**Study protocol: Retrospective data analysis**

**Title:** Understanding the characteristics of survivors of sexual and gender-based violence and their utilisation of services in Cox’s Bazar (CXB), Bangladesh; A 7-year retrospective analysis of SGBV data from MSF CXB projects.

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# List of abbreviations

BKL Balukhali

CXB Cox’s Bazar

DHIS2 District Health Information System 2

ERB Ethical Review Board

FDMN Foreign Displaced Myanmar National

GBV Gender-based violence

HIV Human Immunodeficiency Virus

IPV Intimate partner violence

KTP Kutupalong

MoWCA Ministry of Women and Children’s Affairs

MSF-OCA Médecins Sans Frontières- Operational Centre Amsterdam

MedCo Medical Coordinator

MTL Medical Team Leader

PEP Post Exposure Prophylaxis

RRRC Office of the Refugee Relief and Repatriation Commissioner

SGBV Sexual and gender-based violence

STI Sexually transmitted infection

SV Sexual violence

UMS Unchiprang Make Shift

UNHCR United Nations High Commissioner for Refugees

WHO World Health Organization

# Key Terms and definitions

|  |  |  |
| --- | --- | --- |
| **Term** | **Definition** | **Notes** |
| **Sexual and Gender Based Violence** | Any harmful act that is perpetrated against one person’s will and that is based on socially ascribed (gender) differences between males and females. It includes acts that inflict physical, mental, or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty, whether occurring in public or in private life. | UNHCR definition |
| **Sexual violence** | Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. |  |
| **Intimate partner violence** | Any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship, including physical and sexual violence, emotional (psychological) abuse and controlling behaviours. |  |
| **Survivor** | A survivor is defined as an individual who has experienced SV or any type of IPV. |  |

# Executive Summary

The purpose of this analysis is to describe the trends in sexual and gender-based violence (SGBV) care utilization and the characteristics of SGBV survivors presenting to Médecins Sans Frontières (MSF) OCA clinics in Cox’s Bazar, Bangladesh between 2017 to 2023. This descriptive analysis will help to inform programmatic approaches as well as advocacy tools. Furthermore, the findings will provide useful data to triangulate with other knowledge generated from recent studies and assessments on survivor needs and care in the region. The results will be shared with other stakeholders involved in SGBV care and referral pathways to MSF to highlight the identified gaps in access and care provision to survivors. The analysis will also guide future operational research needs to better understand and improve access and the quality of care for all survivors in the area.

# Background

SGBV is a global issue and is often referred to as one of the most prevalent human rights violations in the world (1). Women and girls are at the highest risk of SGBV, with an estimated 1 in 3 females in their lifetime experiencing SGBV (2). SGBV causes long-term impacts on the physical, psychological, and social welfare of the survivor, their family and community (3). Effects of such violence are further exacerbated by the inadequacy, and lack of access to quality and applicable healthcare and psychological support, as well as lack of proper security, and access to social welfare and justice systems (3). Additionally, although the true incidence of SGBV among is uncertain (4), it is known that war, displacement, violence and trauma are associated with an increased rate of SGBV.

From August 2017 until May 2023, over 960,000 Rohingya have fled violence from Myanmar to Bangladesh, representing one of the greatest and most challenging humanitarians’ crises globally (5). Since resettling in Cox’s Bazar, Bangladesh, these refugee populations (also referred to as Forcibly Displaced Myanmar Nationals [FDMN]), have had limited access to healthcare, education, basic sanitation, and opportunities for employment. There have been growing concerns of instability in the Cox’s Bazar mega camp, carrying potential negative consequences on mental health and violence within these vulnerable populations with traumatic and unstable pasts.

MSF has been providing care to survivors of SGBV in Cox’s Bazar since the influx of FDMN in 2017 and is therefore uniquely placed to characterize the burden of SGBV within this population over time. Also, by providing equal care services to FDMN and host populations, this represents a further opportunity to compare the differences in SGBV care utilization between these populations, including potential effects of confinement and trauma related to the plight from Myanmar.

