

Considerations for Doing Intimate Partner Violence Research in the Time of Coronavirus

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Research: Adapting Face to Face to Different Modalities of Data Gathering

As women around the globe are increasingly quarantined, they are also exposed to increased risk of intimate partner violence (IPV). A well-known statistic, one in three women has experienced some sort of intimate partner or sexual violence in her lifetime. When mothers are victims of violence in the home, it harms their children as well, both their immediate and long-term development. IPV is associated with poverty, and in studies where Innovations for Poverty Action (IPA) measures violence, it is not uncommon to find IPV rates of 50 percent or higher. Given the prevalence before the time of COVID and quarantines, it is likely many women survey respondents are currently experiencing violence in their relationships.

Advocacy groups for women are raising awareness and mobilizing around the globe. Researchers are also figuring out how to best understand and measure the impact of these efforts now that face-to-face surveys have been suspended. The Sexual Violence Research Initiative (SVRI) and IPA grantees and colleagues have asked for insights on how to shift from planned in-person IPV focused surveys to remote data collection methods.

Telephone Surveys

There are several resources on the use of telephone surveys. J-PAL, for example, in response to the need to suspend all face to face research activities published a checklist on the use of computer-assisted technology interviewing in lockdown. They are also “crowd-sourcing best practices for conducting phone surveys” via Google docs. You can also see their recently held webinar on conducting phone surveys.

IPA has also made the pivot to remote surveying exclusively and is rapidly consolidating and

building on its existing phone survey capacity in most countries of operation. To share its learning, IPA has created a [Google doc open platform](#) for best practices of remote surveying, including text messages and interactive voice response (IVR).

However, there remain valid doubts about the efficacy and safety of remote surveys. Asking about sensitive topics like violence in the household requires building trust and rapport, which can be difficult enough in-person. Shifting exclusively to remote surveys raises questions about everything from data quality to respondent safety. All these concerns are heightened for phone surveying about sensitive subjects, like IPV.

IPV and Phone Surveys¹

SVRI partners and colleagues have been generous in sharing tools for integrating IPV measures into telephone surveys. For example, the **International Violence Against Women Survey (IVAWS)** provides a standardized tool, using a [random sample survey method](#) to strengthen data on violence against women at the country level, gather data for policymaking and make international comparisons. The IVAWS has been implemented in multiple countries by telephone and face to face. A research team in [Argentina](#), for example, successfully implemented the IVAWS using telephone survey methods.

In Brazil, the **DatoSenado Survey**, a government-sponsored, national telephone survey includes IPV items, while Canada periodically conducts the **General Social Survey**—a random digit dial telephone survey including both landline and mobile telephone numbers. This survey assesses Canadians' perceptions of Canada's crime and the justice system and captures information on their experiences of victimization. The complete survey tool is available [online](#).

In the United States, the CDC regularly conducts the **National Intimate Partner and Sexual Violence Survey (NISVS)**—providing national-and state-level data on intimate partner violence, sexual violence, and stalking victimization across the U.S. NISVS, like the General Social Survey, is a random digit dial telephone survey that includes both landlines and mobile phone numbers. The NISVS includes around 60 questions on IPV, SV, and stalking over the lifetime and during the 12 months prior to the interview. 2010 NISVS raw data is open access and available for download [here](#).

The **World Gallup Poll** is also worth exploring. Gallop carries out repeat telephone surveys in 160 countries where telephone coverage reaches 80 percent of the population. Their data collection on actual experiences of (rather than attitudes about) violence against women has been limited, but they have asked about attitudes towards violence, perceived safety, and other issues related to gender, safety, and wellbeing. From the standpoint of telephone methodologies, they have tremendous expertise, though the survey instruments are geared toward policymakers and journalists rather than publication in public health journals.

1. Thank you to Sarah Bott, independent consultant, for inputs on this section.

Other Tools for Gathering Information During Lockdown

Non-interviewer-facilitated options may also be used to gather data during a lockdown. Examples of these include computer-assisted online surveys through software packages such as survey monkey and mobile instant messaging interviews (MIMIs) using platforms like [WhatsApp](#). New technologies bring both opportunities to reach people we often are not able to reach, but they also bring with them a host of ethical issues. For example, the use of commercial platforms to conduct sensitive research on topics like violence is ethically complex and raises ethical questions about the safety and well-being of participants, linkages to care, confidentiality, data protection, and data ownership.

