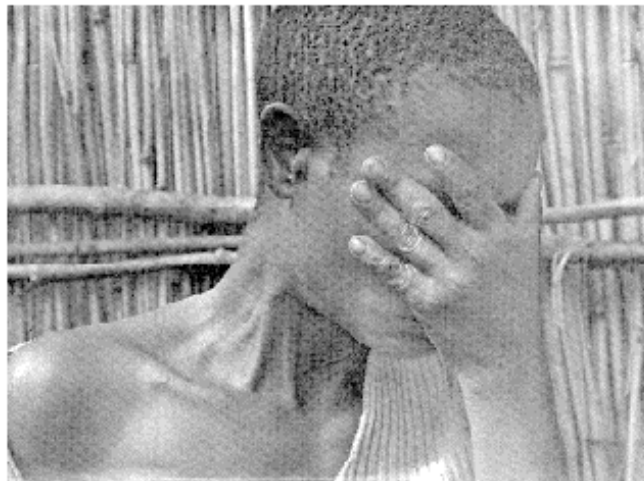


Pain Too Deep for Tears:

Assessing the Prevalence of Sexual and Gender Violence Among Burundian Refugees in Tanzania

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Photographer Martha Rial

Table of Contents

Executive Summary

IRC Project Description
Summary of Assessment Findings
Recommendations and Conclusions

History of Conflict in Burundi

Tanzania Context: Refugee Policy and Living Conditions

General Description of IRC Programs in Kibondo District, Tanzania
Sexual and Gender Violence Project
How Sexual and Gender Violence Affects Refugees

IRC Project Goals and Objectives

Staffing
Funding

Project Phases

Phase One: Orientation

[Key Orientation Questions](#)

Phase Two: Implementation of the Assessment

Step One: Women's Representatives Workshop

Step Two: Block Meeting

Step Three: In-Depth Interviews

Step Four: Feedback from the Women's Representatives

Step Five: Pilot Survey

Step Six: Systematic Sampling

Step Seven: Analysis

Analysis of Results: Who, Where, How, By Whom

[Persons Most Vulnerable to Sexual Violence](#)

[Types of Violence Reported](#)

[Perpetrators of Sexual and Gender Violence](#)

[Situations Where Sexual and Gender Violence Occur](#)

Beyond the Numbers: Survivors Tell Their Own Tales

Lessons Learned

[General Lessons on Participatory Methodology](#)

[Group Discussions](#)

[In-depth Interviews](#)

[Survey](#)

Conclusions and Next Steps

[Assistance Offered to Survivors](#)

Appendices

[Appendix I: Sexual and Gender Violence Response Protocol - IRC Kibondo, Tanzania](#)

[Appendix II: Gender Assault Form](#)

[Appendix III: IRC Confidential Gender Violence Survey](#)

[Appendix IV: Appreciations](#)

[Appendix V: Bibliography](#)

Executive Summary

IRC PROJECT DESCRIPTION

The International Rescue Committee (IRC) has been assisting the Burundi refugees in Tanzania since 1993. Currently, IRC serves approximately 70,000 Burundi refugees in the Kibondo district of southwestern Tanzania through comprehensive primary health care services. These include a broad range of reproductive health care services such as family planning counseling and contraception distribution, education on the prevention of sexually transmitted diseases, antenatal care, and deliveries by trained health workers.

In 1996, IRC further diversified its reproductive health care services by addressing the difficult issues of sexual and gender violence. Reports from the Rwandan refugee camps in northern Tanzania and Zaire suggested that sexual and gender violence were problems in these refugee settings. In Zaire refugee camps, UNHCR estimated that 1.47 per 1,000 women between the ages of 15-44 were raped in 1996. In non-refugee situations in Africa, it is estimated that only 5-10% of the rapes that occur are actually reported. Until now, it was unknown how Burundi refugee women in Tanzania were affected by sexual and gender violence.

In the assessment phase of the Countering Sexual and Gender Violence Project, IRC staff compared two methods of assessing the prevalence of sexual and gender violence in order to understand what method yields the most comprehensive information. The project staff used in-depth interviews and a community survey of women age 12-49 years to gather information. In this report the process and results of the assessment are described. A follow-up report will detail how the findings will be used to engage the refugee community leadership and the responsible agencies to reduce the incidence of sexual and gender violence.

SUMMARY OF ASSESSMENT FINDINGS

Burundi refugees have suffered a high degree of sexual and gender violence. The initial results of the IRC assessment suggest that approximately 26% of the 3,803 Burundi refugee women between the ages of 12-49 in the established camp of Kanembwa have experienced sexual violence since becoming a refugee. Refugees have been subject to such violence at every stage of their quest for safety: in the conflict situation in Burundi, along the Tanzanian border, between the border and the refugee camps, and within and around the camps. Perpetrators have included soldiers, policemen, Burundi and Tanzanian nationals, fellow refugees, relatives, husbands, and one reported case of a rape by a NGO security staff member (who has since been fired for another offence). The vast majority of survivors who have reported incidents of sexual violence to IRC are women and girls. One man and several boys have also reported incidents.

RECOMMENDATIONS AND CONCLUSIONS

Using Participatory Approaches to Assessing the Prevalence of Sexual and Gender Violence

It is critical to involve women in the refugee community in each phase of the design and implementation of a project dealing with sexual and gender violence. Without their trust and guidance such a project could do much more harm than good. In exchange for the support of these women, the project staff must be willing to share power and decision making authority with the women. Through the process of exposing sexual and gender violence, the women involved relive a degree of the pain experienced and develop a determination to want change in the security situation of the camp environment.

In-Depth Interviews

This method of collecting information on incidents of sexual and gender violence has

several distinct advantages. The informants come at a time when they are ready to discuss this private matter. The loose format of the interviews allows the interviewer to probe for further information which may not be anticipated in the design of a survey instrument. On the other hand, the lack of a standardized question guide means that the same questions are not answered by each respondent and the coding of narrative is time consuming.

Surveys

Surveys are appealing because they produce quantitative results which are valued by authorities who are asked to pay attention to the issue of sexual and gender violence. Women in the community can help design and conduct the survey. Survey sampling may miss affected portions of the population (age and sex specific) and richness of descriptive detail about incidents needed for planning interventions. Analysis using a software package such as Epi-Info takes the analysis of the results away from the refugee women and can slow the analysis if the project staff are not familiar with the software. However, it is much easier to examine frequencies and to conduct cross-tabulations of results using computer software.

Responding to the Problem

It is critical that referral services for the medical and protection needs of violence survivors be in place when an assessment is conducted. It would be unconscionable to not offer women assistance once they reveal their concerns resulting from incidents of sexual and gender violence such as the need for sexually transmitted disease screening, protective custody, or emergency contraception for women who come forward immediately. Although the details of the community response process will be detailed in the next report, it must be clear that project staff worked with the survivors of sexual and gender violence, camp management, IRC medical staff, and IRC social workers to meet the needs as they were identified.

Those who have experienced pain will understand. Most of these women came to us and in front of us showed the pain they felt. Tears welled up in their eyes but tears never fell, tears just stayed in their eyes because the pain they felt was just too deep to be expressed by shedding tears. We could feel and see that they mourned, but they mourned with their souls. When pain has gone beyond your body, beyond your mind, and beyond your heart to your gut, to something deeper, it touches your soul, it touches you. The pain is just too great and the tears from the heart do not carry it away.

Sexual violence touches the innermost

privacy for the woman affected without permission or choice, and goes further to make that privacy public. Most of us as human beings want to keep something about ourselves private, and it is from those things that we find identity for ourselves. An experience of sexual violence not only makes a woman feel insecure physically, medically, emotionally and psychologically, but also affects her sense of personal identity. The strong stigma from society and close relations does not make it any easier for the woman to deal with this. It becomes very important for the woman to feel safe and trusting of the person she will share her experience.

Women therefore come to you and firstly they just look at you, and they see deep in your eyes, in your heart and they understand what you feel, and think of and about them, and then from all that they see and feel they decide whether to trust you. As they narrate the ordeal they do not look at you and one hand is constantly holding one eye. When it moves it is to squeeze the nose so as to stop the mucus from running down.

After you part, their faces stay with you. As I wrote each one of these case histories I could see them and sometimes hear them talk with difficulty about their experiences. They bring across the lack of animalism in men that commit such atrocities. Animals have feelings for each other, especially for their own kind. For example, science has shown that lions care for each other and they mourn when one of them dies. The men in these experiences have made women almost lose trust in humanity, the feeling that these men were something, but certainly not something that thinks nor feels for another. They have proved that

they do not have any animal feelings.

