RESEARCH FOR CHANGE

Assessing Responses to the Needs of Survivors of Sexual Violence in Humanitarian Settings

LESSONS LEARNED

Save the Children

KIT Royal Tropical Institute

Funded by European Union Humanitarian Aid

Introduction

The research for change project is a research project focusing on assessing sexual violence responses in the context of disaster-prone and conflict areas. The project was executed by KIT Royal Tropical Institute (KIT) and Save the Children. The studies were initially planned in three different countries: Haiti, South Yemen and Northeast Nigeria. The project started in 2019 and ended in June 2022 and was funded by ECHO.

This document describes the background, study objectives and method, as well as the main findings from South Yemen and Northeast Nigeria. It also includes an explanation of the challenges faced while conducting sexual violence research in humanitarian settings and provides an overview of the different mitigations strategies used during the COVID-19 pandemic. This brief concludes with reflections and overall lessons learned that should be taken into consideration when conducting research on sexual violence in disaster-prone and conflict settings.

Background

Sexual and Gender-Based Violence (SGBV) is among the greatest protection and public health challenges to be faced during humanitarian emergencies. SGBV violates the right to life, the right not to be subject to torture, inhumane or degrading treatment or punishment, the right to equal protection under the law, the right to equality in the family, and the right to physical and mental health (CEDAW 1992)[1]. While women and adolescents are the most common victims of SGBV, men are also affected. Sexual violence is a form of SGBV which is present in all societies. SGBV and especially sexual violence are usually exacerbated by the disruption of the social fabric resulting from conflict or due to a natural disaster. The breakdown in law and order during crises means that perpetrators often abuse with impunity. According to WHO (2021)[2], more than 35 percent of women across the globe experience physical and sexual violence throughout their lifetime. In many conflicts, women's bodies are turned into battlegrounds when rape is used as a tactic to humiliate, dominate, or disrupt social ties. The impact of SGBV goes beyond any physical and psychological consequences for the survivors, it also undermines the resilience of societies, making it harder to recover and rebuild, as emphasised in the Inter Agency Standing Committee guidelines (IASC 2015)[3]. When systems break down, pre-existing gender inequalities are exacerbated, while essential services are lacking, and protection mechanisms fail. Consequently, SGBV is accentuated and affects women, girls, men, and boys in humanitarian setting (Oslo conference, 2019).[4]

1. UN Committee on the Elimination of Discrimination Against Women (CEDAW), CEDAW General Recommendation No. 19: Violence against women, 1992, available at: https://www.refworld.org/docid/52d920c54.html
2. World Health Organisation (2021) Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. Geneva.
3. IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action, 2015

Objectives

The overall objective of this study was to provide evidence-informed recommendations to contribute towards increasing the capacity of humanitarian actors, for them to adequately identify and respond to the needs and rights of groups affected by sexual violence. We want to ensure that services become available for survivors though the public system and through community owned interventions. This study will have a particular focus on sexual violence but will also include references to the full spectrum of SGBV where relevant.

1. To explore how sexual violence in humanitarian settings affect women, girls, boys and men
2. To assess what medical and psychosocial assistance survivors have access to, and identify gaps in protection, in particular with regards to gender
3. To assess whether relevant international standards on medical and psychosocial services, international World Health Organization protocols, as well as international humanitarian law (where applicable) and international human rights law, are adhered to
4. To explore existing good practices in the context of Nigeria, Yemen, and Haiti which should be reproduced.

Methods

This study used a mixed methods approach, drawing on data collected via desk reviews, assessments of health facilities, in-depth interviews and focus group discussions with sexual violence survivors, and wider communities. Interviews were also held with health workers, service providers, local government officials and NGOs. Tools were translated in local languages. The health facility assessment (HFA) included a survey and an observation checklist on specific clinical processes and standards. A team of qualified researchers using a gender-transformative approach conducted the HFA and interviews to ensure participants felt comfortable and safe given the sensitivity of the topic. The study findings are not meant to be representative of the full study sites, but provide a snapshot of the prevailing forms of sexual violence , the available sexual violence related services and gaps in the state of Borno in Northeast Nigeria and in Lahj and Aden governorate in South Yemen.