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Limitations of Remote Measurement

Even when using IPV measurement tools validated in multiple contexts, such as [the WHO VAW survey](#), the accuracy of the data collected using remote collection tools remains a point of contention (see for example [here](#), [here](#), [here](#), and [here](#)). Choosing to rely on remotely collected data for decision making should come with serious data quality scrutiny as well as consideration of the ethical and safety issues.

Respondent safety concerns are linked to survey methodology. Women and girls are less likely to have access to [communication technology](#). Even if they may still be reachable over mobile phones, ingrained sexism around technology access may mean she is less likely to have [technical literacy](#) to manage her remote privacy. This challenge is often compounded by abusers' attempts to limit a woman's communications. Sarah St. Vincent, the director of the Clinic to End Tech Abuse at Cornell University, said in a recent [New York Times interview](#), "We see survivors more dependent on technology that they're not fully in control of." A woman responding to an SMS survey may have her text messages read by her partner. A husband might eavesdrop on a woman talking with an enumerator over-the-phone.

A remote enumerator will have less capacity to minimize confidentiality breaches and safety concerns than in-person enumerators. Informed consent processes require respondents to have a good understanding of the inherent risks involved in the study. The extent to which respondents are able to provide informed consent in a study using technology they do not have control over is questionable.

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However, the enumerator has a diminished ability to both evaluate and react to respondent distress. Although technological advancements can compensate for these shortcomings, relying on them is not realistic for many researchers. Shared phones, respondents' limited technology literacy, poor or nonexistent internet, and other factors are inhibitive to remote surveys.

Referral pathways—i.e. the resources given to respondents so they can reach out to support services—also have new challenges when connected to remote surveys. First, just as research initiatives are scrambling to adjust to lockdowns and social distancing, survivor support providers are also struggling to adapt. Many of our referral resources have shrunk or even evaporated. Second, linking respondents to support has logistical hurdles, often varied and evolving with quarantine restrictions (on survivors and on service providers).

So, what should researchers do? On one hand, there is an unprecedented global crisis exacerbating IPV and family violence on multiple fronts. Understanding the true cost of lockdowns and the impact of mitigation strategies is of paramount importance to policymakers, survivor support organizations, and advocates. On the other hand, remote survey tools could increase risks to respondents and may not precisely measure IPV.

In many ways, the answer to whether or not researchers should pursue a project during COVID is the same as it has always been: an IPV survey should only be conducted if there is a plausible and clear link to improving the future IPV outcomes of those communities surveyed. Now more than ever, researchers need to link prospective findings to programs and policies that improve the lives of communities where the research was conducted, as well as inform global practices. If there is no clear connection between results and action, the research should not be conducted.

Additionally, if an organization conducts a remote IPV survey, they should document and proactively share lessons learned about their remote IPV data collection process. This should include their measurement tools, remote collection challenges, and risk mitigation strategies.

Conducting Remote Research

All researchers are obligated to mitigate risks to the respondents as best as possible. Ethical issues should guide decisions on whether remote IPV surveys can be safely conducted. Although the COVID response is demanding speedy change from all sectors, IPV researchers cannot rush preparation or cut any corners. Primary principles enshrined in existing ethical guidance must still be upheld. ***Some primary sources to review on ethical IPV research can be found below under [Further Reading](#).***

General Safety Issues

While surveys should have embedded reminders for respondents to maintain privacy during the interview, the survey protocol should be framed with the assumption that the respondent's partner is sitting next to her. The respondent should never be encouraged to

say anything aloud explicitly referencing violence, enumerators should have prepared scripts to safely explain the survey to anyone who takes the phone from the respondent or otherwise contacts the researchers, and enumerators should offer several ways to provide referral information (verbally, SMS, email to respondent's friend, etc.). Enumerators must also be trained on what to do if they ever believe a respondent is in danger of immediate harm, and who to contact if this happens.

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Piloting

COVID has, for the time being, changed the landscape for IPV research. In this context, piloting a survey tool is even more critical. Small-scale survey pilots should be followed by a critical reflection period. For example, if you plan a survey with 2,000 respondents, first pilot the survey with 50 to 100 as a general best practice. Then hold an ethical reflection period with research staff and enumerators to discuss how the surveys are going, how respondents are reacting to the sensitive questions, any adverse events that the team did not anticipate, and, most importantly, should the team continue with the survey as-is. Stopping the survey based on feedback from the research field team should always be an option on the table.

