Finding the Path Forward:

Identifying research gaps on gender-based violence among conflict-affected refugees in the Global South.

The Global
Women's Institute
THE GEORGE WASHINGTON UNIVERSITY

BUILDING
GBV EVIDENCE
In Conflict and Refugee Settings

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CONTENTS

INTRODUCTION

Gender-based violence (GBV) is a pervasive issue affecting women and girls in refugee settings. Despite this and the growing number of refugees globally, limited reliable evidence about how GBV operates at the intersection of armed conflict and displacement, and what programming is effective to prevent and respond to this violence, has been generated. In recent years, there has been increased attention and effort to begin to build up the evidence base and improve monitoring and evaluation (M&E) efforts for GBV, including the development of global support and guidance documents (e.g. the Global Women's Institute's [GWI] Research, Monitoring and Evaluation Manual (Murphy et al., 2017), World Health Organization's [WHO] Guidelines on Collecting Data on Sexual Violence in Emergencies (WHO, 2007), etc.). Through these efforts, we see the amount and quality of research, monitoring, and evaluation efforts among conflict-affected displaced populations are slowly increasing. Notable global efforts, such as the DFID funded 'What Works to Prevent Violence Against Women and Girls' program and ELRHA's GBV research portfolio, have also increased dedicated funding and attention to these key issues.

While this increased attention and energy is positive, gaps remain. Research and evaluation efforts are often driven by academics and donor priorities from the Global North. Further support is needed to identify and support locally-driven research and evaluation projects that address the most urgent questions that front-line service providers and communities have. In addition, routine M&E systems need to be strengthened so that organizations can safely and ethically collect data and improve their programming throughout program implementation. Data disaggregation by key demographic variables, such as sex, age, ethnicity, and ability, remains a barrier to more nuanced gender analyses in humanitarian settings and to ensure that programs proactively monitor how they are meeting the needs of the most vulnerable—and often largely overlooked—populations.

To inform further research and evidence generation efforts on GBV in refugee settings, this gap analysis seeks to provide a landscape of the current evidence base specifically on GBV among conflict-affected refugee populations in the Global South. It both summarizes the existing evidence and identifies key gaps that will inform the international community on where future research endeavors should focus. It strives to be a holistic document but also is reflective of some of the limitations of the fragmented evidence base within humanitarian settings (e.g. biased towards documents available online and peer-reviewed articles, divisions between refugee and internally displaced person [IDP] service delivery and research efforts, etc.). Despite these challenges, the resulting analysis provides a practical roadmap for future research endeavors and will help practitioners, donors, and researchers develop research priorities for the GBV community in displacement settings.

METHODS

The inclusion criteria for publications were as follows: (1) published in 2000 or later; (2) research or evaluation conducted in the Global South; (3) published in English; (4) publicly available online; (5) included displaced populations affected by conflict as a main population of focus; and (6) focused on GBV, directly or indirectly. For the purpose of this gap analysis, we used the 2015 Inter-Agency Standing Committee GBV Guidelines definition:

> *Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private. (Inter-Agency Standing Committee [IASC], 2015, p. 5)*

Perpetration of GBV can be a tool to punish a person who defies or fails to fulfill societal prescriptions of gender and a way to reinforce power hierarchies based on gender, particularly "reinforcing gender inequitable norms of masculinity and femininity" (IASC, 2015, p. 5). While people of all genders can all experience GBV (IASC, 2015; United Nations High Commissioner for Refugees [UNHCR], 2020; United States Agency for International Development [USAID], n.d.; Al Usta, 2012; Sexual Violence Research Initiative [SVRI], 2020), the focus of this gap analysis is on women and girls as the largest percentage of GBV is borne by women and girls.

The search strategy included three sources: (1) online academic databases (PubMed and Google Scholar); (2) repositories of grey literature and non-governmental organization (NGO) libraries; and (3) internal review of the compiled reference list for missing relevant publications. For the first source, we used various combinations of the following search terms: conflict, gender, GBV, violence against women, refugee, displacement, and violence. A three-step screening process was employed: first titles, then abstracts, and finally the full text during the data extraction phase. A similar screening process was repeated to identify relevant grey literature. One member of the research team executed the first two steps of the process. Prior to starting data extraction, the compiled list of references was reviewed by other members of the research team to identify any missing relevant publications. The search was conducted in October-November 2020.

Included publications were divided among four reviewers. Relevant information related to the pre-identified gap analysis framework was extracted and sorted into Google Sheets. The gap analysis framework (adapted from Miles, 2017) is as follows:

- **Population Gap**: Research on specific populations are missing or under-researched in the literature (i.e. transgender women have low representation in the collected publications);
- **Knowledge Gap**: Research findings do not exist or need to be evaluated or empirically verified (i.e. intervention is deployed but without empirical evaluation of impact); and
- **Methodological Gap:** Research methods and study design employed do not support reported research findings (i.e. low quality of methods do not encourage confidence in results).

A detailed analysis of the publications that were published in 2010 or later, included refugees, and focused on women and girls are presented in the following four chapters. The first chapter focuses on the WHO: inclusion of specific types of participants. The second chapter is about the WHERE: research sites and contexts. The third chapter is about the WHAT: key findings. Lastly, the fourth chapter focuses on the HOW: conceptualization of the work, including methods used, ethical considerations, and inclusion of partners from the Global South. Short summaries on sub-populations, including IDPs, lesbian, gay, bisexual, transgender, queer, and others (LGBTQ+) people, and men and boys, as well as other topics are also included as call-out features. A summary of the identified gaps, with targeted recommendations, is presented in the table below.

As with all research, this gap analysis is not without limitations. The most important to note is that this gap analysis does not include every research publication written about GBV among conflict-affected refugee populations. While we developed a robust search strategy to capture the majority of the relevant research and evaluations, new work is always emerging and may have been published after we completed the collection and review process. We also know that, while we identified specific NGOs and repositories we thought were the most comprehensive and relevant to collect grey literature, there are additional online libraries that may include other publications. Another inherent limitation of this design is the exclusion of work published in languages other than English, particularly those most relevant to the countries where the work was conducted (i.e. Arabic and Spanish). It is likely that locally-produced knowledge is missing from this effort; thus the results must be considered within this English-only framing. Lastly, the first two steps of the screening process were conducted by a single member of the research team, whereas best practices would have had an additional person involved to ensure relevant publications were not missed.

GAPS & RECOMMENDATIONS

GAP	RECOMMENDATIONS
Population	
Lack of recruitment of, and limited research questions related to, refugee populations with multiple marginalized or stigmatized identities, such as survivors of GBV, including men and boys; people with disabilities; LGBTQ+ individuals; and sex workers.	• Assess the risks associated with recruiting individuals with marginalized identities, such as being LGBTQ+, by context, and intentionally recruit these populations when it is reasonably safe to do so. • When the context allows for it, explicitly ask questions regarding sex, gender, and sexual orientation rather than making assumptions about participants or ignoring these identities. • Apply an intersectional (Crenshaw, 1991) lens to research to understand how different marginalized identities inform risk of, exposure to, and impact of GBV on refugee populations.
Limited analysis that disaggregates by age groups, specifically including adolescent girls and elderly women.	• Make age disaggregation standard procedure in analyses, similar to disaggregation by gender. • Explicitly define context- and culture-specific age groups within analyses. • Commit to making data–anonymized and with consent from participants–openly available from refugee settings to facilitate secondary data analyses on under-researched populations. • Research the GBV-related needs, experiences, and exposures of elderly displaced women.
Lack of studies focusing on refugee populations in South Asia (e.g. Pakistan, Afghanistan), Central America, West Africa and the Sahel, and the Middle East and North Africa (MENA) region beyond Lebanon and Jordan.	• Conduct research regarding GBV among refugee populations in under-researched regions and countries.
Lack of studies in urban, as well as peri-urban and suburban, settings.	• Conduct research outside of refugee camp settings to reflect where most refugees live in the Global South.
Knowledge	
Limited examination of GBV perpetration among refugee populations, including prevalence and drivers, from the perspective of men and boys broadly and as perpetrators specifically.	• Recruit men and boys as study participants, not just for their perspectives as community members, but as the main perpetrators of GBV against women and girls, with due attention to the risks associated with working with perpetrators in displacement settings. • Utilize quantitative measures to test the causal pathway from displacement to intimate partner violence (IPV) perpetration as well as mediation pathways through feelings of emasculation due to changing gender roles and/or substance use.
Lack of information on overall experiences of GBV as well as risk factors and drivers during flight from country of origin to country of asylum.	• Conduct research using both qualitative and quantitative methods to document and understand the journeys girls and women undertake in different settings with a focus on the GBV they experience and/or fear.
Limited information on temporality around when GBV occurred and its impact on immediate and long-term outcomes.	• Use longitudinal study designs when possible. • Include time-bound questions regarding both when violence and when outcomes associated with violence each occurred to better understand the temporal relationship between them.
Lack of understanding on the role xenophobia plays in GBV exposure among refugees and follow-up access to care for survivors.	• Utilize qualitative and quantitative methods to examine the relationship between xenophobia and GBV against refugees, specifically including host community members and local authority figures.
Limited understanding about what GBV looks like for refugee girls and women in different contexts, including relationships between violence experienced inside and outside of the home.	• Employ multiple modes of data collection, including the use of existing data, to capture a more comprehensive understanding of where GBV occurs and under what circumstances, instead of relying on a single source or type of data. • Conduct analyses that test associations and potential pathways between violence perpetrated in public and private spaces.
Limited evidence on adolescent girls' exposure to GBV, including early marriage, and their resulting needs in a variety of contexts.	• Research the prevalence of early marriage among refugee populations, particularly in South and Southeast Asia. • Research the experiences and needs of adolescent girls beyond the issue of early marriage in the MENA region. • Research adolescent refugee girls' exposure to GBV in the Caribbean and Latin American region.
Limited understanding of the effectiveness and appropriateness of different types of practitioners and modes of service delivery to serve and care for GBV survivors.	• Conduct research on the risks and rewards of including refugee community workers in the care provision and case management systems in and outside of camp settings. • Assess the effectiveness of response service provider training (e.g. the Clinical Care for Sexual Assault Survivors training tool[1]) in multiple contexts and settings, including South Asia and Latin America. • Evaluate the impact of mobile service delivery models for GBV survivors in more countries.
Lack of evaluations for GBV prevention and risk mitigation programming.	• Evaluate and publish results on the effectiveness of GBV prevention and mitigation interventions among refugee populations.

1 https://iawg.net/resources/clinical-care-for-sexual-assault-survivors

GAP	RECOMMENDATIONS
Methodological	
Lack of validated, appropriate, and survivor-centered approaches to collect data on GBV experiences.	• Continue to test alternative data collection methods, such as Audio Computer-assisted Self-interviewing (ACASI) administered surveys and participatory methods, to better understand how they relate to the information participants share and how to capture the most accurate data while understanding that underreporting will likely always be an issue. • Test the acceptability and usefulness of ACASI technology with women (18+ years) and in more locations to better understand the best application of it to capture data on refugee women and girls' experiences of GBV. • Test the acceptability and usefulness of the ASIST-GBV screening tool with adolescent girls and women in more locations.
Lack of quantitative analyses that utilize non-logistic regression models.	• Create and test the validity of non-binary violence outcome measures. • Employ other analytical approaches, such as linear regression or latent class analysis.
Lack of studies that use multiple time points in the analysis.	• Conduct longitudinal evaluations in both camp and non-camp settings. • Include studies that look at the impact of displacement itself over time on a variety of outcomes. • Test hypotheses related to causality, mediation, and moderation.
Limited collection and analysis of qualitative data in the original language of participants.	• Analyze original transcripts of data and only translate specific quotes as needed for publication in other languages, such as English. • Only employ real-time translation during interviews as the absolute last resort.
Lack of clear detail of methods employed and consideration of limitations of those methods, particularly in grey literature and qualitative studies.	• Capture non-data information through daily memo-ing by data collectors and debriefing among the research team in qualitative studies, particularly if some team members do not speak the language used in the interview. Incorporate this information into the analysis process. • Include a limitations section for any research or evaluation publication, regardless of publication type or length.
Limited integration of quantitative and qualitative approaches in mixed methods studies.	• Utilize data collection tools that integrate both approaches. • Present results together in publications rather than separating into individual components.
Limited research grounded in and guided by local expertise.	• Seek out studies conducted by researchers from the refugee or host community, including non-English language publications, to inform the development of study design. • Incorporate study participants in the review and validation processes of research, not just reporting back the findings to them. • Utilize local Technical Advisory Groups (TAGs) in addition to university, government, or NGO ethical review boards.
Lack of clear documentation of ethics, ethical considerations, and ethical decisions made in the course of the research process.	• Provide specific details of how each of the WHO guidelines were considered and accounted for within the study design and implementation. • Avoid or do not conduct studies focused on GBV among conflict-affected refugee populations that cannot adhere to the WH O guidelines.

