

Title: The ethics of researching intimate partner violence in global health: A case study from global health research

Author names and affiliations: Jenevieve Mannell^a, Adrian Guta^b

a) Institute for Global Health
University College London
30 Guilford Street
London WC1N 1EH
UK
Email: j.mannell@ucl.ac.uk
Phone: +44 (0)20 7905 2626

b) School of Social Work
University of Windsor
167 Ferry Street
Second Floor, Room 205
Windsor, Ontario N9A 0C5
CANADA
Email: Adrian.Guta@uwindsor.ca
Phone: (519) 253-3000 Ext: 6761

Corresponding author: Jenevieve Mannell

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Abstract:

There has been an increase in attention to intimate partner violence (IPV) as a health issue that contributes to the spread of HIV, physical and emotional stress, depression, substance use, serious injuries, and higher rates of mortality in low-income settings. This paper explores the ethical implications raised by research on IPV by global health scholars. Drawing on Hedgecoe's work on critical bioethics to analyse a qualitative study of IPV in Rwanda, this paper discusses the risks and benefits of conducting research on IPV as part of the global health agenda. We discuss ethical issues that have become evident through our work in this area, including: raising IPV as an issue of concern in women's lives in settings where economic support for women experiencing IPV may not exist; recording interviews and focus group discussions in contexts with significant government surveillance; ethical tensions in appropriating local voices in ways that position women as 'victims' of violence; and the risks associated with framing IPV as a global health issue separate from feminist advocacy. We recommend more tailored approaches to ethics in IPV research, which considers the specificity of the social, cultural and economic context.

Introduction

Intimate partner violence (IPV) has been recognised by the World Health Organisation (WHO), World Bank, and UN Women as a pressing concern for women's health (Raghavendra, Carney, Duvvury, & Callan, 2013; UN Women, 2012; WHO 2013). Over the past 15 years IPV has expanded beyond its previous position as a women's rights issue to become part of the global health agenda (Heise, Raikes, Watts, & Zwi, 1994). Previously, IPV was perceived to be the primary domain of social work and feminist scholarship (Dobash & Dobash, 1979) with little attention being paid to how the health sector should respond to IPV (Chibber & Krishnan, 2011). More recently scholars have helped shed light on global factors that mitigate women's risk of IPV including secondary education, high socio-economic status and formal marriage, as well as factors that increase the risk of IPV including cohabitation, a young age and attitudes that support wife beating (Abramsky et al., 2011). Other insights include the role that feminist activism has played in establishing policies that address violence against women, including legal reforms, public education campaigns, and support for shelters and rape crisis centres (Heise et al., 1994; Weldon & Htun, 2013). However, despite a significant rise in IPV-related policies around the world, there remains a lack of evidence on the specific mechanisms that work to reduce instances of violence (Jewkes, 2014).

In order to help address this dearth of evidence, we conducted a qualitative study of community-based IPV prevention and support for women in Rwanda. Through undertaking this work we encountered ethical issues beyond those already recognised within general procedures for research with human subjects such as confidentiality, informed consent, and psychological and physical risks to participants (Ellsberg & Heise, 2002). While this was not a study of ethics in the first instance,

important ethical issues emerged as part of the process of conducting the research. Our discussion of these ethical issues builds on the work of researchers who have written about the ethical dilemmas they faced while collecting survey data on IPV prevalence and how these issues were dealt with (Ellsberg & Heise, 2002; Jewkes, Watts, Abrahams, Penn-Kekana, & García-Moreno, 2000; Paavilainen, Lepistö, & Flinck, 2014). Researchers have asked women directly about experiences of participating in surveys on IPV and its potential implications for their lives (Sikweyiya & Jewkes, 2012). In 2001, researchers belonging to the International Research Network on Violence Against Women (IRNWAW) turned their research experiences into a set of ethical guidelines for researching violence against women for the World Health Organisation (WHO 2001), which were subsequently used to inform household surveys in a large multi-country study of IPV prevalence (Ellsberg & Heise, 2002). These WHO guidelines, summarised in *Table 1*, are frequently referenced as an ethical standard in IPV research (Heimer, 2013).

TABLE 1: *WHO recommendations for research on domestic violence against women*

Ethical and safety recommendations for domestic violence research
1. The safety of respondents and the research team is paramount, and should guide all project decisions.
2. Prevalence studies need to be methodologically sound and build upon current research experience about how to minimize the under-reporting of violence.
3. Protecting confidentiality is essential to ensure both women's safety and data quality.
4. All research team members should be carefully selected and receive specialized training and on-going support.
5. The study design must include actions aimed at reducing any possible distress caused to the participants by the research.
6. Fieldworkers should be trained to refer women requesting assistance to available local services and sources of support. Where few resources exist, it may be necessary for the study to create short-term support mechanisms.

Ethical and safety recommendations for domestic violence research

7. Researchers and donors have an ethical obligation to help ensure that their findings are properly interpreted and used to advance policy and intervention development.
8. Violence questions should only be incorporated into surveys designed for other purposes when ethical and methodological requirements can be met.

In this paper we examine the ethical issues faced while conducting a qualitative research study, as a methodology neglected by current discussions on the ethics of researching IPV in global health. A focus on survey methods obscures the ethical issues raised by other methods used in global health, including qualitative, intervention-based evaluations, participatory methodologies and randomised controlled trials (Bowling, 2014). We further explore ethical issues beyond those implicated in the methods of data collection in order to consider the ethics of researching IPV as part of a broader global health agenda. To accomplish this aim we build on Hedgecoe's (2004) attempts to reconcile philosophical bioethics and social science techniques for empirical inquiry through an emerging "critical bioethics". Outlined in detail below, we extend Hedgecoe's framework to integrate the wider relational, socio-political, and contextual issues raised by global health's interest in IPV research, allowing us to engage with broader ethical questions about the production of knowledge, community engagement and research impact.

Critical bioethics of IPV research

Critical bioethics refers to a growing body of theoretical work that seeks to move beyond binaries in ethical thinking (e.g. good versus bad ways of doing things) by examining the socio-political, socioeconomic, historical, cultural and contextual dimensions of an issue (Murray & Holmes, 2009). Drawing on post-structuralist insights about knowledge, power and discourse, such critical approaches to ethics

operate outside the normative project of classic philosophical ethics. They take issue with the 'principalist' focus within bioethics and research ethics, which pays exclusive attention to principles of autonomy, beneficence, non-maleficence and justice (Heimer, 2013).