Piloting should also be used to refine enumerator scripts. In addition to having a fully scripted survey for all quantitative research, researchers may be able to anticipate some follow-up and clarification questions and include scripted responses for these. However, piloting will almost certainly uncover additional respondent questions and scenarios. Researchers should hold post-piloting debriefs with all enumerators to collect unexpected questions and draft appropriate scripted material for enumerators during the formal data collection period. As data collection progresses, researchers should update scripts as new situations arise.

Scripted surveys help minimize oversight errors, improving both respondent safety and data quality. Many survey software options, such as [SurveyCTO](#) often used by IPA, allow for fairly robust if/then scripting of questionnaires.

Voluntary Informed Consent

As always, before any personal information is collected, the enumerator must obtain voluntary informed consent. Usually, an enumerator can rely on eye contact and proximity to ensure the respondent is engaged – this is not possible in most remote surveys. The consent needs to be stripped of any superfluous or confusing language. If feasible, there should be comprehension test questions about the consent content at the end of the consent process. If the respondent cannot answer them, the survey should not be conducted.

If there are any situations in which the respondent's personal information will be shared—such as if she discloses that she is considering suicide or harming someone else—this must be shared with her in the consent process.

Opening Questions

If consent is obtained, the next assumption should be that the enumerator will have to re-contact the respondent or an emergency will occur, such as a respondent spontaneously disclosing she is considering suicide to end the abuse. The enumerator should also determine the level of privacy she has both during the interview and with access to communication tools after the survey. For example, if it's a phone survey, the enumerator should find out whose phone is being used, if it is shared, if there is a better contact number to reach her, etc.

Safeguarding During the IPV Survey

If the respondent appears to be experiencing discomfort or negative reactions due to the questions, the enumerator should remind her that she does not have to answer any of the questions. If the respondent indicates she wants to end the survey or take a break, it is imperative the enumerator does her best to share the referral pathway information.

Referral Pathway Partnerships

“Do not prioritize data over women’s safety. If the data collection exercise cannot ensure privacy and confidentiality; if referral of women to support services if needed is not possible; if it puts the woman at greater risk of harm or causes undue distress, do not proceed with data collection.” [UNWomen and WHO, 2020](#)

Referral pathways must be updated to reflect the current availability of referral services. Do health clinics have the capacity to treat survivors? Are mental health and psychosocial support services available? Every country and every setting is different. Before a study begins, enumerators must be aware of what services are available for survivors during the lockdown period.

Even if a researcher has worked with a partner organization previously, it must test all referral contact information before beginning surveying. Given the COVID upheavals, verifying functioning contact information and existing services is crucial.

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Keeping the IPV Survivor at the Center of IPV Research

Each research project must continually ask itself at every step if survivors are at the heart of its purpose and protocols. Every time a new challenge arises, researchers must ask if their response is keeping survivor support the top priority. As survey tools are being devised and updated, they must ask if the tool is amplifying the voice of survivors and those who are harmed by IPV. Researchers must perpetually search for methods to make each IPV research project safer.

"While we need robust data and large-scale evidence on VAWG, in a crisis situation the priority initially is to target resources to ensure that women survivors of violence have access to quality services and support." [UNWomen and WHO, 2020](#)

Advocacy and implementing organizations along with leaders around the world have worked tirelessly to shine a spotlight IPV during the COVID crisis. As researchers, we are here to boost their efforts and support tangible, positive change.

Further Reading:

Some Primary Sources to Review on Ethical IPV Research Include:

Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women, Department of Gender and Women's Health Family and Community Health. World Health Organization. 1999.

Researching Violence against Women: A Practical Guide for Researchers and Activists. World Health Organization and Program for Appropriate Technology in Health (PATH) 2005

Ethical and Safety Recommendations for Research on Perpetration of Sexual Violence. Jewkes R, Dartnall E and Sikweyiya Y. SVRI and Medical Research Council South Africa, 2012; and Ethical and safety recommendations for intervention research on violence against women. RTI and WHO 2016.

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