the protocols developed? How satisfied were women with the care they received at the clinics?	Before and after surveys of providers' attitudes and knowledge Review of service data Focus groups with providers and clients Exit interviews with clients
A Voluntary Testing and Counseling (VCT) clinic in Tanzania was interested in finding out whether the threat of violence after disclosure of HIV status was an obstacle for women to come in for testing. The program managers also wanted to know whether violence was a risk factor for women contracting HIV.[9]	What percentage of women attending voluntary clinical treatment services have been physically or sexually abused by their partners? Did the violence take place before the testing or afterwards? Was fear of violence an important issue in women's ability to protect themselves from HIV? Was fear of violence a reason that women might be reluctant to go for VCT?	Survey of clients In-depth interviews Focus groups with community men and women

(Adapted from Shrader, 2000.[3])

focus on five broad types of designs that are often used in public health research.

Quantitative approaches

- Cross-sectional surveys
- Cohort studies
- Case-control studies

Qualitative approaches

- Rapid assessment techniques
- In-depth qualitative studies

These study designs will be described in greater depth in Chapters 4 and 5.

QUANTITATIVE OR QUALITATIVE METHODS?

Quantitative research methods produce information that can be presented and analyzed with numbers, such as the percentage of women who have been raped or who attend shelters for battered women. These methods are drawn largely from the fields of epidemiology, sociology, economics, and psychology. In contrast, **qualitative** methods gather information that is presented primarily in text form through narratives, verbatim quotes, descriptions, lists, and case studies. Qualitative methods are primarily borrowed from the disciplines of anthropology, sociology, nursing, and psychology. As we mentioned earlier, although research methods are not necessarily tied to a specific theoretical tradition, quantitative methods tend to be used in research using a positivistic or post-positivistic framework, whereas qualitative methods are more associated with the naturalistic or interpretive framework.

__Quantitative methods__ usually produce findings that can be summarized in numbers. __Qualitative methods__ produce results that are commonly summarized in words or pictures.

__Quantitative methods__ tend to provide less in-depth information about many people, while __qualitative methods__ give more detailed information about relatively few people.

The two approaches represent different **research paradigms**, or views about the nature of reality and how knowledge is produced. The positivistic paradigm assumes that there is only one true version of reality and that it can be uncovered through scientific research. In contrast, the naturalistic paradigm assumes that reality is subjective rather than objective—it exists in the views, feelings, and interpretations of individuals, including the researcher. According to this perspective, many different and equally valid versions of reality may exist at the same time, and some of these versions may actually be created through the interaction of researchers and subjects. Positivistic researchers try to reduce outside influences or **bias** to a minimum, whereas naturalistic researchers believe that research is inherently biased. They try to be aware of different sources of subjective bias, for example, by keeping reflexive journals of their own reactions and thoughts throughout the research process.

A third paradigm has emerged in recent years, known as a critical or "emancipatory" paradigm.[10-12] According to Ford-Gilboe and colleagues, "The aim of research within the critical paradigm is the development of approaches that have the potential to expose hidden power imbalances and to empower those involved to understand, as well as to transform, the world."[12] Critical theory is embraced by most feminist and participatory researchers, and because it emphasizes uncovering power relations based on class, gender, and ethnicity, it is particularly well suited for research on violence against women.[13] As Ulin and colleagues point out, "An important premise of feminist theory is that social life and behavior are constrained in various ways by what is considered acceptable behavior based on gender. Feminist research focuses on the political dimension inherent in understanding these constraints from the standpoints of

people in different power and gender positions."[14] Because the underlying goal is to contribute to social change, critical researchers tend to be more pragmatic in the use of methods, and often use a combination of qualitative and quantitative data depending on what is likely to be most persuasive to policy makers and to the public.[12]

Quantitative methods are useful for drawing conclusions that are valid for the broader population under study. They are particularly appropriate for measuring the frequency of a problem or condition and its distribution in a population (for example, how many women in a community have experienced violence and which age groups are most affected). Surveys are often used to obtain information about people's opinions and behavior, for example through Knowledge, Attitudes, and Practices (KAP) surveys. When quantitative data are collected about a group of people that is chosen using special methods known as "random sampling techniques," it is possible to carry out statistical analysis and to generalize the results of the study to a larger population. (For more information about sampling techniques, see Chapter 7.) If the target group of the program is not very large—for example, if it is limited to a single community—then it may be possible to survey all homes or individuals in the study population (i.e., conduct a census).

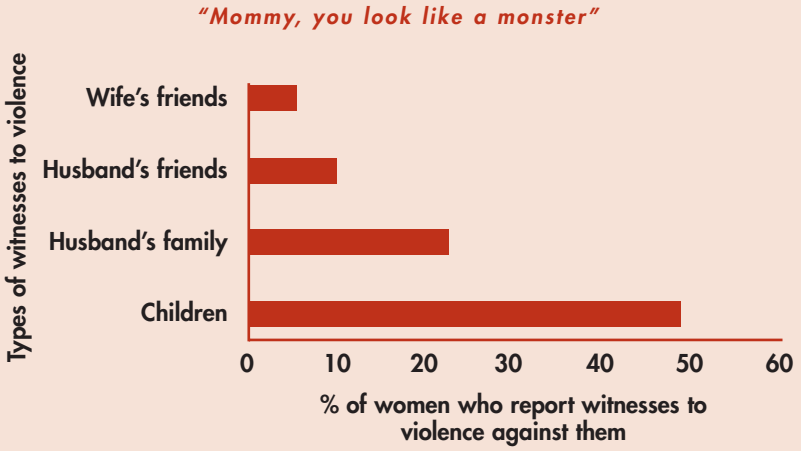
The main disadvantage of surveys is that they often provide fairly superficial information, and may not contribute much to understanding complex processes or their causes. For example, a survey may indicate how many women are experiencing violence or how many have heard an educational message, but it provides less information about how women experience violence, or how well they understood the educational message. Qualitative methods are more appropriate when the aim is to gain understanding about a process, or when an issue is being studied for the first time in a particular setting. Qualitative results allow you to understand the nuances and details of complex social phenomena from the respondents' point of view. Although you cannot say your findings are true for everyone, you can reveal multiple layers of meaning for a particular group of people. This level of understanding is particularly important when studying human behavior and trying to discern how it interacts with people's beliefs, attitudes, and perceptions.

As an example, the National Committee for the Abandonment of Harmful Traditional Practices in Mali, a network of organizations that work to discourage female genital mutilation (FGM), wanted to learn why some approaches had been more successful than others in motivating villages to abandon FGM. Instead of carrying out a population-based survey to measure individual behaviors and attitudes towards FGM, they decided to carry out a qualitative study in three villages where the practice of FGM had been abandoned. Although this study did not give information about the number of villages that had taken this step, it provided very rich information about the different issues and considerations that helped village leaders and community members make their decision. For the purpose of improving community-level interventions, this study was much more useful than a survey would have been.[15]

Most research objectives are best achieved through a combination of qualitative and quantitative methodologies. We encourage researchers to use a variety of methods to look at the same issue, or **triangulation**, to enhance the validity and utility of their research. Because triangulation allows you to view your subject from different perspectives and to look for potential inconsistencies, it increases the validity and trustworthiness of

Triangulation *refers to the use of more than one method to look at the same issue. It can also involve the use of one method on different study populations. Triangulation helps to ensure that your findings are trustworthy, or convincing to others.*

FIGURE 3.2 AN EXAMPLE OF COMBINING QUALITATIVE AND QUANTITATIVE DATA



"When he would beat me, my daughters would get involved in the fight. Then he would throw them around in his fury, and this hurt me more than when he beat me. …and once, I was recovering after he had beaten me, and my daughter came up to me and said "Mommy, you look like a monster." And she began to cry, and what really hurt me wasn't so much the blows, it was her sobbing and the bitterness that she was feeling… *Survivor of violence from Nicaragua*

(From Ellsberg et al, 2000.[16])

your findings. For example, the results of survey research may be complemented and enriched by in-depth interviews with a subsample of women who were interviewed. Their words, thoughts, and observations lend depth and meaning to the numbers generated to describe the essentially painful reality of physical and sexual abuse. Similarly, one can strengthen qualitative data displays and narrative with references to population-based data, thereby giving an approximation of how widespread certain types of violent behavior are.

In Nicaragua, researchers combined the results of a survey of 488 women on experiences of violence with narratives of three women's experiences obtained through in-depth interviews.[16] The narratives covered many of the same themes as the survey, and often provided moving illustrations of how women felt about the violence. Figure 3.2 illustrates how survey results and narratives may be used to provide different perspectives on how children are affected by domestic violence. Although the feelings expressed by the young woman cannot be generalized to all battered women, her story provides a window into the devastating impact that abuse can have on women and their children. This type of insight is difficult to obtain from numbers.

Likewise, a research project in Tanzania used qualitative and quantitative methods to examine how violence affected women's decisions to seek VCT for HIV/AIDS.[9] Through in-depth interviews with men and women, the researchers learned about how testing and disclosure of HIV status could lead to violence. Two women described the aftermath of disclosing their seropositive status with the following words:

"It took two weeks to tell him. He told me, 'You know who has brought it?' I told him, 'If you are blaming me then blame me, but you are the one who has brought it.'"

"When I informed him of the results there was endless violence in the house."

In a second stage, the researchers interviewed 245 women who attended the clinic, and asked them standardized questions about experiences of violence. They found that HIV positive women were twice as likely to have been beaten by a partner than were HIV negative women, and among young women, HIV positive women were ten times more likely to have been beaten than HIV negative women. The researchers concluded that violence is a risk factor for HIV/AIDS because it limits women's ability to protect themselves. Moreover, HIV positive women are at greater risk of physical abuse if they disclose their serostatus. It was difficult to determine from survey data alone when the violence took place in relation to disclosure of serostatus. Thus, the qualitative information provided insights useful in interpreting the survey results.

POPULATION- OR SERVICE-BASED RESEARCH?

A key decision regarding design is whether to draw one's sample from the community at large (this is often referred to as a "population-based study") or from a service provider, for example, a women's crisis center or a community health center. The decision should be based on the goals and objectives of your research. If the goal of the research is to evaluate a service (e.g., how well the women's police station meets victims' needs) or determine what proportion of emergency room clients suffer abuse, then it makes sense to focus your research on women attending these services. If, however, your goal is to be able to say something that applies to abuse victims more generally, then it is important to recruit your sample from the community at large. Too often, researchers rely on service-based data (police statistics, hospital records, or interviews with women attending crisis services) to draw conclusions about patterns of physical or sexual abuse in a larger population. In reality, these data apply only to women who seek formal services—a group that differs substantially from the full universe of abused women and children. Women that make their way into police or hospital records have frequently suffered more severe abuse and are more likely to have been abused by a stranger than women that do not report abuse.

An example of this can be seen in the comparison of results from two studies carried out in Nicaragua on sexual abuse of children. One study was based on police records, and included only cases of abuse that were reported to the police. This study concluded that in 95 percent of child sexual abuse cases girls were the victims of abuse.[17] In contrast, a study carried out in León, Nicaragua, asked men and women who were randomly selected from the community to respond to an anonymous questionnaire about their experiences of sexual abuse in childhood. This study found that 30 percent of the total number of incidents of child sexual abuse were reported by men.[18] These findings indicate that either boys are less likely than girls to disclose abuse when it happens, perhaps because of shame or fear of being stigmatized, or that parents are less likely to report cases of abuse of boys to the police. This comparison shows that the information obtained from service-based samples can differ greatly from results obtained from a community-based survey.

Record reviews can nonetheless yield important information, especially about the quality of services that women receive from health and justice system professionals. A case in point is a study conducted by the South African NGO ADAPT that reviewed the charts of 398 women presenting with a history of assault to the Casualty Department of Alexandra Health Clinic during October and November in 1991. (Alexandra Township is a rapidly urbanizing community near the heart of Johannesburg.) This study found that providers failed to record the identity of the perpetrator in 78 percent of cases. The charts included only disembodied descriptions of the violence such as "chopped with an axe" or "stabbed with a knife." Organizers used these data to emphasize to clinic administrators the need to sensitize providers to issues of violence and to encourage more complete and accurate documentation.[19]

In another example, the IPPF carried out a study before initiating a program to train providers to screen for abuse in three Latin American countries (Peru, Venezuela, and Dominican Republic). They reviewed records to see how many women were being asked about violence in reproductive health clinics, and carried out a survey among providers to measure their knowledge and attitudes towards survivors of violence. By carrying out periodic follow-up surveys and record reviews, program

managers were able to measure changes in attitudes as a result of training, and increases in screening and care for survivors of violence.[8]

COLLABORATION BETWEEN RESEARCHERS AND ACTIVISTS

Throughout this manual, we emphasize the importance of creating partnerships between researchers and those who are in a position to use the research effectively, such as service providers, government agencies, women's health advocates, or NGOs. We believe that this is the best way to ensure that research objectives are grounded in local needs and perspectives, and that the results will be used for promoting social change. Those who work with victims of abuse also bring knowledge and skills that will surely enrich the research process and improve its quality.

"Collaboration works best when there is mutual learning on both sides," notes Gita Misra of SAKHI, a community-based group that works with South Asian battered women in New York City. SAKHI encourages anyone undertaking research on abuse in the South Asian community to participate in its 20-hour intensive training course for community volunteers.

We recognize, however, that successful partnerships between researchers and practitioners are not always easy to forge, as each group brings a different set of expectations, needs, and skills to the endeavor. Practitioners frequently worry that the research process could compromise their primary mission or undermine services. Researchers, for their part, often fear that nonresearchers may not appreciate the importance of scientific rigor.

There is also a legacy of past experiences that any potential collaboration must overcome. Researchers are sometimes surprised when their overtures to activists or service providers are met with suspicion. They don't realize that many activists have had negative experiences with researchers.

At a 1993 symposium on research around sexual coercion, a panel of service providers and activists explored the origins of the historical tension between researchers and community-based organizations. As panel members explained, many NGOs had experiences with research in the past that left them distrustful of requests to "collaborate" on research. Frequently, they noted, researchers appear more concerned with their own professional advancement than with the well-being of the respondents. The power imbalance between researcher and respondent becomes especially problematic when northern researchers conduct research in southern countries. Panelists could all relate instances in which research results from developing countries were widely reported at international conferences, but remained unavailable and unknown in the host country.

At the same time, all panelists could give examples of research collaborations that were highly positive. In these examples, the researchers involved the service providers or community group in the formulation of the research questions. The investigators treated the NGO as a true partner, as opposed to a site for research. They also recognized the practical expertise that comes from years of living with or working on an issue. Most importantly, the study generated knowledge that was useful, not only for advancing the field of violence research, but also for improving the work of the service providers.

Past experiences have highlighted the following points as key to facilitating successful collaboration:[20-22]

- Flexibility
- Shared goals
- Clear sense of responsibilities and roles
- Benefits on both sides
- Mutual respect and recognition of each other's strengths
- Equal access to funding and credit

The last point is particularly important. The organization that controls the budget in any collaboration often wields the greatest power. Collaborating partners, therefore, should develop written agreements in advance about how to allocate available resources and/or how practitioners and their agencies will be compensated for their time and expertise.

The WHO VAW study has developed an effective model for research based on the partnership between researchers, policymakers and women's organizations that work on violence against women. The goals of the study explicitly included strengthening national capacity to address violence against women by raising awareness and fostering collaboration between local actors. To achieve this, each national research team included researchers with the technical skills needed to carry out the research, as well as representatives from organizations involved in work on violence against women. In addition, consultative groups were formed in each country to bring together policy makers, researchers, and activists to oversee the implementation of the study. This process has helped establish long-term working relationships between these groups that in some cases have continued beyond the study. Both the researchers and activists agree that this model of collaboration has been important, both by increasing the quality of the data and the interpretation of the findings, and by ensuring that the results are used to inform policy changes.[23]

DRAFTING THE PROTOCOL

Once all the basic issues regarding study design have been resolved, it is time to draft the study protocol. The protocol summarizes the decisions that have been made thus far regarding the study objectives, study population, and sampling strategy,

BOX 3.2 SUGGESTED OUTLINE OF STUDY PROTOCOL

Title: As short as possible, but covering and indicating the research problem formulated.

Researchers: List of researchers, their titles, and professional affiliations.

Background: Explain why this study should be done. What is already known about the problem through other studies? What experience do you have in this research area? What is your theoretical or conceptual framework? A well-referenced literature review is essential.

Research objectives: State the general objectives of the study and specify each of the specific research questions. The objectives should correspond to study design and methods used.

Study area: Specify the geographical area for the study. What is known about the social, economic, and epidemiological context?

Study design: Will the design involve a population-based survey, a case-control study, participatory action research, in-depth interviews, focus groups, or some combination of the above?

Study population: This specifies who makes up the study population, including age, sex, other characteristics, and follow-up period.

Sampling design and procedures: What is the sample size and the rationale for the sample size calculation? What are the eligibility requirements for participation? How will respondents be located, recruited, and selected? Will the sample be selected using randomization procedures? If so, provide the details.

Study methods: Describe in detail or refer to standard descriptions of methods used. Attach any research instrument to be used (e.g., survey questionnaire, interview guide).

Description of main variables: Include a detailed description of how you will define and measure them.

Data management and analysis plans: How will the data be processed and analyzed?

Organization of fieldwork: All steps in the fieldwork should be described. What should be done, when, how, and by whom? What obstacles are anticipated? How will they be dealt with?

Ethical considerations: Ethical issues should be identified and assessed by the researchers as well as by an ethical review committee.

Timetable: When will stages such as preparations, piloting, study start, study end, analysis, writing, and reporting take place?

Budget: Costs should be specified and should correspond to the time plan and the general description in a realistic way.

Potential policy and program implications: What are the potential policy and program implications of this research? What changes, interventions, or other consequences could you expect as a result of your research?

References: Back up statements with references to other studies and method descriptions.

Appendices: Often the research instrument, such as an interview guide or questionnaire is attached, as well as a curriculum vitae for each researcher and maybe some more specific details and instructions for some parts of the study performance.

(From Persson and Wall, 2003.[2])

and will serve as a guide throughout the research process. It will be essential for obtaining funding and ethical clearance, for training research personnel, and for providing information to the advisory board and others interested in the study. The protocol will evolve over the course of the project, so that the final version, while the same in terms of content, reflects the refinements and details added along the way. Box 3.2 presents a suggested structure for the research protocol. It is a recommendation for the kinds of information a research protocol should have. You probably will want to add other information or rearrange the contents to better reflect your research project.

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PHOTO BY HAFM JANSEN

Quantitative Approaches to Research

Topics covered in this chapter:

Cross-sectional surveys
Cohort studies
Case-control studies

CROSS-SECTIONAL SURVEYS: EXPLORING THE MAGNITUDE OF VIOLENCE

Cross-sectional surveys provide an image of a situation at a specific time. When applied to the study of violence, cross-sectional surveys are useful for providing information about the proportion of women in a community who have experienced or are currently experiencing abuse. In the language of epidemiology, this figure is known as a **prevalence estimate**. (See Box 6.1 in Chapter 6 for a description of how prevalence estimates are calculated.)

Cross-sectional surveys can also give valuable insights into elements that define the context in which violence occurs:

- Characteristics and dynamics of abuse.
- How effectively women are being reached by existing services.
- The attitudes of men and women with regard to violence.
- Gender relations (e.g., decision making and control of resources within the family).

Until recently, violence against women has been virtually invisible in most countries, either because women are ashamed

Interview in Ethiopia

PHOTO BY M. ELLSBERG

BOX 4.1 THE *WHO MULTI-COUNTRY STUDY ON WOMEN'S HEALTH AND DOMESTIC VIOLENCE AGAINST WOMEN*[1]

Cross-sectional surveys

The *WHO Multi-country Study on Women's Health and Domestic Violence Against Women* was initiated in 1997 with the aim of obtaining reliable and comparable data within and across culturally diverse countries on:

- The prevalence and frequency of different forms of physical, sexual, and emotional violence against women, particularly that inflicted by intimate partners.
- The association of violence by intimate partners with a range of health outcomes.
- Factors that may protect or put women at risk for intimate-partner violence.
- Strategies and services that women use to deal with the violence they experience.

It had, in addition to these, a number of process-oriented objectives:

- To develop and test new instruments for measuring violence cross-culturally.
- To increase national capacity amongst researchers and women's organizations working on violence.
- To increase sensitivity to violence among researchers, policy makers and health providers.
- To promote a new model of research on domestic violence, involving women's organizations with expertise on violence against women and fully addressing safety issues and safeguarding women's well-being.

Participating countries

The study involves collaboration between WHO, international research organizations (London School of Hygiene and Tropical Medicine and PATH, an expert steering committee of international content experts (researchers and advocates), and country research teams involving research institutions and women's health and rights organizations. The countries that participated in the first stage of the WHO multi-country study were: Bangladesh, Brazil, Thailand, Peru, Japan, Tanzania, and Namibia. Studies have also been performed in several other countries using the WHO methodology, including Samoa, Chile, Indonesia, Ethiopia, New Zealand, Serbia and Montenegro, and China.

Study methodology

The collection of rigorously sound and internationally comparable quantitative data on intimate partner violence has been a major focus of the WHO study. Qualitative data were also collected to inform the development and country adaptations of the questionnaire, as well as the interpretation of results. In most participating countries, the quantitative component of the study consisted of a cross-sectional population-based household survey conducted in two sites: the capital (or other large city) and one province with rural and urban populations. In each of these sites a representative sample of around 1,500 women aged 15 to 49 was selected to participate in face-to-face interviews. Women were asked about experiences of violence from intimate partners as well as nonpartners. Mechanisms to ensure comparability across countries included: a uniform core questionnaire, detailed documentation of the local adaptations to the core questionnaire (which were kept to a minimum), a standard module for interviewer training, the involvement of the core research team in all interviewer and data-processing training and in piloting activities, and the use of standardized procedures for data processing and analysis.

Questionnaire

A uniform core questionnaire with structured questions was used as the basis for all country questionnaires, with country modifications related to either adding country-specific issues or ensuring appropriate response categories. The questionnaire consisted of 12 sections; early sections collected information on less sensitive issues, whilst more sensitive issues, including the nature and extent of partner and nonpartner violence, are introduced in later sections, after rapport has been established between interviewers and respondents. As in many other surveys of partner violence, estimates of the prevalence of different forms of VAW were obtained by asking female respondents direct questions about their experience of specific acts of physical and sexual violence from any partner. Follow-up questions were asked regarding the timing and frequency of violence. Women were also asked about experiences of emotionally abusive acts and controlling behaviors by their partners, and violence during pregnancy. Questions about women's experience of physical and sexual violence by nonpartners since the age of 15, and of sexual abuse by nonpartners before the age of 15, were also included in the study.

Results

The range of lifetime physical partner violence found among the sites was 13 to 61 percent of ever-partnered women. The range of reported sexual violence was even greater, from 6 to 58 percent, whereas the range of women reporting either sexual and/or physical violence by a partner was 16 to 69 percent. In all of the sites, women who experienced physical and/or sexual violence consistently reported more emotional distress and recent physical problems such as pain, trouble walking, and dizziness.

(From WHO, 2005.[1])

to discuss it, because no one has thought to ask them about it, or because it is considered as a natural part of culture. Therefore, prevalence data are often needed to convince policy makers of both the pervasiveness of violence and its serious implications for women's health. Even surveys carried out in a single region have proven very useful in many countries in drawing attention to the dimensions of violence. Women's rights activists in Cambodia, (described in Box 4.2) Zimbabwe, and Nicaragua used survey results with great success to create public awareness around domestic violence, and to effect changes in national policy as well as legislation.

A cross-sectional survey may not be the most appropriate method to use if the goal is to determine the causes of violence or the impact of violence on women's physical or emotional well-being. Cross-sectional studies provide a snapshot of a condition and its suspected causal agents (referred to as **"exposures"** or **"risk factors"** in epidemiology), where both are measured at the same time.

It is usually difficult to assess accurately which came first, exposure to the suspected risk factor or the condition. For example, many community surveys have found that women who have been battered tend to have more children than non-battered women. However, these studies often do not collect information on when in the marriage the violence began. Nor can one tell from this kind of data whether having many children increases women's risk of being abused, or whether it is actually a consequence of abuse and results from coerced sex or the control many abusive partners exert over their partner's use of contraception. It is sometimes possible to assume that one event occurs before another. (For example, "injuries due to violence" by definition must have taken place after the violence, not before.)

It is often common for cross-sectional surveys to collect some retrospective information (e.g., "when did the violence begin?"). However, to determine causality with greater precision, it is preferable to study individuals over time, or **longitudinally**. **Longitudinal studies** may be either **prospective** (forwards) or **retrospective** (historical). The most common public health research designs for collecting longitudinal data, **cohort studies** or **case-control studies**, will be described in the next section.

Longitudinal studies *follow a group of individuals over time. Longitudinal studies may be either:*

- *Prospective, meaning that changes are followed starting at the present time and into the future, or*
- *Retrospective, or looking at individuals' past history.*

COHORT STUDIES: EXPLORING THE CONSEQUENCES OF VIOLENCE

Cohort studies, also called **follow-up** or **incidence studies**, begin with a group of people (a cohort) that has not experienced a problem or condition. The people are classified according to whether they have been "exposed" to a potential cause (or risk factor) of a condition or disease. The whole cohort is then followed over time to see whether those individuals with the suspected risk factor are more likely to develop the condition or disease than the group without prior exposure. (See Figure 4.1 for an example of how a cohort study could be applied to a

Cross-sectional surveys

- *Provide a snapshot of a population's characteristics.*
- *Can be carried out on a population or community level, or in a service context.*
- *Require special sampling techniques to ensure that the findings are representative of the general population from which the sample was selected.*
- *Are relatively easy and inexpensive to design and implement, compared with cohort and case-control studies.*
- *Can provide retrospective (historical) information.*
- *Make it more difficult to determine when events took place, compared with a longitudinal study. Therefore it is important to be careful in concluding whether one condition or event causes or leads to another (also referred to as causality).*

BOX 4.2 DOMESTIC VIOLENCE IN CAMBODIA: A CROSS-SECTIONAL STUDY

Background and methods

In 1995, Cambodia became the first Asian country to undertake a representative sample survey of domestic violence. This study, initiated as a joint project between the Ministry of Women's Affairs (MoWA) and a Cambodian NGO, The Project Against Domestic Violence (PADV), surveyed 2,764 Cambodian households in six provinces and in Phnom Penh, the capital of Cambodia. The aim of the study was to determine the prevalence and nature of violence in Cambodian families, as well as awareness of violence. The survey grew out of an earlier qualitative study entitled *Plates in a Basket Will Rattle* (see Box 5.5 in Chapter 5). This study revealed the devastating impact of violence on the lives of Cambodian women, but raised questions about how widespread domestic violence actually was and whether men were also victims of partner abuse.

In all, 1,374 women and 1,286 men were interviewed (the men were not the partners of the women, but were sampled from nearby villages). The quantitative study used a modified version of the Conflict Tactics Scale (CTS) as a basis for measuring abusive behavior (the CTS is described in Chapter 6). In this survey, the CTS was modified to include behaviors that the Khmer staff of MoWA and PADV identified as common in Cambodia. Questionnaires were first written in Khmer, then translated and back-translated several times to ensure that the English and Khmer versions were clear, consistent, and meaningful. The survey used two questionnaires per household. The first instrument was a brief questionnaire that served to gather basic demographic information on all of the residents of the household. The second instrument was an individual-level questionnaire that was used to collect information on the respondent's perceptions of violence and on their individual experiences of specific abusive acts. Prior to the field work, all members of the research team underwent a three-week training course on domestic violence issues, interviewing techniques, and the logistics of random selection of households.

Findings

Sixteen percent of women reported having been physically abused by a spouse, and 8 percent, or one-half of all women reporting abuse, sustained injuries. More than 50 percent of reported injuries were head injuries. In contrast, 3 percent of men reported abuse by a spouse and less than 1 percent reported injuries due to abuse. Women living with their natal kin were less vulnerable to spousal abuse, suffering half as much abuse (8.3 percent) as the overall population of women. Thirty-four percent of abused women said they had not sought help from anyone.

(From Nelson and Zimmerman, 1996.[2])

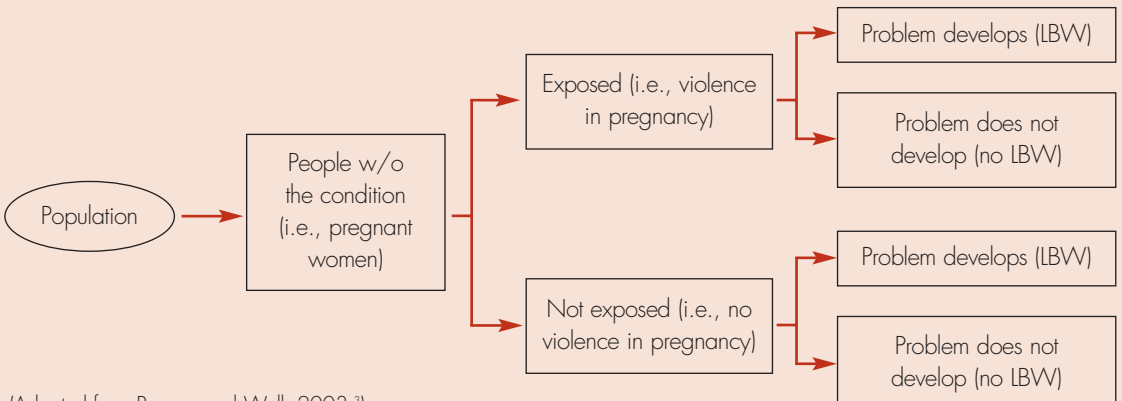
study of violence during pregnancy and low birth weight.)

Well-known examples of this type of research design include long-term studies to determine whether smoking causes lung cancer, or whether exercise reduces the risk of heart disease. The likelihood that an individual who has been exposed to a certain risk factor will contract the disease or condition can be calculated as the **relative risk**, which compares the rates or risks of a specified outcome between groups that have different exposures to the risk factor under study. For example, relative risks are used to estimate the probability that a woman who is beaten during pregnancy will have a baby with low birth weight compared to a woman who has not experienced abuse during pregnancy

Cohort studies provide the best information about the causes of health and social problems and the most direct measurement of the risk of developing a certain condition or disease. They also permit a researcher to study several outcomes with regard to a single exposure. For example, it would be possible to determine the effect of violence during pregnancy on infant birth weight as well as on women's physical and mental health.

A cohort study design might also be used is to evaluate the effectiveness of an intervention over time. For example, the

FIGURE 4.1 DIAGRAM OF COHORT STUDIES (USING A STUDY OF LOW BIRTH WEIGHT AS AN EXAMPLE)



(Adapted from Persson and Wall, 2003.[3])

PHOTO BY M. ELLSBERG

Interview in Ethiopia

Nicaraguan NGO *Puntos de Encuentro* is currently carrying out a cohort study of 4,500 young people in three sites to find out whether their mass media program has been successful in changing the attitudes and behavior of youth with regard to high-risk sexual practices, use of violence, and stigmatizing attitudes toward persons living with HIV/AIDS. The same individuals will be interviewed at the beginning, middle, and end of a television series, developed by Puntos, called *Sexto Sentido* (Sixth Sense). The study will compare changes in attitudes and behavior between individuals who watched the program regularly, and those who never watched the program.[4]

The main drawback to cohort studies is that, despite being conceptually simple, they require more resources and time than other research designs. This is particularly true when studying relatively rare conditions, such as infant or maternal deaths, or where the outcome of interest occurs a long time after exposure to the risk factor, as in the effect of smoking on cancer incidence. These kinds of studies tend to involve very large samples and many years of follow-up before results are obtained.

Box 4.3 presents an example of a relatively simple cohort study by Parker and colleagues carried out in the United States to look at the impact of violence in pregnancy on birth weight. This study would be fairly easy to replicate in other settings because women are recruited to the cohort through their attendance at prenatal services, and because the follow-up period is relatively short. This design would work well in settings where a majority of women attend prenatal care, because the women in the cohort would be likely to be fairly similar to women in the population in general. However, it is less suited to a setting where few women attend prenatal care, because the women in the cohort would likely be quite different from other pregnant women in the community. Also, if women do not give birth close to where they received prenatal care, or if most women deliver at home, it may be difficult to obtain accurate birth weight information. In this case, a case-control design, such as the one described in Box 4.5, may be more suitable.

Cohort Studies

- *Follow a group of individuals over time.*
- *Allow researchers to determine whether individuals who have been exposed to a suspected risk factor for disease are more likely to develop the condition or disease than the group without prior exposure.*
- *May study several outcomes in relation to single (or multiple) exposures.*
- *May be prospective or retrospective (although prospective cohort studies are more common).*
- *Are considered the best way to determine the causes of a disease or condition.*
- *May be costly to perform, as cohort studies often require very large samples and follow-up over long periods.*

CASE-CONTROL STUDIES

Case-control studies—also known as **case referent studies**—are relatively simple and economical to carry out. They include people

Case-control studies

- *Include people with a disease or other condition and a suitable control or reference group of people not affected by the condition or problem.*
- *Collect retrospective data on the individuals' exposure to potential risk factors.*
- *Study only one outcome at a time.*
- *Permit the identification of risk factors for disease.*
- *Usually require much smaller sample sizes than cohort studies.*
- *Are relatively simple and economical to carry out.*

BOX 4.3 ABUSE DURING PREGNANCY: A COHORT STUDY

Background and methods

The purpose of this study was to determine the incidence of physical and sexual abuse in a cohort of adult and teen pregnant women and to determine the effect of abuse on the birth weight of their babies. Using three simple screening questions for abuse, 1,203 African American, Hispanic, and white urban women in the United States were interviewed on their first prenatal visit and in the second and third trimesters. Infant birth weight was obtained by record review.

Findings

Abuse during pregnancy was reported by 20.6 percent of teens and 14.2 percent of adult women. Both abused teens and adults were significantly more likely than nonabused women to enter prenatal care during the third trimester (21.9 vs. 7.5 percent for teens; 15.8 vs. 8.7 percent for adults). Among the total sample of 1,203 women, women who were abused during pregnancy were significantly more likely to deliver infants with low birth weight, and to experience low maternal weight gain, infections, and anemia. They were also more likely to smoke and to use alcohol or drugs.

(From Parker et al, 1994.[5])

BOX 4.4 THE DIFFERENCE BETWEEN ODDS RATIO AND RELATIVE RISK

The association between risk factors and outcomes is expressed somewhat differently in case-control studies and cohort studies. Cohort studies use **relative risk** and case-control studies use **odds ratios.**

Both can be translated into lay terms by referring to the relative likelihood of an outcome occurring in the case of cohort studies (e.g., low birth weight), or the relative likelihood of being exposed to a risk factor (e.g., violence during pregnancy) in the case of case-control studies. Although this distinction may appear small, it is useful to keep in mind when interpreting research results. For example:

- A relative risk of 3.0 in a cohort study of violence during pregnancy and low birth weight indicates that women who are beaten during pregnancy are three times more likely to have low birth weight infants than their nonabused peers.
- An odds ratio of 2.0 in a case-control study on the causes of low birth weight indicates that infants with a low birth weight are twice as likely to have mothers who were beaten during pregnancy.

When an odds ratio or relative risk equals 1.0, it means that there is no association between two variables, and a value greater than 1.0 indicates risk. A value less than 1.0 indicates that the exposure has a "protective" or preventive effect with regard to the outcome. Both odds ratios and relative risk figures are usually accompanied by **95 percent confidence intervals (95 percent CI),** indicating the likely range for the true ratio. A statistically significant range is one that does not include 1.0. Sometimes a statistical test is performed resulting in a p-value. This gives the probability that the observed association is simply due to chance. If the p-value is very small (< 0.05), then we can say there is evidence that the association is real, and not merely due to chance.

with a disease or other condition (such as experiencing violence or depression) and a suitable control or reference group of people not affected by the condition or problem. The "cases" should represent all individuals from the specified population having the condition or disease being studied. The controls are then selected randomly from the same population, excluding those who already have the problem (see Figure 4.2).

Retrospective information is collected from both groups, with particular attention to the time before the onset of the condition. The frequency and distribution of suspected risk factors is then compared between cases and controls, and inferences may be made regarding the causal factors that increase the risk that a particular outcome will occur. The results are expressed as an **odds ratio**, which communicates the odds that a person with the disease or condition was exposed to the risk factor, compared to someone without the condition. See Box 4.4 for an explanation of the differences between odds ratios and relative risk.

In the study of violence, case-control studies may be useful for exploring factors that increase women's risk for abuse, or for examining the effects of violence on other health outcomes. They are particularly useful for studying events or diseases that occur infrequently in a given population, such as infant mortality, because the overall sample size needed is much smaller than in cohort studies. When cases and controls are matched according to known confounding factors such as age and sex, the design is even more powerful in its ability to predict the outcome.

One constraint of case-control studies is that although multiple causes of a condition may be examined, only one outcome can be studied at a time. For example, to study the effects of violence on both birth weight and infant mortality, it would be

necessary to design two different studies, one where the "cases" were infants with low birth weight, and another where the cases were defined as children who died under a certain age.

Boxes 4.5 and 4.6 describe two examples of case-control studies—a low birth weight study that was carried out in a hospital setting, and a study of child mortality risk that was nested as a substudy within a larger household survey on reproductive and child health. The child mortality study in particular demonstrates the potential benefits of integrating research on violence into other research projects. Although violence was not the primary focus of the child mortality study, the integration of a set of questions regarding mothers' experiences of violence complemented other research efforts on violence in the same region. They provided unique insight into violence as a contributing cause of child mortality, which would otherwise have been quite difficult and costly to obtain.

BOX 4.5 DOMESTIC VIOLENCE AND LOW BIRTH WEIGHT: A CASE-CONTROL STUDY

Background and methods

This study was performed in León, Nicaragua, in 1996. It differs from the child mortality study (Box 4.6) in that it was carried out in a hospital setting. This design was chosen because of the difficulties in obtaining reliable birth weight information from women interviewed in a household survey.

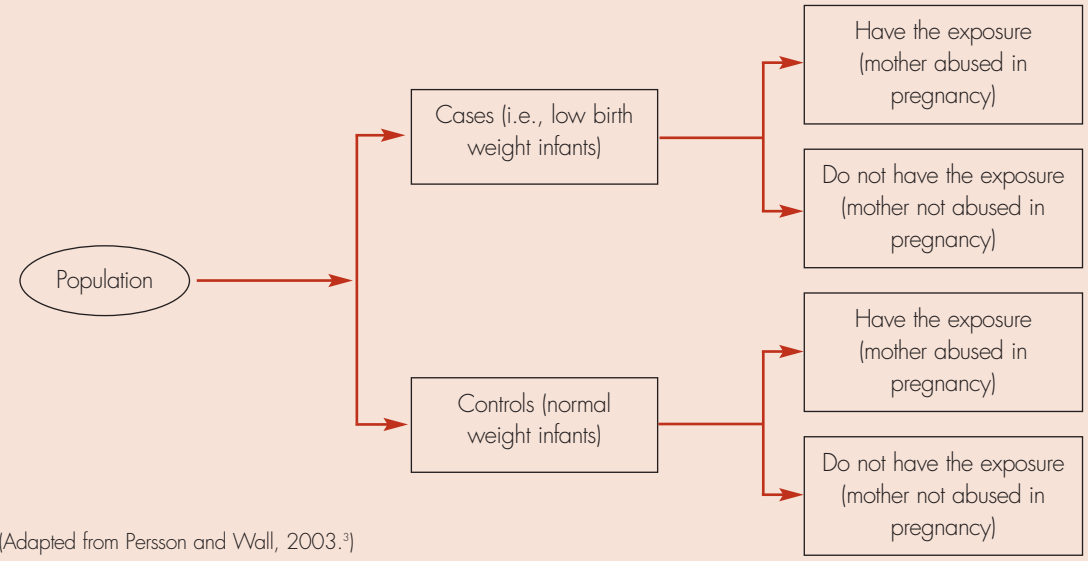
During a two-month period, all births in the León Teaching Hospital were monitored and 101 infants weighing less than 2,500 grams were selected as cases. Two controls were randomly selected for each case among infants weighing 2,500 grams or more. Mothers were interviewed in a special private room before leaving the hospital, usually within 24 hours of delivery. Women's obstetrical histories were taken and compared whenever possible with hospital and prenatal records. Women were also asked about other relevant risk factors for low birth weight (LBW), such as smoking and alcohol use, and experiences of violence ever and during pregnancy, using the Abuse Assessment Screen.

Main findings

In this study, the following factors among mothers were found to be associated with having a LBW infant: mother's young age, pre-eclampsia and bleeding, lack of or inadequate prenatal care, smoking, mother's stress during pregnancy, poverty, and violence during pregnancy. Physical abuse during pregnancy was found in 22 percent of mothers of LBW infants (cases) compared with 5 percent among controls. This association was significant even after adjusting for socioeconomic and medical risk factors. The study concluded that after poverty, violence was the second major cause of low birth weight in León, accounting for about 16 percent of LBW. This placed violence ahead of smoking, pre-eclampsia, or bleeding, all of which are recognized risk factors for LBW.

(From Valladares et al, 2002.[6])

FIGURE 4.2 DIAGRAM OF CASE-CONTROL STUDIES



(Adapted from Persson and Wall, 2003.[3])

BOX 4.6 THE IMPACT OF VIOLENCE AGAINST WOMEN ON CHILD MORTALITY: A CASE-CONTROL STUDY

Background and methods

This study was carried out in León, Nicaragua, in 1996 by researchers from the National University at León and Umeå University, Sweden. The purpose of the study was to determine the impact of physical and sexual violence against women on both infant and under-five mortality risks.

The study was obtained from an ongoing demographic surveillance system in León. A household survey was conducted of 9,500 homes, in which 12,000 women ages 15-49 years were asked about their reproductive histories, including information about any children who were born, or who had died in the last two years. Through this process, 132 children were identified who had died within the previous two years before the age of five. These children were classified as the cases. For each case, two controls, matched by sex and age at the time of death, were randomly selected from the same population. Specially trained interviewers returned to the homes of the cases and controls and administered a new questionnaire to the mothers. The questionnaire focused on the circumstances leading up to the death of the child (for cases) or the 12 months prior to the interview (for controls), including her experiences of physical and sexual abuse. Because it was not possible to trace all the mothers, a final total of 110 mothers of cases and 203 mothers of controls were interviewed.

Findings

The study found that 61 percent of mothers of deceased children and 39 percent of those of controls had lifetime experience of physical or sexual abuse. Physical abuse by a partner during pregnancy was twice as frequent among mothers of children who had died (23 percent vs. 13 percent). The risk of under-five mortality, adjusted for relevant socio-economic factors, was two times greater among children whose mothers had experience of either physical or sexual partner abuse. The risk of under-five mortality for a child whose mother had experienced both physical and sexual partner abuse was six times greater than children whose mothers had never experienced violence. The study concluded, after adjusting for other risk factors, that violence against mothers could be responsible for as much as one third of child deaths in León.

(From Åsling-Monemi et al, 2003.[7])

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PHOTO BY HAFM JANSEN

Qualitative Approaches to Research

Topics covered in this chapter:

Rapid assessments
In-depth qualitative studies

Qualitative research methods are extremely useful to researchers and advocates interested in violence. Qualitative methods—especially rapid assessment techniques—are helpful for assessing community needs, designing prevention campaigns, planning and evaluating interventions, and engaging community actors via participatory research. They are also useful in designing and field-testing questionnaires, and in interpreting quantitative research findings. Qualitative methods provide greater insight into motivation, meanings, and dynamics of violent relationships.

In many cases, a qualitative approach will suit a specific study aim better than quantitative methods. For example, if the primary purpose of research is to help plan an intervention, it may be more constructive to use available resources to understand community attitudes toward violence and the responses and attitudes of institutional actors—such as the police, health care providers, and the clergy—toward victims. In such cases, the very process of doing research can initiate a public discussion of violence and open a dialogue with key institutional actors.

Likewise, if the goal is to better understand the mindset and attitudes of abusive men, it will be more productive to use qualitative techniques to probe how men view their partners, how they justify and interpret their behavior, and the incidents or "transgressions" that set them off. Qualitative techniques will foster much more nuanced understanding of these issues than will quantitative surveys.

For the purposes of this manual, we divide qualitative research into two main types of research designs: **rapid assessments** and **in-depth qualitative studies**. Individuals new to the field of qualitative research will want to seek guidance from someone familiar with these techniques before pursuing a qualitative research project. In addition, readers are encouraged to consult some of the excellent resources on qualitative data collection and analysis listed in Appendix III.

RAPID ASSESSMENTS

A rapid assessment is an exploratory study done as a prelude to designing an intervention or as a means of supplementing and/or refining quantitative research (for example, helping to identify local terms used for different diseases in order to design a questionnaire). A rapid assessment responds over a relatively short period to a few specific questions with concrete applications; for example, What kinds of services do rape victims want? What words do women use to describe abuse? How do community leaders regard the use of advocates to accompany women when they report violence to the police?

A rapid assessment does not pretend to provide a full, detailed account of all aspects of abuse. Its purpose is to guide the development of research instruments (e.g., survey questionnaires), to assess local needs, or to evaluate interventions. Participatory research designs are particularly appropriate when the aim is to stimulate discussion and reflection within a community about an issue, and to promote community-based actions.

In the last 20 years, rapid assessment techniques have become very popular as a means to aid project and instrument design, and to evaluate interventions. The field of public health research—once dominated by Knowledge, Attitudes, and Practices (KAP) surveys and epidemiological research—has now incorporated a broad array of qualitative methods borrowed from the fields of marketing, popular education, agriculture, and social anthropology. **Rapid assessments** can draw on any number of techniques including focus groups, participant observation, in-depth interviews, or more participatory techniques such as mapping, pile sorts, community mapping, and seasonal calendars.

Participatory Rural Appraisal *is a growing family of approaches and methods designed to enable local (rural or urban) people to express, enhance, share, and analyze their knowledge of life and conditions, to plan and to act.* (Chambers, 1994.[1])

Within the larger category of rapid assessments are a variety of research traditions, including Rapid Rural Appraisal, Participatory Rural Appraisal, Participatory Action Research, and situation analysis. The diversity of names and methods used for these approaches reflects their different historical roots as well as some key conceptual differences. One major distinction is the degree to which the investigator versus the community guides and implements the research process. In recent decades, various forms of participatory research have evolved as an alternative to investigator-led initiatives. Participatory research tends to blur the distinction between research and intervention and can be an excellent way to raise consciousness about violence and to initiate community work on sensitive topics like violence. The following is a brief summary of the most commonly used approaches to rapid assessment.

Participatory appraisals

In the 1970s, researchers in the field of agricultural development and natural resource management developed a set of rapid assessment techniques that provided a quick and reliable alternative to traditional methods for conducting agricultural research. Collectively known as **Rapid Rural Appraisal (RRA)**, these methods included such techniques as seasonal calendars to determine patterns of rainfall, crop production, and disease; "transect walks" to document soil and vegetation patterns; and community mapping. The methods of RRA were primarily adapted from social anthropology and quickly became popular among researchers because they produced reliable results, often as good as or better than those obtained by much more costly and time-consuming quantitative studies.

In the 1980s, RRA was increasingly criticized because of its emphasis on extracting information from communities for the use of outsiders. The critiques of RRA led to the development of a new research trend called Participatory Rural Appraisal (PRA). PRA emphasized participation of the local community in the development of the appraisal, the use of diverse methods, and the knowledge generated by the community. In recent years, the methods of PRA have been used in many other fields, including urban development. Although the methodology did not originally incorporate a systematic gender perspective, many of the techniques have been modified to give greater visibility to gender gaps in access and control of resources.

In contrast to PRA, which developed out of the experience of northern-based researchers, **Participatory Action Research (PAR)** is rooted in the popular education movements of the south, particularly those of Latin America. Popular education, initially conceptualized by Paulo Freire in Brazil and later developed by social movements in many countries during the 1980s, considers research within a participatory framework of learning and action, and takes the knowledge and experience of community members as a point of reference. The educational techniques used in PAR are designed to stimulate group reflection on an issue and to motivate participants to act collectively to address the problem.

The PAR process follows a circular logic of research and action; empowerment of individuals and the community is achieved primarily through collective endeavor. Therefore PAR, as well as popular education, is a much more political process than PRA, in that individual and collective empowerment of participants is an explicit goal. In fact, the "success" of a PAR project is measured by the social transformations it catalyzes rather than by the information it generates. PAR is an excellent choice if the main goal is social change and the transfer of skills. If accuracy of the data is

BOX 5.1 SEXUAL VIOLENCE IN KENYAN REFUGEE CAMPS: A PARTICIPATORY APPRAISAL

Background and methods

Sexual violence against women in the Dadaab refugee camps, located in Northeast Kenya, has been an issue since refugees began arriving from Somalia in 1991. The number of reported rapes (106 in a population of 106,000) in the first nine months of 1998 was higher than the number for all of 1997. CARE and the German technical cooperation agency GTZ conducted an assessment of sexual violence in the Dadaab refugee camps as part of a wider initiative by CARE to review women's issues in the camps.

The assessment was designed to collect information to answer several critical questions to guide future programming, including:

- Determining the extent of the problem.
- Determining areas of security concern regarding sexual violence.
- Identifying what services and programs exist.
- Obtaining information and perceptions of those most affected by the issue.
- Obtaining information and perceptions of potential service providers.
- Analyzing the collected information with agencies and community representatives to develop proposal ideas.

The assessment was refugee-driven, in the sense that it focused on substantive discussions with many refugee groups to define the problem and causes and to suggest solutions to reduce sexual violence. Participatory Learning and Action methodologies, including free listing, community mapping, causal flow diagrams, and pairwise ranking, were used to structure discussion sessions with refugees (examples of how these methods were used in the Dadaab appraisal are presented in Chapter 9). The team also interviewed main agencies involved in protection services and prevention activities. Additionally, a record review was conducted of reported cases of sexual violence in the past three months. The following were among the findings that were discussed with the communities and involved agencies to improve security for women at the camps.

Areas of vulnerability

Groups identified several areas within the camps, including in and around bore holes and water tap stands and places where the living thorn fences that surround the camp had been destroyed. Vulnerability was also linked to time: People stated that they were afraid to leave their homes after dark. Women reported that they felt vulnerable when they left their homes to line up predawn at the hospital to be assured an entry ticket for health services that day.

Firewood collection

The record review of sexual violence cases showed that over 90 percent of the reported rapes and attempted rapes occurred when women left the camps to collect firewood. The firewood issue is the most problematic, because inexpensive options to replace firewood as a fuel are limited for a camp population estimated at about 106,000 people. Many women are now traveling in large groups to collect firewood. Sudanese and Ethiopian males collect or purchase firewood to reduce the need to go to the bush in search of fuel.

(From Igras et al, 1998.[2])

BOX 5.2 JIJENGE! A PARTICIPATORY ACTION RESEARCH PROJECT IN TANZANIA

Background and methods

In 1996, Jijenge!, which means to "build yourself" in Kiswahili, was established in Mwanza, Tanzania, in an effort to address the physical and social determinants of women's poor sexual health by promoting sexual health. The programs at Jijenge! include a reproductive health clinic, sexual health and HIV counseling and testing services, advocacy, community awareness, and training, and all work to empower women to proactively claim their rights. In 1997, Jijenge! staff and volunteers decided to undertake a participatory rapid assessment on violence against women. The goals of the project were to initiate public discussion of the topic and to lay the groundwork for a more extensive intervention.

The rapid assessment consisted of focus group discussions (FGDs), a baseline survey, and in-depth interviews. Most of the research, conducted by Jijenge!'s Community Awareness Coordinator and the volunteers, was done in the community, except for a few in-depth interviews and one women's FGD which were held at Jijenge! for safety reasons.

Focus group discussions. Seventy-seven people—37 women and 40 men—were involved in the FGDs: two female groups, two male groups, two mixed groups with general community members, and one mixed group with community leaders. The single sex FGDs were extremely useful; participants shared experiences and opinions honestly and the women were particularly supportive of one another. The two mixed groups with general community members were somewhat less fruitful because some women were noticeably inhibited in the company of men. Participation of both women and men in these mixed groups was clearly influenced by perceptions of status and power, and the roles they needed to maintain in mixed company.

In-depth interviews. Eighteen in-depth interviews were held with ten women and eight men. The interviews provided rich contextual information that deepened understanding about the complexity of beliefs perpetuating violence and the subsequent effects on women and men's lives.

Selected findings

Community members commonly referred to violence as a necessary form of discipline. A man, as the head of the household, is believed to have the responsibility to discipline all family members. In the study, violence—physical, verbal, or emotional—emerged as an acceptable way to teach lessons to women and children. Family violence is a common tactic for asserting authority and power over women.

Although violence occurs at an alarming rate in this community, it is also believed that violence between a husband and wife is a "domestic matter" that should not be raised by an outsider. Some women experiencing violence did not confide in family or friends because they felt that this would label them as a "bad wife or mother." Women accepted responsibility for men's violence, blaming their own behavior instead of their partner's inability to manage his emotions appropriately. This shame and stigma keeps violence underground and prevents community members from supporting the women experiencing violence or confronting violent men.

The findings from this study helped organizers better understand local attitudes toward abuse before designing a program of intervention.

(From Michau, 2002.[3])

critical, a more traditional approach may be a better choice.

The main tenets of participatory research are that:

- **It involves a flexible, iterative process** of exploration that stimulates creativity, improvisation, and flexibility in the use of methods to facilitate learning.
- **Community members direct the process**, in the sense that knowledge is produced on the basis of their own experiences. By the same token, community members define the priorities of the appraisal, as well as the collection, analysis, and interpretation of data.
- **The role of outsiders is to facilitate rather than direct** the learning process and the production of knowledge.
- **Participants, not just the researchers or external agents, own the methods and the results.** The socialization of knowledge and techniques in participatory research is greatly encouraged.
- **Diversity is enhanced rather than averaged out.** Participatory research attempts to reveal differences between situations, attitudes, and practices according to social class, gender, and ethnicity and tries to learn from cases that apparently do not conform to the expected.
- **Triangulation is used to validate results.** This refers to the use of different methods for studying the same phenomena, or using the same method with groups that represent diversity, for instance by gender and class, to see whether results are valid for each group.
- **The entire process, not just the results**, is designed to enhance

empowerment of individuals and communities, thereby stimulating social change.

Examples of participatory research studies are presented in Box 5.1 and 5.2.

Situation analysis

Situation analysis first became popular within family planning research in developing countries. In the 1990s, violence researchers appropriated the term, which they used to refer to a set of rapid assessment techniques designed to evaluate existing community attitudes and practices regarding victims of abuse. Situation analyses were first used in violence research in several Mexican cities; New Delhi, India; and Harare, Zimbabwe. Situation analyses are a useful way to enter a community and begin working on violence.

Situation analyses rely on a combination of focus groups, semistructured interviews, and observation, directed at establishing both community attitudes and beliefs regarding violence and the attitudes and practices of key institutional actors, such as police, judges, social workers, clergy, and health professionals. Generally, situation analyses include focus groups with key subgroups in the population (young women, old women, young men, older men, abused women, rape victims, and so on) and interviews with a quota sample of different providers. Questions are geared toward assessing the adequacy of current institutional responses to victims of violence and the degree of support and/or victim-blaming extended to abused women. An example of a situation analysis performed in Kenya to improve postexposure HIV prophylaxis to rape survivors is described in Box 5.3.

Situation analyses can serve as a sort of community "diagnostic" that provides insights into needed areas of reform. The data they provide can also help convince community leaders that reforms are indeed

BOX 5.3 POSTRAPE SERVICES IN KENYA: A SITUATION ANALYSIS

Background

Violence is an important risk factor contributing towards vulnerability to HIV and AIDS. Discussions of opportunities and challenges around postexposure prophylaxis to reduce HIV transmission following sexual violence is growing. Gender-based sexual violence in Kenya is almost invisible, though reportedly more prevalent than officially acknowledged. Health care workers at primary health centers and voluntary counseling and testing sites are reporting increasing numbers of rape clients. There is increasing demand for VCT services and VCT scale-up as a key Kenyan strategy to fight HIV and provide infrastructure, capacity, and political support for provision of comprehensive postrape services.

Objectives

A qualitative situation analysis was undertaken to develop a strategy for the provision of comprehensive postrape services in the VCT context. A review of literature and international experience on sexual violence and service provision including the use of postexposure prophylaxis was undertaken. The study had two main objectives:

- To establish perceptions of gender-based sexual violence in Kenya.
- To document and analyze service provision for gender-based sexual violence within Kenya.

Methodology

The study focused on three districts. Nairobi, Thika, and Malindi were selected because of availability of VCT services and to capture geographical, social, and religious diversities. Assessment was done in 10 VCT sites, 16 hospitals, and 8 legal and advocacy support programs. Forty key informants were interviewed and 20 FGDs were undertaken. Analysis involved comparing and contrasting key themes emerging from different participants such as counselors and community members. Different research sites and research methodologies such as focus groups and interviews were triangulated.

Findings

Sexual violence was seen as shameful, with diverse views on whether rape happens in relationships. Greater participation in discussions on rape from male groups in comparison to female groups may suggest less social barriers to public discussions of sexuality for men. Generally, views presented by male groups seem to edge towards justification and tolerance for rape, in contrast to women's groups that felt the need for concerted efforts to address rape. Most people were unaware of what to do or where to go in the event of sexual violence. Provision of services by the police and at hospitals was seen to be lacking and rape survivors were often humiliated and retraumatized. Further, there is no documentation for rape and a weak chain of custody for investigation. Counseling services are nonexistent in public health institutions except in places where VCT services are available.

Conclusions

The implementation of postrape services within the VCT framework in Kenya must include:

- Multidisciplinary approaches to developing a regulatory framework.
- Integration of both counseling and clinical management in health care services.
- Building capacities for services provision.
- Development of referral systems.

(From Kilonzo et al, 2003.[4])

BOX 5.4 "LA RUTA CRÍTICA"—INSTITUTIONAL RESPONSES TO DOMESTIC VIOLENCE: A MULTI-COUNTRY QUALITATIVE STUDY

In 1995, PAHO began the implementation of a ten-country diagnostic study to document what happens when a woman affected by family violence decides to break the silence and seek assistance in ending the abuse. In Spanish, this process was called the "ruta crítica" or the "way out." In effect, the study asked, what happens when a woman decides to seek help? To whom does she turn for help? What factors motivate her to act or inhibit her from acting? What kinds of attitudes and responses does she encounter from institutional actors?

Altogether, researchers conducted over 500 in-depth interviews with battered women, interviewed more than 1,000 service providers, and completed approximately 50 focus group sessions.