Sydia Nduna, IRC Tanzania
Sexual and Gender Violence Project Manager

History of Conflict in Burundi

Since colonial times Burundi, like neighbouring Rwanda, has been the scene of recurring ethnic conflicts between the minority Tutsi and majority Hutu tribes, respectively 14% and 85% of the population. Hopes for peace through elections were dashed in October 1993 when the democratically elected president in Burundi's history, Melchior Ndadaye, was killed in a Coup d'Etat. The killing of Mr. Ndadaye set off a frenzy of revenge massacres by his Hutu ethnic group, which had long been excluded from power. His successor, Cyprien Ntaryamira, was killed in a 1994 plane crash along with the Rwandan President, Juvenal Habyarimana.

In June of 1996, a bloodless coup ousted the third civilian president, Sylvestre Ntibantungany, and brought Major Pierre Buyoya to power as the interim president of a military government. In response to this overthrow, the Organization of African Unity countries imposed comprehensive economic sanctions on Burundi. Reports of mass killings by government forces have fueled an increased exodus to the neighbouring countries of Tanzania, Rwanda, and Zaire. It has been estimated that more than 1,000,000 Burundis have been displaced and 150,000 people have been killed in the fighting since 1993. Civilians have been displaced and killed on both sides of the conflict.

In addition to a history marked by violent ethnic conflict, Burundi is also known as one of the poorest countries in the world. The UNDP 1996 Human Development Report, which rates countries according to life expectancy, levels of education, purchasing power and other quality of life indicators, places Burundi 166th out of 174 countries considered. Life expectancy at birth was 39.86 years in 1995.⁴ The total fertility rate is estimated to be 6.63 children born per woman. Infant mortality is 111.9 deaths per 1,000 live births. Only 40% of females and 61% of males age 15 and over can read and write (1990 estimate).

Tanzanian Context: Refugee Policy and Living Conditions

As of August 1997, approximately 60,000 Burundi refugees live in camps in the Kibondo district of Tanzania. Tanzania officially closed the border between Tanzania and Burundi in mid-1995, forcing asylum seekers to evade both Burundi and Tanzanian soldiers in order to reach the refugee camps. Over 100,000 refugees managed to get through the border in the latter half of 1996.

Refugees are subject to the Tanzanian Refugee Control Act of 1965 which regulates their entry, movement, settlement and activities. The Department of Home Affairs represents the government of Tanzania to ensure camp security and enforce respect of host country laws by refugees and relief agencies operating in the camps. The Kibondo camps are managed by the Tanganyika Christian Refugee Services (TCRS), which is responsible for

registration of refugees, food distribution, roads, water, sanitation, and children's education.

The United Nations High Commissioner for Refugees (UNHCR) has a sub-office in Kibondo. The UNHCR program staff at the country office has expressed a keen interest in the protection of refugee women against sexual and gender violence. But as of late 1996 there were no female Protection Officers operating in the camps between Kibondo and Kigoma, which can act as a barrier to women reporting cases of sexual and gender violence. Protection Officers can play a crucial role in documenting cases of abuse and assisting refugees to prosecute offenders.

General Description of IRC Programs in Kibondo District, Tanzania

The International Rescue Committee first began operations in Tanzania when a 1993 outbreak of killings in Burundi led thousands of Burundis to flow into the Ngara region. Since mid-1996, the Burundi population served by IRC has increased dramatically. Currently, IRC provides medical and sanitation services to approximately 70,000 Burundi refugees in Kibondo district of southwestern Tanzania. Burundis are still arriving to Kibondo district at a rate of 40 to 60 per day. In Kibondo, IRC has established medical facilities in four camps, including two new camps constructed in the last quarter of 1996.

In the established camps, IRC medical services include identification and training of Traditional Birth Attendants (TBAs) to staff the maternity centres; in-patient and out-patient beds for acute medical conditions; supplemental and therapeutic feeding for pregnant women and malnourished children; immunization campaigns; community home health visitors who provide public health education and referral to clinic facilities; family planning; sexually transmitted disease (STD) and AIDS education, screening and treatment; and most recently, screening for HIV in the blood supply used for transfusion in the treatment of acute anemia.

Reproductive health services are integrated into the clinical and public health education efforts of IRC. Trained in 1995, the reproductive health educators are a team of men and women who provide group education and individual counseling on family planning and STDs.

As new arrivals continue to cross the border each day, IRC is expanding services to new camps. In the new sites, IRC provides the UNHCR recommended Minimal Initial Service Package (MISP) of reproductive health services.² Condoms, oral contraceptives, and injectables are available upon demand at the maternity centre. TBAs are quickly identified and trained to staff the maternity center. Family planning outreach will be initiated after the camp is. In the meantime, the Community Health Workers (CHWs), who advise people on sanitation and make referrals for the sick and malnourished, also distribute free condoms in the community. CHWs and TBAs make referrals for women to access emergency contraception.

Sexual and gender violence are recognized as serious problems with crucial implications for women's physical and mental health. They are dangers to which these women have been exposed from the time they first left their homes in Burundi.

In addition to serving the direct medical needs of the refugees, IRC operates several programs to improve the general standard of living in the camps. Houses are constructed for vulnerable members of the community, including single female heads of households, widows, unaccompanied minors, the elderly, and the disabled. A self reliance program trains men and women in income generating activities such as sewing, watch and radio repairs, carpentry, brick making, house building, vegetable gardening, poultry farming, grain grinding by mill, typing and literacy. Until the end of 1996, IRC also trained and supervised a team of Burundi para-professional social workers.

SEXUAL AND GENDER VIOLENCE PROJECT

Health Consequences of Gender-based Violence	
NONFATAL OUTCOMES	
<i>Physical:</i>	
STDs	
Injury	
Unwanted pregnancy	
Miscarriage	
Chronic pelvic pain	
Headaches	
Gynecological problems	
Alcohol/drug abuse	
Asthma	
Irritable bowel syndrome	
Injurious health behaviors: smoking, unprotected sex	
Partial or permanent disability	
Pelvic inflammatory disease	
<i>Mental:</i>	
Depression	
Anxiety	
Sexual dysfunction	
Eating disorders	
Post-traumatic stress disorder	
Multiple personality disorder	
Obsessive-compulsive disorder	
FATAL OUTCOMES	
Suicide	Homicide

In recognition of the hidden health burdens accompanying sexual and gender violence, IRC Tanzania initiated the Countering Sexual and Gender Violence Project in October 1996. Tanzania programs have a history of providing some of the world's most comprehensive reproductive health programs to refugees. It was a bold but natural next step to address needs related to sexual and gender violence, but first the staff felt it was important to better understand who was affected and what needs the survivors had that could be met by the community, IRC, and other interested parties.

The next section of this report will describe the general situation relating to sexual and gender violence faced by refugees, and the details of the IRC program assessment procedures and findings. The purpose of providing this information is to enable other refugee workers to analyze the process and results achieved by IRC, in order to consider how to best address these sensitive issues in other settings. The definitions found on the following page are used by the project staff in discussing these issues with the refugee community. The scope of the project encompasses both sexual and

gender-based violence.

Source: World Bank, 1994

Definitions

Sexual violence is defined as the act of forcing another individual, through violence, threats, deception, cultural expectations, weapons, or economic circumstances, to engage in sexual behaviour against her or his will. In circumstances of sexual violence a person has no choice to refuse or pursue other options without severe social, physical, or psychological consequences.

Rape is an aggressive, violent criminal act where one person forces another to have sex without consent. The level of aggressiveness does not define the act rape: whether the perpetrator uses more or less force, or simply uses threats, the crime is still rape. Rape also includes the more contested areas such as cultural expectations that force young women to marry and sexually service men not of their choosing.

Statutory rape is sexual intercourse with someone under a specific age, which is deemed to be unlawful. The survivor is presumed by law to be unable to give consent by reason of his or her tender age. In Burundi, this definition applies to girls 18 years and below, and under Tanzanian law to girls 15 years and below.

Many forms of sexual violence do not fall under the classic concept of rape (vaginal penetration by a penis), such as insertion of objects into genital openings, oral and anal coitus, attempted rape, stripping someone naked, using sexually abusive language, and other sexually abusive acts such as use or threat of force in order to have sexual acts performed by a third person(s).

Hence, the term *sexual violence* is used here to cover all forms of sexual threat, assault, interference and exploitation including statutory rape and molestation without physical harm or penetration.

Gender relations refer to the socially (rather than the biologically) determined characteristics of men's and women's positions in society. Thus, gender analysis examines both women and men and the relative positions between them. Social practices that promote gender inequalities become accepted as normal under different criteria such as cultural, judicial, educational and political practices.