Hedgecoe's (2004) work on bioethics offers an alternative to principlism by considering the social and cultural factors implicated in ethical decision-making. He summarises four characteristics of a critical approach to bioethics. The first is that critical bioethics needs to be rooted in empirical research. An empirical approach has been taken within considerations of IPV research ethics, as demonstrated by the use of research experiences to inform the WHO's recommendations on researching violence against women (2001) discussed previously. However, what is missing from this empirical work according to Hedgecoe's particular form of bioethics is consideration of how women can act as moral philosophers in their own right. In choosing to tell a researcher about an experience of violence, discussing their relationship with a stranger, or talking about a situation that may be considered 'private', women participating in IPV research are 'using values and beliefs about morality to reach a decision that they have to put in practice' (Hedgecoe, 2004:137).

With the second characteristic of critical bioethics, Hedgecoe puts forward the idea that empirical discovery may require one's ethical theories to be revised or discarded. The empirical research should be used to reflect critically on the theoretical approaches used to understand the issue in the first place. Controversially, Hedgecoe highlights how this may mean discarding one's attachments to the notion of a universal ethics as principles that can be applied in any situation. This is particularly controversial for IPV research because of the ways in which it brings into question established frameworks for understanding causes of IPV as well as effective strategies

for prevention and support, such as feminist theories of patriarchy that see IPV as an outcome of structured gender relations (Ali & Naylor, 2013; Walsh, Spangaro, & Soldatic, 2015).

The third characteristic of Hedgecoe's critical bioethics is reflexivity, which he defines as 'acknowledging one's personal context, but not accepting that this undermines the legitimacy of one's claims' (p.139). Reflexivity places an obligation on the researcher to think about how the claims they are making reflect their social position in terms of 'class, ethnicity, profession, religion, sexuality, education and experience' (Hedgecoe, 2004:138). Given professional narratives of objectivity in research, epidemiologists are inherently unlikely to reflect overtly on their social position in their research (Bayoumi & Guta, 2012). Thus, this is neglected in current ethical inquiries in global health IPV research that take an epidemiological approach.

Fourthly, Hedgecoe argues that critical bioethics should be politically sceptical. This takes a critical approach to the role of research in the production of particular claims to 'truth' and knowledge. It requires attention to Shiffman's (2014) call to think about the role of productive power in global health and the ways in which the validity of certain problems and solutions are defined by purveyors of 'truth'. This perspective raises reflexive questions about the role of IPV research in producing or reproducing dominant discourses about IPV as a problem, the types of solutions it requires, and the necessity of intervention by particular global health actors.

Taken together, Hedgecoe's four characteristics of critical bioethics encourage consideration of the role of context in the ethics of IPV research at three different levels. Through its attention to empirical work and reflexivity critical bioethics requires us to examine the 'on the ground' experience of conducting research, collecting data and negotiating the relationships between researcher and participants,

which we refer to as the *micro* level of IPV research. Secondly, it considers the production of knowledge within the research process itself. In this paper we consider how knowledge about IPV is produced through researcher engagement with the research results and the process of analysis and representation (which we refer to as the *meso* level). We also look at the production of knowledge within engagements between researchers and global health policies that outline the types of interventions required for IPV prevention and support (the *macro* level). At the macro level we further draw on insights from the emerging field of critical public health ethics, as advanced by Nixon, which moves beyond the narrow focus of traditional bioethics to consider “global health equity and power relations between rich and poor countries that impact on health” (2006, p. 32). The findings presented in this paper are considered at each of these three levels.

The Case: A study of IPV prevention and support by communities in Rwanda

The aim of the study discussed in this paper was to gain better understandings of community-based IPV prevention and support for women in Rwanda. Rwanda was specifically selected because of the government’s 2009 Gender-Based Violence (GBV) policy, which mandates local government at the community level (known locally as *umudugudu*) to establish GBV committees. The GBV committees are responsible for holding regular meetings, sensitising the population to GBV, providing information about available services, and referring victims to appropriate services (MIGEPROF, 2009). Officially, GBV committees are composed of six members, including the *umudugudu* chief, representative of social affairs, security representative, a female representative, the person in charge of information, and a boy or girl representing children. In practice, members are elected by the community and roles tend to overlap.

The research study itself involved a multisite ethnographic study (Shore & Wright, 1997) of community engagement in providing IPV prevention and support in Rwanda, with the GBV committees as a central focus. Data for the study were collected in two distinct phases. Phase 1, carried out in 2013, explored the IPV experiences of women from different vantage points (women's direct experiences of IPV, women's experiences as friends and neighbours of IPV survivors, and local organisations supporting women experiencing IPV/ involved in IPV prevention). Data included 15 interviews with women who had experienced violence recruited through two local non-governmental organisations (NGOs), and 10 interviews with representatives from NGOs with programmes targeting IPV prevention and support in communities. Four focus groups were also held with 24 women, recruited by a local research assistant. Phase 2, carried out in 2014, explored the response of communities to IPV through both formal approaches (the GBV committees) and informal approaches (community members operating on their own accord to provide support or prevent IPV). Two communities were selected for this phase, both of which reflected standard characteristics of *umudugudu* governance in Rwanda: they were composed of 100-150 households, were represented by a traditional chief, and had an established GBV committee. The *umudugudu* chief was approached by the research team in each community for initial permission to conduct the study. Once permission was granted, interviews were conducted with each member of the GBV committee (6 members in each community), and four focus groups (two per community) were carried out with men and women. Ethical approval for the project was obtained from the London School of Economics (LSE, 5 August 2013).

