The relationship of Sexual and Gender-based Violence (SGBV) to Sexual-risk Behavior among Refugee Women: The Mediating Role of Depression

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Abstract

This study investigated the relationships of SGBV, learned helplessness, depression, and sexual-risk behaviors among refugee women in Botswana utilizing a cross-sectional research design and the theory of learned helplessness. A total of 402 female refugees who were at least 21 years old residing at the Dukwi refugee camp participated in this investigation within a three-month period.

This study found that about 75% of participants had experienced some form of SGBV either in their home country, during flight/transit, or in the host country. More than half (56.4%) had experienced SGBV in their home countries, 39.3% reported experiencing SGBV during flight/transit, and about 37% of the participants reported having experienced SGBV while in Botswana.

Past SGBV was categorized into past physical violence, past intimidation and control, and past sexual violence. Simultaneous multiple regression analysis showed that overall past SGBV predicts current sexual-risk behavior among refugee women ($F = 2.018$; $p < .011$).). The three predictor variables together explained 15% of the variance in sexual-risk behavior. Although, the hypothesized mediating roles of learned helplessness and depression on the relationship between past SGBV and current sexual-risk behavior were not supported in this study, more than half of the participants (55%) experienced learned helplessness and about 90% were depressed.

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Introduction

The problem of Sexual and Gender-based Violence (SGBV) during conflict situations is not a recent phenomenon. It dates as far back as the Second World War, when for example an estimated 100,000-200,000 Korean women were abducted by the Japanese army and forced into sexual slavery (Swiss & Giller, 1993). An estimated 250,000-400,000 women were also raped during the Bangladesh war for independence in 1971 and 39% of Vietnamese women aged 11-40 fleeing their country by sea in 1985 were reported abducted or raped (Swiss & Giller, 1993).

The prevalence of self-reported SGBV in the general population is often difficult to assess and even more difficult to estimate in displaced populations such as refugees and internally displaced persons (World Health Organization [WHO]; 2002). According to UNHCR (1999), the magnitude of SGBV in refugee situations in many areas around the world remains underreported due to factors such as: fear of retribution; shame; powerlessness; lack of support; breakdown or unreliability of public services; and the dispersions of families and communities. The perpetrators are reportedly fellow refugees, members of other clans, religious or ethnic groups, military personnel, relief workers, members of the host population, and family members (UNHCR, 1999).

Persons most vulnerable and at the greatest risk of SGBV in refugee situations include unaccompanied women and lone female heads of household. Children are also very vulnerable to sexual abuse given their high level of trust in adults. Unaccompanied, often orphaned minors who are on their own or who may be residing with families that are caring for them are also especially at high risk. Refugees of all ages and both genders face a significantly increased risk of sexual violence when in detention or

detention-like situations. Those refugees who are the very old, infirm, or are physically or mentally disabled, may be particularly vulnerable to attack (HRW, 2000).

Most refugee women in Africa who flee their homes in search of sanctuary from violence too often find that they have simply escaped violence in conflict to face a different type of violence in the refugee camps. They face protection and security risks in refugee camps, as well as the challenges of heading households while suffering from their disadvantaged status as women. African refugee women are often vulnerable to rape, sexual assault, and other forms of sexual violence (HRW, 1999).

The office of the United Nations High Commissioner for Refugees ([UNHCR], 1999) reports that sexual and gender-based violence (SGBV) occurs during all phases of the refugee experience: prior to flight; during flight; while in the country of first asylum; and during repatriation and reintegration. The perpetrators are reportedly fellow refugees, members of other clans, religious or ethnic groups, military personnel, relief workers, members of the host population, and family members. According to UNHCR (1999):

> SGBV encompasses a wide variety of abuses that include rape, sexual threats, exploitation, humiliation, assaults, molestation, domestic violence, incest, involuntary prostitution (sexual bartering), torture, insertion of objects into genital openings, and attempted rape. (p. 36)

Human Rights Watch ([HRW], 2000) claimed that although SGBV is widespread and constitutes a violation of basic human rights, it is still under-reported in most refugee situations around the world. The magnitude of SGBV in refugee situations in many areas around the world is under-reported due to factors such as: fear of retribution; shame;

powerlessness; lack of support; breakdown or unreliability of public services; and the dispersions of families and communities (UNHCR, 1999). There are generally two principal causes of under-reporting of SGBV in refugee situations: the apparent lack of reporting by victims that may result in distorted figures that suggest the absence of a problem; and the absence of official figures relating to sexual violence in refugee situations within official government and non-governmental statistics (UNHCR, 1999).

Within refugee camps, women refugees may be subjected to rape because of their increased vulnerability or because of their actual or perceived political or ethnic affiliation. Rape and other forms of sexual assault are frequently gender-specific both in their form and in their motivation. Thus, refugee women and girls are raped because of their gender, irrespective of their age, ethnicity, or political beliefs. In host countries, local residents, fellow refugees, military and immigration officials, and police officers, often view refugee women as easy targets for assault (HRW, 2000).

Generally, women are not only vulnerable to sexual violence during conflict, but also during the periods of social disruption and disintegration that follow war---when they are fleeing the conflict and residing in camps for refugees or internally displaced persons. For example, a 1994 survey of 205 Liberian women and children aged 15-70 years found 49% had experienced at least one incident of physical or sexual abuse by Liberian soldiers during the 1989-1997 civil wars (Koss & Kilpatrick, 2001). Similarly, in the war in the Balkans, between 10,000 and 30,000 Kosovo Albanian women and girls are thought to have suffered war-related rape or other forms of sexual assault during the Serbian occupation and 1999 refugee exodus (Koss & Kilpatrick, 2001). In Sierra Leone, a household survey of women revealed that 9% experienced war-related sexual assault

and an additional 9% have been sexually assaulted outside of a war situation (Ampwitz et al., 2002). Garcia-Moreno (2000), in a study conducted in East Timor, found that 39% of respondents reported they had been tortured, with 5% reporting rape and other forms of sexual violence.

Incidence and prevalence of SGBV are reportedly high in many refugee communities in Africa. In a UNHCR review of reproductive health services statistics from refugee camps, the annual number of women reporting rape was .2 per 1,000 among Rwandans in Ngara, Tanzania; .3 per 1,000 among Rwandans in Ngoma, Zaire, .5 per 1,000 among Somalis in Dadaab, Kenya; .6 per 1,000 primarily among the Sudanese in Uganda; and 3.1 per 1,000 among Burundian refugees in Kibondo, Tanzania (Bitter, 1998).

In most African refugee settings, pressures regarding housing, food, security, and other resources often strain domestic situations and erupt in violence. Moreover, extended networks of family, neighbors, and community leaders that may have acted as a deterrent to abuse under normal circumstances no longer exist in the abnormal conditions and unfamiliar territory to which women refugees are exposed. Thus, women refugees generally have limited, or no, legal remedies against sexual and domestic violence, due to their unfamiliarity with, and wariness of local police and judicial authorities, and because of a lack of proactive, timely, systematic, and sensitive responses by the relevant international and local authorities in Africa (HRW,2000). In Africa, the true scale of SGBV against refugees is shadowed by reasons such as: victims' reluctance to report; personal discomfort of refugee workers or humanitarian

officials; and refugee workers' or officials' the frequent dismissals of reported rapes as a private matter (UNHCR, 1999).

The social, psychological, and health consequences of SGBV among refugees

The injuries that refugee women sustain from SGBV persist long after the crime. Refugee victims of SGBV in different parts of the world have reported ongoing medical problems, including miscarriages by women raped when pregnant, hemorrhaging for long periods, inability to control urination, sleeplessness, nightmares, chest and back pains, and painful menstruation (HRW, 2000). They have also reported such medical problems as unwanted pregnancy, unsafe abortion, HIV and other sexually transmitted diseases, sexual dysfunction, trauma to the reproductive tract, and chronic infections leading to pelvic inflammatory disease and infertility. Survivors of SGBV in refugee situations have often experienced depression, guilt, terror, shame, and loss of self-esteem. They may also be rejected by spouses and families, ostracized, and subjected to further exploitation or to punishment (UNHCR, 1999). These physical, psychological, and social consequences of SGBV only add to the pain of uprooting and forced migration.

In terms of the reproductive health of refugee women, it is obvious that several characteristics of refugee life would logically increase exposure to STDs including HIV/AIDS. Several assessments of the point prevalence of HIV and other STDs have been conducted in refuge settings (McGinn, 2000). For example, a 1989 prospective study of 179 pregnant Vietnamese refugees in Hong Kong found 3% prevalence of syphilis and no gonorrhea (King, Duthie & Ma, 1990). The International Rescue Committee (IRC) in 1999 reported similar syphilis rates in a 1998 survey of 876

Sudanese and Somali refugees attending an antenatal clinic at the Kakuma Refugee Camp in Kenya.

A number of other studies have linked the spread of HIV and other STDs to conflicts and the populations shifts they propel (McGinn, 2000). In 1998, the UNAIDS reported a HIV seroprevalence rate of about 9% among Rwandans who had lived in refugee camps in Tanzania or Zaire, representing a 6-8 fold increase over the rates in the rural areas from which they originated. However, the increase was even greater for the internally displaced who remained in Rwanda during the conflict years. Of the women raped, 17% were reportedly HIV-positive (UNAIDS, 1998).