CHAPTER 1:
WHO

CHAPTER 1: **WHO**

GAPS:

- Lack of recruitment of, and limited research questions related to, refugee populations with multiple marginalized or stigmatized identities, such as survivors of GBV, including men and boys; people with disabilities; LGBTQ+ individuals; and sex workers.
- Limited analysis that disaggregates by age groups, specifically including adolescent girls and elderly women.

Age Groups

Adult women refugees were the most consistently represented group from this set of publications, included in roughly 80 percent of the papers. The second most represented group was young and adolescent girls. More than two-thirds of the publications (70%) included this population in the sample.[2] However, various country-specific age ranges were used for adolescent girls (for example, 10-16-year-olds in Uganda (Lowicki-Zucca & Paik, 2013); 13-19-year-olds in Ethiopia (Falb et al., 2017); 13-17-year-olds in Bangladesh (Toma et al., 2018)), making it difficult to summarize information across adolescence. Other studies used age ranges similar to the Demographic and Health Survey program (15-49 years old) or simply recruited individuals 15 years or older (i.e. Horn, 2010; Sipsma et al., 2015; Vu et al., 2017). Among the papers that included adolescent girls as participants, only twelve of them exclusively focused on adolescent girls, and two-thirds were the result of analyses from the Creating Opportunities through Mentoring, Parental Involvement and Safe Spaces (COMPASS) program (i.e. Sommer et al., 2018a, 2018b; Tanner & O'Connor, 2017).

Relatedly, several papers suggested the inclusion of elderly women in their samples but did not always specify the upper age range limit and instead noted that participants were 15 or 18 years and older. In future research, clear definitions are also needed for who is considered elderly within any given population. Only two publications specifically named elderly people and/or widows as participants (El-Masri et al., 2013; UNHCR, 2018), though no specific ages were provided.[3] Only one other publication included an upper age range of participants that included the elderly based on the UN definition of that age range (Holt, 2013). It is possible that so few publications focused on the elderly because older people only make up roughly four percent of the total population of concern for UNHCR (UNHCR, n.d.). Further, it also is possible that the inclusion of participants aged 50+ years would be considered elderly by their own community, but the lack of context-specific information on this population made it difficult to assess within each publication. Regardless of how small the population of elderly women is within refugee communities, they still warrant research focusing on them given the ways in which their age likely informs and perhaps increases their risk of GBV.

A majority of the collected publications included female

2. Any publication that specified participants were younger than 18 years old or were described as girls or adolescent girls without specifying an age range were included in this count.
3. Another publication focused on older women but did not explicitly define or focus on this population as participants (Hirsch-Holland, 2020).

participants younger than 18 years of age, yet very few sought to answer research questions exclusively focused on this population. While a small subset indeed exists that focused just on refugee adolescent girls, most publications came from a single program (COMPASS) and only two countries (the Democratic Republic of the Congo [DRC] and Ethiopia). There is a same dearth of evidence specific to elderly women past reproductive age. Secondary analysis using existing datasets could help fill the gap on evidence specific to these two age groups. The gap could be further reduced by future analyses including age disaggregation as a standard approach.

It is also possible that research and evaluations that focus on adolescent girls were missed due to a specific focus on violence against women and girls in the search strategy. More work may exist within the violence against children canon, but, due to a lack of disaggregation by gender, those publications did not appear in the search results. In future research, disaggregation by gender could allow for a better understanding of the experiences and needs of groups with multiple layers of vulnerability to violence.

Groups with Multiple Marginalized Identities

Among groups with multiple marginalized identities, fewer than ten percent of papers focused specifically on female survivors of GBV (i.e. Al-Natour et al., 2019; Freccero & Seelinger, 2013; Manell & Radice, 2019). Four papers included participants with disabilities (i.e. El-Masri et al., 2013; Foster et al., 2015; Hanley et al., 2018), five included people who identify as LGBTQ+ (i.e. Freccero & Seelinger, 2013; Murfet & Baron, 2020; Rosenberg, 2017b), and three included female sex workers (Bungaard, 2017; Rosenberg, 2016a, 2017c). The decisions to explicitly and intentionally recruit members of these groups must be understood within the broad context of risk for these groups:

- For GBV survivors, they risk being stigmatized and rejected, as well as face additional violence (Kelly et al., 2011; Othman et al., 2013);
- For LGBTQ+ individuals and sex workers, they may face criminalization in addition to stigmatization (Human Rights Watch, 2016a; Vanwesenbeeck, 2017). Further, the LGBTQ+ community risks additional violence if they are outed for their identity (Bowcott & Wolfe-Robinson, 2012; Fitzsimons, 2019);
- For people with disabilities, especially those with limited ability to consent to participate in a study, they risk exploitation by the research team and/or violence from caregivers (Carlson 2013; Mietola et al., 2017).

Additionally, specialized services for each of these groups may not be available where they live, making it unethical to include them knowing support cannot be offered if needed, such as mental health care for retraumatization.

With the exception of the papers that specifically note the inclusion of lesbian women, gay men, transgender women, and gender diverse individuals, all other studies seemed to assume participants are cisgender and heterosexual without asking questions to confirm these identities. Challenges exist operating in socially conservative contexts (e.g. in countries that criminalize the LGBTQ+ community) where it may be difficult, or even dangerous, to ask about gender identity and sexual orientation. While it may not be safe or ethical to ask these questions in every location, a respondents' sexual orientation and gender identity should be documented when it would not place participants at risk. The five publications with LGBTQ+ participants suggest that research conducted with refugee populations in parts of South America, Southeast Asia, and the Middle East should seriously consider

Discrimination, Exclusion & Insecurity in Displacement: LGBTQ+ Individuals

Though it is widely recognized that LGBTQ+ individuals are at risk of GBV, only two identified publications focused specifically on LGBTQ+ individuals (Rosenberg, 2017b; Valiquette et al., 2020), while seven publications included findings or discussion points focused on LGBTQ+ individuals (i.e. Murfet & Baron, 2020; Robinson, 2018; Chynoweth, 2019). This small collection is indicative of the need for more research specifically focused on better understanding the needs of LGBTQ+ refugee and IDP populations in and across different regions (Freccero & Seelinger, 2013).

Select Key Findings

- Individuals who are perceived to be or identify as LGBTQ+ are at risk of discriminatory violence or "corrective" sexual violence by their own community members as well as members of the host community (i.e. Chynoweth, 2019; Murfet & Baron, 2020; Robinson, 2018). Transgender individuals are at particularly heightened risk of being targeted with severe violence, including by authority figures (Rosenberg, 2017b; Valiquette et al., 2013).
- LGBTQ+ refugees and IDPs often are forced to navigate additional barriers to safety, humanitarian services, and GBV survivor support services compared to their cisgender and heterosexual peers (i.e. Rosenberg, 2017b; Valiquette et al., 2020; Hassan et al., 2016).
- LGBTQ+ refugees sometimes report perceiving urban environments as offering greater anonymity, access to non-discriminating supportive services, and the potential to find a network of peers with similar identities compared to camp settings (Freccero & Seelinger, 2013; Rosenberg, 2017b).
- LGBTQ+ individuals indicated their satisfaction with services as well as strengthened peer networks, and an improved sense of safety when engaging with supportive services specifically tailored to their needs; however, these services are often very limited and struggle with lack of funding and limited integration into other services as well as the broader community (i.e. Hanley et al., 2018; Rosenberg, 2017b, 2017a; Freccero & Seelinger, 2013)

asking questions about gender identity and sexual orientation (i.e. Freccero & Seelinger, 2013; Hanley et al., 2018; Murfet & Baron, 2020). Ultimately, ethics and risk assessments need to be the core consideration when defining the inclusion criteria for a study. However, blanket ethical concerns should not be used as a universal excuse to not ask certain questions or seek out certain groups.

Community Context

Almost one-third of papers (32%) presented analyses using a study sample including the overall refugee population. In order to gain a broader understanding of the context, some studies also included perspectives from beyond the general refugee community. A similar proportion of papers (35%) included key informants in some way. These included interviews with representatives from government, UN agencies, NGOs, and community organizations as well as camp management personnel, community leaders, religious leaders, and service providers (i.e. Freccero & Seelinger, 2013; Kawaguchi, 2019; Lowicki-Zucca & Paik, 2013). Another 14 percent of papers included members of the host community as participants (i.e. Melnikas et al., 2020; Nakaijo et al., 2019; Sharma et al., 2020). Further, roughly 12 percent of papers included parents or caregivers of adolescents and young adults to better understand the experiences and needs of girls and young women (i.e. Bartels et al., 2018; Schlecht, 2016; Sommer et al., 2018).

Finally, only one paper–a doctoral dissertation–exclusively included adult male participants in an effort to understand male gender socialization and its relationship with GBV perpetration (Fry, 2019). It is possible that more research exists on this issue of male perpetration of GBV, but was missed in the literature search because of the terms used for this gap analysis. It could be that those publications were labeled under gender equality rather than GBV, for example. But it is also likely that limited research exists, in part because the limited funding made available to focus on GBV is largely directed towards the needs of women and girls. Debates within the GBV researcher and practitioner community continue over whether it is appropriate and ethical to divert money that could directly focus on survivors to instead focus on perpetrators (Apolitical, 2018). However, without a better understanding of who perpetrates this type of violence, under what circumstances, and why (e.g. How does past experience with conflict-related violence inform the likelihood of perpetration among refugees, in either camps or integrated communities? How do social norms and attitudes around GBV perpetration change due to conflict-related migration? Who are key change agents within refugee communities to reduce the risk of perpetration?), it will be difficult to pursue programming that halts perpetration and will continue the need for programming to respond to the consequences of it.

Violence Against Men and Boys: What We Know

Displaced men and boys experience GBV at measurable levels (i.e. Fisher et al., 2018; Gerrard & Myers, 2016; Undie et al., 2016). However, there are significant gaps in knowledge and psychosocial support programming tailored to the needs of male survivors of GBV (i.e. Kawaguchi, 2019; UNHCR, 2016; Rosenberg, 2016a). We reviewed 25 publications that discussed or focused on GBV targeting refugee or IDP men and boys. Publications collectively focused on 19 countries, barring one publication which was a systematic review. Key findings from these works include:

- Men and boys were more likely to be targeted for certain types of GBV, such as castration, forced witnessing of sexual assault being inflicted upon others, forced infliction of sexual assault upon others, physical violence by a non-partner, or forced conscription (Chynoweth, 2019, 2020; Azerbaijani-Moghaddam et al., 2001; Liebling et al,. 2020).
- Displacement, travelling far from camp to collect firewood, living with disability, minority community status, selling sex, and violence occurring between parents or guardians were among the identified risk factors of GBV for men and boys (i.e. Foster et al., 2015; Rosenberg, 2016a; Gerrard & Myers, 2016).
- The belief that GBV targeting men and boys is uncommon contributes to stigmas surrounding male survivors of GBV, especially for those who have experienced sexual assault (i.e. Izugbara et al., 2018; Diamond & Oberg, 2019; Chynoweth, 2020).
- Comparatively few shelters for survivors of GBV are open to single men or boys, with some shelters ageing male survivors out as young as the age of 12 (Freccero & Seelinger, 2013; Feldman et al., 2013; Hanley et al. 2018).

Gaps in the Research

- There is a need for research specifically focused on the experiences of men and boys with regards to GBV (i.e. Hastie et al., 2018; Araujo et al., 2019; CARE, 2017).
- More research is needed to better understand the interaction between harmful substance use and the perpetration or experience of GBV by men in displaced settings (Wirtz et al., 2018; Mootz et al., 2019; Feldman et al., 2013)

CHAPTER 2:
WHERE

CHAPTER 2: **WHERE**

GAPS:

- Lack of studies focusing on refugee populations in South Asia (e.g. Pakistan, Afghanistan), Central America, West Africa and the Sahel, and the MENA region beyond Lebanon and Jordan.
- Lack of studies in urban, as well as peri-urban and suburban, settings.

Geographic Coverage

Sub-Saharan Africa was the most represented region among the publications in this analysis with two-thirds (66%) of the literature focused there. Three countries–Ethiopia, Kenya, and Uganda–represented the bulk of research within the region, generating 46 of the 51 publications. Two studies were located in Cameroon (Parmar et al., 2014; Ndombasi, 2017) and one in Chad (UNHCR, 2016). The DRC (i.e. Smith et al., 2013; Sommer et al., 2018; Stark et al., 2017a) and South Sudan were also included but only in multi-regional studies (Erikson & Rastogi, 2015; Wachter et al., 2018).

The MENA region was the second most represented region, included in about a quarter of the publications and primarily taking place in Lebanon (i.e. Bartels et al., 2018; Holt, 2013; Lilleston et al., 2018) and Jordan (i.e. Al-Natour et al., 2019; Hattar-Pollara, 2019; El Arab & Sagbakken, 2019). A total of four publications included Iraq, though three of these were multi-country studies (i.e. Erikson & Rastogi, 2015, Wachter, et al., 2018, Hirsch-Holland, 2020). Turkey appeared in only one study (Diamond & Oberg, 2019).