Results show many factors—both internal and external—influence a woman's decision to act to stop the violence. In some cases, it takes many years and several attempts at seeking help from several sources. Rarely is there a single event that precipitates action. Findings suggest that many battered women are resourceful in seeking help and finding ways of mitigating the violence.

Battered women identified several factors that act as catalysts for action. An increase in the severity or frequency of the violence may trigger a recognition that the abuser is not going to change. An event may make it clear to her that she cannot modify the situation with her own internal resources. A primary motivating factor is the realization that lives—hers or her children's—are in danger.

> *"He mistreated the children badly. He only knew how to shout orders. There was a period when he would beat them. The children, particularly my oldest son, had become very disobedient, rebellious and had lost all motivation to study. He didn't go to school…"*
>
> *"I finally decided to leave when he burned all my clothes and also burned me."*
>
> *"The moment came when I said to myself that I had to find someone to help me because it was not possible to keep going on in this way. I had become hysterical, problematic, unhappy, mainly because I could see my beaten face every week in the mirror."*

What factors inhibit the process of seeking help?

As with the precipitating factors, the obstacles for seeking help are multiple and intertwined.

> *"One learns to live with the person even though he is an abuser. I don't know, for me he was my companion because I felt alone, without the support of a family. He was my family…"*
>
> *"I used to excuse him for that and I believed that through the love I had for him he was going to get better, and that this was not going to keep on."*

However, economic factors appear to weigh more heavily than do emotional considerations:

> *"The children were very young and I didn't think I could support them on my own. And I didn't want to burden my mother."*

These barriers are reinforced by battered women's feelings of guilt, self-blame, or abnormality.

> *"I tried to reflect on my own actions. What did I do to provoke him? I considered my personality…"*
>
> *"My mother would tell me that I was crazy and that is why I was seeing a psychologist and my brothers and sisters said the same thing."*
>
> *"There came a moment in which I really thought 'Am I crazy?' Then I sought help to make sure that what was happening to me was true."*

Women who sought help rarely began with formal health or police services. They initially relied instead on support from other women in the community, including female family members, neighbors, and health promoters. Many women related instances of being ridiculed or treated with indifference by health providers and local authorities.

> *"I finally told a friend that I trusted. I went to tell her because she is an older lady and she told me that he was wrong, that he was a sadist. She told me that I should get out of the house."*
>
> *"…Almost every time he abused me I would go to my friend's house and she would give me a place to sleep. I would even sleep on the floor, because she was poor. She was the one who finally said, 'This is too much. I am going to help you find help because that man is abusing you too much!'"*

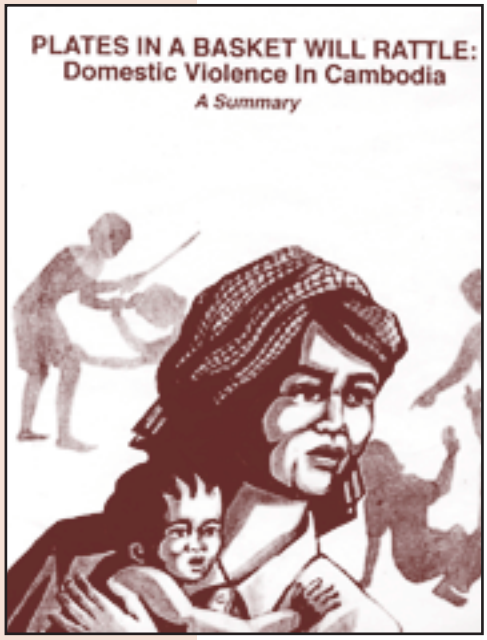
(From Sagot, 2000.[6])

BOX 5.5 "PLATES IN A BASKET WILL RATTLE": IN-DEPTH QUALITATIVE STUDY ON DOMESTIC VIOLENCE IN CAMBODIA

A common Cambodian proverb—"plates in a basket will rattle"—is used to explain family problems.

"If people live in the same house there will inevitably be some collisions. It's normal—it can't be helped. But, from time to time, plates break. So do women."

Background and Methods



The study, *Plates in a Basket will Rattle—Domestic Violence in Cambodia*, is based on in-depth interviews with 50 victims of domestic violence and one interview with the mother of a woman who was killed by her husband. Additional information was gathered from interviews with individuals that an abused woman is likely to encounter in her search for assistance, including judges and court personnel, police officers, district chiefs, village heads, medical workers and midwives, and staff from NGOs.

The subjects for the study were located primarily by word-of-mouth with the help of local community organizations. The main researcher (a North American) worked with two Cambodian colleagues to conduct the interviews. Before the research began, they had first to create words in high and low Khmer to refer to "domestic violence," since no words previously existed. Interviews took an average of half a day, and women were compensated for the income they could have made during this time by trading in the market. (This generally amounted to between 7,500 and 10,000 riels, or between $3 and $5 per woman.)

Prior to beginning the interviews, the team made contingency plans in case there was a woman who might be in immediate danger and request assistance. To this end, they contacted three local NGOs that offered to provide temporary shelter for victims.

Interview information was collected in the form of handwritten notes in Khmer, which were transcribed and translated into English immediately after each encounter.

Findings

The study highlighted the difficult plight of women who were severely beaten by their husbands. It showed how cultural norms, shame, and the lack of viable alternatives kept women in abusive relationships. Many of the women interviewed suffered physical abuse in pregnancy as well as sexual abuse and degrading treatment from their partners. Virtually no public institutions, including the police and health sector, were trained or sensitive to the needs of battered women.

The most important outcome of the study was that domestic violence became a public issue in Cambodia. The research helped catalyze a conference on violence, sponsored by UNICEF, and it played a role in the development of an antiviolence organization called the Project Against Domestic Violence. Many of the findings from the qualitative study proved critical in helping to lay the foundation for the quantitative study carried out subsequently (described in Box 4.2).

(From Zimmerman, 1995.[7])

needed. Situation analyses can be particularly productive when local community members assist in doing the interviews. In the Pan American Health Organization (PAHO) project, members of the local women's organization that provides services for victims of abuse frequently conducted interviews. Because of the demands of assisting victims, many advocates had never taken the time to approach the local forensic doctor, the village priest, or the chief of police. The research provided a structured environment through which to analyze institutional responses and to initiate dialogue with key institutional actors. (See Box 5.4)

IN-DEPTH QUALITATIVE STUDIES

Rapid assessments and **in-depth qualitative studies** differ mainly in the scope of research and methods of analysis. An in-depth qualitative study requires a more

BOX 5.6 SWIMMING UPSTREAM: VIOLENCE AND MASCULINITY AMONG NICARAGUAN MEN

Background

In 1998, the Nicaraguan NGO Puntos de Encuentro embarked on a study designed to gain information useful for designing a public education campaign that called on men to renounce violence in their intimate relationships. The study used qualitative research techniques to generate hypotheses about the type of antiviolence messages that men would accept and find appropriate to their needs and expectations.

Methodology

The research included three phases:

- Compilation and content analysis of the workshop transcripts and reports from meetings about men and masculinity in Nicaragua, including:
  1. Men's views about what it means to be a man in Nicaragua.
  2. Images and attitudes men hold about women.
  3. The advantages and disadvantages of "being a man."
  4. Men's memories of how they were raised to become adults (socialization).
- In-depth interviews with a sample of 12 nonviolent men. Researchers chose to interview nonviolent men based on the rationale that, rather than looking for "causes" of men's violence (and then offer a "medicine" with the campaign), it would be more productive to study what creates "health"—that is, how do we understand men who, in spite of growing up in a violent socio-cultural context, do not become violent themselves? To be considered "nonviolent," men had to be identified by their peers and pass a series of behavioral screens. Men exposed to feminist discourse were explicitly excluded.
- In-depth interviews with "ordinary" men.

Selected results

The research revealed that large differences exist between nonviolent and "ordinary" men. For example, ordinary men say that their relationships are best when their partner does not complain, or when she does what she is told. On the other hand, nonviolent men held very different expectations for relationships. For them, a "good relationship" is one where there is mutuality, reciprocity, and mutual support.

Nonviolent men perceived both benefits and costs to this behavior. Among the benefits identified were greater tranquility and harmony at home; a "good reputation" in the community, feeling good about oneself, health and well-being of one's children, and a household that runs more smoothly day to day. Among the costs of "swimming upstream" against a machista culture were ridicule and ostracism by other men.

Nonviolent men either grew up in very loving homes where they were taught to respect women or in very violent homes, where their own mothers were beaten and they vowed never to be like their fathers.

(From Montoya, 1998.[8])

detailed and more time-consuming research design. It involves extensive data collection, processing, and analysis. While in-depth studies often use many of the same techniques as **rapid assessments** for collecting data (e.g., focus groups, observation, and interviews), they are generally conducted over longer periods, use more respondents, and entail more systematic data analysis. (Chapter 13 describes in greater detail some of the basic techniques for qualitative data analysis.) In general, one conducts an in-depth study for the following reasons:

- To advance theoretical understanding of an issue and/or to gain a more complete understanding of a phenomenon than can be gained during a shorter study.
- To understand cultural norms, beliefs, and behaviors or to capture and analyze complex motivations.

Such studies frequently rely on detailed interviews that require enormous amounts of time and energy to transcribe, code, and analyze. Many researchers underestimate the challenge of coding and interpreting reams of qualitative data. Performing an in-depth qualitative study is

TABLE 5.1 DIFFERENT TRADITIONS IN QUALITATIVE RESEARCH

Dimension	*Biography*	*Phenomenology*	*Grounded Theory*	*Ethnography*	*Case Study*
Focus	Explaining the life of an individual	Understanding the essence of experiences about a phenomenon	Developing a theory grounded in data from the field	Describing and interpreting a cultural and social group	Developing an in-depth analysis of a single case or multiple cases
Discipline origin	Anthropology, literature, history, psychology, sociology	Philosophy, sociology, psychology	Sociology	Cultural anthropology, sociology	Political science, sociology, evaluation, urban studies, other social sciences
Data collection	Primarily interviews and documents	Long interviews with up to ten people	Interviews with 20-30 individuals to "saturate" categories and detail a theory	Primarily observations and interviews with additional artifacts during extended time in the field (e.g., six months to a year)	Multiple sources, documents, archival records, interviews, observations, physical artifacts
Data analysis	Stories, epiphanies, historical content	Statements Meanings Meaning themes General description of the experience	Open coding Axial coding Selective coding Conditional matrix	Description Analysis Interpretation	Description Themes Assertions
Narrative form	Detailed picture of an individual's life	Description of the "essence" of the experience	Theory or theoretical model	Description of the cultural behavior of a group or an individual	In-depth study of a "case" or "cases"

(From Creswell, 1998.[5])

as complex and time-consuming as conducting a community survey.

In-depth qualitative studies are not all the same, however. In fact, this term refers to a broad category with many different traditions. Creswell identifies the five most commonly used traditions in qualitative research as: biography, phenomenology, grounded theory, ethnography, and case studies.[5] Although the methods for data collection are similar, the theoretical underpinnings and the approaches to data analysis and interpretation differ greatly. Table 5.1 presents a brief description of these traditions.

Because an in-depth description of each tradition is beyond the scope of this manual, we recommend that readers consult the resources mentioned in Appendix III for more information about qualitative research.

Further examples of qualitative research on gender-based violence are provided in Boxes 5.4-6. Box 5.4 presents an ambitious multi-country study carried out by PAHO as a point of entry for developing coordinated community interventions against domestic violence in 25 pilot communities throughout Latin America.

Box 5.5 describes one in-depth qualitative study on domestic violence derived from interviews with abused women in Cambodia as well as with community leaders and service providers. This study, entitled *Plates in a Basket Will Rattle*, was the first of its kind in Cambodia, and provided extremely rich information about partner abuse in a society that has long

been ravaged by war. Finally, Box 5.6 presents a qualitative study done in Nicaragua to examine the roots of male violence against women. This study was performed to provide information for the development of a campaign directed towards men on violence prevention.

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PHOTO BY HAFM JANSEN

The Challenge of Defining and Measuring Violence in Quantitative Research

Topics covered in this chapter:

How does one decide what criteria to use to define and measure gender-based violence? Operationalizing main variables is a key issue in all cross-cultural studies, and especially in the study of violence. In qualitative research, it is not usually necessary to finalize these decisions before initiating data collection. In fact, a main goal of a qualitative study may be to understand what kinds of acts are considered violent by a particular woman or group of women. However, in most quantitative studies, particularly when the aim is to estimate the magnitude of violence in different settings, researchers need to develop clear definitions that can be compared across settings.

This chapter explores the challenge of measuring violence and emphasizes estimating the prevalence of different forms of abuse across a wide range of settings. It describes some major conceptual issues that underlie different approaches to measuring violence against women and reviews and critiques some of the most common instruments used internationally.

ESTIMATING THE PREVALENCE OF VIOLENCE

It is difficult to compare most international prevalence data on violence because different methods were used to obtain them. Prevalence is defined as the proportion of women who are abused in a given study population. (See Box 6.1 for a more detailed description of how prevalence figures are calculated.) Therefore, researchers face two major challenges in obtaining accurate prevalence data: how to define "abuse" and how to determine the study population. Researchers have addressed these methodological issues in

BOX 6.1 DEFINING PREVALENCE AND INCIDENCE

Prevalence is defined as the number of persons having a specific characteristic or problem, divided by the number of persons in the study population who are considered to be at risk of having the problem, usually expressed as a percentage. **Incidence** refers to the number of new cases of a problem divided by the study population over a specific period. For example, the incidence rate of diabetes refers to the number (usually expressed as x out of 1000, etc.) of people who are newly diagnosed with diabetes each year in a community, whereas the prevalence is the total proportion of people with diabetes in the community, regardless of how long ago they were diagnosed. The prevalence of violence against women refers to the number of women who have experienced violence divided by the number of at-risk women in the study population. (In the case of some kinds of violence, such as sexual assault, all girls and women may be considered at risk, but in other cases, such as intimate partner violence, only women who have ever had an intimate partner would be considered as at risk.) This can be measured as:

Period prevalence

$$\frac{\text{Women abused during a certain period (usually the last year)}}{\text{Women at risk in the study population}} \times 100$$

or

Lifetime prevalence

$$\frac{\text{Women abused at any time in their life}}{\text{Women at risk in the study population}} \times 100$$

The incidence rate of partner abuse refers to the number of violent events women experience during a specific period, such as one year. In crime studies, incidence of violence is generally measured as the number of assaults per inhabitant, rather than the number of women being assaulted, so that each beating that a woman receives is counted separately. Thus, the incidence rate can tell you what happened over the last year, but it may not tell you how many people were affected.

Although some kinds of violence might be measured as discrete incidents (e.g., a sexual assault by a stranger), many forms of gender-based violence, such as child sexual abuse and partner violence, may be ongoing processes and not easily captured as discrete events. Furthermore, the effects of a single assault may be long-lived. For this reason it is less practical or useful to measure violence in terms of incidence rates, and the magnitude of gender-based violence is most commonly presented in terms of prevalence.

many different ways, and there is little consensus as to the most appropriate method. A further complication is that surveys do not measure the actual number of women who have been abused, but rather, the number of women who are willing to disclose abuse. It is always possible that results are biased by either overreporting or underreporting.

In reality, researchers around the world have found no evidence that abuse is overreported.[1] To be identified as a victim of abuse in most societies is so shameful that few women report abuse when it has not actually occurred. Women are far more likely to deny or minimize experiences of violence due to shame, fear of reprisals, feelings of self-blame, or loyalty to the abuser. Box 6.2 outlines some of the most critical issues that can affect how prevalence data are calculated and interpreted.

THE STUDY POPULATION: CHOOSING INTERVIEW SUBJECTS

Study populations used for gender violence research vary greatly. Many studies include all women within a specific age range (frequently 15-49 or over 18), while other studies classify women according to marital status, and interview only women who have been married at some point in their lives, or women who are currently married. The logic underlying differences in the range of women included rests in the way researchers define the population at risk of abuse. Table 6.1 gives an overview of approaches used in past studies of partner violence.

Sometimes, researchers decide not to interview women below a certain age because of specific legal requirements regarding the participation of minors as research informants. In some countries, this decision depends on the average age of marriage. Because many prevalence studies are embedded in larger studies that focus on women's reproductive health—such as the Demographic and Health Surveys (DHS)—only women of reproductive age are included, thereby excluding the experiences of older women.[2]

Relationship status

Some studies further refine the study population according to the relationship status

of respondents. For example, studies on partner violence often include only women who are currently married because experience shows that these women are at greatest risk of current partner abuse. In some cases, researchers exclude from studies women in common-law relationships, or those who have been married for less than one or two years (see Table 6.1). We recommend using the broadest criteria possible for defining the study population. In the case of wife abuse, this would include interviewing all women in a specified age range, or at least all those who have ever had an intimate partner. Restricting the study population further may bias results for the following reasons:

- **The risk of partner abuse is not confined to women who are currently in formal marriages.** Some studies indicate that women in common-law relationships suffer a greater risk for violence than do married women.[3] Unmarried women may also be abused by their boyfriends. Many studies find that women who are currently separated are more likely to have been abused at some point in their lives by a partner, indicating that violence may be an important reason for women to separate from or divorce their partners.[2] In some countries, women are at greatest risk of abuse and even homicide immediately after separating from their partners. Therefore, excluding these women from the study population means that valuable information may be lost, and the study results will not reveal a true picture of how violence is affecting women's lives.

- **The risk of partner abuse is not confined to women who have been in a relationship for a certain length of time.** Some research indicates that wife abuse starts early in a relationship. In the Nicaragua survey, for example, 50 percent of abused women reported that the violence began in the first two years of the relationship, and 80 percent reported that the violence began within four years.[4] This indicates that women are at risk of partner violence

BOX 6.2 ISSUES THAT AFFECT THE MEASUREMENT OF GENDER-BASED VIOLENCE

How is the study population identified?

- Are there cut-off ages?
- Is marital status considered for eligibility?
- What geographic area is included in the study?

How is violence defined and measured?

- Who defines abuse—the researcher or the respondent?
- Over what period of time is violence being measured?
- Does the study distinguish between different types of abusers in terms of their relationship to the victim?
- Is frequency of violence measured?
- What types of violence are included (e.g., physical, sexual, emotional, economic, etc.)?
- Does the study gather information regarding the severity of violence?

Is the interview carried out in such a way that women are likely to disclose experiences of violence?

- How are questions on violence worded?
- What questions precede them?
- How are the questions introduced?
- How many opportunities do the respondents have to disclose?
- What is the context of the interview (privacy, length, skill of interviewer)?

TABLE 6.1 VARIATION AMONG STUDY POPULATIONS FROM RECENT POPULATION-BASED SURVEYS ON PARTNER VIOLENCE*

Country	*Study Population*
Cambodia	Ever-married women and men
Canada	All women aged 18 or older
Chile	Women aged 22–55 married or in a common-law relationship for more than two years
Colombia	Currently married women aged 15–49
Egypt	Ever married women aged 15–49
Nicaragua	All women aged 15–49
Philippines	All women aged 15–49 with a pregnancy outcome
Uganda	All women 20–44
Zimbabwe	All women 18 years or older

** References for the studies are listed in Table 1.1.*

BOX 6.3 FROM THE FIELD: NICARAGUA

An example from Nicaragua shows how prevalence estimates for intimate partner violence can vary greatly according to how the study population is defined, and whether the figures include only recent experiences or lifetime experiences of violence. In a study of 488 women ages 15-49 in León, Nicaragua, researchers compared the prevalence of lifetime and current violence between different subgroups of the sample and found large differences.[5] Only 8 percent of women who had dated but never cohabited with a man reported violence, compared to 52 percent of women who had lived with a partner at least once.

Researchers also found important differences between the prevalence of lifetime and current abuse among ever-married women (52 percent versus 27 percent). In the case of recent experiences of violence, not surprisingly, women who were married at the time of the interview had experienced more violence within the last 12 months than separated women. Nonetheless, the fact that 17 percent of women who were no longer married had also recently experienced violence draws attention to the possibility of violence by exspouses.

Lifetime and current prevalence of violence according to women's marital status.

	All women 15–49 (n=488)	Never partnered with boyfriend (n=79)	Ever partnered women 15–49 (n=360)	Currently partnered women (n=279)	Formerly partnered women (n=81)
Lifetime physical violence	40%	8%	52%	52%	53%
Current physical violence	20%	—	27%	30%	17%

the moment they enter into a relationship, and there is little advantage to excluding recently married women from the study.

- **Although partner abuse is one of the most common types of violence against women, women frequently experience other forms of physical, sexual, and emotional abuse during their lives.** Many of these experiences are intertwined with wife abuse, where, for example, sexual assault by a stranger can increase a woman's vulnerability to discrimination or abuse by her family or spouse. Experiencing multiple forms of abuse can make the effects of wife abuse particularly devastating. Because these patterns vary across cultures and settings, it is a good idea to define the study population as broadly as possible. This provides the opportunity to look at the patterns of violence that women experience throughout their lives, before narrowing the focus in subsequent analyses.

National versus regional studies

Two distinct research trends are emerging as more international data on violence against women become available. First, large-scale surveys primarily designed for other purposes increasingly solicit information on violence. For example, several Demographic and Health Surveys and Reproductive Health Surveys conducted by the Centers for Disease Control have included questions on violence in national surveys.[2,6] Although many of these surveys use one or two aggregate "gateway" questions to measure any type of violence, such as, "Have you ever been beaten by anyone since you were 15/were married? By whom?" some of the more recent studies include a module on domestic violence with more detailed information.

The second trend is represented by studies that are primarily designed to gather detailed information on women's experiences of violence. Many of these studies, such as the prevalence studies in Nicaragua, South Africa, and the WHO multi-country study, have relatively

smaller sample sizes and cover a limited geographical region, although there are important exceptions, such as the National Surveys on Violence Against Women in Canada (1993),[7] the United States (1997),[8] Sweden,[9] and Finland (1997).[10] These studies tend to gather much more information about different types of violence and perpetrators, as well as information on circumstances and women's responses to violence. They also tend to devote more attention to the interaction between interviewers and respondents and issues of safety.

There are potential advantages to including violence questions in national surveys designed primarily for other purposes. For example:

- In many cases, national statistics bureaus conduct the studies, and the results assume the legitimacy of "official statistics." This can be very useful for purposes of advocacy.
- Nationally representative data are useful for local program planning, and also permit in-depth analysis of variation between regions.
- The large data sets generated by these studies, including many other reproductive and child health outcomes, can be used to deepen understanding of risk factors and health consequences of violence.

There are also drawbacks to this strategy:

- In general, prevalence estimates have been higher in the more focused studies than in the national surveys designed primarily for other purposes.[11] One explanation may be that because the focused studies emphasize the use of methods for enhancing disclosure, they are able to produce more accurate prevalence estimates.[12]

  Thus, one tradeoff of using multipurpose surveys to produce prevalence estimates on violence is the risk that violence will be significantly underreported. Such underreporting can dilute associations between potential risk factors and health outcomes, leading to results that are falsely negative. Underestimating the dimensions of violence could also prevent violence intervention programs from receiving the priority they deserve in the allocation of resources.
- Finally, because many of these studies have not systematically addressed safety concerns, women who participate in them may face increased risk of retaliation or other harm.

Researchers and advocates should consider carefully whether they need national-level data in order to achieve their policy objectives. In many countries, advocates have successfully used the results of representative sample surveys of a single region, province, or significant city to raise public awareness of violence and to guide policy decisions. It is usually more important to have high-quality data that are not vulnerable to criticism on methodological or ethical grounds. Rather than expending extra effort to make a study "national," researchers might do well to explore violence in depth among a smaller, more condensed sample of individuals.

*The **study population** should be as broadly defined as possible, and, if possible, should be diverse with respect to ethnicity and socio-economic background, so that the results will be meaningful to a larger segment of the population.*

When conducting a regional study, it is important to select a study population diverse enough to allow comparisons between women of different socio-economic groups. The study population should also share important characteristics with other parts of the country. The results of a prevalence study carried out in a single

neighborhood of poor urban dwellers or in a small village composed only of members of an ethnic minority may be critically important for designing local interventions. However, because such a study does not include large sectors of the population, such as rural or middle class women or women of different religious or ethnic backgrounds, it is less useful for understanding how different women experience violence. Moreover, such studies are often dismissed as being too narrow, and have little effect on policy.

***Prevalence studies** need to have clearly defined criteria for determining what acts are considered as violence.*

DEFINITIONS OF VIOLENCE

Who defines abuse?

The way in which violence is defined has an enormous impact on the final results. Thus, it is crucial to establish from the beginning how violence will be defined and who will be considered a "case of abuse," to borrow a term from epidemiology.

The following are examples of criteria that have been used in studies of intimate partner violence:

- Any kind of physical, sexual, or emotional violence by any perpetrator at any time.
- One or more acts of physical violence by a partner at any time.
- Only physical violence of a certain level of severity, or which has been repeated a certain number of times.
- Only acts of partner violence occurring in the last year.
- Economic, as well as physical, sexual, or emotional violence.
- Any behavior that women themselves identify as abusive by virtue of its intent or effect (this may include such diverse acts as infidelity, verbal aggression or humiliating acts, coerced sex, or refusing to pay for household expenses).

How does one decide whether to use definitions developed according to criteria established by researchers, or to focus on acts which women themselves view as most harmful? The danger in relying exclusively on women's own definitions of abuse, referred to in social science as an "emic" approach, is that these may vary so greatly from one woman to the next, and between cultures, that it may not be possible to draw meaningful conclusions from the results. For example, the question, "Have you ever been abused by your partner?" is likely to underestimate the true occurrence of violence. Many women may experience severe physical violence and yet not identify this behavior as abusive, either because they are used to it or because such behavior is considered normal in their culture. Other women may answer positively, citing verbal offenses or humiliations as evidence of abuse. This information may help the researcher understand how different women perceive violence, but it is less useful in planning interventions or making cross-cultural comparisons.

One advantage of using externally derived definitions—an **"etic"** approach—is that this enables the researcher to make comparisons across different groups of women. The most common method is to ask women whether they have experienced a series of behaviorally specific acts of physical, sexual, or emotional violence, such as hitting, slapping, kicking, or forced sex. Women who disclose violence are then asked to specify their relationship to the perpetrator and the frequency or period in which it took place. The drawback of this approach is that you cannot know whether these acts have the same

meaning in different cultures or to different women. For example, punching a woman with a fist and kicking her may appear from the outside to be roughly equivalent, if "risk of injury" is used as the main criteria for severity. However, in some cultures, it is particularly demeaning to kick a woman because it implies that she is no better than an animal. In another country, an outsider might assume that a partner's refusal to speak to a woman is less serious than physical abuse. Nonetheless, the woman enduring the abuse might experience the same emotional pain and humiliation that she would from a physical blow.

Many researchers address this dilemma by combining approaches that ask about specific behaviors and ask women to interpret them. A researcher may ask women about specific acts, frequency, and perpetrators, followed by open-ended questions asking her to describe "the worst incident" or any other behavior or experience that she considers abusive. This approach can generate information on violence that researchers can compare to other settings and to other women's perceptions of their experience.

Types of violence

Partner violence. The range of violent acts that women may experience is quite varied, and so is the impact of specific acts on their lives. For this reason, it is important not to define partner violence too narrowly. For example, if you ask only about experiences of being hit or beaten, women may not mention that they have been raped, kicked, or burned. Although researchers initially focused primarily on physical violence, today their work also considers emotional and sexual abuse. Many studies also include other kinds of abusive or controlling behavior, such as limiting decision making power or mobility, or economic violence.

While it may be useful to identify women who have experienced abuse, it is important to present separately the prevalence of each type of violence. For cross-cultural comparisons, aggregating emotional, sexual, and physical abuse in a single domestic violence figure is likely to lead to confusion, for the following reasons:

- Definitions of emotionally abusive acts vary across cultures, which makes it difficult to find a valid definition.
- Combining these categories may reduce the credibility of the findings, as many policy makers consider emotional abuse to be less severe than the other types of violence.
- Different types of violence affect women's physical and psychological health in different ways. Therefore, grouping them together may obscure certain consequences of violence.

You should design your questionnaire so that different types of violence can be appropriately disaggregated. Although grouping some behaviors together can help avoid overly long or tedious lists of questions, these acts should be similar in severity or type of violence. Answers to broad questions such as "Have you ever been insulted, beaten, or raped by your husband?" or questions that combine acts of different severity such as "Has your husband ever hit you on the head or pulled your hair?" will be difficult to interpret.

The list of abusive behaviors need not be exhaustive. Their purpose is not to describe every possible act that a woman may have experienced. Rather, the aim is to maximize disclosure and to allow for general characterizations regarding the most common types and severity of violence.

Some countries may have specific types of violence that are not common elsewhere, such as dowry-related abuse, abuse

by in-laws, and acid throwing in South Asia or group rape in Papua New Guinea and Cambodia. Formative research carried out before developing the questionnaire may help you identify forms of violence that are specific to the country setting and that the survey needs to address. Box 6.4 presents the definitions used by WHO for different kinds of violence.

Rape and sexual coercion. Research on rape also raises important definitional issues. Definitions of rape and coercion variously focus on the type of sexual contact, the abuse of a trusting relationship, the force or tactic employed, the power differential, or the imposition of will upon another person, and whether the abuser is an intimate partner. At a minimum, definitions of rape used in research should include notions of force, nonconsent, penetration, and the age boundary between rape and child sexual abuse.

Internationally, traditional legal definitions of rape tend to be limited to penile-vaginal penetration by force or threat of force. Rape reform initiatives in many countries have widened this definition to include all forms of nonconsensual sexual penetration (vaginal, oral, or anal) obtained by physical force or by threat of bodily harm. Some jurisdictions, including most of the United States, also recognize penetration obtained when the victim is incapable of giving consent by virtue of mental illness, mental retardation, or intoxication. In many settings, penetration by anything other than the penis is classified as sexual assault rather than rape.

Other researchers have operationalized rape differently, relying on notions of "coercion" defined variously as:

- Using physical force or threat of physical force.
- Using verbal or psychological pressure, including trickery or deceit.
- Against a woman's will (unwanted as defined by the woman).
- Ignoring a woman's refusal.

Childhood sexual abuse. As with rape, definitional issues complicate research into the prevalence of childhood sexual abuse. Definitions of child sexual abuse in the North American literature have varied along several dimensions: whether noncontact abuse (e.g., exhibitionism) is included together with sexual touching, the maximum age of the victim, the minimum age of the perpetrator, a minimum age difference between victim and perpetrator (generally five years), and whether only incidents experienced as unpleasant or abusive are considered.[13] The upper limit on childhood, for example, varies in studies from age 12 to age 18. Some definitions require that the incident be experienced by the victim as abusive; others define all sexual contact between a child and someone significantly older as inherently abusive.

Research has shown that differences in definition can greatly affect estimates of prevalence. This effect is demonstrated clearly in the work of Haugaard and Emery who constructed three definitions of abuse: a broad definition that included all forms of contact and noncontact abuse; a narrow definition that excluded exhibitionism and any incident that was experienced as positive; and a very narrow definition that included only oral, anal, or vaginal penetration.[13] Among the middle class college women in their sample, the prevalence of child sexual abuse was 11.9 percent using the broadest definition; 9.6 percent using the narrow definition; and 1.8 percent using the "intercourse only" definition. The level of impact of abuse on the women's health and lives increased as the definition became more restrictive, although some significant relationships emerged even when using the broadest definition of abuse.

BOX 6.4 WORKING DEFINITIONS OF VIOLENCE USED BY *WHO MULTI-COUNTRY STUDY ON WOMEN'S HEALTH AND DOMESTIC VIOLENCE AGAINST WOMEN*

Violence against women and girls is defined in the Declaration on the Elimination of Violence Against Women as occurring in three domains: the family, the community, and perpetrated or condoned by the state. The focus of the WHO VAW study is on intimate partner violence and sexual violence against women.

For the purposes of the study, a series of separate definitions were adopted for the different forms of violence included in the survey:

Domestic violence against women

Any act or omission by a family member (most often a current or former husband or partner), regardless of the physical location where the act takes place, which negatively effects the well being, physical or psychological integrity, freedom, or right to full development of a woman.

Intimate partner violence

Any act or omission by a current or former intimate partner which negatively effects the well-being, physical or psychological integrity, freedom, or right to full development of a woman.

Physical violence

The intentional use of physical force with the potential for causing death, injury, or harm. Physical violence includes, but is not limited to, scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, poking, hair pulling, slapping, punching, hitting, burning, the use of restraints or one's body size or strength against another person, and the use, or threat to use, a weapon (gun, knife, or object).

Severe physical violence

Physical violence that is likely to lead to external or internal injuries.

Abusive sexual contact

Any act in which one person in a power relationship uses force, coercion, or psychological intimidation to force another to carry out a sexual act against her or his will or participate in unwanted sexual relations from which the offender obtains gratification. Abusive sexual contact occurs in a variety of situations, including within marriage, on dates, at work and school, and in families (i.e., incest). Other manifestations include undesired touching; oral, anal or vaginal penetration with the penis or objects; and obligatory exposure to pornographic material.

Forced sex

Where one person has used force, coercion, or psychological intimidation to force another to engage in a sex act against her or his will, whether or not the act is completed.

Sex act

Contact between the penis and vulva, or the penis and the anus, involving penetration, however slight; contact between the mouth and the penis, vulva, or anus; or penetration of the anal or genital opening of another person by a hand, finger, or other object.

Psychological abuse

Any act or omission that damages the self-esteem, identity, or development of the individual. It includes, but is not limited to, humiliation, threatening loss of custody of children, forced isolation from family or friends, threatening to harm the individual or someone they care about, repeated yelling or degradation, inducing fear through intimidating words or gestures, controlling behavior, and the destruction of possessions.*

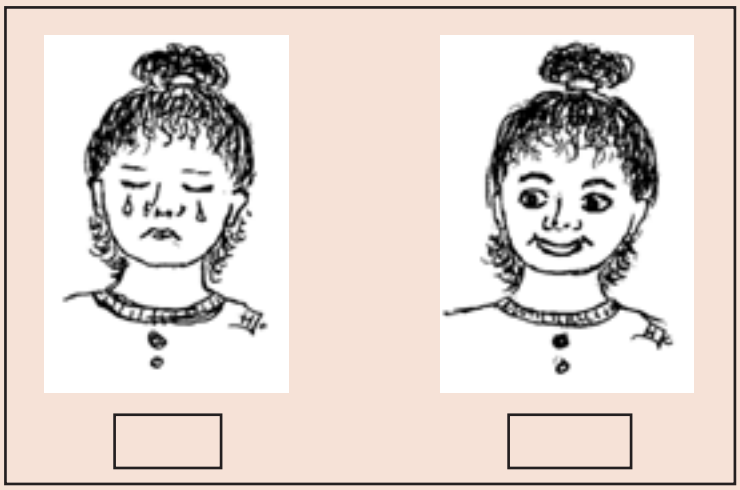
Child sexual abuse

The use of a child (defined as any person under the legal age of consent) by an adult for sexual purposes, whether or not consent is alleged to have been given. It includes, acts of exposure; sexual touching; oral, anal, or vaginal penetration; and the exposing of a child to, or involving a child in, pornography or prostitution. Any form of direct or indirect sexual contact between a child and an adult is abusive since it is motivated purely by adult needs and involves a child who, by virtue of her/his age and position in life, is unable to give consent. Sexual activity between children constitutes sexual abuse when it is between siblings or when it is clear, by difference in developmental levels, coercion and/or lack of mutuality, that one child is taking advantage of another.

* Some of the acts that are perceived as being psychologically abusive may vary between countries. WHO recognizes that there is no accepted definition of psychological abuse, and that there are also many other forms of severe psychological abuse, e.g., having children taken away from you, being evicted from your home, and having your wages taken away from you, that were not included in the questions used in the study.

(From WHO, 2004.[14])

FIGURE 6.1 DRAWING USED IN WHO VAW STUDY TO ASK WOMEN ANONYMOUSLY ABOUT SEXUAL ABUSE



The challenges of deriving appropriate definitions for child sexual abuse are even more difficult when contemplating cross-cultural research, in which even definitions of childhood can be points of contention and debate. The WHO VAW study chose age 15 as a cutoff point between childhood and adulthood and asked respondents whether before the age of 15 had anyone ever touched them sexually or forced them to do something sexual that they did not want to do.

Perpetrators

Just as it is crucial to be able to distinguish between different types of abuse, researchers also need specific information about the number of perpetrators and their relationship to the victim. Some research indicates that women who are victimized in childhood are more likely to be victimized as adults and that women who are victimized more than once are at greater risk for mental and reproductive health problems. Watch out for a fairly common mistake: asking women about the violence they have experienced and the perpetrators, without linking each perpetrator to the specific form of abuse. This can lead to confusing results. For example, in the León, Nicaragua, study, one woman, who was abused by both her mother and her husband, said she was beaten, raped, and emotionally abused. However, because of the way that the questionnaire was structured, it was not possible to determine from the data who did what.

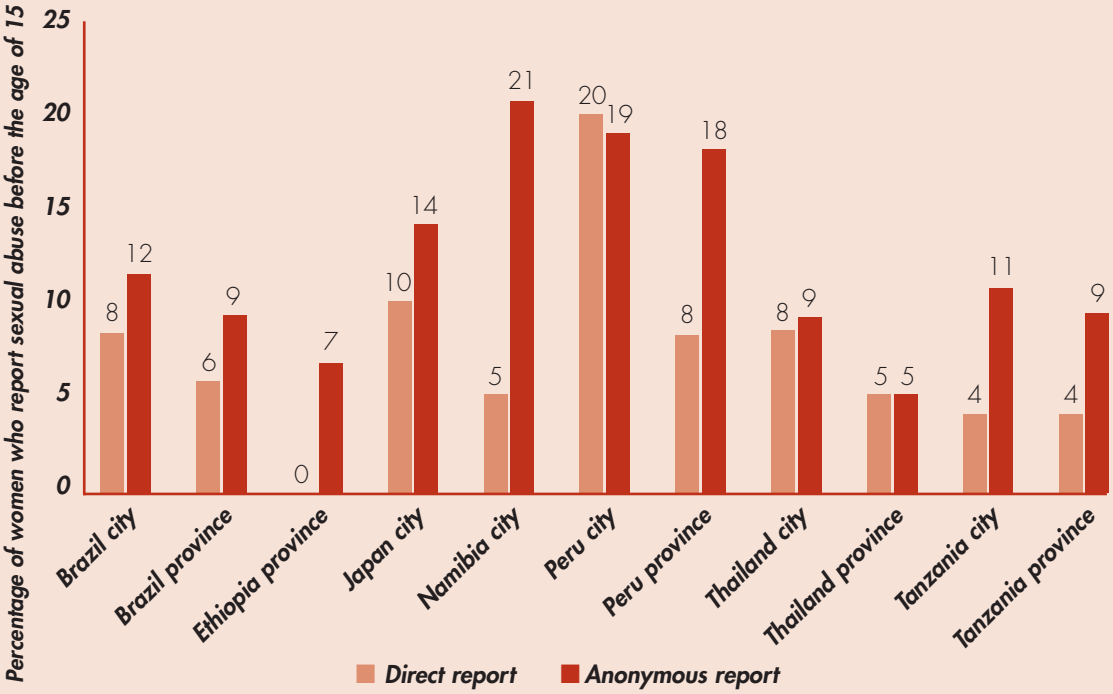
Some researchers suggest that providing specific cues about context may be more effective than a single general question in helping a woman remember violent events.[15] Therefore, interviewers may be trained to probe about specific situations in which women might have experienced violence, such as the workplace or school, or violence by family members.

Time frame and frequency

To fully understand patterns of abuse, researchers need a time frame by which the abuse can be measured. For example, many studies on partner abuse only measure whether women have experienced violence in the last year, or since the start of the current relationship, thereby excluding violence inflicted by former partners, or prior to the last year. This decision may stem from the belief that women are likely to remember recent events more accurately than events in the more distant past. Other times, interventions focus on current victims of abuse.

Using such a narrow time frame obscures the true impact of partner violence, especially because a history of abuse may be the underlying cause of current problems. For example, the Nicaragua study found that women who experienced abuse years before the interview took place were much more likely than non-abused women to be experiencing emotional distress at the time of the interview.[16] Although women may be less likely to recall single incidents of moderate abuse, research indicates that experiences of severe, frequent, or particularly traumatic violence are not easily forgotten, no matter

FIGURE 6.2 COMPARISON OF DISCLOSURE OF CHILD SEXUAL ABUSE USING TWO DIFFERENT METHODS (DIRECT QUESTIONS IN A FACE-TO-FACE INTERVIEW AND ANONYMOUS REPORTING)



(From WHO, 2005.[3])

when they took place.* If no one asks about former experiences of violence, many women with problems related to abuse will be improperly classified as "nonabused." This error will weaken the associations found between violence and specific health or social outcomes.

To determine how many women have experienced partner abuse, it is generally sufficient to obtain information pertaining to the last year and to lifetime experiences of abuse. However, where the purpose is to link the "exposure" to violence to specific health outcomes, for example, in cohort and case-referent studies, more detailed information is particularly useful. Such information might include, for example, when the abuse began, how frequently it occurred, how long it lasted, and whether it took place during a specific relevant period such as pregnancy or before the onset of a health condition.

When the aim of the study is to examine experiences of physical or sexual abuse in childhood, it is important to ask the respondent's age when the abuse started, as well as the age of the perpetrator. Did it happen one time? A few or many times? How many years did the abuse last?

ENHANCING DISCLOSURE OF VIOLENCE

Experience shows that in most settings women are willing to talk about their experiences of violence, although, as we mentioned earlier, most prevalence figures are probably too low. Experience from

* An exception to this observation may be sexual abuse, where women and men have been known to repress memories of particularly traumatic events experienced in childhood

international research nonetheless indicates that some methods are more effective than others in encouraging women to talk about violence. The following series of issues may affect women's willingness to discuss experiences of violence.

"Many women told me that they never talked about this with anyone, not even with the neighbors, friends, or relatives, 'because if I tell her, she might tell her husband or her mother, and word will get around and might reach my husband, which would be terrible. If he found out he would kill me.' So many of them would keep all their suffering inside, for fear that their husbands would mistreat them more…"
Nicaraguan interviewer
(Ellsberg, et al, 2001.[12])

How are women asked about violence?

The methods used to ask women about violence may influence how comfortable they are disclosing abuse. Studies in industrialized countries have found that for the purpose of identifying intimate partner abuse, either face-to-face interviews or interviews by telephone give better results than self-administered questionnaires.[17, 18] On the other hand, anonymous techniques frequently encourage greater disclosure of childhood sexual abuse. The WHO multi-country study tested the use of different methods for eliciting disclosure of child sexual abuse. Women were asked during a face-to-face interview whether they had ever been touched sexually or made to do something sexual against their will before the age of 15. At the end of the interview, women were asked to mark on a separate piece of paper whether they had been sexually abused as a child by placing a check next to either a happy or sad face, regardless of what they had chosen to reveal during the face-to-face interview (Figure 6.1). Women were assured that since their name was not on the paper, no one would ever be able to trace their answer back to them. Then, to preserve the anonymity of the respondents these papers were placed together in a large plastic bag. In most countries, considerably more women disclosed violence using this method than they did in personal interviews (Figure 6.2).

BOX 6.5 FROM THE FIELD: NICARAGUA

A DHS carried out in Nicaragua used two sets of questions to identify partner abuse. One question asked in general, "Have you ever been physically beaten or mistreated by anyone?" Women who responded affirmatively were questioned about the perpetrator. The next set of questions referred to specific acts such as pushing, slapping, choking, beating, and forced sex. For each act, women were asked whether their partner had carried out the act within the last year, or at any time during their marriage. While 14 percent of women reported partner abuse using the first set of more general questions, 29 percent of women reported acts of physical or sexual partner abuse in the more specific set of questions.[12]

Who is asking?

As in all research on sensitive topics, disclosure rates are affected by the skill of the interviewer, and her or his ability to establish rapport with the informant. Women are more likely to be willing to share intimate and potentially painful or embarrassing aspects of their lives when they perceive the interviewer as empathetic, nonjudgmental, and genuinely interested in their situation. It is generally believed that female interviewers are more successful in eliciting personal information from women, although this has rarely been tested. In some settings, difficulties have been encountered when using young or unmarried women as interviewers, or when using interviewers who lack experience discussing sensitive issues. This highlights the importance of using carefully selected and appropriately trained female interviewers.

Although it is often helpful to have fieldworkers who share some cultural background with informants, it may be preferable if they do not belong to the same village or neighborhood, so that the respondent may feel more confident that the information she shares will not get back to others.

How many times should you ask a woman about violence?

It may seem strange at first, and even a little insulting, to ask women more than once

whether they have experienced violence, as if we did not believe her the first time round. However, numerous studies have shown the importance of giving women more than one opportunity to disclose violence during an interview. Women may not feel comfortable talking about something so intimate the first time it is mentioned, or they may not recall incidents that took place long ago. This is why studies that include only one or two questions on violence are likely to result in substantial underreporting of abuse. Researchers have found that many women initially deny having experienced violence, but over the course of the interview, overcome their reluctance to talk. For this reason, it is also wise to avoid using "gateway" or "filter" questions, where women who reply negatively to the first violence question are not asked the more specific questions in the survey. Box 6.5 gives an example of how prevalence estimates for violence were doubled by adding a set of specific questions after an initial general question.

The context of the interview

The overall framework of the survey and the items immediately preceding questions on abuse can profoundly affect how women interpret and respond to violence-related questions. For example, embedding questions on physical assault immediately following items on relationships will cue respondents to the issue of partner abuse, whereas asking a similarly worded question after items on crime victimization will tend to cue respondents toward assaults perpetrated by strangers.

The issue of context is particularly relevant in large-scale surveys in which abuse-related questions are integrated into questionnaires designed for other purposes. When questions on violence immediately follow lengthy discussions on unrelated topics such as family planning, nutrition, or childhood illness, a woman may be disconcerted and less likely to disclose experiences of violence. In this case, it is particularly important to give the respondent a chance to "switch gears." An introductory paragraph can make it clear that the interview is shifting to a completely different subject.

"…In the first question, they would say that he didn't beat them, but when we got to the other questions, then they would say 'Yes, sometimes he beats me and kicks me or uses a gun,' or whatever."
Nicaraguan interviewer
(Ellsberg, et al, 2001.[12])

Questions on violence may themselves be framed in a variety of ways that convey different messages to the women being interviewed. For example, one well-known instrument, the **Conflict Tactics Scale**, presents the use of violence as a way of resolving conflict and includes a series of questions about nonviolent ways to resolve conflicts, such as "discussing the issue calmly" or "sulking." This lead-in could be problematic in a country where physical assault is not understood as a way to resolve conflict, but rather as a form of punishment or discipline. Other instruments describe acts that the partner "does when he is mad."

Some researchers have used lead-in questions that allow women to describe positive aspects of the relationship, as a way of showing women that they are not interested in only the bad things a partner does. The rationale for this approach is that women may be more willing to disclose abuse if given an opportunity to acknowledge that their relationship is complex, with both good and bad parts.

"…They would say that they had never told anyone before their situation. But then we got to be so close during the interview that she would ask me 'What do you think I should do?' Sometimes we couldn't get off the subject…"
Nicaraguan interviewer
(Ellsberg, et al, 2001.[12])

Even the timing of the violence questions within the overview interview may affect how women respond, particularly when the questions are part of a much larger study. Asking about violence too early may not provide interviewers enough time to build rapport with the informant.

BOX 6.6 ENSURING THE COMPARABILITY OF DATA IN THE *WHO MULTI-COUNTRY STUDY ON WOMEN'S HEALTH AND DOMESTIC VIOLENCE AGAINST WOMEN*

One of the greatest challenges of a multi-country study is ensuring that cross-country comparability is maintained, and that the same core issues and concepts are being explored and analyzed in the same way in each participating country. At the time the study was carried out, there were still many gaps in knowledge about the prevalence, causes, and consequences of domestic violence against women. The WHO VAW study and future research using the study methodology have the potential to substantially advance current understanding. For this reason, maintaining cross-country comparability is a high priority for WHO. For the first phase of the study, to ensure that a high level of teamwork, coordination, and communication was maintained, WHO committed resources to establishing a core research team, which regularly met with each country team. They also brought together the different country team members at important points in the study, to ensure that the key developments were finalized together.

Several steps were also taken to ensure that there was central coordination of each phase of the study and to maintain cross-country comparability:

- Careful selection and standardized training of interviewers and supervisors occurred at the country level.
- Core research team members made country visits during the interviewer training and piloting phases of the study.
- The core questionnaire and study procedures were finalized at a central level with a question-by-question description of the questionnaire, as well as detailed training manuals for facilitators, supervisors, interviewers, and data processors.
- Sampling strategies were carefully reviewed, discussed, adapted, and documented by a member of the core research team.
- Adaptations to questionnaires were carefully reviewed and documented by a member of the core research team.
- One data entry system and the same database structure was used in all countries with interactive error checking and compulsory double entry and data validations. Adaptation of the data entry program, as well as training of data entry and data processing procedures, was done on site by one of the members of the core research team.
- During field implementation, standard quality control measures were implemented in all countries, such as questionnaire checking on site, regular debriefings, and support to the interviewers.
- Data cleaning was done with support of one member of the core research team to ensure similar procedures were followed in all countries.
- A standard list of preliminary analyses was identified and conducted in each country.
- Annual meetings were held with the country research teams to share lessons learned.

(From WHO, 2004.[15])

On the other hand, if questions are placed at the end of a long interview, both the interviewers and the respondents may be tired or anxious to finish the interview and therefore less likely to probe into experiences of violence.

One important way to ensure confidentiality is to interview only one woman per household. When the study is exclusively focused on violence, this is relatively easy to achieve. Chapter 9 describes a few ways to randomly select the woman to be interviewed. The situation is more complex when other members of the household are to be interviewed on other topics, such as reproductive health. When incorporating a module on violence in the Nicaraguan DHS, researchers selected only one woman per household to answer the violence portion of the survey, presented as a section on "Household Relations." Interviewers were instructed to inform her that she was selected by chance to be asked these questions, and that no one else in the household would know she was being asked.

By the same token, both ethical and methodological principles suggest that it is better to avoid interviewing women and men from the same household on violence. It is true that questioning both partners of a couple would enable comparisons between wives and husbands, as well as direct information about life events preceding abusive behavior by men. However, this method may place a woman at risk if her abusive husband suspects that she has been talking about his behavior. In anticipation of his reaction, she may be reluctant to disclose violence. Therefore, we recommend that surveys not include women and men from the same household. If it is necessary to interview husbands for some other reason, do not ask about violence, and let the woman know that she is the only one being asked about abuse.

COMMON TOOLS FOR MEASURING VIOLENCE

Intimate Partner Violence

The **Conflict Tactics Scale (CTS)** is one of the best known tools for measuring intimate

partner violence, particularly in the United States. The original CTS has several subscales that measure acts used in the course of conflict, including negotiating tactics, and verbal and physical aggression. The physical aggression subscale of the CTS measures the frequency and severity of specific acts of physical violence within the family, including husband-to-wife, wife-to-husband, and parent to child violence.[19, 20] The revised version, called the CTS2, also includes questions on sexual violence and injuries.[21] The CTS approach is particularly useful for international comparisons because it is behaviorally specific. Therefore it is likely to detect women who have experienced acts of violence but do not necessarily identify themselves as battered or abused. Although it was designed to measure all kinds of violence between husbands and wives, the subscales can be used independently.

Used alone, however, many researchers observe that the CTS has some drawbacks. It provides limited information about the context and consequences of abuse, as well some of the more complex issues of control and psychological degradation that many researchers consider central features of wife abuse.[18]

A further problem with the CTS is that it frames the occurrence of violence within the context of conflict resolution, and includes a subscale of negotiating tactics for resolving conflict. Feminist researchers question the assumption of gender neutrality behind the CTS because they view male violence as a coercive tactic for maintaining power and domination within a relationship. In an international setting, the assumption that equal partners come together to "negotiate" conflict is even more problematic, since many cultures define women as perpetual minors, both socially and legally. Men are granted the right to physically correct or punish their wives much as parents in other cultures are granted this right over children.[22]

BOX 6.7 RECOMMENDATIONS FOR MEASURING VIOLENCE

- Use broad criteria in defining the study population. For studies that address multiple forms of violence, all women from a specific age group should be included. For studies of intimate partner violence, consider including all women who have ever been married or who are in a common-law relationship.
- Provide multiple opportunities to disclose. Do not use "gateway" or "filter" questions.
- Use behaviorally specific acts to ask about violence. Use at least two or three questions per type of violence.
- Be specific about time frames—include at least one recent (last year) and one long-term time frame (since you were 18; since you were married).
- Ask about specific perpetrators and specific contexts to cue the respondent's memory.
- In order to ensure confidentiality and increase disclosure, interview only one woman per household. Do not interview men and women from the same households about violence.

Because the focus of the CTS is on the acts themselves, it does not provide information about the context, or the intention behind the use of violence. For example, it does not distinguish between violence used for self-defense and violence used for the purpose of control or punishment. Therefore, when used to measure both husband-to-wife and wife-to-husband violence, the CTS has led to what many researchers consider to be misleading conclusions about the supposed symmetry of marital violence.[23] Most international research, however, consistently shows that violence used by males and females is both quantitatively and qualitatively different.[24, 25] Whereas female violence is more likely to take place in the context of self-defense, male violence is more likely to lead to injury.

Other well-known instruments for measuring wife abuse include the **Index of Spouse Abuse**, which is a 30-item self-report scale designed to measure the severity or magnitude of physical (ISA-P) and nonphysical abuse (ISA-NP).[26] More concise instruments such as the **Abuse Assessment Screen** have been used successfully in

screening for abuse, particularly within health services.[27] The Abuse Assessment Screen, which has only five questions, is an effective tool for measuring physical and sexual abuse in the last year and during pregnancy.

Another recently developed instrument, the **Women's Experience with Battering Framework (WEB)**, is unique because it measures battering based on the subjective experience of the woman, rather than on discrete incidences of physical violence.[28, 29] The WEB scale has ten items, based on qualitative research with U.S. battered women, which describe different dimensions of the experience of battering, such as shame and diminished autonomy. Examples of questions are "I feel ashamed of the things he does to me," and "He has a look which terrifies me even when he doesn't touch me." However, the WEB Framework has not yet been validated internationally to determine whether the experiences provide a meaningful measure of battering in a cross-cultural context.

Two more recently developed instruments for international surveys are the **Domestic Violence Module** of the **Demographic and Health Surveys**,[2] and WHO's instrument for the VAW study. The DHS module is designed to be included in a larger survey on women's reproductive health and can be obtained from http://macroint.com. The WHO questionnaire is designed primarily as a standalone questionnaire for violence research. This questionnaire, which has been enriched by the experiences of previous international research, collects detailed information about acts of physical, sexual, and emotional violence committed by partners and nonpartners. It includes information about the frequency and duration of violence, violence during pregnancy, health consequences for women and their children, women's responses to abuse, and access to services for battered women. The study also explores such related issues as community norms regarding violence, decision making within the family, women's financial autonomy, and physical mobility. The full questionnaire is available from the WHO by writing to: genderandhealth@who.int.

A subset version of the WHO questionnaire, called the **Violence Against Women Instrument**, includes a basic set of questions that may be included in other surveys for the purpose of measuring violence. In a relatively concise manner, this instrument measures experiences of violent acts carried out by a partner, including emotional abuse, moderate and severe physical violence, and sexual coercion with and without the use of physical force. It further measures the frequency of each type of violence during the last year and at any time. This instrument, together with notes on the use of the instrument, is presented in Appendix I.

Sexual coercion/rape

Instruments to measure sexual coercion and/or forced sex are less well developed cross culturally than those to measure partner violence. Due to the shame associated with sexual violation in many settings, it is even harder for women to speak freely about forced sex than it is to admit to being beaten.

There is general agreement that measures of sexual coercion should include reference to the type of sexual act, the type of tactic or force used, the relationship with the perpetrator, the number of perpetrators, and whether the acts were attempted or were in fact completed. In addition, researchers should preferably refer to specific acts, rather than vague terms such as "sexual abuse" or "assault."

In the United States, the most commonly used instrument for measuring sexual aggression is the **Sexual Experiences**

Survey (SES) first developed by Koss.[1, 14, 30-32] The revised SES uses ten items to assess different forms and degrees of sexual coercion. An example of a question describing a relatively mild level of sexual coercion is "Have you ever given in to sex play (fondling, kissing or petting, but not intercourse) when you didn't want to because you were overwhelmed by your partner's continual arguments and 'pressure'?" A sample question that refers to more severe aggression asks "Have you ever had sexual intercourse when you didn't want to because you were threatened or because someone used some degree of physical force (twisting your arm, holding you down) to make you?" Within each item, sexual aggression is treated dichotomously (yes, no), although some investigators have modified the SES to assess the frequency of different experiences.

Child sexual abuse

Individuals researching child sexual abuse have used instruments specific to sexual abuse as well as broader instruments designed to capture different forms of maltreatment in childhood. An increasingly popular instrument known as the **Childhood Trauma Questionnaire (CTQ)** investigates a variety of forms of trauma that children can experience growing up, and yields separate estimates of emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect.[33]

In contrast to instruments that inquire about specific acts, the CTQ presents respondents with a series of statements about childhood experiences that are ranked on a five-point scale, with response options ranging from "never true" to "very often true." Most items are phrased in objective terms (e.g., "When I was growing up, someone touched me in a sexual way or made me touch them."), whereas others call for more subjective evaluation ("When I was growing up, I believe I was sexually abused.") The questionnaire is introduced with the statement "In this section, we would like to know about experiences you may have had before you were 18 years of age."

Other instruments inquire about a series of specific sexual acts, followed by clarifying questions regarding when and with whom it happened, how it made the respondent feel, and the degree of persuasion or force used.

Violence against women in conflict situations

In recent years, researchers have addressed the specific challenges of documenting violence suffered by women in conflict situations.[34, 35] A group of organizations involved in the Reproductive Health Response in Conflict Consortium has developed a series of excellent tools for monitoring and evaluating violence against women in conflict situations. One of these tools is a survey instrument that measures different kinds of violence against women, including physical and sexual violence by partners and by others, including soldiers or paramilitary forces, and aid workers.[36] More information can be found about these instruments at http://www.rhrc.org/.

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Developing a Sampling Strategy

Topics covered in this chapter:

Sampling considerations in qualitative studies
Sampling considerations in quantitative research surveys

One cannot overemphasize the importance of developing an appropriate sample for the type of research design selected. Although qualitative and quantitative research use different approaches for selecting the individuals or groups to be studied, in all studies it is crucial to plan the sampling strategy carefully. Particularly in the case of population-based surveys, a poorly selected sample may harm the credibility of a study, even if the rest of the study is well executed.