Among Mozambican refugees in two camps in Swaziland, Van Rensburg, Lemmer and Joubert (1995) found a 11% HIV seroprevalence rate among those refugees residing in a camp located near Swaziland's two major cities (with estimated HIV seropravalence of 18%) compared to 1% among refugees residing in an isolated camp in a sparsely populated area further south of Mozambique.

McGinn (2000) had argued that the location of refugees, rather than refugee status per se, was important in the examination of the spread of HIV infection in Angola in 1997 and 1998. In a study of 1,695 relatively healthy individuals and patients (seeking treatment for tuberculosis and other illnesses) in six provinces, Santos-Ferreira et al., (1990) concluded that seropositivity for HIV was highest among patients and healthy individuals in the northern areas (near Zaire), among refugees in the most affected war zones and among military personnel. Thus, although it is evident that conflict situations increase the spread of STDs including HIV, in most cases through displacement and

military presence, the direction of spread often depends on the relative prevalence levels in countries of origin and destination.

Sexual and gender-based violence against refugees is a global problem and constitutes a violation of human rights as enshrined in international declarations and treaties. Although some reports are available, the nature and extent of SGBV and the particular implications for the incidence and transmission of STDs including HIV have not been systematically documented in the African refugee context. The population of refugee women in Botswana is particularly at high risk for HIV and AIDS due to the high prevalence of HIV infection and AIDS in that country (about 39% of the sexually active population; UNAIDS, 2003) not withstanding their experience of forced migration.

This study investigated the relationships of SGBV, learned helplessness, depression, and sexual-risk behaviors among refugee women in Botswana. It was guided by the reformulated theory learned helplessness (Abramson, Seligman, & Teasdale, 1978). The possible mediating roles of depression and learned helplessness were explored as well. The specific research questions that were addressed in this investigation included the following:

1. What is the relationship between SGBV and sexual-risk behaviors in refugee situations and how does depression affect this relationship?
2. How does learned helplessness explain the relationship between SGBV and sexual-risk behaviors in refugee situations?
3. Does learned helplessness (as a result of SGBV) increases the likelihood of engaging in risk-sexual behaviors by refugee women?

4. Is depression an outcome of learned helplessness by refugees?

Theoretical Framework

This study utilized the reformulated theory of learned helplessness (Abraham et al., 1978), an extension of Seligman's (1975) theory of learned helplessness, to investigate the relationship of SGBV and sexual-risk behaviors among refugee women in Botswana.

Learned helplessness theory was originally developed to explain why dogs experiencing uncontrollable electric shock failed to learn escape or avoidance behavior (Overmeier & Seligman, 1967). Seligman and his colleagues discovered that when laboratory animals were repeatedly and non-contingently subjected to shock, they became unable to escape from the painful situation, even when escape was possible and readily apparent to animals that had not been subjected to helplessness training (Walker, 2000).

The early experiments found that dogs learned to be completely passive when faced with unpleasant environments that the animals could not control. In order to create such environments, dogs were exposed to series of electric shocks that they could neither avoid nor control. When placed in similar situations that involved shocks that could actually be controlled by a simple response, the dogs that had experienced the uncontrollable situations passively submitted to the controllable shocks. Conversely, the dogs that had not had uncontrollable experiences quickly learned to avoid the shocks altogether (Walker, 2000).

Walker (2000) explained that the dogs were thought to have learned that their behaviors had no influence over external events, and therefore learned to be completely passive, or helpless, in response to stressful situations. Seligman (1975) likened this phenomenon to a kind of human depression, and showed it has cognitive, motivational, and behavioral components. He labeled this phenomenon "learned helplessness." This cognitive explanation for the dogs' passive behaviors soon came to be known as the "learned helplessness theory" (Maier & Seligman, 1976). However, this original theory proved to be too simple for humans. Whereas the original model hypothesized that all humans would become totally dysfunctional and completely passive in response to all uncontrollable situations, it soon became clear that not all people respond in the same way to perceivably uncontrollable situations (Abramson, Seligman, & Teasdale, 1978; Peterson & Park, 1998).

Several theoretical inadequacies were subsequently identified in the original theory relative to the effects of uncontrollability on human behavior (Abramson, Seligman & Teasdale, 1978). The possibility of more than one type of perceived helplessness existing (universal versus personal) was the first inadequacy identified. No apparent consideration had been given to the likelihood that an individual's behavioral repertoire of controlling responses might be an important element in the development of learned helplessness. A second concern was the failure to consider the means whereby generalizability of the helplessness response occurred across situations. Finally, the theory failed to deal with the chronicity of the helplessness response over time (Olson, 1983).

Resolution of the identified inadequacies was attempted by incorporating elements of attribution theory into the original theoretical model that became known as the *Reformulated Learned Helplessness Theory* (Abramson et al., 1978; Abramson, Garber, & Seligman, 1980). Abramson et al. (1978) explained the apparent variability in human responses by looking at individual causal attributions for negative events; that is, how an individual explains the apparently uncontrollable and unpleasant event. The new model suggested that such attributions were influenced by the perceived salience of situational cues; the more ambiguous the event, the more likely an individual will be subject to his/her attribution biases. These attribution biases, in turn, were thought to reflect an individual's common belief about what caused the negative and uncontrollable event. An associated belief concerned the individual's own ability to influence the final outcome of the event, or locus of control (Rotter, 1966). In such a way, individuals were found to be subject to their beliefs about both the cause of the event (attributional bias) and the outcome (Peterson, Maier, & Seligman, 1993).

The reformulated theory of learned helplessness

Abramson et al.'s (1978) reformulated theory of learned helplessness posits that causal attributions for unpleasant and perceivably uncontrollable events have three dimensions: global versus specific (globality), stable versus unstable (stability), and internal versus external (internality). Any one of eight combinations can be made from these three dimensions and an attribution bias is represented by the most persistently applied combination.

The reformulated theory suggests that a global, stable, and internal attribution bias for unpleasant events represents the quintessential state of learned helplessness and has therefore come to represent the concept. A global causal attribution occurs when the individual presumes that the cause of negative events is consistent across multiple situations, whereas a specific causal attribution occurs when the individual presumes that the cause is unique to only one situation. A stable causal attribution occurs when the individual presumes that the cause is consistent across time, whereas an unstable causal attribution occurs when the individual presumes that the cause is specific to one point in time (Abramson et al., 1978).

Finally, the reformulated learned helplessness theory asserts that an internal causal attribution connotes *personal helplessness,* or a belief that the uncontrollable situation occurred due to some inherent personal characteristic. Not surprisingly, internal causal attributions are associated with lowered self-esteem (Olson, 1983). External causal attributions, on the other land, indicate *universal helplessness,* or a belief that the perceivably uncontrollable situation came about because of independent external forces (Abramson et al., 1978).

The assumptions of the reformulated theory include the expectation that events are uncontrollable as the critical determinant of non-contingency and postulates that attributions by an individual serve a mediating role between perception and expectation of non-contingency. Thus, reactions to uncontrollable events are determined by the causal attributions about the event (Olson, 1983).

Although the reformulated theory of learned helplessness has not been scientifically tested in refugee populations with histories of SGBV, it has had wide spread

applications in the social, behavioral and health sciences in understanding behavior in a variety of situations. For example, in describing the relevance of learned helplessness theory to nursing practice, Stoner (1985) examined its possible applicability to understanding individuals' psychological adjustment to cancer. Stoner demonstrated that it is likely that learned helplessness is experienced by some individuals with cancer and this knowledge of patients' perceived controllability, attributions for uncontrollable events, expectations that actions will improve outcomes, and the knowledge that cancer patients lack motivation will help nurses determine appropriate interventions (Stoner, 1985).

Learned helplessness has also been utilized as an interacting variable with self-care agency (McDermott, 1993) among healthy working adults. In this study, self-care agency, which was defined as the enabling ability a person must possess in order to engage in self care (McDermott, 1993) was examined in relationship to learned helplessness and adults' perception of their power to perform self care. Learned helplessness was found to be inversely related to self-care agency with the implication that an interaction of learned helplessness and self-care agency can affect self-care behaviors.

Learned helplessness, SGBV, Sexual-risk Behavior, and Depression

Learned helplessness has been shown to be a potential outcome of involuntary exposure to forced sex and attendant STD risk components (Eisenstein & Carlson, 1997; Seligman, 1975). When applied to risk-taking in general, learned helplessness typically develops when attempts to avoid harm (e.g. potential exposure to STD through sexual-risk taking) does not yield diminished risks where the victim cannot avoid exposure

(Hogben et al., 2001). Thus, through experience, the victim learns that trying to avoid risk is futile.

