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CLINICAL ARTICLE

A cross-sectional survey on gender-based violence and mental health among female urban refugees and asylum seekers in Kampala, Uganda

Diane F. Morof [a,*], Samira Sami [b], Maria Mangeni [c], Curtis Blanton [b], Barbara Lopes Cardozo [b], Barbara Tomczyk [b]

[a] Division of Reproductive Health, Field Support Branch, Centers for Disease Control and Prevention, Atlanta, GA, USA
[b] Division of Global Health Protection, Emergency Response and Recovery Branch, Centers for Disease Control and Prevention, Atlanta, GA, USA
[c] Community Services, Gender-based violence Project, United Nations High Commissioner for Refugees-Uganda, Kampala, Uganda

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ABSTRACT

Objective: To assess gender-based violence and mental health outcomes among a population of female urban refugees and asylum seekers. *Methods:* In a questionnaire-based, cross-sectional study conducted in 2010 in Kampala, Uganda, a study team interviewed a stratified random sample of female refugees and asylum seekers aged 15–59 years from the Democratic Republic of Congo and Somalia. Questionnaires were used to collect information about recent and lifetime exposure to sexual and physical violence, and symptoms of depression and post-traumatic stress disorder (PTSD). *Results:* Among the 500 women selected, 117 (23.4%) completed interviews. The weighted lifetime prevalences of experiencing any (physical and/or sexual) violence, physical violence, and sexual violence were 77.5% (95% CI 66.6–88.4), 76.2% (95% CI 65.2–87.2), and 63.3% (95% CI 51.2–75.4), respectively. Lifetime history of physical violence was associated with PTSD symptoms ($P < 0.001$), as was lifetime history of sexual violence ($P = 0.014$). Overall, 112 women had symptoms of depression (weighted prevalence 92.0; 95% CI 83.9–100) and 83 had PTSD symptoms (weighted prevalence 71.1; 95% CI 59.9–82.4). *Conclusion:* Prevalences of violence, depression, and PTSD symptoms among female urban refugees in Kampala are high. Additional services and increased availability of psychosocial programs for refugees are needed.

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1. Introduction

Studies among female refugees have shown that gender-based violence (GBV) is a health problem of considerable magnitude [1]. The negative health consequences of GBV include unintended pregnancy, sexually transmitted infections, fistula, and adverse mental health conditions such as depression and post-traumatic stress disorder (PTSD) [2].

During conflict, women and girls are frequently targets of rape and can be forced to trade sex for food, shelter, or safety [3]. In Sierra Leone, 94% of displaced women experienced sexual violence, including rape and/or torture, in the last 10 years of conflict [4]. In Lofa County, Liberia, 60% of women reported at least one incident of sexual violence during the 1999–2003 conflict [5]. In East Timor, levels of sexual violence by non-familial perpetrators decreased by 57% after the conflict ceased in 1999 [6]. These statistics document the public health burden of GBV, although the mental health outcomes of GBV also need to be understood to determine the full impact and establish interventions.

Mental health outcomes and incidents of GBV are under-reported. Studies in conflict-affected regions have found poor mental health outcomes and a high prevalence of GBV [7–9]. For example, after the end of civil conflicts in 2009, the prevalence of depression and PTSD symptoms in Jaffna District, Sri Lanka, was 22% and 7%, respectively [7]. In 2002, 73% of Afghani women reported depression symptoms and 48% reported PTSD symptoms [9]. In the Democratic Republic of Congo (DRC) in 2010, the prevalence of depression and PTSD among women was 42% and 54%, respectively [8].

The United Nations High Commissioner for Refugees (UNHCR) defines GBV as "physical, sexual, and psychological violence occurring in the family and in the community" [10]. The UNHCR, which is mandated to protect and assist refugees, has established guidelines to address GBV prevention and response. However, new challenges have emerged as the urban refugee caseload has swelled globally, making it difficult to address the GBV needs of this population.

There are 32 500 urban refugees and asylum seekers residing in Kampala, Uganda, accounting for 14% of the total refugee population in the country [11]. Half are from the DRC (50%), 18% from Somalia, 14% from Eritrea, and the remaining 18% are from Rwanda, Ethiopia, Sudan, and Burundi. Determining the magnitude of GBV and mental health problems is crucial to provide optimal health and psychosocial services to urban refugees and asylum seekers. Therefore, the aim of

* Corresponding author at: Division of Reproductive Health, Field Support Branch, Centers for Disease Control and Prevention, 4770 Buford Hwy. MS-F-74 Atlanta, GA 30341, USA. Tel.: +1 770 488 3989; fax: +1 770 488 3266.
E-mail address: dmorof@cdc.gov (D.F. Morof).

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the present study was to examine the prevalence of different types of violence, characteristics associated with violence, and mental health outcomes to determine the public health burden of GBV and mental illness among urban refugees and asylum seekers in Kampala.

2. Materials and methods

The present questionnaire-based, cross-sectional survey included female refugees and asylum seekers aged 15–59 years from the DRC and Somalia who were living in Kampala, Uganda, between September 11 and October 14, 2010. Women aged 15–17 years were included if they met the criteria for emancipated minors and were able to communicate in Congolese Swahili or Somali [12]. The study was determined to be non-research by the Centers for Disease Control and Prevention and was approved by the Ugandan National Council on Science and Technology's institutional review board. All participants provided verbal informed consent.