TABLE 2: Details of data collection for a study of community-based IPV prevention and support in Rwanda (n=82)

	Sample	Recruitment techniques
Phase 1: Women’s experiences of IPV (direct and indirect)	15 interviews with women who had experienced violence directly (n=15)	Recruited through two NGOs providing services to women experiencing violence
	4 community-based focus group discussions (FGDs) with women (n=24)	Recruited through personal network of local research assistant
	10 interviews with NGO representatives (n=10)	Contacted by lead researcher using a list of locally identified organisations
Phase 2: Community responses to IPV	10 interviews with GBV committee members in 2 communities (n=10)	Recruited through local leader (initial contact made by the project’s interpreter)
	2 FGDs with men in 2 communities (n=12)	Recruited through local leader (initial contact made by the project’s interpreter)
	2 FGDs with women in 2 communities (n=11)	Recruited through local leader (initial contact made by the project’s interpreter)

As a piece of research involving interviews with a vulnerable population a number of specific measures were put in place to minimise any adverse effects of the study for both participants and researchers, following WHO’s recommendations (*Table 1*). Standard procedures were used to ensure confidentiality and informed consent (WHO recommendation no.3 to protect confidentiality for women’s safety and data quality). Participants signed a consent form translated into Kinyarwanda that explained the objectives of the study and their choice to opt out at any time for any reason. Pseudonyms were used to protect anonymity. Additional safeguards included ensuring that women who had experienced violence were already receiving social

services through formally established organisations (WHO recommendation no.5 on reducing possible distress caused by participation in the research), and hiring university-trained social workers as interviewers to ensure a sensitive approach was taken. A list of available GBV-related services was created for focus groups outside of established organisations, e.g. focus groups with women and men in communities (WHO recommendation no.6 on using trained fieldworkers and ensuring mechanisms of support). A summary of the final results was translated into Kinyarwanda and copies were distributed to participants who provided their contact information, NGOs where recruitment had taken place, and NGO representatives who participated in the study (WHO recommendation no.7 on using research to advance policy and intervention development).

Methods

We draw on a case study methodology to examine the ethical challenges that arose in the Rwanda IPV study. As a methodology, case studies are particularly well suited for understanding linkages between a particular phenomenon (in this case the research study) and its surrounding context (Yin, 2013). Empirical studies that describe ethical decision-making processes and tensions offer important lessons for researchers and practitioners (Heimer, 2013; Strike, Guta, de Prinse, Switzer, & Carusone, 2016).

Multiple sources of data were included to ensure credibility of the data, including the principle researcher's daily field notes, debriefing with research assistants following each interview and focus group discussion (captured in the field notes), and transcripts from interviews and focus groups conducted as part of the research study. These various data sources were analysed to identify themes about the ethical tensions produced in the interaction between the study design and the context surrounding it.

Results: ethical tensions at micro, meso and macro levels

The ethical challenges resulting from our analysis are outlined in *Table 3* according to the three levels identified previously: micro, meso and macro.

TABLE 3: Overview of ethical challenges observed during a qualitative study of community-based IPV prevention and support in Rwanda

	Ethical challenges	Lessons learned (applying critical bioethics)
Micro: Relationship between researcher and research participants	<ul style="list-style-type: none"> - Women who had experienced violence were concerned about how the results were going to be used by the government - Focus group participants wanted to know about the researchers' personal experiences (of violence, with marriage and with children) - Inadequate support services for research participants (available services do not address socio-economic realities of IPV) 	<p>Reflexivity:</p> <ul style="list-style-type: none"> - Reflexivity plays a role in the research process, not only academic debates - Reflexivity needs to also involve consideration of the political context and how research is perceived <p>Empirical-based ethics:</p> <ul style="list-style-type: none"> - Doing IPV research ethically involves ensuring access to financial and legal services in addition to psychosocial supports for women disclosing IPV
Meso: Relationship between researcher and the results	<ul style="list-style-type: none"> - In writing up results it is easy to reproduce problematic narratives of women experiencing IPV as 'victims' and men as 'perpetrators' 	<p>Theory challenging (Feminist):</p> <ul style="list-style-type: none"> - A need to better consider the role of research participants as moral decision-makers in IPV research and practice
Macro: Relationship between researcher and global health policy and interventions	<ul style="list-style-type: none"> - The types of 'evidence' frequently adopted as policy were inconsistent with the methods needed to answer the research questions - Historically, the lives of women experiencing IPV have been more affected by socio-political changes brought about by feminist activism than by public health interventions or research 	<p>Politically sceptical:</p> <ul style="list-style-type: none"> - A need for greater attention to the politics of evidence in global health research on IPV <p>Theory challenging (IPV):</p> <ul style="list-style-type: none"> - A need for greater attention to the existing potential of local knowledge and resources to serve the needs of women experiencing IPV

Micro: Relationship between researcher and research participants

Three main ethical challenges arose in the relationship between the researchers and the research participants during the study, which were related to: (1) participants' concerns about the potential use of the research results, (2) responding appropriately to participants' questions about the personal lives of the researchers, and (3) what to do in the face of inadequate support services for participants. We discuss each of these challenges in turn.

The first challenge relates to a consistent question posed by the participants when filling out the ethics forms at the beginning of interviews and focus group discussions (FGDs): 'how will this information be used?' In particular, women who had experienced violence and were telling their stories raised concerns about the use of a tape recorder in the interviews. One woman directly asked if the interview would be broadcast on the public radio. Concerns were also raised about the tape recording of FGDs, with participants asking questions about the government's involvement in the research and whether or not the government would have access to the recordings. All participants were extremely reluctant to sign the consent form for fear of how it might be used against them at a later time. This occurred despite significant efforts by the research team to explain the purpose of the consent forms, which had been written in Kinyarwanda and were read aloud to participants before the interviews/ FGDs. The research team responded sensitively to participants' concerns, reiterating the aims of the research and explained carefully that the tape recording and signed consent forms would not be used for any public purpose or shared with the government. All participants were also given the option of marking the consent forms with an 'x' rather than signing their name. The team engaged in a conversation about consent

with participants until they felt that these concerns had been addressed and they said they were willing to participate.

These questions from participants are telling of the values and belief system that shape and define what it means to participate in research in contemporary Rwanda. The Government of Rwanda has established a decentralised form of governance at four levels of government (*umudugudu*, cell, sector and district). While decentralised governance has given the state an unprecedented ability to reach local populations with public services, the accountability of local officials remains attached to higher levels of government rather than the local populations they serve. As a result, a number of poorly implemented interventions carried out in local communities (for instance, an intervention to eradicate homes with leaf roofs for the risks they posed to the lives of inhabitants) have contributed to a sense of the government's potential to hurt its own people in the name of progress (Ingelaere, 2014). This has created a context in which unequal power, lost trust, and vulnerability are considerations for all research and programmatic initiatives. Thus, unique ethical issues emerge when conducting research in a context where standard research techniques may be viewed as complicit with government surveillance.