Qualitative studies generally focus in depth on a relatively small number of cases selected **purposefully**. By contrast, quantitative methods typically depend on larger samples selected **randomly**. These tendencies evolve from the underlying purpose of sampling in the two traditions of inquiry. In quantitative research, the goal of sampling is to maximize how **representative** the sample is so as to be able to generalize findings from the sample to a larger population. In qualitative inquiry, the goal is to select for information richness so as to illuminate the questions under study.[1]

This chapter discusses the major issues that should be taken into account when designing a sample for qualitative or quantitative research. It also gives examples of how different strategies have been used to fit the specific needs and circumstances of research projects.

SAMPLING CONSIDERATIONS IN QUALITATIVE STUDIES

There are no hard and fast rules for sample sizes in qualitative research. As Hudelson points out, "The sample size will depend on the purpose of the research, the specific research questions to be addressed, what will be useful, what will have credibility, and what can be done with available time and resources."[2]

In qualitative sampling, the selection of respondents usually continues until the point of **redundancy** (saturation). This means that when new interviews no longer yield new information and all potential sources of variation have been adequately explored, sampling may stop. For most qualitative studies, 10 to 30 interviews and/or 4 to 8 focus groups will suffice. Table 7.1 summarizes a number of

TABLE 7.1 TYPES OF SAMPLING STRATEGIES FOR QUALITATIVE STUDIES

Type of Sampling	*Purpose*	*Example*
Intensity sampling	To provide rich information from a few select cases that manifest the phenomenon intensely (but are not extreme cases).	Interviewing survivors of date rape to learn more about how coerced sex affects women's sexuality.
Deviant case sampling	To learn from highly unusual manifestations of the phenomenon in question.	Interviewing men who do not beat their wives in a culture where wife abuse is culturally accepted.
Stratified purposeful sampling	To illustrate characteristics of particular subgroups of interest; to facilitate comparisons.	Interviewing different types of service providers (police, social workers, doctors, clergy) to compare their attitudes toward and treatment of abuse victims.
Snowball or chain sampling (Locate one or two key individuals, and then ask them to name other likely informants.)	To facilitate the identification of hard-to-find cases.	Finding commercial sex workers to interview about experiences of childhood sexual abuse by getting cases referred through friendship networks.
Maximum variation sampling (Purposely select a wide range of variation on dimensions of interest.)	To document diverse variations; can help to identify common patterns that cut across variations.	Researching variations in norms about the acceptability of wife beating by conducting focus groups among different sub groups: young urban women, old urban women, young rural men, old rural men, women who have been abused, women who have not experienced abuse.
Convenience sampling (Select whoever is easiest, closest, etc.)	To save time, money, and effort. Information collected generally has very low credibility.	Forming focus groups based on who is available that day at the local community center, rather than according to clear criteria.
Criterion sampling	To investigate in depth a particular "type" of case; identify all sources of variation.	Specifically interviewing only abused women who have left their partners within the last year in order to better understand the variety of factors that spur women to leave.

(From Patton, 1990.[3])

different approaches to qualitative sampling.

In qualitative research, the sampling strategy should be selected to help elucidate the question at hand. For example, researchers with the Nicaraguan organization *Puntos de Encuentro* embarked on a project to collect information useful for designing a national media campaign that called on men to renounce violence in their intimate relationships. They wanted to understand the beliefs and attitudes that existed in Nicaraguan culture that supported violent behavior toward women. More importantly, they wanted to know if there were any "benefits" of nonviolence that could be promoted to encourage men to reconsider their behavior (Box 5.6).

Rather than concentrating on collecting

information on the norms and attitudes of "typical" Nicaraguan men, the researchers decided to use "deviant case" sampling and concentrate on interviewing men who had already had a reputation for being nonviolent and renouncing machismo.[4] They were interested in finding out from these men what benefits, if any, they perceived from this choice, and what life-course events, influences, or individuals pushed them in this direction. The goal was to investigate what aspirations and life experiences help create "healthy" intimate partnerships. The findings were used to design an information campaign aimed at recruiting more men to a nonviolent lifestyle.

SAMPLING CONSIDERATIONS IN QUANTITATIVE RESEARCH SURVEYS

In contrast to qualitative research, which generally uses nonprobability or "purposive" sampling, quantitative research relies on random sampling of informants. A probability or "representative" sample is a group of informants selected from the population in such a way that the results may be generalized to the whole population.

When a sample is referred to as **random**, it means that specific techniques have been used to ensure that every individual who meets certain eligibility criteria has an equal probability of being included in the study. Failure to adhere to these techniques can introduce error or **bias** into the sample, which may lessen the validity of the study. For example, if a household survey on violence only conducted interviews during the day, then the respondents most likely to be included in the study would be women who work at home, and women who worked outside the home would be less likely to be interviewed. Since women working outside the home may have different experiences with violence, the study results would be biased towards women who work at home. One way to reduce this particular bias would be to return to homes at night or on weekends to increase the likelihood of reaching all women.

PHOTO BY HAFM JANSEN

*A probability or **representative** sample is a group of informants selected from the population in such a way that the results may be generalized to the whole population.*

The way in which the sample is chosen affects its **generalizability**, or the extent to which the situation found among a particular sample at a particular time can be applied more generally. There are many techniques for sampling, each with its own tradeoffs in terms of cost, effort, and potential to generate statistically significant results. Some strategies, such as simple random sampling, may not be feasible where there is little information available on the population under study. The following is a brief

*When a sample is referred to as **random**, it means that specific statistical techniques have been used to ensure that every individual who meets certain eligibility criteria has an equal probability of being included in the study.*

description of the more common sampling techniques used.

Many people underestimate the challenge of obtaining a well-designed sample. Mistakes are often made due to confusion over the meaning of the term **random selection**. A random selection does not mean that participants are simply selected in no particular order. In fact, the techniques for obtaining a truly random sample are quite complex, and inexperienced researchers should consult an expert in sampling before proceeding. A well thought-out and tested questionnaire used on a poorly designed sample will still render meaningless results.

Random samples are often confused with convenience or quota samples. A **convenience sample** is when informants are selected according to who is available, in no particular order. In a **quota sample** a fixed number of informants of a certain type are selected. Neither strategy will result in a random sample appropriate for survey research.

Simple random sampling

This sampling technique involves selection at random from a list of the population, known as the **sampling frame**. If properly conducted, it ensures that each person has an **equal** and **independent** chance of being included in the sample. Independence in this case means that the selection of any one individual in no way influences the selection of any other. The word "simple" does not mean that this method is any easier, but rather that steps are taken to ensure that only chance influences the selection of respondents. Random selection can be achieved using a lottery method, random number tables (found in many statistical books), or a computer program such as Epi Info. To avoid bias, it is very important to include in the sampling frame only individuals who are eligible to be interviewed by criteria such as age, sex, or residence. By the same token, if certain individuals are left off the original list due to an outdated census that does not include individuals who have recently moved into the population area, then these omissions could bias the results, particularly if migration is the result of crises such as war, natural disasters, or economic collapse. In these cases, you will need to update the sampling list.

PHOTO BY HAFM JANSEN

Systematic sampling

In random sampling, each individual or household is chosen randomly. In contrast, systematic sampling starts at a random point in the sampling frame, and every nth person is chosen. For example, if you want a sample of 100 women from a sampling frame of 5,000 women, then you would randomly select a number between one and 50 to start off the sequence, and then select every fiftieth woman thereafter. Both random and systematic sampling require a full list of the population in order to make a selection. It is also important to know how the list itself was made, and whether individuals are placed randomly or in some kind of order. If individuals from the same household or with certain characteristics are grouped together, this may result in a biased sample in which individuals with these characteristics are either overrepresented or underrepresented.

Stratified sampling

Stratified sampling may be used together with either simple random sampling or systematic sampling. This ensures that the sample is as close as possible to the study population with regard to certain characteristics, such as age, sex, ethnicity, or socioeconomic status. In this case, the study population is classified into **strata**, or subgroups, and then individuals are randomly selected from each stratum. Because stratification involves additional effort, it only makes sense if the characteristic being stratified is related to the outcome under study. For the purpose of analysis it is easier if the number of individuals selected from each stratum is proportional to their actual distribution in the population. (See Box 7.1 on self-weighting samples.) For example, in a sample stratified according to urban/rural residence, the proportion of rural women in the sample would be the same as the proportion of rural women in the study population.

A **weighted stratified sample** may be preferable when there are some groups which are proportionately small in the population, but which are relevant for the purpose of the study, such as individuals from a certain geographical region or ethnic group. Ensuring that these groups are adequately represented might require an inordinately large sample size using simple random sampling techniques. In this case, it may be appropriate to oversample, or to select a disproportionately large number of respondents from this stratum. This results in a weighted sample that will have to be taken into account in the analysis process.

Multistage and cluster sampling

Multistage sampling is often used for drawing samples from very large populations covering a large geographical area. It involves selecting the sample in stages, or taking samples from samples. The population is first divided into naturally occurring **clusters** (such as villages or neighborhoods). Then a random sample of these clusters is drawn for the survey. This is the first stage of sampling. The second stage may involve either selecting all of the sampling units (respondents, households) in the selected clusters, or selecting a group of sampling units from within the clusters. Sometimes more than two stages are required. Thus, one might randomly choose districts within a province, and then randomly select villages from the selected districts as the second stage. Individual respondents would be selected from the clusters as a third stage. At each stage, simple random, systematic, or stratified techniques might be used. It is advisable to consult a statistician if you are considering a multistage sampling scheme.

The advantage of multistage sampling is that a sampling frame (e.g., a list of households) is only needed for the selected clusters (villages) rather than for the whole study population. Also, the logistics will be easier because the sample is restricted to the selected clusters and need not cover the whole study area. An example of a multistage sampling strategy in Peru is described in Box 7.3.

The disadvantages of multistage sampling are that the sample size needs to be substantially larger than if the sample was

PHOTO BY HAFM JANSEN

A street map used for locating households in the Japan WHO study.

BOX 7.1 SELF-WEIGHTING IN CLUSTER SAMPLES

The way in which the sample is chosen greatly influences the usefulness of the resulting estimates. Suppose that there is a district with only two villages:

- Village A has 4,000 women, of which 800 (20 percent) have been abused.
- Village B has 800 women, of which 40 (5 percent) have been abused.

The true prevalence of abuse in this district would be calculated as follows:

$$\frac{\text{Total cases of violence}}{\text{Total number of women}} = \frac{(800 + 40) \times 100}{(4000 + 800)} = 17.5 \text{ percent}$$

However, if we decided to determine the prevalence of abuse in this district based on a random sample of 100 women from each village, we would find the following:

- 20 out of 100 women in Village A reporting abuse.
- 5 out of 100 women in Village B reporting abuse.

Combining these two figures we would find that 25 out of the 200 women interviewed were abused, which would give us a prevalence of 12.5 percent.

What has happened here?

Our sampling procedure led us to an underestimated prevalence because the number of informants selected from each village was not in proportion to the relative size of each village. Assuming that we knew the relative sizes of the villages, we could perform a weighted analysis where the results from Village A would count five times as much as those from Village B. However, it is usually preferable to obtain a self-weighting sample. One way to do this would be to select five times more respondents from Village A than Village B. Another approach is to select the villages with probability proportional to size. This means that if you have a list of villages, a large village like Village A would be five times more likely to be selected for the sample than a village the size of Village B. After the villages were selected, you could then to select an equal number of respondents from each village. (For an example of how a self-weighting sample was obtained in Peru, see Box 7.3.)

(From Morison, 2000.[5])

selected by simple random sampling. Also, it can be more complicated to get a self-weighting sample. Another difficulty with multistage sampling can be defining clusters if the study area is, for example, a large urban area. Sometimes these have already been defined for previous censuses or surveys, but otherwise they have to be created from a map or based on some other criteria such as school or health center catchment areas.

How large a sample do you need?

The ideal sample size for a survey depends on several factors:

- **How sure do you want to be of your conclusions?** Larger sample size generally increases the precision of the results, or the confidence with which one can say that they represent a reliable measure of the phenomena under study.
- **What are the characteristics of the study population?** The more variability there is in the population, the larger the sample size needed.
- **How common is the phenomenon under study?** If any of the conditions you want to measure in your study are very rare, for example, infant mortality or maternal mortality, then you will need a very large sample size.
- **What is the purpose of the research?** The sample size calculation will also depend on whether you simply want to measure the prevalence of a condition in a population or whether you want to measure an expected difference between two groups. Programs such as Epi Info contain two different formulas for these two different approaches.
- **What kind of statistical analysis will you use?** This underscores the need to consider how you are going to analyze your data from the very beginning. The sample size must be large enough to provide for desired levels of accuracy in estimates of prevalence, and to test for the significance of differences between different variables.
- **What kind of sampling strategy will be used?** Commonly used sample size formulae and computer packages assume you are using simple random sampling. If you plan to use multistage or cluster sampling, you may need to increase your sample size to achieve the precision you require. Consider asking a

statistician for help in deciding by how much the sample size needs to be increased.

It is better to collect excellent data from fewer respondents than to collect data of dubious validity and reliability from many respondents. Statistical computer packages or mathematical formulas can be used to determine sample size for a study. Box 7.2 presents a table produced by Epi Info's STATCALC program for ideal sample size calculations. This program is available online at http://www.cdc.gov/epiinfo.

If your proposed analysis calls for studying particular subgroups of your sample, the sample size will need to be expanded accordingly. For example, to determine the prevalence of violence, you may need a sample of only 300 women. But if you want to know whether the prevalence of violence varies by age, education, or socioeconomic group, then you will need a sample size sufficiently large to allow for comparisons among these groups.

The initial calculation was made based on a simple random sample from a study population of 100,000 women, where it was assumed that approximately 30 percent of women have experienced violence and that a 10 percent margin of error would be acceptable (5 percent above and 5 percent below). If these assumptions are actually true, the table indicates that with a sample size of 322 women, one would obtain a 95 percent confidence interval for the true prevalence of 25 percent and 35 percent. Note, however, that if the estimates used for sample size calculations are very inaccurate then the required precision may not be obtained.

The table also shows that differences in the size of the study population do not greatly influence sample size, whereas changes in the expected frequency and particularly the level of precision that is needed can have an enormous effect on sample size calculations. It should also be noted that the sample size will need to be increased if a multistage sample is being used. Because these calculations can be quite complex, inexperienced researchers are urged to consult with someone who is knowledgeable in survey sampling techniques.

To explore the health consequences of violence with greater precision, and to compare the occurrence of violence in different sites within each country, the WHO VAW study uses a multistage sampling strategy aiming for 3,000 interviews in two sites; 1,500 in the capital city and 1,500 in a province. However, to end up with 1,500 completed interviews, it is usually necessary to increase the estimated sample size by 10-20 percent to account

BOX 7.2 POPULATION SURVEY USING RANDOM SAMPLING (STATCALC SAMPLE SIZE AND POWER)

Population Size	100,000	10,000	10,000	10,000
Expected Frequency	30%	30%	20%	30%
Worst Acceptable Frequency	25%	25%	15%	28%
Confidence Level	***Sample Size***	***Sample Size***	***Sample Size***	***Sample Size***
80%	138	136	104	794
90%	227	222	170	1,244
95%	322	313	270	1,678
99%	554	528	407	2,583
99.9%	901	834	648	3,624
99.99%	1,256	1,128	883	4,428

How large a sample?

This is one of the most common questions asked of statisticians. A frequent but erroneous answer is "as large as possible" when it instead should be "as small as possible."

It is also important to emphasize that the amount of information that can be gained from a sample depends on its absolute size, not upon the sampling fraction, or its size as a proportion of the population size. It is actually true that 99 out of one million tells you as much about the 1 million as 99 out of one thousand tells you about the one thousand.

(From Persson and Wall, 2003.[6])

BOX 7.3 SAMPLING IN PERU

The WHO VAW Study was carried out in two sites in Peru: Lima, the capital, and Cusco, a mountainous region with a mostly Quechua-speaking population. The research team used two very different sampling strategies for the study.

Lima

1. The team obtained from the National Institute of Statistics and Information (INEI) a list of selected clusters. INEI had divided Lima into 12,000 clusters with about 50 to 150 houses in each cluster. The team randomly selected 166 clusters, using probability proportional to size (assigning a weighted value to the larger clusters to give them a greater likelihood of being selected). INEI provided the team with maps that showed where the clusters were in relation to each other, and a map of each selected cluster indicating buildings such as houses, shops, and warehouses.
2. Because the maps had been made a few years earlier, the Peru team had to update them to take migration into account. A team of enumerators was sent to each cluster a few weeks before fieldwork began and went to each building to verify how many households lived there. They also obtained information regarding the number of eligible women in each household. A total of 21,322 households were enumerated in this process.
3. Based on this information, the team estimated that they would need a sample size of 2,000 in order to end up with 1,500 completed interviews after accounting for refusals and households without eligible women. Therefore, 12 households were selected in each of the 166 clusters. The sampling interval varied according to the size of the cluster. In a cluster with 120 households, every tenth household was chosen, in a cluster with 72 households every sixth house was chosen, and so forth. In the clusters with less than 48 households, a different strategy was used. To avoid interviewing women living very close to each other (this might undermine confidentiality), a minimum interval of four houses between selected households was established. This meant that in a cluster with 36 households, only nine women would be interviewed, instead of 12.
4. To choose the households, the team supervisor chose a house in each cluster at random using the same technique to start off the numbering (for example the northernmost house in a block). Interviewers then followed the sampling interval to select the houses where women would be interviewed. No replacements were allowed in the case of households without eligible women.

Community leaders mapping out villages in Cusco, Peru

Cusco

A multistage sampling strategy was used in Cusco, where there are a few rural towns, and the rest of the population is dispersed throughout the mountains. The region has 12 provinces, and includes the regional capital, Cusco, where a large part of the population lives. The other provinces are mostly rural.

1. Four provinces were selected randomly. These included the town of Cusco plus three rural provinces.
2. INEI selected 46 clusters for the town of Cusco and 66 for the three provinces. Each cluster was selected with probability proportional to size. INEI had maps only for the town, and these were updated in the same fashion as in Lima. In Cusco, 12,558 buildings were enumerated with 5,619 households. Twenty-three households were selected to be visited in each cluster.
3. For the rural clusters, only general maps were available indicating where larger towns were located. In the larger towns, the team made a quick inventory of households and sketched a map. The total number of households was divided by 23 to obtain the sampling interval. The first household was selected randomly, then the rest were selected systematically.

4. In the rural area, no information was available. To generate detailed maps, the team held meetings with the leaders of rural communities and local women's clubs. The leaders were informed about the general goals of the study and the approximate dates that fieldwork would be performed in their communities. The leaders prepared maps of each village, with all houses and landmarks indicated, and then together mapped out the routes that fieldworkers would follow to reach the villages.
5. With the help of the maps, one household was randomly selected, and from this starting point all households were visited following a spiral direction, until 23 households with eligible women were visited. Because households were very dispersed, it was not necessary to have a minimum sampling interval. If one village did not have 23 households in it, then the closest village was visited, following the same procedure until the 23 interviews were completed.

Community map with schools, roads marked.

(From Guezmes et al, 2002.[7])

for missing households, where there is no eligible woman, or where the selected respondent is unavailable or refuses to participate in the study.

Obtaining a sampling frame

As pointed out earlier, to select a random sample, it is necessary to have a list or map of all households or individuals (depending on the sampling unit) in the study population. Wherever possible, previously developed **sampling frames** should be used, for example:

- Official census data.
- Voter registration records.
- Census carried out by the Health Ministry for immunization or malaria campaigns.
- Sampling frames developed by other large-scale studies carried out in the country (such as Demographic and Health Surveys or Living Standards Measurement Surveys).

Each of these options will have to be reviewed carefully to assess the quality of the information. In some kinds of official data, certain individuals may be left out (for example, resident foreigners or domestic servants). Moreover, unless the data were collected quite recently, it will probably be necessary to update the records. Even so, this will be much less time-consuming and costly than developing your own sampling frame. If there is nothing already available then you will have to develop your own sampling frame. This is often done by **enumerating** (listing and mapping) households and/or eligible respondents in the selected clusters. An example of some other approaches used in Liberia in a conflict situation is shown in Box 7.4.

Who is eligible to be interviewed?

Other sections addressed the importance, for safety reasons, of interviewing only one woman per household. However, each research team will have to consider carefully what criteria to use for eligibility. In other words, which women within the household can be considered as a possible informant? For example, will domestic servants be included? What about visiting friends or relatives, or lodgers such as students who are renting a room in the house?

Researchers have resolved these issues in different ways, and each solution has its own advantages and tradeoffs. For example, if whether a woman slept in the household the night before is used as a basic criterion, then domestic servants may be included in their place of work. However, in this case, much of the economic status information collected about the household will not reflect this woman's

BOX 7.4 CREATIVE SAMPLING IN LIBERIA

A study in Liberia on violence against women during the civil war used several different survey sites to maximize the breadth of representation, including market places, high schools, urban communities, and displaced persons camps. Each site required a different sampling strategy. Although each strategy yielded a good approximation of the situation of women from the specific target group sampled, it should be noted that one cannot combine the three groups to obtain a prevalence estimate for Liberian women as a whole.

- **Sampling older women:** In the market places, the sampling unit was a market stall. Surveyors drew a detailed map of the number and location of tables, from which the computed sampling interval and specific tables were randomly selected. Because lotteries were common in Liberia, the team made colorful "lucky tickets" for the tables that had been randomly selected. After introducing herself to a market woman, the interviewer placed the ticket on the table, saying "lucky ticket" and invited the woman to participate in the survey.
- **Sampling young girls:** The team derived a sampling plan for the high schools by obtaining from the teachers the number of girls in attendance that day in grades nine through twelve. After the sampling interval was computed, the girls in each class counted off starting from "one" to the sampling interval. If the sampling interval was four, for example, every girl who counted off "four" was invited to participate in the survey. The sampling was done publicly so that everyone knew that the girls had not been selected because of any particular experience, thereby preventing any stigma that might be attached to being selected to participate in a survey about sexual violence.
- **Sampling refugees:** The availability of food distribution census data made it easier to sample in the communities and in the displaced persons camps. After calculating the sampling interval, households were systematically chosen by selecting a starting household at random using the last two digits of the serial number on a Liberian $5 bill chosen at random.

(From Swiss et al, 1998.[8])

BOX 7.5 TWO METHODS FOR SELECTING INFORMANTS

PHOTO BY HAFM JANSEN

Lottery

Make a list of all the women in the household who are eligible to participate in the study according to the study criteria (such as over 15, ever been partnered). Be sure to include women even if they are not in the house at the time of the visit. Write the name of each woman on a separate piece of paper and place the papers in a paper bag. Ask someone in the household (perhaps the oldest person) to select a paper from the bag. Advantages of this method are the simplicity of administration and that it makes clear to everyone in the household that the person has been selected by chance, not because of any special characteristics. The disadvantage of this method is that it is difficult to monitor whether interviewers are using the system correctly.

Randomized chart

A randomized chart may be helpful for selecting a woman to interview once you have a complete list of all members of the household. This method makes it fairly easy to monitor whether fieldworkers are using the procedure correctly, but it is less transparent to household members.

Check the last digit on the number of the questionnaire. This indicates the row to use. Then, check on the list of household members the total number of women between 15 and 49 who have ever been married or partnered. This indicates the column to use. The number that appears in the intersection of the row and column indicates the number of the woman who should be interviewed.

Last digit on the questionnaire	*Number of eligible women in the household*							
	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*
0	1	2	2	4	3	6	5	4
1	1	1	3	1	4	1	6	5
2	1	2	1	2	5	2	7	6
3	1	1	2	3	1	3	1	7
4	1	2	3	4	2	4	2	8
5	1	1	1	1	3	5	3	1
6	1	2	2	2	4	6	4	2
7	1	1	3	3	5	1	5	3
8	1	2	1	4	1	2	6	4
9	1	1	2	1	2	3	7	5

true status. On the other hand, if domestic servants are not considered eligible in their place of work, then it is important to make sure that they may have an opportunity to be included in their permanent households. This places an additional burden on interviewers because to avoid having a high nonresponse rate, it will be necessary to return in some cases on specific days or evenings when the woman will be home. The key to not introducing bias into the sample is to remember that eligibility criteria must be determined in such a way that all eligible women within the cluster have an equal opportunity to be chosen as informants, whether at their homes, place of work, or school.

The WHO VAW study decided to consider permanent lodgers and domestic servants who spend fewer than two nights per week away from the household as eligible informants. Women who worked in the household as domestic servants but spent at least two nights a week away would not be included. These women could potentially be selected to be interviewed in their own homes on their days off work.

To avoid biasing the sample, it is important that interviewers select the woman to be interviewed using random methods, and not simply the first woman to answer the door, or the oldest, or the one who seems most available. In the WHO VAW study, this was achieved by choosing women's names out of a paper bag. In Nicaragua, a random number chart was used to select the women to interview. Box 7.5 describes how to use these methods. If you are using a list of women's names generated from a sampling frame of individuals, and it is possible to determine whether two women are living in the same household, then you can select one woman from each pair by alternating between the older and younger woman.

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PHOTO BY M. ELLSBERG

Tools for Collecting Quantitative Data

Topics covered in this chapter:

Quantitative data are generally collected using a standardized questionnaire, which may be administered in a face-to-face interview or as a self-administered questionnaire. The process of developing a well-conceptualized and user-friendly instrument for collecting quantitative data is complex and time-consuming, but crucial for successful research.

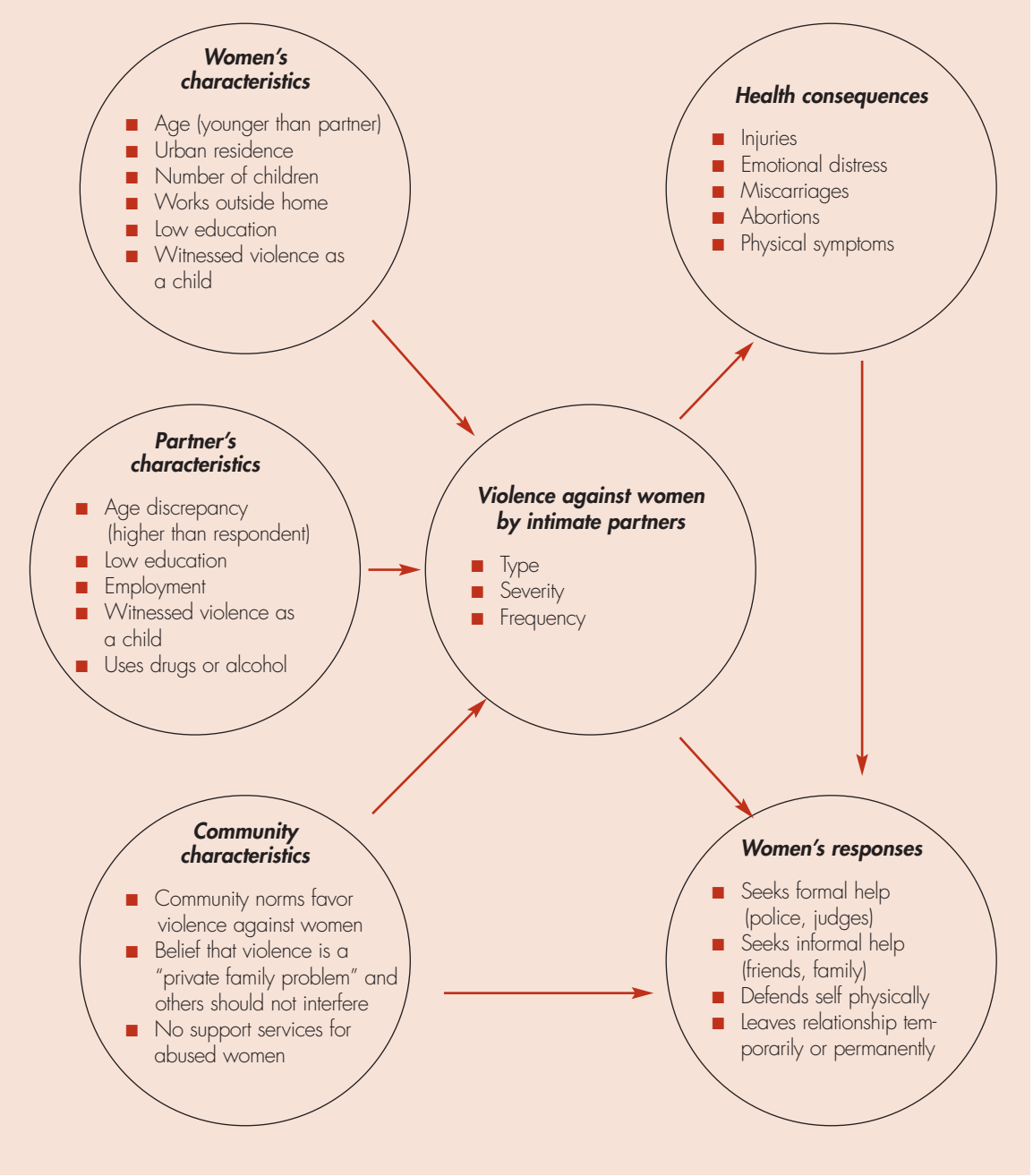
Before starting, clarify what you want to know, according to the goals of your study. Next, consider whether you can obtain all of the answers you seek by questioning respondents, or if you will need to use additional techniques such as observation or analysis of records. How will you administer your questionnaire—by phone, in person, by mail, or by computer? In making this decision, consider both the literacy levels of likely respondents and the positive or negative influence each option may have on the respondents' willingness to disclose personal information.

Finally, decide whether you understand the topic and setting well enough to design a questionnaire. If not, you may want to conduct some formative research to identify areas of inquiry and to refine issues of language. Chapter 9 presents a number of qualitative techniques for gathering information before you design a more structured questionnaire.

DEVELOPING THE CONCEPTUAL FRAMEWORK

Before developing your questionnaire it is essential to decide exactly what information you will need and how you will measure it. One way to do this is to map out visually all the information in your research questions and organize it according to how you think the variables are related to each

FIGURE 8.1 EXAMPLE OF A CONCEPTUAL FRAMEWORK FOR UNDERSTANDING RISKS AND IMPACT OF INTIMATE PARTNER VIOLENCE



other. This exercise will be informed by the review you have carried out of relevant literature and the "brainstorming" sessions that you have carried out with the research team and knowledgeable members of the community. Start out by including as broad a range of factors as possible.

Figure 8.1 shows how individual characteristics of women and their partners, combined with community level characteristics such as norms around violence and the existence of services for abused women, might increase or decrease a woman's risk of being abused by her partner. The characteristics of the abuse, whether sexual, physical, or emotional, and its severity and frequency, are likely to determine whether she will suffer either physical or emotional

health effects from the violence. Finally, the characteristics of the violence, the health effects, and community attitudes and the availability of support services determine the options she has for protecting herself.

If you are looking at a specific outcome for which there are already known risk factors, these risk factors should be included in the map. For example, if you want to examine the relationship between low birth weight and violence, it is important to collect information about a woman's reproductive history—such as number of pregnancies and use of alcohol or tobacco during her pregnancy.

Each concept included in the map will be translated into one or more variables. These are the components of the research question, conceptually isolated and unambiguously defined. The variables that represent specific outcomes under study are known as the **outcome** or **dependent variables**, while those variables that help explain the causes of these outcomes are known as **explanatory** or **independent variables**. Some variables, such as "violence," can be considered as both, depending on whether one is looking at the causes or consequences of violence.

Once you map out all the possible variables, it is time to narrow the focus of the study according to what is feasible and most relevant to the study's objectives. Some of the variables may be outside the scope of the survey. These variables should be discarded; there is no point in collecting data that will not yield meaningful results.

OPERATIONALIZING THE MAIN VARIABLES

Once you determine which specific outcomes and background variables to include in the questionnaire, it is necessary to decide how each will be defined and measured. In Chapter 6, we discussed how different types of violence might be more precisely measured. As an example, Table 8.1 presents how the WHO VAW Study addressed different issues regarding risk and protective factors and consequences of violence.

FORMULATING YOUR QUESTIONS

Once you identify your study variables, it is time to turn them into clearly worded questions. Survey questionnaires commonly use two types of questions:

- **Closed questions.** Respondents are asked to choose from one or more fixed alternatives. These can be **yes/no** questions ("Has your husband ever hit you during pregnancy?") or **ordinal** categories ("Would you say that last year your husband hit you once, several times, or many times?"). Another type of closed question, the **scale item**, asks for a response in the form of degree of agreement or disagreement, or level of intensity, ("How do you feel about the following statement: Women should put up with abuse in order to keep the family together? Strongly agree, Agree, Don't know, Disagree, Strongly disagree.")

- **Open questions.** These do not restrict the content or manner of the reply other than the subject area ("Whom did you tell about your situation?" or "Who was present the last time you were beaten?")

*A **dependent variable** refers to the specific outcome or condition under study (e.g., violence).*

*An **independent** or **explanatory variable** is one that helps explain the causes of the dependent variable.*

The majority of questions in the survey questionnaire will probably be in the form of closed questions. Open-ended questions are flexible and allow the

TABLE 8.1 TOPICS INCLUDED IN THE *WHO MULTI-COUNTRY STUDY ON WOMEN'S HEALTH AND DOMESTIC VIOLENCE AGAINST WOMEN*

Prevalence and characteristics of violence

- Prevalence during last year
- Prevalence ever
- Severity of abuse
- Type of abuse (physical, sexual, emotional)
- Frequency during last year
- Frequency of previous violence
- Relationship to offender
- Violence during pregnancy
- Initiation and duration of violence

Background socio-economic information

Details of respondent

- Age
- Education
- Marital status/marital history
- Household composition
- Socio-economic status of household
- Current or most recent employment/sources of income

Details of current or most recent partner

- Age
- Education and training
- Marital status
- Current or most recent employment

Risk and protective factors for violence against women in families

About woman

- Female access to and control of resources
- History of previous victimization
- Indicators of empowerment
- Resistance to violence
- Whether witnessed violence between parents as a child
- Whether can access support outside the household from friends
- Whether belongs to any group/association
- Use of alcohol or drug

Details of current or most recent partner

- Expectations, communication, and decision making in relationship
- Extent of participation in looking after family and home
- Use of alcohol and drugs
- Employment status
- Whether witnessed violence between parents as a child
- Whether physically aggressive towards other men

(From WHO, 2004.[1])

interviewer to probe a subject in greater depth, but they are also more time-consuming to administer and analyze. We therefore recommend that you limit the use of open-ended questions when conducting large-scale surveys. Piloting and formative research may facilitate the use of open-ended questions by providing suggestions for standard responses that can be precoded and included in the questionnaire.

Use of international instruments

For many concepts, such as emotional distress, socio-economic status, or reproductive health outcomes, **international questionnaires** already exist, and may already be adapted and even validated for use in your country. Using instruments that have already been validated makes it easier to compare the findings in your study with other national and international studies. As the example from South Africa in Box 8.1 shows, it's still important to pre-test the instruments to be sure that the concepts are clear and meaningful in your setting. Box 8.2 describes the process of developing the WHO VAW instrument.

FORMATTING YOUR QUESTIONNAIRE

The way the questionnaire is organized and formatted can make a big difference in how smoothly the interviews go. The main issues are:

TABLE 8.1 TOPICS INCLUDED IN THE *WHO MULTI-COUNTRY STUDY ON WOMEN'S HEALTH AND DOMESTIC VIOLENCE AGAINST WOMEN*

Health outcomes

- Reproductive history including pregnancies, live births, miscarriages, and still births
- Whether she wanted pregnancy with last child
- Details of last child and use of prenatal services
- Use of family planning
- Smoking and alcohol consumption in last month
- Indicators of physical health problems in last month
- Indicators of reduced mobility or functioning in last month
- Indicators of psychological distress in last month
- Suicidal thoughts and attempted suicides
- Health care utilization in last month
- Use of medication in last month
- Hospitalization and operations in last year
- Injuries resulting from physical violence
- Use of health services as a result of injuries

Other consequences of violence

Impact on women's lives

- Perception of whether affected physical or mental health
- Prevented from working
- Disruption of work/ability to earn money
- Ability to attend community meetings

Impact on children's lives

- Reported birth weight for last child under 5
- Child aged 5–12 had to repeat year at school
- Child aged 5–12 ran away from home
- Child has emotional problems (thumb-sucking, bed-wetting)
- Extent to which children witness physical or sexual violence

Women's responses to violence

Sources of help and response

- Who knows about situation
- Who intervened or tried to stop violence
- Use of formal and informal services
- Who got help from/forms of help provided
- Satisfaction with response
- Who she would have liked to get more help from

Actions to prevent or reduce violence

- Did she ever defend herself physically
- Whether she ever hit first
- Whether she ever left/frequency left

(From WHO, 2004.[1])

- The sequence of questions
- Appropriate answer scales
- Appropriate skip patterns

The sequence of questions

Keep two broad issues in mind when considering the order of your questions. One is how the order can encourage or discourage people from completing the survey. The other is how the order of questions or the order of answer choices could affect your results.

Ideally, the early questions in a survey should be easy and pleasant to answer. These kinds of questions encourage people to continue the survey. In telephone or personal interviews, they help build rapport with the interviewer. Grouping together questions on the same topic also makes the questionnaire easier to answer.

Whenever possible, place difficult or sensitive questions towards the end of the survey. Any rapport that has been built up will make it more likely people will answer these questions. If people quit at that point anyway, at least they will have answered most of your questions.

If conducting research in a culture that is not your own, don't assume you can predict what will be considered sensitive. In

BOX 8.1 QUESTIONNAIRE DEVELOPMENT IN SOUTH AFRICA

In 1998, the South African Medical Research Council conducted a survey on violence against women. The survey was applied to a random sample of 750 households per province in three (of nine) rural provinces with women aged 18-49. The questionnaire for the women's survey was developed using instruments from other countries and two South African focus groups. It was tested and refined over a three-month period with abused women, other women, and NGO staff. The final revisions were made after a pilot training session for fieldworkers.

Mental health questions were particularly difficult. At the outset, researchers considered using a 20-item self-reporting questionnaire that had been tested and calibrated to similar African settings. During testing, however, informants and fieldworkers had enormous difficulty understanding the questions, and the instrument's length was problematic in an already long questionnaire. In addition, scores seemed to be improbably high.

This prompted an investigation of indigenous and lay expressions of mental ill health—a process that yielded several expressions of distress shared among all African linguistic groups in South Africa. Idioms used to describe mental distress include "the spirit is low" and, if more severe, "the spirit/heart is painful." These expressions were incorporated into the questionnaire.

(From Jewkes et al, 1999.[2])

the WHO VAW study, for example, the questions considered most sensitive varied dramatically by country. In Bangladesh, it was considered routine to ask women about family planning and this was seen as a good rapport-building topic. In Japan, questions about birth control were perceived as highly sensitive. The Japan team urged leaving these questions until later in the questionnaire.

Another strategy for increasing response rates on highly sensitive questions, or in situations where privacy is difficult to achieve, is to allow individuals to respond by pointing out the appropriate answer on response cards rather than saying an answer out loud. Keep in mind that this strategy only works with literate populations.

BOX 8.2 DEVELOPING THE CORE QUESTIONNAIRE FOR THE *WHO MULTI-COUNTRY STUDY ON WOMEN'S HEALTH AND DOMESTIC VIOLENCE AGAINST WOMEN*

The questionnaire used in the study was the product of a long process of discussion and consultation. This has involved reviewing existing literature and numerous instruments, and incorporating input from technical experts in specific areas (including violence against women, reproductive health, mental health, and drug and alcohol use) from members of the expert steering committee, and from experts in the field of conducting large population-based surveys (e.g., the DHS). Moreover, to ensure maximum comparability across studies, discussions were also held with groups such as the International Network of Clinical Epidemiologists (INCLEN) that were conducting research in related areas. For practical reasons, the questionnaire consists primarily of structured questions with closed responses.

In the development phase, the questionnaire was first translated and pre-tested in a limited number of countries on a convenience sample of women. This process was used to explore a range of issues associated with the content of the different sections of the questionnaire. At this stage, respondents were not only asked to answer questions from the questionnaire, but also were requested to provide feedback on the clarity and acceptability of the questions asked, and the way in which the questionnaire was being delivered. At the end of this first pre-test, all interviewers met with the country research team to review the questionnaire, to determine where problems were arising, and to explore possible solutions. This feedback was used to revise different modules within the questionnaire.

Subsequent drafts were informed by qualitative research in the culturally diverse countries and were field-tested again in a second pre-test in the remaining participating countries. This experience resulted in extensive revisions to improve accuracy and cross-cultural comparability, and in the final content and structure. The final revisions to the questionnaire were made following the fourth research team meeting. The revised questionnaire was then sent to each country research team for a final pre-test. This resulted in version 9.9, which was used in the first eight countries of the multi-country study.

Each country could add only a limited number of relevant country specific questions, and adapted certain response codes to reflect local circumstances.

Between 1999 and 2002, the final questionnaire was used in 13 languages during the implementation of the WHO multi-country study in Bangladesh, Brazil, Japan, Namibia, Peru, Samoa, Tanzania, and Thailand. Additional studies in Chile, China, Serbia, New Zealand, Ethiopia, and Indonesia have also used this questionnaire. The questionnaire and a manual with the question-by-question description of the questionnaire is available from WHO at genderandhealth@ who.int. A shortened version of the instrument can be found in Appendix I of this guide.

(From WHO, 2004.[1])

The other way question order can affect results is habituation. This problem applies to a series of questions that all have the same answer choices. After being asked a series of similar questions people may give the same answer without really considering it. One way to avoid this is by asking some questions so that positive attitudes or beliefs are sometimes scored with a yes answer or a high number on a scale and on other questions with a no answer or a low number.

Box 8.3 presents an example of questions asked in the WHO VAW study about women's attitudes toward gender roles.

BOX 8.3 QUESTIONS FROM THE WHO VAW STUDY ON GENDER ROLES

In this community and elsewhere, people have different ideas about families and what is acceptable behavior for men and women in the home. I am going to read you a list of statements, and I would like you to tell me whether you generally agree or disagree with the statement. There are no right or wrong answers.

A good wife obeys her husband even if she disagrees.	Agree	_____
	Disagree	_____
	Don't Know	_____
	Refused/No Answer	_____
Family problems should only be discussed with people in the family.	Agree	_____
	Disagree	_____
	Don't Know	_____
	Refused/No Answer	_____
It is important for a man to show his wife/partner who is the boss.	Agree	_____
	Disagree	_____
	Don't Know	_____
	Refused/No Answer	_____
A woman should be able to choose her own friends even if her husband disapproves.	Agree	_____
	Disagree	_____
	Don't Know	_____
	Refused/No Answer	_____
It's a wife's obligation to have sex with her husband even if she doesn't feel like it.	Agree	_____
	Disagree	_____
	Don't Know	_____
	Refused/No Answer	_____
If a man mistreats his wife, others outside of the family should intervene	Agree	_____
	Disagree	_____
	Don't Know	_____
	Refused/No Answer	_____

(From WHO, 2004.[1])

In some cases, such as a woman choosing her own friends, a respondent who agrees with the statement would be expressing views in favor of women's autonomy, whereas in the question about the importance of a man showing his wife who is the boss, agreement would indicate acceptance of traditional values.

Appropriate answer scales

Questions related to attitudes, frequency of events, or opinions usually require participants to answer based on some form of scaled response. In the developed world, such scales usually allow for at least five distinct answers. Such complex scales, however, can be difficult for some populations to understand and interpret. Moreover, certain cultural patterns and expectations can influence how individuals reply to different response options. For example, researchers in Nicaragua found when using a five-point scale to measure perceptions of childhood experiences that respondents almost invariably answered that they "strongly agreed" or "strongly disagreed." Almost no responses indicated that they "somewhat" agreed or disagreed. In contrast, in other countries, particularly in Asia, researchers have found that respondents are reluctant to express a very strong opinion, for fear of seeming rude. Therefore, responses tend to be more neutral.[3]

Appropriate skip patterns

The **skip patterns** in a questionnaire determine the order of specific questions that will be asked according to answers that are previously given. They help make the interview flow smoothly and avoid annoying mistakes, such as asking a woman the age of her children when she has already indicated that she has no children, or asking women who have never had sexual relations whether they use birth control. Special care should be taken to ensure that the skip patterns are correctly placed and that women are not inadvertently excluded from being asked important questions.

As an example of how important information may be lost through errors in skip patterns, the León, Nicaragua, survey only asked questions about problems in pregnancy to women who had suffered abuse. This made it impossible to compare the rates of miscarriages and abortions among abused and nonabused women. A similar problem occurred when questions about physical injuries as a result of abuse were asked of women who had only suffered emotional and not physical violence.

TRANSLATING THE INSTRUMENT

Now that you've developed your test instrument, how do you translate it into the local language? You need an accurate and precise translation, but professional translators may not be familiar with the terms women use to talk about violence and intimate relationships.

Several steps can enhance your translation efforts. First, involve activists or service providers in translating the test instrument. You may find that formative research helps you identify the appropriate terms and expressions to describe the issues under study. Researchers often use a technique called **back-translation** (having someone unfamiliar with the study translate the questionnaire back into English) to ensure that the instrument has been properly translated. However, researchers in South Africa and Zimbabwe found that back-translations were not a reliable way to check the accuracy of questions on violence and its consequences. They achieved better results when someone who understood the purpose of the study and who could compare the English version with its translation checked the translated questionnaire.[2] Box 8.4 describes the steps that were taken in translating the WHO VAW questionnaire.

PRE-TESTING THE INSTRUMENT

Before beginning the fieldwork, it is essential to pre-test the questionnaire thoroughly. The many errors or unforeseen situations you will find are fairly easy to correct at this stage, but would be quite costly to repair later. To pre-test, try the questionnaire on women who do not live in the research area, but who are similar to the women you are planning to study (this does not have to be a random sample). This step enables you to detect any problems in terms of the content or wording of questions as well as interview length. Try the test on women of different ages and backgrounds, including women who are known to be experiencing different forms of abuse. The women's organizations participating in your advisory group may be helpful in identifying women who are willing to be interviewed about their experiences of violence.

If the questionnaire is to be translated into different languages, pre-test the translated versions too. In addition, asking respondents to answer questions from the questionnaire, invite them to provide feedback: "Are the questions asked clear and acceptable? How do you feel about how the interview was conducted?" At the end of the pre-test, all interviewers should meet with the research team to review the questionnaire, to pinpoint problems with the questions and coding categories, and to explore possible solutions. Box 8.5 gives some examples of the kinds of questions you might ask in the pre-testing stage.

BOX 8.4 TRANSLATING THE WHO QUESTIONNAIRE

The working language for the development of the core questionnaire was English. Before pre-testing, each country questionnaire was professionally translated into each of the local languages used by the study population. The formative research was used to guide the forms of language and expressions used, with the focus being on using words and expressions that are widely understood in the study sites. In settings where there are a number of languages in use, it was necessary to develop questionnaires in each language.

The translated questionnaire was first checked by local researchers involved in the study who could compare the English version with its translation. Lengthy oral back-translation sessions with step-by-step discussion of each question were conducted with people not familiar with the questionnaire but fluent in the language and with people who understood the questionnaire and violence issues. The main purpose was to identify differences in translations that could alter the meaning and to establish cognitive understanding of the items in the questionnaire. Adjustments were made where needed. Once the translated questionnaire had been finalized during the interviewer training, questions were discussed using the manual with explanations for each question. Having interviewers from various cultural backgrounds aided in ascertaining whether wording used was culturally acceptable. During the training itself, further revisions to the translation of the questionnaire were made. Finally, usually during the field pilot in the third week of the interviewer training, final modifications to fine tune the translated questionnaire were made.

Pitfalls in Translation

In a Zimbabwe study, a series of questions were used to define the time frame during which women had attended health services. In English the question was, "In the last year (1995), have you attended a clinic or hospital because you were sick?"

In Shona, the question was translated as, "In 1995, did you attend…" Since the survey was conducted in May 1996, this question only obtained information about the previous calendar year.

In Nbele, the question was translated as, "In the last year (12 months) have you attended…"

Therefore, the information obtained from the two translated versions referred to different periods.

(From Watts, 1997.[4])

BOX 8.5 SUGGESTIONS FOR PRE-TESTING THE QUESTIONNAIRE

1. During the interview, the interviewer should jot down observations about any questions that seem to be problematic.
2. After the interview, take another 15-30 minutes to ask the respondents their own views about the interview:
   - What do you consider the main topics of the survey?
   - Are there any questions you feel are inappropriate, too personal, or that people would not be likely to answer truthfully?
   - Do you feel comfortable with the informed consent process (i.e., were you adequately informed about the nature of the study)?
   - Were there any questions that you did not understand or that you thought were confusing?
   - Is the length of the interview acceptable or too long? (You may want to ask how long they thought the interview lasted and compare this to the actual duration.)
3. After each interview, take detailed notes of both your own and your respondent's observations.
4. After each researcher/interviewer has performed several interviews, it is useful to sit down and analyze the responses to the questionnaire. The following issues might be explored in this discussion:
   - Are there any questions that are particularly sensitive, or that women seem reluctant to answer?
     In the Nicaragua survey, a question about the last time a couple had intercourse caused a lot of discomfort among respondents, and women often asked why we wanted to know this.
   - Are there questions women seem to answer almost automatically? Are they telling us what they think we want to hear, rather than drawing from their own experiences?
     Researchers in some Asian countries have found that women are unlikely to report violence between their parents and in-laws, as it is considered disloyal to speak ill of relatives.
   - Are there questions for which the women give unusual answers, or seem not to understand the purpose of the question? For example, does the interviewer need to explain it several times, or use different language so that the women understand the question? What wording would be easier to understand?
   - Are there questions for which it is difficult to code the response, or where it seems that the questionnaire is missing important data?
     In one pre-testing exercise, it became clear that many women have been abused by a spouse prior to their current partner. Therefore it was necessary to collect some basic information about former spouses.
   - Do the skip patterns seem to flow smoothly, so that no women are left out of questions they should be asked? Conversely, are women made to repeat the same answers? Are they asked inapplicable questions?
   - Is there a fairly broad range of responses to most of the questions?
     Too much uniformity may indicate that women are answering in a way that they believe is expected, or that they don't really understand the question, or that it is simply not a useful or relevant question.
   - If we ask hypothetical questions such as, "Do you think a woman should accept being beaten in order to keep her family intact?" do women seem to understand that we are asking about opinions and not experiences? *Women who are not used to this kind of question may find it difficult to respond, and may give answers such as, "I can't speak for anyone else."*
   - Are there questions where similarly coded answers might mean two very different things? Do we need to add additional responses or improve the wording of the question to enhance clarity?
   - Do the initial sections allow the interviewer to develop sufficient rapport before asking about violence? Would the questions on violence fit better at an earlier point? Does the order of the questions seem to flow logically and smoothly?
   - Is the questionnaire too long? Do women seem tired or restless by the end of the survey? Does the average duration of the interview correspond to what you have told respondents in the consent form? *Consent forms usually give the respondent an estimate of how long the questionnaire will take to complete. If the average interview during the pre-test is substantially longer than what the consent form suggests, then you may have to revise either the estimate or the questionnaire.*
   - Is it difficult to achieve privacy? Do the procedures for ensuring confidentiality work?
   - Are there differences in the way that women responded in the versions that are translated into other languages? Are there specific problems with the wording or translations?

1. World Health Organization. *WHO Multi-country Study on Women's Health and Domestic Violence: Study Protocol.* Geneva, Switzerland: World Health Organization; 2004.
2. Jewkes R, Penn-Kekana L, Levin J, Ratsaka M, Schrieber M. *He Must Give Me Money, He Mustn't Beat Me: Violence Against Women in Three South African Provinces.* Pretoria, South Africa: Medical Research Council; 1999.
3. Yoshihama M. Personal Communication. Ann Arbor, Michigan; 2004.
4. Watts C. Violence in Zimbabwe. Personal Communication. London, UK;1997.

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Tools for Collecting Qualitative Data

Topics covered in this chapter:

Personal interviews
Focus group discussions
Observation
Free listing
Ranking
Pair-wise ranking
Timelines and seasonal calendars
Causal flow analysis
Open-ended stories
Genograms
Circular or Venn diagrams
Community mapping
Role playing
Body mapping
Photo voice

Researchers employ a wide range of techniques when collecting qualitative data. In fact, most studies rely on a combination of methods. This section describes some of the most frequently used qualitative data collection tools, with examples describing how they have been used by researchers to get individuals to speak openly and honestly about violence.

PERSONAL INTERVIEWS

The **personal interview** is one of the most common means for collecting qualitative data. Talking face to face with respondents on highly sensitive matters requires sensitivity, skill, and the ability to interpret and respond to both verbal and nonverbal cues. Interview styles vary from highly structured or semistructured formats to highly fluid and flexible exchanges. In addition to recording the content of the interview, interviewers may wish to keep a **field log**, where they keep track of their own observations, reflections, feelings, and interpretations. Because the skills required for gathering qualitative data are quite different than

BOX 9.1 STRUCTURED INTERVIEW: GUIDE FOR SERVICE PROVIDERS IN THE HEALTH SECTOR

(As the interviewer, introduce yourself, explain the objectives of the study, and request the respondent's consent to be interviewed. Note the respondent's name, position, and job title; describe his or her duties; and enter the institution's name and location and the date of the interview.)

Work performed by the respondent

- What does your work as _____consist of?
- What percentage of the patients you see are women? What are the most frequent reasons women give for coming to the office/emergency room?
- Are cases of family violence seen? What are the most common cases?
- Do you (or your colleagues) routinely ask questions to determine whether the patient might be a victim of family violence?
- What tests or examinations do you routinely perform when a woman indicates that she has been the victim of violence? How do you decide which tests to perform?
- What is the procedure for obtaining an official report from the medical examiner?
- How many people with this type of problem does your institution serve per month? Do you have a way of keeping records on cases? Is there a form and procedure for recording them? Can you explain it to me?
  (Request a copy of the record form, referral slips, and any other documents that may exist.)
- Do you (or your colleagues) provide follow-up care to women who have been victims of family violence? Are there mechanisms for referring them to other institutions? Do you think the record-keeping system is adequate to identify women affected by family violence, refer them to the appropriate services, and provide timely follow-up services?

Experience with women affected by violence

- Have you ever come into contact with cases of family violence among your clients?
- Can you tell me how these experiences originated, what you did, and what the client did?
- Do you know of other organizations or persons in this community that work on family violence issues? Who are they? What is your relationship with them? Is there coordination with other institutions to address the needs of abused women?
- What changes in legislation, policy, or staffing would facilitate your work?
- What changes in the behaviors or attitudes of the personnel with whom you work would facilitate your work?

those needed for survey interviews, preparation of field staff also needs to be quite different.

Structured interviews

Use **structured interviews** when it is important to collect the same information from every informant. Structured interviews rely on a standardized interview guide that permits easy aggregation of responses across respondents. Because the structured interview guides allow less latitude, interviewers need not be as skilled as those who conduct unstructured interviews.

In structured interviews, the wording and order of interview questions are determined ahead of time. Interviewers are instructed to cover every question included in the guide. For an example of a structured interview guide, see Box 9.1. This excerpt from an interview guide shows how the Pan American Health Organization (PAHO) "Critical Path" study collected information on how different institutions view and respond to survivors of violence.[1]

Semistructured interviews

Semistructured interviews use an open framework that allows focused yet conversational communication. They are useful for collecting information about historical events, opinions, interpretations, and meanings.

Unlike a survey questionnaire, in which detailed questions are formulated ahead of time, semistructured interviews start with more general questions or topics. Relevant topics such as violence or

women's participation on the community council are initially identified and organized into an **interview guide** or **matrix**. (See Box 9.2 for an example of an interview guide used in formative research in the WHO VAW study.)

Not all questions are designed and phrased ahead of time. Most questions arise naturally during the interview, allowing both the interviewer and the person being interviewed some flexibility to probe for details or to discuss issues that were not included in the interview guide.

Semistructured interviews require skill on the part of the interviewer, so it is a good idea to carry out some practice interviews to become familiar with the subject and the questions.

If possible, tape all interviews and then either transcribe them later or develop detailed notes of the conversation based on the tapes. If you cannot tape the interviews, take brief notes during the interview and complete and expand the notes immediately after the interview. It is best to analyze the information at the end of each day of interviewing. This can be done with the interview team or group.

BOX 9.2 SEMISTRUCTURED INTERVIEW GUIDE

1. Can you please tell me a little about yourself? Did you go to school?
   Where do you live now?
   Do you have children?
   How do you normally spend your days?
   What things do you like to do?
2. Tell me about your husband. How did you first meet?
   When did you get married?
   What does he do?
3. When did your problems with your husband start?
   How long has this continued?
   Are there times when this has improved, or gotten worse?
4. Has it had a great effect on your physical well-being? In what ways?
   How has it affected your feelings about yourself?
   Do you think that it is having an effect on your children? In what ways?
   Has it affected your ability to provide for the family or go to work?
   Has it made it difficult for you to meet friends or relatives? How?
5. Have you ever discussed your problems with others? How did they respond?
   Was there more that you would have liked them to do?
   What sort of things would have helped?
6. Looking back at your situation, what advice would you give another woman who has just started to have these sorts of problems with her husband?

(From WHO, 2004.[2])

Unstructured interviews

Unstructured interviews allow the interviewer and respondent the most flexibility. Questions are open-ended, and the interviewer lets the respondent lead the conversation. The interviewer asks additional questions to gain as much useful information as possible.

Unstructured interviews are based on a loosely organized interview plan that lays out the purpose of the interview and includes a list of topics to be explored. The flow of the conversation—not what is written in the guide—determines the timing and sequence of topics. One type of qualitative inquiry called "narrative analysis" particularly relies on unstructured interviews. In this case, the interviewer attempts to obtain a detailed story from a respondent about a specific event or aspect of his/her life. This is a story with a beginning, middle, and an end, although it might not be presented in that order during the interview.

Because unstructured interviews allow a lot of freedom, they require especially skilled interviewers. You need to be especially alert for inconsistencies, pieces of the story that seem to be missing, and new angles that might provide additional information, and then probe accordingly. When conducting in-depth interviews with survivors of violence, beware of the temptation to slip from "interview" mode to "counseling" mode. Because of their conversational style, in-depth interviews tend to encourage emotional disclosure and intimacy. This increases the need for interviewers to stay true to their role, monitor their boundaries, and be attentive to levels of distress of the respondent. (See Box 10.4 for a thorough discussion of the role of the interviewer.)

BOX 9.3 UNSTRUCTURED INTERVIEW GUIDE

Purpose: To explore the impact of sexual harassment on individual women's lives.

Definition/understanding of sexual harassment.

- Behaviors included?
- Contexts included?