4. Oslo conference on Ending Sexual and Gender-Based Violence in Humanitarian crises co-host outcome statement. Released on 24 May 2019

Context Background

Nigeria

In Nigeria, the study covered the Borno State where the Boko Haram conflict has been ongoing since July 2009. Eight and half million people are in need of life-saving assistance.[1] About 1.7 million of those affected are women of reproductive age. GBV prevalence rate is estimated to be at 30% and sexual violence at 16%.[2]

Yemen

The Yemen study focused on Lahj & Aden Governorate in the South of Yemen. The country has been engulfed in more than 7 years of conflict and 23.4 million people are in need of humanitarian assistance. An estimate of more than 3 million women and girls were at risk of gender-based violence and 60.000 at risk of sexual violence, including rape in 2017 according to UNFPA.[4] Currently in 2022 6.5 million women are in need for GBV protection. The economic crisis continues to worsen with numerous outbreaks and changing conflict lines. There are over 4 million internally displaced persons.[5]

Haiti

The study areas selected in Haiti were Port-Au-Prince, Sud & Grand'Anse. Haiti has been going through a series of natural disasters and political insecurities. Some of these include the earthquake in 2010, hurricane Matthew in 2016, and the more recent earthquake in 2021 with many critical political incidents. Although there is a lack of information from Haiti, 4.4 million people were estimated to be in need of humanitarian assistance in 2021 and there are alarming reports of SGBV.[6] Due to a combination of challenges faced that would jeopardise the quality and study ethics, data collection could no longer take place and, therefore, the decision was made to stop research activities in Haiti in 2021.

5. Amnesty International. 'Our Job Is To Shoot, Slaughter and Kill ': Boko Harm's Reign of Terror in North-East Nigeria [Internet]. Amnesty International Reports. 2015. Available from: https://www.amnesty.org.
6. National Population Commisssion (NPC), ICF International. Nigeria Demographic Health Survey 2018. DHS Progr ICF Rockville, Maryland, USA. 2019;748.
7. https://reliefweb.int/report/yemen/yemen-humanitarian-needs-overview-2022-april-2022
8. https://yemen.unfpa.org/en/news/three-million-women-and-girls-risk-violence-yemen
9. UNFPA (2021) Humanitarian response in Yemen, February 2021.
10. https://reliefweb.int/report/haiti/haiti-humanitarian-needs-overview-glance-humanitarian-programme-cycle-2021-march-2021

Main Findings from the Nigeria and Yemen studies

Nigeria

Forms and Magnitude of Sexual Violence

The study found that a variety of sexual violence were prevalent in the study areas, ranging from early and forced marriage to sexual exploitation and rape. Perpetrators commonly included family members, armed actors (armed opposition group fighters, community militia, security forces), community members and in a few cases, staff conducting humanitarian activities. In particular, the responses of armed opposition group fighters when encountering civilians were influenced by gender and age. The likelihood of boys being forcefully recruited meant that young women would often go to the farms for livelihood activities, where they risked being sexually assaulted. The lack of consent in cases of early or forced marriage, the denial of contraceptives by husbands to their wives and in some cases denial to seek abortion services were motivated by toxic masculinity. There was a perception among community members that (male) children were needed to repopulate the community since Boko Haram had killed or taken men away. As explained by many survivors, women and health workers, the stigma and 'kunya' experienced by survivors was high particularly if someone had been abducted or raped. Rape within marriage was often spoken of as 'forced sex within marriage' by some participants, while some women reported that it was common to use allegations of rape (also outside of marriage) as a cover for consensual sex. In contrast, street sexual harassment and in some cases survival and transactional sex were quite normalised. Cases of soldiers luring women into sex in exchange for goods was commonly mentioned by community members. Perpetrators (often having more power) rarely faced any consequences while the survivors and their families were shamed and stigmatised in the community, due to which fear of reporting was high.