The second ethical challenge arose from questions posed by research participants about the personal experiences of the research team. The first research team (phase 1 of the study) was composed of the first author (a UK-based female academic working for the LSE, raised in Canada, fluent in English and French), and two Rwandan female research assistants. A second research team (phase 2 of the study) was composed of a Canadian female research assistant (born in Iran, raised in Canada, and living in Rwanda) and three Rwandan research assistants/ interpreters (2 female and 1 male). In both phases of the study, participants asked personal

information about the researchers, in particular if they were married, if they had children, if they had experienced IPV, and if violence was a problem in their countries of origin (in the case of the non-Rwandan team members).

How should a researcher answer personal questions of this nature? As researchers that are asking sensitive questions about IPV, there is a need to build rapport and a positive relationship with research participants (Dickson-Swift, James, Kippen, & Liamputtong, 2007). Answering personal questions may be necessary for achieving trust in the research process (Ellis & Berger, 2002), and disrupts relations of power between those asking the questions (researchers) and those answering them (participants) (Roer-Strier & Sands, 2015). However, interviews can also serve to reaffirm various forms of power (Kvale, 2006). The purpose of questions about marriage and children in the Rwandan context is to position an individual within a gendered social framework where women are not considered adults until they are married. All of the women researchers involved in this study were unmarried and childless. The research assistants in particular felt that their role in the research was undermined by having to answer questions about marriage and children. While participants asking questions of researchers can ameliorate power relationships inherent in research encounters, in this case these questions served to shift power from the local research assistants to the non-Rwandan researchers who felt less impacted by these personal questions or the social status implications. In effect, this meant that efforts to build local research capacity in global health research through training local researchers (Del Vecchio Good, 1992) were undermined. As critical and reflexive researchers we realise that we enter the field with our own biases and assumptions, and participate in exercises of power. Members of our research team, especially those with dual roles as researcher and community member were affected in one way,

taking issues with participants' questions even though questions posed by participants about marriage are seen as quite normal in everyday social interactions in Rwanda. We continue to reflect on whether the reactions of our research assistants were rooted in unintentional, but deep rooted, expectations as 'experts' to be able to control the research, which is what the participants were resisting.

The third and perhaps most difficult ethical challenge relates to the list of available IPV services created for focus group participants according to WHO guidelines (for use in cases where a participant needs to be referred to IPV services or experiences distress as a result of their participation in the research). In Rwanda, the range of services available for individuals who have experienced IPV include hospital services for physical effects of the violence, psychological services for the impacts of violence on psychological wellbeing, and shelter services for those needing to leave the home to escape situations of violence. This is part of a comprehensive package of services offered by the Rwandan Government, and provided through the Rwandan National Police hospital in Kigali. However, in order to access these services, survivors of violence must report the violence to the police. Non-governmental organisations (NGOs) also offer a range of services, which includes a small number of shelters for women (Rwanda Women's Network 2011).

While none of the participants mentioned personal experiences of IPV that required referral to these services, they did ask questions about what they could do in particular situations. For instance, one woman asked what she could do for a friend who risked having her children taken away from her by the family of her unmarried partner. The partner had refused to support her financially because they were not married, but when she had tried to leave him, his family had claimed custody of the couple's children. In this context, the largest gap in support for women experiencing

IPV is often structural, for example legal support for unmarried women who worry about losing custody of their children, or financial support for women who depend on their husbands for basic survival. The majority of participants in this study who had experienced violence also lacked the financial resources they needed to leave their relationships. They told harrowing stories of being homeless, and depending on neighbours for small bits of money to be able to feed themselves and to send their children to school. The comprehensive list of psychosocial and police services we had prepared were of little assistance for women facing financial and/or legal barriers to seeking help for IPV.

Meso: Relationship between researcher and the results

The main ethical challenges that arose for the research team in writing up the research results from the study was finding a way to acknowledge the complexities of women's lives in ways that did not position them as victims of violence. Once data collection was complete, the principle investigator on the project led the writing process, which involved the two lead research assistants and two other research assistants that had carried out the transcription and analysis of the data. To date, two academic papers and one published report have come out of the study.

In writing these papers, the first challenge arose in trying to balance the dominant discourse in much IPV research on women reporting or leaving violent relationships (see for example Andersson et al., 2010; Kim & Lee, 2011; Scheffer Lindgren & Renck, 2008) and how Rwandans actually respond to violence in their relationships. The women we spoke with highlighted a range of cultural and individual reasons why women want to stay with men who abuse them, are hesitant to report their partners or husbands to the police, and prefer to resolve the conflict rather than leave the relationship. Our desire to stay true to the data and reflect women's

self-described solutions conflicted with our feminist conceptions of women who stay in violent relationship as the unconscious victims of patriarchal ideas of male dominance and control as ‘normal’ (Dobash & Dobash, 1979). The research team had many heated debates about how exactly to describe the findings in a way that would maintain a feminist perspective while also giving voice to the women who participated in the research. Some of us felt that by focusing on barriers for women leaving violent relationships we would be feeding into a well-critiqued tendency within global health research to position women in marginalised settings as victims of oppression (Wilson, 2013). Other members of the research team felt that by exclusively highlighting the actions women take to address violence in their own ways (e.g. acting more subserviently towards their husbands) we would be undermining our feminist interest in shedding light on the way in which gender inequalities structure the possibilities and choices available to women.

This debate ultimately resulted in a paper on recognising women’s agency in responses to IPV in Rwanda as a basis for the development of IPV interventions (see Mannell, Jackson, & Umutoni, 2016). The final paper included both an account of the structural barriers to women’s agency (such as social and cultural norms), and instances of women’s agency within these structural constraints (including how women were trying to manage the situation in the household and asking others for emotional support). In doing this the research team tried to weave a middle ground between the feminist perspective and Rwandan women’s perceptions, arguing for health interventions that support women’s possible actions in coercive social contexts as a starting point for developing more challenging approaches that directly tackle social inequalities. If such a response seems obvious to those working in a critical tradition, it is important to note that complexity and variety are often omitted from the

findings of IPV research. Instead, such state sponsored research, and research conducted under the auspices of international donors, prefer a single narrative and a one-size fits all solution.