Personal experiences of harassment.

- How did it make her feel?
- What did she do?
- How did others react?

Changes in cultural attitudes toward harassment in her lifetime.

- Opinion on whether men can be sexually harassed by women.

Knowledge of others who have been harassed.

(From WHO, 2004.[2])

One advantage of unstructured interviews is that they can yield very rich and nuanced information. The downside is that data analysis may be more complex and time-consuming than in the case of structured interviews.

FOCUS GROUP DISCUSSIONS

Focus group discussions are a powerful method for collecting information relatively quickly. They are better suited for exploring norms, beliefs, practices, and language than for seeking information on actual behaviors or details of individual lives. The **focus group** is a special type of group in terms of its purpose, size, composition, and procedures. A focus group is usually composed of six to ten individuals who have been selected because they share certain characteristics that are relevant to the topic to be discussed. In some cases, the participants are selected specifically so that they do not know each other, but in many cases that is not possible, particularly when participants belong to the same community or organization. The discussion is carefully planned, and is designed to obtain information on participants' beliefs about and perceptions of a defined area of interest.[3-5]

Focus groups differ in several important ways from informal discussion groups:

- Specific, predetermined criteria are used for recruiting focus group participants.
- The topics to be discussed are decided beforehand, and the moderator usually uses a predetermined list of open-ended questions that are arranged in a natural and logical sequence.
- Focus group discussions may also be carried out using participatory techniques such as ranking, story completion, or Venn diagrams (these techniques are all described in this chapter). This may be particularly useful when working with groups with little formal education or when talking about very sensitive issues. (In the Nicaraguan study on a new domestic violence law, described in the following pages, however, participatory techniques were used successfully in focus group discussions with judges and mental health professionals as well as with rural men and women.)
- Unlike individual interviews, focus group discussions rely on the interactions among participants about the topics presented. Group members may influence each other by responding to ideas and comments that arise during the discussion, but there is no pressure on the moderator to have the group reach consensus.

Focus groups have been used successfully to assess needs, develop interventions, test new ideas or programs, improve existing programs, and generate a range of ideas on a particular subject as background information for constructing more structured questionnaires. However, they

are not easy to conduct. They require thorough planning and training of group moderators.

When planning a focus group, consider the following recommendations:*

- Focus groups require trained moderators. You will need three types of people: recruiters, who locate and invite participants; moderators, who conduct the group discussions; and note-takers, who list topics discussed, record reactions of the group participants, and tape-record the entire discussion (if all participants give consent). Note-takers also help transcribe the taped discussions.

- Focus groups are usually composed of homogeneous members of the target population. It is often a good idea to form groups of respondents that are similar in terms of social class, age, level of knowledge, cultural/ethnic characteristics, and sex. This will help to create an environment in which participants are comfortable with each other and feel free to express their opinions. It also helps to distinguish opinions that might be attributed to these different characteristics among groups.

- If possible, experienced focus group leaders suggest conducting at least two groups for each "type" of respondent to be interviewed.

- The optimal size group consists of six to ten respondents. This helps ensure that all individuals participate and that each participant has enough time to speak. However, sometimes, it is not possible to regulate the size of a group, and successful focus group discussions have been carried out with many more participants.

- Analyze the data by group. Data analysis consists of several steps. First, write summaries for each group discussion. Next, write a summary for each "type" of group (e.g., a summary of all discussions conducted with young mothers). Finally, compare results from different "types" of groups (e.g., results from groups of young versus older mothers).

- The discussions may be taped for transcription later, but this substantially increases the time and cost of analysis. One alternative is to take careful notes during the discussion and to refer to the audiotapes for specific areas where there are doubts.

Focus groups give information about groups of people rather than individuals. They do not provide any information about the frequency or the distribution of beliefs or behavior in the population. When interpreting the data, it is important to remember that focus groups are designed to gather information that reflects what is considered normative in that culture. In other words, if wife abuse is culturally accepted, then it should not be difficult to get participants to speak frankly about it. However, some topics are very sensitive because they imply actions or orientations that are either culturally taboo or stigmatizing.

For the same reason, focus group respondents should not be asked to reveal the details of their individual, personal lives in a focus group setting, especially when the subject matter of the focus group deals with sensitive issues such as domestic violence and sexual abuse. If a researcher wants information on women's individual experiences, then that should be done in private individual interviews.

* (Adapted from Hudelson, 1994.[3])

In many cases, facilitators ask respondents to think about the perspectives and behavior of their peers, for example, which allows them to draw on their experiences in general terms but does not ask them to reveal the details of their own behavior or experiences in a group setting. The following example describes how focus groups were used in Nicaragua in advocacy for a new domestic violence law. Box 9.4 presents a sample discussion guide for a focus group discussion on sexual violence performed with members of a refugee camp.

Example of focus group discussion: Evaluating a domestic violence law in Nicaragua

The Nicaraguan Network of Women against Violence used focus group discussions in the consultation process for a new domestic violence law that was presented before the National Assembly. Because the new law was controversial (it criminalized inflicting emotional injuries, and established restraining orders for abusive husbands), the purpose of the study was to assess both the political and technical viability of the new law.

The research team conducted 19 focus groups with over 150 individuals representing different sectors of the population, such as urban and rural men and women, youth, police officers, survivors of violence, judges, mental health experts, and medical examiners.

The main questions asked by the study were, What kinds of acts were considered violent? What kinds of legal measures were considered to be most effective for preventing violence? The researchers used ranking, Venn diagrams, and free listing exercises to initiate discussions. A team of men and women from member groups of the Network were trained as focus group moderators, and two team members led each group. Focus groups sessions were audio-taped and researchers presented typed notes and diagrams from each session. The team did the analysis as a group, and participants' responses were organized according to themes. The study revealed a broad consensus on several issues, the most significant of which were the gravity of psychological injury and the importance of protective measures for battered women. It was widely agreed that the psychological consequences of abuse were often much more serious and long-lasting than physical injuries and that the legal definition of injury should take this into account. One rural woman noted that harsh and demeaning words can make you "feel like an old shoe." A judge noted that "bruises and cuts will heal eventually but psychological damage lasts forever." The results of the study were presented in testimony to the Justice Commission of the National Assembly, which subsequently ruled unanimously in favor of the law.[6]

OBSERVATION

Observation, a time-honored form of qualitative data collection, has its roots in cultural anthropology. Researchers may either actively participate in the phenomenon being observed (known as **participant observation**) or they may observe as "on-lookers."

Observation may be either "structured" or "unstructured." Even the most unstructured observations must have a system for capturing information as clearly and faithfully as possible. Wherever possible, it is best to record observations on the spot, during the event. This can take the form of abbreviated notes that you elaborate on later as you write more detailed notes. Records should denote who was present; any unusual details of the scene; verbatim comments; and incongruities (it may help to ask yourself questions—"Why did he do that?").

BOX 9.4 FOCUS GROUP INTERVIEW GUIDE: DADAAB REFUGEE CAMP, KENYA

[Note: This guide served as the basis for most refugee group discussions, although in later groups, certain topical areas were prioritized to obtain more in-depth information than in more general interviews.]

Name of group interviewed: _____Date:_____Camp:_____

Time discussion started:_____Time ended:_____Team no:_____

Participant summary: _____ Women _____Men _____ Children

Introduction

1. *Introduce facilitators.*
2. *Introduce community members.*
3. *Explain why we are here: "We want help in understanding the health and security problems of women and girls in Dadaab. We will be doing similar interviews in all camps this week."*
4. *Explain how all answers will be treated confidentially. "We are all from organizations working in the camps and will treat answers with respect and will not share them except as general answers combined from all people who talk to us. We will not give names of individuals, to make you feel comfortable in talking freely with us. Participation in the discussion is completely voluntary and you do not have to answer any questions that you do not want to answer." Ask community members whether they are willing to participate in the group interviews.*

Discussion Guide

1. What problems have women and girls experienced in health and security in your community? (PROBE on violence, not on health.)
2. Can you give examples of sexual violence in the camps?
3. When and where does sexual violence occur?
4. Who are the perpetrators? (PROBE: outside/inside of camp, people you know/don't know.) What happens to the perpetrators?
5. What are the problems that women face after an attack? (PROBE: physical, psychological, social problems.)
6. How do survivors of sexual violence cope after the attack?
7. What are community responses when sexual violence occurs? What is done to prevent violence? What is done to help survivors? How could these efforts be improved? Do women's support networks exist to help survivors?
8. What social and legal services exist to help address these problems? (PROBE: health, police, legal counseling, social counseling.) Who provides these services? How could these efforts be improved?
9. Has the problem of sexual violence gotten worse, better, or stayed the same since you arrived in Dadaab?
10. EXTRA QUESTIONS TO ADD FOR SPECIAL GROUPS:

    RELIGIOUS LEADERS: 1. What does Islam teach on sexual violence, both for preventing violence and sanctioning those that are violent against women? 2. Is there anything that religious leaders can do to prevent sexual violence?

    DISABLED: Do the existing services prevent or help those assaulted address you as well, as a special group with special needs?

    WOMEN LEADERS: Is there anything women leaders can do to prevent sexual violence?

Closing

1. *Thank people for their time and ideas, and express how helpful it has been to facilitators.*
2. *Explain next steps: "We will look at all information and will make a presentation of findings to representatives of the community and agencies working in camps. Representatives can give you information after this meeting."*

(From Igras et al, 1998.[7])

Shortly after leaving the field, review these notes and add detail and substance. Getting the full record straight may take as long as the original observation did. As a rule, always prepare the detailed notes of the observation within 24 hours of the field session, and never embark on a second session until you have fully developed your notes from the first. (Adapted from Patton, 1990.[8])

BOX 9.5 OBSERVATION GUIDE TO ASSESS READINESS FOR INTEGRATION OF GENDER-BASED VIOLENCE INTO REPRODUCTIVE HEALTH CLINICS

Time observation is initiated:_____

Characteristics of the clinic:

1. Is there a space dedicated to ob-gyn consultations?
2. Can conversations within the examining room be heard outside the room?
3. Can the client be seen from outside the examining room?
4. Are there interruptions during the consultations?
5. Is there any separation (e.g., a screen) between the desk and the examining table?
6. Is there a place where children can be watched while the mother is in the consultation?
7. Are there educational materials (e.g., posters, videos, pamphlets) regarding domestic violence inside the examining rooms or waiting rooms? What kind of materials? What subjects are covered in the materials?

Time observation is completed: _____

Many women's groups have successfully used observation to assess whether services for abuse victims are adequate and to document bias and/or victim-blaming attitudes by the police, justice system, health professionals, or counselors.

Example of observation: Justice for rape survivors in Bangladesh

The Bangladeshi women's group Narippokko used semistructured observations to document how the courts in Dhaka treat abuse victims and rape survivors. Advocates sat for days in open court recording the behavior, words, and demeanor of Bangladeshi judges. They recorded verbatim comments of judges indicating their bias against rape victims and noted instances of humiliating and degrading treatment of women by court officials. These data were useful for raising awareness of the biases inherent in the treatment of female victims of violence in Bangladesh by the courts.[9]

Example of observation: Readiness of reproductive health clinics to address violence in Latin America

The International Planned Parenthood Federation, Western Hemisphere Region, used an observation guide to assess the readiness of local affiliate centers to integrate gender-based violence into reproductive health programs (Box 9.5). The observation guide was used at the beginning of the project, as part of a situation analysis, and later on as part of the monitoring and evaluation program (the full guide is available in Spanish at www.ippfwhr.org.)

FREE LISTING

Free listing is a particularly useful tool for exploring a subject about which the researcher has little previous knowledge, or when the researcher wants to have as broad a discussion as possible.

The researcher asks participants to generate a list of items that correspond to a particular topic and then writes them on the blackboard or chart. Or, the researcher may hand out cards so that participants can write down their answers and then stick them up on the wall.

Free listing can be an interesting way to compare attitudes or experiences among different groups of individuals. For example, in one study, participants in a focus group were asked to name as many

different forms of violence as they could. A group of women came up with a list of more than 30 types of violence, whereas a group of men was only able to mention five different types.

Another advantage of free listing is that it may enable the researcher to detect issues (for example, a type of violence) that had not previously been considered, but which are important for community members. Free listing can be also used as a starting point for a subsequent ranking exercise to determine which acts are considered, for instance, more severe or more important.

Example of free listing: Causes of sexual violence in Kenyan refugee camps

Free listing was used as part of a participatory assessment of sexual violence in the Dadaab refugee camps in Kenya[7] as a way to identify individuals assessments of the different causes of violence (see Box 9.6). Organizers asked groups of refugees to list all the reasons why women get raped. Then they synthesized the answers according to how many groups listed each problem.

The responses indicated that refugees clearly associated sexual violence with insecurity, both inside and outside the camps. Lack of adequate cooking fuel emerged as a significant source of women's vulnerability because women routinely have to travel long distances outside the camp to collect firewood. When researchers reviewed records of sexual violence cases reported in the preceding year, they found that 90 percent of assaults occurred while women were searching for wood, reinforcing the insights gleaned from the participatory assessment. This combination of data from different sources is also an excellent example of triangulation.

Example of free listing: Support groups for survivors in El Salvador

In a review of Central American gender-based violence programs, health workers were asked to list the symptoms that a woman might have that lead them to suspect that she was living with violence. In

BOX 9.6 FREE LISTING FREQUENTLY CITED CAUSES OF SEXUAL VIOLENCE: DADAAB REFUGEE CAMPS, KENYA

Problem	*Number of groups that noted as cause (n=16 groups)*
Insecurity inside and outside the camps	11
Lack of firewood	9
Lack of fencing	6
Unemployment	5
Poverty	4
Clanism	3
Being a refugee	2
Proximity to border	2
Bandits in camp	2
No police patrol at night	2
More men than women	2
Single women living alone	2
Economic problems	2

(From Igras et al, 1998.[7])

BOX 9.7 FREE LISTING: WHAT WE LEARNED: SUPPORT GROUP FOR SURVIVORS OF VIOLENCE, BARRIO LOURDES, EL SALVADOR

- To be independent
- To value ourselves
- To be more responsible with our children
- To make responsible decisions for oneself
- To recognize our qualities
- Not to be violent
- To esteem ourselves
- To put our abilities into practice
- To say, "I am competent, I can do it."
- To empower ourselves
- To have our rights respected and not be abused
- To love ourselves
- To forgive
- To liberate ourselves
- To respect
- To love
- To have solidarity within the group

(From Velzeboer et al, 2003.[10])

the same study, researchers used free listing to ask women in a self-help group what they had learned from the process (Box 9.7).

RANKING

Ranking is a useful technique to help participants prioritize problems and solutions. The researcher gives participants a series of categories or problems (they may be the ones that resulted from the process of free listing) and asks participants to rank them in order of priority, urgency, or severity. This activity may be carried out with different sectors of the community (such as men, women, or children) to obtain information about differences of opinion. It is also possible to do this activity at the beginning of a program and at later intervals to detect changes in attitudes.

Example of ranking: "What is severe violence?" in Nicaragua

In the participatory study carried out by the Nicaraguan Network of Women against Violence, a ranking exercise was used to identify perceptions regarding the severity of different kinds of violence (physical, economic, sexual, and emotional). In this exercise, the researchers gave each participant a packet of cards with the names of different acts written on them. Participants were asked to classify the acts in five groups according to severity. Afterwards, they were asked to stick the cards on the wall under the signs "not violence," "minor violence," "moderate violence," "serious violence," and "very serious violence."

Then the moderator led a discussion about why some acts are considered more severe than others, and what criteria are used to establish severity. She initiated the discussion around acts that most participants considered serious. The moderator encouraged group members who expressed different opinions to explain their views. A list of the acts mentioned on the cards included:

- Yelling at or humiliating in public
- Throwing things
- Having affairs outside of marriage
- Demanding sex from your partner when she doesn't want it
- Threatening to hit
- Threatening to withdraw financial support
- Destroying objects that belong to the partner (such as clothes, dishes, radio)
- Not paying for household expenses
- Pushing or shoving
- Slapping
- Blows with the fist, on any part of the body except the head, that don't leave a scar
- Beating up with bruises or swelling
- Saying constantly that your partner is stupid or worthless
- Controlling your partner's activities (work, visits, friends)
- Beating up with wounds or fractures
- Blows with a fist to the head
- Blows during pregnancy
- Threats with a gun or knife

The ranking exercise has the advantage of allowing comparisons between different groups around the same acts. For purposes of comparison, one can assess the average severity assigned to an act on a scale of 0 to 4. In the Nicaraguan study, there was a great diversity of opinion as to whether having sex outside of marriage was a form of violence. Whereas middle class women felt that adultery was not violence, rural women considered it to be very severe violence because it often led to men becoming economically irresponsible at home. There was also great divergence between men and women with regard to forced sex in marriage. While men in general felt that forcing a wife to have sex should not be considered violence, most women

FIGURE 9.1 MATRIX FOR PAIR-WISE RANKING EXERCISE

	A. Emotional abuse by husbands of wives	B. Physical abuse by husbands of wives	C. Sexual harassment of women or girls on the street
C. Sexual harassment of women or girls on the street			X
B. Physical abuse by husbands of wives		X	X
A. Emotional abuse by husbands of wives	X	X	X

considered forced sex to be severe violence. In the words of one woman, "If he forces me, I make up excuses, my feelings change, and I come to hate what I once loved."[6]

PAIR-WISE RANKING*

Pair-wise ranking allows community members to determine collectively their most significant problem or issue. They begin by listing problems/issues, and then they compare them systematically by pairs. Community members can compare and contrast the issues they have identified. Each item is successively compared against the others and the winning issue or problem is chosen. Once the matrix is complete community members can score and then rank issues/problems from most important to least important. Pair-wise ranking is a powerful tool to help community members see how different perceptions of significant reproductive health problems can be within a single-sex group and between women and men. In the Dadaab assessment, pair-wise ranking was used to prioritize issues related to sexual violence, such as most important causes of violence, most important solutions, and best coping mechanisms.

The procedure should be as follows:

1. Once rapport has been established with a group of community members, introduce the pair-wise ranking exercise. First, use free-listing techniques to list preferences or problems in response to specific well-phrased questions. For example, what are the types of violence or abuse that women and girls experience in this community? If people identify multiple forms of violence that can be grouped under the same heading (e.g., a husband calling his wife names, telling her she is stupid, or criticizing her feelings), encourage them to identify a general category that captures these multiple forms of violence (i.e., emotional violence by husbands).

2. Draw a matrix (see Figure 9.1). As people identify different types of violence and abuse, write those types in the horizontal column at the top of the matrix. After the participants are satisfied that they have listed as many forms of violence as they can, stop and write the same list in the vertical column, starting the vertical list with the last category listed in the horizontal column. Put an X in the boxes where the pairs are repeated. For example, looking at the matrix in Figure 9.1, A, B, and C each represent a type of violence identified by community members. The X's represent boxes where no ranking is needed, since other boxes already make the same comparison of A with C, A with B,

* (Adapted from Igras, 1998[7] and RHRCC, 2004.[11])

and B with C. Remember that you do not need to prioritize in terms of worst types of violence. At this point, you only need to list different types of violence affecting women and girls in the community.

3. Starting in the upper left-hand corner, ask participants to do the following: "Compare the problem or issue identified in the first row with the problem or issue identified in the first column. Which is the more important of the two?" Let the group discuss and record one answer in the cell.

4. Continue comparing problems listed in the rows with the problems listed in the first column. Be sure to give the group plenty of time for discussion. Through this discussion, individual ranking criteria will emerge and people will begin to understand why another person holds an opinion different from their own.

5. Move on to pair-wise comparisons with the problem in the second column of the problems listed in the row.

6. Continue the process of pair-wise ranking comparisons until all cells in the matrix have been filled.

7. Tally the result, recording a numerical score (count) in the appropriate column. Then prioritize the problems. First priority goes to the problem that received the highest score, second priority to the next, and so on.

8. Discuss the resulting priorities with participants. Most importantly, given the discussion and process, ask if participants feel that the ranking reflects reality. If a community group is going to move ahead with a sexual violence prevention program, will the people support it? Will they participate? Does it speak to their needs?"

Remember to record the visual output (charts, etc.), identifying place, dates, names of participants, if possible. Provide a narrative description of the process and the data. Note: Pair-wise ranking can also be used to rank other issues, such as what kinds of interventions the community feels are most important to reduce violence against women and girls. In this case, sample lead questions might be: What do you think are the most effective methods for reducing sexual violence against women in this community? What do you think are the most effective methods for reducing domestic violence against women in this community?

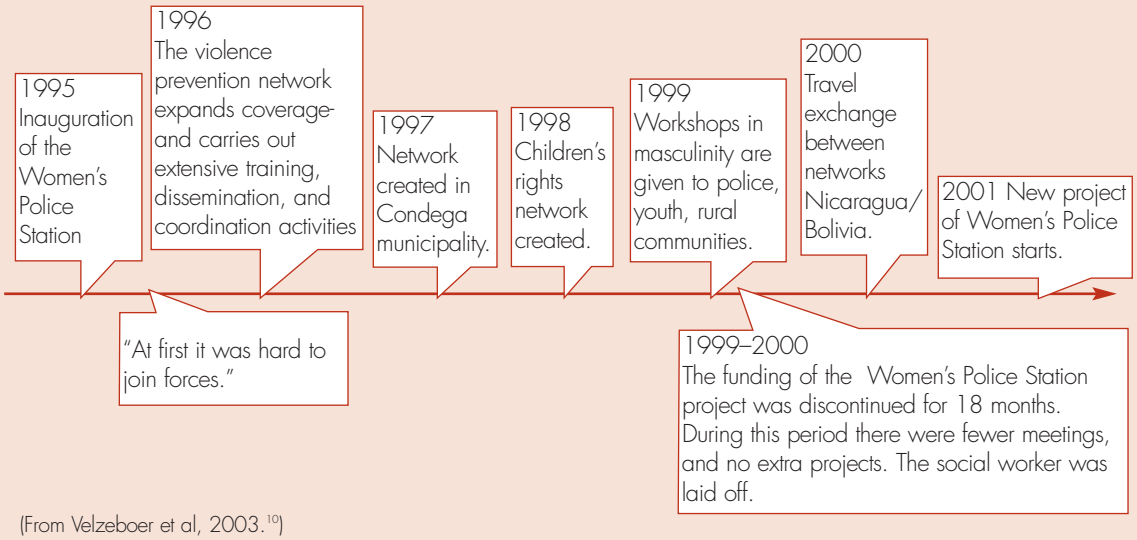
TIMELINES AND SEASONAL CALENDARS

Timelines or seasonal calendars are useful for exploring trends over time, and important events leading up to certain changes. They can be used to measure experiences at a national level (for example, the events leading up to specific changes in domestic violence legislation). They are also useful for diagramming change in a community (e.g., when social violence became a serious problem) or personal experiences in the life of an individual (for example, when a woman first started being abused by her husband, and what actions she subsequently took to overcome the violence).

In a timeline, events or trends are charted according to years, months, or days. Events may be plotted along a line, or a line may be plotted along a vertical axis to indicate increases in the frequency or severity of a specific problem.

A common method in participatory research is to have community members diagram or "draw" the timeline or calendar

FIGURE 9.2 TIMELINE CONSTRUCTED BY COMMUNITY ACTIVISTS IN ESTELI, NICARAGUA.



(From Velzeboer et al, 2003.[10])

on the ground using sticks and other natural items (such as leaves, rocks, or flowers) to mark key events.

Example of seasonal calendars: Sexual violence in Kenyan refugee camps

In the Dadaab refugee camp assessment described above, the organizers used seasonal calendars to monitor periods when women are most vulnerable to rape. They asked community participants to reflect on whether there are periods or events that signal increased or decreased sexual violence. A timeline reproduced the community members' observations about incidence of rape between January 1997 and September 1998. The patterns identified through the seasonal calendar closely track the ups and downs of rapes reported to camp authorities.[7]

Example of timelines: "The Road Traveled" in Central America

In the participatory review of gender-based violence programs in Central America (see Box 9.7), researchers used an exercise called "The Road Traveled." The facilitator gave the following introduction:

If we imagine that every process of change is a road that we follow from one place to another, we can see that the road is not usually a straight line. Sometimes there are curves and bumps. Sometimes there are streams to cross and stones to climb over. Sometimes we end up someplace far away from where we imagined we would be, and sometimes we take a long journey and end up practically at home again. Sometimes, however, we manage to cross long distances, and find many beautiful things along the way—flowers, and trees to give us fruits and shade.

Let's imagine that the work of your group is like a journey. At one end is the place where you started and the other end is where we are now. Let's recreate the steps we took along the way to get to where we are.

When (what year) and how did the journey begin for this group? What were the major steps that helped you grow, or challenged you?

Dates and descriptions are placed along the timeline. Above the line are events that were helpful (the "flowers"). Below the line are placed the negative events or circumstances ("the stones"). Figure 9.2

FIGURE 9.3 EXAMPLE OF CAUSAL FLOW DIAGRAM

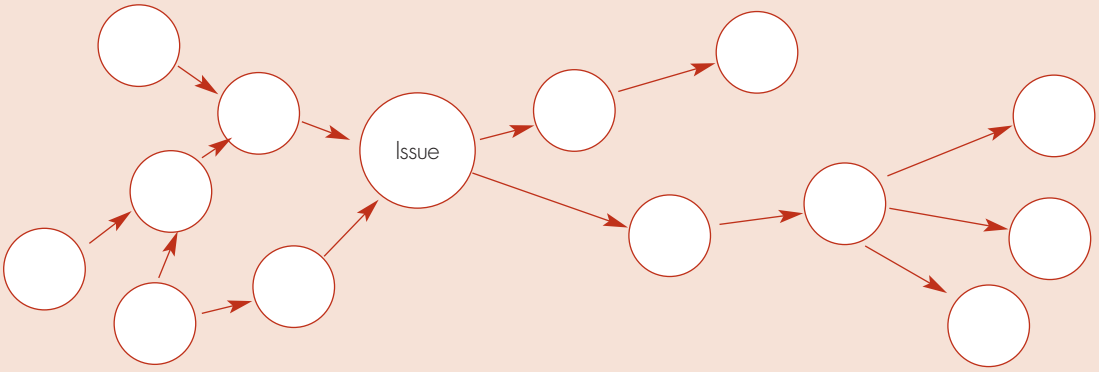
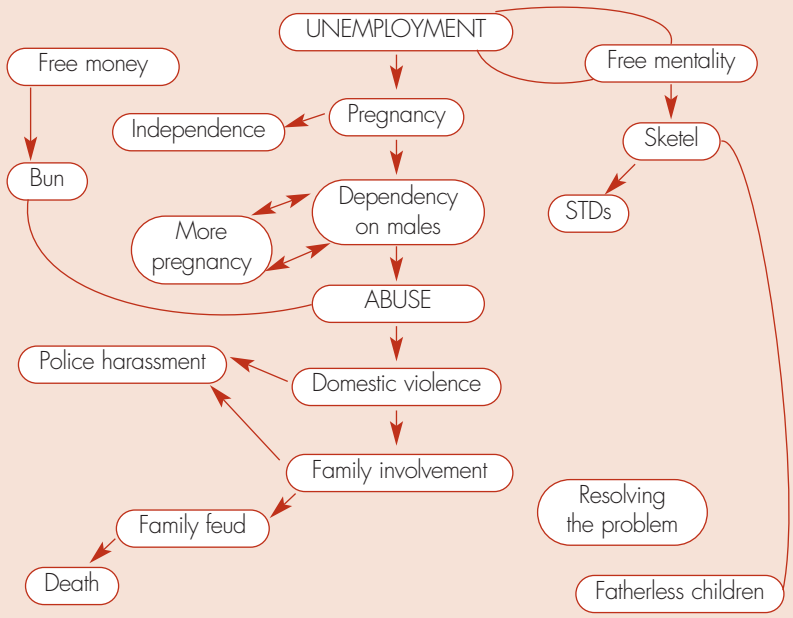


FIGURE 9.4 CAUSAL FLOW ANALYSIS OF UNEMPLOYMENT, PREPARED BY A GROUP OF WOMEN IN PARK TOWN, JAMAICA



Note: "free mentality" refers to too much free time. "Sketel" is a "loose woman."

(From Moser and Holland, 1997.[12])

shows the timeline constructed by a group of community activists in Estelí, Nicaragua.

CAUSAL FLOW ANALYSIS*

A **causal flow** analysis (also known as web analysis) shows the relationship between causes and effects of a selected issue, problem, or desired state. This tool can be extremely useful in gaining an understanding of the underlying causes of sensitive issues. It is especially good for involving community members in setting priorities and in planning interventions.

For a causal flow analysis, the procedure should be along the following lines:

1. Once rapport has been established with a community group of participants, suggest a topic for analysis and try to link it back to comments that group members made during the exercise. For example, "You mentioned that lack of security was a cause of sexual violence. Let's talk about that. Why does sexual violence occur?"

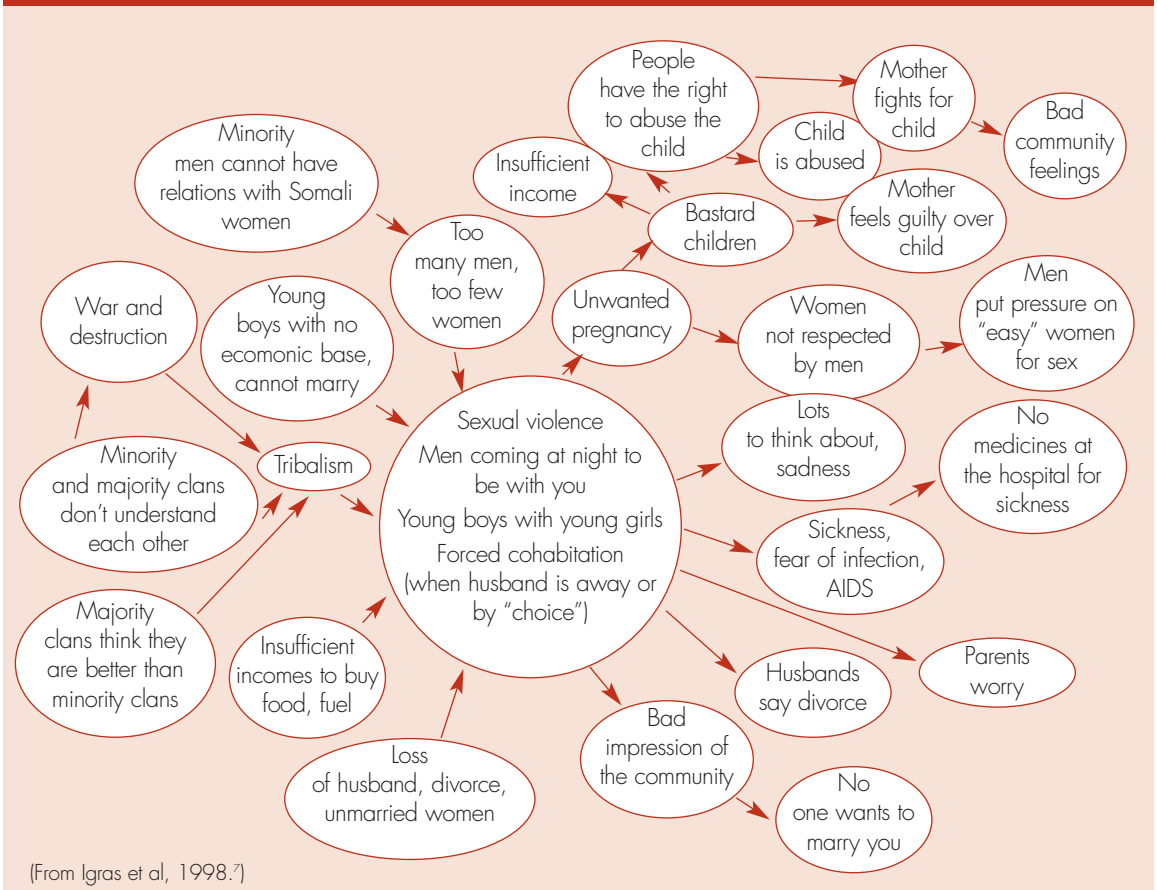
2. On a flipchart, draw a circle and indicate the topic for discussion, which in this example is sexual violence. Ensure that all of the participants understand the topic so that they can participate fully.

3. The facilitator then asks participants to list the causes of the problem or situation.

4. Causes are written on the left-hand side of the topic, with arrows drawn into the center (i.e., from left to right, or ⇨). Write clearly and recheck the direction of the arrows.

* (Adapted from Igras, 1998[7] and RHRCC, 2004.[11])

FIGURE 9.5 EXAMPLE OF CAUSAL FLOW ANALYSIS ON CAUSES AND EFFECTS OF SEXUAL VIOLENCE IN DADAAB REFUGEE CAMPS



(From Igras et al, 1998.[7])

5. Once the list of causes has been exhausted, ask participants to list the effects of the problem. Again, let the group discuss as much as necessary before beginning to record effects on the right-hand side of the topic. The topic is linked to effects by arrows drawn out from the center, (again left to right or ⇨). Recheck the direction of the arrows. This is one of the most common errors in drawing causal flow diagrams.

6. Now "interview" the diagram by asking open-ended questions about each cause and each effect. The diagrams can become quite elaborate and will allow the facilitator to delve even more deeply into an issue. Think about this exercise in terms of unpeeling the outer layers of an onion to get to the inner core.

7. Try limiting the number of causes and effects to 20 or so. Simpler diagrams tend to be easier to follow.

8. Record the visual output as shown in Figure 9.3, identifying it as necessary by place, dates, names of participants, and so on. Include a narrative description of the process.

Researchers from the World Bank and the University of the West Indies explored the impact of violence on poor communities in Jamaica in a Rapid Urban Appraisal. In one exercise, young women were asked to analyze the impact that unemployment among women had on young women in their community. They said unemployment leads to stronger dependency on males for money—either through higher rates of teenage

pregnancy or through a shift from self-reliance to a reliance on "free money" provided by men. This dependency in turn gives rise to an increase in abuse and domestic violence. Subsequent family involvement might either resolve the problem or lead to a family feud and deaths through reprisals.

Figure 9.4 illustrates the web analysis that emerged from this exercise. Significantly, young women in this community clearly articulated the association between community violence and intimate partner abuse, a link that is frequently left out when outsiders analyze community violence.[12] Figure 9.5 shows the results of a causal flow exercise carried out in the Dadaab refugee camps to explore the causes and effects of sexual violence.

OPEN-ENDED STORIES

Open-ended stories are useful for exploring people's beliefs and opinions, and for identifying problems or solutions while developing a program. The method is especially appropriate for use with people with less formal education, and helps stimulate participation in discussions.

In an open-ended story, the beginning, middle, or ending of a relevant story is purposely left out. The audience discusses what might happen in the part of the story that is missing. Usually, the beginning tells a story about a problem, the middle tells a story about a solution, and the end tells a story of an outcome.

To use this technique, consider the following:

- It is important to design the whole story in advance, so that the part that is left out "fits" the complete story. You will need a storyteller with good communication skills. Depending on the amount of group discussion, telling the story and filling in the missing part may take as long as two hours.
- The storyteller must be able to tell the story, listen, and respond to the community analysis. Using two facilitators can help—one to tell the story and one to help the community fill in the "gaps."

The story and the response need to be captured. Tape recording can be helpful in this instance.

Example of open-ended stories: Forced sex among adolescents in Ghana

In Ghana, investigators used a version of the open-ended story technique to discover ways in which adolescents say "no" to sex if they do not want to participate and what would happen if the adolescents tried to use condoms.[13] By learning how young people react in such situations, the team hoped to refine its health promotion materials to support healthy sexual behavior better.

In this adaptation, investigators used a storyline approach in which participants act out a story based on a scene described by the facilitator. At appropriate moments, the facilitator cut into the story to elicit discussion and to introduce a new element or "twist" that might change people's reactions. The storyline technique created a relaxed and entertaining atmosphere for young people to act out and discuss issues of sexuality and abuse in a nonthreatening atmosphere.

The stories allowed participants to discuss an issue without necessarily implicating themselves in the situation. To help animate the characters in the minds of participants, the facilitators solicited input from the group about the names, traits, and personality of the characters. Following is an example of one of the stories used to discuss forced early marriage:

Alhaji married Kande with her parents' blessing. Kande (meaning the only girl among three boys) is 14 years old and

Alhaji is 50 years old. Alhaji has three wives already but none of them gave birth to a son. So one day he calls Kande and discusses his problem and his wish of getting a son from her. He also tells her that since she is a virgin, she will by all means give birth to a boy. Kande gets frightened and tells him that she is too young to give birth now. She also assures him that if he can wait for two more years, she will give him a son. Alhaji replies, "I married you. You can't tell me what to do. Whether you like it or not, you are sleeping with me tonight."

After the drama sketch was played out, the facilitator asked the group if they thought the story was realistic and if similar situations happened in their area. After analyzing their data, the authors noted, "These stories seemed to show that, at least among these participants, coercion, trickery, deceit, force, and financial need are well known and all too common elements of sexuality for youth in Ghana."

Example of open-ended stories: Rosita's story, Mexico

Mexican researchers used a similar approach to explore community attitudes toward women living with abusive partners.[14] As part of a research and demonstration project in Ixtacalco, Mexico, they conducted a series of focus group sessions during which they presented participants with a series of questions based on the lives of a fictional couple, Victor and Rosita. In this case, the facilitator read the scenario. Then researchers handed each subgroup of participants a card with a question on it to spur discussion (Box 9.8).

BOX 9.8 ROSITA'S STORY

Rosita lives with her husband Victor and her two children, a three-year-old son and a five-year old daughter. She finished fifth grade and is a housewife, but for some time now she has wanted to leave Victor. He does not give her enough housekeeping money, and does not let her work because he gets jealous. When he comes home drunk, he insults her and sometimes he forces her to have sex even though she doesn't want to. Rosita has tried talking to him, but it's like talking to a wall. She has put up with this situation for the last four years and hasn't told anybody. She doesn't know what to do…

The facilitator divides the group into four subgroups, and gives a different card to each. Each card describes an alternative that Rosita has and contains a series of questions that the participants are asked to answer to complete the story.

Group One

Rosita decides to ask for help:

1. Where does she go to ask for help?
2. What do they say to her?
3. What does she decide to do?

Group Two

Rosita asks someone to talk to Victor:

1. Who would Victor listen to? What should this person say?
2. What would Victor's reaction be if other people try to intervene?
3. What reasons does Victor give for treating Rosita this way?

Group Three

Rosita decides to leave Victor:

1. What is going to be the most difficult challenge for her?
2. How will it affect her children?
3. What does Rosita need to succeed on her own?

Group Four

Rosita decides to leave Victor but two weeks later returns to him:

1. What makes Rosita return to Victor?
2. How do her family/friends react?
3. Do you think this is best for her and her children?

(From Fawcett et al, 1999.[14])

Example of open-ended stories: Rosita goes to the health clinic

In the PAHO review of gender-based violence services in Central America, the story of Rosita was adapted to talk to health workers about how women living with violence are treated in the health center.[10]

The story ends when Rosita goes to the health center for a routine visit and the nurse asks her whether she has ever been mistreated by her husband. The group is asked to imagine how the story ends through a discussion of the following questions:

- What will Rosita tell the nurse when she asks about violence?

BOX 9.9 COMMONLY USED GENOGRAM SYMBOLS

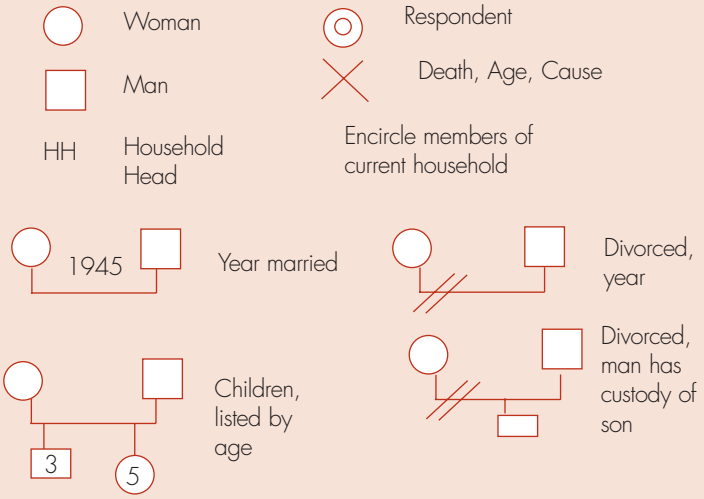
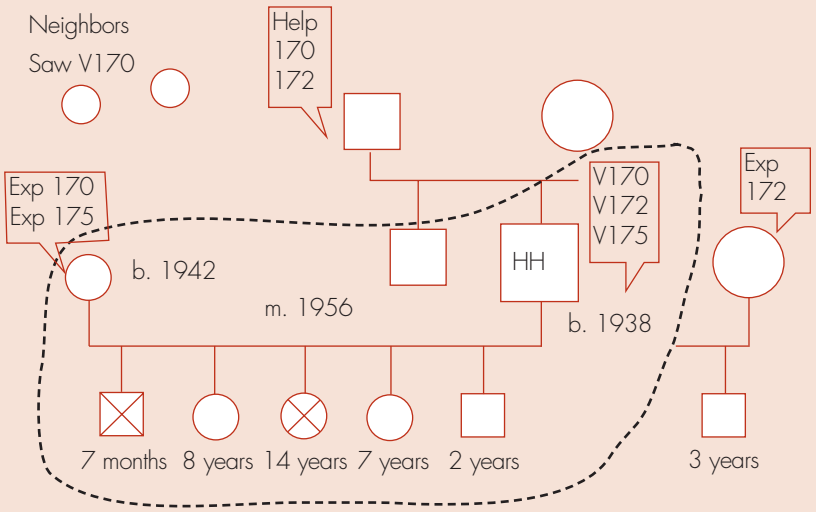


FIGURE 9.6 EXAMPLE OF A GENGRAM, ZIMBABWE



(From Watts et al, 1998.[16])

- How will Rosita feel when she is asked about violence?
- How does the nurse feel about asking Rosita about her family life?
- What will happen to Rosita if she admits what is happening to her at home?
- What type of help would be most useful to her?
- Do you think she will receive this help at the health center?
- Is Rosita's situation common for women in this community?
- What happens when women come to this health center asking for help with domestic violence situations?

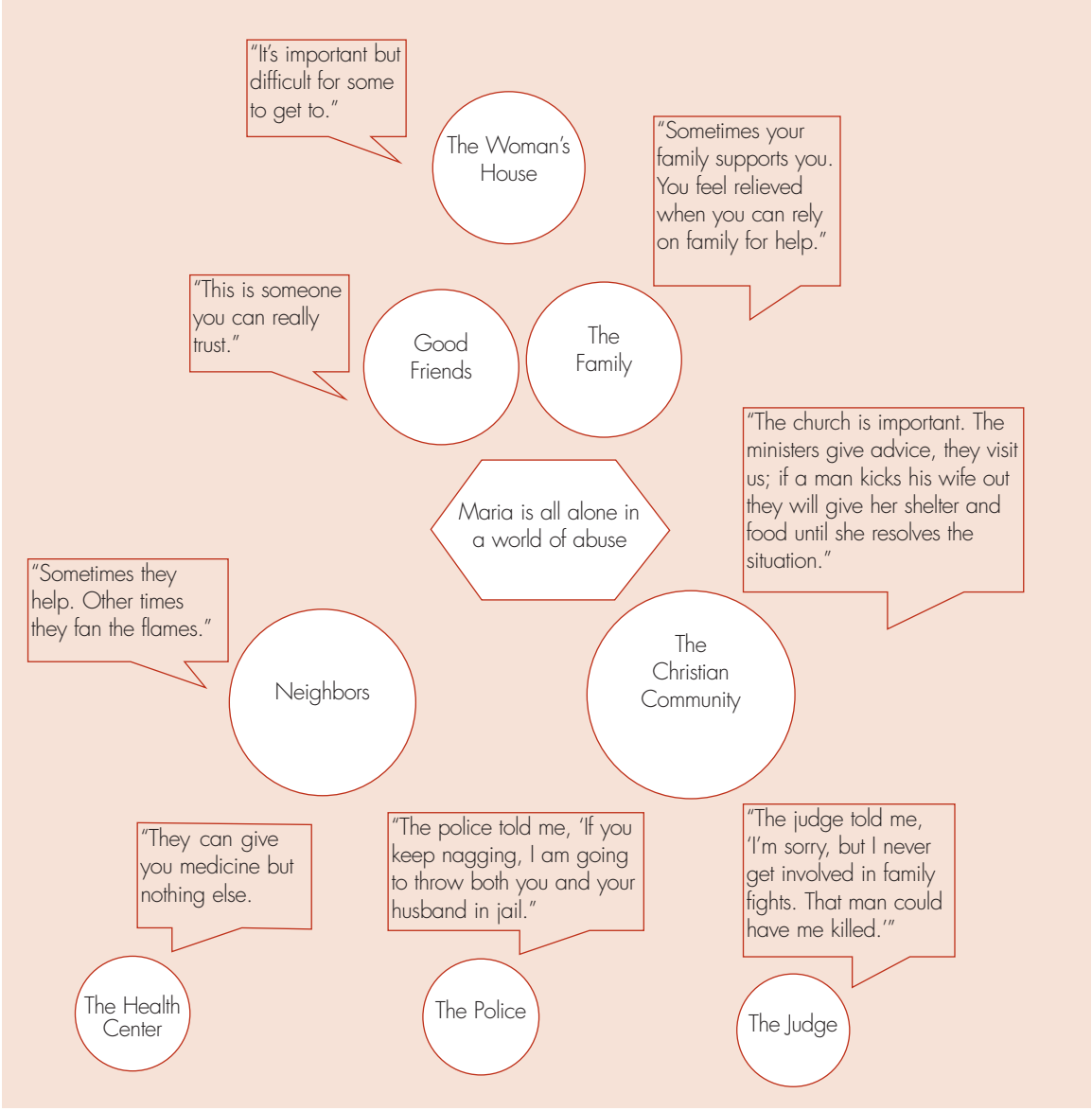
These questions were used to introduce a more focused discussion on the type of services offered to women in Rosita's situation in the participants' health center. The story stimulated a very rich discussion of how providers detected violence in their clients, and how they treated them. Examples of providers' comments follow:

- *I used to treat women with muscle spasms all the time and I never asked them any questions. Then I started to realize that many of these cases were due to violence.*
- *Women are waiting for someone to knock on their door, some of them have been waiting for many years…They are grateful for the opportunity to unload their burden.*
- *Sometimes taking a Pap smear, I'll see older women with injuries, dryness, and bruises from forced sex.*

GENOGRAMS

The **genogram** is a diagramming technique often used in counseling to record general information about families and/or households (such as names, dates of birth, and deaths). It is also used to capture more complex information, such as relationships among members or patterns of violence. Counselors use the genogram to examine patterns of abuse within families to explore possible sources of support. The technique

FIGURE 9.7 OPINIONS OF RURAL NICARAGUAN WOMEN ON SERVICES FOR BATTERED WOMEN USING A VENN DIAGRAM



can be adapted to the research setting to capture complex patterns of violence, including who participates, who intervenes, and who has witnessed violent incidents. The genogram can aid interpretation because it visually summarizes complex data.[15]

The genogram is drawn in a manner similar to a family tree. Box 9.9 includes some symbols used to represent different information in the genogram. The genogram can be used during an interview to document complicated family and household structures. Such visual representations of households are especially helpful in situations in which there are multiple marriages, in which children from various partnerships live under one roof, and in cultures where local kinship terms (such as sister or auntie) are not specific and can refer to individuals with various relationships to the respondent.

Example of genograms: Domestic violence in Zimbabwe

In Zimbabwe, the Musasa Project used the genogram to capture data on patterns of

violence within households.[16] Because Zimbabweans are accustomed to thinking in terms of "family trees," it was relatively easy for most respondents to relate to the genogram. The interviewer began the interview by drawing the genogram, noting dates of birth, death, relationships, lodgers, and other key data. At the section of the questionnaire where the respondent was asked about her experiences of violence, the interviewer returned to the genogram and identified who perpetrated different forms of violence, and whether there were others who also experienced, witnessed, or supported acts of violence by other perpetrators.

For example, if a woman reported being hit by her husband (Q74), the interviewer would write V74 (for violence on Question 74) next to the husband's square on the genogram. If he hit her on several occasions, the interviewer would add more than once. If he had also hit the respondent's son, and the mother-in-law witnessed the incident, the interviewer would note expV74 next to the son's symbol, and sawV74 next to the mother-in-law's symbol.

In Figure 9.6, an example taken from the survey, the respondent is married and lives with her husband who is the head of the household, their three living children, and her brother-in-law. She had two children who died—a boy at seven months, and a girl at age 14. Her husband has a second wife and a three-year-old boy who do not live with them. He has been violent toward the respondent, punching her and kicking her. Her father-in-law supported the violence. Neighbors saw the respondent being humiliated, but did not witness the physical assaults.

CIRCULAR OR VENN DIAGRAMS

Venn diagrams, also known as circular or "chapati" diagrams, are useful for analyzing social distance, organizational structures, or institutional relationships.

The facilitator draws circles of different sizes to represent individuals or organizations that are linked to the problem or community under study. The circles can also be cut out of colored paper and taped to a flip chart. The size of the circles indicates the item's importance. The item's location on the sheet represents how accessible this person or institution is. The technique may be used in small or large groups.

Another method is to make two diagrams per group—one that indicates the real situation, and another that represents the ideal situation. Through these diagrams, one can compare how different groups perceive a subject.

Rural Nicaraguan women in a participatory study carried out by the Nicaraguan Network of Women against Violence produced a Venn diagram to assess the public's view of the proposed domestic violence law (Figure 9.7). The diagram indicates the individuals or institutions that might be able to help "Maria," a woman whose husband beats her. The circles indicate by size and proximity to Maria how helpful and accessible each individual or institution is perceived to be to her. The text accompanying the circles illustrates the views expressed by women in the group.[6]

COMMUNITY MAPPING

A community map is an excellent tool for collecting qualitative data, especially in cultures that have a strong visual tradition. As with many other participatory techniques, maps can be created on paper with colored pens or constructed in the dirt, using natural materials such as sticks and pebbles. Mapping can be used to identify or highlight many aspects of a community, including geographic, demographic, historic, cultural, and economic factors. Following are suggestions for conducting a

mapping exercise by the CARE team's report on the Dadaab refugee camp.[7]

Visit the community and ask community members to participate:

1. Introduce the purpose of your visit, assess people's interest and availability.

2. Request that someone draw a map of the desired area.

3. Some people will naturally reach for a stick and begin drawing on the ground. Others will look around for paper and pencils. Have materials ready to offer, if it is appropriate.

4. As the map is beginning to take shape, other community members will become involved. Give people plenty of time and space. Do not hurry the process.

5. Wait until people are completely finished before you start asking questions. Then interview the visual output. Phrase questions so that they are open-ended and nonjudgmental. Probe often, show interest, let people talk.

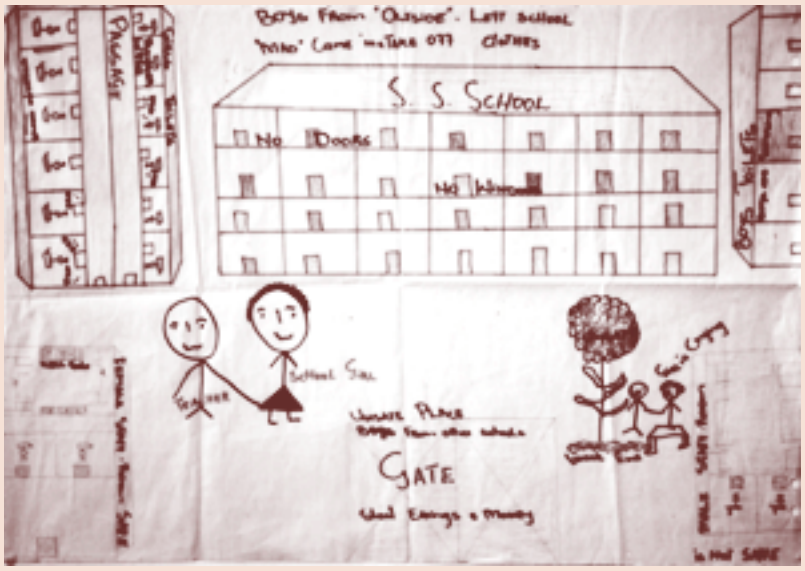
6. If there is additional information that would be useful, you may ask focused questions once conversation about the map has finished.

7. Record any visual output, whether it was drawn on the ground or sketched on paper. Be accurate and include identifying information (place, date, and participant's names if possible).

Example of community mapping: Sexual violence in Kenyan refugee camps

The team from CARE used community mapping as part of its rapid assessment of sexual violence in the Dadaab refugee camps on the border between Kenya and Somalia.[7] Participants were asked to make a map of the camp community and to identify areas of heightened risk for women. The women identified several key areas where they did not feel safe: (1) the bushes around the community well, where attackers lie in wait for women; (2) the camp's western border, where bandits can easily enter through weakened sections of the live thorn fences; and (3) the hospital, where women line up before dawn to collect coupons guaranteeing them access to the health center later in the day. This exercise allowed NGO organizers to identify ways to improve women's safety.

FIGURE 9.8 SCHOOL MAP



A map of their school drawn by female high school students to indicate places where they feel unsafe. The main "unsafe" zones are the girls' toilets (upper left hand corner), the outer entrance, and the male staff room (lower right hand corner), where male teachers harass girls. The picture next to the staff room shows a man taking a girl by the hand with the caption "girl is crying."[17]

(From Abrahams, 2003.[17])

Example of community mapping: Sexual violence in schools in South Africa

Researchers in Cape Town, South Africa, asked high school girls to draw a map of places where they felt unsafe.[17] The map

FIGURE 9.9 DRAWINGS MADE BY CHILDREN AGED 13–16 YEARS HELD IN A HOME FOR ABANDONED CHILDREN AND THOSE WHOSE PARENTS COULD NO LONGER CARE FOR THEM

Picture one: "This girl, her enemy raped her. They were going out first and he said 'If you love me you will have sex with me.' She said 'No.' She doesn't have a T-shirt now. He tore off her T-shirt, you see she is only wearing a bra. He took off her shirt and raped her. He slapped her and she scratched him on the neck and he is smiling. He is saying, 'Yes I raped her.' So she goes to the doctor and asks the doctor to do some tests. The doctor says she has HIV and AIDS…Her virginity is broken."

Picture two: "Mine is a boy who drinks alcohol and he is peeing. He just pees all over and he does not care about people. If he gets drunk he can rape you."

Picture three: "This is me and my own brother has raped me. Here I cry and I don't want to tell my mother."

(Figure 9.8) shows that the girls considered the most unsafe places to be:

- The gates of the school, where former students would come to sell drugs and harass students.
- The toilets, which, in addition to being filthy, were places where girls could be harassed by gangs.
- The male teachers' staff room, where teachers would collude to send girls for errands so that other teachers could sexually harass or rape them during their free hours. The girls were so afraid to go near the staff room that they arranged always to do errands in pairs so as to be able to protect each other.

ROLE PLAYING

Using role-playing can be an effective way to stimulate group discussion, in much the same way as incomplete stories do.

Example: Role playing used in the Stepping Stones program for HIV prevention in South Africa

The South African Medical Research Council adapted the well-known Stepping Stones methodology for HIV prevention to include activities around domestic violence. One of the exercises used role playing, and was an effective tool for understanding community members' views on domestic violence.[18] The exercise is described below.

Different ways that men and women mistreat each other

Divide the group into subgroups of four or five people and ask them to develop a very short role-play showing ways in which men and women mistreat each other.

Present these role-plays to the whole group. After the role-play has finished, ask the characters to stay in role for a few minutes while you invite the rest of the group to ask the characters questions. The characters should answer these in role. The sorts of questions that they might ask are:

- How does she feel when he does this? What does she fear?
- Why does he do this? How does he feel?
- Who else is there? Who witnesses it?

Who is involved in it?

- How do they feel?
- What does the woman do? Why does she respond in this way?
- What do the other people do? Why do they act in these ways?
- What can a person do to help him/herself when he or she experiences such problems?

Replay the role-play showing some of these strategies.

It is important to de-role after this exercise. Go around the group and ask participants in turn to say their name and make a statement about themselves from real life, e.g., "I am Matsie and I am not abused by my husband" or "I am Zolile and I hit a girlfriend once but do not do it anymore."

BODY MAPPING

Body mapping is used frequently in studies of sexuality and reproductive health to gain an understanding of how participants view their bodies, or what information they have about how their bodies function. It is particularly useful for children who may have difficulty expressing their experiences in words, and for discussing sensitive and/or traumatic experiences.

Example of body mapping: Sexual violence against children in South Africa and Namibia

Researchers in South Africa and Namibia conducting interviews with children who had been sexually abused asked the children to draw pictures and tell stories about them. Examples of the drawings made by the children are shown in Figure 9.9.[19]

PHOTO VOICE

The **photo voice** technique, also known as Shoot Back,[20] is an excellent method for participatory research. Wang, who used photo voice with Chinese peasant women to engage them in discussions about their health, notes that "Photo voice enables people to identify, represent, and enhance their community through a specific photographic technique. It provides people with cameras to photograph their perceived health and work realities. Photo voice has three main goals: to enable people (1) to record and reflect their personal and community strengths and concerns, (2) to promote critical dialogue and knowledge about personal and community issues through group discussions of photographs, and (3) to reach policy makers."

The steps of photo voice, as presented by Wang, are the following:

- Conceptualize the problem.
- Define broader goals and objectives.
- Recruit policy makers as the audience for photo voice findings.
- Train the trainers.
- Conduct photo voice training.
- Devise the initial theme/s for taking pictures.
- Take pictures.
- Facilitate group discussion.
- Allow for critical reflection and dialogue.
- Select photographs for discussion.
- Contextualize and storytell.
- Codify issues, themes, and theories.
- Document the stories.
- Conduct the formative evaluation.
- Reach policymakers, donors, media, researchers, and others who may be mobilized to create change.
- Conduct participatory evaluation of policy and program implementation.

More information is available on this method at www.photovoice.com.

FIGURE 9.10 TWO BOYS ATTACKING A GIRL AND TAKING AWAY HER FOOD

When this photo was discussed the girls told researchers that boys often grabbed their breasts and genitals in order to extort food or money.