# Study rationale

The challenging living conditions in which Rohingya are subjected to overcrowded camps, with limited economic opportunities and reliance on humanitarian assistance predisposes women and girls to a greater risk of sexual violence, sexual exploitation and abuse, intimate partner violence, and early and forced marriage. However, little is known about the survivor’s characteristics for the Rohingya population in Bangladesh. By describing the trends in SGBV care utilization and characteristics of SGBV survivors over the past seven years, this retrospective data analysis can inform operational strategies for improved access to SGBV care services and targeted SGBV services for this population.

This analysis will provide an overview of all SGBV care utilization and the characteristics of survivors receiving care from MSF clinics in Cox’s Bazar between January 2017 and May 2023.

# Research Objectives

*Primary objective*

To describe the utilization of SGBV care services and characteristics of SGBV survivors over time provided by MSF-OCA facilities in Cox’s Bazar, Bangladesh, for the period between January 2017 and May 2023.

*Secondary objective*

To assess potential independent risk factors for delays to care following SGBV events between 2017 and 2023.

# Methods

*Study design*

This is a retrospective cohort study using routinely collected data. The data collection took place in the Kutupalong (KTP), Balukhali (BKL) and Unchiprang Make Shift (UMS) facilities in Cox’s Bazar, Bangladesh. This analysis will describe healthcare utilization and population characteristics of all SGBV survivors in MSF-OCA clinics between January 2017 and May 2023.

*Study setting and study sites*

In Cox’s Bazar, MSF-OCA runs three clinics to provide medical care and psychological support to survivors of SGBV among FDMN and host community survivors. The clinics in Cox’s Bazar have been providing care for survivors since 2017 and have collected data on survivor’s demographics, episodes of sexual violence, medical care and psychological support, medical legal certificates, referral pathway and referrals to multi-disciplinary services. More recently, data on barriers to accessing care has been collected since 2021. The longest running clinic is KTP, followed shortly by BKL. UMS only started providing SGBV services in 2022. Geographically, KTP is situated on the north east corner of the mega camp, and UMS is situated in camp 22, which is approximately 15km south of the mega camp (**Figure 1**). In addition, MSF-OCA has SGBV-trained outreach teams who work to increase SGBV awareness and referrals in the community. These teams have catchment areas surrounding each health facility, also shown in **Figure 1**.

*Study population*

All SGBV survivors receiving care from MSF KTP, BKL and UMS clinics from January 2017 to May 2023 will be included in this analysis.

*Data sources and data tools*

Routine data on SGBV consultations was collected on standardised paper-based clinical forms by trained staff during the consultation. Following the consultation, data was entered manually into the SGBV dataset in two sources at different points throughout the study period:

* **1 January 2017 - 5 May 2019**: An excel data collection tool.
* **5 May 2019 - 31 May 2023**: MSF-OCA’s routine health information system also known as District Health Information Software 2 (DHIS2).

Prior to analysis, the two data sources will be merged into a standardized dataset using R software.

**Figure 1.** Geographical location of MSF-OCA clinics and outreach catchment areas



To allow for the analysis of important covariates of interest, the two databases will be combined and the number of individual-level consultations at MSF health facilities (KTP, BKL, UMS) will be analyzed according to standard definitions for the following variables:, survivors’ age (<15, 15-19, 20-24, 25-34, 35-44, 45-54, 55-64 and ≥65 years), survivors sex (male, female or unknown), survivors origin (FDMN, host or unknown), primary type of violence experienced by survivors (IPV, rape, other sexual violence, emotional violence or other violence), delay from SGBV event to care consultation (<72h, 72-120h,>120h or uncertain), safe abortion care provided (yes/no), Medical care provision to rape survivors (received one or more of the following care services: tetanus vaccination, HIV test, PEP, STI medication or a pregnancy test) and origin/camp of residence. Other covariates from more recent years (2019-2023) will also be available for analysis, including age and relationship of the perpetrators, location of the assault, safe identification, referral pathways and mental health outcomes (main symptom, prescription of medication and/or sub-code of mental health outcome). Where data is available, we will also describe the associations between SGBV consultations and mental health follow-up visits and/or progression and severity of symptom complaints. In addition, if the data allows, we will aim to identify and describe child marriage, defined as marriage under 18 years. More details on standardized variables from the two different data sources are provided in **annex I**.