Service provision and support structures in Borno state

The study findings give a snapshot of the different types of services available for survivors of sexual violence in Borno state. The data show that medical services, including psychosocial services and case management were relatively more widely available than legal services and food, shelter and livelihoods (FSL)-related services. Public health facilities usually offered referrals for many services which were implemented by international organisations such as IMC, MSF, NHRC, MDM and others. Some health workers mentioned that survivors prioritised FSL needs as opposed to health needs due to poverty, and lack of economic security. These services and protocols were best developed and standardised for abductees as opposed to survivors of other types of sexual violence. There were considerable challenges in service provision and uptake. Security concerns

and lack of funds hindered both availability and accessibility of services. The lack of infrastructure, particularly to accommodate the needs of people with disabilities, was also raised as a concern, and stock-outs such as HIV-related supplies compromised time-sensitive interventions. Sexual violence services for male survivors were equally limited, with only two facilities reporting service access. The lack of capacity of health workers and service providers, particularly around counselling and communication skills, including language barriers were raised by many female sexual violence survivors and other female community members. The health facility assessment in particular revealed that while 5 out of 6 health facilities had established protocols on privacy and confidentiality and 4 out of 6 documented referrals, 5 out 6 did not have any written guidelines on the same. Only one facility followed international guidelines and there were no legal reporting mandates or documentation required and no specific protocols for people with disabilities. The use of data to monitor and guide sexual violence interventions was lacking at all except one facility.

A few study participants alluded to the increase in sexual violence due to the phasing out of humanitarian assistance and withdrawal of aid. This also had broader impacts on the communities, adversely affecting girl's education and economic empowerment activities. The limited food distribution activities and the politics of eligibility such as the exclusion of female-headed households also limited access for certain groups.

Alongside formal services, there were a variety of informal and community-led structures in place. This included groups of aunties who rallied around sexual violence, pro-active 'bulamas' and community leaders and general support from community members. This also encouraged help-seeking behaviour and the increasing sensitisation around sexual violence and destigmatisation of survivors was slowly encouraging reporting. Some survivors and participants in the study did share that there was very limited prevention work, and the need for male engagement was also emphasised by participants.

Yemen

Forms and Magnitude of Sexual Violence

The study revealed that violence is believed to be influenced by the vulnerabilities the war has magnified in Yemeni society, including a lack of security, the breakdown of legal institutions, poverty and displacement, as well as the breakdown of the social fabric, which exposes people to harmful situations, such as exploitation, forced prostitution, kidnapping and transactional sex. These forms of sexual violence were mentioned by participants, with exploitation being touched upon the most and transactional sex the least. The widespread presence and use of arms and drugs was believed to be one of the main factors for increased sexual violence. There was no mention of mass systematic rape,

however, armed and uniformed personnel were referred to often. Children were the group most frequently mentioned, and rape, especially of children and teenagers, was believed to be the most common form of sexual violence. Male children were mentioned to be more often affected compared to females. Child marriage was thought to be on the increase since the war and the youngest age group recalled was 9 years of age. Most respondents said there was an increase of sexual violence since the war, however service providers reported seeing fewer survivors at the health facilities. The main reason mentioned was lack of trust in safety reporting to the police and health providers. The perpetrator is often known to the survivor, mostly men were mentioned to be the perpetrator. The participants also revealed that they believed sexual violence was happening at all levels in society both inside home and outside in other assumed to be 'safe' spaces. Most of the participants cited psychological and mental health issues as the main consequences of sexual violence. Physical health consequences including pregnancy were less frequently mentioned. Loss of virginity was a main concern. Victim blaming was common with females suffering more than males. Stigma and shame were mentioned as serious issues where again women and girls suffered more and which then led to forced marriage (in some cases to the perpetrator), honour killing and physical violence by family members.

Most survivors reported keeping quiet and not seeking health care services due to fear of breach of confidentiality and stigma/shame and victim blaming.