Example of photo voice: Sexual violence in South African schools

In the study on sexual violence in schools in South Africa, researchers gave female students disposable cameras and asked then to take pictures of places where they felt unsafe. The film was developed the same day, and the following day, the photos were used to initiate discussion around problems at the school. The photos were also used subsequently to convince school authorities to improve the sanitary conditions of the school.[17]

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10

PHOTO BY HAFM JANSEN

Building Your Research Team

Topics covered in this chapter:

Building and training your research team is particularly important when researching violence against women. The value of good fieldworkers, interviewers, transcribers, and data processors that have been sensitized to the issues cannot be overstated. Experiences worldwide consistently indicate that a key to getting reliable, valid, timely data is making sure that field personnel are appropriately selected and trained.[1]

In many ways, the process of selecting and training interviewers for gender-based violence research is similar to that for other research projects. Training workshops are designed to improve interviewing skills, explain the research protocol, detail the sampling procedures, and practice applying the research instruments. Nevertheless, there are several issues that set violence research apart, most notably the need to deal explicitly with violence and gender during the interviewer-training program and the need to provide emotional support to project staff throughout the research process. This chapter will deal with both the issues common to most research projects and the challenges unique to gender-based violence research.

WHAT IS SPECIAL ABOUT RESEARCH ON GENDER-BASED VIOLENCE?

Just as violence research raises special issues around respondent safety, the emotional sensitivity of the topic raises special issues for building and sustaining your field team. Working on a violence project can be extremely taxing, and it is important—both for ethical reasons and to ensure the quality of the data—that researchers take active steps to protect the emotional well-being of team members. This means that research plans and budgets need to include specific measures for addressing the emotional consequences of doing gender-based violence research. Chapter 11 describes in much greater detail the kinds of issues that need to be addressed to protect the safety and well-being of both respondents and interviewers during fieldwork.

BOX 10.1 BUILDING A RESEARCH TEAM

- Don't skimp on field workers. Look for skills you can't teach: intelligence, reliability, imagination, curiosity, and sensitivity.
- Hire people who have a personal and intellectual interest in your study subject: Don't hire people if they are not committed to the issue of violence prevention.
- Look for field workers everywhere. Don't assume that people who make their living doing interviews can perform well, or even adequately. Conversely, don't assume that people with little or no experience will not perform well.
- Do not ask any field worker to conduct more than 100 standardized interviews (including pilot interviews). Interview quality deteriorates rapidly after 100.
- Anticipate a significant trainee dropout rate. Begin training sessions with many more field workers than you want to hire.
- Building a research team should be the goal of your field worker training, not just imparting information or skills. Explain the project and its goals as "our" project and goals; actively solicit the views of team members and use their insights. Include team-building exercises and group dynamics in the training session.
- Pay your field workers well. Pay them more than they usually receive for equivalent work.
- Distinguish pay during the training period, which merely compensates for their time, from pay for carrying out interviews. Pay for specific work produced. Allow for incentive payments for exceptional work.
- Make sure that field workers know when they perform well; when they don't, don't accept their work. But don't blame people when they make a mistake. Solve problems in ways that teach new skills.
- Do everything you can to show your field workers how valuable they are. Have team dinners. Celebrate birthdays or research milestones.
- When field workers begin collecting data, spend a day or half day with each. See the problems that your field workers encounter from their perspective, and solve them.
- Tell your field workers your findings. Ask for their critique. Pursue leads that they suggest.

(Adapted from Handwerker, 2001.[3])

Another reality that all projects on violence must confront is the fact that many members of the research team themselves may have unresolved issues around abuse. The worldwide prevalence of gender-based abuse means that, almost without exception, any research team will have one or more members who have been a direct target of violence or come from a family where violence was common. Some researchers have argued that this personal history will bias the quality of data. They therefore conclude that screening questions for hiring should include past history of abuse. However, several international experiences suggest that these issues, when appropriately addressed, do not adversely affect data quality.[1, 2]

The reality of researchers' own history of abuse has several implications for gender-based violence research. First, it reinforces the importance of providing emotional support to team members throughout the study. Second, it has implications for the training of interviewers. Many researchers have found that it is extremely helpful to raise this issue explicitly during interviewer training and to provide an opportunity for women to acknowledge their own experiences of abuse. Most people learn ways of coping with painful past experiences, and usually do not dwell on them in their everyday lives. However, discussion of violence during training sessions may awaken disturbing images and/or emotions. For many trainees, simply acknowledging that these reactions are normal, and providing timely opportunities to discuss them, will be sufficient to help them complete the training and participate successfully in fieldwork. In those rare cases where feelings become overwhelming, trainees will have an opportunity to withdraw from the project.

Whereas personal experience with abuse may prove problematic for some women, for others it will *improve* their skill and empathy as interviewers. In fact, women who have experienced violence themselves often make very good interviewers. Women frequently find that participating in a research project on violence can be empowering and an important route to healing. An interviewer from the León study in Nicaragua described her experience this way:

…What helped me the most [in my own life] was working on this study. It helped me to be who I am today because I have been able to help others. I felt that I could help them because I had lived through it myself, and I didn't like it, and I wouldn't like for anyone, anyone to live through what I have

lived through in my life ever. And when a woman told these things, I could understand what she was going through…When I was carrying out the interviews, I lived through each experience as if it were my own, and I could say to them, "Yes, I lived through this also, I know what this is." [2]

BUILDING THE FIELD TEAM

Building a good field team involves finding the right people, preparing them well, and sustaining them throughout the research process. This means building personal as well as professional relationships with field staff. A committed and loyal research team is the surest insurance for a successful research project. See Box 10.1 for some team-building tips by a seasoned researcher.

Size and composition of the field team

The number of fieldworkers needed will depend on several factors, such as how many and what type of interviews are planned, how spread out geographically the study region is, how many different languages are needed, and whether the fieldwork needs to be completed during a certain period (for example before the rainy season begins).

Generally, studies relying on qualitative research methods utilize fewer interviewers than surveys. For a population-based survey, you will probably need at least two to three field teams with four to six interviewers per team, as well as a supervisor. Depending on the length and complexity of the questionnaire, it may also be necessary to hire a field editor to check questionnaires for errors as they are completed. In many settings, particularly in rural areas where transportation is not readily available, each team will also need a driver. The drivers may also escort female interviewers in unsafe areas. Depending on how emotional follow-up for respondents and interviewers will be addressed, it may make sense to add a psychologist and/or women's advocate to the overall team. Box 10.2 gives an example of the composition of the research team for a survey performed in Brazil.

BOX 10.2 THE ORGANIZATION OF FIELDWORK IN BRAZIL

The São Paulo research team for the WHO VAW study hired 34 staff members to perform and supervise fieldwork and data entry for a survey of 1500 women.

In addition to the three principal investigators, the research team included the following members:

Central team

1 general field coordinator
3 office editors
3 counselors

Data entry team

1 data entry coordinator
2 typists for the first entry (double entry was used)
1 typist for the second entry

Fieldwork

4 teams were created, each consisting of 7 members:
1 supervisor
1 editor
5 interviewers

Selecting interviewers

There are few "rules" that can be applied to the selection of interviewers, except that generally speaking, women should interview women and men should interview men. An exception to this rule is when women's mobility is so socially constrained that it is not feasible for female interviewers to be out in public. It might also be necessary to use men to interview women when the research requires bilingual interviewers, and few women from the research area are bilingual. This situation occurs frequently among indigenous populations where women are less likely to have received education in the dominant language.

If the characteristics of your study population require using men to interview women, you will need to plan for additional

PHOTO BY HAFM JANSEN

Research training in Namibia

training and extra time for them to absorb information and acquire appropriate interview techniques. If, due to budget or time constraints, additional training is not possible, you should seriously reconsider conducting the research in this particular population. Other criteria—such as whether respondents would be more trusting of individuals from the community or from outside of it—are best explored during formative research.

Interviewers for violence research have generally been drawn from four groups: professional interviewers, community women, health workers, and women's advocates. Each group has strengths and drawbacks that should be assessed prior to conducting the workshop. If possible, an ideal team would consist of individuals

TABLE 10.1 WHO ARE THE BEST INTERVIEWERS FOR SURVEY RESEARCH?

Type of Experience	*Advantages*	*Disadvantages*
Professional interviewers	■ Prior experience in conducting interviews and use of questionnaires ■ Skill in gaining confidence of respondents	■ May not be available to work in remote areas ■ May require higher pay ■ May be resistant to special procedures for violence research or collaboration with community groups
Community women	■ Familiarity with local community customs and language ■ May help in gaining access to the community	■ Respondents may be reluctant to talk to someone from the community for fear of gossip ■ May not have necessary literacy or interviewing skills
Health workers (nurses, psychologists, social workers)	■ Skills in gaining confidence and asking questions; comfortable with sensitive issues ■ Knowledge of health issues (an asset if this is included in the study aims) ■ Used to confidentiality concerns ■ May be more respected by respondents ■ May have knowledge of the local community	■ May have a hard time managing the difference between counseling and research ■ May have a less skills in coding interviews
Women's advocates	■ Experience and knowledge on violence issues ■ Good rapport with respondents ■ May have good ties with community	■ May have less skill in interviewing and coding ■ May have a hard time managing the difference between counseling and research

with varied backgrounds so that they can exchange experiences, learn from one another, and complement one another's abilities.

Table 10.1 discusses some of the advantages and disadvantages of interviewers according to past experiences that may affect the selection process and fieldwork. In Box 10.3 we describe how fieldworkers were selected in the WHO study in Peru.

BOX 10.3 SELECTION OF FIELDWORKERS IN PERU

Interviewers for the WHO VAW study in Peru were selected in two stages. Out of over 100 women who applied for the job, 27 women were chosen to participate in the training program. The criteria and points used for the initial selection were:

- Relevant academic training (0–3 pts)
- Age (between 25–50) (0–3 pts)
- Experience as an interviewer (0–3 pts)
- Experience in women's health (0–3 pts)
- Experience with gender-based violence (0–3 pts)
- Gender training/experience (0–3 pts)
- Interview (0–10 pts)

During the two-week training program, participants were scored on their performance on tests and practice interviews, as well as other skills. All participants were asked to nominate three people they felt would make good supervisors, and their preferences were also taken into account. In the end, 18 women were selected as interviewers and six as supervisors/field editors. The criteria for the final selection were the following:

- Communication skills (0–4 pts)
- Nonverbal communication (0–4 pts)
- Appearance (0–4 pts)
- Drives (0–2 pts)
- Works well under pressure (0–2 pts)
- Works well in teams (0–3 pts)
- Views on violence (0–3 pts)
- Speaks Quechua
- Score on CV (0–10 pts)
- Interview (0–10 pts)

TRAINING FIELDWORKERS

There are at least three important goals to accomplish in the fieldworker training sessions:

- To sensitize your team to issues of gender and violence.
- To instruct them in the use of the research protocol and interviewing techniques.
- To build a team spirit that motivates field staff.

At minimum, consider including the following six topics in the training sessions: gender-based violence, stress management, review of the research protocol, employment expectations, interviewing techniques, and ethics in gender-based violence research.

In this section we outline what should be covered in each topic. A summary of the program and exercises used in the WHO training workshops is included in Appendix II of this manual.

Orientation to gender and violence

Toward the beginning of the training, you will need to devote a significant amount of time to sensitizing the research team to gender-based violence issues. These exercises are part public education, part support group work, and part crisis intervention training. It is a good idea to invite local women's organizations to present or facilitate these sessions.

Begin with the basics. Define the topic and discuss why it is important and include exercises that help reveal the cultural biases and attitudes commonly held about victims of rape or domestic assault. Discuss the physical, psychological, and societal ramifications of abusive relationships, as well as underlying causes. Talk about the myths surrounding victimization and the reasons why women might be reluctant to talk or seek assistance. The use of participatory exercises encourages

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Interviewer training in Bangladesh and Thailand

participants to examine their own experiences and attitudes about violence, although the open sharing of this information should never be required. Mention that virtually all people involved in violence research have had some experience with abuse, regardless of nationality, ethnicity, or background. Interviewers need to be aware of how their personal histories and potential reactions may affect their work.

Finally, you will want to conduct a brief training in crisis intervention techniques. These skills may be used with respondents as well as members of the research staff. Prior to the workshop, it is wise to develop a protocol for dealing with crises, including a list of community resources, structured meetings for staff, and what to do in case a woman is in immediate danger. Emphasize that the interviewers are part of a research team, not a counseling team, but that nonetheless they have an ethical obligation to provide assistance when it is called for. You will want to role-play potential situations and conduct group discussions analyzing the dynamics of abuse.

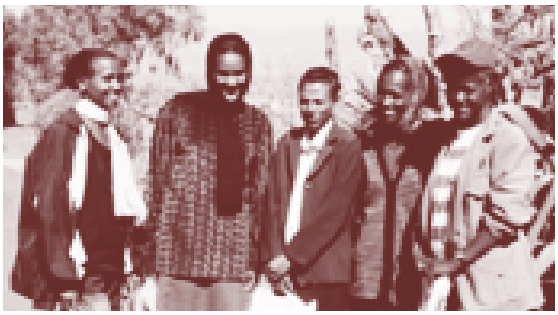
Employment expectations

Early on in the recruitment of interviewers (and other research team members), candidates should be given a job description that outlines the responsibilities and remuneration of field staff. The job description should also include a description of the evaluation criteria that will be used to select final candidates and to evaluate performance.

Trainees should understand that participating in the training does not ensure employment with the project. Only the best, most competent interviewers will be hired after the training. All trainees, however, should be compensated for their time during training, even if they are not hired for the project. Interviewers hired at the end of training should have employment contracts or terms of reference. Sample job descriptions for survey interviewers, supervisors, and field editors are provided in Box 10.4.

Review the research protocol and instrument

A principal training objective is to familiarize the participants with the key elements of the research protocol. When they finish



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Interviewers in Ethiopia

BOX 10.4 THE ROLES OF FIELD STAFF IN THE *WHO MULTI-COUNTRY STUDY ON WOMEN'S HEALTH AND DOMESTIC VIOLENCE AGAINST WOMEN*

The following job descriptions were used by the WHO Multi-country Study on Women's Health and Domestic Violence Against Women in the training of interviewers, supervisors, and field editors:

THE INTERVIEWER

The interviewer plays a central role in the study since she is the one who collects information from respondents. Therefore, the success of the study depends on the quality of each interviewer's work.

In general, the responsibilities of the interviewer include:

1. Locating the households in the sample that are assigned to her and completing the Household Selection Form and Household Questionnaire.
2. Identifying all eligible women in those households.
3. Randomly selecting one eligible woman for interview.
4. Interviewing one eligible woman in the household in private, using the Individual Questionnaire.
5. Checking completed interviews to be sure that all questions were asked and the responses are neatly and legibly recorded.
6. Returning to households to interview women that could not be contacted during her initial visits.

THE FIELD SUPERVISOR

The supervisor is the senior member of the field team. She is responsible for the well-being and safety of team members, as well as the completion of the assigned workload and the maintenance of data quality. The supervisor receives her assignments from and reports to the field coordinator. The specific responsibilities of the field supervisor are to make the necessary preparations for the fieldwork, to organize and direct the fieldwork, and to spot-check the data collected using the questionnaire.

Preparation for fieldwork

Preparing for fieldwork requires that the field supervisor:

1. Obtain sample household lists and/or maps for each area in which her team will be working and discuss any special problems with the field coordinator.
2. Become familiar with the area where the team will be working and determine the best arrangements for travel and accommodations.
3. Contact local authorities to inform them about the survey and to gain their support and cooperation.
4. Obtain all monetary advances, supplies, and equipment necessary for the team to complete its assigned interviews.

Careful preparation by the supervisor is important for facilitating the work of the team in the field, for maintaining interviewer morale, and for ensuring contact with the central office throughout the fieldwork.

Organization of fieldwork

Organizing fieldwork requires that the field supervisor:

1. Assign work to interviewers, taking into account the linguistic competence of individual interviewers and ensuring that there is an equitable distribution of the workload.
2. Maintain fieldwork control sheets and make sure that assignments are carried out.
3. Maintain a fieldwork diary, keeping a record of the main events and issues arising.
4. Regularly send completed questionnaires and progress reports to the field coordinator and keep headquarters informed of the team's location.
5. Communicate any problems to the field coordinator/project director.
6. Take charge of the team vehicle, ensuring that it is kept in good repair and that it is used only for project work.
7. Be responsible for coordinating the referral and/or support of respondents identified as requiring support during the survey.
8. Manage the finances provided to cover fieldwork expenses, including keeping receipts for all expenditures.
9. Support the interviewers as they carry out their work, including holding a daily team meeting with interviewers.
10. Make an effort to develop a positive team spirit. A congenial work atmosphere, along with careful planning of field activities, contributes to the overall quality of the survey.

THE FIELD EDITOR

The specific duties of the field editor are to monitor interviewer performance. Close supervision of interviewers and editing of completed interviews is essential to ensure that accurate and complete data are collected. As the collection of high quality data is crucial to the success of the survey, the study will seek to recruit mature responsible women to act as field editors. It is important that those who are selected execute their duties with care and precision. This is especially important during the initial phases of fieldwork when it is possible to address interviewer mistakes before they become habit.

Monitoring interviewer performance requires that the field editor:

1. Observe the first part of several interviews every day.
2. Edit all completed questionnaires in the field. Editing must be completed prior to leaving the sample area. As far as possible, the field supervisor should assist the editor in performing this task so that all interviews are field-edited while still in the sample area.
3. Conduct regular review sessions with interviewers and advise them of any problems found in their questionnaires.
4. Arrange the completed questionnaires and monitoring forms from a sample area (cluster) in order, and pack them to be sent to the central office.

(From WHO, 2004.[4])

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PHOTO BY HAFM JANSEN

Interviewer training in Bangladesh and Tanzania

the training, participants should be conversant in the protocol's contents and be able to use it as a reference tool throughout the fieldwork.

In reviewing the protocol, it is important to emphasize the importance of accuracy and rigor in identifying and randomizing respondents and collecting data. You will also need to review strategies for glitches in fieldwork. For example, the team will have to develop strategies about what to do in household sampling when no one is home or if there are no eligible respondents. Other important topics are how to approach the household and how to obtain informed consent. (Examples of exercises for establishing contact with the household are presented in Box 10.5.)

Depending on the degree of flexibility in the research timetable and the level of expertise of your trainees, you may want to use the training workshop as a chance to "pilot test" the protocol instrument. You can solicit suggestions and recommendations for improving the questionnaire from the trainees, thereby creating a research product from a group effort.

Practice interviews

The qualities of a good interviewer include the ability to:

- Establish rapport with the interview subject in a short period.
- Communicate complex ideas effectively, directly, and simply.
- Apply the research instrument in such a way that it sounds like a conversation.
- Listen to the respondent without being judgmental.
- Guide the respondent in the interview process without pushing her unnaturally or being rude by cutting her off or ignoring her answers.

Interviewing is more of an art than a science, requiring skill and, to a certain extent, innate talent and empathy. The objective of the training workshop is to enhance natural skills and talents, through role-plays and pilot testing of instruments. Box 10.6 presents some guidelines for interviewing that were used in a qualitative study on violence in Sri Lanka.

After you have reviewed the research protocol, you will want to practice the application of the research instruments

using different techniques. Assigning trainees to the roles of interviewer and respondent is a useful exercise. The respondent may improvise her answers, or you can provide her with an outline "script" to follow. You may also want to assign roles of other members of the household or allow other trainees to observe the exercise. Be sure to allow enough time for an interview from start to finish, as well as time for all participants to evaluate the exercise through verbal feedback. When survey instruments are being used, another good exercise is to have one person interview a "respondent" while a second person observes the interview and also records responses to the questions. Afterwards the sets of answers are reviewed by the team together.

As trainees become more comfortable with the instrument itself, it may be useful to practice with people outside the research team, for example, with family members or friends. It is particularly helpful to include interviews with women who have experienced violence. Often, women's centers can identify women who have attended their centers and who are willing to be interviewed.

Trainees may also pilot test the instruments under more realistic conditions by visiting a community with characteristics similar to those of the research community and applying the questionnaire or other interview schedule, using the same criteria for sampling and respondent selection as will be used in the study protocol.

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Practice interviews in Bangladesh

BOX 10.5 TRAINING EXERCISES FOR GAINING ACCESS TO A HOUSEHOLD

Gaining access to a household in order to talk to the respondent can be very challenging. In this exercise, trainees are divided into small groups and each is given a situation that might be encountered by a fieldworker. They should discuss how they would handle this situation and then present their conclusions to the plenary group for discussion.

Case 1: Maria arrives at a large apartment building where she is supposed to conduct an interview. There is no doorman so she uses the intercom to talk to someone in the household. The person who answers says they do not want to be interviewed and refuses to open the door.

Case 2. Elli needs to interview a respondent living in a compound where the watchman informs her that he is not authorized to let her enter and cannot give her any information about the household.

Case 3. Wassana goes to a small house in a poor neighborhood. A woman answers the door accompanied by several small children. She looks at Wassana suspiciously and as soon as Wassana starts to explain why she is there, the woman interrupts her and says she has no time to talk.

Case 4. Mieko knocks on the door of a house and a man opens the door. As she begins to explain the purpose of her visit, he interrupts and starts to interrogate her with the following questions:

- What are you here for?
- What is this study about?
- Who sent you?
- What do you want to know?
- What are you going to do with the results?

BOX 10.6 INTERVIEWING TECHNIQUES FOR QUALITATIVE RESEARCH ON VIOLENCE AGAINST WOMEN

(Notes for interviewers taken from a qualitative study carried out in Sri Lanka)

In this research, we are asking women to talk about a subject that is embarrassing and painful to them. Your job is to:

- Create a relaxed and supportive atmosphere.
- Collect the information in an unbiased way.
- Make the experience as empowering for the woman as possible.

Create a relaxed and supportive atmosphere.

To help the woman relax, you must be relaxed and confident yourself:

- Check your preparations: interview checklist, notepad and pen, working tape recorder with extra tapes and batteries (and an extension cord if there is a power source), a watch for keeping track of time.
- Calm yourself by deep breathing, if necessary.
- Spend a few moments remembering the purpose of the research and your own personal motivations.

Arranging the space:

- Choose a place where you will have privacy and will not be interrupted.
- Sit facing the woman, on the same level.
- Put the tape recorder between you and the respondent where you can see it, but to one side, if possible, so she does not need to look directly at it. (ALWAYS DO A TEST TO MAKE SURE IT IS CLOSE ENOUGH TO RECORD HER VOICE CLEARLY.)

Your behavior and appearance:

- Dress in a way that conforms as closely as possible to local conservative standards. Consider also your hairstyle, jewelry, and make up. Avoid fashionable or expensive items, or anything transparent.
- Act respectfully: She is the expert on the subject for discussion. Avoid acting as if you are an authority figure, even if she seems to expect that.
- Smile when you meet her for the first time.
- Do not rush into the interview. Take your time explaining the purpose of the research, why her experiences and views are important, what will happen in the interview, and what confidentiality means.
- Answer any questions she may have. (BE CAREFUL NOT TO IMPLY THAT SHE WILL RECEIVE DIRECT PERSONAL HELP IN HER OWN CASE BECAUSE OF DOING THE INTERVIEW.)
- Ask if she is willing to participate in the study.
- Ask her permission to begin.

Your manner of speaking and questioning:

- Speak calmly and gently, in a pleasant tone of voice.
- Appear interested in everything she has to say; keep your eyes and attention focused on her while she is speaking.
- Use words that are easily understood.
- Don't fiddle with your pen, tap your foot, or exhibit other nervous mannerisms.
- Use active listening:
  1. Encourage her to keep talking by giving verbal and visual cues (e.g., nodding, saying "hmmm," mirroring her facial expressions).
  2. Show you have understood both the content and her feelings about it by rephrasing what she said ("So you felt...because...").
  3. Watch her facial expressions and body language for clues about how she is feeling.

Collect the information in an unbiased way.

- Be thoroughly familiar with the checklists, and use them systematically.
- Use open-ended questions that encourage the woman to talk, not closed-ended questions that can be answered with one word.
- Be prepared to reword the question if necessary.
- Don't use "leading questions" that imply a certain answer.
- Avoid using questions beginning with "why." These tend to make people feel defensive.
- Be patient; don't be afraid of silences.
- Avoid showing by your tone or facial expression that you are shocked by, or don't approve of, something she says.
- Never interrupt while she is speaking. If there is piece of information you need to check and think you might forget, jot it on your pad as she speaks and ask her when she has finished.
- If the woman strays off the subject, wait for a pause, then ask a question from the checklist.
- Don't finish her sentences, or put words in her mouth.
- Don't attempt to do any "consciousness raising" during the information-gathering part of the interview. Even remarks intended to encourage her, such as "you didn't deserve that treatment," can bias her responses to later questions.

Make the experience as empowering for the woman as possible.

- Encourage the woman to tell her story in her own way, even if it involves a lot of repetition. Often the process of telling her own story to a sympathetic listener brings relief.
- Avoid the temptation to give advice, even if she asks you to. But you can "brainstorm" with her to help her come up with her own solutions, if she really wants some input from you.
- Make sure you are able to answer any of her requests for information (as opposed to advice) in a way that is locally relevant.
- If she starts to cry during the interview, don't try to stop her. Crying may provide her with some relief. Acknowledge her distress, and express sympathy for her feelings. There is no need to end the interview unless she requests it.
- After the interview, thank her and remind her that by sharing her views and experiences, she is helping to prevent other women from having to suffer as she did/does.

What to do after the interview?

- Review the session in your mind, and make a written list of:
  1. Problems that arose, or items missed.
  2. New insights.
  3. Matters you need to follow up.
- Spend a few moments getting in touch with your own feelings. If you are feeling upset, don't brush it off. Make sure you discuss it with your colleagues and supervisor.
- PAT YOURSELF ON THE BACK!!! Your efforts are helping to make your community a safer place for women.

(From Bradley, 1999.[5])

When trainees become more skilled with the interview scenario, it is time to focus on specific challenges that may arise during the fieldwork. For example, you might have role-playing exercises where there are frequent interruptions or where the respondent wants to discontinue the interview because she is crying. It is important to stress the importance of leaving enough time during the interview to meet respondent's needs while maintaining rigor in the research methodology.

Ethics in gender-based violence research

Because ethical issues arise throughout every stage of the research project, they merit a specific section in the training workshop. It is important to highlight their significance, not only for data collection but also for fieldwork preparation, analysis, and dissemination.

The research protocol should include a section on the ethics of gender-based violence research, outlining the specific ways that these issues will be addressed by the study. During the training workshop, you will need to reiterate the importance of informed consent and confidentiality, as well as protocols for dealing with crises during interviews with informants, protocols for dealing with safety/security issues for fieldworkers, and other pertinent ethical considerations.

Stress management

It is important to address stress-related symptoms among fieldworkers and discuss coping mechanisms for research staff.

As you plan your training workshop, keep in mind the varying strengths and training needs of different members of the research team. Your team may include interviewers; transcribers (in qualitative studies); field supervisors; and administrative and support personnel such as drivers, translators, interpreters, or representatives from collaborating institutions. Each position entails different responsibilities, skills, and training needs. The training workshop should be a team-building effort in which everyone is aware of the role he or she plays and its importance to the study.

It may seem that some personnel, such as data processors or transcribers, do not need training or sensitization in gender-based violence issues. However, experience has shown that even members one or two steps removed from direct contact with respondents may be deeply affected by the subject matter (see Box 10.7). Stress

BOX 10.7 IN THE FIELD: BELIZE

A qualitative study of battered women in Belize generated hours of taped interviews from 24 in-depth interviews and three focus groups. A transcriber was hired to produce transcripts of interviews conducted in the study's three languages of Creole, Spanish, and English.

During the first few weeks of fieldwork, the transcriber's turnaround time was excellent, and the categorization and analysis of the data went smoothly. However, by the third week the transcriber began to make excuses as to why she wasn't finishing the tapes. She complained of feeling under the weather and occasionally would not return phone calls from the supervisor. Eventually, the delayed transcriptions began to hinder progress in the research, and the supervisor confronted the transcriber with this problem. She revealed that the taped interviews were affecting her deeply, particularly listening to the women's voices describe the horrors of their married life. Weeping uncontrollably, many times she had to stop transcribing and each day she found it increasingly difficult to turn on the tape recorder. From this experience, the researchers realized the importance of including all team members, not only in the training on violence, but also in stress management activities.

(From Shrader, 2000.[6])

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Practice interviews in Ethiopia

PHOTO BY M. ELLSBERG

Ethiopian fieldworkers organized a traditional coffee ceremony to celebrate the end of the training workshop.

may show up in a number of ways, including headaches, malaise, reluctance to work, conflictive relationships at home, and so forth. As with fieldworkers, supervisors need to be aware of the signs of stress among research staff and intervene accordingly. If resources allow, the ideal workshop would train all members of the research team, at least in the basics of violence against women, stress management, and the contributions of action research to violence prevention.

REMUNERATION OF INTERVIEWERS

The system for paying field staff can have important implications, not only for the research budget, but also for data quality.

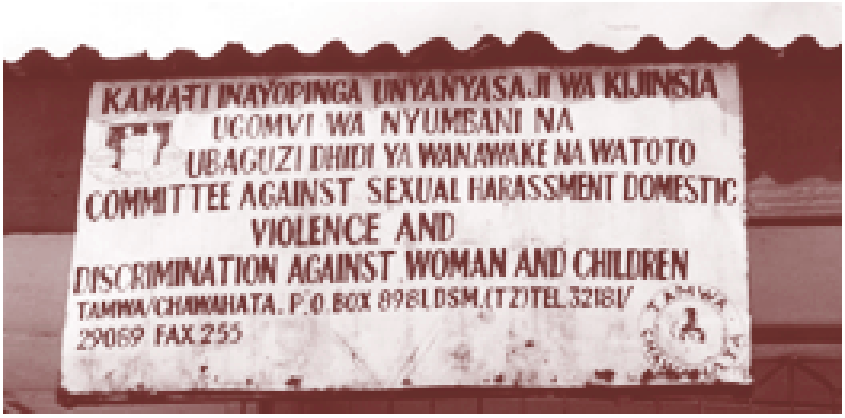

PHOTO BY HAFM JANSEN

Trainees in Tanzania visited the local shelter for abused women to learn about violence in their community.

The most commonly used approaches are payment per completed interview and payment for time.

Per completed interview

With this system, interviewers are paid a fixed amount for each questionnaire or set of notes that they complete. This approach tends to maximize the number of questionnaires turned in and creates an incentive for reducing the duration of fieldwork. However, it can also create an incentive to turn in incomplete or poor quality questionnaires. Of greater concern is that it may lead unscrupulous employees to falsify interview data. Because women who have been abused usually take longer to interview, a per-interview approach risks creating a situation where interviewers consciously or unconsciously discourage disclosure.

Daily or weekly rate of pay

This strategy involves remunerating interviewers by time worked rather than by product delivered. Because there is no built-in incentive to work quickly, interviewers are encouraged to take the time that they need to do quality interviews. This is especially important in studies that collect data on sensitive topics. The primary disadvantage of this system is that the likelihood of running over budget and overtime is greater. One way to offset this risk is to offer individual or group incentives to meet project timelines and that reward good work.

Based on our field experiences, we recommend that interviewers be paid on a daily or weekly basis, with monetary incentives for quality work. Additionally, you should consider creating mechanisms for public recognition of work well done to ensure that interviewers feel valued.

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11

In the Field

Topics covered in this chapter:

Organizing the fieldwork
Negotiating community access
Protecting the safety and well-being of respondents and fieldworkers
Finalizing the procedures and instruments
Managing nonresponse
Data quality control
Data entry

The process of data collection is the most critical link in the research chain. Mistakes made during this period are the most likely to have repercussions for women's safety, as well as for determining the usefulness of data. No amount of careful analysis can make up for flaws in data quality. This chapter will outline some of the main steps for carrying out fieldwork with attention both to the safety of women participating in the study and to the quality of data.

ORGANIZING THE FIELDWORK

Before beginning data collection, it is critical to make a detailed plan for how basic organizational and logistical issues will be addressed. This is particularly important in survey research, where the numbers of interviews are usually much greater, and where precision in selecting the right respondent is crucial to the validity of the data. A great many practical issues need to be resolved before initiating fieldwork such as:

- **Preparation of a detailed budget.** This includes training, equipment, salaries of fieldworkers, transportation, and contingencies.
- **The timing of the fieldwork.** Does fieldwork coincide with periods during which access to communities will be more difficult, such as rainy season, elections, or when people are likely to be away from their homes for harvesting crops, seasonal labor, or religious or cultural festivals?
- **Transportation.** Arrangements may vary among different regions and between urban and rural areas. It is important to determine where public

BOX 11.1 AND DON'T FORGET . . .

In addition to the basic materials needed for performing interviews, there are many other items that research teams have found useful to take into the field with them, such as:

- Packets of tissues for interviewers to offer respondents if they cry.
- Coloring books, balls, and other distractions to keep children busy during interviews.
- A first aid kit with plenty of aspirin.
- A petty cash fund to be used to subsidize women's transport to sources of follow-up support.
- Cash reserves for emergencies.
- Educational materials about violence.
- Malaria prophylaxis for interviewers, where necessary.
- Small gifts for respondents such as posters, calendars, pens, canvas book bags.
- Phone cards or cellular phones (where appropriate).

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PHOTO BY HAFM JANSEN

transportation may be available, and when it will be necessary to hire vehicles, horses, boats, or other modes of transportation.

- **Food and lodging.** Basic necessities for fieldworkers may be difficult to arrange in some areas, whereas in other areas fieldworkers may be able to purchase food or rent rooms. In many rural areas, fieldworkers may need to carry provisions with them and prepare their own food or hire someone to cook.

- **Printing of questionnaires, manuals, pamphlets, and other materials.** These include supervisor forms, referral sheets, and directories for local services for women.

Transportation conditions may vary a great deal between sites (examples from Japan, Bangladesh and Tanzania

PHOTO BY HAFM JANSEN

- **Computers and equipment for data processing.** In survey research, several computers and printers will probably be needed in order to enter the data at the same time as the data collection is being performed.

- **Field office.** It may be necessary to borrow or rent a space for the period of the fieldwork to provide a meeting place for field staff storage for completed questionnaires and others materials, and space to perform data entry. This is especially important due to the need to maintain the confidentiality of the information collected.

- **Payment.** You need to plan in advance procedures for making sure that field workers receive their payment while in the field. If supervisors will be carrying large sums of cash, how will the money be protected? Breakdowns in financial systems can be demoralizing to staff and lead to serious disruptions in fieldwork.

- **Communication.** It is important to organize a system for maintaining contact between fieldworkers and main researchers during data collection. In some areas, telephones may be available, whereas in others, it will be necessary to look for alternative sources of communication, such as radios or cellular phones.

- **Purchasing and preparation of supplies.** Large amounts of materials need to be prepared in advance for interviewers and supervisors such as:

  - Backpacks for carrying materials
  - Identification cards
  - Special vests or T-shirts for interviewers, where appropriate
  - Blank paper
  - Colored pens and pencils
  - Clipboards
  - Tape, clips, staplers

- **Management and transportation of completed questionnaires.** A system

PHOTO BY HAFM JANSEN

Preparing questionnaires in Bangladesh

PHOTO BY HAFM JANSEN

Sampling households in Thailand

must be developed for ensuring that completed questionnaires arrive intact to the field office as soon as possible and are stored in a secure location.

Keeping track of all these details is an enormous job, and most survey researchers find that it is helpful to hire a full-time staff person to coordinate logistics. This should include sending out advance teams to update maps, to find out what arrangements are needed regarding food, transportation, and lodging, and to identify any possible obstacles to fieldwork. Investing resources in finding a person who is experienced in conducting community surveys will save enormous amounts of time and effort later on, and will ensure that the data collection proceeds smoothly.

NEGOTIATING COMMUNITY ACCESS

In addition to discussing plans with the advisory board and obtaining ethical clearance, it is important to obtain clearance from local authorities in each community. The research should be framed in general terms, for example, as a study on women's health or family relations, to avoid having the content of the study become widely known beforehand. The same explanation can be used to describe the survey to other members of the community and in the households where women will be interviewed. In some areas, local groups provide services for victims of violence. These groups should also be contacted before initiating the study to explore the possibility of referring women with violence-related problems to these services, or coordinating in some other way. In the WHO study in Peru, rural community leaders were invited to an informational meeting where they helped the research team to construct community maps for sampling and to plan the route to follow between communities (see Chapter 7). In Thailand, village health workers were recruited to accompany the interviewers to each house in order to introduce them to the head of the household, and to help secure cooperation for the study.

PROTECTING THE SAFETY AND WELL-BEING OF RESPONDENTS AND FIELDWORKERS

The risk of harm to both respondents and fieldworkers has already been addressed at length in Chapter 2. This section will address more specifically the measures that will help to ensure the health and safety of respondents and interviewers while in the field.

Maintaining confidentiality

Much of the information provided by respondents will be extremely personal. As experiences in Ethiopia and South Africa illustrate (Box 11.1), the act of revealing details of abuse to someone outside the family can expose respondents to further risk. For these reasons, it is critical to maintain the confidentiality of information collected during a survey or from qualitative

research with survivors of violence. A number of mechanisms should be used to protect the confidentiality of the information collected, including:

- **Interviewer emphasis on confidentiality.** All interviewers should receive strict instructions about the importance of maintaining confidentiality. No interviewers should conduct interviews in their own community.

- **Do not write the respondent's name on the questionnaire.** Unique codes should be used to distinguish questionnaires. Where identifiers are needed to link a questionnaire with the household location or respondent, they should be kept separately from the questionnaires. Upon completion of the research, they should be destroyed, or, if consent was obtained for follow-up visits, should be kept safely and destroyed after an agreed upon period. In all further analysis, the codes should be used to distinguish questionnaires.

- **Privacy of interviews.** Interviews should only be conducted in a private setting. The participant should be free to reschedule (or relocate) the interview to a time (or place) that may be more safe or convenient for her. Other field staff (drivers, supervisors) may be enlisted to help distract spouses and other family members if it is difficult to achieve privacy.

- **Training on how to handle interruptions.** Interviewers should be trained to terminate or change the subject of discussion if an interview is interrupted by anyone. A short alternative questionnaire on a less sensitive topic concerning women's health (such as menstruation, family planning, or child spacing) can be developed to assist with this. The interviewer can forewarn the respondent that she will turn to the alternative questionnaire if the interview is interrupted.

PHOTO BY M. ELLSBERG

Interviews in Ethiopia

- **The logistics of safety.** Logistics planning should include consideration of respondent and interviewer safety. This will require that sufficient time is budgeted to accommodate the possible need to reschedule interviews. It may also be necessary to identify additional locations (such as a health center) where interviews can be conducted safely and privately. It is a good idea for female interviewers to travel in pairs with a male escort in areas known to be unsafe for women alone. This is particularly true in circumstances where there is some likelihood that an interview may be interrupted, or where interviewers may have to conduct interviews in the evenings.

- **Secure storage of data sources.** Where tapes are made of in depth interviews with survivors of violence, these should be kept in a locked file and erased following transcription.

Again, no record of the names of the women interviewed should be kept.

- **One interview per household.** When the sampling unit for the survey is the household, only one woman per household should be interviewed about her experiences of violence. This is done to protect the confidentiality of the interview. In households with more than one eligible woman, the *WHO Ethical Guidelines for Researching Violence Against Women* recommend that a single respondent should be selected randomly for interview. Any interviews conducted with other household members (either male or female) should not include questions directly exploring their use of violence, as this may result in them concluding that the key respondent was also asked about violence.*

"Sometimes when I offered them the pamphlet the woman would say to me, 'No no, please don't give me the pamphlet, write the address down where I can go and put it on a separate paper, because if my husband found this paper he would kill me.' So I would write the address in my notebook for her…"
Nicaraguan interviewer
(Ellsberg et al, 2001.[4])

Support for respondents

Although most women interviewed will not require any special help after participating in the interview, some women may be particularly distressed, or may ask the interviewer for help in overcoming their situation. It is important to have resources set up in advance to deal with these situations. The research team should identify existing resources where women may be referred in each site, for example, a women's center or shelter, or community clinic where personnel have some training in helping abused women. An interviewer can then provide a woman with a leaflet with the address of the center and times when she can be attended to there. Some researchers have found it helpful to put a number of other addresses on the same piece of paper so that it is not obvious that these are services for abused women, in case someone else reads the paper.

Where few resources exist, it may be necessary either to arrange for the interviewers themselves to receive training in crisis intervention or to train other local individuals to provide such support. In particularly remote areas, it may be easier to have a trained counselor or women's advocate accompany the interview teams and provide support on an as-needed basis. This may take the form of alerting all participants that a staff person trained in family issues will be available to meet with anyone who wishes at a set time and place. Preferably, this location should be a health center, church, or local organization where women can easily go without arousing suspicion. In Indonesia, during fieldwork in a rural area, a psychologist from the women's crisis center in the city came on a weekly basis to visit the field site. In the morning, she would meet with any of the respondents who had been referred for counseling by the fieldworkers. In the afternoon, she would hold a group debriefing session for fieldworkers, as well as individual sessions if needed.[1]

Finally, educational leaflets may be provided to women, giving additional information about violence and suggestions for how to protect themselves and where to go for help if they or someone they know is being abused. The leaflets should be small enough to be easily hidden, and care should be taken to ask women whether it is safe for them to receive the leaflet.

* This procedure can lead to a biased sample, as women in households with many eligible women will have a lesser chance of being selected to be interviewed. However, we believe that the risks of interviewing more than one woman per household outweigh the benefits obtained by a more complete sample. It is possible to adjust for this potential bias in the analysis stage. Experiences in Nicaragua and in the WHO multi-country study indicate that the prevalence estimates of violence were not significantly affected by this measure.

Emotional support for field staff

Listening day in and day out to stories of abuse can have emotional and personal consequences for interviewers. A common occurrence recounted by researchers on violence is that feelings evoked during the research begin to invade other areas of staff members' lives. For example, it is not unusual for team members involved in gender-based violence research to begin to have problems in their own relationships, either because they start to recognize aspects of their own relationships as abusive, or because the anger they feel towards male perpetrators begins to generalize to the men in their own life. This occurs so frequently in violence research that many researchers openly discuss it during interviewer training and encourage team members not to make any major life decisions during the course of the project.

Emotional support for team members is essential. Not only does it help interviewers withstand the physical and emotional demands of intense fieldwork, but it also contributes to the quality of the data collection process. A focus group conducted with interviewers after completing a large-scale health survey that included a module on violence illustrates how disturbing and draining this work can be when appropriate support is not provided.[4] One woman acknowledged that she had lived through similar experiences herself, and found it particularly hard to listen to the stories of abuse. Another interviewer admitted that she had dropped out of the study because she was unable to withstand the pressure of listening to women's stories. She explained:

…When we got to the part about violence, [the respondent] started to tell me that she had been raped first by her brother and her stepfather, but her mother never believed her, and mistreated her…She broke down crying, and I was so moved that I didn't know what to do, because as a human being you can't listen to a story like this and not be moved. I tried to calm her down and give her some encouraging words, but the image of these stories affects you, to see how these women suffer, and especially the feeling that no

BOX 11.2 PROTECTING THE SAFETY OF RESPONDENTS IN GROUP DISCUSSIONS: EXPERIENCES FROM ETHIOPIA AND SOUTH AFRICA.

In the WHO VAW study in rural Ethiopia, researchers visited a village for the purpose of piloting the questionnaire.[2] In this village, women were very reluctant to speak to interviewers alone, and when the subject of violence was brought up, many of them refused to continue the interview. Almost no woman who completed the interview acknowledged having ever been beaten by her husband (in stark contrast with the study findings that more than half of Ethiopian women in this region had been physically abused by a partner). One woman told an interviewer, "Do you think I am a fool, that I would talk to you about such things? My husband would kill me if I did." Eventually, the team learned that a group of people from the city had come to talk about domestic violence with the women. They asked women to describe their experiences in a public meeting, and one woman told how her husband had beaten her. Later in the day, the husband found out and beat her savagely. Everyone heard her cries but no one came to her rescue. Many women thought she had brought the abuse on herself by discussing personal matters in public and shaming her husband.

In another study carried out among female high school students in Cape Town, South Africa, the students revealed in the focus group discussions that they had been sexually harassed by male teachers in the school.[3] According to the researchers,

The learners were grateful to have a sympathetic listener and spent a lot of time discussing these incidents. The girls were clearly victimized and feared these educators and did not want to identify them and neither did they want to be identified as being part of the research group. Plans had to be devised to keep their participation in the research secret from these men. During one incident, a male educator spoke to the researchers enquiring about the research, just outside the room in which the discussions took place. He appeared more than normally interested and asked to see the room. He was very forceful and opened the door, clearly wanting to see more than the room. It is suspected that he had some idea of what the research was about and he wanted to see which learners were involved. Luckily, none of the learners had arrived yet.

BOX 11.3 HOW TO PREVENT INTERVIEWER BURNOUT

1. Include as part of the research team a part-time psychologist or someone with counseling skills who can provide timely counseling for research staff.
2. Schedule weekly debriefing sessions for research staff to specifically discuss the ways in which the fieldwork is affecting their personal lives and physical and mental health.
3. Rotate job responsibilities among field staff to reduce the intensity of information gathering.
4. Schedule frequent team-building activities such as celebrations of achievements and birthdays to help team members feel comfortable asking for support when they need it.

PHOTO BY HAFM JANSEN

PHOTO BY HAFM JANSEN

PHOTO BY HAFM JANSEN

It is important to organize regular activities to help field staff relax and "decompress" from the stress of interviews (examples from Samoa, Bangladesh and Peru).

one supports them, these are experiences that you never forget…

…We spent days thinking about that poor girl and how we left her, without being able to help her. All we did was give her the pamphlet and leave, and the interviewers were very upset, because they would think about their daughters, and that tomorrow something could happen to them and there would be no one to help them…[4]

Even in situations where support is available, researchers may be surprised by the intensity of the emotions that are awoken. One of us (Ellsberg) described an early experience with violence research this way:

Although I was not involved in the daily interaction with abused women, even supervising the fieldwork and analyzing the data turned out to be more painful than I could possibly have imagined…I found myself in tears as I added up the numbers of women who had been kicked in the stomach during pregnancy, or scrolling down the pages of responses to the question "How were you affected by the violence?" where the same words were repeated over and over, "I cry a lot," "I am very nervous," "I am always afraid."

…What sustained us through this period was the sense that women had entrusted us with their stories and it was our job to

ensure they were used to help other women. We reminded ourselves that our main contribution was to bear witness to women's experiences, and that women were also grateful for the chance to be able to tell their stories… [5]

There are many ways that researchers can provide needed support to team members. One strategy is to retain a part-time psychologist or someone with counseling skills, trained in gender-based violence issues, who can provide timely counseling to interviewers and other research staff. The counselor can participate in the training workshop as well, assisting in discussions of post-traumatic stress disorder, crisis intervention, and other relevant topics.

A second preventive strategy is to schedule periodic "decompression sessions" or debriefings for field staff to discuss how the emotional impact of the research experience is affecting them. These meetings, similar to a "self-help group," should be separate from meetings for reviewing technical aspects of the research. In these sessions, maintaining the confidentiality of both respondents and field staff is a primary consideration. The purpose of the debriefing sessions is to create an opportunity for the interviewers to discuss the content of the interviews and their feelings about the work. The goal is to reduce the stress of the fieldwork and prevent any negative consequences. Scheduling weekly sessions should meet the needs of most research teams. This strategy has the added advantage of being relatively cost-effective, as opposed to hiring a team psychologist or social worker for crisis intervention or counseling sessions.

A third strategy is to rotate job responsibilities, so interviewers have a break from listening to heart-wrenching stories. Research team members could temporarily shift from field interviews to quality control, driving, data entry, clerical and/or administrative tasks. This strategy also allows fieldworkers to participate in and understand various stages in the process of data collection and preparation. It is important to be on the lookout for signs of "burn out" among field staff and to take immediate steps to reduce their exposure to potentially upsetting situations (Box 11.3). A single day's rest can often be enough to allow team members to recuperate from stress.

"Have faith, women: Protect your health!" was the message of these canvas tote bags given to respondents in the Peru WHO study.

PHOTO BY HAFM JANSEN

Thai researchers prepare gifts for respondents

Compensation for respondents

The decision to compensate respondents for their participation is a sensitive one, and should be discussed carefully with the local advisory group to ensure that the study is in line with what is considered appropriate locally. In many settings, it is felt that offering money to respondents provides an incentive for participation that violates the ethical principle of voluntary participation. On the other hand, it is important to recognize that respondents have sacrificed valuable time and effort to cooperate with the study. Many research teams have found ways of compensating respondents that do not involve money, such as key chains, canvas bags, calendars, and wall clocks with messages related to women's rights. In Japan, respondents were given gift certificates for bookstores.

It is important that the messages do not mention violence, as this could put women at risk. In Peru, canvas bags were printed with the message "Have faith, women, protect your health!" In Brazil, calendars marking important dates for human rights and women's issues were distributed.

The Tanzania research team making the final adjustments in the questionnaire

PHOTO BY HAFM JANSEN

FINALIZING THE PROCEDURES AND INSTRUMENTS

After the questionnaire has been pre-tested and the necessary adjustments have been made, the next step is to perform a final pilot test before actual data collection begins. By this time, the questionnaire should not require substantial revisions. The pilot testing is used mainly to refine the overall data collection procedures. Usually this phase is carried out as part of the process of training field staff.

After the interviewers have studied the questionnaire and practiced on each other, they can be sent to perform interviews in a neighborhood that is similar to, but not included in, the actual study sample. This process gives interviewers and supervisors the opportunity to practice selecting eligible households and informants, to make sure that questionnaires are being filled out properly, and to detect any other survey procedures that need to be streamlined or adapted. The questionnaires should also be entered by the data entry personnel, and used to test the data entry screens and data quality tables for errors.

MANAGING NONRESPONSE

Nonresponse occurs when the selected woman is unavailable because she has moved away and cannot be located, because she is temporarily away, or because she refuses to participate in all or part of the study. A high **nonresponse rate** reduces the validity of the findings because we cannot tell whether women who have experienced violence have participated to a greater or lesser extent than nonabused women. As a result, findings may underestimate or overestimate the prevalence of violence. For example, a survey on violence in León, Nicaragua, found that several

women had left their homes since the time when the sampling frame was developed. Efforts were made to track the women down in other cities and to talk to family members regarding the reason for the migration. It was found that many of the women had left their homes because of domestic violence, and in a few cases, women were currently hiding from their abusive spouses. This indicated that abuse might be even more common among nonrespondents than among the overall sample of women.

Nonresponse may be a great problem in certain areas, such as cities where most women work outside the home or live in apartment buildings.

Nonresponse may be classified in different groups, for example:

- Household refusal (no one in the household will give information about its members).
- No eligible woman is found in the household.
- The eligible woman is selected but she is not available to be interviewed.
- The eligible respondent refuses to participate in part or all of the survey.

PHOTO BY HAFM JANSEN

Gaining access to a household in Brazil

In all surveys, it is important to minimize the degree of nonresponse. Box 11.4 gives examples of measures that research teams in the WHO multi-country study took to reduce refusals. It is a good idea to monitor the details of nonresponse by cluster, with follow-up procedures implemented in locations with high levels of nonresponse. It is important to obtain as much information as possible about nonresponses, to identify whenever possible why the person did not participate in the survey, and to assess whether there may be any degree of bias (such as lower prevalence of abuse) resulting from the incomplete data.

TABLE 11.1 CALCULATING RESPONSE RATES

	N	%	IRR*
Eligible woman refused/absent/didn't complete interview	184	5	5
Individual interviews completed	3255	**83**	**95**
Total households with an eligible woman	3439	87	100
No eligible women in household/ household empty/destroyed	502	13	
Total households selected	3941	100	

* Individual response rate (IRR) is calculated as: number of completed interviews/number households with eligible women x 100.

BOX 11.4 TECHNIQUES FOR MINIMIZING REFUSALS

These are some of the measures that were used in the WHO study in Peru, Brazil, and Japan to reduce refusals:

- Sending letters in advance on official stationary asking for permission to visit, and calling by phone to set up appointments.
- Sending letters to building managers asking permission for interviewers to enter the building.
- Meeting with community leaders beforehand to encourage community participation.
- Visiting households several times if necessary to find the respondent at home, including at night and on weekends.
- Asking community leaders or village health workers to accompany fieldworkers on the initial visit to a household.

Further, nonresponses should be carefully documented. Table 11.1 illustrates how the response rate may be calculated and presented. In this case, interviews were completed in 83 percent of the 3,941 households selected. However, in 13 percent of the households, there were no eligible women or the house on the map was empty or had been destroyed. Because the response rate only measures the percentage of completed interviews out of households with an eligible woman, the individual response rate is 95 percent rather than 83 percent.

Checking questionnaire in Thailand

PHOTO BY HAFM JANSEN

DATA QUALITY CONTROL

Maintaining control over the quality of data as it is being collected and entered into the computer will avoid many problems later on. Following are some suggestions for improving data quality.

Standardized training manuals

- **Training manuals for interviewers and supervisors.** The instruction manual helps ensure that all procedures with regard to carrying out the interviews are performed in a uniform way, thereby reducing the possibility of systematic bias in the study. The manual should outline the roles and responsibilities of each member of the field staff, how to select and approach households, and how to deal with unexpected situations.

- **Question-by-question coding manual.** This may be included with the interviewer manual if the questionnaire is not too long. It provides additional information about the purpose of each question and how it should be asked, as well as how to code the answers.

Supervision

The role of supervisors is to ensure that interviewers are following the guidelines of the study, for example in the way they are asking questions and maintaining privacy. Supervisors may observe interviews occasionally to monitor the quality of the interviews. Either the supervisors or an editor will review each questionnaire before leaving the field to make sure that it is filled out properly, that the skip patterns are followed, no information is missing, and the information obtained makes sense. This should be done as soon as possible after the interview is completed. Any mistakes

found at this stage should be corrected immediately. Interviewers may need to return to a household to obtain missing information (unless the respondent did not want to provide that information).

Random repeat interviews

Supervisors may randomly repeat parts of interviews to make sure that the information in both the interviews is the same. This is particularly important in the study of violence, where an interviewer's own attitudes or behavior may influence whether a woman will disclose experiences of violence. Therefore, the "interviewer effect" is particularly important to control as much as possible. If supervisors will be revisiting households, it is important to mention this in the informed

PHOTO BY HAFM JANSEN

Fieldworkers editing questionnaires in Samoa

BOX 11.5 ENSURING DATA QUALITY IN THE *WHO MULTI-COUNTRY STUDY ON WOMEN'S HEALTH AND DOMESTIC VIOLENCE AGAINST WOMEN*

Within each country, a range of mechanisms was used to ensure and monitor the quality of the survey implementation in different settings. This included:

- The use of a standardized and detailed training package.
- Clearly explaining the requirements and conditions of employment to each interviewer and supervisor, and maintaining the option to fire staff who were not performing adequately, or who had negative attitudes towards the topic of study.
- Compiling details of eligible members of each household during the survey. Possible sampling biases could then be explored by comparing the sample interviewed with the distribution of eligible respondents.
- Close supervision of interviewers during fieldwork, including having the beginning of the interview observed by the supervisor for a proportion of interviews.
- Conducting random re-checks of some households, without warning. Several respondents were reinterviewed by the supervisor using a brief questionnaire. This visit was used to assess how the respondent was selected and to assess the respondent's perceptions about the interview (at the time of the original interview respondents were asked for permission for the supervisor to return).
- Continuous monitoring for each interviewer and each team of a number of performance indicators such as the response rate, number of completed interviews, and rate of disclosure of physical violence.
- Having a questionnaire editor in each team, who reviewed each of the questionnaires once they were completed, identifying inconsistencies and skipped questions. Within any cluster, this enabled any gaps or errors to be identified and corrected before the team moved on to another cluster.
- A second level of questionnaire editing was done upon arrival in the central office by "office editors."
- Extensive validity, consistency, and range checking was conducted at the time of data entry by the check program that is part of the data entry system.
- All the survey data were double entered, and inconsistencies were identified and addressed through a comparison of the two data sets.

(From WHO, 2000.[6])

PHOTO BY HAFM JANSEN

All WHO VAW study sites used standardized data entry screens that were modified in each site to include any additional questions (example from Bangladesh).

consent procedure and to ask for permission to revisit the respondent.

Technical debriefing

In addition to the emotional debriefing meetings already referred to in Chapter Ten, regular meetings with interviewers during the fieldwork are important for identifying and correcting problems in the data collection. Such problems include ambiguities in questions that are being interpreted differently by various interviewers or questions where large discrepancies are found.

Interviewer observations

Whenever possible, interviewers should be encouraged to write detailed observations at the end of the interview. These observations can include information about the interview itself, such as whether anyone interrupted and whether the informant seemed nervous or credible. The observations can also provide additional information about the woman's history that may help to clear up apparent inconsistencies, or contribute valuable insights into the problem under study.

BOX 11.6 EXAMPLE OF A FIELDWORKER'S OBSERVATIONS

This woman was raped by her brother, and then beaten and sexually abused by her husband. She finally left him, after 10 years of abuse, but he continued to follow her, to threaten her with a machete, and once dragged her by the hair down the street. She went to the police for help, but they said there was nothing they could do. She is still frightened that he will come back to kill her, and she broke down crying during the interview. I gave her a booklet about violence and I referred her to the university mental health clinic. Nicaraguan interviewer

(From Ellsberg, 2000.[5])

Final debriefing

A final debriefing should be carried out with fieldworkers and supervisors after the data collection is completed. The purpose is to gather information about the field process in general, problems that were encountered that might influence the quality of the data, and the general views of staff regarding the veracity of the information provided by respondents. For example, it would be useful to hear whether women seemed reluctant to answer the questions on violence, and whether there were problems achieving complete privacy. Did it appear that respondents were telling the truth about their experiences? In one such debriefing, a fieldworker commented that "some women said no with their mouths [about being abused] but yes with their eyes."[4] These comments will be extremely valuable later on in helping to interpret the findings.

DATA ENTRY

Data entry and analysis is greatly facilitated by using a computer package designed specifically for the entry and statistical analysis of survey data. We recommend the use of Epi Info, an epidemiological package developed by the Centers for Disease Control (available in DOS or Windows format at http://www.cdc.gov/epiinfo/). The advantages of Epi Info are many:

- It is free, easy to obtain, and has been translated into several languages.

BOX 11.7 DATA ENTRY AND PROCESSING IN THE *WHO MULTI-COUNTRY STUDY ON WOMEN'S HEALTH AND DOMESTIC VIOLENCE*

A data entry system was developed in Epi Info 6.0 with standardized data entry screens and extensive error check programs. In each country, all information collected on the administration sheet, household selection forms, household questionnaire, and female questionnaire needed to be entered in this system. The system was developed centrally. A member of the Core Research Team installed the program in each country, assisted in customizing the program to accommodate country adaptations of the questionnaire, and trained data entry staff and the data entry supervisor during one week in use of the program and in all other aspects of data processing. Although some of the questions and/or answer options differed between countries, a standardized approach to coding was adopted and every deviation of the original question was carefully documented in a central codebook. These procedures helped ensure that the data in each country were essentially entered in the same way, and that decisions about coding were implemented universally. All data were double entered and double entry errors were identified using the validation module Epi Data.