Motivational, cognitive, emotional, and behavioral deficits that lead to depression have also been identified in humans experiencing learned helplessness (Southwood, 1986). Similar to helpless animals, depressed humans were found to have negative, pessimistic beliefs about the efficacy of their actions and the likelihood of obtaining future rewards. Both depressed humans and helpless animals exhibited motivational deficits in the laboratory. Both exhibited signs of emotional upset with illness, phobias, sleep disturbances, and other symptoms similar to those described as being part of the battered woman syndrome, a subcategory of post traumatic stress disorder (Walker, 2000).

Depression is a condition that has been shown to be a typical collateral outcome of learned helplessness (Klein et al., 1976; Klein & Seligman, 1976; Miller & Seligman, 1975). Klein et al. (1976) demonstrated the relationship between learned helplessness and depression in a study of performance measures of depressed and non-depressed college students. Performance measures for anagram solutions were obtained from depressed and non-depressed students previously exposed to either "solvable" or "no discrimination" problem sets. Consistent with predictions generated by the learned helplessness theory, both depressed students given solvable problems (induced learned helplessness) and the depressed control group (no discrimination problem) manifested similar performance deficits relative to a non-depressed control group (Southwood, 1985).

Abramson et al. (1978) postulated the existence of a depressive attributional style among individuals with depression. Thus, depression-prone individuals are likely to attribute negative outcomes to global, stable, and internal causes. Olson (1983) argued that the learned helplessness-depression model also implies that attributing positive outcomes to external, specific, and unstable factors might increase vulnerability to depression.

Raps, Reinhard, Peterson, Abramson, and Seligman (1982), in a comparative study of the relationship of attributional style and depression in a psychiatric population, found that depressive patients attributed negative outcomes to internal, stable, and global factors and positive outcomes to external and unstable factors. Garber and Hollon (1980) also suggested that depressives' expectations of response-outcome and non-contingency are restricted to situations in which they are personally involved and do not represent generalized beliefs regarding uncontrollability in the world.

Higher rates of depression and a putative increase in depression are attributable to forced sex or physical violence (Hogben et al., 2001). Victims of forced sex in general are typically more depressed than non-victims (Fishbach & Herbert, 1997). According to Isaac and Schneider (1992), depression, which is also related to a perceived loss of control, may be associated with sexual-risk behaviors among women who normally avoid such behavior and may predict sexually transmitted diseases (STDs). In this study learned helplessness is hypothesized to result in increased risk for passive sexual behaviors by refugee victims of SGBV.

Method

This study identified refugees as those persons who, owing to external aggression, occupation, foreign domination, or events seriously disturbing public order in either part or the whole of their country of origin, are compelled to leave their place of habitual residence in order to seek refuge in another place outside their country of origin or nationality (OAU Convention, 1969). Study participants included those female refugees who were at least 21 years of age, resided at the Dukwi refugee camp, and were registered with the UNHCR in Botswana.

A survey questionnaire that was informed by the relevant theoretical and empirical literatures served as the data collection instrument. The data collection approach was primarily quantitative, utilizing survey methodological techniques to obtain data relevant to test the central study variables. Trained female research assistants interviewed participants at their preferred locations in one the four widely-spoken languages (Mbukushu, Lozi, Swahili, and English) at the camp. Participation in the interview was voluntary and all information obtained was made confidential. After completion of the interview participants were given a package containing a bathing soap, educational materials on safe sex practices/HIV/AIDS, and information on referrals for physical and mental health services available to refugees in Botswana. Those refugees that declined to participate in the research were also offered the package.

The Research Setting

The setting for this study was the Dukwi Refugee Camp in Botswana. It is located along the main highway that links the north and south of the country, about 560

km (about 350 miles) from Gaborone, the capital city of the Republic of Botswana. The camp covers an area of approximately 20 square km, inhabited by refugees from 16 countries, predominantly from Southern Africa, the Great Lakes region, and the Horn of Africa.

The camp is occupied by approximately 3000 refugees, of which about 65% are women and 35% are men. There are three schools in the camp-- nursery, primary and secondary schools. The nursery school has an enrollment of 250 students, the primary school 650, and the secondary school has only 200 students (UNHCR, 2003). A police station is also located at the camp. In addition, there is a health center at the camp that is staffed by the Botswana government and the Botswana Red Cross.

The Dukwi Camp is under the jurisdiction of the government of Botswana with supervision by representatives from the Office of the President of Botswana. The Settlement Commandant liaises directly with the Office of the President, UNHCR, and other humanitarian organizations that are referred to as *Implementing Partners*: The Botswana Council for Refugees (BCR), the Botswana Red Cross Society, the Botswana Christian Council (BCC), and Habitat for Humanity and Enterprise Botswana (EB), all with representatives at the camp.

The refugees live in houses, tents or huts that are assigned on a first come-first serve basis. Those refugees who arrived at the camp about five years earlier are fortunate to live in the limited number of houses that were built by the government years back to host refugees fleeing Apartheid minority rule in South Africa. Nowadays, all recent arrivals are offered tents by UNHCR or other implementing partners and others live with relatives in huts owned by refugees. There is a near-by village about 1.6 km (1 mile)

away called the Dukwi village that has grocery and liquor stores. There are also small businesses in the camp that are mostly owned by the Somalia refugees that sell grocery and other petty items. The refugees receive food supplies once a month that includes a bottle of cooking oil, a gallon of paraffin, a bag of maize meal, a bag of beans, and a packet of salt. Refugees have no source of income, as they are not allowed to take up formal employment outside the vicinity of the camp. There are, however, vocational projects at the camp that refugees can engage in to learn a vocation.

Population and Sampling

The population in this study are refugee women residing at the Dukwi camp in Botswana who, owing to external aggression, occupation, foreign domination, or events seriously disturbing public order in either part or the whole of their country of origin, were compelled to leave their place of habitual residence in order to seek refuge in Botswana (a place outside their country of origin or nationality) (OAU Convention, 1969). There are approximately 3000 registered refugees at the Dukwi camp, predominantly from Angola, Namibia and Somalia; about 1950 of these registered refugees are women (UNHCR, 2003). The camp is divided into three zones---Zone 9 (mostly Angolans), Zone 5 (mostly Somali), and Zone 4 (mostly Namibians)--based on a UNHCR housing arrangements. These housing zones constituted tents, huts and houses and there were a total of about 900 households at the camp. Thus, one household in this study is the equivalent of one tent or hut or house.

The sampling design was systematic random sampling of households and selecting an eligible participant in a household by simple random sampling. Systematic

random sampling yields estimates that are more precise than those produced by simple random sampling or even stratified sampling (Pedhazur & Schmelkin, 1991). The inclusion criteria were gender, age and residence at the Dukwi camp. Thus, a female refugee who was 21 years or older and residing in a household at the Dukwi refugee was eligible to participate in the study. Based on a total number of households of 900 (N) and a minimum sample size of 393 (n) (based on power calculations), a random sampling interval (K) of 2.2 was determined (i.e., $k = N/n$) (Pedhazur & Schmelkin, 1991). The number 2 was randomly chosen as the starting point of sampling and every second household was selected and an eligible participant in the selected household was interviewed until the desired sample size of a minimum of 393 participants was obtained. An eligible female refugee from each selected household who met the recruitment criteria and agreed to participate through her informed consent was in turn selected for participation in the study. In the event of more than one eligible female in a household, participants were selected through a random technique that involved a coin toss. Households with no eligible participants and those with eligible participants who declined to participate were replaced by selecting the next eligible household at end of the systematic sampling frame. The households at the camp served as the sampling frame. A total of 73 of the selected households did not have an eligible participant. Either female refugee below the age of 21 or a male refugee inhabited those households. Due to the fact that the experience of SGBV is usually under-reported, particularly in refugee settings (UNHCR, 1999), I was concerned about precision of estimates in the determination of the sample size, since precision is often largely affected by sample size (Pedhazur & Schmelkin, 1991). Results of a power analysis of a population size of 2000

registered refugee women (UNHCR, 2003) showed that a minimum sample size of 393 was necessary to test the hypotheses with a suggested alpha of .05, power of .80 and an effect size of .20 (Cohen, 1988). A total of 27 eligible refugees declined to participant in the study. Thus, a total of 402 female refugees were interviewed for this study with a response rate of about 97%.

Research Design

A cross-sectional research design was used to test the main hypotheses of the study. A structured questionnaire, developed for this study was administered by trained female interviewers to adult female refugees at the Dukwi camp in Botswana. As stated in chapter one, the study addressed five main research questions. These included:

1. What are the dimensions of the problem of SGBV (and its consequences for reproductive health in particular STD and HIV) among the refugees at the Dukwi camp?
2. What is the relationship between SGBV and sexual-risk behaviors in refugee situations and how does depression affect this relationship?
3. How does learned helplessness explain the relationship between SGBV and sexual-risk behaviors in refugee situations?
4. Does learned helplessness (as a result of SGBV) increases the likelihood of engaging in risk-sexual behaviors by refugee women?
5. Is depression an outcome of learned helplessness by refugees?

Hypotheses

This study utilized the reformulated theory of learned helplessness (Abraham et al., 1978) to investigate the relationship of SGBV to sexual-risk behaviors (SRB) among refugee women in Botswana and the possible mediating roles of depressive symptomatology and learned helplessness.