Less than one-fifth of the publications (16%) included the experiences of women and girls in Southeast Asia, specifically in Thailand (i.e. Ezard, 2014; Falb et al., 2013a, 2014), Bangladesh (i.e. Melnikas et al., 2020; Nelson et al., 2020; Jaham Seema & Rahman, 2020), and India (i.e. Rosenberg, 2016a, 2017a, 2017c). However, three of the publications from Thailand were generated from the same cross-sectional study (Falb et al., 2013a, 2013b, 2014). Likewise, the three articles from India were generated from one multinational (and multi-regional) project (Rosenberg, 2016a, 2017a, 2017c).

Fewer, if any, studies were collected that feature other regions: six publications covered South America and included refugee populations in Ecuador (i.e. Manell & Radice, 2019; Murfet & Baron, 2019; Rosenberg, 2016a, 2016b), Colombia (Murfet & Baron, 2020; Feldman et al., 2013), Venezuela (Murfet & Baron, 2020), and Peru (Murfet & Baron, 2020). All but one (Manell & Radice, 2019) were multi-country studies, and only one multi-country study was specific to the region (Murfet & Baron, 2020). Within the publications collected, no studies were conducted among refugee populations in Latin America and the Caribbean outside of South America. Finally, only one study included Central Asia: a multi-regional qualitative study that examined older women's potential roles in stopping IPV (Hirsch-Holland, 2020).

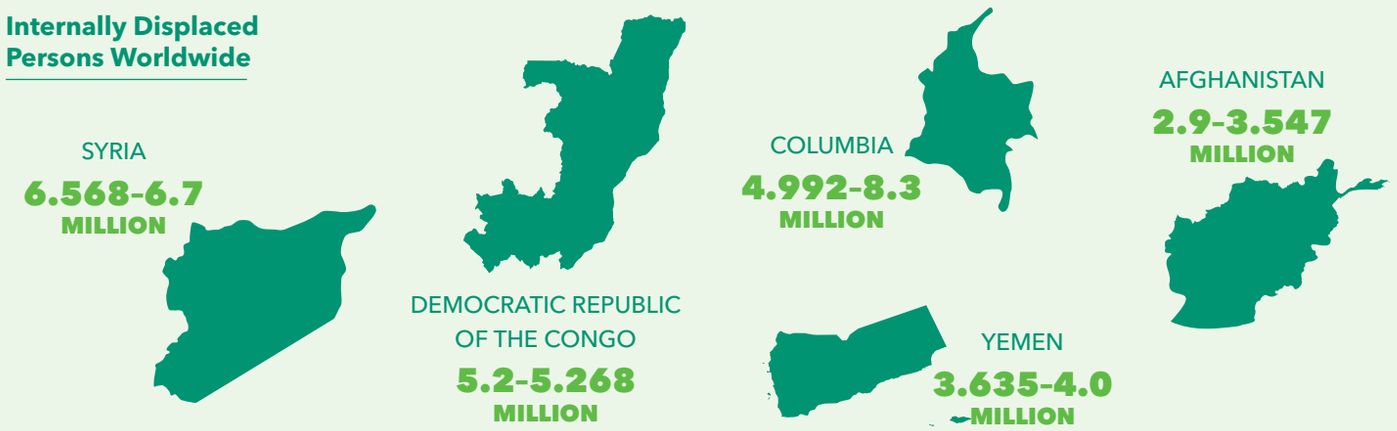
The geographic coverage within these publications does not reflect the distribution of refugees in the Global South. For instance, while the majority of studies were conducted in East Africa, more refugees are hosted in the South Asia and MENA regions at the time of this report being produced (UNHCR, 2019). West and Southern Africa were not represented at all in this sample, despite ongoing conflict and increasing displacement, and few studies were focused on refugees in Central Africa or the Sahel region. The whole of North Africa[4] was absent in this set of publications, as were long-standing host countries, such as Pakistan, despite hosting the third-largest refugee population (UNHCR, 2021).

Settings

Almost two-thirds of the publications (60%) focused on rural populations. Among these, the vast majority of the studies were conducted in camp settings (91%) (i.e. Ezard, 2014; Liebling, et al., 2020; Namy et al., 2019), three in integrated communities (Lilleston et al., 2018; Mourtada et al., 2017; Parmar et al., 2014), and one included both camp and integrated populations (Parcesepe et al., 2016). Rural populations were more prevalent in Sub-Saharan Africa and Southeast Asia, particularly in Thailand at the Thai-Burma border and in Bangladesh, where all studies included in this analysis were conducted in Cox's Bazar (i.e. Melnikas et al., 2020, Jaham Seema & Rahman, 2020; Shefa Sikder,

4. Only one study was collected from North Africa, specifically in Egypt, but it was published before 2010 and therefore not included in the detailed review and analysis.

In Danger at Home: Internally Displaced People



There were more than 48 million IDPs throughout the world in 2020 (UNHCR, 2021). While IDP population estimates vary, the most current estimates suggest that the greatest number of IDPs due to conflict are currently in Colombia (4.992-8.3 million), Syria (6.568-6.7 million), the DRC (5.2-5.268 million), Yemen (3.635-4.0 million), and Afghanistan (2.9-3.547 million) (UNHCR, 2021; Internal Displacement Monitoring Centre, 2021). From the past two decades, 21 publications discussing or focusing on IDP populations were identified in our review. Altogether, research and evaluations included populations in Sub-Saharan Africa; the Middle East; Central, South, and Southeast Asia; and Latin America.

Factors Contributing to GBV

IDPs constantly live under the threat of GBV. Participants in Sub-Saharan Africa, the Middle East, and Central Asia identified minority status, food or financial insecurity, fractured social networks in the context of conflict and changing norms, and overcrowded neighborhood environments as factors that heighten the risk for GBV (i.e. Cardoso et al., 2016; Hiddleston et al., 2001; Hennion, 2014). Within IDP camps, foraging for firewood (Hiddleston et al., 2001; Patrick et al. 2006) and using water, sanitation, and hygiene (WASH) facilities (Hastie et al., 2018; Cavill et al., 2018) were identified as potential drivers of GBV when either task is far from camp or must be undertaken alone or in small groups.

There is some evidence of the long-term impact of experiences of GBV within IDP populations. Data from studies in Colombia and Somalia suggest intergenerational correlations between witnessing domestic violence at a young age and either experiencing or perpetrating it as an adult (Wirtz et al., 2014, 2018). Existing data indicate that some forms of GBV may cause severe PTSD or depression symptoms (Goessmann et al., 2020; Hassan et al., 2016). Alongside stigma and shame surrounding IPV and GBV, the quality, comprehensiveness, and levels of support provided by service providers served as barriers that prevent help-seeking activities (i.e. Austin et al., 2008; Feldman et al., 2013; Stark et al., 2010).

Future Research

Study authors recommended several areas of focus for future research:

- To better capture the breadth of IDPs' perspectives, there is a need for the intentional inclusion of men's and caregivers' perspectives; amplification of women's and girls' voices; and reduction of exclusionary practices that affect the participation of LGBTQ+ individuals, older adults, individuals with disabilities, and individuals with other marginalized identities (Asghar et al., 2018; Hynes et al., 2016; Women's Refugee Committee [WRC] & the International Organization for Migration [IOM], 2017).
- More comprehensive and longitudinal data collection regarding incidents of GBV in IDP populations is needed to develop more effective interventions (i.e. Asgary et al., 2013; Austin et al., 2008; Wirtz et al., 2014).
- There is a need to focus research on the prevention of GBV in conflict-affected communities, especially as exposure to conflict may increase vulnerability to GBV (Glass et al., 2018; Mootz et al., 2019; Austin et al., 2008).
- Cross-sectional study designs, along with community-level participatory methods, should be considered when collecting data and also when designing and implementing interventions (Asgary et al., 2013; Stark et al., 2010; Glass et al., 2018).
- Significant gaps in the literature on IDPs include particular vulnerabilities of older adults, persons living with disabilities, and LGBTQ+ persons (i.e. WRC & IOM, 2017; Hassan et al., 2016; Feldman et al., 2013).

FOCUS ON URBAN REFUGEES: WOMEN'S REFUGEE COMMISSION TACKLES THE GAP

While there is generally a dearth of research focusing on refugees in urban settings, the Women's Refugee Commission (WRC) has focused multiple research efforts towards better understanding the barriers and protective factors that affect urban refugees' wellbeing and safety. The WRC publications we reviewed cover 10 countries across seven regions, from Cairo to Quito, Beirut to Delhi, and several cities in sub-Saharan Africa. Further research is needed to fill the remaining gaps about GBV among refugees in urban areas, specifically persons living with disabilities, sex workers, LGBTQ+ individuals, and men and boys (Foster et al., 2015; Rosenberg, 2016a, 2017a, 2017b, 2017c).

Discrimination and legal difficulties in acquiring work permits and safe housing, GBV experienced at or en route to the workplace or home, and acute poverty collectively increase individuals' risk for GBV. These factors often force displaced individuals to engage in informal and unregulated work, such as sex work and domestic house work, which in turn carries increased risk for exploitation and GBV (i.e. Heller & Timoney, 2009; Rosenberg, 2016a, 2017c, 2017b; Foster et al., 2015).

Few resources exist for refugees who have experienced GBV and wish to seek supportive services (Rosenberg, 2016a; Heller & Timoney, 2009). Existing resources often lack dedicated space for men and boys; LGBTQ+, specifically transgender, individuals; persons with disabilities; sex workers; and adolescents (Heller & Timony, 2009; Rosenberg, 2016a; Chynoweth, 2019). These services may be logistically difficult to access safely and affordably (Heller & Timony, 2009; Rosenberg, 2016a, 2017c; Chynoweth, 2019).

Persons living with disabilities; female caregivers; sex workers; single women; LGBTQ+ individuals, especially transgender individuals; unaccompanied minors; and members of households living in poverty or in female-headed households are often acutely at-risk for GBV in their immediate environments as refugees in urban settings, particularly individuals at the intersections of multiple marginalized identities (i.e. Chynoweth, 2019; Rosenberg, 2016a, 2017a, 2017b, 2017c; Foster et al., 2015).

2020). No rural-focused studies based in South America were uncovered in our search.

Urban populations were studied mainly in the Middle East and South America, accounting for 71 percent of the 17 urban-based studies (i.e. Hattar-Pollara, 2019; Yoshikawa, 2015; Rosenberg, 2016a, 2016b). Three additional studies each were conducted in Kampala, Uganda (Logie et al., 2019; Nara et al., 2019; Rosenberg, 2017c), and Delhi, India (Rosenberg, 2016a, 2016b, 2017a), as well as one study from Duhok, Iraq (Strang et al., 2020). Among urban studies, the majority of refugee populations were exclusively living in integrated settings (59%).

Seven studies were conducted in mixed settings, sampling urban and rural populations living in camps and integrated situations and were generally tied to a specific topic, such as health care provider training (i.e. Smith et al., 2013), tool (i.e. Wirtz et al., 2016), or toolkit (i.e. Murfet & Baron, 2020) development, or to a specific sub-population, such as persons with disabilities (i.e. Foster et al., 2015). A handful of the publications did not specify a setting.

The urban-rural divide in the research collected represents the opposite of the refugee experience. While 60 percent of refugees live in urban settings (UNHCR, 2019), 60 percent of the collected research has been conducted in rural areas. In addition, refugees living in peri-urban and suburban integrated settlements are increasingly common (UNHCR, 2019), though few, if any, studies to date have examined the unique needs of refugees in these settings.

CHAPTER 3:
WHAT

CHAPTER 3: **WHAT**

GAPS:

- Limited examination of perpetration of GBV among refugee populations, including prevalence and drivers, from the perspective of men and boys broadly and as perpetrators specifically.
- Lack of information on overall experiences of GBV as well as risk factors and drivers during flight from country of origin to country of asylum.
- Limited information on temporality around when GBV occurred and its impact on immediate and long-term outcomes.
- Lack of understanding on the role xenophobia plays in GBV exposure among refugees and follow-on access to care for survivors.
- Limited understanding about what GBV looks like for refugee girls and women in different contexts, including relationships between violence experienced inside and outside of the home.
- Limited evidence on adolescent girls' exposure to GBV, including early marriage, and their resulting needs in a variety of contexts.
- Limited understanding on the effectiveness and appropriateness of different types of practitioners and modes of service delivery to serve and care for GBV survivors.
- Lack of GBV prevention and risk mitigation program evaluations.

Conflict Victimization and Migration Journey

Broadly, we know that women and girls are at risk for GBV during conflict, in flight, and in displacement (i.e. Ivanova et al., 2019; Liebling et al., 2020; Robinson, 2018). However, the majority of research on refugees has focused on women and girls' experiences during displacement, with little evidence on conflict-related experiences and exposure. Some research shows that women experienced more violence during conflict than in flight, and that the conflict-related experiences may influence their future exposure to violence, specifically IPV, while displaced (Falb et al., 2013b; Sipsma et al., 2015).