Open-ended questions were initially entered verbatim, and then coded, based on a uniform coding system that was developed after reviewing the responses obtained in each country. Each country team was responsible for the entry, cleaning, and preliminary analysis of the data for their own country. Assistance from the central technical support team was provided where necessary.

(From WHO, 2000.[6])

- It is easy to use, and many researchers and data analysts are already familiar with it.
- It allows for data entry screens with logical checks, and basic statistical analysis. The Windows version also does more advanced statistical analysis, such as logistic regression and life table analysis.
- Data entered in Epi Info can easily be exported to other statistical programs for more advanced analysis, such as SPSS or Stata.

PHOTO BY HAFM JANSEN

Data entry in Tanzania

No matter what data entry system you use, it is important to ensure that the data are entered correctly. Sloppy data entry can lead to enormous problems later on, that take months to detect and clean. Whenever possible, data entry should be carried out at the same time as data collection. This will make it much easier to identify and correct problems in the data collection before it is too late. Following are some of the most common methods for controlling the quality of data entry.

- **Logical controls.** Many data processing software packages (including Epi Info) allow you to program logical checks into the data entry program. These checks can reduce errors by specifying the values that can be entered in a specific field (for example, if it is a yes/no question, then only the two values representing yes and no will be accepted). They can also carry out automatic checks to maintain the internal consistency of the data. For example, the program will check to make sure that a woman's reported age coincides with her birth date, or if she has already

indicated that she has no children, the program will automatically skip any questions regarding children.

- **Double entry of data.** This is the most reliable way to ensure the quality of data entry. It involves entering each questionnaire twice by different people, and then comparing the data for discrepancies. While this is a very reliable method, it does increase costs. Therefore, some researchers prefer to use double entry at the beginning of data entry, to identify and correct common mistakes. Then, as errors are reduced, data can either be entered once, or double entry of data can be performed randomly on a smaller proportion of questionnaires.

- **Data quality tables.** Data quality tables are useful for determining refusal rates and comparing results on specific variables for which information already exists. They can reveal problems occurring in specific field teams or with individual interviewers. In prevalence studies, it is a good idea to keep track of the percentage of women disclosing violence per interviewer, and to perform additional supervision of interviewers with particularly high or low rates of disclosure.

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12

PHOTO BY HAFM JANSEN

Analyzing Quantitative Data

Topics covered in this chapter:

Basic analysis of survey data on violence against women
Looking at associations between violence and other variables
Assessing the validity of survey results
Interpreting the results

Once the fieldwork has been completed, the next task, and arguably the most rewarding part of the research process, is to unravel the mysteries hidden within the data. This involves transforming endless pages of words, numbers, and codes into meaningful results to inform theory building or action.

One of the common limitations of survey research on violence is the tendency to present results mostly in the form of descriptive statistics, for example, percentages of women who are abused and characteristics of abuse. While these types of figures are certainly necessary, there is a broad range of statistical techniques for data analysis that allows researchers to explore the relationships between violence and other variables with greater depth and precision. In this chapter, we show how a variety of statistical techniques may be combined to enrich data analysis. Providing detailed guidance for advanced statistical analysis is beyond the scope of this manual, and we urge researchers needing further assistance to consult an experienced statistician during this stage.

BOX 12.1 STEPS FOR ANALYZING AND INTERPRETING THE DATA

- Inspect and clean the data matrix.
- Display frequencies of the variables.
- Make cross tabulations to check for inconsistencies.
- Check graphic distributions of relevant variables.
- Review basic hypothesis.
- Plan initial tables.
- Write down expected results.
- Carry out additional analysis.
- Illustrate results in tables and graphs.
- Interpret results and assess critically.
- Synthesize results in writing.

(Adapted from Persson and Wall, 2003.[1])

BASIC ANALYSIS OF SURVEY DATA ON VIOLENCE AGAINST WOMEN

Look at the data matrix

Before initiating data analysis, it is important to make sure that the data are entered properly and that there are no obvious mistakes. There are several ways

TABLE 12.1 EXAMPLE OF A DATA MATRIX

Record	Code	Abused	Age	Numchild	Educ	Poverty	Urban
1	MY132	1	15	1	4	1	1
2	KJ423	1	29	3	2	0	2
3	MC341	2	31	2	2	1	2
4	KJ153	2	46	5	3	2	1
5	MI253	1	24	3	1	1	1
6	KU124	2	19	2	3	0	2

to do this. One way to check data entry is to look over the data matrix frame by frame and make sure that nothing is missing.

Another method is to make frequencies of the basic variables. Look for variables that seem to have been miscoded, and check for missing values on key variables such as age and education.

Finally, do cross-tabulations to look for obvious inconsistencies. For example, make sure that all the women who have answered questions about the characteristics of violence are also coded as having been abused, and that none of the women coded as not having children have answered the questions about children's age and schooling.

Whenever you find inconsistencies or missing data, you will probably need to consult the original questionnaire to find the correct answer. Be sure to keep a log of any corrections made to the data file. As soon as you have a fully updated and cleaned version of the data set, make several copies and keep them in a safe place!

This is certainly the most tedious part of data analysis. Doing it carefully can, however, save you time and anguish later on. Table 12.1 presents an example of what a data matrix looks like. Each row represents a different informant, and the columns represent different variables.

Prepare for data analysis

In preparing for the data analysis, you should return to your hypothesis and review the relationships you are expecting to test. These can be presented in the form of empty tables that serve as your initial analysis plan. First, look at the frequencies of variables such as age and education to see how they are distributed. One way to look at distribution graphically is by means of a **histogram** (Figure 12.1), which measures the frequencies of observations in each category. This will be helpful later on in finding meaningful ways to recode the data into smaller categories, such as age group and educational attainment.

Different ways to describe the occurrence of violence

One of the most important findings of a prevalence survey on violence is the percentage of women who have been abused. However, there are many different ways to quantify and describe the frequency of violence, and you will need to analyze your data from several different angles to find the most meaningful way to describe your results. Following are some examples of the different ways that data on violence may be presented.

As we mentioned in Chapter 6, the prevalence of violence can be expressed as the percentage of women interviewed who have experienced violence during a specific period of time (for example, the last 12 months), or as the percentage of women who have ever experienced violence in their lives.

It is also useful to break down these figures according to the type of violence

FIGURE 12.1 HISTOGRAM INDICATING THE AGE DISTRIBUTION OF EVER-MARRIED WOMEN 15–35 YEARS OF AGE

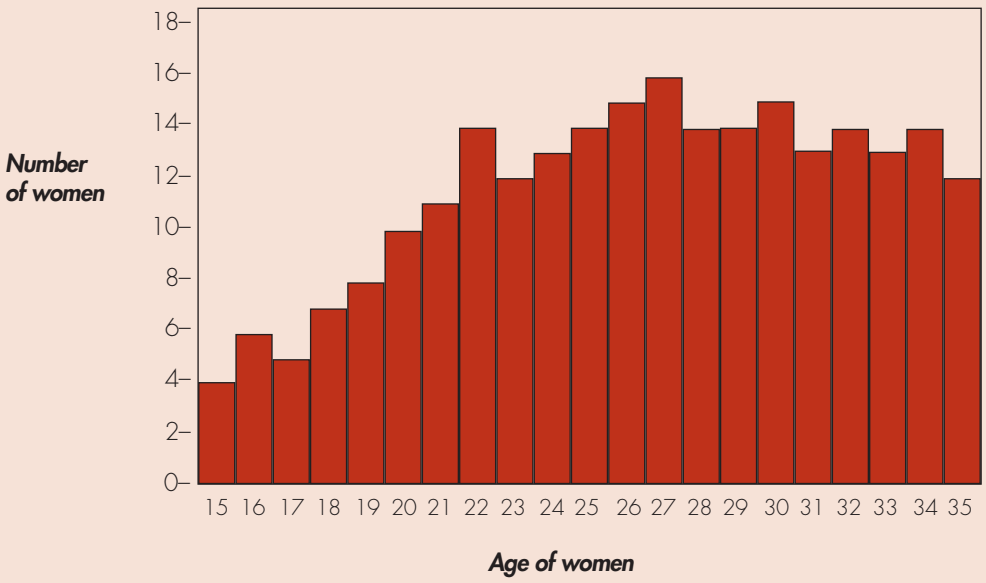
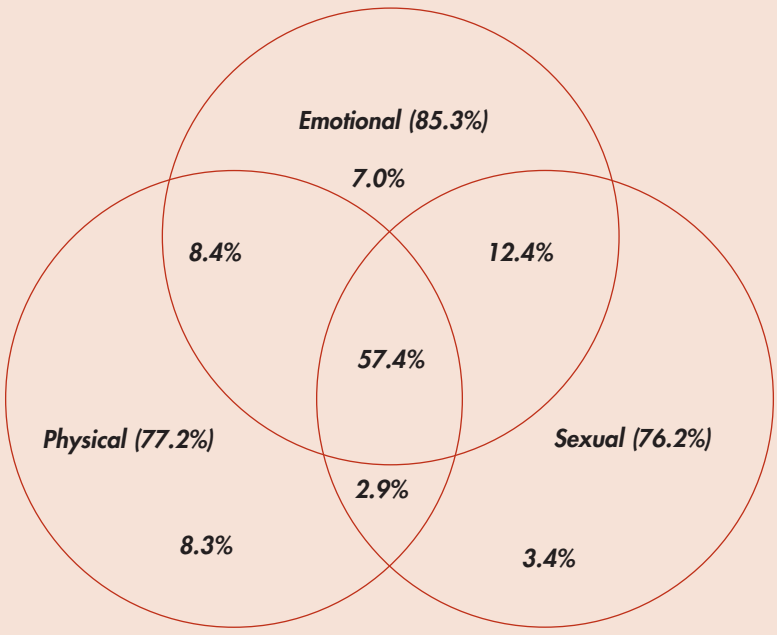


FIGURE 12.2 OVERLAP BETWEEN SEXUAL, PHYSICAL, AND EMOTIONAL VIOLENCE EXPERIENCED BY 613 WOMEN IN JAPAN

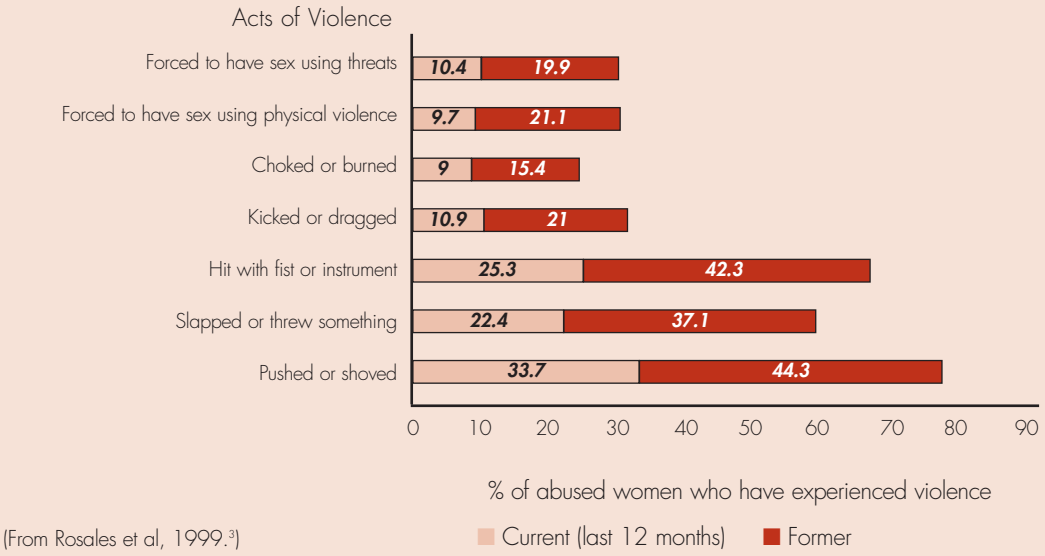


(From Yoshihama and Sorenson, 1994.[2])

(physical, sexual, emotional, or economic) and the perpetrator (in other words, abuse by partner should be presented separately from abuse by other individuals).

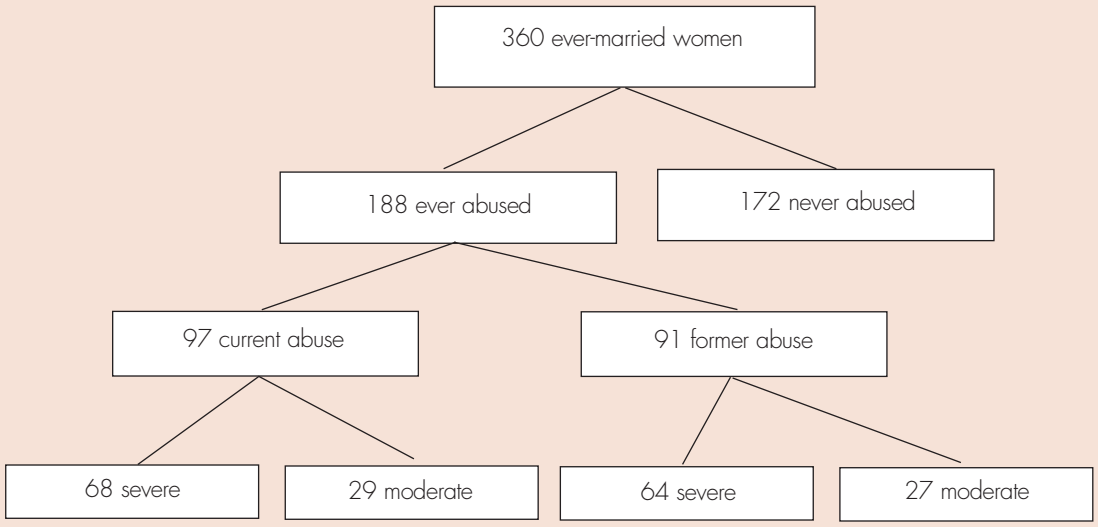
It is further useful to look at the overlaps between different types of violence, for example, how many women have experienced both partner and nonpartner abuse, or how many women have experienced both sexual and physical violence. These can be illustrated using Venn diagrams. The diagram in Figure 12.2 was

FIGURE 12.3 DESCRIPTION OF THE SPECIFIC ACTS OF VIOLENCE EXPERIENCED BY NICARAGUAN WOMEN DURING THE LAST 12 MONTHS AND PRIOR TO THE LAST 12 MONTHS



(From Rosales et al, 1999.[3])

FIGURE 12.4 WOMEN'S EXPERIENCES OF PARTNER VIOLENCE IN LEÓN, NICARAGUA, ACCORDING TO SEVERITY AND TIME FRAME



(From Ellsberg et al, 1999.[4])

produced by Yoshihama and Sorenson, and presents the types of abuse that were reported by women in Japan.[2] The percentages within parentheses represent the proportion of abused women who experience each type of abuse, whereas the numbers without parentheses represent the proportion of abused women who experienced specific combinations of violence. In this example, 57 percent of abused women experienced all three types of abuse.

Most women who suffer abuse experience several different acts of violence, as well as repeated incidents of violence. To enable readers to visualize the range of abusive behaviors, it may be helpful to describe the percentage of abused women who have experienced specific acts of violence. These may be presented as lifetime experiences, or as in Figure 12.3, from the

1998 Nicaraguan Demographic and Health Survey, broken down by recent and former acts of violence experienced.

Figure 12.4 and Table 12.2 present other examples of how to present descriptive information on violence. Figure 12.4 shows that about half of the women reporting violence were abused during the last 12 months, and that 70 percent of both current and former violence was classified as severe. Table 12.2 shows that 60 percent of the women experiencing violence during the last year suffered more than one incident, and that 22 percent of women were severely abused more than five times in the last year. After completing this descriptive analysis, we recommend developing a scale that enables you to group women according to their experience of violence, for example: never abused, former moderate abuse, former severe abuse, current moderate abuse, and current severe abuse. This kind of detailed information about what kind of violence women suffer will be critically important later on for looking at the relationship between violence and specific health outcomes. (For an example see the association between violence and emotional distress shown in Figure 12.11.)

TABLE 12.2 FREQUENCY OF VIOLENCE IN LEÓN, NICARAGUA, DURING THE LAST 12 MONTHS ACCORDING TO SEVERITY (N=97)

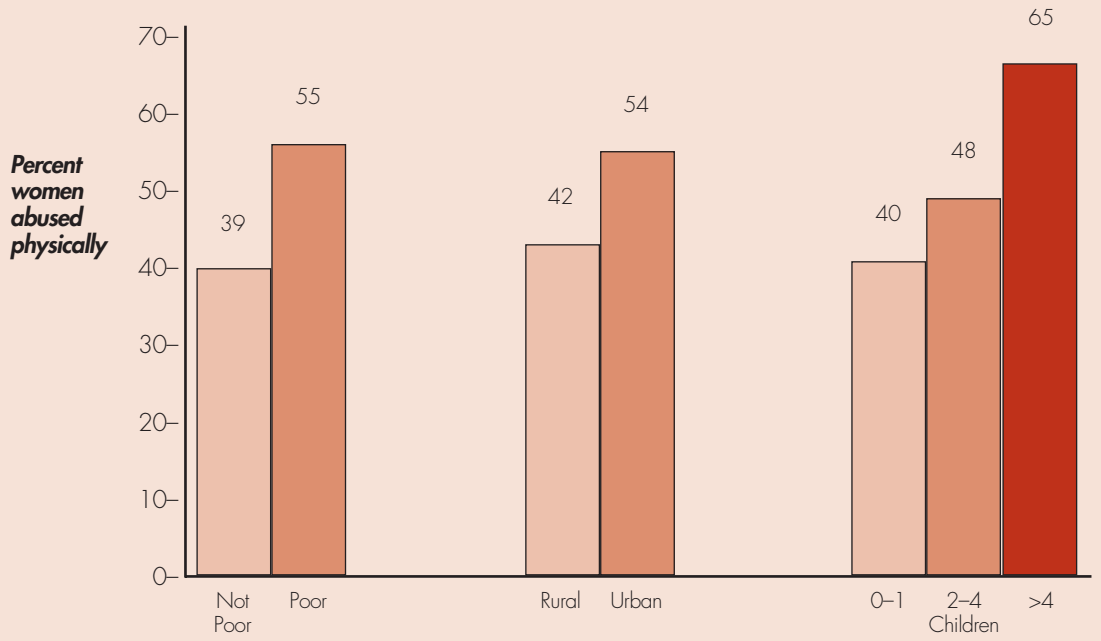
Frequency	*Moderate Violence % (N)*	*Severe Violence % (N)*	*Total % (N)*
Once	18 (17)	22 (21)	40 (38)
Occasional (3–5 times)	10 (10)	28 (27)	38 (37)
Frequent (6–20 times)	2 (2)	9 (9)	11 (11)
Very frequent (more than 20 times)	0	11 (11)	11 (11)
Total	30 (29)	70 (68)	100 (97)

(From Ellsberg et al, 1999.[4])

LOOKING AT ASSOCIATIONS BETWEEN VIOLENCE AND OTHER VARIABLES

After completing the descriptive analysis, the next step is to perform cross-tabulations to look for associations between

FIGURE 12.5 THE PREVALENCE OF VIOLENCE AMONG 360 EVER-MARRIED WOMEN IN LEÓN, NICARAGUA, ACCORDING TO SOCIO-ECONOMIC STATUS, URBAN/RURAL RESIDENCE, AND NUMBER OF CHILDREN



(From Ellsberg et al, 1999.[4])

FIGURE 12.6 THE PERCENTAGE OF EVER-MARRIED NICARAGUAN WOMEN WHO REPORT THAT THEY HAVE CONSIDERED OR ATTEMPTED SUICIDE RELATED TO EXPERIENCES OF VIOLENCE (N=8507)

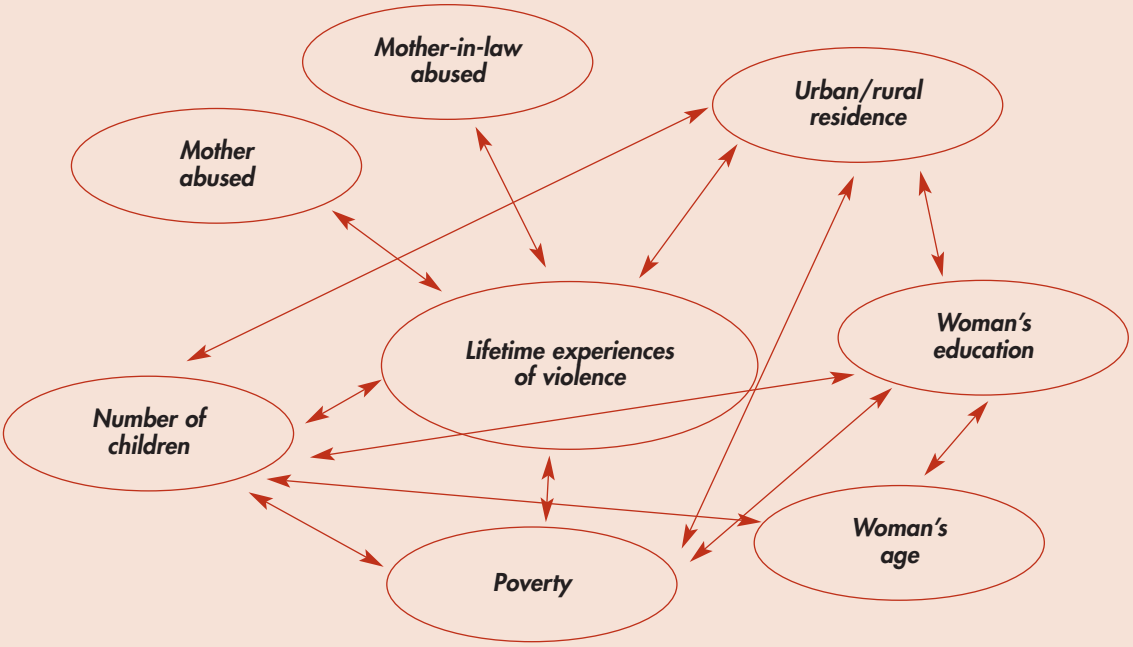
(From Rosales et al, 1999.[3])

violence and possible risk or protective factors or specific health outcomes. Simply stated, this involves comparing different groups of women to find out whether there is more violence among women with certain characteristics, or whether women who have experienced violence have a greater frequency of certain kinds of problems. Figures 12.5 and 12.6 show how these differences might be presented by means of a bar graph. You will certainly want to look at the associations between experience of violence and such background factors as age, urban rural residence, socio-economic status, education, and number of live children. You should also look at how each of these variables is related to the others. It may be helpful to map the associations out visually, as shown in Figure 12.7.

In order to determine whether the prevalence of violence actually varies according to different characteristics such as age or education, you will need to perform tests for **statistical significance**. When used by researchers, the word significance refers not to the importance or size of the difference, but to the likelihood that the associations are real and not simply due to chance. Two of the most common tests for statistical significance are chi-square (X^2) and the Student's T test, and most computer packages can perform them automatically. Each test is appropriate for different kinds of data. Therefore, you should consult a statistician to determine the most appropriate statistical tests for your data.

For example, initial analysis of survey data in León, Nicaragua, found that lifetime experience of physical violence was significantly associated with poverty, living in the urban area, and having a mother or mother-in-law who was also abused. No associations were found between violence and a woman's age or education. However, both age and low education were associated with a high number of children, and low education was associated with poverty and living in the rural area (Figure 12.7). In Figures 12.8 and 12.9, bar graphs show findings from a study in Central Java, Indonesia. Figure 12.8 shows that

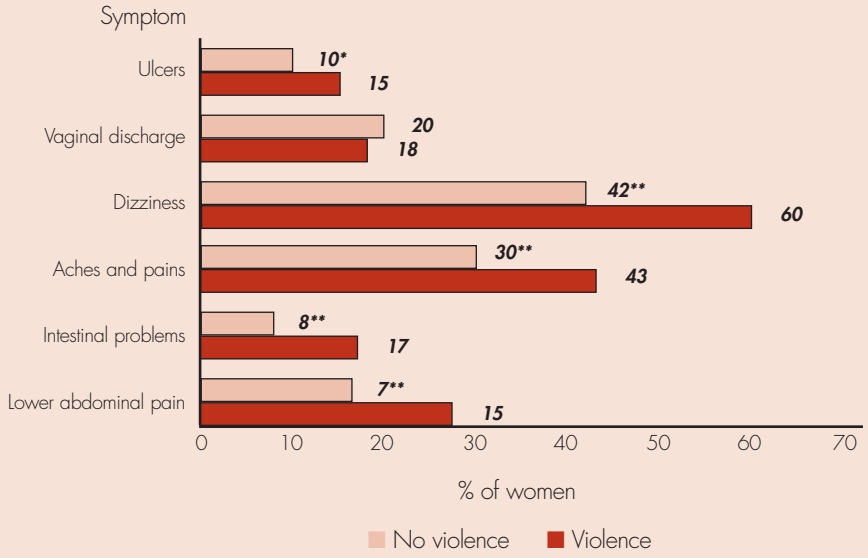
FIGURE 12.7 VISUAL MAPPING EXERCISE TO SHOW ASSOCIATIONS FOUND BETWEEN BACKGROUND VARIABLES AND THE RISK OF WIFE ABUSE IN LEÓN, NICARAGUA



Lines with arrows between variables indicate significant associations.

(From Ellsberg et al, 1999.[4])

FIGURE 12.8 PHYSICAL SYMPTOMS AMONG WOMEN ACCORDING TO EXPERIENCES OF SEXUAL AND PHYSICAL PARTNER VIOLENCE IN CENTRAL JAVA, INDONESIA

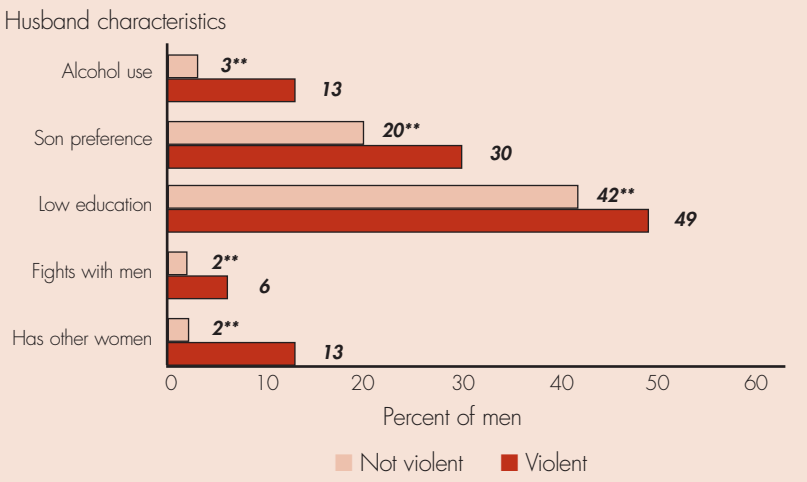


Percentages are given for women who had experienced each symptom in the previous four weeks according to whether they had ever been physically or sexually abused by an intimate partner. Asterisks indicate that associations are statistically significant.

(From Hakimi et al, 2002.[5])

* p<.05 **p<.001

FIGURE 12.9 HUSBAND'S CHARACTERISTICS ACCORDING TO USE OF VIOLENCE (AS REPORTED BY WIFE) IN CENTRAL JAVA, INDONESIA



Percentages are given for the proportion of men with each characteristic, according to whether or not they have ever used physical or sexual violence against their wives.[5]

(From Hakimi et al, 2002.[5])

** p<.001 N=765 men

Indonesian women who had ever experienced partner violence reported more recent symptoms of ill health such as pain, dizziness, ulcers, and intestinal problems. Figure 12.9 shows that Indonesian men who have been violent towards their wives are also more likely to have used alcohol, and to have had extra-marital relationships. They are more likely to have been involved in fights with other men, to prefer sons over daughters, and to have little or no education.

ASSESSING THE VALIDITY OF SURVEY RESULTS

Once you have found what seem to be the most important results from your data, and you have performed basic statistical tests between variables (for example, violence and ill health), you need to assess their **validity**. This means you need to determine to what degree the study measured what it was supposed to, and whether the findings mean what they are supposed to. **Internal validity** refers to the extent to which variations in a specific outcome (for example, the risk of violence) may be attributed to variations in an independent variable (for example women's age or education). **External validity** refers to the degree to which results from a given study may be used to draw conclusions about a larger population. If a study is performed on a randomly selected population, it should be possible to generalize the results of the study to the general population from which the sample was drawn.

Another important question is Are the findings consistent? That is, do they make sense, according to what is known about the subject locally and internationally? If they differ greatly from previous findings, are there any additional data to support the new results? Are there any aspects of data collection, sampling, design, or analysis that might have altered the results by introducing bias? Has the analysis taken into account possible sources of confounding? The following pages present different ways to address these issues.

The effects of confounding in data analysis

In studying the association between risk factors and a specific problem, **confounding** can occur when another characteristic exists in the study population and is associated with both the problem and the risk factor under study.

Confounding can have a very important effect on study results, and can create the appearance of a cause-effect relationship that in reality does not exist. Age and social class are often confounders in epidemiological studies. In the study of risk factors for violence, confounding variables can give misleading impressions about what risk factors influence the occurrence of violence. **Stratified analysis** and **multivariate analysis** are two ways to control for the effects of confounding variables.

Stratification involves analyzing data separately using defined categories of the confounding factor, such as age groups. For example, some studies using **bivariate analysis** (analysis using only two variables) have found that pregnant women were more likely to be abused than non-pregnant women. However, after analyzing the same data stratified by age groups, it turned out that this association was confounded by age. It turned out that being young was the real risk factor for violence rather than pregnancy. It just happened that younger women were more likely to be pregnant than older women. This explained the increased prevalence of violence among pregnant women.

Violence can also be analyzed as a confounding variable for other risk factors, as shown in the following example of a study on mental distress. Preliminary results found that women who had been married at least once in their lives had twice as much emotional distress as women who had never been married (Table 12.3). This would imply that marriage is an important risk factor for mental distress.

However, when the prevalence of mental distress among ever-married women was analyzed separately according to whether women had experienced wife abuse, a large difference was found between the two groups. Thirty-one percent of abused women suffered mental distress, compared to only seven percent of women who had never been abused, which is even less than the prevalence of distress among never-married women (Table 12.4).

Since wife abuse is associated with marriage (by definition only ever-partnered women can experience wife abuse) and it is also associated with mental distress, it has a confounding effect on the association between marriage and mental distress (Figure 12.10). Therefore, after stratified analysis it becomes evident that it is wife abuse and not marriage itself that accounts for the increase in mental distress among married women.

This analysis is further strengthened by comparing women's current mental distress according to the severity of violence they experienced and when it took place, as shown in Figure 12.11. Breaking down the analysis this way demonstrates that women who were severely abused in the last 12 months were over ten times more likely to be distressed than women who had never been abused. Further, it revealed that the severity of abuse was more important than when it took place, since women experiencing severe

TABLE 12.3 PREVALENCE OF EMOTIONAL DISTRESS ACCORDING TO MARITAL STATUS AMONG NICARAGUAN WOMEN

Selection of women	*Percentage of emotional distress*
All women 15–49 (n=488)	17%
Ever-married women (n=360)	20%
Never-married women (n=128)	10%

(From Ellsberg et al, 1999.[6])

TABLE 12.4 PREVALENCE OF EMOTIONAL DISTRESS AMONG EVER-MARRIED NICARAGUAN WOMEN ACCORDING TO EXPERIENCES OF WIFE ABUSE

Experience of wife abuse	*Prevalence of emotional distress*
Never abused (n=172)	7%
Ever abused (n=188)	31%

(From Ellsberg et al, 1999.[6])

FIGURE 12.10 THE CONFOUNDING EFFECT OF VIOLENCE ON THE ASSOCIATION BETWEEN MARRIAGE AND MENTAL DISTRESS

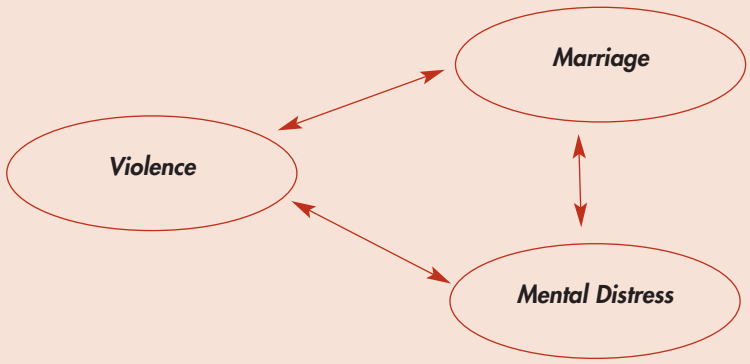
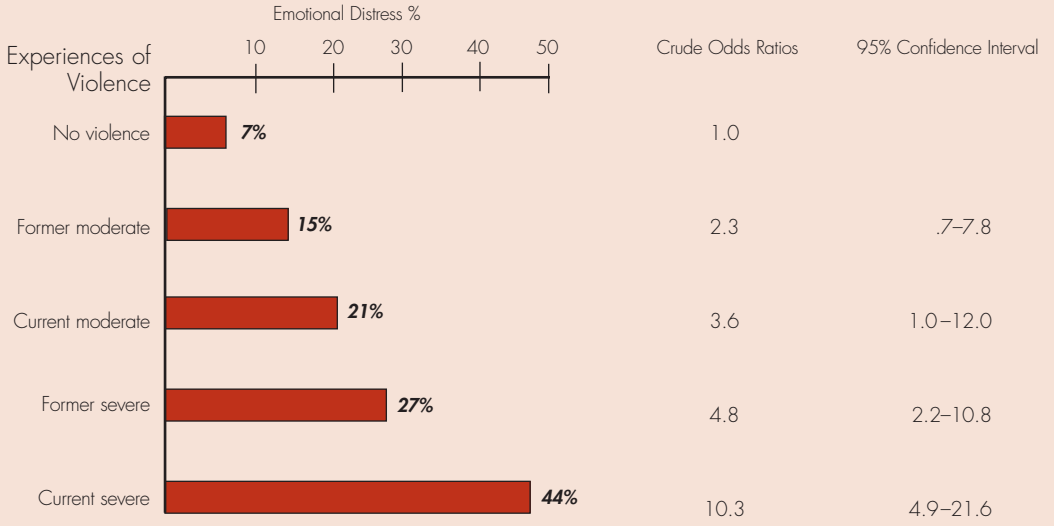


FIGURE 12.11 PREVALENCE OF EMOTIONAL DISTRESS ACCORDING TO EXPERIENCES OF VIOLENCE AMONG NICARAGUAN WOMEN



Percentages are given for the proportion of ever-married women who experienced emotional distress in the four weeks prior to the survey, according to whether they had experienced physical partner violence. Violence was classified by severity and by whether it took place within the 12 months previous to the study, or earlier. In the right hand columns, crude (unadjusted) odds ratios and their corresponding confidence intervals are given. Intervals where the lower and upper figures do not include 1.0 are considered statistically significant. (In this case, all types of violence except for former moderate violence are significantly associated with emotional distress.)

violence formerly were still more likely to be currently distressed than women who had suffered only minor abuse, even though it took place more recently.

The use of multivariate analysis to adjust for confounding factors

When it appears that there are several variables confounding an association, then it is no longer practical to use stratified analysis, as it would be excessively complex to perform. For example, in Figure 12.7, we saw that in the León study there were several variables, such as poverty, living in the urban area, and number of children, which were associated with the risk of violence. It was further shown that these three variables are associated with each other as well as with women's level of education. Could it be that poverty is the true underlying factor influencing women's risk of violence, and therefore that urban women and women with many children are found to have greater levels of violence, simply because they are more likely to be poor? How can we unravel the complex relationships between these variables?

Multivariate analysis techniques, such as **logistic regression modeling**, are useful for examining the relationships between several explanatory factors and a specific outcome variable. **Logistic regression** helps to uncover the degree to which several explanatory variables are related and to control for confounding variables. In Table 12.5 (next page), the same relationships presented in Figure 12.7 are examined using crude or unadjusted odds ratios as well as multivariate or adjusted odds ratios. The 95 percent confidence intervals are used to assess the statistical significance of the association by indicating that there is a 95

percent probability that the true figure lies between this range. If the range between the lower and upper figure in the confidence interval does not include one, then it can be said that there is a 95 percent probability that the association is not due to chance.

When comparing the crude and multivariate odds ratios for each variable, one can see that they do not vary much in most of the cases. The association between violence and poverty, having more than four children, and a history of family violence in the husband's family are all maintained. Living in the urban area, which had a confidence interval slightly below one in the crude analysis, becomes significant in the multivariate model, while a history of family violence in the wife's family becomes insignificant. After performing the multivariate analysis, it is possible to say that although poverty, urban/rural residence, and high parity are all related, their effect on women's risk of violence is independent and should not be interpreted as the result of confounding.

TABLE 12.5 ASSOCIATIONS BETWEEN BACKGROUND FACTORS AND PREVALENCE OF VIOLENCE AMONG 360 EVER-MARRIED NICARAGUAN WOMEN AGES 15–49

Variable	*Categories*	*Crude OR (95% CI)*	*Adjusted OR (95% CI)*
Poverty	Nonpoor	1.0	1.0
	Poor	1.91 (1.12–3.23)	1.82 (1.03–3.23)
Zone	Rural	1.0	1.0
	Urban	1.62 (.94–2.78)	2.07 (1.12–3.82)
Number of children	0–1	1.0	1.0
	2–3	1.40 (.82–2.39)	1.34 (.74–2.43)
	4 or more	2.77 (1.59–4.82)	2.23 (1.21–4.15)
Family history of abuse	No history in wife's family	1.0	1.0
	Wife's mother abused	1.8 (1.24–2.90)	1.28 (.79–2.09)
	No history in husband's family	1.0	1.0
	Husband's mother abused	3.13 (2.00–4.96)	2.98 (1.86–4.73)

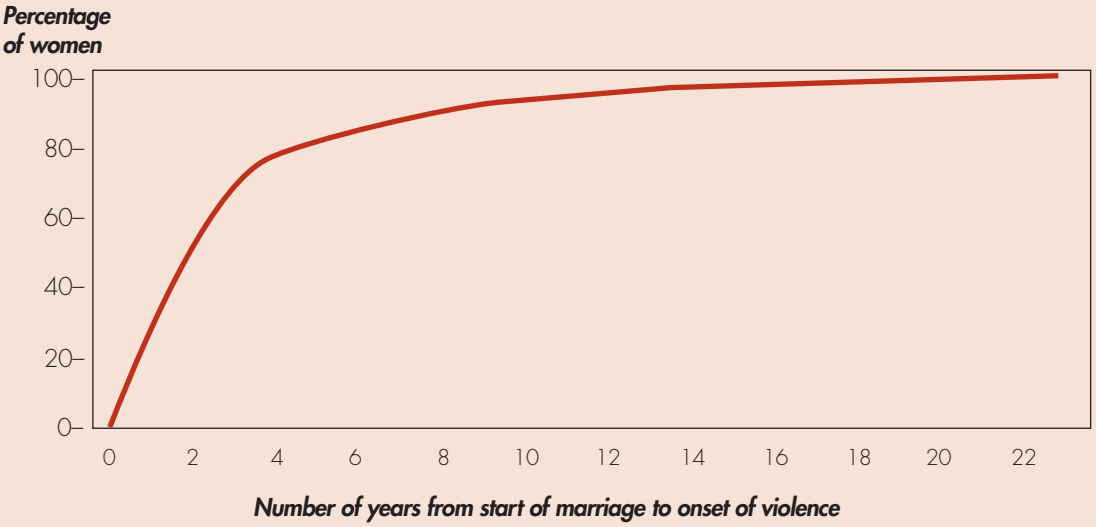
Crude and adjusted odds ratios are given (together with 95 percent confidence intervals) for having experienced violence at least once in their lives.

(From Ellsberg et al, 1999.[4])

Using advanced statistical analysis creatively

In earlier sections of this chapter, we presented the most commonly used techniques for statistical analysis of survey data

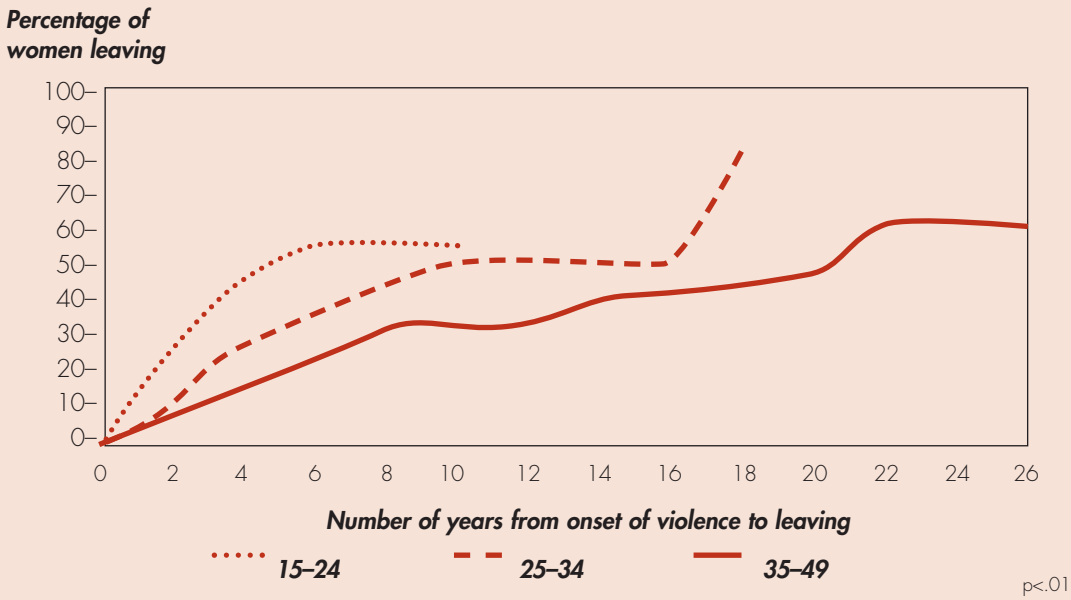
FIGURE 12.12 TIME FROM THE START OF A RELATIONSHIP TO THE ONSET OF VIOLENCE



The figure shows the cumulative incidence of domestic violence over time among 188 women who reported having experienced marital violence at least once in their lives, using Kaplan Meier Life Table Analysis.[8]

(From Ellsberg et al, 2000.[8])

FIGURE 12.13 THE PROBABILITY OF LEAVING AN ABUSIVE RELATIONSHIP OVER TIME, BASED ON A WOMAN'S CURRENT AGE GROUP



This figure shows that 50% of young women (ages 15–25) leave a relationship within four years of violence starting, whereas 20 years was the median time of older women.

(From Ellsberg, 2000.[10])

on violence. However, additional insight may be revealed by the creative use of more advanced statistical techniques.

For example, **life table** or **survival analysis** was used to gain a deeper understanding of the relationship between violence and high parity in Nicaragua. Many international studies have found a similar association.[7] One interpretation for this is that having many children places additional stress on a marriage and increases a woman's likelihood of being beaten by her husband.

However, using **life table analysis**, a statistical technique which measures the probability of events occurring over time, it was possible to determine that violence began early on in relationships, in many cases well before women had started bearing children. Figure 12.12 shows that 50 percent of violence begins within two years of marriage, while 80 percent of abuse starts within four years. This implies that high parity, instead of being a risk factor for abuse, is more likely to be a result of violence, because battered women are less likely to be able to control the timing of sex or the use of birth control.

The same techniques were applied to the likelihood of a woman leaving an abusive relationship, and it was found that 70 percent of women eventually did leave their abusers, although some women stayed as long as 25 years or more before separating. Stratifying this analysis according to age groups shows that younger women are more likely to have left an abusive relationship within four years, compared to women between 35-49 years (Figure 12.13). This indicates that younger women are less likely to tolerate abuse than older women. In order to use survival analysis techniques, it is necessary to collect detailed data regarding each of a

woman's relationships: when did it start, how long did it last, was there violence, and if so, when did the first and last incidents of violence take place. These types of analyses are somewhat complicated to perform and interpret, so it is important to consult with an experienced statistician.

INTERPRETING THE RESULTS

The process of data analysis will often take longer than you initially expect. However, you can plan data analysis in stages, so that initial findings, such as prevalence and descriptive characteristics, can be made available as soon as possible to the communities and local institutions that have been supporting the research, and that will be anxiously awaiting results. Further analysis can be performed over a longer period to explore some of the more interesting findings in greater depth. Box 12.2 presents guidelines for writing up research results for publication in scientific journals. Chapter 14 will discuss in detail how research results may be tailored to fit the needs of different groups.

When interpreting and writing up the results of data analysis, it is important to be cautious. Each research design yields different kinds of data, with their respective limitations. Be careful not to draw conclusions that are not supported by the data, as overstating your results can seriously undermine the credibility of the research. People are more likely to listen to your findings when you are open about whatever limitations the study had in terms of design, data collection, or analysis. Some examples of common pitfalls are the following:

- Inferring causal relationships from cross-sectional data. Cross-sectional surveys can highlight associations between two variables, but unless you have good information about when different conditions or events occurred it is difficult to know with certainty what came first. A good example of how causal relationships can be misinterpreted is the relationship between parity and violence presented in the last section. It is a good idea when presenting results from cross-sectional surveys to talk about "associations" rather than causes. The discussion section can assess which variables are most likely to be causes or outcomes, based on your conceptual framework and other studies on the subject.

- Inferring causal relationships from bivariate analysis. As we showed in the

BOX 12.2 SUGGESTED GUIDELINES FOR WRITING A SCIENTIFIC PAPER

Abstract
Approximately 100 words.

Background
Literature, national context, objectives.

Methods
Describe the study population, how the sample was selected, what instruments were used, how the fieldwork was conducted, how data were analyzed, how ethical clearance was obtained, and any special measures, such as safety procedures.

Results
This section should describe all the major results of data analysis, including relevant tables and figures, and measures of statistical significance.

Discussion
The purpose of this section is to interpret the meaning of data, assessing the validity and generalizability, possible sources of bias, how the findings relate to international and national studies on the same subject, and possible explanations for the most important findings.

Conclusions
These are sometimes included in the discussion section. How might these findings be used for improving interventions and policy? What are areas that might benefit from future research?

References
Make sure to include citations from the most relevant literature in the field of study.

(From Persson and Wall, 2003.[1])

example on marriage and emotional distress, other variables may confound a relationship between two variables. If you have not performed stratified or multivariate analysis, it is wise to be cautious in interpreting your results.

- Generalizing conclusions for different populations than the study population. Results that are representative for one region are not necessarily true for other regions in the country, or for the country as a whole. This does not mean that regional studies cannot provide important insights that are relevant for a much broader context. There are many examples of regional studies that made critical contributions for guiding national policies and programs. However, it is still important to be careful in stating clearly what the limitations of the sample are, both in terms of its power to capture important associations and its generalizability.

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PHOTO BY HAFM JANSEN

13

Analyzing Qualitative Data

Topics covered in this chapter:

Approaches to qualitative analysis
Data coding
Using a computer for coding and categorizing
Data reduction and data displays
Ensuring rigor in qualitative research

In this chapter, we concentrate on making sense of textual data in the form of expanded field notes, transcripts of recorded interviews, or naturally occurring texts such as newspaper accounts, popular literature, or policy documents.

APPROACHES TO QUALITATIVE ANALYSIS

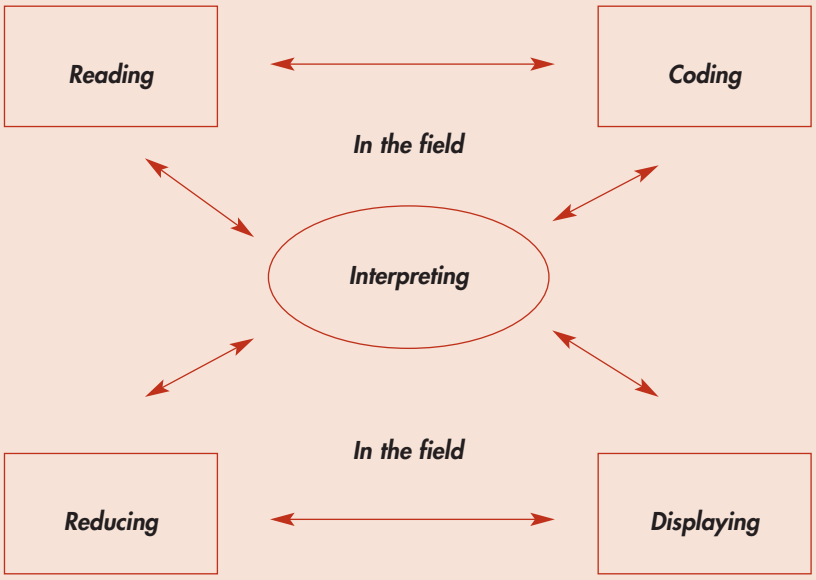
There are as many different ways to analyze qualitative data as there are means to collect it. Generally, however, all forms of analysis involve organizing the data according to specific criteria, reducing it to a more manageable form, displaying it in a form to aid analysis, and interpreting it.

Analyzing reams of written text is as complex and time-consuming as analyzing quantitative data—if not more so. Good qualitative analysis is part art and part science, and hundreds of books have been written on the topic. This chapter is not intended to substitute for these texts or to "teach" qualitative data analysis. Rather it is meant to acquaint the reader with the process and to direct interested parties to useful texts in the field. Generally, projects involving qualitative data analysis should proceed under the direction of someone trained in qualitative research.

We have found the framework of researchers Miles and Huberman helpful in understanding qualitative analysis.[1] Analysis, according to them, consists of "three concurrent flows of activity: data reduction, data display, and conclusion drawing or verification." Ulin and colleagues offer a slightly revised version of the Miles and Huberman framework that identifies four separate flows of activity—data reading, coding, reducing, and displaying—all informing a constant process of interpretation.[2] As emphasized in Figure 13.1, this constant interplay of activity is an iterative process that begins in the field and continues at your desk once all the data are collected.

Below we describe each of these processes briefly before exploring data

FIGURE 13.1 THE PROCESS OF QUALITATIVE DATA ANALYSIS



(From Miles & Huberman, 1994[1] and Ulin, et.al, 2002.[2])

coding and interpretation in greater depth.

Data immersion is the process of reading and rereading each set of notes or transcripts until you are intimately familiar with the content. Early readings of the data can help guide future data collection. Are you getting the kinds of data that you expected? Does your reading suggest new avenues of inquiry? Repeated readings are also the first step toward identifying emerging themes, possible relationships among themes or categories, and unusual or contradictory responses.

Data coding means attaching labels or **codes** to different segments of text that are associated with different issues. Coding is a way to help separate information into categories or themes so that information from different sources can be easily sorted and compared. With key themes coded in this way, you can later search and retrieve interesting segments and look at them as separate files. Data can either be coded by hand (by writing codes into the margins of the text) or with the aid of a computer. Computers have helped revolutionize qualitative data analysis by greatly easing the task of sorting text segments by thematic code.

Data display is defined as an organized assembly of information that allows conclusions to be drawn and actions to be taken.[1] Most frequently qualitative data is displayed as narrative text, which tends to overload people's information-processing capabilities. Matrices, graphs, networks, and charts can present information in more compact form that make the data more accessible. Many of these techniques are presented later in this chapter.

Data reduction involves selecting, focusing, simplifying, abstracting, and transforming the "raw" data of field notes or transcriptions into typed summaries organized around themes or patterns based on the original objectives of the research. Data reduction continues until the final report is written.

Interpretation/conclusion drawing refers to the process of deciding what things mean, noting themes, regularities, patterns, and explanations. The researcher may begin to draw conclusions in draft form throughout the entire data collection

BOX 13.1 WHERE TO START: AN APPROACH TO QUALITATIVE DATA ANALYSIS

Transcribe and organize the information into files—one for each interview, focus group, or observation session.

Immerse yourself in the data. Get a sense of the whole. Read through all of the transcripts several times. Perhaps jot down some ideas as they come to mind.

Pick one transcript or document—the most interesting, the shortest, the one on the top of the pile. Go through it, asking yourself: What is this about? Read both for content and to identify emergent themes and insights into underlying meaning. Write thoughts in the margin or in your field notebook.

When you have completed this task for several documents, make a list of all the topics you encountered. Follow the trail of issues, intuitions, and ideas that arise from reading the data. Cluster together similar topics. Form these topics into columns that might be arrayed as major topics, unique topics, and leftovers.

1. Develop preliminary coding categories. Start by listing all the issues, perceptions, attitudes, beliefs, and other important aspects identified during the preceding stage. Once the principal coding categories have been identified, review the list and see if any categories overlap or are repeated. Then assign a code and, if so desired, code by color.
2. Now take this list and go back to your data. Write the codes next to the appropriate segments of the text. Try out this preliminary organizing scheme on several transcripts to see whether new categories and codes emerge.
3. Make a final decision on the abbreviation for each category and alphabetize these codes.
4. In the margin of each transcript, write the code assigned to each category found in the text (or use a computer to assign codes to particular segments of text).
5. Assemble the data belonging to each category in one place and perform a preliminary analysis.
6. Look for the most important relationships between the data. Also look for relationships between different analysis categories. In other words, look for the most important relationships between people, events, ideas, perceptions, behavior patterns, and other aspects of the data.
7. Discovering what is significant should lead to a search for similarities and differences. Look for the most common and recurrent norms and patterns in behavior, ideas, perceptions, attitudes, and expressions. Also look for the most salient differences.
8. Consider using one or more data display techniques to help make sense of your data—for example, matrices, decision trees, or flow charts.

(Adapted from Creswell, 1994[3] and Shrader and Sagot, 2000.[4])

exercise, but eventually these become more explicit and firm at the point when the "final report" is written. Conclusions must also be verified as analysis proceeds. As researchers try to explain what the data mean, they should continually examine their explanations for plausibility and validity—do their explanations make sense within the context of the study? It is often possible to test the validity of conclusions by presenting preliminary findings and interpretations back to project stakeholders and/or members of the population being researched. Researchers can then incorporate this feedback into the final version of their written report.

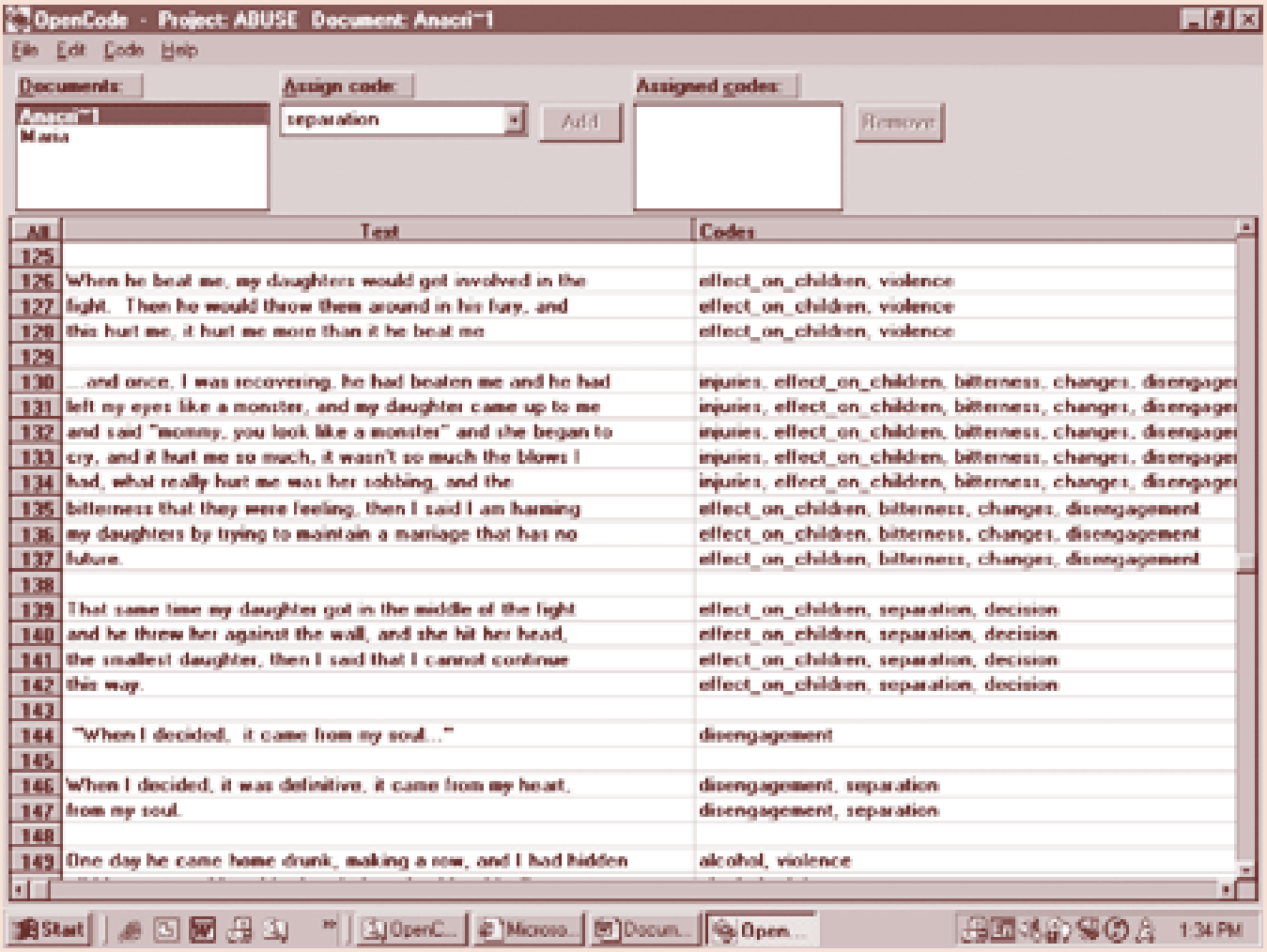
DATA CODING

Although most qualitative research uses some process of coding to organize data, there are no standard rules about how to do so. As Ulin and colleagues observe:

Researchers differ on how to derive codes, when to start and stop coding, and the level of detail they want. Some researchers develop codes that closely match the ideas or language found in the textual data. They want to avoid imposing words or concepts that might prevent them from seeing their data in a new way. Others borrow terms from the social science literature that represent more abstract concepts

BOX 13.2 AN EXAMPLE OF DATA CODING USING OPENCODE

The following is an example of data coding and organization using the software OpenCode developed by Umeå University, Sweden. OpenCode allows the researcher to apply an unlimited number of codes to specific pieces of text, which may then be reorganized according to specific themes, or sets of codes. In this example, we used two interviews from Nicaraguan women, Ana Cristina and Maria, both of whom had been abused by their former husbands. In the interviews, both women described the characteristics of the violence, its effect on them and their families, different strategies they had used for coping with the violence, different sources of family and social support (or lack thereof), and finally how they made the decision to separate from their abusive partners.