Based on the reformulated theory of learned helplessness, the following major hypotheses were proposed:

1. A history of past SGBV (uncontrollable event) predicts engagement in sexual-risk behaviors among refugee women.
2. Learned helplessness predicts sexual-risk behaviors among refugee women.
3. Learned helplessness predicts depression among refugee women.
4. Depression and learned helplessness mediate the relationship between past SGBV and sexual-risk behaviors among refugee women.

The hypothesized relationship between the central study variables is shown in figure 1.0 below:

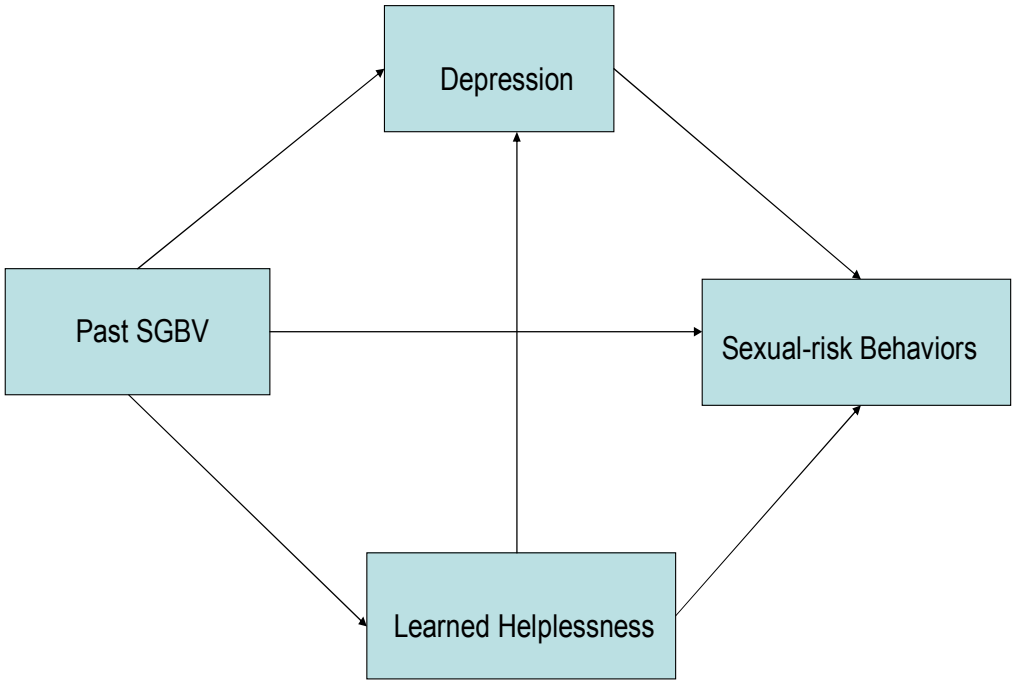

Figure 1.0

Hypothesized Model of SGBV, Depression, Learned Helplessness, and Sexual-risk Behavior

Variables

Learned helplessness was characterized as the failure to take harm-avoidant responses even when such responses lead to reduced exposure to harm or risk of harm as measured by the Learned Helplessness Scale (Quinless & McDermott, 1988).

Depression was defined as encompassing the depressed mood symptomotology. It comprised the symptoms of depression in the last week as measured by the Hopkins Symptoms Check List-15.

Sexual and gender-based violence was defined as any type of abuse that includes rape, sexual threats, exploitation, humiliation, assaults, molestation, domestic violence, incest, involuntary prostitution (sexual bartering), torture, insertion of objects into genital openings, and attempted rape (UNHCR, 1999). A history of SGBV was assessed.

Sexual-risk behavior was considered a constellation of behaviors involving inconsistent or no condom use during vaginal, oral and anal intercourse with primary and non-primary male partners (Jones, 1999). It also included having sex with partners who are perceived by the participant to be having sexual intercourse with other women and/or men, take drugs, or alcohol (Aral & Wasserheit, 1995).

Measures

Learned helplessness scale. The Learned Helplessness Scale (LHS) is a 20-item scale that measures learned helplessness. Developed by Quinless and McDermott (1988), each item on the LHS was rated on a 4-point likert scale from strongly agree (1) to strongly disagree (4). The LHS addresses the three dimensions outlined in Abramson et al.'s (1978) reformulated model of learned helplessness, i.e. globality, stability, and internality. It produces a composite score representing learned helplessness. Total

possible scores range from 20 to 80. The higher the LHS score, the higher the individual's level of learned helplessness (Post, 1999). Thus, the LHS does not attempt to produce separate scores for the three theoretical dimensions of internality, globality, and stability. This measure has been used successfully to establish a significant positive correlation between the degree of learned helplessness and both procrastination and dysphoria, as well as a significant negative correlation between the degree of learned helplessness and grade point average in undergraduate college students (McKean, 1993). Wilson et al. (1992) used the LHS to show that help-seeking abused women evidenced higher degrees of learned helplessness than non-abused women and those abused women not seeking help.

An adapted version of this scale was used in this investigation with only 19 items, deleting the item: *I am unsuccessful at most tasks I try*. This item was considered inappropriate for the current study population when the study was designed based on what is known about the state of refugees in a camp setting. Internal consistency for the 19 items was Cronbach's Alpha = .80. The composite learned helplessness score was the average of the individual scores. Thus, possible scores for the learned helplessness scale in this research ranged from 1 to 5. The composite LH score was used to categorize participants into low and high groups of learned helplessness based on the median split for descriptive purposes only. Those participants who scored above the median (55.3%; n= 211) were classified as the high-learned helplessness group and those who scored below the median (44.7%; n=187) were the low group.

Hopkins symptoms check list. The HSCL-25 is a well-known and cross-nationally used screening instrument with a history that dates to the 1950s. Originally designed at

Johns Hopkins University by Parloff, Kelman and Frank in 1954, the HSCL-25 is a symptom inventory that measures symptoms of anxiety and depression. It consists of two parts with a total of 25 items. Part I consists of 10 items that measure anxiety symptoms and Part II has 15 items that measure depression symptoms. The scale for each question includes four categories of responses: *Not at all, A little, Quite a bit,* and *Extremely,* rated 1 to 4, respectively. Three scores are usually calculated representing anxiety, depression and a total score of all 25 items. The depression score is the average of the 15 depression items and the anxiety score, the total of the 10 anxiety items.

The HSCL-25 score has been consistently shown in several populations to be highly correlated with severe emotional distress of unspecified diagnosis, and the depression score correlated with major depression as defined by the Diagnostic and Statistical Manual of the American Psychiatric Association, IV Version [DSM-IV] (Harvard Program in Refugee Trauma, 2003). In a study of the development and validation of Cambodian, Laotian, and Vietnamese versions of the HSCL-25, the inter-rater reliability for the total anxiety and depression scores for the three language groups was found to be higher than .98 (Mollica et al., 1987).

The HSCL-25 was used in this study because of its sensitivity and specificity as a screening instrument with refugee populations. In a study of newly admitted patients into a mental health facility, the sensitivity and specificity for the presence of depression (based on the cut-off score of 1.75 on the 15 depression items) according to the DSM-III diagnosis for major depression were .88 and .73, respectively (Mollica et al., 1987). In contrast to other known depression scales, the Hopkins Symptoms Check List has been extensively used to identify distress in refugee populations (Mollica, Narcisa, Chernoff,

Lavelle, Vukovic, Massagli & Michael, 2001). Moreover, it has also been widely translated and used in several studies among diverse groups (Cardozo, Vergara, Agani, & Gotway, 2000), validated against clinical diagnosis (Smith, Murphy, Pham, Lin, Poole & Mollica, 1997), and shown to have high internal consistency in studies of Russian, Arabic, Farsi, English, Bosnian, and Croatian-speaking patients (Mollica et al., 2003). An adapted version of the HSCL-25 with the item *feeling blue* changed to *feeling sad* (to place the item in the proper cultural context) was used in this study, which employed only the 15 items from the depression scale. The other 10 items that measure anxiety symptoms were not used since anxiety was not the focus of this study.

The cut-off score of 1.75 (Mullica et al., 1987) was used to classify participants into depressed and non-depressed groups. Those participants with depression scores of 1.75 and higher (90 %; n =363) were classified as depressed and those with scores lower than 1.75 (10 %; n =35) were non-depressed. The Cronbach's Alpha for the HSCL-15 in this study's sample was .76.

Sexual and gender-based violence measure. The Sexual and Gender-based Violence measure was adapted from the Gold Standard SGBV Questionnaire of the Reproductive Health of Refugees Consortium ([RHRC], 2003). The Gold Standard SGBV Questionnaire is a 188-item measure that assesses SGBV in refugee and/or conflict settings by estimating the prevalence of sexual and physical violence during several periods defined by historical markers such as prior to the war, during war, during occupation and while internally displaced.