Little is known about GBV against women and girls during migration. Collected publications suggested that GBV was often opportunistic with women targeted by those they depended on while in transit to their destination (Wirtz et al., 2013). Some studies found that women were at greater risk of and experienced more violence while in refugee camps than while in flight (Parcesepe et al., 2016; Ndombasi Kinsumba Ndamuso, 2017). The work by Ndombasi Kinsumba Ndamuso (2017) further showed that GBV acts increase after leaving from one's country of origin, as refugees in Cameroon reported that 12 percent of GBV acts occurred while displaced in their country of origin and 15 percent occurred while displaced outside of it (though none actually occurred in a camp). While research and anecdotal evidence shows that violence, including rape (International Medical Corps, 2011; Wirtz et al., 2013), does occur during the journey, these findings suggest that women and girls may be at greatest risk when in a set location, but not enough is known about the migration journey to make any conclusions. Overall, the majority of the publications collected focused on the conditions and experiences at the destination of the migration journey and refugees' experiences of GBV in camps or within host communities.

Defining GBV in Displacement

Regardless of whether one is displaced in a camp or host community, women and girls are exposed to and fearful of a variety of types of GBV, including IPV, forced and early marriage, unwanted physical touching, sexual exploitation, trafficking, and rape (i.e. Iyakaremye & Mukagatare, 2016; Robinson, 2018; Toma et al., 2018). Seven papers from Colombia and several countries in sub-Saharan Africa suggested that between 2.5% and 64.8% of conflict-affected refugee women and girls experience GBV (i.e. Ivanova et al., 2019; Parmar et al., 2014; Vu et al., 2017).

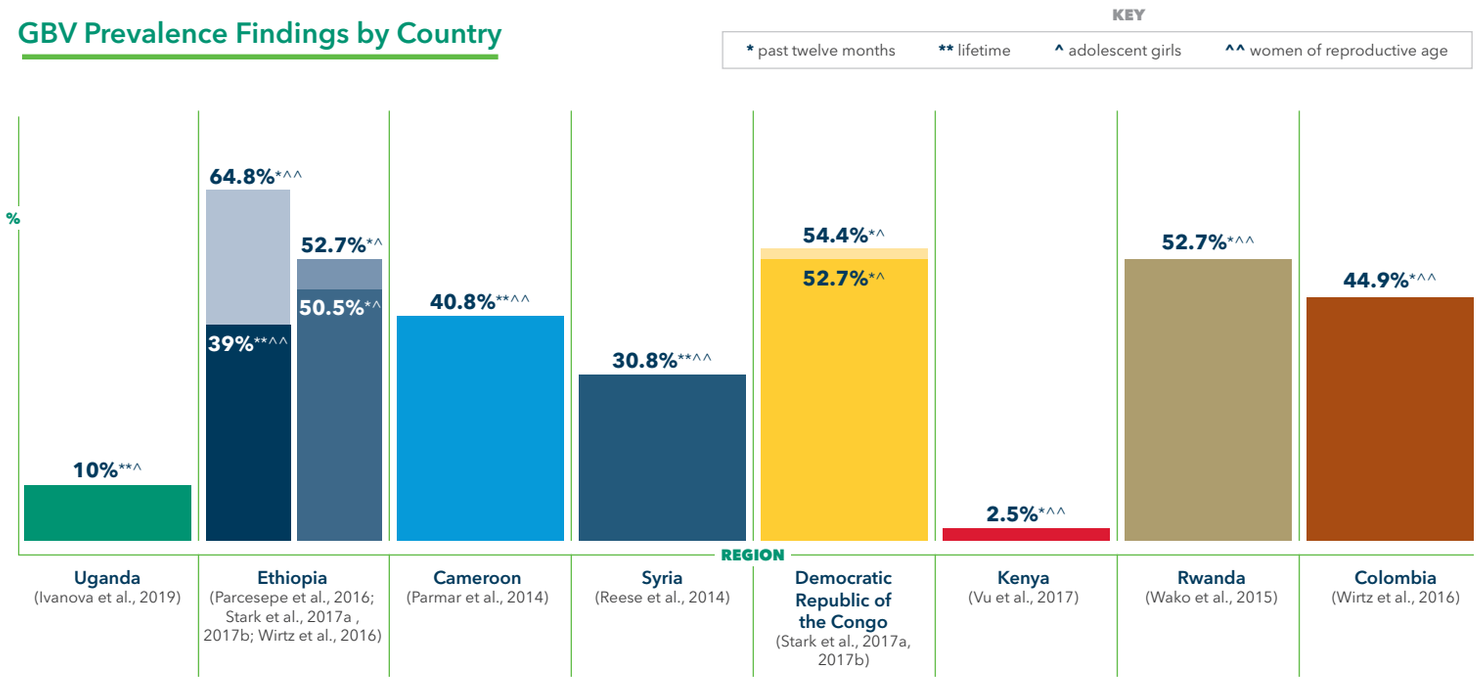
The most studied form of GBV among conflict-affected refugee populations in the Global South was IPV. In a three-country study, physical violence was the most common form of IPV reported, but psychological and sexual violence, as well as control over a woman's movement, behavior, access to social networks and economic resources, were also found (Erikson & Rastogi, 2015). Publications documenting the prevalence of IPV included studies among refugees on the Thai-Burma border and in several countries in sub-Saharan Africa; the range of reported IPV in these reports varied from 7.9% to 85.8% (i.e. Falb et al., 2013b; Logie et. al., 2019; Parcesepe et al., 2016).

Some studies also found higher rates of GBV were experienced

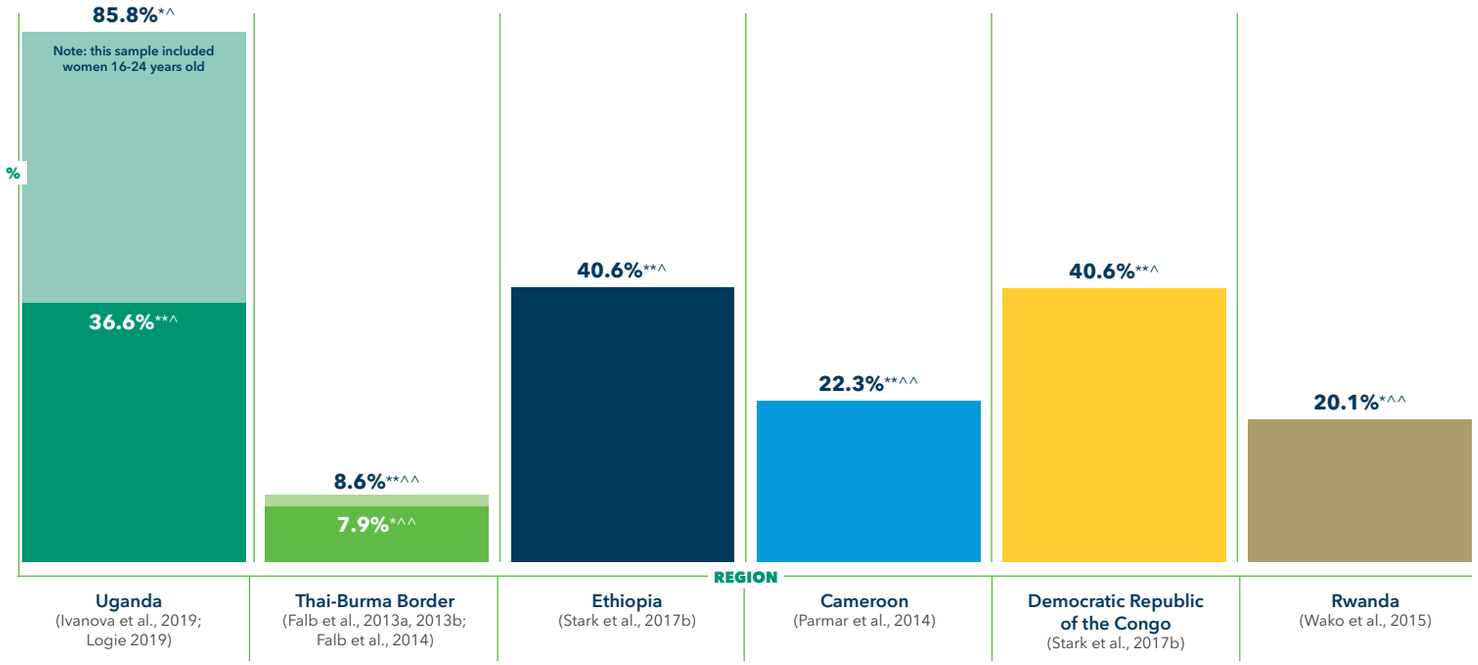
during the conflict, either directly related to the conflict or IPV that occurred during the conflict period in their home country (Falb et al., 2013b; Sipsma et al., 2018; Wako et al., 2015). On the Thai-Burma border camps, conflict victimization significantly increased the odds of women reporting past-year IPV compared to those who did not experience conflict victimization (Falb et al., 2013b). Another study found that experiencing non-familial violence significantly increased the odds of a woman also reporting IPV (Wako et al., 2015). Both of these studies point to a connection between exposure to violence inside and outside of the home, though more work is needed to better understand this relationship. Furthermore, Wako et al. (2015) reported that more than half (52.7%) of the Congolese refugee women respondents experienced violence perpetrated by a non-family member in the past year. Even taking into account that IPV is often underreported, this number (52.7%) and the association with IPV exposure warrants further examination in future studies to better map out all of the forms of GBV experienced by refugee women and girls.

Particular attention was also paid to vulnerability of and exposure to GBV among adolescent girls and young women, though this was mostly focused on in Central and Eastern Africa (the DRC,

GBV Prevalence Findings by Country



IPV Prevalence Findings by Country



Ethiopia, and Uganda) with limited coverage elsewhere (Jordan). Two papers, both of which used the baseline survey from the COMPASS program evaluation, found high prevalence rates of emotional, physical, and sexual violence in the past 12 months among adolescent girls in the DRC and Ethiopia, with more than half of participants in both countries (51.6%) reporting at least one type of violent victimization in that time period (Stark et al., 2017a; Tanner & O'Connor, 2017). Similar results were reported from a study in Uganda that focused on young adulthood violence, specifically girls and young women ages 16-24 years old, where more than half of the participants (53.7%) reported any violence experience (emotional, physical, and sexual) at or since the age of 16 (Logie et al., 2019).

Among the COMPASS participants, roughly 30 percent reported physical violence, 36 percent reported emotional violence, and slightly more than one quarter reported experiencing sexual violence, including forced sex, sexual coercion, and unwanted sexual touching (Stark et al., 2017a; Tanner & O'Connor, 2017). Alarmingly, those who reported sexual violence experienced it repeatedly (Tanner & O'Connor, 2017). This again mirrors findings from Uganda, where almost one in ten participants (9.3%) reported polyvictimization broadly, and more than half of those who reported experiencing IPV in the past 12 months (54.5%) reported polyvictimization (Logie et al., 2019). From high rates of IPV (85.8% in Uganda [Logie et al., 2019]) to concerns about verbal, physical, and sexual harassment outside of the home (UN Women, 2013), adolescent girls and young women in camps and host communities are at high risk for GBV.

Additional studies (conducted in Bangladesh, Lebanon, Jordan, Uganda, and Ethiopia) focused specifically on adolescent girls' GBV risk and exposure through the lens of early marriage. While none of the studies presented statistics on how common the practice was within the respective communities, common explanations for why the practice occurred–and was perceived by participants to happen more frequently while displaced–emerged. Families marrying their young daughters was seen to be driven by a combination of gender roles within families; financial hardship; and fear of GBV compounded by social, cultural, and religious practices and norms (i.e. Bartels et al., 2018; Hattar-Pollara, 2019; Mourtada et al., 2017).

Many of the reasons given as why early marriages are increasing can be understood as negative coping strategies by families due to the conditions brought on by displacement. The economic struggles refugees face may make early marriage appealing because it means one fewer person to support (Bartels et al., 2018; Mourtada et al., 2017). Further, a family's honor is often linked to a daughter's sexual purity, and unmarried girls and women may be more vulnerable to abuse. Early marriage is a way to theoretically protect both the daughter from violence and the family from shame (Bartels et al., 2018; Hattar-Pollara, 2019; Schlecht, 2016). In Lebanon and Jordan, the issue of disrupted access to education for adolescent girls was also raised as a factor that resulted in early marriage (Bartels et al., 2018; Hattar-Pollara, 2019; Mourtada et al., 2017).

One study from Bangladesh suggested that the increase in early marriage among Rohingya refugees was the result of religious and cultural practices that had been repressed in Myanmar but were now possible to practice in the camps (Melnikas et al., 2020). As the only study on this refugee population and the only study from the South and Southeast Asia region, more research is needed to better understand how prevalent the practice is and what the drivers behind it are. Further, gaps exist on the experiences and needs of adolescent girls beyond the issue of early marriage in the MENA region as well as any research on adolescent refugee girls' exposure to GBV in the Caribbean and Latin American region.