Each interview was coded separately, and more than 100 different codes were generated at this stage. Some of the codes were related to specific language or feelings that the respondents used (e.g., "bitterness," "sadness") whereas others were thematic categories such as "effects on children" or "disengagement." After both interviews were coded, we organized the data into common themes, using the program's "search" option.

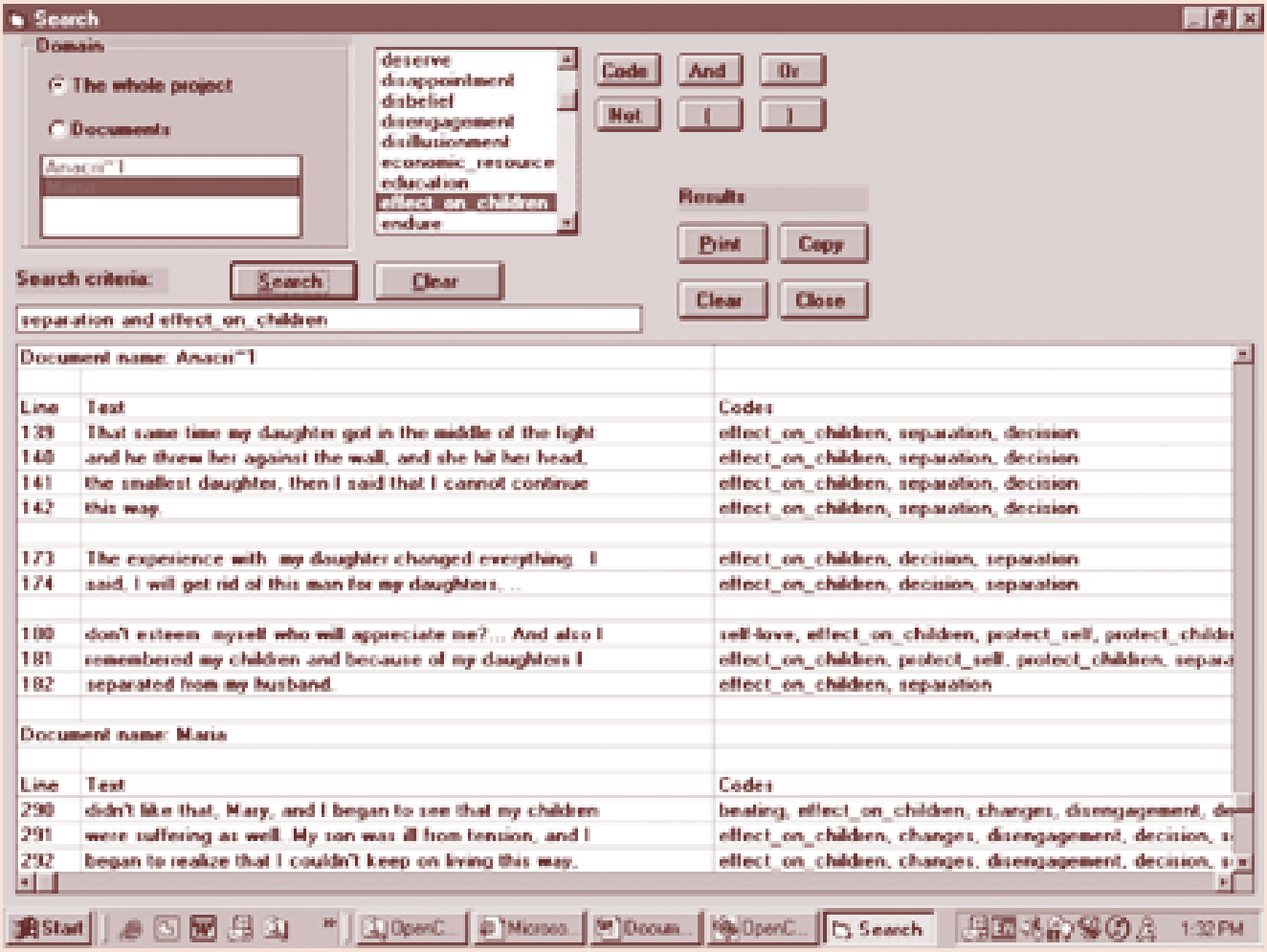
The second figure shows a piece of text where Ana Cristina describes how her children were affected by her husband's violence, as well as how their suffering influenced her own views towards the marriage. It appeared that the desire to protect her children was a significant factor in Ana Cristina's decision to leave her husband. To see whether similar themes might also be relevant for Maria, we conducted a search of both interviews using the criteria "effect_on_children" AND "separation."

The text that appears in the next figure shows that both women felt that their children's suffering was a major influence on their decision to leave.

In further analysis, we looked for commonalities and differences in other types of motivations mentioned for leaving (for example, the existence or lack of family support, economic resources, self-esteem) The same results could certainly have been accomplished by cutting and pasting text, but the use of the computer software was particularly useful for looking at a single piece of text from different perspectives, and in different combinations of codes.

BOX 13.2 AN EXAMPLE OF DATA CODING USING OPENCODE

Using computer software (OpenCode) to organize text by common themes.



important to their field. These have the advantage of being understood by a wider audience. Whether borrowed or emergent, labels allow you to assemble under one concept many seemingly disparate pieces of text and to search for connections.[2]

In part, these different approaches to coding evolve from the theoretical underpinnings of different types of qualitative research. **Grounded theory**, an approach to qualitative research pioneered in the late 1960s by Glaser and Straus, emphasizes coding that sticks close to the text and then constructs increasingly abstract categories and domains by analyzing the relationships among codes. Because this approach allows conceptual categories to emerge from the text rather than from the mind of the researcher, it is especially well suited for theory building.[5]

For more applied research projects, it is possible to code segments using categories that correspond to well-recognized phenomena or concepts. For example, when coding an interview from a woman living with abuse, it is easy to imagine codes emerging that correspond to different feelings, coping strategies, responses to abuse, and reactions of others. Even when working with more categorical

TABLE 13.1 SAMPLE MATRIX: FACTORS THAT MOTIVATE AN ABUSED WOMAN TO SEEK HELP OR INHIBIT HER FROM SEEKING HELP

Forms of Violence	*Motivating Factors* *Internal*	*External*	*Inhibiting Factors* *Internal*	*External*
Physical	■ Fear that her daughter will be taken away. ■ Search for protection, she is beaten because of another woman.	■ Beatings, biting, miscarriages. ■ Loss of teeth. ■ Referred by a service provider; taken by her family.	■ He is the father of her children. ■ She does not believe in the system, fears more abuse.	■ The abuser is released from jail. ■ He threatens to kill her.
Psychological	■ Depression; takes drugs to feel better. ■ Seeks support because of stress; wants to vent her feelings; wants to be heard. ■ Wants someone to talk with her husband.	■ He leaves the home. ■ He refuses to marry her. ■ The children have problems at school.	■ She doesn't think this a matter to be handled by the authorities. ■ She thinks it is her fault. ■ She thinks he will change. ■ She thinks that her jealousy causes his infidelity.	■ Her mother tells her she should put up with it. ■ The church tells her to forgive him. ■ He asks forgiveness. ■ He leaves the other woman.
Sexual	■ Fear of dying of an infection because he does not get treated. ■ Loss of libido.	■ Sexual rejection from him. ■ She has been told that this is sexual aggression.	■ She is ashamed to have others find out about her problem. ■ She thinks no one will believe her.	■ She thinks it is her duty to accept her relationship with her husband.
Economic	■ She thinks he should support and help her. ■ She doesn't think her status should be reduced unfairly.	■ He won't give her money. ■ Her mother-in-law stays she should turn him in to the authorities.	■ Fear. ■ She thinks she does not need money or prefers not to insist on it in order to keep the peace.	■ The authorities do not force him to pay. ■ They do not monitor his support payments.

(From Shrader & Sagot, 2000.[4])

labels, one's coding system will necessarily evolve over time as new insights and ways to organize the data emerge.

Figure 13.1 describes one approach to tackling qualitative analysis, following the conceptual approach outlined by Miles and Huberman and Ulin and colleagues. It begins with data immersion and includes developing and applying more categorical labels to segments of text. For very simple projects, it may be possible to organize segments of text according to the various research questions of interest and then begin to look for similarities, differences, themes, and relationships. By its very nature, one's approach to qualitative analysis will vary based on complexity of the research question being asked and the resources and time available for analysis.

USING A COMPUTER FOR CODING AND CATEGORIZING

Sometimes a more complex classification scheme is necessary than can be managed and interpreted by hand. Here is where computers can come in handy. When using a computer for text-based analysis, the investigator still must "code" the data—that is associate a code word with pieces of the text that represent a certain theme. But the computer allows the investigator to search and organize large volumes of data according to predefined codes and combinations of codes.

Many computer programs are available for use in coding and analyzing data, and all are different. Examples of some of the more common programs used for qualitative data analysis include HyperQual, NUDIST, Ethnograph, and QUALPRO. Generally these programs allow the investigator to attach one or more codes to different text segments. Data can then be sorted and resorted according to different themes and coding categories. A number of popular qualitative software programs are available commercially through Scolari Software at: http://12.22.103.11/.

We especially recommend considering one of three free "share-ware" programs that have been explicitly developed to assist researchers in the field of public health. The first, known as OpenCode, is a versatile, but highly accessible, program that can be downloaded from the web site of Umeå University, Sweden, at http://www.umu.se/phmed/epidemi/forskning/open_code.html. The second is CDC EZ Text, a simple program designed by the Centers for Disease Control and Prevention (CDC) to facilitate analysis of open-ended responses to structured questionnaires. CDC has also developed a third program, called AnSWR, which is designed for more complex qualitative projects. Both CDC programs can be downloaded from http://www.cdc.gov/hiv/software.

There are also potential drawbacks to using computers, and the time and cost of using computers must be weighed against the potential benefits. For example, it is time-consuming to set up and code data by computer and the investigator must invest time, money, and energy into acquiring and learning a new software program. Clearly, for many small projects, it is best to conduct the analysis manually using highlighters and colored pens.

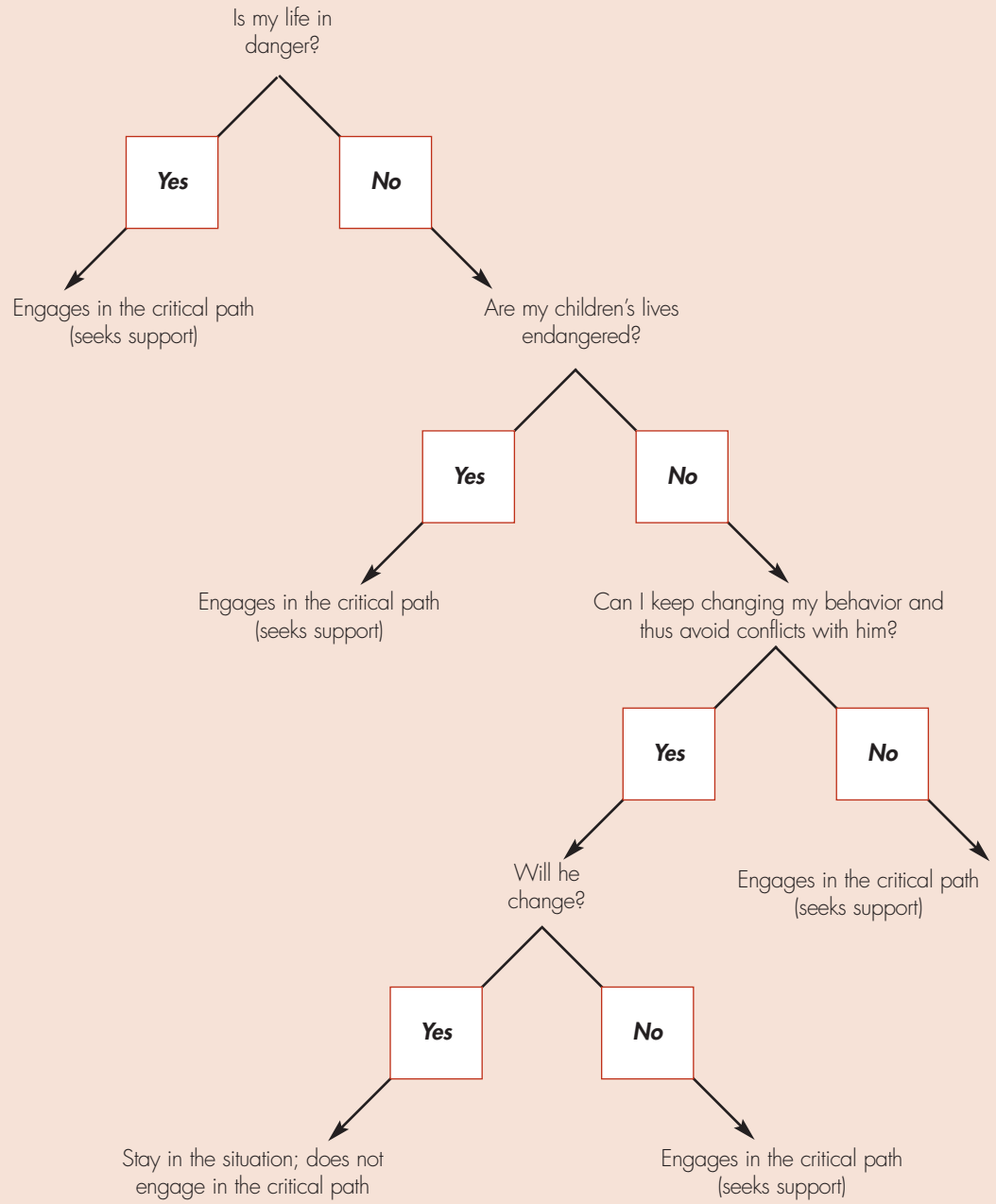
DATA REDUCTION AND DATA DISPLAYS*

Data reduction means distilling the information to make visible the most essential concepts and relationships. The reduction process usually begins after all the data have been collected, coded, and the researcher is thoroughly familiar with the material. The goal of data reduction is to get the bigger picture from the data and begin to discern distinctions between primary and secondary themes.[2] While coding helps break down the data into smaller parts, data reduction is the process of abstracting back out from the particular to the conceptual.

To get a wider perspective on the data, it is often helpful to use one or more visual devices known as data displays. Data display is a nonnarrative way of analyzing and presenting qualitative data. The analysis may be intra-case (that is, analysis of the data related to a single respondent) or inter-case (comparative analysis of the data from two or more respondents). As with any other aspect of qualitative analysis, it is necessary to document the processes followed, the

* Information in this section is reprinted with permission from Shrader and Sagot, 2000.[4]

FIGURE 13.2 SAMPLE DECISION TREE: MAKING THE DECISION TO SEEK HELP



(From Shrader & Sagot, 2000.[4])

conclusions generated, and the way in which the analysis influenced the subsequent stages of the fieldwork.

Matrices, decision trees, and taxonomies are examples of different data display tools that can be useful for aiding analysis as well as in presenting results. Following is a presentation of these three methods using examples from the "Ruta Crítica" study, a multi-country study qualitative study on women's responses to violence performed by the Pan American Health Organization in ten Latin American countries. (See Box 5.4 for a description of the study.) Keep in mind that it is not necessary to display data in every way

suggested, only in those that can elucidate some aspect of the analysis.

Matrices

A matrix is a table that displays the intersection of two or more concepts. It consists of cells, which may be filled with summary text, graphs, or other explanatory information. The matrix is very useful for summarizing a great deal of information or presenting comparative information on a single sheet. Table 13.1, for example, represents a data matrix used to summarize the factors that emerged as critical to either motivating a woman affected by violence to seek outside help or inhibiting her from seeking help. This particular matrix is taken from the Panama country report of the Ruta Crítica study. It illustrates the complexity and detail that can be included in a single table.

Decision trees

A decision tree is a graphic representation that depicts the sequence of decisions that leads to an action. In general, the decisions are formulated as a dichotomous question, i.e., one that is answered with "yes" or "no." Arrows indicate the consequent question, depending on the answer given. A simple decision tree shows the sequence of decisions made by a person; a complex decision tree shows the combined decisions of one or more persons.

Figure 13.2 illustrates a simple decision tree derived from Ecuador data of PAHO's Ruta Crítica study. The figure illustrates the thinking and decisions characteristic of an abused woman's process of deciding whether to seek outside help for the violence.

Flow charts

Also known as an explanatory network, flow charts show the relationship between two or more elements, emphasizing directionality, causality, or temporary association. Geometric figures and arrows usually are used to indicate temporary or causal relationships between the concepts. Figure 13.3 presents a sample flow chart showing the path followed by a woman who seeks to escape from a violent relationship. The chart includes an analysis of the time elapsed between one violent incident and the next one, as well as the time it takes to carry out the trial. It reveals that this respondent was the victim of three serious incidents of violence before finally obtaining the desired result—for him to stop drinking and beating her.

Taxonomies

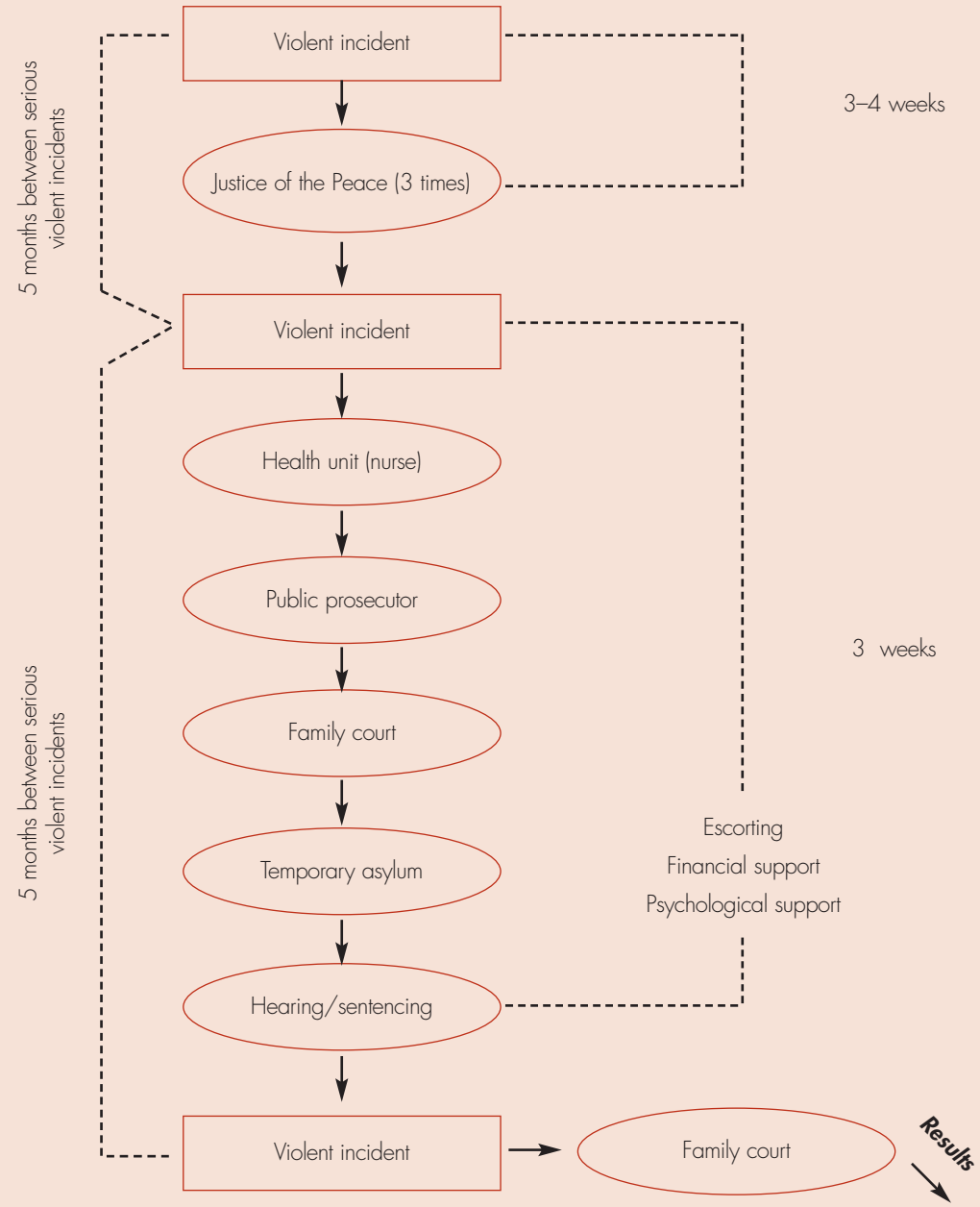
A taxonomy attempts to summarize concepts in a hierarchy that goes from the greatest level of generalization to the greatest level of specificity. Taxonomies are useful for showing the relationship between many separate concepts, joining concepts that share one or more characteristics in cumulative stages.

Figure 13.4 presents an example of a taxonomy developed by the U.S. Centers for Disease Control to describe several forms of interpersonal violence.

ENSURING RIGOR IN QUALITATIVE RESEARCH

Ensuring rigor, while equally important in qualitative as in quantitative research, is addressed somewhat differently by the two traditions. Lincoln and Guba suggest that the four issues that must be addressed in any systematic enquiry into humans and human behavior are truth value, applicability, consistency, and neutrality.[6] (See Table 13.2.) Whereas quantitative research tends to use such criteria as external and internal validity, reliability, and objectivity to assess whether research has been carried out and interpreted using accepted scientific standards of rigor, qualitative research tends to assess the trustworthiness of research in terms of credibility,

FIGURE 13.3 SAMPLE FLOW CHART: ITINERARY OF A WOMAN LIVING WITH VIOLENCE

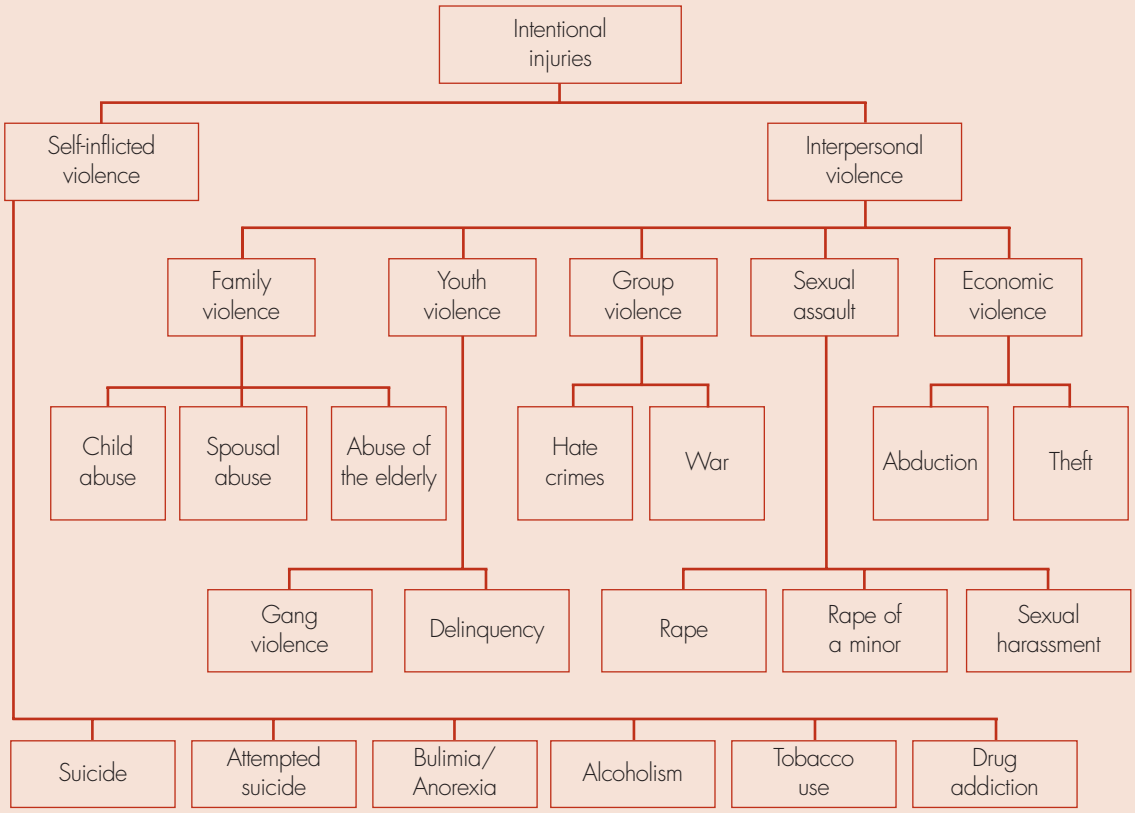


From data presented in the final report of the critical path study in El Salvador. (From Shrader & Sagot, 2000.[4])

transferability, dependability, and confirmability. The naturalistic research tradition does not assume that there is a single truth that may be revealed by inquiry. Instead it affirms that many truths may exist at the same time, and these may be discovered by research, and at the same time modified by the research endeavor itself. Different standards are therefore needed to assess the rigor of qualitative research. Table 13.2 presents a comparison of how different aspects of rigor are addressed in the different traditions.

Lincoln and Guba also propose alternative criteria and techniques for establishing trustworthiness within a naturalistic

FIGURE 13.4 SAMPLE TAXONOMY: PUBLIC HEALTH PERSPECTIVES TOWARD VIOLENCE



This taxonomy was adapted from a typology used by Rosenberg et al. of the United States Centers for Disease Control and Prevention (CDC), Center for Injury Prevention and Control, Atlanta, Georgia. (Cited in Shrader and Sagot, 2000.[4])

framework. In place of validity, credibility is suggested as a criterion for determining the truth value of a qualitative study. According to Sandelowski,

A qualitative study is credible when it presents such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognize it from those descriptions or interpretations as their own. A study is also credible when other people (other researchers or readers) can recognize the experience when confronted with it after having only read about it in a study.[8]

There are a variety of techniques that may enhance credibility of a study. For example:

Prolonged engagement in the field. The researcher should be involved in a community or study site long enough to be thoroughly oriented to the cultural and historical context, and to be able to detect and take into account possible distortions due to misinformation or his or her own subjective responses to the data.

Triangulation. The use of multiple sources, methods, and investigators to explore the same topic can increase credibility. For example, if the goal of a study is to assess the quality of care given to survivors of abuse in a community clinic, it might be useful to compare the views of health care providers with women who have used the services. The use of multiple sources might reveal important differences, not only as to the overall level of client satisfaction, but also in the way that clients and providers define quality of care. A mix of methods, for example, combining an

TABLE 13.2 CRITERIA ASSESSING THE TRUSTWORTHINESS OF RESEARCH FINDINGS ACCORDING TO QUANTITATIVE AND QUALITATIVE RESEARCH TRADITIONS

Aspect	*Qualitative criteria*	*Quantitative criteria*	*Question asked*
Truth value	Credibility	Internal validity	Have we really measured what we set out to measure?
Applicability	Transferability	External validity	How applicable are our results to other subjects and other contexts?
Consistency	Dependability	Reliability	Would our findings be repeated if our research were replicated in the same context with the same subjects?
Neutrality	Confirmability	Objectivity	To what extent are our findings affected by personal interests and biases?

(From Dalgren, et al, 2003.[7])

exit survey of clients with in-depth interviews, focus groups, or reviews of medical charts, might provide additional insight. Having two different researchers code interview transcripts and compare results afterwards is another form of triangulation that may increase the credibility of the findings.

Negative case analysis. This refers to seeking cases actively that appear to be exceptions to the general pattern, as a way of testing and refining hypotheses. The method relies on the analysis of "outliers" to improve the credibility of the findings.

Member checking. Member checking refers to the process by which data, conclusions, and interpretations are presented to members of the groups from which the data were collected. It is a powerful technique for establishing credibility. Member checking may be performed throughout the research process, through both formal and informal sessions. It allows stakeholders the opportunity to react to the data and to correct errors in the collection and interpretation of data. Most importantly, it helps to establish the meaningfulness of the findings and interpretations. In a review of Central American health programs addressing gender-based violence, the preliminary results were presented to representatives from the different countries that participated in the original focus group discussions. The purpose of the session was to correct factual errors, as well as to hear reactions to the overall conclusions of the study. Not only did the discussion strengthen the interpretation of the findings, but it also created ownership of the findings among the participants. The study results were disseminated and discussed widely among the programs, and many of the recommendations were implemented.

Qualitative research refers to the transferability of findings instead of external validity or generalizability. In survey research, the ability to generalize findings to a broader population depends largely on how representative the sample is with regard to demographic characteristics and other key variables. Since qualitative research relies on purposive rather than random sampling, there is no expectation that findings from one small group of study participants can be statistically representative of a larger population. Theory generated from qualitative research may well be generalizable to a broader population. As Dahlgren and colleagues argue, qualitative researchers aim for analytical generalizations, taking into account that,

Each subject has been selected to contribute to the theory that is being developed, and the knowledge gained from this theory should fit all scenarios that may be identified in a larger population. Hence the theory is applicable also beyond the study sample to all similar situations, questions and problems, regardless of demographic characteristics. In this way, qualitative researchers are

no less able to generalize beyond their sample than are epidemiologists. [7]

In quantitative research, consistency or reliability of results is a key aspect of trustworthiness. If another researcher conducted the same study using the same or similar methods on the same or similar population, would the same results be obtained? Reliability is enhanced in quantitative research by such measures as accurate instruments and equipment, well-trained fieldworkers, and uniform data collection procedures. In contrast, qualitative research is based on the premise that researchers and study participants are intimately related, and their interaction inevitably shapes the research process. Therefore, there is no pretense that the same results could be achieved with different researchers and participants.

Accordingly, qualitative research is assessed by its dependability, or the degree to which the researcher can describe and account for the way data were collected, interpreted, and how changing conditions were addressed throughout the process. The research process may be documented by means of an **audit trail**, including field notes, raw data (such as transcripts and diagrams) and process notes (procedures, designs, and strategies.) An audit trail should allow another to follow the "decision trail" used by the researcher.[6]

Finally, quantitative and qualitative traditions diverge on the issue of neutrality. Quantitative researchers aspire to maintain an objective attitude during the research process, and to avoid letting their feelings or subjective views influence the data collection or statistical analysis. Qualitative researchers argue that subjectivity is unavoidable, and that the interaction between participants and researchers actually enriches qualitative research. The neutrality of the data rather than that of the researcher is sought, using the criteria of confirmability. Audit trails also help establish confirmability. If the research can be confirmed the auditor should be able to find conclusions grounded in the data.[6]

1. Miles M, Huberman AM. *Qualitative Data Analysis: An Expanded Sourcebook.* 2nd ed. Thousand Oaks, California: Sage Publications; 1994.
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8. Sandelowski M. The problem of rigor in qualitative research. *Advances in Nursing Science.* 1986;8(3):27-37.

14

PHOTO BY HAFM JANSEN

From Research to Action

Topics covered in this chapter:

Outreach to key constituencies
Matching your message to your audience
Sharing findings with the community
Reaching beyond your borders

Research is a means to an end. A researcher's task is only complete once the findings from a research project are put into the hands of the individuals and organizations positioned to use them. For violence research, this generally includes policy makers, legislators, advocacy groups, the academic community, service providers, and the respondents themselves.

This chapter briefly highlights some creative ways that different research teams have approached these challenges.

OUTREACH TO KEY CONSTITUENCIES

Research can either be a positive force for change or it can sit on a shelf, advancing only the career paths of individual investigators. The field of international violence research is filled with examples of both.

In the past, it was not uncommon for women's groups and others working on violence to be totally unaware that research on violence had been conducted in their country, often by foreign investigators or university-based researchers who presented their results only at international conferences or in academic journals.

Fortunately this approach is being supplanted by a new ethic of research in which researchers and advocates join forces to ensure that research findings are used for social change. This section includes several examples of how different research teams have used their findings strategically to change laws, influence policy, design service programs, and place the issue of violence against women on the public agenda.

The first step is to make a list of different constituent groups and individuals that should be made aware of the research findings. The study's advisory group will be particularly helpful in this regard. Next strategize about the different means and venues available for reaching these

Example of a Stakeholder List

- *Ministry of Health*
- *Office of Women's Affairs*
- *Members of Parliament, especially Women's Commissions*
- *Local women's groups/networks*
- *Local rape crisis center*
- *Local journalists*
- *School of Public Health*
- *Department of Justice*
- *Local radio—call-in show*
- *School of Social Work*
- *Catholic diocese*
- *Municipal authorities*

audiences. Also recognize that the type of message and style of presentation that will be persuasive to different audiences will likely vary. (See Matching Your Message to Your Audience, below.)

Let's Create Love and Peace in Intimate Relationships: National dissemination of research findings in Thailand

It may be possible to reach a number of target groups at once by holding a stakeholder meeting or a symposium at which the results are presented and discussed. Members of the Thai research team of the WHO multi-country study, for example, worked with the Task Force to End Violence Against Women and the Coalition for Women's Advancement to organize a month-long program of activities on violence against women in Thailand. The month was kicked off with a press conference to present the Thai findings from the WHO multi-country study and to highlight current activities of organizations working to eliminate violence and gender discrimination in Thailand.

FIGURE 14.1 *LET'S CREATE LOVE AND PEACE IN INTIMATE RELATIONSHIPS* WAS THE MESSAGE TIED TO THE DISSEMINATION OF STUDY RESULTS IN THAILAND

To unify the campaign and project a positive image, the researchers developed an eye-catching logo and printed 20,000 stickers with the slogan "Let's create love and peace in intimate relationships." In addition, the team distributed over 2,000 fact sheets and posters about violence against women (see Figure 14.1). The key activity of the month was a two-day national seminar, held at the National Women's Council in Bangkok, and attended by more than 400 people. On the first day, the research team made an official presentation of the research and its findings. On the second day, six women with direct experiences of violence shared their own stories of pain and survival followed by presentations by other researchers and well-known experts in the field. Outside the seminar room, various concerned organizations set up exhibit booths to advertise their organizations and services.

The research team evaluated the impact of the activities throughout the ensuing months, including tracking coverage of the findings in the media. Overall, the research findings were presented at events in more than 20 provinces. Significantly, findings on the prevalence of forced sex in marriage also proved critical to a legislative campaign to amend Article 276 of Thailand's criminal code that gave immunity to men who rape their wives.

Silence for the Sake of Harmony: Engaging local leaders in the dissemination of results in Indonesia

The SEHATI Research Project, a partnership between Gadjah Mada University and Rifka Annisa Women's Crisis Center (both in Indonesia), Umeå University in Sweden, and PATH, carried out a prevalence study in Central Java that showed that one in ten women had been physically abused by an intimate partner. To reach a wider audience, researchers asked the Queen of the Province of Yogyakarta in Central Java to host the launch of their report. The launch was attended by local authorities, media,

FIGURE 14.2 STUDY REPORT FROM CENTRAL JAVA, WHICH INCLUDED PREFACES FROM THE QUEEN OF THE PROVINCE OF YOGYAKARTA, THE INDONESIAN MINISTER OF HEALTH, AND THE MINISTER OF WOMEN'S EMPOWERMENT

(From Hakimi et al, 2002.[1])

and religious and community leaders. The Queen also wrote a preface to the violence report, lending legitimacy to this once taboo area of research. A similar session was held in Jakarta, the capital of Indonesia, hosted by the Minister of Health and the Minister of Women's Empowerment, both of whom also wrote prefaces for the report (Figure 14.2).

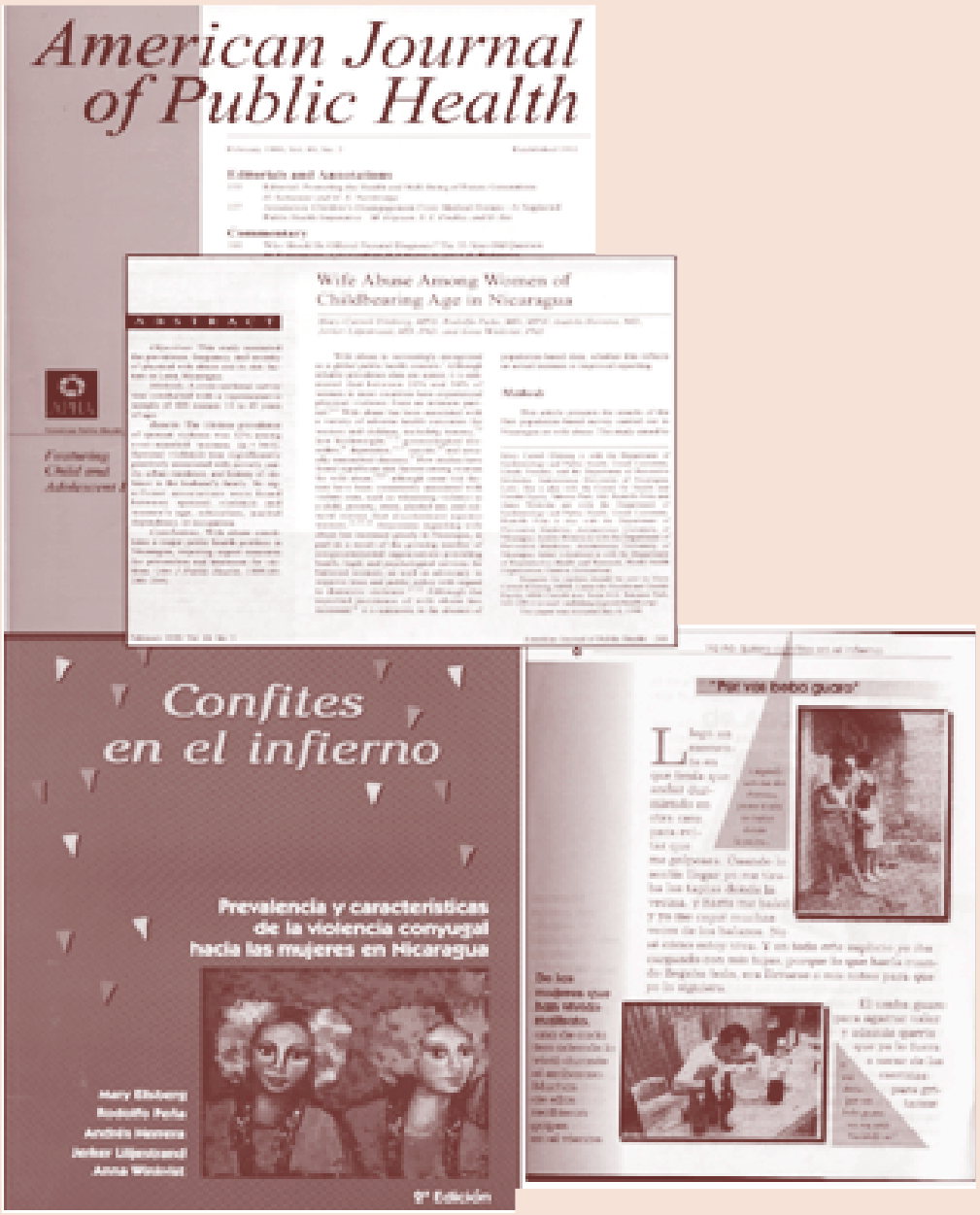
MATCHING YOUR MESSAGE TO YOUR AUDIENCE

A key to achieving impact is to tailor your message to the various audiences that you seek to influence. The language, style, and message that may be persuasive to one group may be wholly unconvincing—or unintelligible—to another. The way the data are presented also should vary. For technical, academic, or policy audiences, it is important to follow scientific convention and to include all required background information so that others can evaluate the findings, such as sample size, measures of significance, and margins of error. For other audiences, this information is merely confusing and detracts from the message.

Candies in Hell: Using research for social change in Nicaragua

A good example of how the same information can be adapted to different audiences comes from the Nicaraguan Network of Women Against Violence. The Network collaborated with researchers from the University of Nicaragua in León and Sweden's Umeå University to conduct in-depth interviews of battered women and a household survey on the rate of domestic violence among women in León. The basic

FIGURE 14.3 PRESENTING RESEARCH RESULTS IN DIFFERENT WAYS FOR DIVERSE AUDIENCES IN NICARAGUA



(From Ellsberg et al, 1997[2] and Ellsberg et al, 1999.[3])

finding of the study—that 52 percent of ever-married women ages 15-49 have been hit, slapped, or beaten by a partner—was presented in a variety of ways to make different points to different audiences.

The results were presented in a publication using graphs and charts to appeal to the professional and scientific communities. To influence health policy and the behavior of health workers, researchers and the Network cosponsored a symposium at the medical school in León, where the results were presented to local providers, health-related NGOs, and ministry staff. The same presentations were later repeated for a national audience at the public health

school in Managua. Here, the emphasis was on the health consequences of abuse and the potential role of health workers in responding to the problem.

These meetings helped launch several initiatives, including the production of a specialized manual for health workers on responding to abuse and the development of educational material on violence for incorporation into medical school and nursing curricula.

To reach community members, especially women, the Network published the findings in the form of a popular booklet entitled *Ya No Quiero Confites en el Infierno* (I No Longer Want Candies in Hell). The booklet told the story of Ana Cristina, one of the informants in the study, and the booklet's margins included easy-to-understand statistics drawn from the survey. The booklet included basic information about where women could get help as well as questions to guide group discussions (see Figure 14.3).

The prevalence data were also mentioned in a pocket-sized card urging battered women to get help, under the title "You are not alone: recent studies have shown that one out of every two women has been beaten by her husband, and one out of every four is beaten each year."

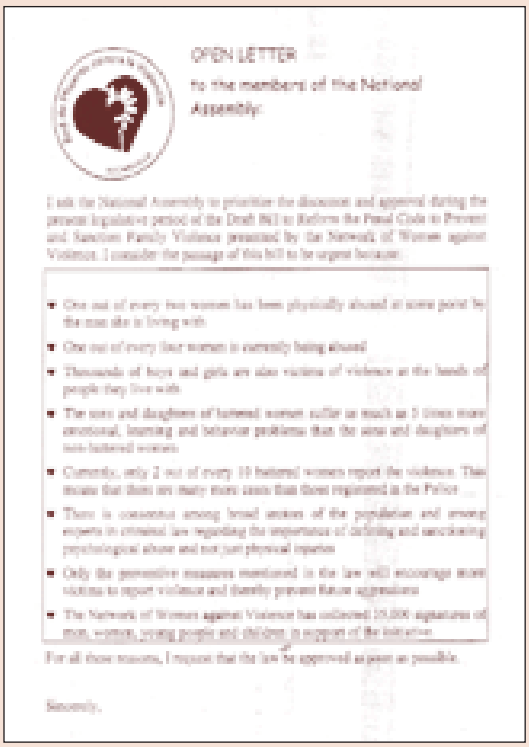
Several activities were also undertaken to reach legislators and to use the results of the study to push for new domestic violence legislation. The results were included in the Preamble of the Draft Penal Code Reforms for the Prevention and Sanction of Family Violence, which was drafted and presented to the National Assembly by the National Network of Women Against Violence. But more significantly, the findings were translated into simple language and incorporated into a national petition campaign asking legislators to approve the domestic violence bill pending before the National Assembly. Network members held "petition-signing parties" and reproduced the petition as a full-page, tear-out ad in the national newspaper. In a few months, more than 16,000 signatures were obtained and presented in great packages to parliamentarians. They were so overwhelmed by the public pressure, especially since it was an election year, that they voted unanimously to pass the law (Figure 14.4).

SHARING FINDINGS WITH THE COMMUNITY

One step often overlooked in research is the process of communicating findings back to the community. Traditionally research has been an "extractive" process whereby results and insights derived from the research seldom make their way back to the original respondents. In recent years, there has been a move toward "giving something back" to the community in addition to sharing the results of research with policy makers, opinion leaders, and front-line providers. As the quote from the respondent in Papua New Guinea makes clear, community members appreciate the opportunity to see what comes of the time they invest with researchers.

"I would like to ask if you find something to help us or to help us know more, can you please come again? Do not take our stories without coming back and telling us what you have learned."
Woman from Papua New Guinea

FIGURE 14.4 PETITION TO THE MEMBERS OF THE NATIONAL ASSEMBLY, CITING THE LEÓN RESEARCH AND ASKING FOR A NEW DOMESTIC VIOLENCE LAW TO BE PASSED



OPEN LETTER

to the members of the National Assembly

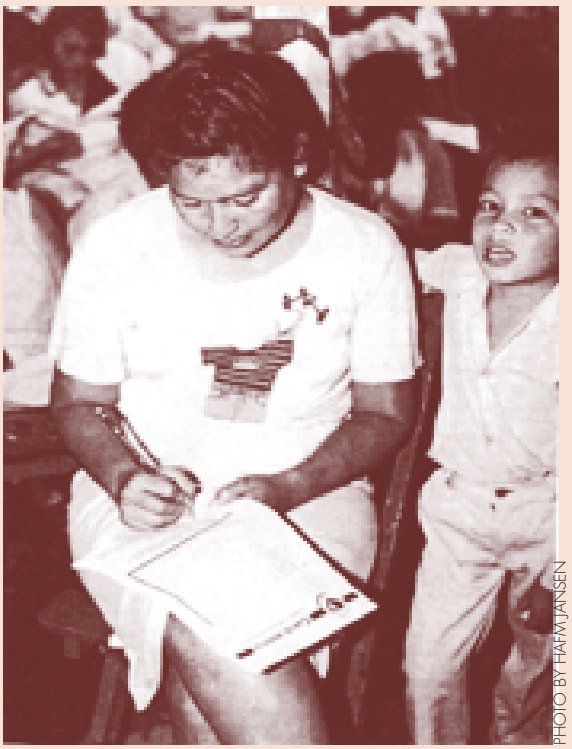


PHOTO BY HAFMJANSEN

These letters were distributed in community meetings, parties, and through the newspapers. The National Network of Women Against Violence collected more than 16,000 signatures in the space of a few weeks.

(From Ellsberg et al, 1997.[2])

Sometimes this process of sharing can take the form of directly communicating the findings back to the community via workshops or focus groups. Sharing preliminary results with community members can be an excellent way to test the validity of findings—do they ring true to those who participated in the research? Respondents may also be able to offer insights that are helpful in interpreting surprising or unexpected findings.

Community Theater: Disseminating research findings in Liberia, Uganda, and Kenya

Investigators have also used a variety of innovative techniques to communicate the essence of research findings back to low-literacy populations. In Liberia, for example, researchers studying sexual coercion during war translated their findings into drama vignettes to communicate their results back to rural women. Based on survey findings, the researchers derived a profile that represented the average experiences of the women surveyed. Local health promoters then worked with researchers to develop a storyline that reflected the experiences of the majority of women in the survey. The health promoters acted out the experiences that women discussed in the survey and then the community discussed the "results."[4] Similar techniques were used in Uganda by the organizations CEDOVIP and Raising Voices (See Figure 14.5).

In Kenya, theater was used to communicate findings of a study carried out by the Kenya Adolescent Reproductive Health

FIGURE 14.5 UGANDAN COMMUNITY THEATER GROUP PERFORMS A PLAY ON THE LINK BETWEEN HIV AND DOMESTIC VIOLENCE IN A KAMPALA MARKET

PHOTO BY M. ELLSBERG

Project (KARHP). The project was launched to bring reproductive health education and support to communities in Vihiga and Busia districts. Dozens of parents, teachers, religious and political leaders, health clinic staff, and hundreds of young people, chosen for their capacity to speak candidly to their peers, were recruited by KARHP to reach out with information on sexual violence, sexually transmitted diseases, and other reproductive health issues.

Like most development programs, KARHP used baseline and diagnostic studies to evaluate its effect on the communities it serves. But the question was how to communicate those findings to the relative stakeholders—people and organizations in a position to interpret, even improve on how such information relates to our work. Using a new dissemination methodology, KARHP found two innovative ways:

1. The project implementation team drafted a summary report containing key findings and presented them to stakeholders—many of whom did not speak English—in simple format and language.

2. The team then selected two local youth theatre groups—*Visions 3000* based in Kakamega and Mwangaza in Mambale

Dancers and drummers opening a street theater performance in Kampala, Uganda.

PHOTO BY M. ELLSBERG

PHOTO BY M. ELLSBERG

CEDOVIP activists carry out informal discussions with men under a mural painting on domestic violence in Kampala, Uganda.

District—and trained them to present key learnings in an entertaining and visually exciting manner. To prepare, the actors were provided with a presentation of the major findings, general information on adolescent reproductive health, and tips on communication skills. A theater consultant worked with both groups to develop "storylines" for skits that required audience participation.

Both the skits and the summary report were then presented in three locations in western Kenya to an audience that included government staff, religious leaders, village elders, local groups, and community members. Not only was the information shared with the community, but the researchers had an opportunity to vet their findings and ask the community if the skits represented their communities. These research dissemination sessions helped the community to articulate their situation and own the problems. Then, with everyone sharing a joint understanding of the situation, the community was actively engaged in designing interventions to respond to the challenges that young people face today.[5]

Reaching communities through traditional art: The Jijenge! mural campaign against violence in Tanzania[6, 7]

In a similar effort, staff members at Jijenge!, a women's health center in Mwanza, Tanzania, took great pains to convey back to the community the results of its needs assessment on domestic violence. (See Box 5.2 for a description of the participatory study.) This was done through a workshop with the community volunteers and a series of community street meetings. As part of its multifaceted media campaign against violence, Jijenge! also appropriated the folk-art tradition of mural painting as a means to communicate important messages about family violence and gender issues. A series of bright and colorful murals was designed and painted on small walls outside kiosks, shops, and buildings all over Mwanza municipality. The images and simple yet controversial messages were intended to stimulate dialogue. Two primary characters—a woman and man in their early to mid-30s—were created and used in most of the murals. These characters are shown in conversation with each other and the audience (Figure 14.6). One mural, for example, shows the woman with her arm around her husband and the husband confidently stating, "I don't beat my wife, we talk about our problems instead." A rights statement such as "Women have a right not to be beaten!" appears in each mural to relate practical life choices to the broader framework of women's rights. The murals address many issues concerning violence against women, including emotional well-being, solidarity among women, and causal factors of

FIGURE 14.6. MURALS PAINTED ON COMMUNITY WALLS IN TANZANIA AND UGANDA TO ENCOURAGE COMMUNITY DISCUSSION OF DOMESTIC VIOLENCE

violence such as inequality and economic dependence. Similar techniques are now used successfully by the Ugandan organizations CEDOVIP and Raising Voices, which grew out of the Jijenge! experience in Tanzania.

A disaster that men can prevent: A multimedia campaign targeting Nicaraguan men

In other cases, research is used explicitly as part of a communication for social change strategy. For example, findings from the study on men's violence in Nicaragua (see Box 5.6) were incorporated into a mass media campaign using television and radio commercials, bumper stickers, T-shirts, community workshops, and billboards. The messages targeted men, and referring to Hurricane Mitch that had recently devastated the region, suggested that "Violence against women is one disaster that we men can prevent" (Figure 14.7).

Matlakala's Story: Communication for social change in South Africa

Another example of how effective research can be in social change efforts is provided by Soul City in South Africa. The Soul City Institute for Health and Development Communication produces a prime time television drama, a radio drama in nine languages, and full-color information booklets to promote social change around a variety of health and social issues. Soul City's fourth series focused on gender-based violence, including domestic violence and sexual harassment. In order to develop the storyline about a woman named Matlakala, formative research was carried out with audience members and experts in the field of gender-based violence. The story also incorporated findings from a survey on violence recently carried out in three provinces by the South African Medical Research Council.[8] Partnerships were established between Soul City and organizations active in the field, such as the National Network on Violence Against Women, a coalition of 1,500 activists and communication organizations from rural and urban areas. These partnerships aimed to ensure that the messages developed conveyed appropriate and accurate information on

FIGURE 14.7 MEDIA CAMPAIGN FOR MEN CARRIED OUT BY PUNTOS DE ENCUENTRO FOUNDATION IN NICARAGUA BASED ON FINDINGS OF QUALITATIVE RESEARCH ON MALE VIOLENCE AGAINST WOMEN

women's rights, raising awareness of the topic and promoting changes in attitudes, social norms, and practices around gender-based violence to help connect audiences to needed services, including through a toll-free helpline; to promote individual and community action; to create an environment conducive to legislative change; and to develop training materials on gender-based violence for various audiences.

The Soul City series on violence then enlisted independent researchers to evaluate the program through three studies:

- A national survey carried out before the show started, and nine months later, that included face-to-face interviews with 2,000 respondents.
- A sentinel site study conducted several times in a rural and an urban site, with a cohort sample of 500 respondents at baseline, twice during the time that Soul City's fourth series was on the air, and post intervention.
- A national qualitative impact assessment composed of 31 focus group interviews and 30 semistructured interviews with community leaders.

The evaluation found an association between exposure to Soul City media and increases in knowledge and awareness of the population regarding domestic violence and domestic violence legislation. The results of the evaluation were presented in numerous documents and peer-reviewed journals, as well as on an easy-to-read fact sheet (Figure 14.8).[9-11] Even more importantly, the show and the research findings helped create a positive

FIGURE 14.8 COMMUNICATION MATERIALS IN ENGLISH AND ZULU AND AN EVALUATION FACT SHEET PRODUCED BY SOUL CITY IN SOUTH AFRICA

social environment for reforming domestic violence legislation.

Elsewhere, researchers have turned to the Internet to publicize findings of domestic violence research and seek input and feedback from a broader constituency. The Thai team of the WHO multi-country study posted the results of their survey on a local Thai-language web page that included a "bulletin board" where viewers could post their own comments and questions. The web page received thousands of hits and comments during its first month of operation.

The findings of the WHO study in Namibia were published in the popular women's magazine *Sister Namibia*.

REACHING BEYOND YOUR BORDERS

In addition to local outreach, it is also important to consider reaching audiences beyond local borders. Given the general lack of data available on violence against women, every research study is a potentially important addition to the global knowledge base.

Consider publishing your results in the academic literature, especially in a peer-reviewed journal indexed in one of the computerized services such as Index Medicus, Psych-Lit, or POPLINE. Then, individuals who search for articles on violence will be able to access your findings.

Additionally, the Center for Communication Programs at Johns Hopkins University in Baltimore, Maryland, and the United Nations Development Fund for Women (UNIFEM) have joined forces to produce a central depository for information on violence against women, including documents, journal articles, training materials, posters, and TV and radio programs. Materials forwarded to the Center will be entered into the Center's online service, known as POPLINE, and will be featured on the Center's End Violence Against Women web site (http://www.endvaw.org). Individuals can search for materials using key words, and copies will be sent to developing country practitioners free of charge.

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PHOTO BY HAFM JANSEN

The WHO Multi-country Study on Women's Health and Domestic Violence Against Women

World Health Organization

WHO VIOLENCE AGAINST WOMEN INSTRUMENT

This instrument consists of two sets of questions designed to capture information critical to assessing the prevalence, frequency and severity of different forms of violence against women, perpetrated both by intimate partners and others. The first set of questions focuses on violence by intimate partners only and should be used in its entirety to measure violence by intimate partners. The second set addressing violence by others, can be added onto the first set if violence against women is explored in a broader context.

Violence against women by intimate partners

The first set of questions focuses on violence perpetrated against women by their intimate partners (questions 703 to 706, 709, 801, 802, 904 and 905 in the core questionnaire). These questions on partner violence explore aspects of controlling behaviours, emotional abuse, physical violence, and sexual violence (703-706) as well as physical violence during pregnancy (709) by current or former intimate partners. This section also has questions for women who have suffered physical violence by an intimate partner, that assess the degree of injury (801 and 802). Finally there are two questions that explore whether the woman herself used violence against the most recent partner who used violence against her, and whether this aggression was offensive or in self-defence (904 and 905). The instrument does not aim to document every abusive action that a woman may experience, but rather aims to assess whether the respondent is likely to be experiencing 'severe' and/or 'moderate' levels of abuse in her relationship. The questions on injury contribute to providing a crude measure of the severity of the violence. They should not be interpreted as a measure of the health effects of violence as, in practice, the health effects of violence are far more wide-ranging than immediate injury. The questions about whether the respondent was ever physically violent herself toward her partner and whether this violence was offensive or in self-defence, provide information critical to interpreting the context of the violence.

Because of the complexity of defining and measuring emotional abuse in a way that is relevant and meaningful across cultures, the questions regarding emotional violence should be considered as a starting point, rather than a comprehensive measure of all forms of emotional abuse. Researchers are encouraged to add questions referring to

locally relevant forms of abuse. Because so little is presently known about measuring emotional violence across cultures, the WHO Multi-country study does not include emotional violence when reporting the prevalence of violence by intimate partners. Instead, the study reports lifetime and 12 month prevalence of physical, sexual, and physical or sexual violence by intimate partners.

In the WHO study, this section of the instrument is applied primarily to women who have had an intimate partner with whom they have co-habitated. In countries where it is common that women have intimate partnerships without co-habitating, the instrument can be used to capture "dating" violence with only minor accommodations in language.

Violence against women by others than intimate partners

The second part of the instrument includes a set of questions (questions 1001-1003 and 1201 in the core questionnaire) designed to address other types of violence that women have experienced outside of the context of an intimate partner relationship. Questions 1001-1003 enable the collection of minimal data on the prevalence of sexual abuse in childhood and on the prevalence of physical and sexual violence in adulthood by people other than intimate partners. These questions do not capture physical, emotional or other types of neglect or maltreatment in childhood. Question 1201 offers the respondent the opportunity to report childhood sexual abuse in a linked concealed way. This section of the instrument may be asked of all women, regardless of relationship status.

USE OF WHO STUDY PROTOCOL AND QUESTIONNAIRE

The WHO Study questionnaire, together with the protocol and other supporting materials such as the training manuals and data entry system, have been developed to permit the collection of standardised data, and thus facilitate cross-cultural comparisons. To this end, wide dissemination and utilisation of the questionnaire is encouraged. While recognising that some adaptation to local conditions may be necessary, these should be minimal, in order to ensure that as far as possible, comparability can be maintained. This is particularly the case for the questions that make up the Violence Against Women Instrument.

Those using the WHO Study protocol and/or questionnaire are requested to acknowledge the WHO source documents in all publications and/or documents that arise from study (as detailed below). In addition, WHO will make available to interested parties all manuals, accompanying documentation and data entry programs developed for use in the WHO Multi-country Study in exchange for a copy of the final, cleaned data set, for cross-national comparison.