Gender-based violence is violence which is directed specifically against a woman because she is a woman, or which affects women disproportionately. It includes but is not

How Sexual and Gender Violence Affects

Refugees

Strong evidence from Bosnia and Rwanda suggests that sexual and gender violence are commonly used as instruments of war relating to ethnic cleansing, tribal conflict, and boundary disputes. War and conflict often force large numbers of people to flee their home and seek refuge in neighbouring countries. Women and children typically make up the bulk of displaced persons and have acute health, sustenance, shelter, and security needs. In this context the problems of sexual and gender violence tend to be viewed as secondary. History has proven, however, that it is precisely under such circumstances that these atrocities should be of Paramount concern.

A refugee woman who suffers gender violence is still living under the gender relationships that existed in her home

women's positions in society. Thus, gender analysis examines both women and men and the relative positions between them. Social practices that promote gender inequalities become accepted as normal under different criteria such as cultural, judicial, educational and political practices.

Gender-based violence is violence which is directed specifically against a woman because she is a woman, or which affects women disproportionately. It includes but is not limited to physical, sexual, and psychological violence in the family, within the general community, and that violence which is perpetrated or condoned by the state.

society. The same norms, practices, beliefs, and traditions predicate her response and reaction to sexual violence. The same extent of pressure that she would suffer in Burundi if she were raped would also apply in the camp. This pressure may even increase if she has lost the support of family members, friends and the community in which she was raised.

Sexual and gender violence is severely stigmatized in Burundi culture. Individuals who have experienced such violence are encouraged to remain silent. In coming forward, the survivor and her family risk being ostracized by the community. The survivor may herself be blamed and may consequently be punished. She may be unable to marry or stay married. Bringing charges against offenders is further complicated by a lack of knowledge, both on the part of the survivor and many aid workers, of the laws and procedures in place to protect refugee women.

IRC Project Goals and Objectives

The purpose of the IRC Sexual and Gender Violence Project is to reduce the risks of sexual and gender violence and to minimize their physical, social, intellectual, and

psychological consequences, by providing appropriate training of refugee workers on psychosocial care to survivors and perpetrators of violence. This is to be achieved through four related activities.

1. Assess the prevalence of sexual and gender violence experienced by the refugee population since the time conflict erupted in Burundi in 1993. Use participatory methods of conducting group discussions, in-depth interviews, and a survey on the causes, nature, seriousness, and consequences of sexual and gender violence. Design specific intervention strategies to combat sexual and gender violence.
2. Train refugee workers to identify cases, design prevention strategies, and implement appropriate responses to survivors of sexual and gender violence.
3. Mobilize the community leaders, the relevant agency staff and the State to prosecute the perpetrators and institute legal measures against them.
4. Provide counseling and rehabilitation programs for the survivors.

Staffing

The project was initiated by the IRC Field Coordinator and the Country Director with support from the New York based Reproductive Health Program Officer. New staff were recruited to devote their efforts to assuring the success of this project. The Sexual and Gender Violence Project is primarily managed by an expatriate social worker from Zambia and a Burundi refugee woman who is an elected community leader in the Kanembwa refugee camp. The social worker has a background in gender analysis training, domestic abuse advocacy, psychiatric social work, and HIV counseling. The Burundi project assistant previously worked as an IRC social worker in the camp and as an accountant in Burundi.

Funding

The Countering Sexual and Gender Violence Project was first funded by the Andrew W. Mellon Foundation, which has provided a three year grant to IRC to work with the Reproductive Health for Refugees Consortium to institutionalize reproductive health in refugee settings. Additional funding to complete the needs assessment and implement an intervention in 1997 was granted from the LeBrun Foundation, which provides funding for innovative pilot projects, and the Packard Foundation, which supports IRC reproductive health programs in five countries around the world.

PROJECT PHASES

The Project is being implemented in three phases. In Phase One the new staff became familiar with IRC and with the Burundi refugee population. In order for the process to be participatory the staff needed to take time to identify individuals and groups in the refugee community who have an interest in the topic and who could work with the staff

to develop the project in a culturally appropriate fashion. In Phase Two the assessment of the prevalence of sexual and gender violence was initiated. Phase Three will be covered in a future report on engaging all concerned players in responding to the prevalence of sexual and gender violence.

The methods used by IRC to assess and address the prevalence of sexual and gender violence reflect the organization's values, including respect for the human rights of refugees, provision of culturally appropriate services, and promotion of community participation. Recognizing that any identification of a survivor of sexual and gender violence could cause more difficulties for the survivor, deliberate attention was paid to the choice of methods so as to minimize the risk of disclosure.

Data collection and referrals for follow-up services were important to the project staff, and women in the community came to recognize that the staff could help them get medical appointments or negotiate with the camp authorities to improve their protection.

Special attention was given to the establishment of a positive relationship between the project staff and the community by using the participatory process. This process involves the use of methods that motivate participants to critically analyze and learn from their own experience. The information, beliefs, traditions, culture, practices, systems and structure that already exist in the community are recognized. The participatory process invests in the community capacity to own the process, influence it, and be able to carry on the work within their own given structures and systems. Many programs fail because the community is not given the right to define the need(s) and influence the program.

Participatory methods of conducting needs assessments and addressing sexual and gender violence should therefore give the community control over relevant decisions and processes. As a result, women in the community feel less threatened and more in control which affects their desire to change the situation and seek solutions that are within their means, resources, and control.

The ultimate aim of the participatory process is to enable the community based support system to own and sustain the violence response and prevention strategy. In 1997, IRC will document the steps taken to engage the community in owning the project and responding to the problem as they deemed appropriate. The next section of this report will outline the steps taken to orient the project staff, to implement the assessment, and to start to respond to the needs identified.

PHASE ONE: ORIENTATION

The project began with a thorough investigation of what had previously been done to address the problems of sexual and gender violence in Kibondo camps. IRC project documents and current personnel profiles, qualifications, and responsibilities were reviewed. The Project Manager used the following questions to guide her orientation to IRC and the refugee community:

Key Orientation Questions

- What resources are available or needed for the project (interpreter, computer, transport, materials, money, appropriateness of operating space)?
- What is the proposed time frame?
- What does the organization want to learn about the issue?
- How will the outcome be shared with the relevant constituencies: community, NGOs, UNHCR, host government?
- What formal or informal refugee leadership structures exist?
- What is the age and gender distribution of the refugee population?
- How are women represented in leadership forums?
- Has the existing leadership structure addressed sexual and gender violence?

The project staff were committed to involving members of the community in every step of the project. In determining which category of refugee workers to align the project with, the following criteria were considered: rapport with refugee women, experience handling women's issues in the public sphere, and fluency in the native language, Kirundi. In this light, Women's Representatives, who are themselves refugees and are elected by community women to provide leadership, were considered the most appropriate. They had earned community trust and played a very important role in supporting refugee women. They were involved in:

1. accompanying and representing women in the local court in cases of gender violence: sexual, domestic, and/or other conflict issues affecting women,
2. serving as counselors within the community,
3. reporting to appropriate agencies and authorities on issues concerning individual and community welfare, and
4. organizing important events (International Women's Day celebration).

Answers to the key orientation questions were solicited from IRC staff, TBAs, social workers, and various categories of refugee health personnel. Social workers conducted a census of all female refugees over the age of 12, recording name, age, and address. Initially, the project staff assumed that most cases of gender violence would involve females over age 12. Having a complete census made it possible to systematically select survey participants. Community maps were drawn to visualize the population and incident location distribution. Later the maps were used to locate women who participated in the survey to offer follow-up support services as needed.

PHASE TWO: IMPLEMENTATION OF THE ASSESSMENT

A series of seven steps were taken to build rapport with the Women's Representatives, introduce the project to the refugee women living in the community, conduct in-depth interviews, and prepare, conduct and analyze the survey. The project was designed to use two methods of assessing the prevalence of sexual and gender violence experienced by Burundis. As a pilot project we wanted to learn which method was more efficacious in helping to understand who was affected by sexual and gender violence and how comparable the results would be.

Step One: Women's Representatives Workshop

The implementation phase began with a five day workshop designed to familiarize the Women's Representatives with the goals and methodologies of the sexual and gender violence project. An important aim of the workshop was to gain the trust and allegiance of the representatives by clearly defining why the assessment was being conducted. Sessions covered a number of topics including: the political situation in Burundi, the experience of sexual and gender violence in Burundi and Tanzania, and the community's traditional and current response to such acts. The meetings were scheduled to accommodate the women's busy lives.