Service Provision and Support Structures in Yemen

Existing laws against some forms of sexual violence are very weak and don't deter perpetrators. As revealed during the desk review, there are no laws and policies in place to address or prevent sexual violence. There are no SGBV or SRHR policies and the legal age limit for marriage is not defined in law. There are penalties for rape or child abuse for perpetrators, but due to the conflict, these penalties are hardly applied and impunity is the norm as reported both with the desk review as well as the responses from the participants of the study. The study showed that most survivors would keep silent and not seek services for sexual violence although the Ministry of Public Health and Planning has designated health facilities to provide services for sexual violence. None of the health facilities reported any survivors presenting within 72 hours and the most common age group to seek services were children and teenagers. No male survivor had received services at the designated health facilities. The reasons presented by the study participants include fear of recurrent abuse by perpetrators, other community members and fear of breach of confidentiality and lack of trust on service providers. The participants revealed a lack of awareness around available health services, while others also mentioned a lack of services. There was an understanding by a majority of study participants for a need to go to the police first when faced with sexual violence before accessing services at a health facility.

The health facility assessments showed that some level of training has been provided to front line providers, however the capacity building efforts are not standardised. There is no designated technical guidance being followed by the providers. The study also depicted a lack of formal and clear referral pathways for survivors of sexual violence.

Challenges and Mitigation Strategies

Contextual Challenges	Mitigation Strategies
In chronic humanitarian settings the need for health services in general and reproductive health services in particular is high. Sexual violence may not be at the top of this priority list for the stakeholders responding to the crisis.	There is a need to prioritise and build in time to discuss with the reproductive health working group about sexual violence and/or gender-based violence in relation to the humanitarian response. It is important for decisions related to sexual violence research and programming to have consensus from the Ministry of Health and Reproductive Health working group/sub-cluster.
In conflict settings and particularly where the situation has been deteriorating for years, many other challenges also exist and can disrupt plans for research. These include political insecurity, shifting fighting frontlines, outbreaks of diseases and sometimes natural disasters (flooding, drought, and others). The activities for this research had to be adjusted several times.	Flexibility with the research project timeline and budget is critical. In our case, the donor, Ministry of Health as well as the study teams were very flexible, and it was a collective decision-making process to keep re-planning activities for the research.
The precarious and changing security situation also meant: • It was challenging for international staff to travel for the research training workshop. Visa and travel processes were lengthy and tedious. • Some selected sites for the study were no longer accessible due to the conflict or the insecurity increased • There was a need to change plans for data collection on certain days due to sudden security issues.	• Working with experienced consultants, knowledgeable about SGBV research in these specific contexts, while maintaining a close working arrangement with assigned technical people from the international research team and the local Save the Children team with the technical and contextual understanding in the study area was critical to implement the research • There was a need to discuss sampling of geographic locations and select alternate sites/health facilities. • Data collection (study teams – interviewers and participants) were all prepared for a change in plans and contacted for when data collection for a particular day had to be postponed or cancelled. • Ensure a robust and very active security follow-up and monitoring for the data collection process and other activities to ensure there is no harm done and participants and research team are safe.

The authorities and other national stakeholders are also managing other very urgent and pressing challenges in a humanitarian situation. Research is never considered as a first priority and therefore keeping the attention and focus on a research project is not easy.	Despite competing agendas in humanitarian settings, engaging the authorities and national stakeholders from the start to the end of the study as well providing updates on the on-going process and challenges are recommended to keep the discussion on the research going.
When funds are available and there is a big need to conduct research on sexual violence, and most preparations were done, to stop the research is a difficult decision to make, but required when combined political, security and humanitarian situations affect the quality of the research.	To decide to stop the study at the data collection phase in Haiti to prevent doing harm, as multiple challenges would negatively affect a proper execution of the study.
COVID-19 Related Challenges	**Mitigation Strategies**
COVID-19 evolved into a pandemic just as we launched this research and survey. As mentioned above, the priority was to keep all people (survey team and participants) safe and protected as well as to allow ample time for a health response to be set up. • Activities were stopped for periods of time during the pandemic waves • Methods of training had to be changed • Data collection methods were revised • Data analysis workshops were not done with the study team as initially planned.	• The donor and study team showed flexibility and were willing to adjust plans when activities had to be delayed. • Personal protective equipment and other physical measures were all provided to study teams and respondents (community members) both. • Study training was done for smaller groups of 3 and 4 – teams were divided according to geographic allocations. • Respondents were invited to safe and protected sites where Personal Protective Equipment was provided. Focus group discussions were done in meeting room venues that were sanitised and social distancing and masks were used. • Analysis was done remotely by the research team in NVIVO through a series of virtual consultation meetings. • Methods also fitting for sexual violence among vulnerable groups (LGBTQIA+, children/young adolescents etc.), such as using art and body mapping, participatory methods etc., was difficult given the general uncertainty of the timeline due to security and the pandemic.