According to Ward, Hynes, Koss and Zuckerman (2003), the Gold Standard Questionnaire has been pilot tested cross-nationally in Rwanda (Africa), Kosovo

(Europe), and East Timor (Asia). To facilitate accumulation of a cross-national database and to benefit from the efforts of previous investigators, the measure's creators employed items from pre-existing surveys whenever possible, with response options frequently added to tailor the questions to the conflict setting (Ward et al., 2003). The psychometric properties of the Gold Standard Questionnaire are yet to be determined.

For the purposes of this research, only five sections of the SGBV Gold Standard Questionnaire were used to create the SGBV measure. The first three sections of the measure assessed SGBV during the occupation and/or conflict, flight/displacement, and post conflict (host country) on 6-point likert format rated 1-6. Response options were: *never, 1-2 times, 3-5 times, 6 or more times, weekly* and *daily.* The fourth section investigated a *Most Serious Incident of SGBV,* and asked participants to report whether they consider a particular incident or experience of SGBV most serious or not on a dichotomous *yes* or *no* scale. The fifth section elicited information on the participant's history of abduction and/or forced detention. All five sections also asked participants to provide information on perpetrators of the reported violence and .the nature and extent of the violence. The reliability coefficient of the SGBV measure in this study's sample was .97.

To obtain composite SGBV scores, items on the SGBV measure were categorized into *Physical Violence (PV); Intimidation and Control (IC),* and *Sexual Violence (SV).* Physical violence was defined as pulled hair, slapped/twisted arm, hit with fist or something else, pushed down/kicked, choked. Intimidation and control was defined as forbidden to see friends or family, kept away from medical care, and refusal to give money for food, insulted or swore at you, threatened to hurt you, threatened with weapon.

Sexual violence was defined as partner using threats of physical harm or using force to obtain sex, or forcing the woman to have sex with other people (Ward et al., 2003). The items in the different categories are shown on Table 1.0.

Exploratory factor analysis of the SGBV was performed to assess construct validity and to detect structure in the relationships between the variables (classify) and to confirm the established SGBV categories. Construct validity of the SGBV scale was completed using principal components factor analysis with a varimax rotation. The data were analyzed using the SPSS version 12.0 computer program based on 402 cases. Participants with missing responses or unanswered items were eliminated from the analysis. The factor analysis provided a listing of three factors with eingen-values above 1.0.

A factor loading of .30 was determined to be the lowest acceptable loading since this analysis was exploratory. Thus, correlations of .30 or greater with at least one other item indicated that the items shared a common factor. Based on the factor extraction data, eingen values, scree plot, and variance, three factors were identified. Principal components factors analysis was then performed with varimax rotation that confirmed three factors that manifested the underlying dimensions of the original categories of physical violence, intimidation and control, and sexual violence. The items were then categorized and reduced to 20 and were used in subsequent analyses.

Past SGBV (independent variable) was defined as reported experiences of SGBV in home country and during flight, while current SGBV were incidences of SGBV in the host country (Botswana). Thus, past physical violence, past intimidation and control, and past sexual violence were defined as such acts while the participant was in her country of

origin or home country and during flight or transit. Composite scores for each of the SGBV categories were the average score for the total items in the category.

Sexual-risk behavior scale. The Sexual-risk Behavior Scale (SRB) was adapted from the Women's Relative Sexual Risk Scale (WRSRS) that was developed by Jones (1999). The WRSRS is a 31-item scale that was developed as a culturally relevant instrument to assess women's unprotected intercourse with male partners who engage in HIV-risk behaviors during the previous three months. According to Downey et al (1995) a three month sexual history recall period is recommended to assess sexual behaviors because it is considered long enough to be representative of sexual behaviors, but short enough for more reliable recall of them.

The WRSRS was developed to be theoretically consistent with the view that the person and environment are in a mutual process (Jones, 1999). It consists of two dimensions that assess HIV sexual risk. The first dimension assesses the numeric frequency of the participant's engagement in unprotected vaginal, oral, and anal sex during the last three months. The other dimension taps the participant's perceived likelihood that her partner engaged in sex with other women, sex with men or used drugs or alcohol during the same time period.

All items were in the context of a primary or a non-primary partner and were based on the previous 3 months For example, participants were asked: *During the past three months, of all the times you and your primary partner had oral sex, how many times was a condom used?* Response options for the unprotected sex items ranged from *no time* to *four or more ti*mes. For the perceived partner sexual behaviors, participants were asked questions such as: *How much of a chance is there that this non-primary partner*

had sex with other women during the past 3 months? Response options ranged from *not at all* to *definitely could* (Jones 2001).

Table 1.0

SGBV Categories and Items: SGBV Measure

SGBV Category
Physical Violence • Slapped or hit • Choked • Beaten or kicked • Shot at or stabbed • Experience physical disfigurement of your body • Beaten on sexual parts of your body
Intimidation and Control • Tied or blindfolded • Deprived of food, water or sleep • Detained against your will • Forced to watch someone being physically assaulted • Forced to watch someone being sexually assaulted • Threatened with a weapon of any kind • Subjected to improper sexual comments
Sexual violence • Forced to remove or strip off your clothing • Given internal body cavity searches • Subjected to unwanted kissing • Touched on sexual parts of your body • Forced or threatened with harm to make you give or receive oral, or have vaginal or anal sex • Penetrated with an object in your vagina or anus • Compelled to engage in sex in order to receive something such as food, water, protection for you, your family or other reasons

Four independent content experts who rated the relevance of each item to the conceptual definition of sexual risk behaviors established the content validity of the WRSRS. Face validity was established with a culturally diverse representative group of undergraduate nursing students by engaging them as consultants who suggested appropriate changes to the items based on culture, gender and age relevance (Jones 2001). Inter-rated agreement on item relevance was established by a content validity index (CVI), a four-point scale, ranging from 1 = not relevant to 4 = very relevant. Due to the diversity of sexual risk behaviors, theta reliability was conducted in the main study, an approach designed to address the problem of alpha reliability as a lower bound estimate of reliability in a homogenous instrument. The theta reliability for the WRSRS was .82 (Jones, 2001).

The composite SRB score was the sum of the weighted frequency of unprotected vaginal, oral, and anal intercourse and the perceived partner behavior score. Each unprotected intercourse was weighted on its relative, not absolute, HIV transmission risk potential (Vaginal =1; oral = .1; and anal sex = 2) as recommended by Susser, Desvarieux, and Wittkowski (1998). The perceived partner's behavior was weighted according to the strength of the women's certainty. *None at all* was scored as 1 rather than zero, indicating negligible risk; *don't know* was scored as 2, indicating some risk; *possible* was scored as 3, and *definitely could* was scored as 4, indicating certainty. The unprotected sex score and the perceived partner behavior score were standardized to place them on the same metric and summed for a composite score (Jones, 1999). The composite SRB score was the sum of the standardized weighted frequency of unprotected sex score and the standardized perceived partner behavior score for both primary and

non-primary partner combined. A higher SRB score translates to a higher level of sexual-risk behavior.

My study utilized 17 items from the WRSRS to create the sexual-risk behavior scale. One item that assessed vaginal sex with the primary partner was deleted to increase the internal consistency of the SRB scale from a Cronbach's Alpha = .65 (17 items) to Cronbach's alpha = .77 (16 items).

Research Design Implementation

The refugees at the Dukwi camp were predominantly from Angola, Namibia and Somalia and other East African Countries (UNHCR, 2002). The questionnaire was therefore translated into *Kiswahili, Mbukushu,* and *Lozi based on* Brisling's (1970) recommendations by which the questionnaire was translated from the source language (English) into the three target languages (*Kiswahili, Mbukushu,* and *Lozi)* and then back-translated into English to ascertain whether meaning errors and translation equivalence. These translation steps were useful in preserving the validity and reliability of the measure because they helped ascertained whether unexpected findings are due to errors in translation or other confounding variables in the data (McDermott & Palchanes, 1994).

Three female research assistants were recruited and hired to conduct the interviews based on their gender, educational background, language skills, clinical sensitivity and prior interview experience. I paid them on a bi-weekly basis. They attended a comprehensive four-day training program that comprised, but was not limited to, the following domains: face-to-face interview techniques; confidentiality and respect for privacy; the aims of the study; ethical issues in survey research; the research protocol;

and on the elements of the questionnaire. I trained the interviewers in one of the classrooms at the Refugee Camp High School with assistance by staff from the UNCHR (based at the camp) who had culturally–relevant knowledge and expertise on the problem of SGBV among the study population. The training was interactive in nature with interviewers providing inputs on the questionnaire and interview procedures. They observed and participated in role-plays. The training curriculum and schedule was based on the research protocol and the needs of the interviewers and potential study participants.

The interviewers were trained to understand their role as *data collectors* and not as *counselors.* They were required to sign a Confidentiality Agreement that conveyed the nature and purposes of the research. The Agreement included detailed descriptions of the expectations for research conduct, professional integrity, and dignity, confidentiality, information sharing, impartiality, and accuracy in transmission of information from the research participant.