During the sessions, topics were introduced in an abstract way evolving slowly into discussions of personal experience. Women's Representatives were actively engaged through the use of plenary sessions, group discussions, interviews, role plays, story telling, game playing, and art. For instance, the group divided into small groups and developed a role play which portrayed their experiences of fleeing their homes, crossing the border, traveling to the camp, arriving at the camp reception center, and living in the camp. The group discussed which problems affected women, men, children, or everybody. Attention was paid to identifying when and where sexual and gender violence were experienced.

Once the group identified sexual and gender violence as issues, their collective experiences were used to build a critical analysis of sexual and gender violence. It was very difficult for the women to talk about their personal experiences of various forms of violence, but discussing it helped them to understand the sense of violation experienced by someone who survives an incident of sexual or gender violence. The following questions were used to encourage and direct group discussions:

Group Discussion Questions

- What problems did the community face as a whole?
- What problems were specific to men?
- What problems were specific to women?
- What problems were specific to children?
- What are sexual and gender violence?
- What constitutes acts of sexual and gender violence?

- Where did incidents occur?
- Who were/are the survivors?
- Who were/are the perpetrators?
- How do survivors cope?
- What support structures exist in the camp for the survivor?
- Who are the governing bodies officially charged with this issue?
- What happens to survivors and perpetrators in the judicial system?
- How has the community responded to this issue?
- How have Women's Representatives responded?
- What have been successful responses?
- How could these responses be improved?

The workshop established trust between the project staff and the Women's Representatives. The Women's Representatives advised the project staff on how to respect and incorporate the refugee culture and community structure in order to assure success in having women reveal cases of sexual and gender violence.

At the conclusion of the workshop, it was decided that Women's Representatives would approach refugee women immediately. They felt confident to educate the community about the purpose of the project and assure women that their safety and privacy would be well guarded. They planned and organized block meetings in which IRC project staff introduced the topics of sexual and gender violence to the larger community of refugee women.

Step Two: Block Meetings

Block meetings between project staff, Women's Representatives, and women in the community began with an overview of how sexual and gender violence have been used as tools of war worldwide. An average of about 100-200 women would attend each of the outdoor meetings. The project staff described sexual and gender violence experienced by women and children in other conflict situations and the importance of exposing such atrocities. They discussed the current lack of documented knowledge regarding these issues in the Burundi refugee context and introduced the aims of the project, namely, to work with the community to improve the sexual and gender violence response and prevention strategies. The possible implications and the importance of talking about these experiences were explored. Staff described the type of assistance that survivors may need and the services available in the camp. They expressed their hope for the potential impact that this information could have toward improving the camp security situation.

The meetings ended with a brief question and answer period. Most questions related to issues of confidentiality and trust. Why should the women trust the project staff? How would their confidentiality be respected? Where could the project staff be located? The

staff articulated their commitment to confidentiality, assured women that their identities would not be revealed, and confirmed that women could exercise their freedom of choice in deciding whether they wanted to come forward or not. The staff also reminded women that they could discuss any concerns with the Women's Representatives. The project staff could be contacted at the IRC maternity, family planning, and antenatal compound which was easily accessible to women, promoted confidentiality and safety, and was close to supporting medical facilities.

Step Three: In-Depth Interviews

Community response was tremendous. During the first two months, 68 women and children in Kanembwa camp came forward and recounted cases of rape, domestic violence, sexual harassment, STDs, and other gynecological problems including unexplained bleeding, infertility, and pregnancy related health complications.³ The Women's Representatives would escort women who were too nervous to come on their own to meet the project staff.

Step Four: Feedback from the Women's Representatives

Meetings were held between the project staff and the Women's Representatives to discuss the successes and short comings of the block meetings and in-depth interviews. At the first meeting they reviewed perceptions of the views of women, men, and the community in general toward the project. The preliminary results of the in-depth interview response rate and findings were discussed. The women determined that a survey was necessary.

By the time of the second meeting, the questionnaire was developed, translated and presented for comment by the Women's Representatives (see Appendix III). They tested the questionnaire among themselves and the project staff incorporated their revisions into the pilot survey. The Women's Representatives determined that for the sake of confidentiality they would be in the best position to implement the survey. Four literate representatives were selected to conduct the pilot survey.

Step Five: Pilot Survey

The four representatives chosen to conduct the pilot were trained to establish informed consent and correctly administer the survey. They each received ten questionnaires and randomly chose women to interview.

Upon completion of the pilot, the four representatives met to discuss what they had learned. They reviewed their successes and difficulties with the rest of the Women's Representatives, and agreed on necessary changes to the survey tool. They confirmed that the community was sufficiently aware of the project to effectively respond to survey questions. They determined that to maintain confidentiality only one representative could interview an individual women. The other Women's Representatives who were not conducting the pilot survey met with women to be surveyed to explain the survey and set appointments for the interviewers.

Step Six: Systematic Sampling

Out of a total population of 3,803 between the ages of 12-49, 400 (over 10% of the target

population) were randomly selected and asked to participate in the survey. Using the registry of females between the ages of 12-49, every 10th woman listed was selected and assigned to one of the four interviewers. Three women had left the camp and could not be contacted. Of the remaining 397 women, 58 (15%) women declined to participate. Common reasons given for not participating included statements such as "it did not happen to me", or the respondent said she was too young or simply did not want to speak. A total of 339 (85%) consented to participate in the survey.

Step Seven: Analysis

The survey results were translated into English, frequencies were calculated using Epi-Info software, and analyzed by the project staff. A meeting was held with the Women's Representatives to discuss the results. The Women's Representatives were excited and proud of their ability to implement the survey. They organized meetings with the women in the community to report on the preliminary results.

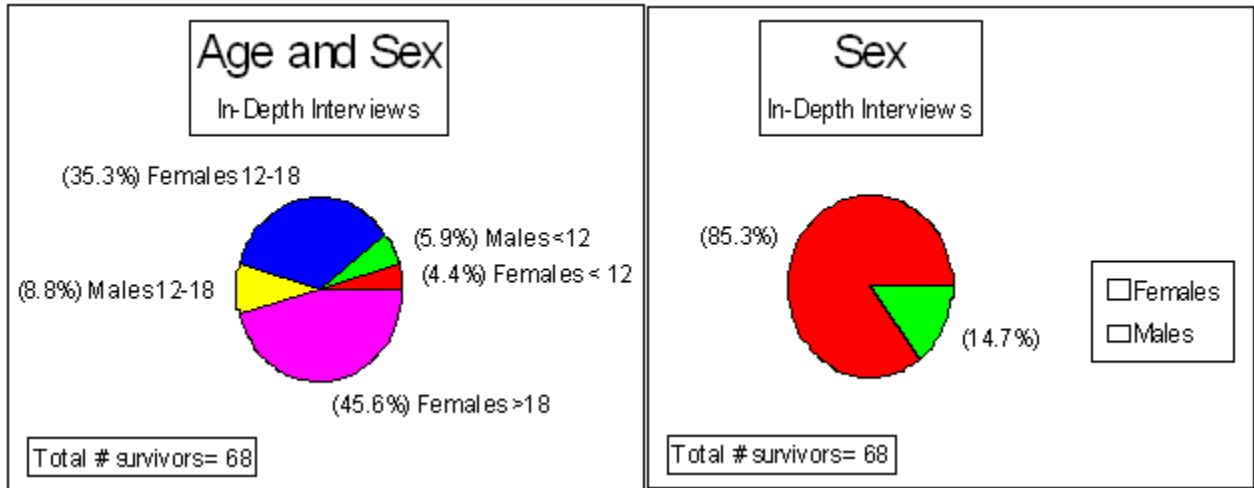
The involved parties concluded that it was necessary to have a daily presence of project staff because of the demand for emergency contraception and the need for timely medical reports for the police to use in lodging a complaint. Five Women's Representatives were hired to act as focal points for sexual and gender violence reporting.