The sampling frame was drawn from UNHCR's ProGres computerized database of all registered refugees and asylum seekers in Uganda, and included eligible women listed by name, age, and nationality, with contact information. A sample size of 500 (318 from the DRC and 182 from Somalia) was calculated by using a prevalence for physical violence of 59% [13,14], a 95% confidence interval (CI) of $\pm 5.0\%$ ($\alpha = 0.05$), and a non-response rate of 25% on the basis of previous refugee surveys in Kampala. Overall, 22 438 female refugees and asylum-seekers (14 595 from the DRC and 7479 from Somalia) comprised the study population of interest. The study sample was selected using a two-stage stratified random sample design with proportional allocation to two strata: Congolese and Somali women. Stage one was random selection of households. In stage two, one eligible woman (15–59 years) was randomly selected from those households containing more than one.

Standardized survey instruments were used to develop the questionnaire, which was reviewed by the UNHCR, InterAid-Uganda (a non-governmental organization partner), and other GBV experts [13,15–18]. Mental health was assessed via the Hopkins Symptom Checklist-25 for depression symptoms and the Harvard Trauma Questionnaire for PTSD symptoms [19,20]. The survey was piloted among a separate, small population of Congolese and Somali urban refugees.

The final survey tool collected information on demographic characteristics, physical and sexual violence, and mental health. Demographic characteristics included age, relationship status, religion, education, income, household head information, and time in Kampala and Uganda. Physical violence included pushing and slapping; hitting with a fist, kicking, and beating with an object; and use or threatened use of a weapon. Sexual violence was measured by attempted sexual violence (a failed attempt by a man or woman to make a woman have sex by using physical or verbal force) and completed sexual violence (when someone, male or female, forced the respondent to have sex). Lifetime history and location of violence were captured. Study instruments were translated into Swahili and Somali, and translated back to English to check the original translation. The study team included 16 female refugees who were fluent in Swahili or Somali and English, and had previous survey experience or community leadership. The UNHCR employed mental health professionals to provide onsite counseling to the survey team and participants.

The UNHCR contacted and recruited women by posting participant's names on a bulletin board at the implementing partners' offices, calling mobile phones, and using community mobilizers. The survey was conducted at a central location to improve monitoring and ensure security. The investigators followed best study practices based on WHO's recommendations for research on domestic violence [21]. Researchers informed recruited women that participation was voluntary and involvement would not affect their legal status, or access to and quality of care. The data were de-identified, stored in a locked room, and maintained on a secure server.

The data were double-entered into Epi-Info version 3.5.1 (CDC, Atlanta, GA, USA). Analysis was completed with SAS version 9.2 (SAS Institute, Cary, NC, USA). Estimates were weighted on the basis of the probability of selecting households within a stratum and the number of women in each household. Weighted percentages were calculated to generate estimates that were representative of the Congolese and Somali urban refugee and asylum-seeking population. Unweighted percentages were calculated to identify the lower range for outcomes of interest if all nonrespondents were found and either had the outcome of interest or did not.

Each item on the Hopkins Symptom Checklist-25 15-item subscale for depression was scored from 1 to 4 [19]. A mean cumulative cutoff score of 1.75 or more for 15 depression symptoms, used in previous research on mental health in refugees [20], has been found to be valid in predicting the clinical diagnosis of affective disorders, whereas a validation study in an African conflict-affected population found that a cutoff score of 2.65 or more for the Hopkins checklist for symptoms of depression performed optimally [22]. For the present study, the prevalence of symptoms of depression was calculated by both cutoff scores.

The 16 items of the PTSD symptoms section of the Harvard Trauma Questionnaire were scored from 1 to 4, and a mean cumulative score of 2.5 or more was used to meet PTSD symptom criteria [20]. Factors associated with symptoms of PTSD were identified via χ^2 or Fisher exact test and modelled by logistic regression. Only four respondents did not have depression symptoms; therefore, depression was not used for bivariate analyses or logistic regression. $P < 0.05$ was considered statistically significant.

3. Results

Among the 500 woman randomly selected for the study, 117 (23.4%) completed interviews. Six (1.2%) refused to participate, 48 (9.6%) were ineligible (i.e. did not meet language criteria, were not emancipated minors, or did not live in Kampala), and 329 (65.8%) could not be located because of movement, security, or limited contact details.

Of the 117 respondents, 16 (13.7%) were from Somalia and 101 (86.3%) were from the DRC. Approximately 70% of respondents were refugees (Table 1). The weighted mean age was 31.6 years (95% CI 29.3–34.0). The average number of years lived in Uganda was similar to the number of years lived in Kampala (Table 1). The main reason for moving to Kampala reported by the women was safety and security issues (Table 1).

Most respondents reported that they had been married or had a partner, and approximately one-third were currently married or living with a partner (Table 1). The weighted mean age at first marriage was 19.8 years (95% CI 18.7–20.9). Most households were headed by women (Table 1). Only approximately 45% had attended secondary school or higher education; nine women had never been to school (Table 1).

Overall, 102 respondents reported some type of physical and/or sexual violence during their lifetime (weighted prevalence 77.5%; 95% CI 66.6–88.4) (Table 2). A total of 99 reported physical violence during their lifetime (weighted prevalence 76.2%; 95% CI 65.2–87.2), and 84 reported any sexual violence (weighted prevalence 63.3%; 95% CI 51.2–75.4). The weighted prevalence of completed forced sex was 48.8% (95% CI 36.7–60.9) and that of attempted sex was 58.3% (95% CI 46.1–70.6).

Violence occurred both inside and outside Uganda (Table 2). Among 102 women who experienced violence, 28 reported that it occurred inside Uganda (weighted prevalence 23.8%; 95% CI 15.3–32.4), 41 outside Uganda (weighted prevalence 54.1%; 95% CI 45.8–62.3), and 33 both inside and outside Uganda (weighted prevalence 22.1%; 95% CI 15.0–29.2). Women who had experienced physical violence, sexual violence, and attempted sex also reported that it occurred mostly outside Uganda (Table 2). The location of completed forced sex could not be reported because of the small sample.