A pre-test of the questionnaire was conducted to assess the adequacy of the instruments. The three trained female research assistants (each of whom was fluent in at least one the interview languages) interviewed at least 10 refugee women at the Dukwi village. A total of 40 interviews were conducted during the pre-test. This pre-test sample size was deemed adequate to test the psychometric properties of the instrument. Participants were located by a snowball method by which information of the location of an eligible refugee was obtained from a refugee previously interviewed. The interviews were conducted in the participants preferred language and all responses to a specific item were recorded. The interviews lasted an average of 60 minutes as expected. Confirmatory

factor analysis was conducted on the scales in the instrument to assess their cross-cultural validity and reliability. Thus, the WRSRS was modified after the pre-test by deleting the item that asks about condom use during vaginal sex with primary partner.

The initial contact with participants was at their homes (houses, huts and tents), after a systematic random sampling of the households. They were volunteers that met the inclusion criteria of being at least 21 years of age and female. Participation in the study was voluntary and the interviews were conducted in the privacy of their homes or at another preferred location. In the absence of the eligible participants in particular households, the interviewers tried to obtain information on when they would be home and paid a return visit. After three attempts at a household without a completed interview, that household was dropped and replaced by a household at the end of the sampling frame. This occurred on five occasions.

Interviews were conducted in private at a place chosen by participants where they felt comfortable to talk about their experiences. All of the interviews in this study were conducted at the households of the participants. The questionnaire items and their respective responses were read to the participant by the female interviewer in one of the interview languages preferred by the participant, after obtaining her informed consent. Seventy-five percent (n=301) of the interviews were conducted in English, 12% (n=49) in Lozi, 8% (n=32) in Mbukushu, and 5% (n=20) in Swahili. Two interviews were terminated due to privacy concerns and continued at a later time at the participant's discretion and convenience.

Mechanisms were in place for crisis situations such as a participant becoming distressed during the interview due to the sensitive nature of the issues discussed. The

interview was to be terminated and the participant was encouraged to seek psychological help and referrals to available mental health services were to be initiated. The interviewers reported only one such case. I made myself readily available to provide case management in crisis situations, as there was no other social worker or counselor in the camp. All participants in the study were given a package containing a bathing soap as a token of appreciation for their time, and an information package containing literature on how to access health and mental health facilities in their community and education messages on safe sex practices and HIV/AIDS. This package was given to every participant including those that declined to be interviewed.

I supervised the interviewers in the field and also assigned households to them in the various zones based on their language proficiencies. Every interviewer was accompanied to her first interview to ensure she followed the correct sampling procedures. I did not sit in any of the interviews. For the duration of the fieldwork, I continuously provided guidance, revisions, and advised each individual interviewer as needed. I reviewed each completed survey, gave immediate feedbacks about errors and incomplete interviews on a daily basis

This research received permission from the Office of the President of the Republic of Botswana to conduct research with human subjects in Botswana. Permission was also granted by the *Chief of Party* of the UNHCR Office in Botswana to conduct research with the refugee population at the Dukwi camp (see Appendix C). Both approvals were granted after a thorough review of my research protocol.

Approval for this study was also granted by the University of Pittsburgh's Institutional Review Board (IRB) after an "exempt review" of human subjects

considerations. The IRB process involved the completion of an IRB review application and the submission of a research protocol. An IRB protocol modification approval was also granted for modifications made to the instrument after pre-testing in the field.

I was aware of the potential psychological harm that accompanies the disclosure of sensitive and personal information related to sexual behaviors. To minimize such risks, I employed and trained female research assistants who were from the predominant refugee communities in the camp to conduct the interviews. They were multi-lingual in the target languages with some form of prior SGBV knowledge and training. In addition to their language proficiencies and cultural sensitivity based on their ethnic backgrounds, these research assistants attended a four-day training program that included clinical sensitivity and survey interview skills training. This study also obtained the approval of the IRB of the University of Pittsburgh, the UNHCR, and the government of Botswana. Endorsement by refugee camp administrators at the Dukwi camp was also received before the research was conducted.

Participation in the study was voluntary and this was made known to the participants through an introductory consent statement that was read to participant by the interviewers before start of the interview. In this consent statement participants were reminded of their right to terminate the interview at any time during the process for any reason. The interviewers obtained verbal individual informed consent from the participants by reading from the informed consent statement on the questionnaire and asking participants whether they agreed to be interviewed and indicating their response on the consent form. The interviewers also signed the form to demonstrate that they read the introductory consent statement to the participant.

Anonymity was assured by not asking or recording participants' names or identifiers on the survey instrument. This prevented the researchers from identifying a given response with a particular participant. Data analysis protocol included assigning number codes to participants to ensure anonymity. Confidentiality concerns were addressed by assuring participants that all information would be used solely for research purposes and promising them not to distinguish their individual responses in any published product of this research. Participants were also assured that their participation in the study was strictly confidential and whether or not they participated in the study would not be disclosed to anyone at the camp including UNHCR and Botswana government camp administrators.

Results

I entered the quantitative data obtained from the survey with the Statistical Package for the Social Sciences (SPSS) version 12.0. A case summary was performed and a data set was created. Bi-variate analyses were performed to examine the relationships between the variables. Pearson Product Moment correlations and one sample t-tests were used to test for associations Linear multiple regression analyses were performed to test the central study variables. A fully recursive path analysis was also employed to test the mediating roles of learned helplessness and depression in the hypothesized model.

Descriptive Information

A total of 402 refugee women residing at the Dukwi camp in Botswana were interviewed. They ranged in age from 21 to 63 years, with a mean age of 29.24 years (SD

= 7.20). Participants in this study originated from nine African countries: Angola, Burundi, Democratic Republic of Congo, Namibia, Rwanda, Somalia, Sudan, Uganda, and Zimbabwe (see Table 5.1). About half were from Namibia (49.3%; n = 198) and another 28.6% (n = 115) from Angola. The predominant tribes among the participants were the *Mufwe (*Angola) and *Mbukushu* (Namibia) tribes, with 22.6% (n = 91) and 22.4% (n = 90) respectively. About 20% (n = 79) of the participants refused to report their tribal or ethnic origins.

In terms of sexual partnerships in the last three months, more than half (67.7%; n = 280) of the participants reported having only a primary partner(s), about 15% (n = 59) said they had only non-primary partner(s), 1.5% (n = 5) had both primary and non-primary partners, and 14.4% (n = 58) had no sexual partner(s) (Table 2.0). Ninety-eight percent (n = 278) of participants with a primary partner reported having only one primary partner in the last three months. About 76% (n = 216) said their primary partner was their husband and 22.1% (n = 63) claimed their main boyfriend was their primary partner. More than half (59.3%; n = 38) of participants with a non-primary partner reported their non-primary partner was someone they had seen occasionally in the last three months, while the rest (40.7%; n = 26) said their non-primary in the last three months was someone whom they saw for only one night. Almost two-third (65%; n = 42) reported having only one non-primary partner in the last three months and 15.6% (n = 10) claimed to have had four or more non-primary partners in the last three months (see Table 2.0).

Overall, about 75% (n = 303) of participants reported having been victims of SGBV either in their home country, during flight/transit, or in Botswana. As shown on Table 3.0 more than half of the participants (56.4 %; n = 227) experienced some form of

SGBV in their home country during the conflict, while about 2 out of 5 participants (39.3%; n = 158) reported SGBV during flight. In the host country, 36.8% (n = 148) of the participants reported having experienced SGBV (Table 3.0)..

Table 2.0

Demographics of Participants: Sexual Partner Information (Last three Months)

Item	Frequency	Percentage
Sexual Partner Information (N = 397)		
Primary partner only	280	69.7
Non-primary partner	59	14.7
Primary & non-primary partner	5	1.2
None	58	14.4
Type of Primary Partner (N=285)		
Main boyfriend	63	22.1
Husband	216	75.7
Fiancé	6	2.2
Number of Primary Partners (N=285)		
One	278	97.5
Two	5	1.7
Three	1	.4
Four or more	1	.4
Type of Non-Primary Partner (N=64)		
Someone you saw occasionally	38	59.3
Someone you saw one night only	26	40.7
Number of Non-Primary Partners (N=64)		
One	42	65.6
Two	7	11.0
Three	5	7.8
Four or more	10	15.6

Table 3.0

SGBV Occurrences and Main Perpetrators in Home Country, during Flight/Transit, in Botswana (Host Country), and Main Dates of Occurrence

Item	Frequency	Percentage
SGBV Location		
Experienced in home country (N=402)	227	56.4
Experienced in flight (transit) (N=402)	158	39.3
Experience in Botswana (host country) (N=402)	148	36.8
SGBV Perpetrators		
In home country (N=227)		
Soldiers	167	73.5
Paramilitary	77	33.9
Civil defense force	55	24.2
During flight/transit (N=158)		
Soldiers	97	61.3
Paramilitary	50	31.6
Civil defense force	45	28.4
In Botswana (host country) (N=148)		
Police/interrogator	62	41.8
Family member	40	27.0
Soldiers	35	23.6

Inferential Statistical Findings

Learned helplessness score was dichotomized using the median split to create high and low learned helplessness groups. The three SGBV variables (past physical violence, past intimidation & control, and past sexual violence) were then assessed in relation to this dichotomized learned helplessness variable. T-tests were used to compare the means of groups of participants with low and high levels of learned helplessness relative to the three SGBV variables. The difference between the low ($\underline{M}$ = -.20; $\underline{n}$ = 178) and high ($\underline{M}$ = -.07; $\underline{n}$ = 219) learned helplessness groups relative to past sexual violence was statistically significant [$t(395) = 3.73$; $p<.01$]. The difference between the low ($\underline{M}$ = -.20; $\underline{n}$ = 178) and high ($\underline{M}$ = -.07; $\underline{n}$ = 219) learned helplessness groups relative to past physical violence was also statistically significant [$t(395) = 2.04$; $p<.04$]. However, low and high learned helplessness groups did not differ in their reports of past intimidation and control, as shown on Table 4.0.