Analysis of Results: Who, Where, How, By Whom

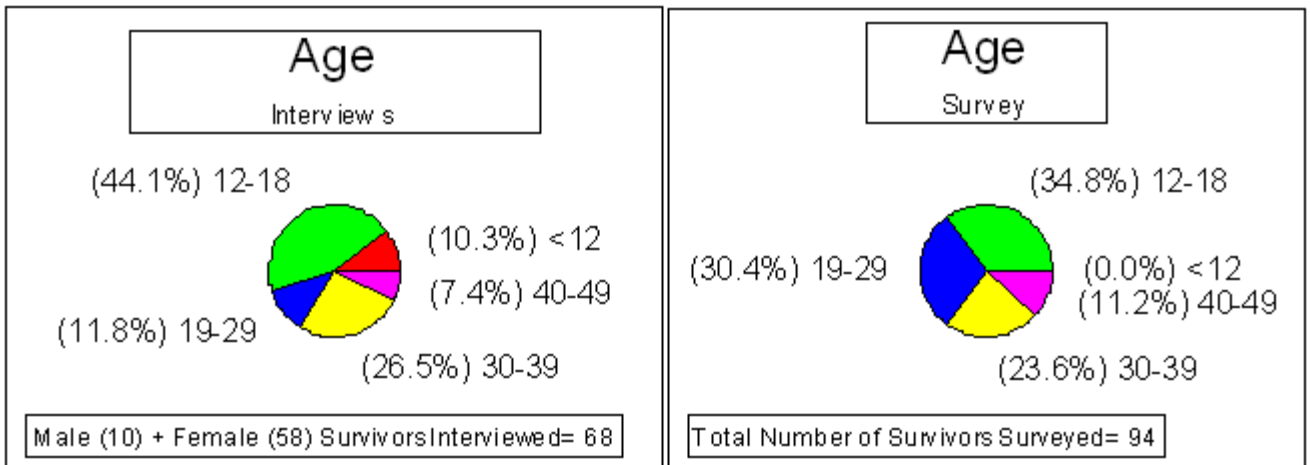
The following results were obtained using two distinct methods: in-depth interviews and a survey. A comparison of the results revealed commonalities and differences which suggest what types of information can best be collected using one approach or the other. The basic finding that sexual violence affects a significant portion of the population in the camp is supported by both data sources: 22% of women between the ages of 12-49 voluntarily reported during in-depth interviews having experienced sexual violence since the conflict erupted in Burundi, and 27% of randomly surveyed females in the same age group reported having experienced the same.⁴ In addition to sexual violence involving vaginal penetration, the in-depth interviews also revealed cases of other forms of gender violence including domestic abuse, sexual harassment, withholding of ration cards from estranged wives, and a wide variety of gynecological concerns.

PERSONS MOST VULNERABLE TO SEXUAL VIOLENCE

The vast majority of cases identified through the in-depth interview process were females over the age of 12. The open invitation to come forward with stories of sexual violence also elicited responses from a total of 10 males under the age of 18 and three girls under age 12.



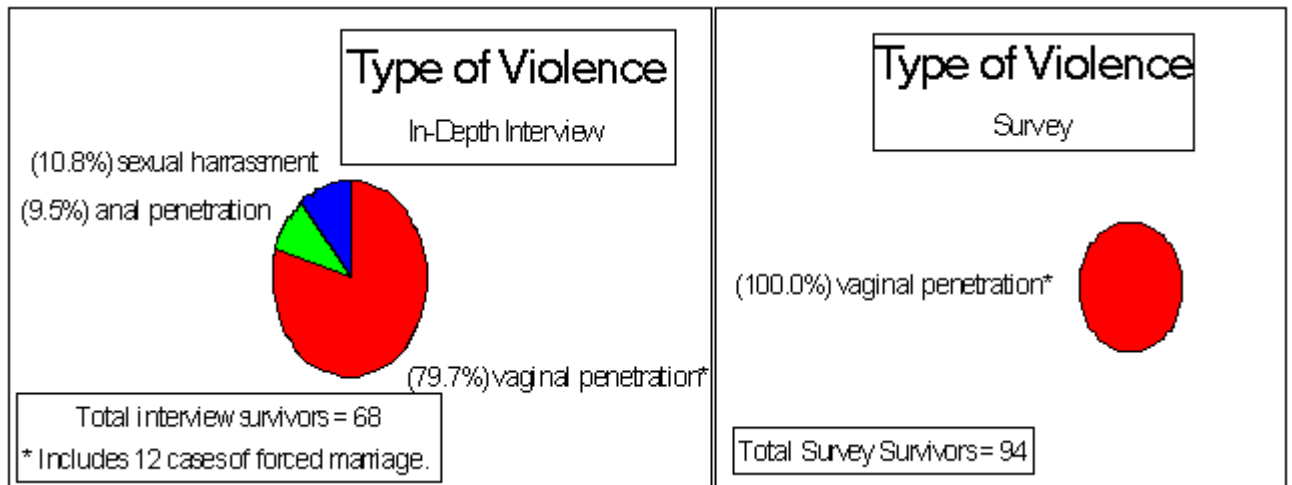
Adolescents between the ages of 12-18 reported the most cases of abuse, including forced marriages (12 cases). The survey did not sample people under the age of 12, nor did it include males, so it is difficult to compare the results except to say that the survey approach missed cases of abuse involving men, children under age 12, and women over the age of 49. Most of the children were brought forward by their parents to be interviewed and we doubt that a survey would be effective in identifying cases involving children under 12. It is clear from the in-depth interview process that sexual abuse of boys is also an issue in the camp and attention needs to be paid to how this group can be included in the process of gathering information and providing services.



TYPES OF VIOLENCE REPORTED

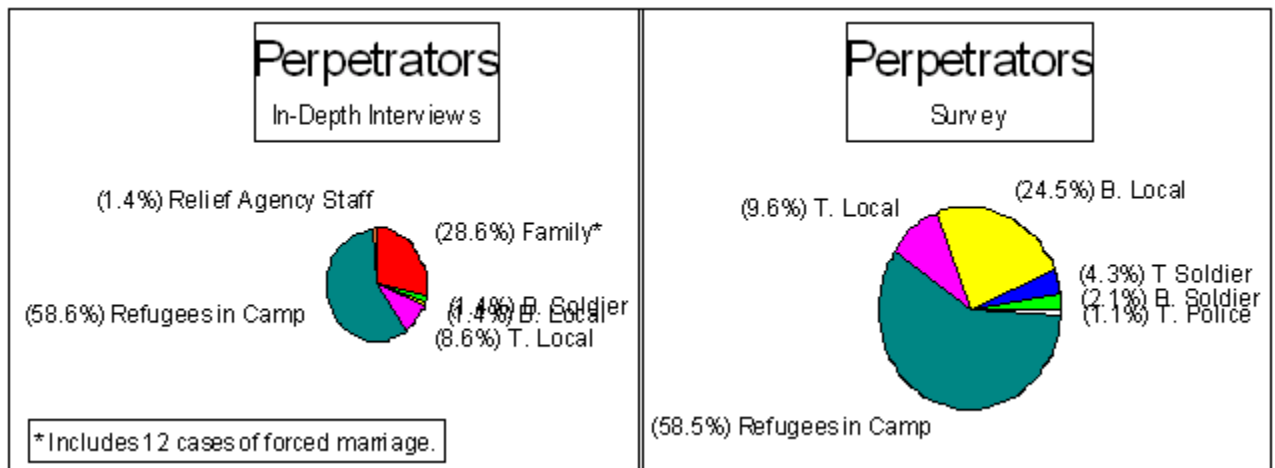
The in-depth interview results provided detail on a wider variety of forms of assault. This was probably due to the open ended nature of the questions asked and the narrative recounting of the experience. The survey asked, "Have you experienced any form of sexual violence or abuse? YES or NO" and "Describe what happened to you." When the staff coded the responses to the survey they found that all respondents reported vaginal penetration as the form of assault and did not describe other possible forms of trauma. This could be due to the wording of the question, the respondents' preconceived ideas

about what constitutes sexual violence, or the lack of additional detail recorded by the interviewer.



PERPETRATORS OF SEXUAL AND GENDER VIOLENCE

The primary perpetrators are fellow refugees living in the camp. In the in-depth interviews, a significant number of women reported abuse by husbands and uncles, which included 12 cases of arranged marriage. Women are also at risk of being attacked by Tanzanian locals when they venture out of the camp for food, farming, or in attempt to earn income. One adult male reported he was raped by prison guards and other inmates while detained in a Tanzanian jail. Most of the children knew their attackers, who were either neighbours or relatives.