Macro: Relationship between the researcher and global health policy

As a global health research team we felt it was important to ensure that our research findings were taken up by national and/or international policy for both practical and ethical reasons. Practically, health researchers are under increasing pressure from funders to ensure their findings have a policy impact (Nutley, Walter, & Davies, 2007). Ethically, there are implications for ensuring that research on IPV has direct policy effects on the lives of women experiencing IPV (World Health Organisation, 2001). Two significant ethical challenges arose in trying to establish effective connections between our research findings and the policy-making process: (1) the types of ‘evidence’ that are taken seriously by global health policy-makers were inconsistent with the methods needed to answer our research questions; (2) historically, the lives of women experiencing IPV have been more affected by socio-political changes (e.g. changes in policy) brought about by feminist activism than by public health interventions.

The first challenge relates to the design of our study and the research questions posed. The study was designed to explore the enablers and barriers to community-based efforts to prevent IPV and support women, with the main research question being: ‘In what ways can communities prevent IPV and support the needs of women in low-income settings?’ This question arose from a gap in research on how community characteristics such as collective efficacy, social cohesion, and social ties facilitate the prevention and support of IPV outside the U.S. (VanderEnde, Yount, Dynes, & Sibley, 2012). The absence of any studies looking at these characteristics in

low-income settings required an approach that was both exploratory and open to a wide range of possible answers, which is consistent with a qualitative approach to research (Creswell, 2012). However, selecting a qualitative approach for this study marginalised us within the ‘hierarchy of evidence’ (Barnes & Parkhurst, 2014). We therefore had to choose between compromising research integrity by using methods that were likely to be adopted by policy-makers at a global level (such as those that answer questions about the impact on health outcomes), or paying attention to questions that are critical for understanding health outcomes but may be unanswerable using RCTs or systematic reviews, such as the influence of social context on community mobilisation (Cornish, Priego-Hernandez, Campbell, Mburu, & McLean, 2014). As a research team we decided to maintain our focus on the social contexts that enable community mobilisation for IPV prevention and support, recognising that this would limit the potential for policy impact.

The second ethical challenge mentioned above arose at the end of the study when the research team disseminated the main findings in Kinyarwanda to NGOs that had participated in the study. The research was focused on a national policy rather than the specific activities of these NGOs making it difficult for them to see the direct relevance of the findings for their own activities. The literature on social change and IPV highlights how the research-policy interface has historically had little influence over progress on gender-based violence. Rather than a reaction to evidence of the prevalence of IPV in certain contexts or the damage it does to women’s lives, the establishment of women’s shelter and legal precedence for punishing perpetrators of violence in the U.S. and Europe was brought about by the influential actions of the woman’s movement in advocating for women experiencing IPV and bringing the issue of violence against women into broader public scrutiny (Barner & Carney,

2011). The issue was then brought into the global arena through the efforts of transnational advocacy networks that linked activists around the world in making calls to global institutions (Keck & Sikkink, 1998). While there may be an ethical obligation for researchers to ensure findings are taken up in policy, in the case of IPV, history tells us that social activism rather than research has been much more important in bringing about real change for women's lives. However, there is also the potential for a symbiotic relationship between the two, with activism informing research and policy and evidence being taken up by activists in local and international settings to advance change. While such a relationship is promising, this raises new questions about reconciling an ethics of activism rooted in social justice and the minimal standards offered by research ethics.

Discussion

As described, our experience of conducting research on IPV in Rwanda was fraught with ethical issues in the relationship between researchers and research participants (micro); the relationship between the research team and the results (meso); and the relationship between our role as researchers and the recommendations we were making for global health policy and interventions (macro). Hedgecoe's framework for critical bioethics provides a useful analytical tool for interpreting these ethical issues and reflecting on their implications for IPV research and global health ethics more broadly.

Hedgecoe's argument that bioethical inquiry needs to be situated within empirical research was confirmed through our experience of researching IPV in Rwanda. In practice, the act of conducting research in present-day Rwanda is embedded within a socio-cultural environment defined by significant government surveillance over citizen's everyday lives. This has implications for how participants

understand their participation in research, which is further emphasised by the sensitive nature of IPV and concerns over the sharing of personal stories with government agencies. The WHO recommendations for research on IPV fall significantly short in considering this type of ethical challenge, as would any attempt to establish a universal code of ethics applicable to research contexts with different political environments. As Heimer (2013) points out, the ‘official ethics’ of institutional bodies is often detached and irrelevant to the form of ethical engagement required by researchers ‘on the ground’.

The mismatch between official ethics and ethics ‘on the ground’ was also highlighted in our Rwandan study by individualistic assumptions inherent in determining appropriate IPV support services. Our list of support services followed WHO guidelines to ensure participants would have access to psychosocial and police services to ‘treat’ violence if needed. However, this is inconsistent with the intersecting social, economic and cultural contexts that often make individual responses to IPV (such as leaving a husband or reporting violence to the police) impossible in coercive social settings (Campbell & Mannell, 2016). Heimer (2013) warns that efforts to establish universal codes of ethics make the ethical issues that arise within empirical engagements largely intractable. This is certainly the case for universal approaches to IPV research ethics that obscure how IPV manifests in relationships and is reproduced through social norms embedded in families, communities and societies. Our empirical example suggests that ethical IPV research in Rwanda may need to be tailored for specific IPV experiences, including providing financial support for women in cases where financial need is a barrier to getting help for IPV. Overall, our experience suggests that a more contextualised approach to IPV

research is needed, which acknowledges the influence of social, cultural and economic contexts in ensuring access to IPV services.

Attention to the neo-colonial tendencies of IPV research narratives raised additional ethical challenges for us as feminist researchers, and a conflict between our feminist commitment to addressing patriarchal social norms and the desire of many participants to stay with their violent partners (a theme arising from recent studies of IPV in Rwanda (Umubyeyi, Persson, Mogren, & Krantz, 2016), as well as Sierra Leone, Liberia (Horn, Puffer, Roesch, & Lehmann, 2015) and Tanzania (McCleary-Sills et al., 2015). In following Hedgecoe's thinking of research participants as moral decision-makers we see that the women and men we spoke to had nuanced understandings of the social, cultural and economic factors that perpetuate IPV in their communities. Many were actively involved in trying to address these factors as part of community-based GBV committees (Mannell & Dadswell, 2017). Understanding the moral-decisions of participants provides a new way of thinking about conflicts between forms of feminism that try to disrupt gender norms and community representations of violence that maintain these norms. This involves focusing on the ways in which participants are dealing with moral decisions, and paying attention to how they resolve conflicts between the factors they see as perpetuating IPV and their own efforts to stop it.