The depression score was dichotomized into depressed and non depressed groups using a score of 1.75 (Mollica et al., 1987) as the cut-off. T-tests were used to compare the means of the depressed and non-depressed groups of participants relative to the three past SGBV variables. The differences between the depressed and non-depressed groups relative to past physical violence, past intimidation and control, and past sexual violence were not statistically significant, as shown on Table 5.0.

Table 4.0

T-test: High and Low Learned Helplessness Groups with Past SGBV

	Learned helplessness	***N***	***Mean***	***df***	***t***	***p***
Past Physical Violence	High	219	-.19	395	2.04	.04*
	Low	178	-.28			
Past Intimidation & Control	High	219	-.21	395	1.13	.25
	Low	178	-.26			
Past Sexual Violence	High	219	-.07	395	3.73	.01**
	Low	178	-.20			

Sig. (2-tailed) *p < .05 **p < .001

Table 5.0

T-test: Depressed and Non-depressed from with Past SGBV

	Depression	*N*	*Mean*	*df*	*t*	*p*
Past Physical Violence	Depressed	362	-.24	395	-1.2	.21
	Non-depressed	35	-.15			
Past Intimidation & Control	Depressed	362	-.23	395	-.02	.97
	Non-depressed	35	-.23			
Past Sexual Violence	Depressed	362	-.13	395	-.91	.35
	Non-depressed	35	-.08			

Past SGBV and sexual-risk behaviors among refugee women

To test the relationship of past SGBV with sexual-risk behaviors, a simultaneous multiple regression analysis was performed with sexual-risk behavior as the dependent variable and past physical violence, past intimidation and control, and past sexual violence as the independent variables. A residuals scatter plot test was used to examine the variables for assumptions of normality, linearity, and homoscedasticity of residuals. The residuals were normally distributed about the predicted dependent variable scores and had a linear relationship with the predicted dependent variable. The variance of the residuals about the dependent variable scores was the same for all of the predicted dependent variable scores. There was an overall statistically significant effect ($F = 2.018$; $p < .011$) on sexual-risk behavior. The three predictor variables together explained 15% of the variance in sexual-risk behavior. However, when the standardized regression coefficients of the individual independent variables are examined, only past sexual violence was found to contribute significantly to the prediction of sexual-risk behavior (Beta = .461; $p< .024$), as shown on Table 6.0.

Learned helplessness and sexual-risk behaviors among refugee women

Regression analysis was performed to test whether learned helplessness predicts sexual-risk among refugee women. A residuals scatter plot test was used to examine the variable for assumptions of normality, linearity, and homoscedasticity of residuals. The effect of learned helplessness on sexual-risk behavior was not statistically significant (Beta = .005; $p < .91$) (see Table 7.0).

Table 6.0

Coefficients of the Simultaneous Multiple Regression Analysis of Past SGBV to Sexual-risk Behavior

Independent Variables	**Beta**	**t**	**p**
Past Physical Violence	-.033	-.173	-.863
Past Intimidation & Control	.005	.025	.980
Past Sexual Violence	.461	2.267	.024*
$R^2 = .015$; F = 2.018, p<.011			

*P<.05

Learned helplessness and depression among refugee women

Simultaneous multiple regression analysis was also employed to test whether learned helplessness predicts depression among refugee women. The effect of learned helplessness on depression was statistically significant (Beta = .360; $p < .001$) (see Table 8.0). Thus, there is a linear relationship between learned helplessness and depression suggesting that learned helplessness predicts depression among refugee women.

Table 7.0

Coefficients of Regression of Learned Helplessness with Sexual-risk Behavior

Independent Variable	Beta	t	p
(Constant)		-082	.935
Learned helplessness	.005	.102	.919
R^2 = .001; F = .010			

Dependent variable: Sexual-risk behavior

Table 8.0

Coefficients of Regression of Learned Helplessness with Depression

Independent Variable	Beta	t	p
(Constant)		7.470	.000
Learned helplessness	.360	7.676	.000**
R^2 = .130; F = 58.918			

Dependent variable: Depression
**p < .001

Mediating Roles of Depression and Learned Helplessness

To test this hypothesis, a fully recursive path analysis of the hypothesized model was performed to determine the paths and effects of the predicted relationships. A path diagram of the fully recursive hypothesized model is shown on Figure 5.0.

Only four paths were significant: the past physical violence to learned helplessness path; the past sexual violence to sexual-risk behavior path; the learned helplessness to depression path; and the past sexual violence to learned helplessness path. Although, past sexual violence was found to have a significant effect on both sexual-risk behavior (Beta = .122; R^2 = .015; p<.010) and learned helplessness (Beta = .173; R^2 = .030; p< .001), the path between learned helplessness to sexual-risk behavior was not significant (Beta = .005; R^2 = .001; p<.919).

This implies that learned helplessness did not mediate the relationship of past sexual violence and sexual-risk behavior. However, learned helplessness was found to have a significant effect on depression (Beta = .360; R^2 = .130; p< .001), but the path between depression and sexual risk-behavior was not significant (Beta = .022; R^2 = .001; p<.668). Thus, since depression had no significant effect on sexual-risk behavior, it was not a mediator. Past physical violence had a significant effect on learned helplessness (Beta = .129; R^2 = .017; p<.010), while past intimidation and control was found not have a significant effect on any of the hypothesized relationships (see Figure 2.0).

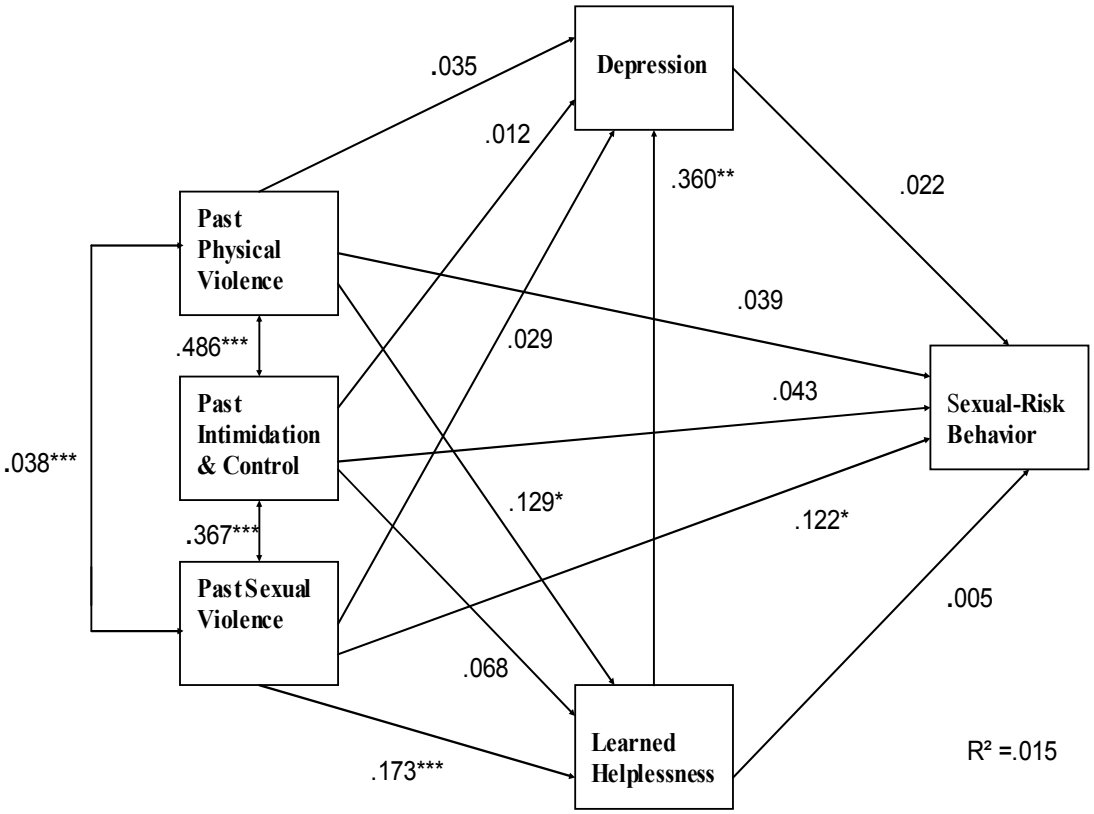

Figure 2.0. **Path-analytic model: The influence of past physical violence, past intimidation & control, past sexual violence, learned helplessness, and depression on sexual-risk behavior.**

*p < .05; **p < .01; ***p < .001

Discussion

This study found that about 75% (n = 303) of participants had experienced some form of SGBV either in their home country, during flight/transit, or in the host country. This prevalence of SGBV among refugees at the Dukwi refugee camp is relatively high compared to results obtained in other regions of Africa. A 1994 survey of 205 women in Liberia found that 49% had experienced at least one incident of SGBV (Koss & Kilpatrick, 2001).