Drivers of GBV in Displacement

While displaced women and children were particularly affected by GBV (UNHCR, 2016), some differences in the risks for exposure and drivers of violence exist between camp and integrated community contexts, while other factors seem to be more universal. Many of the factors associated with IPV exposure were similar to non-displaced populations, such as age and education level (Capaldi et al., 2012; WHO, 2021). Other factors were distinct to being a refugee, including their precarious legal status and separation from one's social support network, including family, friends, and their community overall (Al-Natour et al., 2019).

A consistent narrative did emerge, however, around the ways in which conflict-related displacement informs IPV perpetration and exposure. One study suggested that the conflict was the beginning of the perpetration of IPV–before displacement–due to the way war changes spousal relationships (Al-Natour et al., 2019). The displacement context further exacerbates changes to gender norms and roles, specifically women being partially or entirely responsible for financially supporting their families–a role previously held primarily by men (i.e. Erikson & Rastogi, 2015; El-Masri et al., 2013; Wachter et al., 2018). This was often driven by limited employment opportunities for men and harsh conditions necessitating women to also seek paid work (Holt, 2013). While some women felt these changes were positive and empowering (El-Masri et al., 2013), not all felt that way, and many men felt frustrated and emasculated (Robinson, 2018). The combination of feeling unable to provide for and protect their families, untreated conflict-related trauma, and idleness due to unemployment led some to be violent against their intimate partners, which was sometimes related to alcohol and/or substance use (i.e. International Medical Corps, 2011; Sharma et al., 2020; Wachter et al., 2018). It is important to consider this trend across studies within the confines of the qualitative methods employed. None of these studies specifically recruited men who had perpetrated IPV, thus they represent the perspective and understanding of survivors and the broader community on what is happening and why. Further, none of these studies utilized quantitative measures to test the hypothesis that the causal pathway from displacement to IPV perpetration is mediated through feelings of emasculation

due to changing gender roles and/or substance use.

Beyond violence perpetrated within the home, at least two studies also raised the issue of violence perpetrated by authority figures in both camps and integrated communities (Murfet & Baron, 2020; Toma et al., 2018). In Cox's Bazar, Rohingya refugees raised numerous issues of abuse and exploitation by those with power. This included physical abuse by Rohingya community-based volunteers and community representatives, who were responsible for the distribution of food and other aid, and coercion to exchange money or sex for help by majhis, who are key points of contact for all NGOs working on community aid distribution (Toma et al., 2018). Research on the issue of exploitation and abuse in humanitarian settings is growing, in part because of the exposure of abuses perpetrated by UN peacekeepers and international NGO staff (Human Rights Watch, 2016b; Gharib, 2018; Wheeler, 2020). More research on this issue exists, but sexual exploitation and abuse (SEA) was not included as a focus of this gap analysis and therefore those publications were not included in this analysis.

Within refugee camps, the overall structure itself was identified as a driver of GBV (Horn, 2010; Holt, 2013; International Medical Corps, 2011). The layout, infrastructure, and security systems all informed the fear felt by women and girls (i.e. Fisher et al., 2018; Freccero & Seelinger, 2013; Iyakaremye & Mukagatare, 2016). Further, in some places, women and girls were fearful within their living spaces due to the lack of privacy and trust of community members as well as traveling alone in and around the camps for fear of kidnapping and trafficking (Toma et al., 2018).

Within integrated communities, xenophobia has implications for refugees' access to basic services, such as housing and employment, which in turn relate to GBV risk and exposure (Murfet & Baron, 2020; Rosenberg, 2016a). For housing, an unwillingness of host community members to rent accommodations to refugees meant they may end up living in unsafe and unsanitary conditions (Murfet & Baron, 2020). This can mean their home is not secure, the neighborhood is unsafe to walk in, or that the toilets and bathing facilities are communal. Further, as women and girls seek out paid work, they are at risk for sexual violence and exploitation due to limited livelihood options, such as sex work, and limited understanding of the systems that protect them in a new country. This may be further exacerbated by the xenophobic perceptions of host community members that certain refugees, such as Venezuelan refugees living in neighboring countries, are hypersexual, which increases their vulnerability to sexual exploitation and violence (Murfet & Baron, 2020). Beyond being marginalized for their refugee identity, Rosenberg (2016a, 2016b) also noted the ways in which refugee status may intersect with other marginalized identities (women, LGBTQ+ individuals, people with disabilities, sex workers, etc.) to inform the perpetration of GBV by authorities and service providers, particularly in cities where the sociocultural context endorses discrimination against those groups.

A strength of the work by Murfet & Baron (2020) and Rosenberg (2016a, 2016b) was that their studies were conducted in multiple countries, potentially suggesting more global themes related to the vulnerability of refugees in host communities. Further, other work showed the ways in which social integration–or the lack of it–has broad implications for refugees' ability to begin to build a new life (Maclin, 2017). However, these studies either exclusively used or heavily relied on qualitative methods. Additional studies utilizing quantitative measures would help understand the extent to which xenophobia informs GBV exposure among refugees,

Meta-Analyses, Literature Reviews & Systematic Reviews

Six meta-analyses, systemic reviews, and literature reviews met our inclusion criteria. The publications each synthesized between eight and 110 texts. One exception was Asgary et al. (2013), which did not find any publications that met their inclusion criteria. The following overarching findings and gaps were found across these reviews:

- Displacement can disrupt previously existing support and protection mechanisms, including those that prevent child marriage and IPV (El Arab & Sagbakken, 2019; Hassan et al., 2016; Samari, 2017).
- Policies around deportation in host countries, combined with cultural stigmas already present in communities, may inhibit refugee women's willingness to formally report IPV and GBV (Hassan et al., 2016; Samari, 2017).
- Health providers working with refugee and IDP populations must be trained to properly collect data regarding GBV, particularly in locations where government-produced population health statistics do not report information that includes non-citizen populations (Asgary et al., 2013; Samari, 2017).
- Researchers should consider implementing cross-sectional studies in multiple locations to test interventions as opposed to attempting controlled trials in IDP and refugee populations, and efforts should be made to employ consistent methodologies across different sites and regions for evaluation purposes (i.e. Asgary et al., 2013; Cavill et al., 2018; Hassan et al., 2016).
- Significant evidence gaps include rates of GBV in men and children; rates of GBV in LGBTQ+ populations; context-specific rates of GBV in populations across multiple regions; differences in risk and protective factors affecting child marriage for different demographics; and evaluations of GBV prevention and mitigation strategies, such as the impact of lighting in WASH facilities (i.e. Araujo et al., 2019; Asgary et al., 2013; El Arab and Sagbakken, 2019).

Lessons Learned from the COMPASS Program: Adolescent Girls in Displacement

The Creating Opportunities through Mentoring, Parental Involvement, and Safe Spaces (COMPASS) program was developed in a joint effort between the International Rescue Committee (IRC) and Columbia University with the intent to empower adolescent girls while supporting their health and safety (Tanner & O'Connor, 2017). The program was implemented and subsequently evaluated among three populations between 2014-2017: primarily Sudanese refugees in Ethiopian refugee camps; communities in eastern Democratic Republic of Congo (DRC); and internally displaced and non-displaced communities in northwest Pakistan (Tanner & O'Connor, 2017; Falb et al., 2016b). Our review collected eight publications discussing the design, implementation, and evaluation of the COMPASS program.

According to the research findings in Ethiopia and the DRC, violence was used to enforce gender norms regarding girls and limit their autonomy (Sommer et al., 2018). In Ethiopia, 29 percent of refugee girls in camps reported experiencing sexual violence and 52 percent reported experiencing GBV in the past 12 months (Tanner & O'Connor, 2017). In Pakistan, the impact of this violence meant that girls remained at home or only moved outside of their home when accompanied by an adult (Asghar et al., 2018).

Broadly, these publications discussed themes surrounding adolescent girls' and caregivers' perceptions of girls' responsibility for their own safety and their interactions with men and boys as well as community perceptions of appropriate responses to GBV (i.e. Tanner & O'Connor, 2017; Falb et al., 2016a, 2016b; Stark et al., 2018a, 2018b). In Ethiopia and Pakistan, girls were more likely to report having one or more non-familial friend and could identify services and trusted non-familial individuals they could reach for GBV support after the completion of the program (Tanner, 2017; Asghar et al., 2018).

Remaining Gaps and Future Research

There remains considerable gaps in our learning about the experiences of adolescent girls during times of displacement. For one, there has been insufficient development of quantitative and qualitative data collection methods tailored for adolescent girls (Tanner & O'Connor, 2017). In addition, research on the health and safety of adolescent girls should expand to evaluate trends in mental health and service access following participation in empowerment programs (Falb et al., 2016b), to explore questions around sexual consent and non-violent sexual relationships involving adolescent girls (Sommer et al., 2018), and to understand the effects of empowerment programs on girls' self-esteem (Stark et al., 2018a). Data collection should also be expanded to include the perspectives of men and adolescent boys as well as caregivers in order to engage them in conversations around community norms of gender equity, and to encourage their participation as allies in adolescent girls' safety and wellbeing (Sommer et al., 2018; Asghar et al., 2018).

particularly with the inclusion of host community members and authority figures.

Impact of GBV in Displacement

Several studies pointed to the health implications of GBV among refugee women and girls, particularly mental health and sexual and reproductive health outcomes. Both qualitative and quantitative studies showed that IPV is linked with poor mental health, including feelings of shame, fear, humiliation, and suicidal ideation (i.e. Al-Natour et al., 2019; Falb et al., 2013a; Sipsma et al., 2018). Conflict victimization was also associated with high stress and suicidal ideation as well as pregnancy complications and gynecologic conditions (Falb et al., 2013a, 2014; Reese Masterson et al., 2014). Finally, looking specifically at adolescent girls and young women, Logie et al. (2019) examined the association of young adulthood violence exposure with a variety of outcomes, such as depressive symptoms, food insecurity, and sexual relationship power–each of which was statistically significant. Overall, these findings highlight the immediate and potential long-term implications of GBV.

Caring for Survivors in Displacement

Before even considering what services are offered and how well they are implemented, there are barriers for survivors to access them or even disclose that they experienced GBV. Consistent barriers across countries were largely based on social norms and logistical knowledge. For the former, factors included fear of stigmatization; belief that IPV and sexual violence are private family matters and fear of dishonoring one's family; and fear of retaliation or reprisal violence (i.e. Erikson & Rastogi, 2015; Ndombasi Kinsumba Ndamuso, 2017; UN Women, 2013). With regards to knowledge, many refugee women and girls did not know about the services available to them, how to access them, or the potential benefits they might have (i.e. Kawaguchi, 2019; Tanner & O'Connor, 2017; UN Women, 2013). Lack of knowledge of services and lack of confidence in the care offered could be exacerbated when program continuity is interrupted (Kawaguchi, 2019; Liebling et al., 2020), further reducing the likelihood of survivors seeking care. This combination of factors meant that some survivors only felt comfortable disclosing situations of GBV to family or friends, if that, rather than through more official channels (Tanner & O'Connor, 2017; UN Women, 2013). A study in two refugee camps in Cameroon found that only six percent of survivors sought care at a health center for treatment, with 88 percent not seeking any treatment, and the remaining six percent self-treated (Ndombasi Kinsumba Ndamuso, 2017).

Multiple studies also pointed to the need for capacity building within clinics for screening of GBV survivors and the knowledge, attitudes, and skills of service providers to properly and respectfully care for survivors. When universal screening programs for GBV have been piloted, the protocols were not always fully implemented because of competing, higher-ranked health priorities within clinics and health posts. GBV-focused processes also could be further complicated by the need for privacy, psychosocial support, GBV case management infrastructure, and resources to support this work–not all of which were available in health centers (i.e. Kawaguchi, 2019; Liebling et al., 2020; Shefa Sidker, 2020).

For providers, including medical professionals, community health workers, and refugee community workers, most were not adequately trained and socialized to care for GBV survivors in a sensitive and respectful manner (i.e. Hossain et al., 2018; Liebling et al., 2020; Smith et al., 2013). A study based in the Dadaab camp found harmful attitudes held by refugee community workers regarding violence, such as wife-beating not considered to be GBV (Izugbara et al., 2018). In a paired mixed-methods evaluation of an integrated case management system that included refugee community workers, survivors also expressed concerns about having services delivered by members of their own community, including bias based on clan differences and confidentiality (Hossain et al., 2018). Despite these issues, the evaluation showed that the inclusion of refugee community workers in the case management and referral process led to improved mental health outcomes for survivors over time, suggesting that the overall model was successfully reaching those in greatest need to access care (Hossain et al., 2018). As the examination of refugee community workers as part of the care provision system was only focused on in one camp, more research is needed to fully understand the risks and rewards of the approach.