When funds are available and there is a big need to conduct research on sexual violence, to still decide not to continue with the research due to the combined challenges faced that can affect the quality of the research. This was a difficult decision to make for Haiti.	To decide to no longer conduct the study, due to a very delayed timeline, volatile political context, COVID-19 situation, and the lack of sexual violence research expertise in country. It is important to note that in very fragile states although research that is planned initially may not be possible, it is important to weigh all risks versus outcomes when making this decision.
Technical Challenges	**Mitigation Strategies**
Sexual Violence is a sensitive topic, particularly for conservative settings like Borno State, Nigeria and South Yemen. It is not a topic that is widely discussed and a first priority for the stakeholders. Although sexual violence against men, adolescents, and LGBTQIA+ people was specifically explored in the desk review, these groups were not included among study participants as they required specific approaches, more time, and/or had particular risks in the context of Nigeria. These groups are distinct and for this research, it was not feasible to identify big enough sample sizes to understand the perspectives among these subgroups.	More than six months were spent on bilateral consultations and preparation to ensure all stakeholders were on board and in consensus. The Ministry of Health was the main partner for this research and for the consultations and planning as well. It is a good strategy to build in time for this with a research project of this kind. The study set up, desk review, ethical clearance and recruitment of research team took a year. Research in humanitarian settings should be planned for a longer time span. Tools were designed and delivered in ways to not only 'do no harm' but also 'do better', for example by integrating appreciative inquiry. Debrief meetings of the research team reflected on conflict and gender dynamics in research locations. The topic was new to many of the data collectors and therefore the research training had to start with orientation and training on the topic area. During focus group discussions and in-depth interviews, the team encouraged research participants, especially young people and others who often experienced social exclusion, to feel comfortable with the research process and be empowered to discuss sensitive issues. One method for doing so was to start the interview by asking the participants to tell their story, allowing them to begin on their own terms and discussing the issues and the extent to which they wanted to share. Engage and involve national organisations that have a history and rapport for sexual violence programming (service provision and support to survivors) in the different regions in the study, to be able to make connections with community as well as other formal entities.

The definition and understanding of main terms and concepts for sexual violence and other gender-based violence topics was different for different stakeholders.	Terms and definitions are very important to discuss and agree upon during the planning meetings. It is important to establish and agree on definitions in English but also in the language that is spoken in the communities. It is also critical to discuss these terms and definitions in the local language with the Ministry of Health.
Conducting sexual violence research particularly in conflict/fragile settings also affects the research team, particularly those conducting interviews	In terms of research ethics, a robust approach was followed, and systems put in place to ensure standards are always adhered to. The team discussed self and collective care during the research workshop, particularly salient given the topic at hand, and checked in with each other regularly as data collection progressed.

Specific Challenges

Nigeria

In Borno state, the difficulties and the changing security situation meant that the sampling of different local government areas (LGA) were affected. Hence one of the LGAs had to be dropped out of the final sample given the security situation at that time. Monguno, a Northern Borno LGA, which was initially chosen, had to be dropped from data collection due to security reasons which also affected other northern Borno locations in the North. As the topic of sexual violence is a particularly sensitive one, and the perpetrators include armed groups, it was important for the topic guide to have questions that were framed sensitively. Additional checks after the translation and a discussion among the research team were carried out to ensure this. Since the topic of marital rape is also contentious and is not illegal in Nigeria, the research team and the participants spoke about 'forced sex in marriage'.