Refugee women were more likely to experience SGBV in their home countries (during conflict) than during flight or in the host country. More than half (56.4%) of the refugees had experienced SGBV before they even fled their countries. During their attempt to reach a safe haven, 39.3% experienced SGBV. After reaching Botswana, about 37% of the participants reported having experienced SGBV. These findings suggest that refugee women are not only vulnerable to sexual violence during conflict, but also during the periods of social disruption and disintegration that follow war, when they are fleeing the conflict and residing in camps for refugees. This is consistent with what has been reported by Hynes and Lopes-Cardozo (2001). Further, these findings suggest the need for interventions that address the physical, psychological and social consequences of SGBV among refugees in camp settings.

The most common perpetrators of SGBV were soldiers, Civil Defense Forces, paramilitary, and family members. Soldiers were the main perpetrators in the home country and during flight whereas the police or interrogators were the main perpetrators of SGBV once the refugee had entered Botswana. These findings suggest that these refugee women lacked the protection and recourse that international law afforded to

them. International human rights law requires national governments to provide protection against violence to all persons within their territory, to investigate and punish perpetrators of violence, and to ensure equal access and protection under the law to all without discrimination on the basis of race, color, sex, national origin, or other grounds (HRW, 2000).

Host governments have an affirmative obligation to protect refugees from sexual and gender-based violence and to ensure that victims have full access to the local legal system. By failing to ensure that police and court officials investigate, prosecute, and punish perpetrators of SGBV against refugee women, a host country is in breach of its international law obligations as mandated in the 1951 U.N. Convention Relating to the Status of Refugees to provide refugees equal protection of the law (HRW, 1999). These obligations extend to all refugees and asylum seekers within a host country. The international community also has the legal responsibility of ensuring that the rights of refugees are respected.

The current study found that more than half of the participants (55%) experienced learned helplessness and about 90% were depressed. This is congruent with prior research on battered and abused women (Walker, 2000) in which women's experiences of uncontrollable violence produced over time learned helplessness and eventually depression as repeated experiences of violence diminished the victim's motivation to respond (Abraham et al., 1978). Learned helplessness was also found to be moderately and significantly correlated with depression in the sample. This finding is also congruent with the learned helplessness model of depression, which suggests that depression is a

typical collateral outcome of learned helplessness (Klein et al., 1976; Klein & Seligman, 1976).

Past physical violence was found to be positively and significantly correlated with learned helplessness, although it was not correlated with depression. There was also no significant difference between the depressed and non-depressed groups in relation to past physical violence when a T-test was used to compare the two groups. Learned helplessness, on the other hand, was found to be moderately and significantly correlated with depression. This finding supports the learned helplessness-depression model, as first proposed by Klein and Seligman (1976).

The finding that past SGBV predicts predict present sexual-risk behavior suggests that refugee women with histories of SGBV were more likely to engage in sexual-risk behaviors than their counterparts without such histories. Specifically, past sexual violence predicted current sexual-risk behavior in this study. This finding is consistent with prior research (Hogben et al., 2001; Susser et al., 1998; Tubman et al., 2001) that has examined the correlates of sexual-risk behaviors among vulnerable populations.

The hypothesized relationship between learned helplessness and depression with sexual-risk behavior were not significant. This suggests that both learned helplessness and depression (as potential outcomes of past SGBV) do not predict current sexual-risk behavior. Thus, the hypothesized mediating roles of learned helplessness and depression in the relationship between past SGBV and current sexual-risk behavior were not supported in this study.

A fully recursive path analysis was used to examine the paths in the hypothesized model (see Figure 2.0). Although past sexual violence was found to have a significant

effect on learned helplessness and on sexual risk behavior, the path from learned helplessness to sexual-risk behavior was not significant. Learned helplessness was, however, found to have a significant effect on depression, although the path between depression and sexual risk-behavior was not significant. Therefore, it is worth noting that this study found that learned helplessness is a likely mediator of the relationships between past sexual violence and past physical violence to depression, which could be the subject for further research.

Limitations

The cross-sectional nature of this study may limit interpretation of the findings. Cross-sectional research designs are apt to constrain the determination of causal inferences due to difficulties in establishing temporal order. Longitudinal studies will be needed to provide stronger evidence of association.

This study is also limited by the self-report measures employed in the instrument. Self-report measures may be influenced by social desirability, response bias, or inaccurate recall. The sensitive nature of some of the questions (i.e. sexual violence, sexual-risk behavior, abduction, forced detention etc.) may also be particularly prone to under-reporting. Like similar studies of SGBV among refugee populations (i.e., UNHCR, 1999), participants in this study may have under-reported their SGBV experiences out of fear of stigmatization, especially when the interviewers were themselves female refugees residing at the refuge camp.

Another limitation of this study design concerns the scales used to measure learned helplessness and women's relative sexual-risk. The learned helplessness scale is limited in its cross-cultural use beyond western populations (Quinless & McDermott,

1988) and has yet to be validated with refugee populations. The cross cultural applicability of the women's relative sexual risk scale has yet to be established (Jones 1999). The lack of cross-cultural data on these measures may limit the interpretation of the findings of this study

Finally, since the instrument in this study was translated in three target languages, any errors in translation may affect the psychometric properties of the individual measures of the research instrument, thus limiting the interpretation of the findings.

Policy and Program Implications

Sexual and gender-based violence is known to occur during all phases of the refugee situation (UNHCR, 1999). This study found that refugee women were more likely to experience SGBV in their home countries than during flight/transit or in a host country. This finding underscores the need to adapt prevention and response measures to suit the different circumstances of each migration phase.

Sexual and gender-based violence has acute physical, psychological and social consequences among refugee populations and communities (UNHCR, 1999). About 75% of the participants in this study have been victims of SGBV and about 90% scored above the cut-off point to be classified as depressed, suggesting that refugee women may have unmet mental health needs. Psycho-social programs that are usually lacking in most refugee camps should be established to address psychological and social consequences of SGBV in refugee populations.

Like most refugee situations, SGBV in this study was under-reported and more than half of the incidences of SGBV in this population were never reported. This finding underscores the need for education programs that highlight the rights of women in

refugee situations. Reporting and interviewing techniques should be adapted to encourage both victims and camp administrators to report and document incidents. This study suggests that reporting and follow-up of SGBV must be sensitive, discreet, and confidential to protect the victim from stigmatization and retribution. Public health practitioners and social workers working with refugee populations should establish trust and rapport with victims and provide safe and confidential environments for effective reporting.

This study found a statistically significant relationship between past sexual violence and current sexual-risk behavior among refugee women. This finding has important implications for HIV/AIDS prevention programs. First, it suggests that interventions might best make a distinction between women who have never experienced forced sex and those who have. For women who have experienced forced sex, clinical and therapeutic activities should focus upon the building of trust and the capacity for intimate relationships in an attempt to prevent sexual-risk behaviors. Second, the findings in this study may be useful in HIV/AIDS behavioral surveillance and in the allocation of prevention resources for refugee populations.

The findings of this study regarding the relationships among SGBV, learned helplessness, depression, and sexual-risk behaviors among refugee women will equip practitioners with the knowledge of the risk-factors and indicators that may be applicable in the design and implementation of surveillance systems and behavioral change interventions that target sexual-risk behaviors in refugee settings.

The patterns of vulnerability to SGBV evident in this study suggest specific prevention approaches for governments and other responsible agencies. These bodies

must publicly acknowledge and discuss the problem, establish effective and efficient systems of reporting cases that protect victims, enforce existing laws and policies regarding violence against women, and effectively enforce disciplinary measures.

Conclusion

The violence that often produces refugees has complex and multiple direct and indirect effects on refugee communities in relation to reproductive health and psycho-social well-being. The findings of this study provide public health-social work practitioners and humanitarian workers --- faced with the multi-faceted tasks of designing and implementing programs in refugee situations---with some indicators of the psycho-social and reproductive health needs of refugee women in a camp setting.

SGBV has long been used as a strategy of war—the root cause of uprooting and refugee movements. It has been used as a highly effective means of terrorizing entire communities and cultures in Africa because of the emphasis placed on women's sexual virtue. Perpetrators often humiliate and demoralize their victims. The issue of SGBV against refugees, however, remains inadequately addressed by humanitarian and refugee agencies. SGBV victims usually weigh their health and psychological needs against possible stigmatization within the family or community and potential retribution from the unpunished perpetrator, as is the case in most refugee camps. Bringing the issue of SGBV into the open represents the first step in fostering the development of responses to this problem.

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