A four-country evaluation (Kenya, the DRC, Ethiopia, and Jordan) further showed that training health workers can lead to changes that improve the care and wellbeing of survivors (Smith et al., 2013). The intervention sought to address the attitudes, knowledge, confidence, and practice of health care providers. The Clinical Care for Sexual Assault Survivors training tool[5] proved effective at improving providers' respect for patients' rights and knowledge of and confidence in clinical care provision, which manifested into improved care as shown through significant increases in survivors' receiving HIV post-exposure prophylaxis, STI prophylaxis and treatment, and emergency contraception (Smith et al., 2013). Even though the training tool did not significantly shift providers' attitudes around women and sexual assault, it did enough to shift their behavior in a way that better served their patients. Testing this training tool, as well as developing and testing other tools and approaches to improve care for GBV survivors, in other contexts is needed to better understand how universally acceptable and effective the approach is.

Where sufficient GBV services exist to handle increased caseloads, routine GBV screening may be an effective strategy to overcome these barriers to enable survivors to access the care they need

5. https://iawg.net/resources/clinical-care-for-sexual-assault-survivors

(IRC, 2015; Wirtz et al., 2013). An evaluation of the ASIST-GBV instrument, a GBV screening tool developed for humanitarian settings and tested in Kenya, Ethiopia, and Colombia, found that the instrument had good internal consistency, reliability, and psychometric properties and was acceptable for both women and providers (Vu et al., 2016, 2017; Wirtz et al., 2016). In addition, Lilleston et al. (2018) found potential solutions with their mobile service delivery model (e.g travelling to communities to provide GBV services directly in communities rather than relying on static clinics), which they ran in Lebanon to reach Syrian refugees. Both of these approaches, however, are dependent on skilled service providers who are trained to serve this particularly vulnerable and isolated population (Lilleston et al., 2018; Wirtz et al., 2013). Applying these strategies, tools, and models in more contexts–keeping culture, gender norms and attitudes, and religion in mind (IRC, 2015)–would further build the evidence on their effectiveness in meeting the needs and improving outcomes for GBV survivors..

CHAPTER 4:
HOW

CHAPTER 4: **HOW**

This chapter is broken into two main sections. The first examines the methods employed across the collected publications. This is then followed by a consideration of issues related to ethics and power.

Methods

GAPS:

- Lack of validated, appropriate, and survivor-centered approaches to collect data on GBV experiences.
- Lack of quantitative analyses that utilize non-logistic regression models.
- Lack of studies that use multiple time points in the analysis.
- Limited collection and analysis of qualitative data in the original language of participants.
- Lack of clear detail of methods employed and consideration of limitations of those methods, particularly in grey literature and qualitative studies.
- Limited integration of quantitative and qualitative approaches in mixed methods studies.

Roughly 45 percent of the analyzed publications used or presented only qualitative methods, 25 percent only quantitative methods, and the remaining 30 percent employed and presented mixed-methods designs. These methodological designs are explored in more detail based on data collection and analysis, with author-identified methodological limitations throughout.

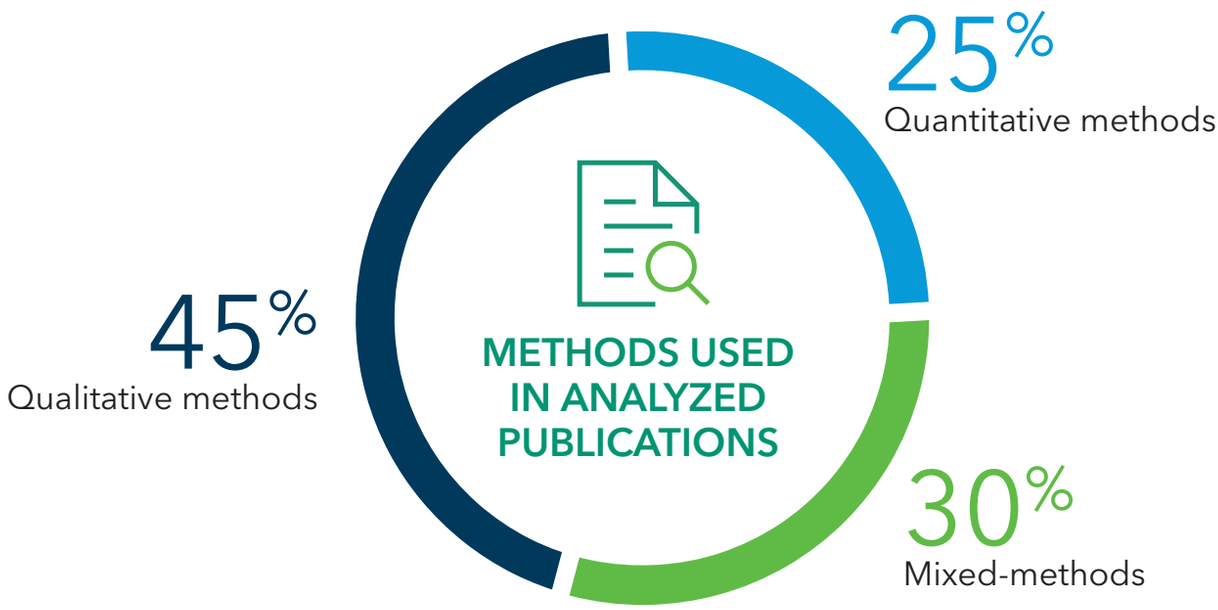
Qualitative Studies

DATA COLLECTION: With very few exceptions, all of the qualitative-specific publications featured original data with some also supported by desk or literature reviews. Every qualitative-specific publication described the use of at least one of three standard data collection methods–focus group discussions, in-depth interviews, and/or key informant interviews–with semi-structured interview guides. Some publications detailed the addition of less traditional forms of data collection, including participatory mapping exercises, scenario-based questions, and safety audits (i.e. Sommer et al., 2018a, 2018b; Robinson, 2018). These novel approaches were used to create a more comfortable environment to discuss potentially sensitive topics for particularly vulnerable groups, such as adolescent girls (Sommer et al., 2018a, 2018b). While standard qualitative tools may work well for studies examining less personal topics like community norms or to ask more general questions about the needs or experiences of refugee populations, they may not be as effective with more marginalized populations or when exploring more sensitive subjects. The use of participatory methods that allow for respondents to more freely and creatively share their stories, which may also take off some of the burden they might feel during the interview process, should be considered when the context allows for it. Further, for focus group discussions, almost all publications noted that groups were separated by gender and age, which should also bolster the comfort of participants to speak openly being in similar peer groups.

Among the publications that provided details on how data collection occurred, most noted using purposive, convenience, or snowball sampling strategies to recruit participants. Almost every publication reported that at least one member of the data collection team in the room with participants (i.e. interviewer, translator, note taker) was the same gender as the participant(s) when possible. Some noted the need for live translation during interviews, while others said interviews were done in the language most comfortable for the participants and then later translated to English.

Questions were raised across publications about the quality of data collected due to limited training of data collectors; issues around translation; a mismatch between the research question and methods employed; or the logistics of data collection not being ideal, such as whether interviews took place in a private space (i.e. Horn, 2010; Mourtada et al., 2017; Wachter et al., 2018). Authors from several publications noted that they were presenting a rapid gender analysis or had limited time in the field, which prevented them from being as detailed or thorough as might be warranted or confident that they had reached saturation in the data they had collected.

While qualitative research methods may be viewed as easier to implement, it should be viewed through the same rigorous lens



as quantitative methods. Beyond the actual interviews and then analysis of transcripts, there are other important methodological procedures that help ensure non-verbal information that is not visible in transcripts is captured and considered in analyses. For example, detailed memo-ing and debriefing after interviews, particularly if some members of the team do not speak the language in which the interviews were conducted, are considered best practice for qualitative data collection. These processes help researchers reflect on their own role in the process of data collection and the ways in which they might influence the information collected. While it might be that authors were constrained by word counts or felt these details were irrelevant for publication, it is concerning that only a few publications detailed memo-ing and debriefing as part of their research process (i.e. Ezard, 2014; Nara et al., 2019; Yoshikawa, 2015).

ANALYSIS: Across the qualitative-focused publications, a consistent data analysis process was used. In the majority of papers, authors described the translation of audio-recorded interviews to English, a team of researchers developed a codebook of inductive codes, and then conducted and presented a thematic analysis (i.e. Ezard, 2014; Horn, 2010; Wachter et al., 2018). Thematic analysis was not universal though, with some conducting conventional content analysis (Sharma et al. 2020), narrative statement analysis (Hattar-Pollara, 2019), or phenomenological analysis (Al-Natour et al., 2019).

Almost all studies required translation of the original words of the participants to English, which created the possibility, if not likelihood, that some of the original message was lost. Melnikas et al. (2020) employed a unique approach to mitigate the fact that some of the researchers on their team did not know Bengali, the relevant local language for their study. The authors described having the Dhaka-based researchers review the Bengali transcripts to develop a codebook, which also identified themes in English in the data, which the US-based researchers then used when coding the English transcripts. This process likely helped the team maintain greater fidelity to the original content of the interviews, which can be lost through translation, by both including the original transcripts in the analysis process for a longer period and collaborating across the two research teams.

A major concern across the qualitative-specific studies was the potential for bias and influence of social desirability as well as the impact of the role of researcher as an insider or outsider from the refugee community (i.e. Hattar-Pollara, 2019; Ezard, 2014; Gerrard & Myers, 2016). A small number of publications specifically reported validating key themes and results with external experts (not key informant interviews) as a way to assess the quality of their work (i.e. Mourtada et al., 2017; Wachter et al., 2018). Fry (2019) further noted the inclusion of a subset of study participants directly to "examine the code set, verify patterns and themes, make contrasts and comparisons, and aid in assembling data into a cohesive story that accurately represented their shared experiences" (p.56). Both of these approaches may further help address any blindspots that exist among members of the research team in understanding the original data and meaning.

Quantitative Studies

DATA COLLECTION: About two-thirds of the quantitative-focused publications were based on original data collection (i.e. Vu et al., 2016; Wako et al., 2015; Parcesepe et al., 2016) with the remaining papers presenting secondary data analysis (i.e. Falb et al., 2013a; Sipsma et al., 2015; UNHCR, 2016). The majority of the publications featured cross-sectional data (i.e. Reese Masterson et al., 2014; Wako et al., 2015; UNHCR, 2016). Only two papers presented analyses that utilized more than one time point (Undie et al., 2016; Stark et al., 2018b). It is noteworthy that both of these studies took place within camps, possibly because it is a more controlled environment and thus easier to manage follow-up than

when refugees are dispersed among a host community.

As the vast majority of the quantitative-focused papers noted their use of cross-sectional data, many mentioned the inability to test or establish causality (i.e. Logie et al., 2019; Stark et al., 2014; Wako et al., 2015). Further, there were challenges within the cross-sectional surveys with attempting to establish or assess temporality, such as how different phases of conflict-related migration relate to violence exposure or how past and current violence respectively impact various health, social, and economic outcomes (i.e. Falb et al., 2013a, 2013b; Sipsma et al., 2015). Some of these questions are particularly challenging to address as one cannot know in advance where conflict will arise and therefore baseline data may be difficult to collect. Further, the fact that a population is in transit makes it difficult to follow them during their journey or maintain a relationship for follow-up questions over the course of their displacement. There is a need for more specific time-bound questions in survey instruments to better capture the timeline of events.

Only four publications mentioned any sort of theoretical or conceptual model, either to frame the intervention being evaluated, the study design, or the results (i.e. Logie et al., 2019; Undie et al., 2016; Parmar et al., 2014). This is particularly relevant for quantitative studies as they are often testing relationships between variables, including potential pathways. Theoretical and conceptual models can help identify what variables are relevant and how they may relate to each other; not only can these models help guide a study being implemented, but the results can help the research community better understand how certain models may operate within refugee populations.

With regards to sampling and recruitment, the publications described a variety of strategies. More than half of the quantitative-focused publications employed some sort of random sampling. When the study sought to specifically identify survivors of GBV, some researchers did so through health care facilities (IRC, 2015; Vu et al. 2016), while others employed peer network sampling (Logie et al., 2019). For both of these recruitment strategies, populations that may be hard to find or recruit openly were found using available resources in order to do so in a relatively safe manner. However, authors also noted issues related to the ways in which their sampling strategies and/or inclusion criteria meant they could not make claims of generalizability of their results (i.e. Logie et al., 2019; Reese Masterson et al., 2014; Wako et al., 2015). Beyond that, some described how the sample they did recruit limited their analysis. Logie et al. (2019) noted the inability to recruit sub-populations, such as people with disabilities, which meant not running any analyses on differences between groups. Insufficient sample sizes also limited statistical power and precision (i.e. Falb et al., 2013a; Stark et al., 2018a, 2018b). There is a need for the explicit and intentional recruitment of sub-groups with samples to ensure that a more inclusive examination of any given question is possible, including sub-group analyses and comparisons.