The Rwandan case also highlights the necessity of reflexivity in ethical approaches to global health research, following Hedgecoe's third recommendation for critical bioethics. Reflexivity by the research team was necessary when considering how to respond to personal questions asked of the researchers and women's concerns about the use of their personal stories. Our Rwandan case study also showed how local research assistants may be marginalised during data collection by participants'

efforts to negotiate research interactions. Similarly, taking a reflexive approach to analysing how we presented the data in published papers makes visible the power dynamics involved in selecting particular narratives about those experiencing IPV in low-income contexts. As global health researchers we often conduct research in contexts that perceive us as outsiders, and therefore need to reflect on the power dynamics involved in research settings (Smith, 1999). Our experience conducting IPV research in Rwanda supports growing calls for acknowledging the importance of reflexivity in bioethics practice and language use, rather than as an intellectual activity separate from the research process (Ives & Dunn, 2010; Murray & Holmes, 2009).

Hedgecoe's fourth and final criterion for a critical approach to bioethics is to remain politically sceptical about claims of 'truth' embedded in research. Assumptions about the inherent 'truth' of IPV and IPV research in global health are evident throughout our Rwandan case study. The ethical recommendations for IPV research from the WHO make assumptions about the need to protect individuals who may be experiencing IPV rather than communities, families or intimate relationships. In addition, we have discussed how feminist assumptions about the truth of women's oppression in patriarchal societies can contribute to narratives that present women experiencing violence solely as victims, obscuring their own voices and preferences. Another 'truth' that needs to be approached sceptically is the assumption that the most appropriate focus for IPV research is to support global health policy and intervention, particularly when feminist advocacy has potentially played a more important role in bringing IPV to the global health agenda. Finally, attention to IPV as a form of violence independent of the broader definition of gender-based violence (GBV) carries its own assumptions about the causes of violence as based in either personal or

interpersonal factors, and can obscure attention to violence against LGBT communities, violence in intimate same-sex relationships, and the role played by broader structural factors in perpetuating IPV in particular contexts (Anderson, 2005, 2013).

Through engaging with critical bioethics to explore the case of an IPV research study in Rwanda, we have shown how a context-specific approach to ethical inquiry is needed for IPV research. A few general points emerge for future research in this area:

1. Ethical considerations for IPV research should be based on empirical evidence of what it means to conduct research on violence in a particular context, including localised understandings of trust and the micro-politics of power within research engagements. This requires researchers to share their research experiences in addition to sharing research findings. It also requires funders and journals to support foundational research on ethical issues related to IPV research in contexts where knowledge of such experiences may be inaccessible.
2. Taking account of the moral decision-making process of women experiencing IPV and of communities trying to prevent violence against women is part and parcel of context-specific ethical engagements, and key to avoiding top-down approaches to IPV research that positions women exclusively as victims and communities solely as the locus of harmful social norms.
3. Reflexivity is a critical part of any research project, but particularly important for research on highly sensitive topics such as IPV where one's social position can have a significant bearing on the rapport that one is able to establish with

research participants, the quality of data collected, and the interpretation of the results.

4. The availability of economic support in addition to medical or psychosocial support for women disclosing violence as part of the research process should be considered by researchers in low-income settings where economic and legal realities can play a significant role in preventing the safety and security of women experiencing IPV. In contexts where these supports are not available, researchers may need to question the value of their research for broader advocacy efforts to obtain these forms of support through local activism.
5. Researchers need to work with activists to support a symbiotic relationship between evidence and policy. The best potential for addressing IPV comes from a full engagement between researchers, policy-makers and those advocating on behalf of women experiencing violence and their communities.

This call for more contextually relevant ethical engagements should not be seen as a replacement to the WHO's recommendations for IPV research, but rather an addition focused on how research can be localised and made more relevant for specific socio-economic contexts.

Conclusions

The rise of IPV in global health research and its recognition by global health actors presents a range of ethical issues raised in this paper. Critical bioethics helps us move beyond universal approaches to research ethics in order to consider the implications of research contexts for ethical questions related to data collection, as well as broader issues of knowledge production, community engagement and research impact in global health research on IPV. Our experience conducting IPV research in Rwanda

demonstrates the need for more tailored approaches to ethical engagements with research contexts that consider the specific social, cultural and economic issues presented by the research setting. It highlights the potential of using the moral decisions of research participants as an entry point for this engagement and the critical need for reflexivity in all stages of the research process in order to ensure ongoing adaptability to any ethical challenges raised. We see this paper as contributing a critical perspective to ongoing ethical discussions about gender and global health issues such as IPV.

References

- Abramsky, T., Watts, C. H., Garcia-Moreno, C., Devries, K. M., Kiss, L., Ellsberg, M., ... Heise, L. (2011). What factors are associated with recent intimate partner violence? findings from the WHO multi-country study on women's health and domestic violence. *BMC Public Health, 11*(1), 109. <https://doi.org/10.1186/1471-2458-11-109>
- Ali, P. A., & Naylor, P. B. (2013). Intimate partner violence: A narrative review of the feminist, social and ecological explanations for its causation. *Aggression and Violent Behavior, 18*(6), 611–619. <https://doi.org/10.1016/j.avb.2013.07.009>
- Anderson, K. L. (2005). Theorizing Gender in Intimate Partner Violence Research. *Sex Roles, 52*(11–12), 853–865. <https://doi.org/10.1007/s11199-005-4204-x>
- Anderson, K. L. (2013). Why Do We Fail to Ask ‘Why’ About Gender and Intimate Partner Violence?: Comment on Cui et al. (). *Journal of Marriage and Family, 75*(2), 314–318. <https://doi.org/10.1111/jomf.12001>
- Andersson, N., Cockcroft, A., Ansari, U., Omer, K., Ansari, N. M., Khan, A., & Chaudhry, U. U. (2010). Barriers to Disclosing and Reporting Violence Among Women in Pakistan: Findings From a National Household Survey and Focus Group Discussions. *Journal of Interpersonal Violence, 25*(11), 1965–1985. <https://doi.org/10.1177/0886260509354512>
- Barner, J. R., & Carney, M. M. (2011). Interventions for Intimate Partner Violence: A Historical Review. *Journal of Family Violence, 26*(3), 235–244. <https://doi.org/10.1007/s10896-011-9359-3>
- Barnes, A., & Parkhurst, J. (2014). Can Global Health Policy be Depoliticized? A Critique of Global Calls for Evidence-Based Policy. In G. W. Brown, G. Yamey, & S. Wamala (Eds.), *The Handbook of Global Health Policy* (pp. 157–173). John Wiley & Sons, Ltd. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1002/9781118509623.ch8/summary>
- Bayoumi, A. M., & Guta, A. (2012). Values and Social Epidemiologic Research. In P. O'Campo & J. R. Dunn (Eds.), *Rethinking Social Epidemiology* (pp. 43–65).