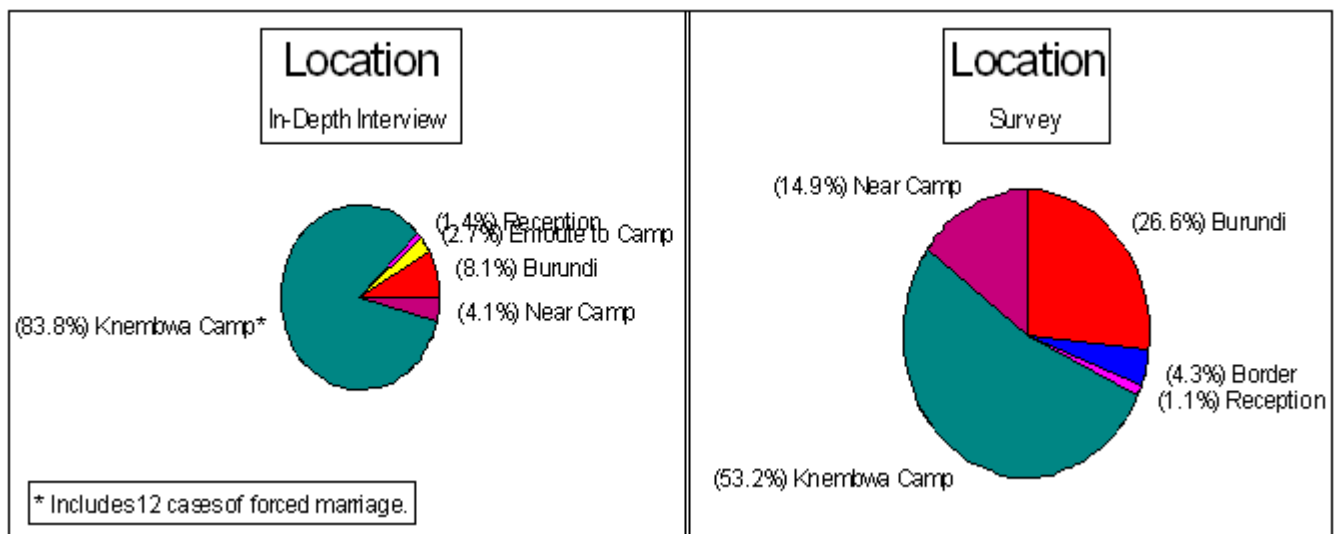


SITUATIONS WHERE SEXUAL AND GENDER VIOLENCE OCCUR

Most of the incidents occurred within Kanembwa camp. The majority of the population has lived in the camp over three years, hence the time exposure to the risks of experiencing sexual and gender violence has been greatest in this camp.

It is unclear from the results why a higher percentage of the survey respondents reported incidents in Burundi. This may relate to the structure of the survey which started with questions about the time when they left their homes and probed for information on multiple incidents. The in-depth interviews indicate that in Burundi many of the women's homes were destroyed or they feared attack so they hid in the bushes prior to fleeing the country. This homeless state may explain why so many women experienced sexual violence at that time.

The third most frequently reported location was near the camp where women farm, shop, and illegally attempt to find work. In comparison to the new 1996 arrivals, the respondents in Kanembwa do not report many incidents at the border, en route to the camps, or at the reception centre. In comparison, the 1996-1997 arrivals to a newer camp report many incidents at the border, en route to the camp, or at the reception centre.



Beyond the Numbers: Survivors Tell Their Own Tales

In addition to the statistics, the project has collected the stories of sexual survivors. Here are the tales of three survivors who were courageous enough to come forward.

Girl aged 13 years old.

She is an orphan and the eldest girl in a family of six. The father was killed in Burundi and the mother was killed when a tree fell on her in the Kanembwa camp. The husband to her aunt who took her after both her parents' death started to demand sex from her, especially when his wife was working away from home. She was still going to school. Her uncle would beat her for small reasons when she refused to have sex with him and he would strip her naked in front of the smaller children and then rape her late at night when they were asleep. "The only solution I had was to get married, so when this boy abducted me by the water tap as I collected water and forced me into marriage, I thought it was a solution for me so I refused to go back home when my aunt came to get me." Soon after

she became pregnant and was experiencing a lot of complications, such as bleeding. She also experienced domestic violence in her new home. She had a miscarriage at six months of pregnancy. She was seen by a doctor and advised not to immediately become pregnant again. At age thirteen, she has a very immature body. She has still refused to go back to her aunt's place who does not know what her husband did and is now threatening to send her back to Burundi.

Boy aged 8 years old.

One day the assailant had left for a Tanzanian village to earn some money. The boy went to his house and took a calaboose, because the door was not locked. When the assailant came back he went to the boy's home and asked who took the item. When he was told that the boy took it, the assailant asked for the child to go spend the night with him. "When we reached his home he did not even put on the fire, we went straight to the bedroom. In the night I was sleeping facing the wall. I felt the assailant pushing strongly and hard something inside my anus." "Did you see the thing he was pushing inside you?" "Yes, it looked like a snake and it was big. It was the same as what I use to pass urine except bigger. I started crying because it was very painful. I begged him to stop but instead he pushed even harder and faster. He made me sit on it and he was pushing hard, and just, oh it was so painful. I cried even more and begged him to stop. He did not stop. Instead, he told me that was what he did to children who took things from his house without permission. He did it more than two times in the night, each time saying he was punishing me. Sometimes he would make me sit on it or sleep facing the wall and him sleeping behind me. I could not go to the toilet the following day, I just cried each time I tried to."

Woman aged 33 years old.

"We were coming from the big market. I was with another woman when we saw two men standing by the road. When we reached section D (of Kanembwa camp), we separated because she had reached home, and I continued toward my section. After about three minutes I found the two men again. The assailants blocked my way, they seemed to be waiting for me. I tried to run, but I was seven months pregnant and I could not run fast. They easily caught up to me and pushed me down by force. They tore off my clothes while beating me with fists and a stick. I began to cry. They tied my mouth with one of my cloths, hitting my face and shoulder, while threatening me that they would kill me. I sustained wounds on my face, shoulder and hand as a result of the beating. They were beating me with something, I could not see what it was as it was getting dark. After this they took turns raping me. Finally people heard my cries, but by the time they came [the men] had run away. You see, one of these men had raped me a year ago. I told my husband and we reported this to the sector block leader, who made [the perpetrator] pay money, 1,500 Tanzanian shillings (US\$3), from which [the section leader] took half for himself and the other half he gave to my husband. The block chairman then asked us not to say anything about the whole case." The assailant is known to the woman because they live in the same neighborhood. The block leader reacted in the same manner as during the first incident. The woman was not happy so she insisted to her husband that they go to the police and report the matter, but people advised them not to report to the police. Eventually the woman went and reported to the police, but the assailants were tipped off

and they ran away from the camp. The relatives of the assailants then started to threaten the woman and her husband that they would kill them. The Sexual and Gender Violence Project helped reestablish their security by going with the police to her place and giving a formal warning to the family member of the assailants.

LESSONS LEARNED

General Lessons on Participatory Methodology for Assessing Sexual and Gender Violence Participatory methods of conducting needs assessments and addressing sexual and gender violence affect the community; these methods make the community desire change. Participatory methods give the community control over decisions and processes that influence and direct the needs assessment. As a result, the women in the community feel less threatened and more secure. It is a process that should only be used if programs to address the issues of concern to the community will be developed.

The ability of the project staff to communicate with the beneficiaries is a critical issue for participatory methods of assessment. Ideally, all involved parties should speak the same language. In refugee settings translation is usually required. Using a translator creates distance between the project staff and the community. Without careful attention, vital information can be lost due to poor translation or the personal bias of the translator.

Initially, it is possible to have project staff available at each site on a limited number of days per week. However, it becomes necessary to have a consistent presence as the program becomes recognized by the community. For example, demand for emergency contraception requires immediate attention (within 72 hours of unprotected intercourse for oral contraceptives).

The participatory process can be implemented with very few paid staff as it relies heavily on voluntary personnel from the community with minimal remuneration. In Kibondo, lunch and soap were provided as incentives for the Women's Representatives. As the project develops it may be necessary to pay key members of the community who invest a significant portion of their time to the project. Eventually, four Women's Representatives were paid for conducting the survey and acting as focal points for violence counseling.

It is important to begin the project by working directly with the marginalized, affected group members (survivors) in order to build their capacity to confront the hierarchical power structure of the predominately male camp leadership forum on issues of sexual and gender violence.

Refugee women have many responsibilities so their time constraints must be considered when scheduling meetings.

Giving sincere and truthful information to the community builds trust in the project staff who are outsiders. In meetings and counseling sessions, staff answer questions about a full range of questions relating to health, camp living conditions, and refugee policy.

Every step in the process of initiating an assessment is a delicate step requiring maximum attention; any mistake can affect all the positive work that has been done, as well as future work.

Assessing the prevalence of sexual and gender violence is very hard and taxing for the individuals who actually implement the work. The tales of human suffering affect more than the body and heart; the work constantly touches your innermost core, your soul. Staff need to have someone with whom they can debrief about the horrible stories they hear on a daily basis; they need to maintain personal boundaries but also have empathy for survivors.

Group Discussions

Group conversations allow women to describe their experiences, ask questions using the third person and by observing the participation of other group members, encourages women to discuss these issues.