A fairly consistent process emerged across publications for how data collection occurred. Surveys were administered in-person by a local research assistant or NGO staff member who was trained in GBV research best practices (i.e. Undie et al., 2016; Parcesepe et al., 2016; Falb et al., 2014). The interviews were conducted in the language most comfortable to the participant, in a private location either at a central location or a location selected by the participant, and based upon a structured or semi-structured interview instrument (i.e. Logie et al., 2019; Wako et al., 2015; Sipsma et al., 2015). In a small set of publications, data collection was done through Audio Computer–Assisted Self-Interview (ASACI) and Computer-Assisted Personal Interview programming, in large part because the studies were assessing these data collection tools among refugee populations (i.e. Stark et al., 2017b, 2018a, 2018b).

Two-thirds of the publications noted the possibility of participants underreporting their experiences of GBV due to stigma, concerns about privacy, lack of rapport with data collectors, among others (i.e. Falb et al., 2014; Parmar et al., 2014; Wako et al., 2015; UNHCR, 2016). Alternative methods, such as surveys administered with ACASI technology or art-based approaches, present less direct means of asking sensitive questions, which may create a safer and more comfortable environment for participants. Similarly, issues around self-reported data that could not be verified were also raised as threats to validity (i.e. Parmar et al., 2014; Reese Masterson et al., 2014). The combination of adding field observations and document reviews may prove useful to attempt to verify or triangulate participant reports.

Several publications noted that an existing and validated instrument was adapted for the specific study context or population. These included the Gender-based Violence Tools Manual For Assessment & Program Design, Monitoring & Evaluation in Conflict-Affected Settings (Reese Masterson et al., 2014), the Reproductive Health Assessment Toolkit for Conflict-Affected Women (i.e. Falb et al., 2013a; Sipsma et al., 2015; Wako et al., 2015), the Gender Equitable Men (GEM) Scale (Undie et al., 2016), and the Center for Disease Control and Prevention's Violence Against Children Survey (VACS) and the Ispcan Child Abuse Screening Tools (ICAST) (Stark et al., 2017a). While limited, there was also some discussion of not only adapting these validated tools but also of pilot testing the adaptation among the study population before it was deployed (Reese Masterson et al., 2014).

ANALYSIS: Similar to a consistent pattern emerging among the means of data collection, a pattern also emerged in terms of data analysis. Almost half of the publications presented descriptive statistics of their sample, ran bivariate associations using tests like chi-square test or Pearson correlations, and then ran logistic regression–simple, multivariate, multivariable, multinomial (i.e. Logie et al., 2019; Reese Masterson et al., 2014; Stark et al., 2017a). The popularity of logistic regression makes sense given that most often the outcomes of interest, such as experiencing violence, are conceptualized as a dichotomous yes-or-no variable.

However, examining violence exposure in this way, either as the dependent or independent variable, is limited and hinders our ability to consider different experiences of violence and how those differences relate to other social, economic, and health issues of concern. More analytical approaches should be utilized in order to capture a more nuanced understanding of the relationship being investigated.

At least one paper presented linear mixed regression models (Stark et al., 2018a), and several others referenced generalized estimating equations (Falb et al., 2013a, 2013b, 2014). Other less common analysis methods employed included receiver operating curve analysis to evaluate the predictive value of certain indicators on experiencing sexual violence (Parmar et al., 2014); principle component analysis to assess if a subscale accurately reflected a construct and then create a score to reflect the construct based on participants' responses (Reese Masterson et al., 2014); and latent class analysis to identify underlying classes of violence experiences among participants and then if those classes impact other health outcomes (Sipsma et al., 2015). These papers highlighted other analytical methods that are possible and should be considered in future work.

Further, two publications raised issues that relate to the need for local knowledge and how its omission stunts the development of new evidence. Wako et al. (2015) noted that their background research, which informed the development of their study on Congolese refugees in Rwanda, was only conducted in English, suggesting that an unknown amount of relevant research and information about the Congolese experience and Rwandan context are missing from their study design. On the other end of the research process, Falb et al. (2016) said that questions remain unanswered about the perceived usefulness of the ACASI tool by the adolescent girl participants, but that qualitative data would offer greater insight into its acceptability. Both of these publications highlight the need to incorporate local voices into all aspects of the research process to ensure that the work is contextually grounded.

With two pairs of publications, we can consider the different approaches to evaluating interventions with longitudinal data and validating data collection tools. For the first pair, Undie et al. (2016) assessed the impact of the 'Zero Tolerance Village Alliance' Intervention in Uganda, by comparing key indicators from baseline and endline, using significant tests of proportions and chi-square tests. Stark et al. (2018b) examined the impact of the COMPASS program on economic vulnerability among adolescent girls in Ethiopia. This evaluation was somewhat more complex as it not only had two time points but also control and intervention groups to compare. They ran four unique logistic regression models controlling for the outcome of interest at baseline to assess the impact of receiving the intervention (Stark et al., 2018b). While both of these papers point to different ways to evaluate interventions over time, the fact that there are only two in the entire sample of collected publications points to a need for more longitudinal evaluations of programming and publishing the results of those evaluations.

Emerging Technology for Data Collection in Refugee Settings: Audio Computer-assisted Self-interviewing

A majority of adolescent girls in the DRC and Ethiopia (90% and 75%, respectively) felt that a survey administered as part of the COMPASS program using ACASI technology was easy to understand (Falb et al., 2016a). Beyond the acceptability among the participants, the tool also aided in the administration of the survey and ensured confidentiality and anonymity regarding experiences of violence (Falb et al., 2016a). An analysis comparing ACASI and group-based qualitative methods for violence-related questions also found that the former method yielded more experiences of violence perpetrated by intimate partners and family members, while the latter brought forth more stories of violence perpetrated by strangers or individuals less connected to the participants (Stark et al., 2017b). As this technology was only assessed with adolescents and in two countries within the same broad region, testing its acceptability with other age groups and in other contexts is an important next step.

For the second pair of papers, Vu et al. (2016) attempted to validate the ASIST-GBV tool, and Falb et al. (2016a) assessed the feasibility and acceptability of ACASI among adolescent girls in Ethiopia and the DRC. For the latter paper, they ran logistic regression models to understand whether different demographic variables, such as age or education, were associated with the participants' perception of how easy the questions were to understand, as well as chi-square tests to examine whether statistically significant differences existed in responses by those demographics (Falb et al., 2016a). As Vu et al. (2016) were seeking to validate an entire instrument, their approach was more multifaceted and based on several analytical strategies: item response theory, factor analysis, and Cronbach's alpha.

Mixed Methods Studies

When considering the component parts of the 23 mixed methods publications, similar patterns emerged regarding data collection, analysis, and limitations. Thus, this section provides a broad summary of the publications and then focuses on the unique feature of mixed methods designs, which is the combination and integration of those methods, rather than largely repeating the same information about the separate parts.

OVERVIEW: More than half of the mixed methods papers (57%) presented evaluations of programming (i.e. Manell & Radice, 2019; Tanner & O'Connell, 2017; Nakaijo et al., 2019) or methods (Stark et al., 2017b; Vu et al., 2017). Forty percent were descriptive in nature (i.e. Fisher et al., 2018; Ivanova et al., 2019; Toma et al., 2018), and only one publication detailed both a formative descriptive aspect as well as an evaluation (Foster et al., 2015).

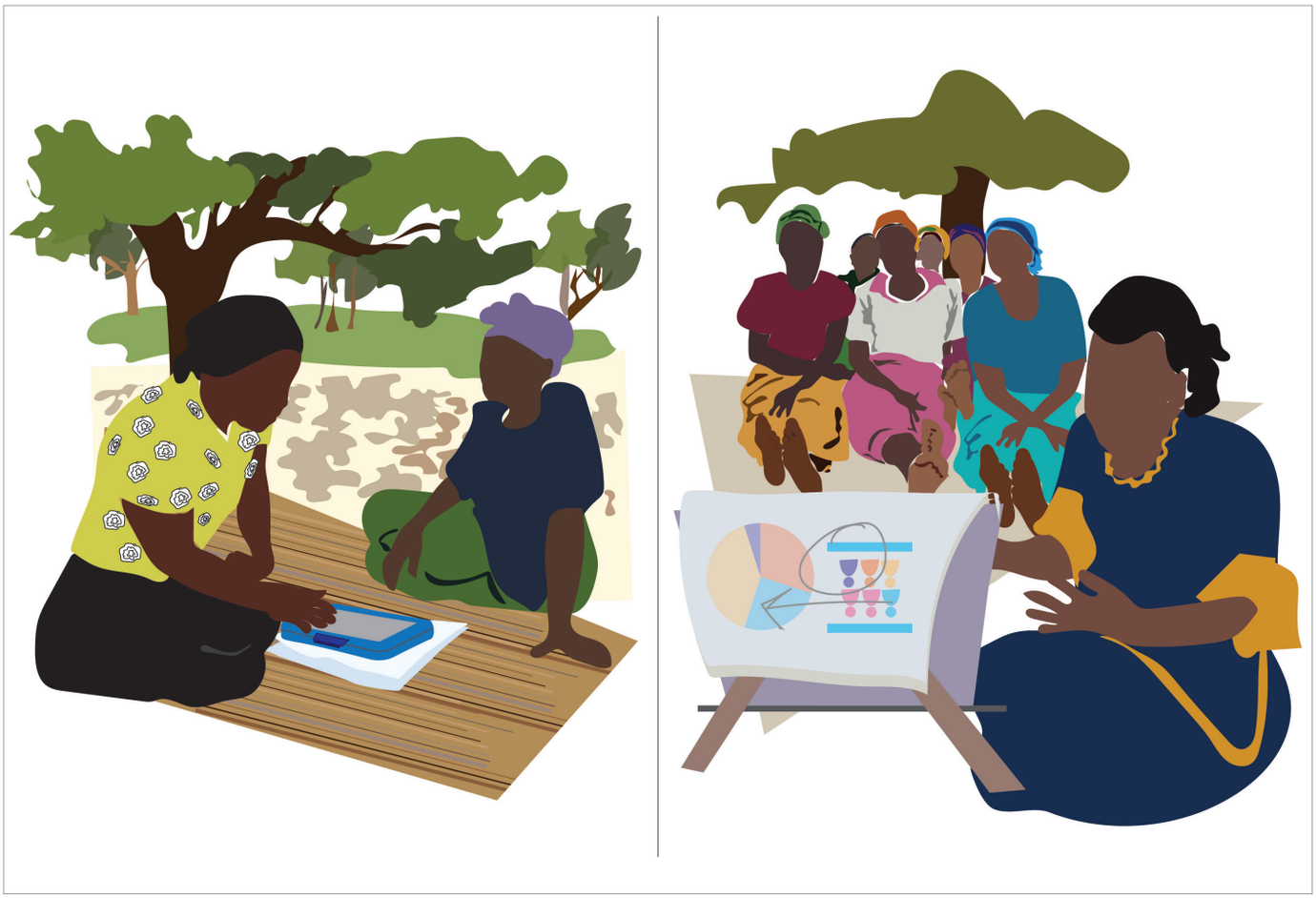
In addition to a quantitative data component, which was a survey

in almost every paper, roughly 25 percent used one qualitative method, 30 percent used two, and 40 percent used three or more.[6] More than three-quarters of these publications featured individual (both in-depth and key informant) interviews, and about 65 percent of them had focus group discussions. Beyond the use of standard group and individual interviews, studies included other qualitative methods, such as participatory social or community mapping (i.e. Murfet & Baron, 2020; Stark et al., 2017b; Strang et al., 2020); medical record audits or document reviews (Smith et al., 2013; Hanley et al., 2018); or field observation (Fisher et al., 2018; Toma et al., 2018).

MIXING METHODS: Roughly one-third of the mixed methods publications made explicit connections between the different methods employed. Rather than being employed simultaneously, most publications described an iterative approach where one method was used and then the other as a way to affirm, understand, or expand upon the results from the initial mode of data collection (i.e. Fisher et al., 2018; Jaham Seema & Rahman, 2020; Smith et al., 2013). In a limited number of cases, this iterative approach was specifically used to create or refine study instruments, as Wirtz et al. (2016) did using qualitative research to inform the preliminary version of the ASIST-GBV screening tool, and UN Women (2013) did using their first round of survey data to design focus group discussions.

This process was particularly important when unforeseen circumstances or results emerged. For Hossain et al. (2018), the context in which they collected their earlier rounds of data in the Dadaab refugee camps changed over the course of the study timeline because the Kenyan government announced the intention to close the camps. By adding an additional round of key informant interviews, they were able to frame the results within this new context (Hossain et al., 2018). Having multiple methods ideally reinforce each other, but at times the results from each may not match. For example, Toma et al. (2018) noted that when contradictions between the survey and qualitative interviews arose, they felt the qualitative data was more reliable because of potential issues with rushed survey enumerators or poor understanding of the questions by respondents.