*Statistical analysis*

For descriptive analyses, categorical variables will be displayed as frequency and proportions and continuous variables will be displayed as mean (SD) or median (IQR) values, where appropriate. P-values will be assessed using Chi-square test or Fishers exact test. In addition, to describe associations between potential independent risk factors for delays to seeking care, defined as presenting to care services >72 hours following the SGBV event, Odds Ratios and 95% confidence intervals (CI) will be estimated using logistic regression analysis. Models will be adjusted for important confounders such as age and sex. In addition, models will be stratified by age, MSF facility, type of SGBV event, survivor nationality (Host/FDMN) and year of consultation. Where possibly, stratified analysis will also include adjustment for potential confounders. All analyses will be conducted using R.

# Data management and storage

Data will be managed and shared in accordance with MSF’s Health Data Protection Policy and General Data Protection Regulation (GDPR). All data will be protected from improper disclosure, use and modifications. The data will be stored on MSF’s DHIS2 server. They will be downloaded for the purpose of the analysis and stored and processed on the local project level operational research SharePoint folder. Once analyses are complete, all data will be archived according to MSF policy and destroyed five years after the end of the analysis.

*Data quality control*

For DHIS2 data, the MTL and MedCo will have routine oversight of the quality of the data collected as part of the routine data collection. The PI will do a quality check of the data prior to starting the full analysis including a review of the amount of missing data. Data standardization and merging will be cross-checked by the data manager and the study analyst.

# Potential Limitations

*Generalisability*

As this analysis includes a specific population in a unique context of a confined refugee camp, the findings may not be widely generalizable to all other settings. Furthermore, restrictions to access to care changed considerably over time, which may obscure or alter the trends observed in the analysis. However, we will take steps to counteract this in the analysis by stratifying by MSF facility, population (Host/FDMN) and time period of consultation (year) to identify any potential events that might bias the interpretation of the analysis. We will also produce an updated timeline of potential biasing events, such as the event table included in **annex II.**

*Incomplete or inconsistent data between data sources*

This is a retrospective analysis of existing data, meaning that it is limited by the quality and completeness of data that was collected in the past. As a result, some early years had slightly different data collection methods, which are not completely compatible with data collected during more recent years. To mitigate this, prior to combining and standardizing datasets, we will analyse data separately by data source, to observe any potential biases introduced by inconsistent data collection methods.

*Lack of follow-up data*

The SGBV data tools do not have separate follow-up entry records. These records are taken manually and not entered in the DHIS2 tool, which prevents the analysis of follow-up cases and only allows new cases to be included in the analysis.

# Ethical Considerations

. As these analyses will be carried out on historical data, they are exempt from the MSF Ethics Committee process but will be reviewed by the MSF OCA research committee. In addition, the protocol will also be presented to the independent ERB of Cox’s Civil Surgeon to ensure the necessary resources and permissions have been obtained locally. All procedures will be in line with MSF ethics protocols and established procedures.

*Expected risks*

As all data are retrospective in nature and data are fully anonymised, we do not anticipate any potential harms or risks to individuals or the community. However, we are cognizant of the fact that risk may depend on who the perpetrators and survivors are and how the findings are shared. For this reason, dissemination will be carefully planned by the study coordinator, who is a subject matter expert in this area and has experience balancing the risks and benefits of disseminating this type of scientific finding among similar vulnerable populations previously.

*Potential Benefits*

The findings of this analysis will provide essential data for the MSF team in Cox’s Bazar and will support the project in its goal to increase access to care by providing a better understanding of the characteristics of SGBV survivors, their access to care, experiences of violence, utilization of medical care and interventions, and referrals to multidisciplinary services for additional support. This information will inform program approaches and advocacy efforts to address SGBV in Cox’s Bazar and can be used to inform future operational research in this project. Additionally, it will provide the team with a better understanding of the population they are serving and therefore, help them to tailor their services accordingly.