Some researchers may wish to generate prevalence estimates comparable to the WHO Multi-country Study, but may not want to fully replicate the study. In order to ensure that the prevalence data obtained is comparable to the WHO study, investigators should, at a minimum, incorporate the **WHO Violence Against Women Instrument** (either the first section on partner violence alone, or also the questions on experiences of violence by others). Again, for comparison purposes, the sample should enable the disaggregation of data to obtain prevalence estimates for a representative sample of ever-partnered women 15-49.

In addition to the **WHO Violence Against Women Instrument**, researchers may choose to incorporate other questions and/or entire sections from the WHO core questionnaire. In such cases the researchers should acknowledge the WHO questionnaire in the following manner:

"This study adheres to the WHO

World Health Organization

WHO VIOLENCE AGAINST WOMEN INSTRUMENT

Incorporated in the Core Questionnaire Version 10
WHO Multi-country Study on Women's Health and Domestic Violence Against Women
20 September 2003

INDIVIDUAL CONSENT FORM

Hello, my name is *. I work for *. We are conducting a survey in STUDY LOCATION to learn about women's health and life experiences. You have been chosen by chance (as in a lottery / raffle) to participate in the study.

I want to assure you that all of your answers will be kept strictly secret. I will not keep a record of your name or address. You have the right to stop the interview at any time, or to skip any questions that you don't want to answer. There are no right or wrong answers. Some of the topics may be difficult to discuss, but many women have found it useful to have the opportunity to talk.

Your participation is completely voluntary but your experiences could be very helpful to other women in COUNTRY.

Do you have any questions?

(The interview takes approximately * minutes to complete). Do you agree to be interviewed?

NOTE WHETHER RESPONDENT AGREES TO INTERVIEW OR NOT

[ ] DOES NOT AGREE TO BE INTERVIEWED → THANK PARTICIPANT FOR HER TIME AND END

[ ] AGREES TO BE INTERVIEWED

↓

Is now a good time to talk?

It's very important that we talk in private. Is this a good place to hold the interview, or is there somewhere else that you would like to go?

TO BE COMPLETED BY INTERVIEWER

I certify that I have read the above consent procedure to the participant.

Signed: _____

ethical guidelines for the conduct of violence against women research and uses the WHO Violence Against Women Instrument as developed for use in the WHO Multi-country Study on Women's Health and Domestic Violence Against Women. Additionally it incorporates questions/sections from the WHO study questionnaire (describe which questions/section were used)."

For copies of the various documents mentioned above, as well as further information on the study and on arrangements to replicate the study can be obtained from Dr Claudia Garcia-Moreno, Study Coordinator (garciamorenoc@who.int) or from Dr Henriette Jansen, Epidemiologist to the Study (jansenh@who.int).

SECTION 7 RESPONDENT AND HER PARTNER

	EVER MARRIED / EVER LIVING WITH A MAN / *EVER SEXUAL PARTNER* [ ] ↓	NEVER MARRIED / NEVER LIVED WITH A MAN / *NEVER SEXUAL PARTNER* [ ] →	→ S.10

When two people marry or live together, they usually share both good and bad moments. I would now like to ask you some questions about your current and past relationships and how your husband / partner treats (treated) you. If anyone interrupts us I will change the topic of conversation. I would again like to assure you that your answers will be kept secret, and that you do not have to answer any questions that you do not want to. May I continue?

703 I am now going to ask you about some situations that are true for many women. Thinking about your (current or most recent) husband / partner, would you say it is generally true that he:

		YES	NO	DK
a) Tries to keep you from seeing your friends?	a) SEEING FRIENDS	1	2	8
b) Tries to restrict contact with your family of birth?	b) CONTACT FAMILY	1	2	8
c) Insists on knowing where you are at all times?	c) WANTS TO KNOW	1	2	8
d) Ignores you and treats you indifferently?	d) IGNORES YOU	1	2	8
e) Gets angry if you speak with another man?	e) GETS ANGRY	1	2	8
f) Is often suspicious that you are unfaithful?	f) SUSPICIOUS	1	2	8
g) Expects you to ask his permission before seeking health care for yourself?	g) HEALTH CENTRE	1	2	8

704 The next questions are about things that happen to many women, and that your current partner, or any other partner may have done to you.

Has your current husband / partner, or any other partner ever….

	A) (**If YES continue with B. If NO skip to next item**)		B) Has this happened in the past 12 months? (**If YES ask C only. If NO ask D only**)		C) In the past 12 months would you say that this has happened once, a few times or many times? (**after answering C, go to next item**)			D) Before the past 12 months would you say that this has happened once, a few times or many times?		
	YES	NO	YES	NO	One	Few	Many	One	Few	Many
a) Insulted you or made you feel bad about yourself?	1	2	1	2	1	2	3	1	2	3
b) Belittled or humiliated you in front of other people?	1	2	1	2	1	2	3	1	2	3
c) Done things to scare or intimidate you on purpose (e.g. by the way he looked at you, by yelling and smashing things)?	1	2	1	2	1	2	3	1	2	3
d) Threatened to hurt you or someone you care about?	1	2	1	2	1	2	3	1	2	3

705	Has he or any other partner ever….	A) (**If YES continue with B. If NO skip to next item**) YES NO	B) Has this happened in the past 12 months? (**If YES ask C only. If NO ask D only**) YES NO	C) In the past 12 months would you say that this has happened once, a few times or many times? (**after answering C, go to next item**) One Few Many	D) Before the past 12 months would you say that this has happened once, a few times or many times? One Few Many
	a) Slapped you or thrown something at you that could hurt you?	1 2	1 2	1 2 3	1 2 3
	b) Pushed you or shoved you or pulled your hair?	1 2	1 2	1 2 3	1 2 3
	c) Hit you with his fist or with something else that could hurt you?	1 2	1 2	1 2 3	1 2 3
	d) Kicked you, dragged you or beat you up?	1 2	1 2	1 2 3	1 2 3
	e) Choked or burnt you on purpose?	1 2	1 2	1 2 3	1 2 3
	f) Threatened to use or actually used a gun, knife or other weapon against you?	1 2	1 2	1 2 3	1 2 3

706		A) (**If YES continue with B. If NO skip to next item**) YES NO	B) Has this happened in the past 12 months? (**If YES ask C only. If NO ask D only**) YES NO	C) In the past 12 months would you say that this has happened once, a few times or many times? (**after answering C, go to next item**) One Few Many	D) Before the past 12 months would you say that this has happened once, a few times or many times? One Few Many
	a) Did your current husband/partner or any other partner ever physically force you to have sexual intercourse when you did not want to?	1 2	1 2	1 2 3	1 2 3
	b) Did you ever have sexual intercourse you did not want to because you were afraid of what your partner or any other partner might do?	1 2	1 2	1 2 3	1 2 3
	c) Did your partner or any other partner ever forced you to do something sexual that you found degrading or humiliating?	1 2	1 2	1 2 3	1 2 3

707	VERIFY WHETHER ANSWERED YES TO ANY QUESTION ON PHYSICAL VIOLENCE, **SEE QUESTION 705**	YES, PHYSICAL VIOLENCE ..... 1 NO PHYSICAL VIOLENCE 2	
708	VERIFY WHETHER ANSWERED YES TO ANY QUESTION ON SEXUAL VIOLENCE, **SEE QUESTION 706**	YES, SEXUAL VIOLENCE ..... 1 NO SEXUAL VIOLENCE 2	

	EVER BEEN PREGNANT [ ] ↓ **NUMBER OF PREGNANCIES** [ ][ ]	**NEVER PREGNANT** [ ] →	→ **S. 8**

709	You said that you have been pregnant TOTAL times. Was there ever a time when you were slapped, hit or beaten by (any of) your partner(s) whilst you were pregnant?	YES ..... 1 NO ..... 2 DON'T KNOW/DON'T REMEMBER ..... 8 REFUSED/NO ANSWER 9	

SECTION 8 INJURIES

	WOMAN EXPERIENCED PHYSICAL OR SEXUAL VIOLENCE [ ] ↓	WOMAN HAS NOT EXPERIENCED PHYSICAL OR SEXUAL VIOLENCE [ ] →	→ S.10

I would now like to learn more about the injuries that you experienced from (any of) your partner's acts that we have talked about (MAY NEED TO REFER TO SPECIFIC ACTS RESPONDENT MENTIONED IN SECTION 7).
By injury, I mean any form of physical harm, including cuts, sprains, burns, broken bones or broken teeth, or other things like this.

801	Have you ever been injured as a result of these acts by (any of) your husband / partner(s). Please think of the acts that we talked about before.	YES ..... 1 → NO ..... 2 DON'T KNOW / DON'T REMEMBER ..... 8 REFUSED / NO ANSWER 9	S.9
802 a)	In your life, how many times were you injured by (any of) your husband/partner(s)? Would you say once or twice, several times or many times?	ONCE/TWICE ..... 1 SEVERAL (3-5) TIMES ..... 2 MANY (MORE THAN 5) TIMES ..... 3 DON'T KNOW / DON'T REMEMBER ..... 8 REFUSED / NO ANSWER 9	
802 b)	Has this happened in the past 12 months?	YES ..... 1 NO ..... 2 DON'T KNOW / DON'T REMEMBER ..... 8 REFUSED / NO ANSWER 9	

SECTION 9 IMPACT AND COPING

I would now like to ask you some questions about what effects your husband /partner's acts has had on you . With acts I mean… (REFER TO SPECIFIC ACTS THE RESPONDENT HAS MENTIONED IN SECTION 7).

IF REPORTED MORE THAN ONE PARTNER VIOLENCE, ADD: I would like you to answer these questions in relation to the most recent / last partner who was physically or sexually violent toward you..

	WOMAN EXPERIENCED PHYSICAL VIOLENCE [ ] ↓	WOMAN HAS EXPERIENCED SEXUAL VIOLENCE ONLY [ ] →	→ S.10

904	During the times that you were hit, did you ever fight back physically or to defend yourself? IF YES: How often? Would you say once or twice, several times or most of the time?	NEVER ..... 1 → ONCE OR TWICE ..... 2 SEVERAL TIMES ..... 3 MANY TIMES/MOST OF THE TIME ..... 4 DON'T KNOW / DON'T REMEMBER ..... 8 REFUSED / NO ANSWER 9	905
905	Have you ever hit or physically mistreated your husband/partner when he was not hitting or physically mistreating you? IF YES: How often? Would you say once or twice, several times or many times?	NEVER ..... 1 ONCE OR TWICE ..... 2 SEVERAL TIMES ..... 3 MANY TIMES ..... 4 DON'T KNOW / DON'T REMEMBER ..... 8 REFUSED / NO ANSWER 9	

SECTION 10 OTHER EXPERIENCES

In their lives, many women experience different forms of violence from relatives, other people that they know, and/or from strangers. If you don't mind, I would like to briefly ask you about some of these situations. Everything that you say will be kept private. May I continue?

1001 a)

Since the age of 15, has anyone (FOR WOMEN WITH CURRENT OR PAST PARTNER: other than your partner/husband) ever beaten or physically mistreated you in any way?

IF YES:
Who did this to you?

PROBE:
How about a relative?
How about someone at school or work?
How about a friend or neighbour?
A stranger or anyone else?

		b) ASK ONLY FOR THOSE MARKED. How many times did this happen? Once or twice, a few times, or many times		
		Once or twice	A few times	Many times
NO ONE ..... A	→ **1002**			
FATHER ..... B		1	2	3
STEP FATHER C		1	2	3
OTHER MALE FAMILY MEMBER ..... D		1	2	3
FEMALE FAMILY MEMBER: _____ E		1	2	3
TEACHER ..... F		1	2	3
POLICE/ SOLDIER ..... G		1	2	3
MALE FRIEND OF FAMILY ..... H		1	2	3
FEMALE FRIEND OF FAMILY I		1	2	3
BOYFRIEND ..... J		1	2	3
STRANGER ..... K		1	2	3
SOMEONE AT WORK L		1	2	3
PRIEST/RELIGIOUS LEADER ..... M		1	2	3
OTHER (specify): _____ X		1	2	3

1002 a)

Since the age of 15, has anyone (FOR WOMEN WITH CURRENT OR PAST PARTNER: other than your partner/husband) ever forced you to have sex or to perform a sexual act when you did not want to?

IF YES:
Who did this to you?

PROBE:
How about a relative?
How about someone at school or work?
How about a friend or neighbour?
A stranger or anyone else?

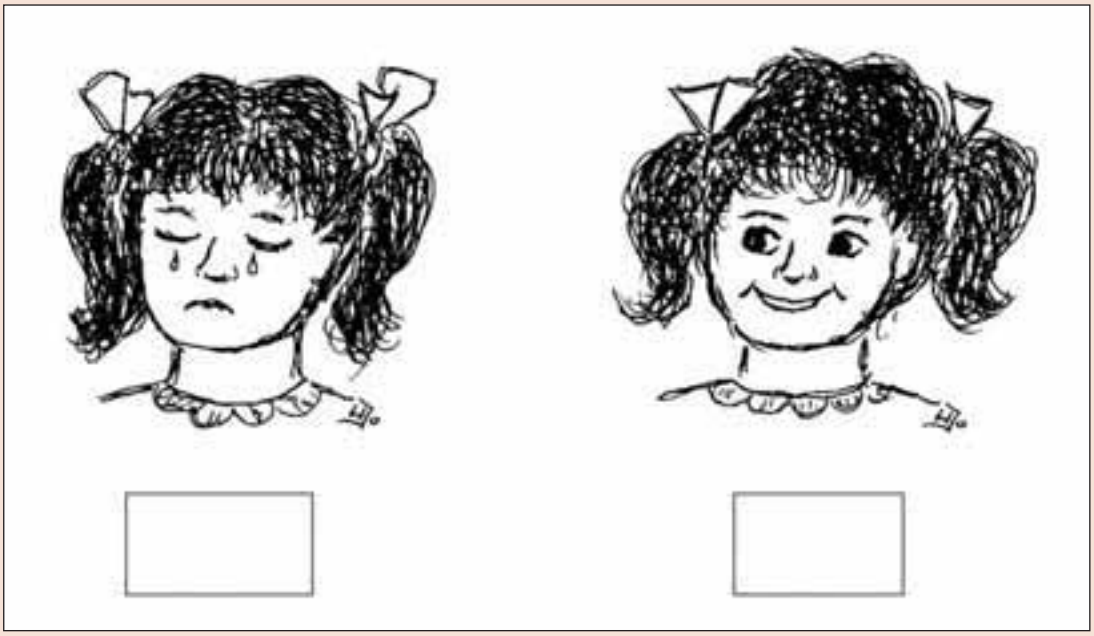
		b) ASK ONLY FOR THOSE MARKED. How many times did this happen? Once or twice, a few times, or many times		
		Once or twice	A few times	Many times
NO ONE ..... A	→ **1003**			
FATHER ..... B		1	2	3
STEP FATHER C		1	2	3
OTHER MALE FAMILY MEMBER ..... D		1	2	3
FEMALE FAMILY MEMBER: _____ E		1	2	3
TEACHER ..... F		1	2	3
POLICE/ SOLDIER ..... G		1	2	3
MALE FRIEND OF FAMILY ..... H		1	2	3
FEMALE FRIEND OF FAMILY I		1	2	3
BOYFRIEND ..... J		1	2	3
STRANGER ..... K		1	2	3
SOMEONE AT WORK L		1	2	3
PRIEST/RELIGIOUS LEADER ..... M		1	2	3
OTHER (specify): _____ . X		1	2	3

1003 a)								
	Before the age of 15, do you remember if any one in your family ever touched you sexually, or made you do something sexual that you didn't want to? IF YES: Who did this to you? IF YES OR NO CONTINUE: How about someone at school? How about a friend or neighbour? Has anyone else done this to you? IF YES: Who did this to you?	NO ONE ..... A → **1004**	ASK ONLY FOR THOSE MARKED IN 1003a					
			b) How old were you when it happened with this person for the first time? (more or less)	c) How old was this person? PROBE: roughly (more or less).	d) How many times did this happen?			
					Once/ twice	Few times	Many times	
		FATHER ..... B	[ ][ ]	[ ][ ]	1	2	3	
		STEP FATHER C	[ ][ ]	[ ][ ]	1	2	3	
		OTHER MALE FAMILY MEMBER / (BROTHER, ETC) _____ .... D	[ ][ ]	[ ][ ]	1	2	3	
		FEMALE FAMILY MEMBER: _____ E	[ ][ ]	[ ][ ]	1	2	3	
		TEACHER ..... F	[ ][ ]	[ ][ ]	1	2	3	
		POLICE/ SOLDIER ..... G	[ ][ ]	[ ][ ]	1	2	3	
		MALE FRIEND OF FAMILY ..... H	[ ][ ]	[ ][ ]	1	2	3	
		FEMALE FRIEND OF FAMILY I	[ ][ ]	[ ][ ]	1	2	3	
		BOYFRIEND ..... J	[ ][ ]	[ ][ ]	1	2	3	
		STRANGER ..... K	[ ][ ]	[ ][ ]	1	2	3	
		SOMEONE AT WORK L	[ ][ ]	[ ][ ]	1	2	3	
		PRIEST/RELIGIOUS LEADER ..... M	[ ][ ]	[ ][ ]	1	2	3	
		OTHER (specify): _____ ... X	[ ][ ]	[ ][ ] DK = 98	1	2	3	

SECTION 12 COMPLETION OF INTERVIEW

1201			
	I would now like to give you a card. On this card are two pictures. No other information is written on the card. The first picture is of a sad face, the second is of a happy face. No matter what you have already told me, I would like you to put a mark below the sad picture if, someone has ever touched you sexually, or made you do something sexual that you didn't want to, before you were 15 years old. Please put a mark below the happy face if this has never happened to you. Once you have marked the card, please fold it over and put it in this envelope. This will ensure that I do not know your answer. GIVE RESPONDENT CARD AND PEN. MAKE SURE THAT THE RESPONDENT FOLDS THE CARD; PUTS IT IN THE ENVELOPE; AND SEALS THE ENVELOPE BEFORE GIVING IT BACK TO YOU. ON LEAVING THE INTERVIEW SECURELY ATTACH THE ENVELOPE TO THE QUESTIONNAIRE (OR WRITE THE QUESTIONNAIRE CODE ON THE ENVELOPE).	CARD GIVEN FOR COMPLETION..... 1 CARD NOT GIVEN FOR COMPLETION..... 2	

SAMPLE OF CARD



Exercises for Sensitizing Interviewers on Violence

ACTIVITY 1: WHAT IS GENDER-BASED VIOLENCE? (30 MINUTES)

Goal: To encourage participants to think about different kinds of acts that can constitute violence, and to recognize that violence can be physical, verbal, emotional, sexual, and economic.

Step 1 Ask the participants to mention all the different kinds of violence that are common in their community and write up the answers on the flipchart or blackboard. An alternative is to hand out cards for participants to write down their answers and then stick them up on the wall.

Step 2 Ask the group "Are all these acts of violence the same?" "What kinds of differences are there between them?" "What kinds of violence are more likely to happen to women and girls than to men and boys?" What do you think are the effects on the health of women and girls of this kind of violence?" If cards are used, they can be grouped together, according to the types of violence (emotional, verbal, economic, sexual, or physical), or according to which types of violence are suffered primarily by women and girls, which are mostly experienced by men and boys, and which are suffered equally by men and women.

Step 3 Present overheads and distribute handouts on the definitions and characteristics of gender-based violence, wife abuse and sexual coercion.

ACTIVITY 2: MYTHS AND TRUTHS ABOUT VIOLENCE (30 MINUTES)

Goal: To challenge existing beliefs about violence and to identify areas of consensus and disagreement within the group.

Step 1 Place three signs up around the room with the words "I AGREE," "I DISAGREE," and "I DON'T KNOW."

Step 2 Read out loud the following statements and ask participants to move to the sign that represents their opinion about the statement. Ask a few participants on each side to explain their opinion. The facilitator may ask questions to stimulate discussion, but it is not necessary to provide "correct" answers, as these will be discussed in greater depth later on. On a flipchart the facilitator can write down the number of people agreeing and disagreeing with each statement.

- Men are violent by nature.
- Violence is usually due to alcohol.
- Sometimes violence is a way of showing affection.
- Boys who witness their father's violence towards their mothers are more likely to be violent when they grow up.
- A woman should put up with violence in order to keep her family together.
- Some women like to be beaten.
- Violence against women exists in every society in the world.
- Violence is never justified.
- Girls who are sexually abused in childhood are more likely to drink and use drugs when they are older.
- Nobody deserves to be beaten. Violence is always the responsibility of the person who uses it.

ACTIVITY 3: WHAT CAUSES VIOLENCE AGAINST WOMEN? (1 HOUR)

Goal: To identify the issues at the level of both an individual and society that perpetuate violence against women, and to examine the consequences of violence, not only for victims, but also for families and communities.

Step 1 Place a circle or square at the center of a blackboard or large sheet of paper, with the words "violence against women" in the middle. Ask participants to brainstorm possible causes of violence. These can be immediate causes (for example "alcohol" or "economic problems" or larger problems such as "cultural attitudes," "machismo," "unemployment," "educational system," etc. Either write the answers on the board or ask each participant to write the causes on cards and place them on the board with tape. All the problems considered as "causes of violence" should be placed on one side of the center circle, either above or to the side.

Step 2 For each problem identified, ask the group if it is related (either as a cause or a result) to any other problem already listed. If so, draw an arrow between the two boxes, indicating the direction(s) of the relationship.

Step 3 After completing this side of the web, ask the group to name important effects or consequences of violence. These can be any kind of problem, health, economic, or social — resulting from violence. It is a good idea to try to discuss effects on individual women first, and then on families, communities, and society as a whole next. Again, for each problem, ask the groups to examine possible relationships between different problems and to draw arrows between these issues, indicating the direction(s) of the relationship.

ACTIVITY 4: WHY DOESN'T SHE JUST LEAVE? (45 MINUTES)

Goal: To understand some of the reasons that women stay in abusive relationships and the barriers that they face in seeking help.

Step 1 Show the group a small bird cage and ask them to imagine that inside is a women living with violence. The bars on the cage represent the different barriers that women confront when trying to overcome abuse. Ask, "What are some of the different reasons that keep women in abusive relationships?" Write the different answers on the flipchart.

Step 2 Have participants read the story Candies in Hell in small groups of three to four and discuss the following questions:

- Is Ana Cristina's story familiar to you? Has something like this ever happened to any one you know?
- Why do you think that Ana Cristina stayed in the marriage after her husband began to beat her?
- What do you think about the reactions of Ana Cristina's family and the police?
- What do you think that the expression "Candies in Hell" means?"
- What advice would you give Ana Cristina if she were your friend?

Step 3 Have participants discuss in the larger group what they have learned and summarize their discussion. Present overheads on women's experiences of violence and the stages of violent relationships.

CANDIES IN HELL: THE STORY OF ANA CRISTINA

Ana Cristina was married at the age of 15 to a man in his late 30's. Her husband was a soldier and that quickly earned him the respect and approval of Ana Cristina's mother. Shortly after the marriage, he began to beat Ana Cristina savagely and continued to do so regularly throughout the subsequent five years. She learned to listen for him at night and be ready to escape with the children if necessary.

... I had to sleep in other people's houses to avoid getting beaten when he came home. I would have to climb over the back wall with my daughters when he arrived, and he would shoot at me. I escaped many times from his bullets. I don't know why I'm still alive…

…When I didn't want to have sex with my husband he simply took me by force... When he came home drunk he would beat me, and do what he wanted with me. Then I fought with him, but what could I do against a man who was stronger than me? I couldn't do anything, so I had to put up with it and suffer…

...He used to tell me, "You're an animal, an idiot, you are worthless." That made me feel even more stupid. I couldn't raise my head. I think I still have scars from this, and I have always been insecure ...I would think, could it be that I really am stupid? I accepted it, because after a point ... he had destroyed me by blows and psychologically... …When he beat me, my daughters would get involved in the fight. Then he would throw them around in his fury and this hurt me, it hurt me more than when he beat me…

…Once, when I was recovering, because he had beaten me and he had left my eyes swollen and black, my daughter came up to me and said, "Mommy, you look like a monster" and she began to cry… It hurt me so much. It wasn't so much the blows I had, but what really hurt me were her sobbing and the bitterness that she was feeling.

…He was so jealous, my grandmother used to say, "If you stay with him he's going to put blinders on you like the horses that pull carriages." I couldn't look at anyone on the street, nor have either men or women friends, nor greet anyone. And if a man looked at me, he would smack me right there on the street.

…My mother would say to me, "Do you think you're the only one to live through this?" She told me not to leave, and my mother-in-law also told me that I should put up with it, ..." You have to maintain your marriage, remember that you are his wife and he is the father of your children."

…Once I went to the police for help, but since he was in the military they let him go right away and gave him a ride back to my house. That time he kicked down my door…

… After that, I didn't know what to do. I felt trapped, a prisoner and I couldn't escape…

…After the blows he always came back to court me, bought me clothes and afterwards he always said, "forgive me, I won't do it

again," but then he always did the same afterwards. And then my grandmother would say to me "Child, what are you going to do with candies in hell?"

Alternative exercise:
After reading the story and discussing it in groups, ask participants to write a letter or a poem to Ana Cristina. This is a very good exercise for identifying stereotypical reactions on the part of participants and for encouraging empathy for survivors of violence. Following is a letter written to Ana Cristina by a field worker in Peru during her training:

Ana Cristina – you have the right to live with dignity and to be happy

Dear Ana Cristina,

My name is Rosalia Amada. I am a social worker. I am grateful for the chance to get to know you and accompany you on your journey to rebuild yourself. You are a very brave woman. I know it must have been difficult to share your story and remind yourself of old wounds that must still hurt so much.

You have taken the first step, by recognizing the violence against you. You are like so many women in Peru who decided to live. Ana Cristina, you are beautiful because you are freeing yourself daily from resignation, fear, and manipulation. No one has the right to destroy our dreams, don't ever forget that.

You are the star of your own journey to freedom.

Good luck!

Rosalia Amada

TRAINING PLAN FOR FIELD WORKERS FOR A POPULATION-BASED SURVEY

	Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*
1st week	Gender and violence exercises		Overview of study objectives and interviewing techniques/ safety measures	Question by question review of the instrument	
2nd week	Debriefing from interviews Practice in groups of three with case studies	Review of practice Practice with survivors	Practice household selection, first contact	Field practice	Debriefing
3rd week	Pilot testing	Pilot testing	Debriefing	Pilot again if necessary	Debrief again
			Start data entry with pilot data and debug data entry system Final questionnaire printed		
4th week	Field work begins		For data typists: Start data entry with survey data and debug and finalize data entry system; familiarize them with all data management procedures		

GBV Resources Section

The following resource materials have been compiled to facilitate access to information and organizations working on gender-based violence.

OVERVIEWS

Costs of Intimate Partner Violence at the Household and Community Levels: An Operational Framework for Developing Countries. **Duvvury N, Grown C, Redner J. Washington, DC, ICRW, 2004.**

This publication summarizes studies that have estimated economic costs of intimate partner violence against women and lays out a framework to measure the costs of intimate partner violence in developing countries, factoring in prevention, response, and opportunity costs. http://www.icrw.org/docs/2004_paper_costingviolence.pdf

Advancing the Federal Research Agenda on Violence Against Women. **National Research Council Steering Committee for the Workshop in Issues in Research on Violence Against Women. Committee on Law and Justice, Division of Behavioral and Social Sciences and Education. Washington, DC, The National Academies Press, 2004.**

This publication describes the efforts of the National Research Council since 1998 and provides detailed information about the interventions research launched in the past few years (virtually all in the United States). It also includes discussion of methodological issues, challenges, gaps, and findings.

The Economic Dimensions of Interpersonal Violence. **World Health Organization, 2004.**

This publication demonstrates that the consequences of interpersonal violence are extremely costly, prevention studies show evidence of cost effectiveness, and for most of the developing world and many developed countries, there is not even descriptive information about the direct costs of treating the consequences of interpersonal violence. http://www.who.int/violence_injury_prevention/publications/violence/economic_dimensions/en/

How to make the Law Work? Budgetary Implications of Domestic Violence Policies in Latin America. **ICRW, 2003.**

The document analyzes national domestic violence laws and policies in seven Latin American countries. One key finding of the report was that none of the countries in the study had passed laws with actual budgetary appropriations, which greatly limited the implementation of the programs and services. http://www.icrw.org

Intimate partner violence: causes and prevention. Jewkes R (2002). *The Lancet* 359:1423-1429.

This article presents a concise review of available research on risk factors for intimate partner violence and the implications of those findings for prevention.

***Domestic Violence against Women and Girls.* Innocenti Digest 6 United Nations Children's Fund (UNICEF), 2000.**

This study on domestic violence describes the powerlessness of women in situations of violence and notes that up to half of the world's female population may be victimized by those closest to them at some time in their lives.
http://www.unicef-icdc.org/publications/pdf/digest6e.pdf

Ending violence against women. Heise L, Ellsberg M, Gottemoeller M (1999). *Population Reports* 27(4).

This article describes an in-depth study by the Johns Hopkins School of Public Health and the Center for Health and Gender Equity. Based on over 50 population-based surveys and more than 500 studies of domestic violence, the report finds that by far the greatest risk of violence comes not from strangers, but from male family members, including husbands.
In English:
http://www.infoforhealth.org/pr/l11edsum.shtml
Download pdf: http://www.infoforhealth.org/pr/online.shtml#l
In Spanish:
http://www.infoforhealth.org/pr/prs/sl11edsum.shtml

***Bringing Rights to Bear: An Analysis of the Work of the UN Treaty Monitoring Bodies on Reproductive and Sexual Right.* Center for Reproductive Law and Policy, 2002.**

This report charts the collective work of six United Nations committees as they work to translate international human rights standards into state responsibility on a broad spectrum of reproductive rights issues, including violence against women.
http://www.reproductiverights.org/pub_bo_tmb.html.

***Gender-Based Violence: A Human Rights Issue.* [Mujer y Desarrollo Series #16.] Economic Comisión for Latin America and the Caribbean, 1996.**

The study explores the various forms of gender-based violence (GBV) and how growing awareness of the phenomenon in recent years has led to the establishment of new institutions and the adoption of legislative amendments, which in turn have served as a focal point for collective action by women.
http://www.eclac.cl/publicaciones/UnidadMujer/7/lcl957/lcl957i.pdf

FEMALE GENITAL MUTILATION (FGM)

***Abandoning Female Genital Mutilation/Cutting: Information From Around the World.* Population Reference Bureau, 2005.**

This CD-ROM contains an extensive compilation in English and French of articles and documents on FGM.
http://www.prb.org

***Female Genital Mutilation: The Prevention and the Management of the Health Complications. Policy Guidelines for Nurses and Midwives.* World Health Organization, 2001.**

The purpose of these policy guidelines is to promote and strengthen the case against the medicalization of FGM to support and protect nurses, midwives, and other health personnel in adhering

to WHO guidelines regarding the management of FGM related complications. http://www.who.int/entity/gender/other_health/en/guidelinesnursesmid.pdf

Female Genital Mutilation - A joint WHO/UNICEF/UNFPA statement. World Health Organization, 1997.

This joint statement by the World Health Organization, the United Nations Children's Fund, and the United Nations Population Fund confirms the universally unacceptable harm caused by female genital mutilation, or female circumcision, and issues an unqualified call for the elimination of this practice in all its forms. http://www.who.int/reproductive-health/publications/fgm/fgm_statement.html

GBV AND HEALTH

***WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Initial Results on Prevalence, Health Outcomes and Women's Responses.* WHO. Geneva, Switzerland, 2005.**

This report presents the results of a multi-country study of 10 countries and 16 sites—findings on prevalence, health outcomes, and women's responses to a variety of types of sexual and physical violence perpetrated by intimate partners as well as non-partners. http://www.who.int/gender/violence/en/

***Reproductive Health and Rights: Reaching the Hardly Reached.* PATH, 2002.**

This publication is a compendium of articles that highlight the negative impact that marginal status has on the health and well-being of vulnerable groups. Various aspects of gender-based violence are presented in several articles. http://www.path.org/publications/pub.php?id=503

Violence against women: effects on reproductive health. Shane B, Ellsberg M (2002). Outlook 20(1): 1-8.

This issue presents an overview of violence from a public health perspective. It provides examples from research and successful programs and explores how the health sector can take an active role in the prevention and treatment of violence against women. http://www.path.org/files/EOL20_1.pdf

***World Report on Violence and Health.* World Health Organization, 2002.**

This publication provides a comprehensive and global review of evidence related to violence. Most relevant are the chapter devoted to violence by intimate partners (Chapter 4) and the chapter devoted to sexual violence (Chapter 6). Both chapters include a review of evidence on interventions to prevent violence and care for survivors worldwide. http://www5.who.int/violence_injury_prevention/main.cfm?p=0000000682 www.who.int/violence_injury_prevention/violence/world_report/wrvh1/en/ In French and Spanish: www.who.int/violence_injury_prevention/violence/world_report/en/Summary_Spanish.pdf

***Symposium 2001 Final Report: Gender-Based Violence, Health, and Rights in the Americas.* Pan American Health Organization, 2001.**

This symposium brought together representatives from the ministries of health, women's nongovernmental organizations (NGOs), civil society, and U.N. agencies from 30 countries of the Latin American and Caribbean region as well as international donor agencies to identify priorities and formulate strategies for strengthening the response of the health sector to GBV. This report summarizes many of the key recommendations and lessons learned from those reports, and

provides an overview of organizations working to improve policies in the region.
http://www.paho.org/English/HDP/HDW/Symposium2001FinalReport.htm

Annotated Bibliography on Violence against Women: A Health and Human Rights Concern. **World Health Organization, 1999.**

This bibliography was commissioned by the Global Commission on Women's Health and prepared by Rights and Humanity in collaboration with the WHO Women's Health and Development Unit and the Global Commission on Women's Health.
http://www.who.int/gender/documents/Annotated%20Bibliography%20green%20A4.pdf

Gender and Public Health Series

This series published by PAHO contains the following GBV-related topics:
№1 *Battered Women: A Working Guide for Crisis Intervention,* 1999
№7 *Helping Ourselves to Help Others: Self-Care Guide for Those Who Work in the Field of Family Violence,* 1999.
http://www.paho.org/English/HDP/HDW/gphseries.htm

The Intimate Enemy: Gender Violence and Reproductive Health. **The Panos Institute, 1998.**

The report shows how local communities around the world are providing medical, legal, and counseling services for victims of gender violence and lobbying for changes in laws and customs to address the problem head-on.
http://www.panos.org.uk/PDF/reports/IntimateEnemy.pdf

GBV AND HIV

Dying of Sadness: Sexual Violence and the HIV Epidemic. **United Nations Development Program (UNDP), 2000.**

This preliminary overview of available literature suggests that, within the context of gender and the HIV epidemic, sexual violence is a complex phenomenon with multiple determinants, consequences, and manifestations.
http://www.undp.org/hiv/publications/gender/violencee.htm

The intersections of HIV and violence: Directions for future research and interventions. Maman S, Campbell J, Sweat MD, Gielen AC, (2000). ***Social Science and Medicine*** **50(4):459-478.**

This article provides a comprehensive overview of current research on gender-based violence and HIV/AIDS.

REFUGEES/CONFLICT

Interagency Manual on Reproductive Health in Refugee Situations: Sexual and Gender-Based Violence. **UNFPA, 2001.**

Chapter 4 of this publication focuses on sexual violence against women. Most reported cases of sexual violence among refugees involve female victims and male perpetrators. It is acknowledged that men and young boys may also be vulnerable to sexual violence.
http://www.unfpa.org/emergencies/manual/

Gender-based violence in refugee settings. Ward J, Vann B (2002). ***The Lancet*** **Supplement, Vol. 360: (Supplement 1) s13-s14.**

http://www.rhrc.org/pdf/lancet1.pdf

Gender-Based Violence: Emerging Issues in Programs Serving Displaced Populations. **Vann B. Arlington, VA, Reproductive Health Response in Conflict Consortium, 2002.**
http://www.rhrc.org/pdf/gbv_vann.pdf

If Not Now, When? Addressing Gender-Based Violence in Refugee, Internally Displaced and Post-Conflict Settings: A Global Overview. **Ward J. New York, Reproductive Health Response in Conflict Consortium, 2002.**
http://www.rhrc.org/resources/gbv/ifnotnow.html

Gender-based Violence Tools Manual for Assessment & Program Design, Monitoring and Evaluation in Conflict-affected Settings. **Reproductive Health Response in Conflict Consortium, 2004.**
http://www.rhrc.org/resources/gbv/gbv_tools/manual_toc.html

TRAFFICKING

WHO Ethical and Safety Recommendations for Interviewing Trafficked Women. **World Health Organization, 2003.**
http://www.who.int/gender/documents/en/final%20recommendations%2023%20oct.pdf

The health risks and consequences of trafficking in women and adolescents: Findings from a European study. **Zimmerman C, et al. London, London School of Hygiene & Tropical Medicine (LSHTM), 2003.**
http://www.lshtm.ac.uk/hpu/docs/traffickingfinal.pdf

RESEARCH METHODOLOGIES

The following texts provide excellent overviews on methods for both quantitative and qualitative research.

Quantitative

Basic Epidemiology. **Beaglhole R, et al. Geneva, WHO, 1993.**

Research Design: Qualitative and Quantitative Approaches. **Creswell J W. Thousand Oaks, CA, Sage Publications, 1994.**

Epidemiology for Public Health. **Persson L-A, Wall, S. Umeå, Sweden, Umeå International School of Public Health, 2003.**

Qualitative

Developing Focus Group Research: Politics, Theory and Practice. **Barbour R, Kitzinger J, eds. London, Sage Publications, 1995.**

Doing Qualitative Research. **Crabtree B, Miller W. Newbury Park, CA, Sage Publications, 1992.**

Qualitative Inquiry and Research Design: Choosing Among Five Traditions. **Creswell J W. Thousand Oaks, CA, Sage Publications, 1998.**

Qualitative Methodology for International Public Health. **Dahlgren L, et al. Umeå, Sweden, Umeå University, 2003.**

Qualitative Data Analysis: An Expanded Sourcebook. Second Edition. **Miles M, Huberman A M. Thousand Oaks, CA, Sage Publications, 1994.**

Qualitative Evaluation and Research Methods **2nd ed. Patton M. Newbury Park, CA, Sage Publications, 1990.**

Qualitative Methods: A Field Guide for Applied Research in Sexual and Reproductive Health. **Ulin P, et al. Research Triangle Park, NC, Family Health International, 2002.**

Embracing Participation in Development: Wisdom From the Field. Shah M K, Kambou S D, Monahan B, eds. Atlanta, CARE, 1999.
http://www.careinternational.org.uk/resource_centre/civilsociety/embracing_participation_in_development.pdf

ETHICS

Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence against Women. **World Health Organization, 1999.**
Research on violence against women raises important ethical and methodological challenges. Researching abuse is not like other areas of investigation—the nature of the topic means that issues of safety, confidentiality, and interviewer skills and training are even more important than in other forms of research.
http://www.who.int/gender/violence/womenfirtseng.pdf

Bearing witness: ethics in domestic violence research. Ellsberg M, Heise L (2002). ***The Lancet*** **359:1599-1604.**
http://www.thelancet.com/journals/lancet/article/PIIS0140673602085215/fulltext

CONVENTIONS/LAWS

1950 Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others
http://www.unhchr.ch/html/menu3/b/33.htm

1974 Declaration on the Protection of Women and Children in Emergency and Armed Conflict
http://heiwww.unige.ch/humanrts/instree/e3dpwcea.htm

1979 Convention on the Elimination of All Forms of Discrimination against Women http://www.un.org/womenwatch/daw/cedaw/

1989 Convention on the Rights of the Child
http://www.unicef.org/crc/crc.htm

1993 World Conference on Human Rights
http://www.unhchr.ch/html/menu5/wchr.htm

1993 Declaration on the Elimination of Violence against Women
http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/A.RES.48.104.En?Opendocument

1994 Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (Convention of Belém do Pará)
http://www.undp.org/rblac/gender/osavio.htm

1994 International Conference on Population and Development
http://www.un.org/popin/icpd2.htm

1995 Fourth World Conference on Women (Beijing) http://www.un.org/womenwatch/daw/beijing/platform/

2000 Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention against Transnational Organized Crime http://www.uncjin.org/Documents/Conventions/dcatoc/final_documents_2/convention_%20traff_eng.pdf

2000 United Nations' Security Council Resolution 1325 on Women, Peace, and Security http://www.un.org/events/res_1325e.pdf

INTERVENTIONS

Community-based

Addressing Gender-Based Violence in the Latin American and Caribbean Region: A Critical Review of Interventions. **Morrison A, Ellsberg M, Bott S. Washington, DC, World Bank. Policy Research Working Paper 3438, 2004.**

This paper examines good practice approaches to addressing gender-based violence in the Latin American and Caribbean regions justice, health, and education sectors, as well as multisectoral approaches. http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTGENDER/0,,contentMDK:20262193~pagePK:148956~piPK:216618~theSitePK:336868,00.html

Preventing and Responding to Gender-Based Violence in Middle and Low-income Countries: A Global Review and Analysis. **Bott S, Morrison A, Ellsberg M. Washington, DC, World Bank. Policy Research Working Paper 3618, 2004.**

This paper provides a global review of promising approaches to addressing gender-based violence in the justice, health, and education sectors, as well as multisectoral approaches. The paper reviews existing evidence on successful interventions and offers a framework for assessing good practices. http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTGENDER/0,,contentMDK:20262193~pagePK:148956~piPK:216618~theSitePK:336868,00.html

Not a Minute More: Ending Violence Against Women. **UNIFEM, 2003.**

In 1996, the UNIFEM Trust Fund began funding projects to address gender-based violence through advocacy, awareness raising, public education, legal advocacy, and youth projects. This publication describes these projects and documents their achievements, limitations, lessons leaned, and future challenges. They provide examples of good practices as well as of strategies that did not meet expectations. http://www.unifem.org/resources/item_detail.php?ProductID=7

With an End in Sight: Strategies from the UNIFEM Trust Fund to Eliminate Violence Against Women. **Spindel C, Levy E, Connor M. New York, UNIFEM, 2000.**

This publication documents seven important programs dedicated to ending violence against women in Bosnia and Herzegovina, Cambodia, Honduras, India, Kenya, Nigeria, and the West Bank and Gaza. http://www.unifem.org/index.php?f_page_pid=71

Mobilizing Communities to Prevent Domestic Violence: A Resource Guide for Organizations in East and Southern Africa. **Michau L, Naker D. Nairobi, Raising Voices, 2003.**

This document is a resource guide outlining a five-phase approach to producing social change within a community.

This project uses a variety of strategies, including gathering baseline information about local attitudes and beliefs, raising awareness about domestic violence among the whole community and among key selected groups, building networks, and transforming institutions.
http://www.raisingvoices.org/resourceguide.shtml

Beyond Victims and Villains: Addressing Sexual Violence in the Education Sector. **Panos Institute, 2003.**

This is an excellent and extensive review of the literature on sexual violence in educational settings, including interventions and strategies that have been used in developing countries to address all forms of sexual violence in schools and universities.
http://www.panos.org.uk/PDF/reports/Beyond%20Victims.pdf

Justice, Change, and Human Rights: International Research and Responses to Domestic Violence. **Center for Development and Population Activities, 2000.**

This paper employs both a human rights and a development framework to identify the limitations and strengths of each approach for understanding and responding to domestic violence, as well as to clarify the links that need to be made between the frameworks.
http://www.cedpa.org/publications/pdf/violenceprowid.pdf

La ruta crítica que siguen las mujeres afectadas por la violencia intrafamiliar. **Pan American Health Organization, 2000.**

Translated into English as: *Domestic Violence: Women's Way Out.*

This research protocol addresses violence against women and aims to improve the services available for women affected by it.
Spanish:
http://www.paho.org/Spanish/HDP/HDW/rutacritica.htm
English:
http://www.paho.org/English/HDP/HDW/womenswayout.htm

Communications

Picturing a Life Free of Violence: Media and Communication Strategies to End Violence against Women. **United Nations Development Fund for Women (UNIFEM), 2001.**

This report showcases a variety of media and communications strategies to be used to end violence against women. The report is a collaboration between UNIFEM and the Media Materials Clearinghouse of the Johns Hopkins University Center for Communications Programs.
http://www.unifem.org/resources/item_detail.php?ProductID=8

Making a Difference: Strategic Communications to End Violence Against Women. **United Nations Development Fund for Women (UNIFEM), 2003.**

"Making a Difference" is an indispensable tool for planning strategic communications to raise awareness about and combat gender-based violence.
http://www.unifem.org/resources/item_detail.php?ProductID=6

Communication/Behaviour Change Tools: Entertainment-Education. **UNFPA. Programme Briefs No. 1, 2002.**

This issue of Programme Briefs reviews the lessons learns from "entertainment-education" programs throughout the world, many of which address the issue of violence against women. The issue profiles programs such as Sexto Sentido in Nicaragua and Soul City in South

Africa, and provides a summary of the state of knowledge about these efforts. www.unfpa.org/upload/lib_pub_file/160_filename_bccprogbrief1.pdf

Health Sector Response

Addressing Gender Based Violence from the Reproductive Health/HIV Sector: A Literature Review and Analysis. **Guedes A. Washington, DC, Poptech, 2004.**

This is an extensive review of existing interventions to address gender-based violence in developing countries. The review is divided into six broad categories: 1) behavior change communication programs (2) community mobilization programs (3) service delivery programs (4) policy programs (5) youth programs and (6) programs working with refugees and displaced populations. The review includes a discussion of broad lessons learned as well as profiles of "promising" interventions in each area. The profiles include details about evaluation as well as program design. http://www.poptechproject.com/pdf/04_164_020.pdf

Improving the Health Sector Response to Gender-Based Violence: a Resource Manual for Health Care Managers in Developing Countries. **Bott S, Guedes A, Claramunt C, Guezmes A. New York, IPPF/WHR, 2004.**

IPPF/WHR coordinated a multi-site initiative to improve the health sector response to gender-based violence within four associations, Profamilia (Dominican Republic), INPPARES (Peru), and Plafam (Venezuela), with some participation from BEMFAM (Brazil). This publication is a compilation of all the lessons leaned, tools, and recommendations that emerged from that collective effort. It was published in English and Spanish, and although the lessons learned reflect the situation in selected sites in Latin America and the Caribbean, the publication is designed to address the specific needs of health care managers in any resource-poor setting, particularly those working in nongovernmental organizations. http://www.ippfwhr.org/publications/publication_detail_e.asp?PubID=63

A Practical Approach to Gender-Based Violence: A Program Guide for Health Care Providers and Managers. **United Nations Population Fund, 2001.**

This publication contains practical steps needed to integrate gender-based violence programming into reproductive health facilities. It is also meant to help a wider range of readers understand the interrelationships between reproductive and sexual health and violence. http://www.unfpa.org/publications/detail.cfm?ID=69&filterListType=3

Diagnostic and Treatment Guidelines on Family Violence. **American Medical Association, 1999.**

This publication presents separate modules establishing guidelines on the following seven aspects of violence: child physical abuse and neglect and child sexual abuse, domestic violence, elder abuse and neglect strategies for the treatment and prevention of sexual assault, mental health effects of family violence, physician guide to media violence, and a physician firearms safety guide. http://www.ama-assn.org/ama/pub/category/3548.html

National Consensus Guidelines: On Identifying and Responding to Domestic Violence Victimization. **Family Violence Prevention Fund, 1999.**

This is a multi-specialty, comprehensive routine screening document on domestic

violence. In addition to specific guidelines for primary care, obstetrics and gynecologic, family planning, urgent care, mental health, and in-patient settings, it includes an extensive bibliography, documentation forms, and other useful materials.
http://endabuse.org/programs/healthcare/files/Consensus.pdf

Promoting Early and Effective Intervention to Save Women's Lives. **Family Violence Prevention Fund, 1999.**
This kit contains a series of information packets for health care providers interested in developing a comprehensive health care response to domestic violence. Packets include: General Information on the Health Care Response to Domestic Violence, The Emergency Department Response to Domestic Violence, Screening Patients for Domestic Violence, Mandatory Reporting of Domestic Violence by Health Care Providers, and Violence against People with Disabilities.
http://endabuse.org/programs/display.php3?DocID=55

Building Data Systems for Monitoring and Responding to Violence against Women. **CDC, 1998.**
This report provides recommendations regarding public health surveillance and research on violence against women developed during a workshop held by CDC on 29–30 October 1998.
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4911a1.htm

Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers. **Family Violence Prevention Fund, 1996, revised 1998.**
This manual includes information to educate practitioners on screening, identification, assessment, and interventions with victims of domestic violence and their batterers. It offers practical tools including a model hospital intervention packet outlining effective protocols and sample forms for screening, domestic violence/abuse assessment, documentation, safety planning, and discharge. Finally, it provides ideas to help develop and implement response strategies and programs within a variety of health care practices and settings.
http://endabuse.org/programs/display.php3?DocID=238

Intimate Partner Violence and Sexual Assault: A Guide to Training Materials and Programs for Health Care Providers. **CDC, 1998.**
This guide was developed to help individuals and organizations find appropriate materials for group or self-training.
http://www.cdc.gov/ncipc/pub-res/ipvasa.htm

Intimate Partner Violence during Pregnancy: A Guide for Clinicians. **American College of Obstetricians and Gynecologists, 1998.**
This guide was designed as a training tool for clinicians to increase understanding of the role they can play in identifying, preventing, and reducing intimate partner violence. It includes a situation report and potential areas of action for clinical staff.
http://www.cdc.gov/reproductivehealth/violence/IntimatePartnerViolence/

Violence Against Women: The Health Sector Responds. **Velzeboer M, Ellsberg M, Clavel Arcas C, Garcia Moreno C, Washington, DC, Pan American Health Organization, PATH, 2003.**
This book describes PAHO's efforts to address gender-based violence (GBV) in seven countries of Central America. It

includes the results of a participatory review that identifies the lessons learned from activities conducted at the clinic level, the community, and the broader local and national policy arena.
http://www.paho.org/English/DPM/GPP/GH/VAWhealthsector.htm

***Compendium of Indicators for Evaluating Reproductive Health Programs.* Bertrand JT, Escudero G. MEASURE Evaluation Manual Series, No. 6. Washington DC, Measure Evaluation, 2002.**

This manual contains a concise subsection on methodological issues related to evaluating interventions that address violence against women, including those interventions carried out in developing countries. It is written from the perspective of the health sector and primarily from the perspective of local rather than national initiatives.
http://www.eldis.org/static/DOC13086.htm

Dilemmas and opportunities for an appropriate health-service response to violence against women. Garcia Moreno C, (2002). *The Lancet* 359:1509-1514.

This article reviews what is known about the evidence from developing countries on the effectiveness and limitations of programs that train providers to identify and care for women who have experienced intimate partner violence. The article raises significant concerns about introducing routine screening programs in organizations that have not succeeding in transforming the attitudes and beliefs of providers.
http://www.thelancet.com/journals/lancet/article/PIIS0140673602084179/fulltext

International conference on the role of health professionals in addressing violence against women, 15th October 2000, Naples, Italy, International Journal of Gynecology & Obstetrics Supplement. [Garcia-Moreno C, Benegiano G, Guerra R (2002).]

This journal issue contains a collection of papers from an international conference devoted to the role of health professionals in addressing violence against women. The collection includes descriptions of programs and evaluation data (when available) from developing countries such as Bangladesh, Brazil, China, Russia, South Africa and Thailand. In addition, it includes articles that present the ongoing efforts of international organizations.

OTHER RESOURCES

Material Collections

End Violence against Women, Johns Hopkins University, Center for Communications Programs

This site features an online collection of materials and resources on preventing violence against women. It is part of an ongoing effort to share information with health professionals who seek information and resources on this subject.
http://www.endvaw.org/

A Life Free of Violence: It's Our Right (United Nations Inter-Agency Campaign on Women's Human Rights in Latin America and the Caribbean)

This site is part of the UNDP's contribution to the U.N. Inter-Agency Campaign on Women's Human Rights and provides a compilation of materials provided by all partner agencies.
http://www.undp.org/rblac/gender/

Minnesota Center against Violence and Abuse (MINCAVA)

The MINCAVA Electronic Clearinghouse strives to provide a quick and easy access point to the ever-growing number of

resources available online on the topic of violence and abuse. One focus of the Clearinghouse is to assist faculty and staff in developing higher education curricula on violence and abuse. The Clearinghouse shares in electronic form curricula and syllabi used in violence education programs at institutions of higher education across the United States.
http://www.mincava.umn.edu

National Sexual Violence Resource Center

This clearinghouse provides information, resources, and research related to all aspects of sexual violence. Activities include collecting, reviewing, cataloguing, and disseminating information related to sexual violence; coordinating efforts with other organizations and projects; providing technical assistance and customized information packets on specific topics; and maintaining a website with up-to-date information.
http://www.nsvrc.org

Reproductive Health Outlook (RHO)

PATH's RHO website provides links to numerous sites of organizations addressing violence against women and includes sections on gender and men and reproductive health.
http://www.rho.org/

Networks/Coalitions/Consortiums

GBV Prevention Network

This network is a virtual community for the 100+ member organizations in the Horn, East, and Southern Africa working to prevent gender-based violence. A resource for activists and practitioners in Africa and beyond, it provides a rich database of regional program approaches, communication materials, publications, reports, tools, and resources. There are also international documents, resources, and links relevant to GBV prevention and opportunities to dialogue, contribute, and share experiences.
www.preventgbvafrica.org

Coalition against Trafficking in Women

The Coalition is composed of regional networks and affiliated individuals and groups and serves as an umbrella that coordinates and takes direction from its regional organizations and networks in its work against sexual exploitation and in support of women's human rights.
http://www.catwinternational.org/

Intercambios

Intercambios is an alliance of international and national organizations based in Latin America that aims to strengthen the capacity of the public and private health sectors to address gender-based violence through a public health and human rights approach. Intercambios carries out activities on GBV in the fields of research, advocacy, training and communication.
http://www.alianzaintercambios.org
info@alianzaintercambios.org

National Violence against Women Prevention Research Center (NVAWPRC)

The Center serves as a clearinghouse for prevention strategies by keeping researchers and practitioners aware of training opportunities, policy decisions, and recent research findings.
http://www.vawprevention.org

Nursing Network on Violence against Women (NNVAW)

The NNVAW was formed to encourage the development of a nursing practice that focuses on health issues related to the effects of violence on women's lives.
http://www.nnvawi.org/

Reproductive Health for Refugees Consortium (RHRC)

This Consortium is a partnership of seven organizations dedicated to increasing access to a range of high-quality, voluntary reproductive health services for refugees and displaced persons around the world. Gender-based violence is one of the four essential and complementary technical areas of reproductive health on which RHRC focuses its work. The website also features several links to reports and guides on addressing gender-based violence in refugee settings.
http://www.rhrc.org/resources/gbv/index.html

Violence Against Women Electronic Network (VAWnet)

This network provides support for the development, implementation, and maintenance of effective violence against women intervention and prevention efforts at the national, state, and local levels through electronic communication and information dissemination. VAWnet participants, including state domestic violence and sexual assault coalitions, allied organizations, and individuals, have access to online database resources. http://www.vawnet.org

Organizations

Center for Women's Global Leadership

The 16 Days Campaign of Activism Against Gender Violence is an international campaign originating in 1991. This 16-day period starts on November 25, the International Day Against Violence Against Women, and ends on December 10, International Human Rights Day. The 16 Days Campaign has been used as an organizing strategy by individuals and groups around the world to call for the elimination of all forms of violence against women by raising awareness about gender-based violence as a human rights issue at the local, national, regional, and international levels. Since 1991, the 16 Days Campaign has included the participation of over 1,700 organizations in approximately 130 countries.
http://www.cwgl.rutgers.edu/

Centre for Research on Violence Against Women and Children

The Centre is one of an alliance of five research centers in Canada whose purpose is to promote the development of community-centered action research on violence against women and children and to facilitate individuals, groups, and institutions representing the diversity of the community to pursue research issues and training opportunities related to the understanding and prevention of abuse.
http://www.uwo.ca/violence/index.html

Family Violence Prevention Fund

The Family Violence Prevention Fund, through the National Health Initiative on Domestic Violence (NHIDV), addresses the health care response to domestic violence through public policy reform and health education and prevention efforts. The NHIDV develops educational resources, training materials, and model protocols on domestic violence and screening to help health care providers better serve abused women.
http://endabuse.org/

International Planned Parenthood Federation (IPPF), Western Hemisphere Region (WHR)

The IPPF/WHR website contains information on its GBV projects in Latin America and the Caribbean. IPPF/WHR publishes a quarterly newsletter called ¡BASTA!, which can be accessed and downloaded from its website. ¡BASTA!

reports on the efforts of IPPF affiliates in Latin America and the Caribbean to address GBV within the framework of sexual and reproductive health and offers practical information and tools to service providers who wish to work in this area.
http://www.ippfwhr.org/

Isis Internacional

Together with the Isis affiliate offices in Manila and Kampala, Isis in Chile oversees the Program on Violence against Women, an information and communications initiative that provides informational materials and resources to organizations worldwide. (Information in Spanish only)
http://www.isis.cl/

World Health Organization/Pan American Health Organization (WHO/PAHO)

The World Health Organization has several initiatives that deal with gender-based violence. The Department of Gender, Women and Health coordinated the WHO Multi-country Study on Women's Health and Domestic Violence against Women, and it has several publications on the effects of GBV on women's health.
http://www.who.int/gender/en/

WHO is also the coordinator of the Sexual Violence Research Initiative (SVRI), a project that aims to strengthen the health-sector response to sexual violence.
http://www.who.int/svri/en/

The Gender, Ethnicity and Health Unit of the Pan American Health Organization (PAHO) has numerous publications and fact sheets about GBV and health.
http://www.paho.org/english/ad/ge/home.htm

PATH

PATH is an international, nonprofit organization that creates sustainable, culturally relevant solutions, enabling communities worldwide to break long-standing cycles of poor health. PATH promotes gender equity in health and the prevention of GBV using a systems approach to link communities, institutions, and policies. PATH works with local and international partners to carry out evidence-based advocacy and to strengthen health systems and communities to address GBV from a human rights and public health perspective.
http://www.path.org

United Nations Development Fund for Women (UNIFEM)

UNIFEM provides financial and technical assistance to innovative programs and strategies that promote women's human rights, political participation, and economic security. The website features information about international resolutions concerning violence against women, UNIFEM's work, available resources, and the application process. The UN Internet Gateway on the Advancement and Empowerment of Women (WomenWatch) facilitates internet searching through UN organizations for materials on GBV.
http://www.unifem.org/
http://www.un.org/womenwatch/asp/user/list.asp?ParentID=3004

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