Amsterdam: Springer Netherlands. https://doi.org/10.1007/978-94-007-2138-8_3

Bowling, A. (2014). *Research Methods In Health: Investigating Health And Health Services*. Maidenhead, Berkshire: McGraw-Hill Education (UK).

Campbell, C., & Mannell, J. (2016). Conceptualising the agency of highly marginalised women: Intimate partner violence in extreme settings. *Global Public Health, 11*(1–2), 1–16.
<https://doi.org/10.1080/17441692.2015.1109694>

Chibber, K. S., & Krishnan, S. (2011). Confronting Intimate Partner Violence: A Global Health Priority. *Mount Sinai Journal of Medicine: A Journal of Translational and Personalized Medicine, 78*(3), 449–457.
<https://doi.org/10.1002/msj.20259>

Cornish, F., Priego-Hernandez, J., Campbell, C., Mburu, G., & McLean, S. (2014). The impact of community mobilisation on HIV prevention in middle and low income countries: a systematic review and critique. *AIDS and Behavior, 18*(11), 2110–2134. <https://doi.org/10.1007/s10461-014-0748-5>

Creswell, J. W. (2012). *Qualitative inquiry & research design: choosing among five approaches* (3rd ed.). London: Sage Publications.

Del Vecchio Good, M.-J. (1992). Local knowledge: Research capacity building in international health. *Social Science & Medicine, 35*(11), 1359–1367.
[https://doi.org/10.1016/0277-9536\(92\)90039-S](https://doi.org/10.1016/0277-9536(92)90039-S)

Dickson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P. (2007). Doing sensitive research: what challenges do qualitative researchers face? *Qualitative Research, 7*(3), 327–353. <https://doi.org/10.1177/1468794107078515>

Dobash, R. E., & Dobash, R. (1979). *Violence against wives: a case against the patriarchy*. New York: Free Press.

Ellis, C., & Berger, L. (2002). Their Story/My Story/Our Story: Including the Researcher's Experience in Interview Research. *Communication Faculty Publications, Paper 280*, 467–493.

- Ellsberg, M., & Heise, L. (2002). Bearing witness: ethics in domestic violence research. *The Lancet*, 359(9317), 1599–1604. [https://doi.org/10.1016/S0140-6736\(02\)08521-5](https://doi.org/10.1016/S0140-6736(02)08521-5)
- Hedgecoe, A. M. (2004). Critical bioethics: beyond the social science critique of applied ethics. *Bioethics*, 18(2), 120–143.
- Heimer, C. A. (2013). ‘Wicked’ ethics: Compliance work and the practice of ethics in HIV research. *Social Science & Medicine*, 98, 371–378. <https://doi.org/10.1016/j.socscimed.2012.10.030>
- Heise, L. L., Raikes, A., Watts, C. H., & Zwi, A. B. (1994). Violence against women: A neglected public health issue in less developed countries. *Social Science & Medicine*, 39(9), 1165–1179. [https://doi.org/10.1016/0277-9536\(94\)90349-2](https://doi.org/10.1016/0277-9536(94)90349-2)
- Horn, R., Puffer, E. S., Roesch, E., & Lehmann, H. (2015). ‘I don’t need an eye for an eye’: Women’s responses to intimate partner violence in Sierra Leone and Liberia. *Global Public Health*, 1–14. <https://doi.org/10.1080/17441692.2015.1032320>
- Ingelaere, B. (2014). What’s on a peasant’s mind? Experiencing RPF state reach and overreach in post-genocide Rwanda (2000–10). *Journal of Eastern African Studies*, 8(2), 214–230. <https://doi.org/10.1080/17531055.2014.891783>
- Ives, J., & Dunn, M. (2010). WHO’S ARGUING? A CALL FOR REFLEXIVITY IN BIOETHICS: Who’s Arguing? A Call for Reflexivity in Bioethics. *Bioethics*, 24(5), 256–265. <https://doi.org/10.1111/j.1467-8519.2010.01809.x>
- Jewkes, R. (2014). *What Works in Preventing Violence Against Women and Girls: Evidence review of the effectiveness of response mechanisms in preventing violence against women and girls* (p. 41). London: Department for International Development (DFID). Retrieved from <https://www.gov.uk/government/publications/what-works-in-preventing-violence-against-women-and-girls-review-of-the-evidence-from-the-programme>
- Jewkes, R., Watts, C., Abrahams, N., Penn-Kekana, L., & García-Moreno, C. (2000). Ethical and methodological issues in conducting research on gender-based

- violence in Southern Africa. *Reproductive Health Matters*, 8(15), 93–103.
[https://doi.org/10.1016/S0968-8080\(00\)90010-7](https://doi.org/10.1016/S0968-8080(00)90010-7)
- Keck, M. E., & Sikkink, K. (1998). *Activists beyond Borders: Advocacy Networks in International Politics*. Ithaca: Cornell University Press.
- Kim, J. Y., & Lee, J. H. (2011). Factors Influencing Help-Seeking Behavior Among Battered Korean Women in Intimate Relationships. *Journal of Interpersonal Violence*, 26(15), 2991–3012. <https://doi.org/10.1177/0886260510390946>
- Kvale, S. (2006). Dominance Through Interviews and Dialogues. *Qualitative Inquiry*, 12(3), 480–500. <https://doi.org/10.1177/1077800406286235>
- Mannell, J., & Dadswell, A. (2017). Preventing Intimate Partner Violence: Towards a Framework for Supporting Effective Community Mobilisation. *Journal of Community & Applied Social Psychology*, published online.
<https://doi.org/10.1002/casp.2297>
- Mannell, J., Jackson, S., & Umutoni, A. (2016). Women’s responses to intimate partner violence in Rwanda: Rethinking agency in constrained social contexts. *Global Public Health*, 11(1–2), 65–81.
<https://doi.org/10.1080/17441692.2015.1013050>
- McCleary-Sills, J., Namy, S., Nyoni, J., Rweyemamu, D., Salvatory, A., & Steven, E. (2015). Stigma, shame and women’s limited agency in help-seeking for intimate partner violence. *Global Public Health*, 11(1–2), 224–235.
<https://doi.org/10.1080/17441692.2015.1047391>
- MIGEPROF. (2009). *Guidelines for setting up GBV committees*. Kigali, Rwanda: Ministry of Gender and Family Promotion. Retrieved from
www.migeprof.gov.rw/%2FIMG%2Fdoc%2FGUIDELINES_FOR_SETTING_UP_GBV_COMMITTEES.doc&ei=RuqTVaXqK4uAU-Sel8gI&usg=AFQjCNHqg9mzZVFQEZdYYMzmhyFjiLTYGA&sig2=isxDx8sasJ8xwOfImk2azQ&bvm=bv.96952980,d.d24&cad=rja
- Murray, S. J., & Holmes, D. (Eds.). (2009). *Critical Interventions in the Ethics of Healthcare: Challenging the Principle of Autonomy in Bioethics*. Farnham, England ; Burlington, VT: Ashgate Pub Co.