Overall, however, a limited integration of methods, analyses, and results was presented. In at least one publication, authors noted that the main purpose of the paper was to present only



6. Not all publications provided clear details on what methods or data collection tools were used, which is why these numbers do not sum to 100 percent.

the quantitative results with the addition of some supportive qualitative quotes where appropriate, but that the full qualitative analysis would be presented elsewhere. This approach of separating the components into distinct papers may be due to word length limits of peer-reviewed journals.

One example of a truly integrated approach was employed by Bartels et al. (2018), using the Cognitive Edge's SenseMaker data collection tool. They used the Sensemaker app to examine Syrian refugee girls' experiences related to child, early, and forced marriage in Lebanon. They described their approach as follows:

> *Choosing one of three open-ended prompting questions, participants were asked to share an anonymous story about the experiences of Syrian girls in Lebanon. The SenseMaker survey intentionally did not ask direct questions about child, early or forced marriage…to allow stories about child marriage to emerge from the broader landscape of experiences thus situating them in the everyday lives of Syrian girls. After sharing a story, participants were asked to interpret the experiences by plotting their perspective between three variables (triads), using sliders (dyads) or plotting their perspectives on a graph (stones)….Multiple-choice questions collected demographic information and contextualised the shared story (eg, emotional tone of the story, how often do the events in story happen, who was the story about, etc) (p. 3).*

And then "patterns in the responses were analysed in SPSS and the accompanying qualitative narratives were reviewed to facilitate interpretation of the quantitative results," (Bartels et al., 2018, p. 1).

While an iterative approach–commonly formative qualitative work, then a survey, then more qualitative work to better understand the survey results–is a strong and valuable mixed-methods design, the analysis and presentation of those results are not always combined. The means of data collection and analysis employed by Bartels et al. (2018) serves as an example of how study methods can move beyond the more traditional approach of collecting quantitative data (through a survey) and qualitative data (through individual or group interviews) separately to have them collected and analyzed simultaneously through the same instrument, thus taking better advantage of the strength of both methodological approaches combined. For those studies where an iterative approach is best suited, a greater effort should be made to integrate the analysis and dissemination processes to ensure the strengths of the mixed methods design are kept throughout the study process.

Ethics & Power

GAPS:

- Limited research grounded in and guided by local expertise.
- Lack of clear documentation of ethics, ethical considerations, and ethical decisions made in the course of the research process.

While a majority of articles (56%) reported some kind of internal review board (IRB) or governmental review and approval, this was primarily seen in articles published in the academic literature (83%) and only about one-quarter of grey literature articles noted some form of review. Furthermore, while IRB approval was gained and detailed for most peer-reviewed studies, this was often just sought at universities based in the Global North or through NGO-specific boards (80%) rather than through local universities or governments where the research was occurring (53%). Local IRBs may not always be appropriate in the case of refugees, which are often under the remit of specific government ministries or the UNHCR; however, alternatives such as specifically formed local bodies, such as TAGs, were possible, yet were rarely utilized. Moreover, given the general remit of many IRBs, more expansive uses of local TAGs may be helpful to provide context review on complex issues such as GBV even in places where IRBs are utilized.

While published studies provided little detail on the specifics of how ethical principles were operationalized in their research, we can assume that any study that received IRB approval met basic ethical good practices (e.g. assessment of risks and benefits, informed consent, etc.). However, research on GBV requires us to go beyond the basic ethical principles and consider specific issues such as re-traumatization, increased violence, and the need to connect survivors to services (if they want them) in addition to normal research ethics.

In order to understand how ethics were accounted for in each study, we compared the provided ethical details to seven of the eight WHO Guidelines for Researching Violence Against Women and Girls: (1) Risks/Benefits, 2) Referrals, 3) Safety, 4) Confidentiality, 5) Informed consent, 6) Information gathering team, and 7) Special considerations for children.[7] During this review, we found that some articles simply noted that they followed the WHO guidelines without providing any details. Other publications specifically noted that referrals were provided (27%); described how they considered safety (primarily by conducting the interview in a private location) (19%); noted something about confidentiality (36%); required informed consent (56%); and provided training on how to administer questions on GBV for the data collection team (17%). While the limited word count available for peer-reviewed articles may affect the ability of some authors to describe their application of the WHO guidelines in full, it is surprising that so few published articles documented their procedures given the importance of ethics in research design around GBV.

Furthermore, some of the WHO principles were completely absent in the research write-ups. For example, there were no risks/benefit assessments documented that explored how the overall

7. As methodologies are considered elsewhere in this report, we did not consider them again in this section.

potential benefits of the research compared against the risks for participants. While it was sometimes noted that these risks/benefits were explained to participants, and there is presumably more detail on this in IRB applications, given the importance of this ethical consideration both to general research and in the WHO guidelines, there should be more attention paid to this process in the final articles and reports.

Additionally, only a few studies specifically discussed what the concept of "informed consent" meant in a refugee context where participants are reliant on humanitarian aid for food and other supplies (i.e. Yoshikawa, 2015). Given the particular power imbalances inherent between research teams and refugee communities, it is disconcerting that there was not more consideration to this issue in the publications.

Concerningly, specific ethical considerations relevant for sub-populations that might be at higher risk for negative consequences or less able to provide informed consent, such as special considerations for research on violence with children, were not detailed in papers that included children as a population. Again, it is possible that these procedures were detailed in IRB applications and implemented in practice; however, the lack of discussion of these issues in the published papers is troublesome.

Regarding the issues of power, few members of any affected populations were involved in the conceptualization or implementation of the research and evaluations reviewed. Community advisory boards were sometimes used to review research plans and provide suggestions (i.e. Sharma et al., 2020; Watcher et al., 2018). The most common way of engaging the community in the research process was the recruitment and use of community members as data collectors (i.e. Logie et al., 2019; Melnikas et al., 2020). In some cases, these data collectors had more full roles, such as helping develop the data collection tools (i.e. Horn, 2010). In addition, there were a few participatory research projects (i.e. Foster et al., 2015) that allowed for deeper engagements with community members to collect and make meaning from the collected data. Other research efforts prioritized engaging NGO staff and community volunteers in the study design, including on ethical considerations (i.e. Jaham Seema & Rahman, 2020). In other cases, initial results were shared back with participants for interpretation and validation (i.e. Al-Natour et al., 2019). Few articles explicitly acknowledged the power dynamics between the researchers and participants, though some researchers explored their positionality/potential biases as a researcher coming into a community in the published literature (i.e. Hattar-Pollara, 2019; Holt, 2013; Nara et al., 2019).

When considering the composition of the research team included as study authors–less than half of reviewed studies (47%) had study teams that comprised researchers from both the Global South and North or were all from the Global South. Only one study in the collected literature had an authorship team fully based at institutions in the Global South–highlighting the deficiencies in research fully led by the Global South being published internationally. Localization should not only be considered in the context of locally-led programming but also by prioritizing research led by local research groups and considering the barriers (e.g. weaker financial and administrative structures, knowledge of rigorous research practices, limited willingness of donors to directly fund) that prevent research being led by those based in the Global South

CONCLUSION

CONCLUSION

This gap analysis aimed to create a global landscape of available evidence on GBV in refugee settings in the Global South in order to provide a roadmap of gaps for researchers, donors, and programmers to inform a path forward for future research and evaluation endeavors. Through a standardized search strategy, we collected and reviewed 120 papers, reports, and briefs from peer-reviewed journals and grey literature. While not exhaustive, the publications collected for this gap analysis allow us to better understand what is known about GBV among conflict-affected displaced women and girls in the Global South. But, more importantly, this collection of research and evaluations illuminate priorities for the next wave of work regarding who is included, where the work is done, what we need to examine, and how we do it.

WHO: The existing research provided ample evidence on women of reproductive age, as this was the most commonly included type of study participant in the collected work. Alongside this, there is a growing body of work specifically focused on adolescent girls, particularly given the collection of papers and reports evaluating the COMPASS program. Missing from these publications, however, were other groups vulnerable to GBV, including elderly women, women and girls with disabilities, and LGBTQ+ individuals. For underrepresented age groups, future analyses of existing or new datasets could examine age to understand the risks of GBV among older women, for example, as a group compared to their younger counterparts. For individuals with disabilities and those who identify as LGBTQ+, great care is required to ensure that participants' safety is prioritized above all else, but also not used as an excuse to exclude or ignore those with multiple marginalized identities.

WHERE: The analysis of where research occurred–both by country and setting–highlights a mismatch between where the majority of refugees are and where the majority of the work took place. Two-thirds of the publications were based in Sub-Saharan Africa, largely in Ethiopia, Kenya, and Uganda. Yet only one country in the region, South Sudan, was in the top five countries of origin for refugees in 2020, and only one country, Uganda, was in the top five list of hosting countries (UNHCR, 2021). The top three hosting countries–Turkey, Colombia, and Pakistan–are almost entirely absent from the collected publications (UNHCR, 2021). Similarly, roughly 60 percent of the publications focused on refugee camps, yet almost two-thirds of refugees live in urban settings (UNHCR, 2019). Future research should migrate to reflect the spaces and places where refugees are today.

WHAT: Being displaced outside of one's home country and how displacement informs GBV vulnerability–from the severed social ties and the physical infrastructure of a camp to power imbalances between refugees and authority figures and xenophobia among host communities–was the main context of the research covered. Little information exists among the collected publications on the journey from country of origin to country of asylum and how GBV occurs during that process. GBV broadly, and IPV specifically, among partnered women and adolescent girls was the outcome of interest for much of the research. Further, among adolescent girls, some focus was placed on early marriage, though more research across regions is needed on the experiences and vulnerability of girls for both this outcome and other forms of GBV. The publications reviewed largely sought to define women and girls' GBV exposure with little to no attention on the perpetration of GBV by men and boys–a topic that requires investigation among refugee populations. Finally, experiencing GBV impacts displaced women and girls in numerous ways, from their mental health to pregnancy outcomes. Seeking care while displaced is complicated by factors including limited knowledge of services available, social stigma associated with being a GBV survivor, and providers having limited training to screen or care for survivors of GBV. While some training of providers and screening tools were evaluated, testing these approaches and piloting new interventions in more countries and contexts is needed. In addition, more evaluations of programming that seeks to prevent GBV–or mitigate the risk of it occurring–need to be prioritized.

HOW: Methodologically, the studies reviewed relied heavily on qualitative methods and mostly cross-sectional (for both quantitative and qualitative studies) data. Those that employed a mixed-methods approach presented limited integration of the various methods employed. There is a need for longitudinal studies, employing statistical analyses beyond logistic regression, and testing pathways between various risk factors and violence outcomes. Moreover, future research would be improved through the collection and analysis of data in the language spoken by participants in order to more closely capture the experiences of the refugee women and girls. More work is also needed to further validate existing data collection methods and tools to understand their applicability across refugee populations.

From an ethical standpoint, while a majority noted some form of IRB or government oversight, the publications reviewed provided limited information about how ethics, such as those detailed in the WHO Guidelines for Researching Violence Against Women and Girls, were integrated into the study design and implementation. While it is possible that the studies did take these guidelines into account, but did not publish those details, greater transparency is needed to ensure this sensitive research among a vulnerable population is done ethically–or not done at all. Another clear finding is the lack of local leadership, expertise, and community engagement in much of the work published by researchers largely based in the Global North. Greater efforts are needed to create meaningful North-South partnerships, where the people most affected lead future research efforts.

Moving beyond the publications collected for this gap analysis, research continues to evolve and new work is emerging (or was beyond the scope of our search strategy for this analysis) that will help fill some of the gaps noted in this study. For example, more attention is being paid to the importance of participatory action research as a practical and action-oriented form of research that can break down inequitable power dynamics between research teams and affected communities (e.g. the Empowered Aid project). In addition, long-term research projects (e.g. the Gender and Adolescence (GAGE) project) are using longitudinal approaches to understand the lives of adolescents (including refugee and conflict-affected populations in Bangladesh, Jordan and Palestine) over time (e.g. Ahmed Raha et al., 2021; Baird et al., 2020; Guglielmi et al., 2020; Jones et al., 2020). Further, findings from major research efforts such as the What Works to Prevent Violence in Conflict and Humanitarian Crisis Consortium provide valuable insights into issues such as the prevalence of GBV among conflict-affected (though not specifically refugee) populations (Ellsberg et al., 2020) and the effectiveness of programming to prevent GBV (Falb et al., 2019; Noble et al., 2019; Palm et al., 2019). Finally, new studies led by researchers based in the Global South (e.g. Barada et al., 2021) continue to emerge.

Despite its limited scope, this review demonstrates that there is a considerable amount of research on GBV emerging from refugee contexts and helps us better understand what women and girls experience during times of crisis and displacement and what is needed going forward. Research is an opportunity for us to highlight critical issues facing displaced women and girls, by generating data that will help fuel meaningful advocacy and improve programming. It is imperative to bring together researchers, practitioners, and donors to improve methodologies, better consider issues of power and ethics, and synthesize lessons learned from both refugee and other conflict-affected communities. We must take these lessons learned and use them to forge our collective path forward in service of conflict-affected displaced women and girls in the Global South and beyond.

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