*Confidentiality, privacy and anonymity*

This is a retrospective analysis of existing data; all data have been collected anonymously. The data will be presented in aggregated format ony, and no individual-level data will be reported. All individual-level data will be kept confidential and will only be accessible to authorized personnel involved in the analysis. The MSF policy on data protection will be strictly followed and the team will ensure that the data are handled in a confidential and respectful manner, taking into account the rights and dignity of the participants and community. It is important to note that the data will be handled only by the MSF team and will not be shared with any external parties or organizations without the written consent of the MSF management. In addition, the data used for the analysis will not include any directly identifiable information – it will contain a clinic record identifier, but it will not contain person name, contact details, address or national identification number.

*Consent*

No consent for individuals whose data will be used in this analysis will be sought. This project will involve a retrospective analysis of routinely collected operational data which does not contain personally identifiable information in the electronic databases. To seek consent would require retrieval of the securely stored paper case files that do contain identifiable information and then contacting those individuals to seek consent, both steps which would create additional risk and potential harm for participants and are therefore not considered justified.

# Institutional collaboration

As co-investigators, Cox’s Bazar Civil Surgeon and Refugee Relief and Repatriation Commission (RRRC) will provide technical support to the principal investigator for interpretation of analysis and report write up.

# Funding/resources

No additional costs are foreseen for this as the analysis and report writing will be done by the project with HQ support remotely. This project will be funded by MSF-OCA. Publication costs for open access publication (between 500-2000 Euros depending on the journal) will be covered by OCA.

# Study timeline

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Study week** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **Month/Week** | **Jul****W4** | **Aug****W1** | **Aug****W2** | **Aug****W3** | **Aug****W4** | **Sept** **W1** | **Sept** **W2** | **Sept** **W3** | **Sept** **W4** | **Oct****W1** |
| Protocol development |  |  |  |  |  |  |  |  |  |  |
| MSF RC approval |  |  |  |  |  |  |  |  |  |  |
| Data analysis |  |  |  |  |  |  |  |  |  |  |
| Report  |  |  |  |  |  |  |  |  |  |  |
| MSF Sci Days |  |  |  |  |  |  |  |  |  |  |
| Other outputs |  |  |  |  |  |  |  |  |  |  |

# Dissemination of findings

A report will be drafted for sharing within the mission and relevant counterparts at MSF headquarters. This will be used as a tool for advocacy and communication with key stake holders. Findings/lessons learned would be extended for further discussions (e.g. MSF organized round table discussion / Symposia) among key SGBV actors working with this population.

The above will serve as MSF’s catalyst for change role for SGBV care and improving access and make MSF visible at national level among MoWCA, MOHFW and other actors providing care for survivors of SV and IPV.

The content of the dissemination plan will depend on the findings but will include at least the following:

* MSF – project, mission, headquarters: MSF report will be disseminated and presentations done at project, country and HQ levels (e.g., MSF Scientific Days Asia)
* Participants: Data will be displayed on posters in the treatment rooms of the clinic and receive feedback from patients.
* Community: If feasible, round table discussions with key stakeholders including community representatives will be organised to discuss the recommendations and ways forward.
* In country partners (including MoH): RRRC, Cox’s Bazar Civil Surgeon, MoWCA, MoHFW, UNFPA, ICDDR,B, Local legal/Judicial actors.

International dissemination (including WHO and other agencies, scientific publication): scientific publication to relevant journal planned after data analysis. Including submission of abstract for oral presentation in national and international forums.