- Nixon, S. A. (2006). Critical Public Health Ethics and Canada's Role in Global Health. *Canadian Journal of Public Health / Revue Canadienne de Sante'e Publique*, 97(1), 32–34.
- Nutley, S. M., Walter, I., & Davies, H. T. O. (2007). *Using Evidence: How Research Can Inform Public Services*. Bristol: Policy Press.
- Paavilainen, E., Lepistö, S., & Flinck, A. (2014). Ethical issues in family violence research in healthcare settings. *Nursing Ethics*, 21(1), 43–52.
<https://doi.org/10.1177/0969733013486794>
- Raghavendra, S., Carney, P., Duvvury, N., & Callan, A. (2013). *Intimate partner violence : economic costs and implications for growth and development* (Women voice, agency and participation research series) (pp. 1–94). Washington, D.C.: The World Bank. Retrieved from
<http://documents.worldbank.org/curated/en/2013/11/18486239/intimate-partner-violence-economic-costs-implications-growth-development>
- Roer-Strier, D., & Sands, R. G. (2015). Moving beyond the 'official story': when 'others' meet in a qualitative interview. *Qualitative Research*, 15(2), 251–268.
<https://doi.org/10.1177/1468794114548944>
- Rwanda Women's Network, MRC South Africa, & International Center for Research on Women. (2011). *Exploring community perceptions and women's experiences of violence against women and use of services in Bugesera District, Rwanda* (p. 46). Kigali, Rwanda. Retrieved from
http://www.rwandawomennetwork.org/IMG/pdf/Exploring_Community_Perceptions_Women_s_Experiences_of_VAW_Services_Use.pdf
- Scheffer Lindgren, M., & Renck, B. (2008). Intimate partner violence and the leaving process: Interviews with abused women. *International Journal of Qualitative Studies on Health and Well-Being*, 3(2), 113–124.
<https://doi.org/10.1080/17482620801945805>
- Shiffman, J. (2014). Knowledge, moral claims and the exercise of power in global health. *International Journal of Health Policy and Management*, 3(6), 297–299. <https://doi.org/10.15171/ijhpm.2014.120>

- Shore, C., & Wright, S. (Eds.). (1997). *Anthropology of policy: critical perspectives on governance and power*. London: Routledge.
- Sikweyiya, Y., & Jewkes, R. (2012). Perceptions and Experiences of Research Participants on Gender-Based Violence Community Based Survey: Implications for Ethical Guidelines. *PLoS ONE*, 7(4), e35495. <https://doi.org/10.1371/journal.pone.0035495>
- Smith, L. T. (1999). *Decolonizing methodologies: research and indigenous peoples*. New York: Zed Books.
- Strike, C., Guta, A., de Prinse, K., Switzer, S., & Carusone, S. C. (2016). Opportunities, challenges and ethical issues associated with conducting community-based participatory research in a hospital setting. *Research Ethics*. <https://doi.org/10.1177/1747016115626496>
- Umubyeyi, A., Persson, M., Mogren, I., & Krantz, G. (2016). Gender Inequality Prevents Abused Women from Seeking Care Despite Protection Given in Gender-Based Violence Legislation: A Qualitative Study from Rwanda. *PLOS ONE*, 11(5), e0154540. <https://doi.org/10.1371/journal.pone.0154540>
- UN Women. (2012). One-stop centres (OSC). Retrieved 8 March 2016, from <http://www.endvawnow.org/en/articles/1564-one-stop-centres-osc.html?next=1565>
- VanderEnde, K. E., Yount, K. M., Dynes, M. M., & Sibley, L. M. (2012). Community-level correlates of intimate partner violence against women globally: A systematic review. *Social Science & Medicine*, 75(7), 1143–1155. <https://doi.org/10.1016/j.socscimed.2012.05.027>
- Walsh, J., Spangaro, J., & Soldatic, K. (2015). Global understandings of domestic violence. *Nursing & Health Sciences*, 17(1), 1–4. <https://doi.org/10.1111/nhs.12197>
- Weldon, S. L., & Htun, M. (2013). Feminist mobilisation and progressive policy change: why governments take action to combat violence against women. *Gender & Development*, 21(2), 231–247. <https://doi.org/10.1080/13552074.2013.802158>

- Wilson, K. (2013). Agency as 'Smart Economics': Neoliberalism, Gender and Development. In S. Madhok, A. Phillips, & K. Wilson, *Gender, agency and coercion* (pp. 84–101). Basingstoke: Palgrave Macmillan.
- World Health Organisation. (2001). *Putting women first: Ethical and safety recommendations for research on domestic violence against women* (p. 32). Geneva, Switzerland: Department of Gender and Women's Health. Retrieved from http://www.who.int/gender-equity-rights/knowledge/who_fch_gwh_01.1/en/
- World Health Organisation, London School of Hygiene and Tropical Medicine, & South African Medical Research Council. (2013). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence* (No. 9789241564625) (p. 51). Geneva, Switzerland: World Health Organisation. Retrieved from <http://www.who.int/reproductivehealth/publications/violence/9789241564625/en/>
- Yin, R. K. (2013). *Case Study Research: Design and Methods*. Thousand Oaks, CA: SAGE Publications.