Small group discussions proved very useful as they gave the most silent members of the group the opportunity to participate. They also offered a non-threatening, friendly atmosphere since people knew each other and got to even know each other better through working together.

Dancing and games were also very useful at the beginning and end of meetings. They made people relax and they forged a link of acceptance between the project staff and the women; the refugee women realized that the project manager was just another woman. It created a very positive atmosphere conducive for critical thinking on very sensitive and private issues.

In a group it is difficult to provide support for individuals who experience emotional upset during the discussions. For this reason, the facilitators may discourage personal disclosure in group settings. Some of the women who wanted to share their story in the group and were asked to wait for a private interview did not arrange to meet the staff after the meeting.

In-depth Interviews

The process of conducting in-depth interviews requires less preparation time than is necessary for the development of questionnaire forms, translation, back translation, and training of interviewers, because the contact is mostly individual and verbal. The process personalizes and humanizes the collection of information.

Interviews can be conducted even in the early stages of a refugee crisis. For instance, Traditional Birth Attendants can be identified from the first days to identify cases of

sexual and gender violence and make referrals for emergency contraception and trauma treatment.

Individual interviews make it possible for critical needs of survivors to be taken care of immediately. Referrals are made on the spot for medical, legal, and social welfare services. One-to-one interviews should not be conducted unless there are basic referral facilities for health and social welfare.

Interviews provide an ideal opportunity to get to know what reproductive health issues generally affect the women in the community. Important data can be collected if all cases and concerns of the women who come forward are documented. Interviews produce rich qualitative information. Interviewers should avoid registering only cases which report incidents of sexual and gender violence (i.e. interviewers should register all cases, which include domestic violence, gynecological concerns, family dynamic problems, etc.).

In-depth interview results are valued less by some people than survey results. NGO staff, UNHCR, and local authorities all expressed doubt about the validity of the interview findings due to lack of random sampling and the possible introduction of interviewer bias. However, the results of the IRC Tanzania comparison indicate that in-depth interviews provide more breadth of descriptive information and revealed a wider variety of cases among children and males.

Some people questioned the motivation of women in reporting their experiences of sexual and gender violence. No material incentives were offered to women who participated in interviews.

Survey

Quantitative analysis of survey results provides policy makers and community leaders with a sense of the magnitude of the problem. The specifics on who is attacked, by whom, where and when is needed for the design of prevention measures.

Surveys can be implemented by people with very basic levels of education as long as they can read and write in at least their native language. The Women's Representatives took great pride in being able to conduct the survey.

Qualitative responses are difficult to analyze using standard statistical software. The survey results are inconclusive on qualitative questions regarding the range of violence experienced (i.e. survey results indicated that all women who experienced sexual and gender violence experienced vaginal penetration and no other forms of violence were reported).

Surveys take a lot of time and input from project staff and the community. In Tanzania, it took over four months to develop the survey instrument, translate and back translate the survey, train the interviewers, conduct the survey, enter the data into Epi-Info, and analyze the results. The process was supported by the groundwork laid by the Women's

Representatives in the two months prior to the introduction of the survey idea. The analysis was delayed because Epi-Info expertise was not immediately available on site.

Rapid survey techniques are not appropriate for use on the topic of sexual and gender violence unless significant participatory sensitization has transpired prior to the implementation of the survey. For this reason, it is not advisable to conduct surveys in pre-stabilization phases of a refugee situation.

CONCLUSIONS AND NEXT STEPS

Both methods of assessing the prevalence of sexual and gender violence produced valuable insights into the needs of refugee women and children in the camp. The results were similar regarding the majority of the sexual and gender violence cases. Namely, of females between the ages of 12-49, approximately 22% to 27% report having experienced sexual violence since becoming a refugee. The survey process missed vital information regarding the less typical cases (younger girls and all males affected by sexual and gender violence), the degree of variation in the type of violence experienced, and the types of related reproductive health and protection needs survivors felt free to express in interviews. Both results could be analyzed quantitatively but the interview results were much more time consuming to code since the information was not organized and the same questions were not answered in every case.

We conclude that both methods are useful, but that the limitations in the design of the survey tool may limit the depth of the results. In the Tanzanian context, it was felt that more women participated in the interviews and the survey because of the strong participation of the Women's Representatives. It is unclear if the response rate would have been as high if the meetings with the Women's Representatives and the women of the community had not occurred first. The staff feel strongly that their results are the fruit of trust built with the Burundi refugee women.

After completing the assessment of the prevalence of sexual and gender violence experienced by Burundi refugees, the next step is to work closely with the community to plan appropriate response and prevention strategies.

Assistance Offered to Survivors

The response to the needs identified starts concurrently with the assessment. The acute needs of the survivors are immediately addressed by the IRC Gender Violence Protocol (see appendix II). It is anticipated that most new cases will first be reported to the Women's Representatives, the social workers, or the gender violence project staff. The first point of contact is responsible for responding to the critical medical and protection needs of the person making the report. After the immediate needs are met, the person is referred to the gender violence staff for initial intake counseling and follow-up.

Assistance offered by the project staff includes:

- Counseling on how to continue to live within the community

- Medical exams for trauma, STDs including HIV, and pregnancy
- Material support such as soap and clothes for the most needy
- Referral to camp management through social workers to apply for family separation in cases where women fear continued domestic violence
- Referral to the camp police to investigate in cases where the woman wants to seek prosecution
- Open invitation to return as often as they want to further discuss the incident or their feelings

Sensitization Training

In order to better enable the community and authorities to respond appropriately to the needs of gender violence survivors, the results of the needs assessment will be presented in a training which describes the extent of the problem, the interventions suggested by survivors and women's representatives, and an introduction to gender dynamics which create circumstances in which women and children are victimized. The main point of the training will be to educate people that women and children are not culpable in cases of sexual and gender violence and that confidentiality is critical to anyone who is brave enough to report an incident. The survivors interviewed and the Women's Representatives recommend that incidents would decrease if authorities widely publicized and applied the penalties for rape, statutory rape of girls under the age of 15, and domestic violence found in the Tanzanian law.⁵

Women's Representatives will be trained to conduct the sensitization training within the camp community. They will describe the results of the assessment and solicit the support of the community leaders to prevent gender violence and to encourage compassion for survivors, especially those who choose to pursue prosecution of perpetrators.

Community leaders will be encouraged to work with the Ministry of Home Affairs, the TCRS camp management team, the UNHCR protection officers and the IRC project staff to reduce the incidence of sexual and gender violence and to promote prosecution of offenders.

Camp Management, police, UNHCR, and NGO staff, including IRC staff, will be informed of the survey results and offered recommendations on how to assist survivors who have protection, medical or psycho-social needs. Support will be sought for implementation of response and prevention strategies. The Gender Violence Protocol will be reviewed and endorsement will be sought by the relevant agencies. Monthly meetings will be held to review progress to date on the implementation of the Gender Violence Protocol.

One male Medical Assistant has already been trained to do syndromic diagnosis of STDs and the IRC Medical Officer plans to also train a female Medical Assistant. All the Medical Assistants will be trained to be more sensitive to the need for absolute confidentiality to be respected in cases of sexual and gender violence. The Women's Representatives recommend that a Medical Assistant who is trained to deal specifically

with rape exams be introduced to the women of the community in order to increase their familiarity and comfort with this person.

Social Workers will receive refresher training on how to handle referrals in cases of on-going vulnerability to gender violence including wife beating, rape, and incest.

Appendix I

Sexual and Gender Violence Response Protocol IRC Kibondo, Tanzania ⁴

Key Points to Remember

- Ensure the physical safety of the survivor
- Prevent any further suffering by the survivor
- Be guided by the best interest of the survivor
- Guarantee confidentiality
- Be sensitive, discreet, friendly and compassionate when dealing with the survivor
- Ensure same-gender interviewer/interpreter/doctor

DEFINITIONS

Gender Based Violence:²

Violence which is directed against a woman because she is a woman or which affects women disproportionately.

It encompasses but is not limited to the following:

- a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry related violence, marital rape, female genital mutilation and other traditional practices.*
- b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution.*
- c) Physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs.*

Gender-based and Sexual Violence

All forms of gender-based violence against women and also sexual violence against men and boys.

IMMEDIATE ACTION

The Protocol is to be enacted whenever a refugee (male or female, adult or child) makes a report of gender-based or sexual violence.

Responsible Party:

It is assumed that refugees will usually first report an incidence of sexual violence to the Women's Representative of the camp committee, a social worker of the same sex, or to the Sexual Violence Project staff members. The plan of action should be followed by any IRC staff or women's representative.