Yemen

We conducted the study in South Yemen and our geographical areas were affected by COVID-19, outbreaks such as Dengue, Malaria and chikungunya, flash/seasonal floods, and many instances of increased active conflict and frontlines. This delayed plans but also required very thorough planning for the research. There was change in senior level authorities and therefore the research concept and protocol had to be shared and discussed many times over. It was important to spend time with different stakeholders, data collectors and other study teams to understand definitions and appropriate skills in managing a sensitive topic such as sexual violence.

Haiti

Haiti was selected as a setting that is prone to natural disasters. However, as the project was started in Haiti it was clear that we were dealing with a setting that had complex issues of political instability and natural disasters as well as the long-term effects of the other disasters. There was an extremely high turnover of personnel, and a shortage of staff both at the implementing organisation and the stakeholders and authorities that we were working with, which led to the need to re-introduce the study and delayed the processes further during the COVID-19 pandemic. It was difficult to find local researchers with expertise on SGBV that spoke the local language and that could lead the research and support research assistance within Haiti. The political unrest remained throughout, with gang violence, the assassination of the president, an earthquake, storms, and landslides all happening in 2021, conducting research on sexual violence, despite the extremely high occurrence rate in Haiti, could no longer be a priority for the Save the Children office due to the emergencies Haiti was facing.

Good Practices and Key Learnings

General:

- Recruit highly qualified researchers with extensive experience working on gender issues/gender-based violence/SRHR
- Bring on board national organisations that have a history and rapport for sexual violence programming
- Flexibility on timeline, plans and budgets to adjust activities during delays
- Willingness to adjust the programmatic activities on part of the donor, the national stakeholders, and the study team.

Study Preparation Phase:

- Collective buy in from the reproductive health working group/sub clusters and ministries of health is essential
- Agreement on terminology and definitions by unpacking sexual violence, SRHR and translation in English and local languages is critical. This was done for both contexts with specific focus on the sub national context
- A desk review and mapping of health facilities providing services on sexual violence is key and very important.

Study Training:

- Training on sexual violence as a topic
- Training days and training methods were adjusted with more emphasis on role play and techniques to address a sensitive topic.

Study Data Collection:

- Adjust methods according to the insecurity and challenges
- Ensure safety and confidentiality of study participants
- Daily (de)briefings about the study and security situation

- A referral mechanisms was put in place to access NGOs and Health facility services on sexual violence, if needed for study participants. This information was included as part of the consent process during data collection.

Data dissemination:

- Adapt dissemination activities keeping the contextual and political humanitarian sensitivities in consideration
- Ensure the Ministry of Health and reproductive health stakeholders are part of the study and lead the dissemination activities.

General reflections

There is definitely added value in experience and expertise in forming a partnership like Save the Children (humanitarian programming and long-term presence in the areas) and KIT (knowledge and research institute with research and training expertise in fragile settings). Save the Children's presence, footprint, and logistical capacity in country allowed for profound contextual knowledge that enabled manoeuvring politically complex settings. Save the Children's presence at the sub-national level contributed because of the established working relationships with the clusters and Reproductive Health sub working group as well as the relevant government entities and national and international organisations working in Yemen and Nigeria. The security team from Save the Children were helpful in navigating the rapidly changing environment and were able to inform the safety and security of the study team as well as the participants. KIT's experience of conducting research on SRHR and SGBV in collaboration with local research teams and the technical expertise added to training, capacity strengthening and analysis of data for this study was very critical and important. ECHO's flexibility and engagement was essential to finalise two of the three studies and to be able to stop the research process in Haiti.

Conclusion

Despite the COVID-19 pandemic and other context specific challenges, the study was beneficial in highlighting important concerns and opportunities related to sexual violence in Borno State in Nigeria and in Lahj and Aden in South Yemen. The studies managed to reinforce the attention of the respective Ministries of Health and other national and international organisations on the situation related to sexual violence in the two settings. This has resulted in a momentum to utilise the findings of the study and to address both the short- and long-term challenges within the health systems in managing sexual violence. Therefore, we strongly recommend to replicate the study in other conflict and natural disaster settings.

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