# References

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3. Rayhan, Istihak & Akter, Khaleda. (2021). Prevalence and associated factors of intimate partner violence (IPV) against women in Bangladesh amid COVID-19 pandemic. Heliyon. 7. e06619. 10.1016/j.heliyon.2021.e06619
4. UNFPA. Managing Gender-based Violence Programmes in Emergencies. Available: <https://extranet.unfpa.org/Apps/GBVinEmergencies/index.html>
5. United Nations High Commissioner for Refugees (UNHCR). (4 May 2023). Bangladesh. Retrieved from <https://reporting.unhcr.org/operational/operations/bangladesh#toc-populations> [Accessed 25th July 2023]

|  |  |
| --- | --- |
| **Variable** | **Valid values** |
| **All years (DHIS2 + Excel)** |  |
| age\_group | <15, 15-19, 20-24, 25-34, 35-44, 45-54, 55-64 and ≥65 years |
| host\_status | Host community, FDMN, unknown |
| Hours\_btw\_assault\_presentation | [1] <72h; [2] 72-120h; [3] >120h; [4] uncertain  |
| sgbv\_type | 1 = rape, 2 = other sexual violence, 3 = IPV, 4= emotional, 5 =other |
| SGBV\_SAC\_provided | 0 = no, 1 = yes |
| gender | f = female ,m = male |
| date\_of\_visit | [datetime variable] |
| case\_number | [unique ID variable] |
| clinic | KTP, BKL, UMS |
| data\_source | DHIS2, excel\_tool |
| year | 2017, 2018, 2019, 2020, 2021, 2022, 2023 |
| patient\_origin | [Camp number] |
| HIV\_test\_provided | 0 = no, 1 = yes |
| Tetanus\_dose\_provided | 0 = no, 1 = yes |
| PEP\_provided | 0 = no, 1 = yes |
| Preg\_test\_provided | 0 = no, 1 = yes |
| STI\_prophylaxis | 0 = no, 1 = yes |
|  |  |
| **Post-2019 (DHIS2 only)** |  |
| Identified through safe identification | 0 = no, 1 = yes |
| Mental health: Main presenting symptom | 1 Age related problems ;2 Physical complaints; 3 Problems related with Social functioning; 4 Family related problem(s); 5 Economic functioning6 Behaviour related symptoms; 7 Anxiety related symptoms8 Mood related problems; 9 Loss/Mourning; 10 Other Serious MH Condition(s); 11 Neuropsychiatric related symptoms |
| Knowledge of services | Individual interaction; Community event; Poster/flyer; Multimedia; Training / workshop; Other; Social media; Hotline/ helpline |
| Referral pathway | Self; Family (Parents, Spouse/Sibling); Neighbours/ friends; MSF health care facility; Other health facility (not MSF); Authorities (Police, etc.); Other humanitarian actor or NGO; Helpline/toll free number; Teacher/ school; Community; Health promotion staff/ Community health worker; MSF supported community based care model; Other |
| Location of assault | Free text field |
| Survivor intends to report to police | Yes reported; I Intends to report; N Chooses not to report; D UndecidedU Unspecified/ undisclosed |
| **Post- July 2021 (DHIS2 only)** |  |
| Barriers to accessing care | Lack of information about SV and where services are availableLack of community/ family supportLong distance to health care serviceCost of transportationFear of mandatory reporting to policeInsecurity (conflict, violence)Fear of gossip/ stigmatization or other social consequencesThreats from perpetratorOther difficulties accessing careSpecify other difficulties accessing care |
|  |  |

**Annex I.** Key variables and harmonization/standardization of valid values across data sources

|  |  |
| --- | --- |
| **Key dates** | **Description of event** |
| 25th November 2017 | BKL opened SGBV clinic |
| 2018 (unknown date) | Outreach team BKL major scale-up  |
| 5th-11th May 2019 | Switched to DHIS2 (complete switch- no duplication) |
| July – August 2021 | Data collection on barriers to care started  |
| March 2021 | Major camp fire damaged BKL clinic and disrupted services |
| 1st January 2022 | UMS opened SGBV clinic |
| February 2022 | Tuk-tuk’s banned in the Rohingya refugee camps |
| December 2022 | Outreach team implemented a CBC approach |
|  |  |

**Annex II.** Key dates of events occurring throughout the proposed study period