Action Steps:

Assess whether immediate medical attention is required and if so ensure survivor is escorted to the appropriate venue.

Inform survivor of the availability of emergency post-coital contraception available at the clinic (combined oral contraceptive pills and copper IUDs).

Determine whether immediate notification of authorities is required according to the wishes of survivor.

Assess the security of survivor and take necessary action.

Arrange for survivor to meet with the Sexual and Gender Violence Project staff (including the appointed Women's Representatives) to do initial intake and provide follow-up.

Interview and Case Management by Sexual and Gender Violence Project Staff

A member of the Sexual and Gender Violence staff who is trained to manage sexual violence cases will conduct a confidential interview using the Sexual Violence Information Form (under draft). Sexual and Gender Violence Project staff coordinates with camp management, police, medical staff, and UNHCR under the direction of the Sexual and Gender Violence Project Manager.

Incident report copied for UNHCR protection officer.

Sexual and Gender Violence Project staff counsels survivor.

Medical Care

Allow survivor to be accompanied by support person of survivor's choice.

Explain all medical procedures to minimize possibility of further traumatization.

Medical (forensic) examination and incident report must be done according to local government requirements which requires that the doctor must be registered in Tanzania.

Post-coital contraception is discussed with survivor.

Medical follow-up is scheduled and patient informed of urine pregnancy test option if next menses are missed.

Survivor with confirmed pregnancy is counseled on pregnancy options. Under Tanzanian law abortion is permitted in cases of rape until the 12th week of pregnancy only if the survivor can provide a police form including a medical report which confirms a rape has occurred.

Information about HIV and AIDS should be given and the HIV test offered. If the HIV test is positive, appropriate counseling, follow-up and referrals should be given with full respect for confidentiality. The test is provided by the local hospital. IRC pays for the test.

The following tests and treatments should be available to the examining physician:

- sedation/analgesia
- syphilis blood test (VDRL or equivalent)
- prophylactic antibiotic cover against STDs
- tetanus toxoid
- HIV test
- pregnancy test
- emergency post-coital contraception (combined oral contraceptives or copper IUD)
- referral for abortion to be performed at local hospital

If tests are positive, appropriate counseling, follow-up and referrals should be given with full respect for confidentiality. Survivor should be advised to have her sexual partners treated for the same STDs.

Legal/Protection

Legal follow-up is arranged in conjunction with UNHCR and the Tanzanian Ministry of Home Affairs. Implications of legal action and possible difficulties should be explained.

In cases of sexual and gender violence within the home, if the woman requests separation from the husband, the cases will be referred to the Ministry of Home Affairs in order to request a new plot, ration card, non-food items, and custody of children.

Follow-Up Plan

Follow-up counseling for survivor is scheduled to include:

- support for post-traumatic effects
- support for dealing with family and community reactions
- support during legal procedures

Appendix II

GENDER ASSAULT FORM

NAME:

EXAMINATION DATE:

DATE OF LAST MENSTRUAL PERIOD:

TESTS: Urine Pregnancy Test: _____ Results: _____ Action:

VDRL: _____ Results: _____ Action:

HIV Test: _____ Results: _____ Action:

Syndromic Assessment for STDs:

Vaginal Discharge

Urethral Discharge

Pelvic Pain

Lesions/sores

Diagnosis:

TREATMENTS:

Sedation:

Analgesia:

Emergency Post-Coital Contraception:

REFERRALS:

FOLLOW-UP APPOINTMENT DATE AND INDICATION:

EXAMINING PHYSICIAN:

EXAMINING MEDICAL ASSISTANT:

INTERPRETER:

Appendix III

International Rescue Committee: Kibondo, Tanzania

CONFIDENTIAL GENDER VIOLENCE SURVEY

SURVEY NUMBER _____

AGE _____ CAMP (CIRCLE)

1. KANEMBWA
2. MTENDELI
3. MKUGWA
4. NDUTA
5. KEZA

MARITAL STATUS

- 1.SINGLE
- 2.MARRIED
- 3.SEPARATED
- 4.DIVORCED
- 5.WIDOW
- 6.REMARRIED

CURRENTLY LIVE WITH:

1. ALONE
2. HUSBAND
3. CHILDREN
4. PARENTS
5. OTHER _____

PREVIOUS OCCUPATION _____

CURRENT OCCUPATION _____

ETHNICITY

1. HUTU
2. TUTSI
3. OTHER _____

DATE LEFT HOME IN BURUNDI _____

NUMBER OF DAYS TRAVELED FROM HOME IN BURUNDI TO BORDER

DATE OF ARRIVAL IN TANZANIA (DAY/MONTH/YEAR) _____

DATE OF ARRIVAL IN CAMP (DAY/MONTH/YEAR) _____

MODE OF TRAVEL TO CAMP

1. WALK
2. PRIVATE VEHICLE
3. TRUCKED TCRS
4. BIKE
5. CART
6. OTHER

SINCE LEAVING YOUR HOME WHAT PROBLEMS HAVE YOU EXPERIENCED BECAUSE YOU ARE A WOMAN?

WHAT PROBLEM DID YOU SEE OTHER WOMEN FACE?

HOW MANY WERE YOU IN YOUR GROUP?

HAVE YOU EXPERIENCED ANY FORM OF SEXUAL VIOLENCE OR ABUSE?

YES NO

INCIDENT NUMBER : _____ DATE: _____ TIME: DAY

(6 AM TO 7 PM) NIGHT (7 PM TO 6 AM) LOCATION:

DESCRIBE WHAT HAPPENED TO YOU:

NUMBER OF ASSAILANTS: _____

DESCRIPTION OF ASSAILANT(S)

WHO WAS WITH YOU WHEN YOU WERE VICTIMIZED?

DO YOU BELIEVE YOU WERE SPECIFICALLY TARGETED FOR ANY REASON?

YES NO WHY?

DID YOU HAVE ANY PROBLEMS AS A RESULT OF THE INCIDENT?

DID YOU RECEIVE MEDICAL ATTENTION? YES NO

WHAT IS YOUR GREATEST CONCERN RELATED TO THIS INCIDENT?

HAVE YOU BEEN VICTIMIZED MORE THAN ONCE: YES NO (IF YES, REPEAT THIS PAGE OF QUESTIONS FOR EACH INCIDENT.)

Appendix IV

Appreciations

This report was made possible by the generous support of the Andrew W. Mellon Foundation, LeBrun Foundation, and Packard Foundation. The authors are grateful for the editorial support of Julia Hen, Julia Cohen, Lori Wichhart, Mariana Zantop and Lorraine Anglin. The analysis of the survey results was made possible by the assistance of Kerry Demusz. Numerous IRC staff members in Tanzania and New York have supported this project through fund raising and advocacy. The Kanembwa Women's Representatives offered invaluable support and guidance for the development of the work in the camp. Most of all, we deeply appreciate the courage of the Burundi women and children who came forward to share their tales of pain. We share their hope that someday they will no longer face the danger of sexual and gender violence.

Appendix V

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Footnotes

¹ World Factbook 1995, Washington Post web page: <http://www.washingtonpost.com/wp-srv/inatl/longterm/worldref/cia/burundi.htm> citing, the CIA Web site. [Go Back](#)

² UNHCR Interagency Field Manual on Reproductive Health in Refugee Settings, Geneva 1996. [Go Back](#)

³ Another 82 cases were identified in two other camps where a similar investigation was initiated by IRC using the traditional birth attendants as the link between the project staff and the community. [Go Back](#)

⁴ Fifty-five females age 12-49 out of a population of 3,803 voluntarily came forward to report having experienced sexual violence since becoming a refugee. This represents 1.45% of the female population between the age of 12-49 in Kanembwa Camp. According to UNHCR, in non-refugee settings in Africa, it is estimated that only 5-10% of rapes are reported. Based on this assumption, we estimate that the 1.45% of the females who came forward represent between 15-29% (or an average of 22%) of females who have experienced sexual violence. [Go Back](#)

⁵ According to Tanzanian Law 130, marriage must be consent-like; it allows for marriage between men and women by mutual agreement. Punishment for rape is 30 years in prison. Attempted rape, hastily arranged marriage or marriage by force: 14 years in prison; marry a girl under age 17 without parental consent: 14 years; rape a minor under the age of 12: death sentence or imprisonment for life; to rape a "foolish" or attempt rape: 14 years. [Go Back](#)

⁶ Protocol based on "Sexual Violence Against Refugees: Guidelines on Prevention and Response", UNHCR, Geneva, 1995. [Go Back](#)

⁷ Declaration on the Elimination of Violence Against Women, Articles 1& 2. [Go Back](#)

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